In the matter of the *Commissions of Inquiry Act 1950*
Commissions of Inquiry Order (No.4) 2015
Barrett Adolescent Centre Commission of Inquiry

AFFIDAVIT

Judith Krause of [redacted] in the State of Queensland, Divisional Director, states on oath:

I have been provided with a Requirement to Give Further Information in a Supplementary Written Statement dated 24 December 2015.

In this affidavit, former patients of the Barrett Adolescent Centre will be referred to using the following codes:

(a) [redacted]
(b)
(c)

1. **The Commission understands that it was the Barrett Adolescent Strategy Planning Group (convened by West Moreton Hospital and Health Service (WMHSS)), which established the Expert Clinical Reference Group (ECRG). Please confirm whether the Committee referred to in paragraph 9 of your statement is the Barrett Adolescent Strategy Planning Group.**

I cannot confirm the name of the meeting, I only recall it was held at the Mental Health Alcohol and Other Drugs Branch at Butterfield Street.

2. **The Commission understands from paragraphs 11 and 17-20 of your statement that you attended a Barrett Adolescent Strategy Planning Group on 23 July 2013. Please confirm:**

[redacted] [redacted]
Deponent A J.P., C.Dec., Solicitor

AFFIDAVIT

On behalf of the State of Queensland

Crown Solicitor
11th Floor, State Law Building
50 Ann Street
BRISBANE QLD 4000
TEL: [redacted]
Email: [redacted]

(a) **Was this the first Barrett Adolescent Strategy Planning Group meeting that you had attended?**

Yes, as far as I am aware (refer to response to question 1).

3. **With reference to paragraph 12 of your statement, please explain how you became aware of the following reasons supporting the closure of the BAC, and the basis for, or source of these reasons:**

(a) **That there had been several reviews of the BAC which identified that the model of care was not contemporary and lacked appropriate governance structures. In particular, please provide details of the reviews including when the reviews were conducted, by whom and the basis for findings of the reviews regarding models of care and governance structures. Please also explain the extent, if any, of your involvement in the reviews.**

I had access to a hard copy of the confidential 2009 review to assist with the review of the Model of Service Delivery in early 2010, I cannot recall who gave me a copy of this document. After email communication with Professor Crompton I was advised to summarise the key points of this review and circulate them to the expert group reviewing the Model of Service Delivery as the review had not yet been circulated to relevant West Moreton staff. The 2009 review was undertaken by Dr Garry Walter, Psychiatrist and Director of Rivendell Mental Health facility, Mr Martin Baker, Psychologist from Rivendell Mental Health facility and Ms Michelle George, Nurse Unit Manager, Mater Child and Youth Mental Health Service.

The 2009 review (Exhibit X to my original affidavit) had summarised the previous reviews of the Barrett Adolescent Centre, including one conducted by Dr Brett McDermott in 2003 and the Australian Council of Healthcare Standards recommendations from the 2008 review. The review clearly articulated that there were a range of challenges with the governance structures of the Barrett Adolescent Centre. These included, that:

(a) there did not appear to be clear lines of responsibility and accountability to senior levels within Queensland Health for the overall quality of the clinical care at the Barrett Adolescent Centre;
(b) there did not appear to be clear policies that were integrated with wider policies aimed at managing risk;

(c) there did not appear to be procedures for all professional groups to identify and remedy poor performance; and

(d) there appeared to be a lack of quality improvement activities and no use of clinical guidelines/evidence based practices; continuing performance development, clinical audits and effective monitoring of clinical care deficiencies, no system for the management of complaints, poor evidence of research and development or systems in place to manage the collection and use of patient information.

The 2009 review further articulated that there was an apparent lack of evidence based treatment applied in the unit and recommended that a model of care should be formulated based on the currently available evidence and nature of clients presenting to the service.

I had no involvement in any of the reviews of the Barrett Adolescent Centre. I believe that the 2003 McDermott Review and the Australian Council of Healthcare Standards 2008 review have been provided to the Commission. I do not have copies in my possession.

(b) That the Park Centre for Mental Health (the Park) was expanding its adult only forensic footprint and that this was deemed an inappropriate environment for 13 to 18 year old adolescent mental health patients.

I believe this was communicated by West Moreton Hospital and Health Service (West Moreton) in a Project Plan provided to us for the purposes of establishing the Adolescent Mental Health Extended Treatment Initiative (AMHETI). **Exhibit A** to this affidavit is a copy of this Project Plan.

(c) That the BAC was an isolated facility and not integrated or properly aligned with any CYMHS. In particular, why was the BAC isolated and why was it not aligned with any CYMHS?

The 2009 review (Exhibit X to my original affidavit) articulated that the role of the Barrett Adolescent Centre in both The Park hospital and the Queensland Plan for Mental Health 2007 – 2017 was unclear. The Barrett Adolescent Centre did not feature in The Park hospital organisational charts and its role was not articulated in any State-wide Plan for Child and Youth Mental Health Services. The Barrett Adolescent Centre was the only adolescent service situated within the Park Centre for Mental Health which was an adult mental health facility.

The 2009 review further articulated that the Barrett Adolescent Centre did not appear to have a framework which aligned with state legislation, Queensland Health policy directives, nor local protocols governing the credentialing and defining the scope of clinical practice of medical, nursing and allied health practitioners working within the unit.

Furthermore the review noted Barrett Adolescent Centre did not have a defined Model of Service Delivery. My understanding is that the Mental Health Alcohol and Other Drugs Branch Model of Service delivery development was designed to enhance integration of service responses with clearly defined admission, treatment and discharge criterion and clearly outlining pathways for clients transitioning into, between and out of Queensland Health's public child and youth mental health facilities.

The 2009 review recommended that a Model of Service delivery for the Barrett Adolescent Centre be developed. I do not have any further information on this topic and would refer you to West Moreton who had clinical and corporate governance for the Barrett Adolescent Centre at the relevant time.

(d) That in the past there was a lack of services to discharge these young people to. In particular, please explain what is meant by "in the past" and how a lack of services to discharge patients to supports the decision to close the BAC? In your opinion, was there also a lack of services to discharge BAC patients to at the time the closure decision was made, during the transitional period and in the months following the closure of the BAC in January 2014?

In the past relates to the timeframe prior to that when the range of services were developed within the continuum of care for Child and Youth Mental Health Services, i.e. pre 2010. Examples of enhanced Child and Youth Mental Health Services post 2010 included the establishment of new inpatient and day program services in Toowoomba and Townsville.

I have had informal discussions with Dr Trevor Sadler, former Clinical Director of the Barrett Adolescent Centre, during the Model of Service Delivery review in 2010 where he stated that there were limited services to discharge young people to that could not return to the family home.

In my opinion and to the best of my knowledge the clients that were transitioned out of the Barrett Adolescent Centre when it finally closed were appropriately placed within either adult mental health services or local Child and Youth Mental Health Services or other appropriate services.

4. With reference to paragraph 12(c) of your statement, please confirm whether you are referring to the 2008 or 2012 Australian Council of Healthcare Standards review.

The reference was to the 2008 Australian Council of Healthcare Standards review as summarised in the 2009 Walter, Baker and George review.

5. With reference to paragraph 12(e) of your statement, please provide the following details:

(a) What was the name of the facility management project group which you sat on in relation to the "Redlands project"?

The Mental Health Capital Works Program; Facility Project Team Meeting – (Redland Project).

(b) When was the facility management project group first convened and by whom?

The group appeared to commence in August 2009. My predecessor Ms Denisse Best was originally a member of the group and I commenced membership in January 2010. The Chair of the group was Professor David Crompton, the Clinical Director of Mental Health Services, Metro South Hospital and Health Service. **Exhibit B** to this affidavit is a copy of the agenda of the meeting on 20 August 2009.

(c) How was the funding for the "Redlands project" redirected?

I do not know how the funding was re-directed.

6. With reference to paragraph 12(f) of your statement, confirm that the review of model of service delivery referred to is the review of the Queensland Health Statewide Model of Service Delivery for the Adolescent Treatment and Rehabilitation Inpatient Service (formerly known as the Barrett Adolescent

Centre) (MOSD BAC). If so, explain the ways in which discharge planning was identified as problematic during the review of the MOSD BAC in 2010.

In the first part of the question above I cannot confirm that the reference is to the Queensland Health Statewide Model of Service Delivery for the Adolescent Treatment and Rehabilitation Inpatient Service. The review of the Model of Service Delivery I undertook in 2010, was linked to the broader Mental Health Alcohol and Other Drugs Branch initiative, requiring all mental health services to have a defined model of service in a consistent format.

As aforementioned in response to 3(d), I had discussions with Dr Trevor Sadler as part of the Model of Service Delivery review in 2010 where he stated that there were limited services to discharge young people to where those young people could not return to their family home. That had led to longer lengths of stay, some young people had been in the Barrett Adolescent Centre for over three years. There were limited day programs at the time (one only at the Mater Child and Youth Mental Health Service) which was only accessible to young people in the South Brisbane catchment.

I believe that in 2010 there was very limited youth accommodation available for adolescents under 18 years of age and no supported youth accommodation that was suitable for young people with mental health issues. There were no assertive outreach models or acute response models of care within Child and Youth Mental Health Services at that time. According to anecdotal information provided informally to the group by Dr Sadler this had significantly limited options for discharge for some Barrett Adolescent Centre clients.

7. **The Commission understands from paragraph 29 of your statement that the State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy Steering Committee (SWAETRIS Steering Committee) developed new services by reviewing existing literature on adolescent extended treatment and rehabilitation. Identify which literature was reviewed by the SWAETRIS Steering Committee when developing new services.**

Paragraph 29 describes the action that was taken by the Project Team (myself, Dr Stephen Stathis and Ms Ingrid Adamson). The Steering Committee referred to above, did not undertake these activities but rather reviewed the outputs from these activities which were later endorsed as the AMHETI continuum of care. I believe that this literature has previously been provided to the Commission.

8. **The Commission understands that you, Dr Stephen Stathis and Ms Ingrid Adamson met with Sandra Radovini on 10 December 2013 to discuss the proposed model of care for adolescent mental health services in Queensland. Please provide details of the discussions which occurred at this meeting and copies of any notes that were made.**

Ms Ingrid Adamson made notes during this meeting. It is my understanding these were the only notes taken. **Exhibit C** to this affidavit is a copy of the notes made by Ms Adamson.

Ms Radovini also provided us with information about the Intensive Mobile Youth Outreach Service (IMYOS). **Exhibit D** to this affidavit is a copy of this information sheet.

9. **With reference to exhibit L to your statement, please identify to the best of your knowledge and recollection, the literature listed under the heading "Intent" which Sandra Radovini was going to share, and which was associated with the models of care implemented in Victoria for adolescents with complex and multiple mental health problems.**

Ms Radovini's presentation cited the following references:

- Schley C, Radovini A. [2007] Engaging the Unengageable: Assertive Outreach with High- Risk Youth. *Australian and New Zealand Journal of Psychiatry,*V. 41 [supplement 2], pp A305
- Schley C, Ryall V, Crothers L, Radovini A, Fletcher K, Marriage K, Nudds S, Groufsky C and Yuen H P (2008) Early intervention with difficult to engage, 'high-risk' youth: evaluating an intensive outreach approach in youth mental health. *Early Intervention in Psychiatry Journal, 2, pp, 195-200*
- Schley, C, Radovini A, Halperin S, Fletcher K (2011) Intensive outreach in youth mental health: description of a service model for young people who are difficult to engage and "high-risk." *Children & Youth Services Review, 33(a), 1506-1514*
- Schley C, Yuen K, Fletcher K, Radovini A (2012) Does engagement with an intensive out reach service predict better treatment outcomes in "high-risk" youth? Early Intervention in Psychiatry Journal, 6, pp. 176-184

I do not have copies of these papers in my possession. I understand that litrature regarding the Victorian IMYOS has been provided to the Commission.

10. With reference to exhibit K to your statement:

(a) The minutes of the SWAETRIS Steering Committee meeting held on 9 October 2013 (co-chaired by you) state that "the WG1 forum did raise the need for a multidisciplinary statewide panel to assess consumer needs to look at a range of options for consumers in the area. JK raised whether this fits in with Complex Care Coordination, being a similar concept". Explain the concept of "complex care coordination" and how this fits in with the establishment of a multi-disciplinary state-wide panel to assess consumer needs and options, as proposed by one of the SWAETRIS Steering Committee working groups.

The concept of Complex Care Co-ordination provides a client centred approach to co-ordination of services to best meet the needs of the young person. This may be drawing from a range of available community support services across Government, non-Government and the primary health care sector. My understanding is that this is a similar concept to the minuted Working Group 1 requirement for a state-wide panel to assess and co-ordinate the needs of the individual clients that the Clinical Care Panel were reviewing. I note that the main difference is the state-wide panel referred to in Working Group 1 is to assess suitability of referrals whereas complex care co-ordination is more to determine seamless and co-ordinated treatment, generally via a lead complex care co-ordinator.

(b) The minutes of the SWAETRIS Steering Committee meeting held on 4 November 2013 (co-chaired by you) refer to a decision that a proposed Financial Workforce Planning Working Group (the FWPWG) which was to be established by the SWAETRIS Steering Committee was no longer required. These minutes also state that there was lack of agreement between WMHHS and CHQHHS regarding the purpose and terms of reference for the FWPWG. Please elaborate on the reasons for the decision that the FWPWG was no longer required, including the basis for the lack of agreement between WMHHS and CHWHHS regarding the purpose and terms of reference for the FWPWG.

I understand from a review of the Statewide Adolescent Extended Treatment Rehabilitation Financial and Workforce Planning Transition Working Group minutes dated 22 October 2013, that the Workforce management of the Barrett Adolescent Centre was deemed to be the sole responsibility of West Moreton by Ms Sharon Kelly, Executive Director, Mental Health, West Morton and not within the scope of the Working Group. The re-allocation of funds was to be managed via the Department of Health service level agreement variation and amendment window process and there was a limited role for the working group in relation to this and relevant financial elements of the Working Group function could be mobilised on an 'as needs' basis rather than have an established group.

I understand the lack of agreement referred to was in relation to the role of the group. I do not have further information on this as I did not attend this working group and the minutes do not articulate this in any further depth. **Exhibit E** to this affidavit are copies of the minutes of the Statewide Adolescent Extended Treatment Rehabilitation Financial and Workforce Planning Transition Working Group meeting on 22 October 2013 and the email ceasing this group dated 21 November 2013 at 9:13am.

(c) **The minutes of the SWAETRIS Steering Committee meeting held on 4 November 2013 (co-chaired by you) refer to you and Dr Stephen Stathis visiting the Walker and Rivendell Units in New South Wales and state that "RH raised the question: what are the resource differences for NSW families compared with QLD? JK stated further information could be collected on this". Please provide further information about your visit to the Walker and Rivendell Units and explain what, if any, further information was collected on the resource differences for New South Wales families compared with Queensland. Please provide copies of any notes you made during your visit and the Site Visit Report which the Commission understands was circulated to the SWAETRIS Steering Committee following the meeting on 4 November 2013.**

No additional formal information was able to be collected on the resource differences between NSW and Queensland. **Exhibit F** to this affidavit is a copy of the Site Report which summarises the visits to the Walker and Rivendell units and articulates the availability of resources such as day programs and residential small group homes within NSW and the strong consultation liaison model supporting the paediatric services within the state. This

information was given as feedback to the Steering Committee as outlined in 3.1 of the minutes dated 18 November 2013.

(d) **The minutes of the SWAETRIS Steering Committee meeting held on 18 November 2013 (co-chaired by you) refer to a "transition plan of services" developed by WMHHS, which would "retain governance for these services until such time as consumers and new service options are ready for transition to occur". Explain, to the best of your knowledge and understanding, what happened with this plan, and how Children's Health Queensland Hospital and Health Service (CHQHHS) worked with WMHHS to ensure continuity of service delivery the during this time.**

The transition plan of services was managed by West Moreton, in collaboration with Aftercare, and involved a holiday activity program for current Barrett Adolescent Centre consumers and establishment of a Resi Rehab. The governance for the Resi Rehab was later transferred across to Children's Health Queensland Hospital and Health Service (Children's Health Queensland) in February 2014. My understanding is that the pilot day program and pilot community outreach team located within West Moreton referred to in the abovementioned Steering Committee minutes were not progressed. I do not have any further information about these programs. **Exhibit G** to this affidavit is a copy of the West Moreton Transitional Services Options Overview.

(e) **The Commission understands that at the SWAETRIS Steering Committee meeting on 28 January 2014, the name of the SWAETRIS Steering Committee was changed to the Adolescent Mental Health Extended Treatment Initiative Steering Committee (AMHETI Steering Committee). The minutes of the AMHETI Steering Committee meeting held on 28 January 2014 (co-chaired by you) state that the assessment and waiting lists for BAC patients were to be handed over to the CHQHHS. However, the Commission understands that this did not occur. Explain the basis for this proposal and the reason why it did not occur.**

The Steering Committee Minutes dated 10 February 2014, reflect that Dr Stephen Stathis and Dr Leanne Geppert conducted a review of the Assessment and Wait Lists, together with Dr Anne Brennan, Acting Clinical Director, Barrett Adolescent Centre. It also noted that there are a number of people that no longer required follow up. There were others that Dr Brennan

would be following up. I was not involved in this process. For more information refer to Dr Stephen Stathis, Dr Leanne Geppert or Dr Anne Brennan.

(f) **The minutes of the AMHETI Steering Committee meeting held on 28 January 2014 (co-chaired by you) state that prior to that meeting, the chief executive gave approval to progress with the first phase of alternative services and that a proposal was made for the AMHETI Steering Committee to establish a Service Implementation Working Group. However, the Commission understands that the Service Implementation Working Group was never formally established. Elaborate on the role and responsibilities of the proposed Service Implementation Working Group and provide details in relation to the informal discussions which occurred in lieu of its formal establishment. Identify who participated in the informal discussions.**

The Service Implementation Working Group referred to was primarily to establish the Assertive Mobile Youth Outreach Services (AMYOS) and the North Brisbane Day Program. This was an informal working group with no Terms of Reference or minutes. Action Items were added to the Project Gannt chart to document progress.

To the best of my recollection, discussions were held with Amanda Tilse, Operational Manager, Alcohol and other Drugs and Campus, Mater Child and Youth Mental Health Service, Judith Piccone, Statewide Allied Health Professional Leader, Children's Health Queensland, Josie Sorban, Director of Psychology, Children's Health Queensland, Dr Stephen Stathis, Medical Director, Children's Health Queensland Child and Youth Mental Health Service, Mr Dan O'Brien, Team Leader Mater Child and Youth Mental Health Service Day Program, Ms Emma Hart, Nurse Unit Manager, Townsville Adolescent Day Program and Inpatient Unit, Mr Graham Stark, Manager, Toowoomba Child and Youth Mental Health Service, Kerry Geraghty, Consumer and Carer Consultant, Mater Child and Youth Mental Health Service and Ingrid Adamson, Project Manager AMHETI.

There may have been other discussions with people not listed that I cannot now recall. Individuals were approached on an as needs basis during service establishment and consequently the Service Implementation Working group was not formally established. This was reflected in the minutes of the Steering Committee meeting on 7 April 2014 (included in Exhibit K to my original affidavit).

(g) The minutes of the AMHETI Steering Committee meeting held on 28 January 2014 (co-chaired by you) state that the "Committee was informed of the Step Up/Step Down Unit being built in Cairns". The Commission understands that this Unit has not yet been built. State whether this is correct, and if so, to the best of your knowledge and understanding, why.

This is correct. This unit has not yet been constructed and the planning phase is underway and being managed by Cairns Hospital and Health Service and the Mental Health Alcohol and Other Drugs Branch. Children's Health Queensland has participated in the refinement of the Model of Service Delivery. The Cairns Step Up Step Down was a separately funded venture which was aligned to AMHETI by Mental Health Alcohol and Other Drugs Branch. I have had no involvement in the decision making regarding this project.

(h) The minutes of the AMHETI Steering Committee meeting held on 10 March 2014 (co-chaired by you) state that the "AMHETI Business Case has been presented to the Department of Health Policy and Planning Unit. They have advised that there are no new funds for 2014/15... CHQ will provide a revised business case with new funding from 2015/16." The Commission understands that the AMHETI Business case was developed by the SWAETRIS Steering Committee/AMHETI Steering Committee through its research and consultation process. The Commission also understands that the AMHETI Business Case represented the new proposed model of care and services. The minutes of the AMHETI Steering Committee Meeting on 7 April 2014 (co-chaired by you) state that the "business case has been re-submitted to the Policy and Planning Unit in the Department of Health in the hope of securing some funds in 2014/2015". Explain, to the best of your knowledge and understanding:

(i) How the elements in the AMHETI Business Case were initially prioritised.

In regard to the question above I wish to clarify that the Steering Committee did not 'develop' the AMHETI Business Case. This was developed by Ms Ingrid Adamson in consultation with myself and Dr. Stephen Stathis and Children's Health Queensland Executive. The Steering Committee was responsible for endorsing the Business Case prior to progression to the Department of Health.

As per the AMHETI Business Case Section 5.2, elements of AMHETI were prioritised based on a phased approach to implementation with consideration of available funds, population data which drives service demand, and the local mental health service capacity to establish services in the proposed locations. Consideration has also been given to local mental health service infrastructure, and their capacity to support the new services and integrate them within their existing team structures.

The format for service implementation has also been developed based on the following assumptions:

(a) acknowledgement that all resources cannot be recruited at once;
(b) recurrent funding sources need to be identified for new services;
(c) service coverage in metro and regional areas will expand over time; and
(d) telepsychiatry support from centralised Child and Youth Mental Health Service specialists will be a requirement to support clinical services in rural and remote areas.

Please note Version 3.0 provided to this request for information is not the latest version of the Business Case. The latest is version, 4.0 dated July 2014. I understand that this document has been previously provided to the Commission.

(ii) Who from the Department of Health Policy and Planning Unit communicated this to CHQHHS (and how), and who from CHQHHS received this communication.

I was not involved in meetings with the Department of Health regarding the Business Case and my understanding based on verbal updates from Ms Ingrid Adamson is that Children's Health Queensland's Chief Financial Officer, Ms Loretta Seamer and Children's Health Queensland's Senior Director, Performance Management and Analysis, Mr. Alan Fletcher, were the key contacts responsible for re-presenting the Business Case to the Department of Health on a number of occasions.

(iii) How the AMHETI Business Case was revised in response to the Department of Health notifying CHQHHS that there would be no new funding until 2015/16.

The Business Case was developed with a phased approach to implementation, consequently it was not revised due to the lack of available new funds. It is my understanding that the Business Case was revised simply to include figures using updated labour and non labour calculation work sheets and to provide some additional clarifying information requested by the Department of Health. This is the revision that was referred to. The changes in the Business Case are reflected in the July 4.0 version referred to above.

(iv) How any gaps in service were addressed.

The Business Case purpose was to seek funding to support a full continuum of care for adolescent mental health. As noted in section 6, existing gaps in the continuum of care services would continue if appropriate new funding was not forthcoming. It is my understanding that mental health clinical teams are continuing to provide specialist assessment, treatment interventions and recovery focussed care to young people and their families within their communities, within the current available service continuum.

(v) When each service option included in the AMHETI Business Case was in fact established/is now projected to commence and explain any delays.

The timing of service establishment was contingent upon recruitment activities and processes. In regard to AMYOS, establishment of teams was dependent upon the activation and implementation of recruitment and selection processes within other Hospital and Health Services. I cannot comment further on their delays. In relation to Children's Health Queensland, recruitment activities commenced in March and commenced operations from July 2014. It should be noted that the establishment of new services and new positions within government is a complicated process requiring multiple levels of position evaluation and approvals.

There were delays in establishing the adolescent day program in North Brisbane due to difficulties identifying an appropriately zoned premises of the required size. Children's Health Queensland reviewed nine properties prior to locating a suitable site. To prevent further delays in service establishment Children's Health Queensland made the decision to locate the North Brisbane Day Program at an interim site on the old Royal Children's Hospital campus, until a suitable site was secured and able to be appropriately fitted out. An appropriate site has been

secured in Chermside and is currently undergoing fitout. It is estimated to be operational in late May or June 2016.

Service	Location	Projected Commencement	Operation Date
AMYOS teams	North Brisbane	From July 2014	July 2014
	South Brisbane	From July 2014	July 2014
	Redcliffe/Caboolture	From July 2014	July 2014
	Toowoomba	From July 2014	December 2014
	Townsville	From July 2014	December 2014
	Logan	From July 2014	May 2015
	Gold Coast	From July 2014	November 2015
Adolescent Day Program	North Brisbane	From July 2014	January 2015
Youth Resi Unit	Greenslopes	From February 2014	February 2014
Sub-Acute Beds	Mater/LCCH	From February 2014	February 2014

(i) The minutes of the AMHETI Steering Committee meeting held on 1 September 2014 (co-chaired by you) refer to Dr Stephen Stathis visiting the Time Out House Initiative (TOHI) in Cairns and meeting with Aftercare to discuss modifying the TOHI "into a Resi". Explain to the best of your knowledge and understanding the impetus for converting the TOHI into a Residential Rehabilitation Unit.

Dr Bill Kingswell and Dr Stephen Stathis had recently visited the Time Out House Initiative (TOHI) in Cairns (August 2014) and noted that the level of mental health acuity of the young people in the TOHI was severe and complex. To the best of my knowledge, they determined that these young people would benefit from a more focussed mental health approach. The decision was made by Dr Bill Kingswell that the Resi Rehab model would be more suitable for these young people.

The TOHI was deemed to be able to be refurbished and more appropriately staffed to be more suitable for the more complex mental health clientele in relation to risk mitigation. I was not directly involved in any of these discussions and was only informed of this decision via the AMETHI Steering Committee so am unable to elaborate on my comments any further.

11. Please confirm whether the date on which you attended a meeting of the Chief Executive and Department of Health Oversight Committee (the Oversight Committee) as proxy for Dr Stephen Stathis was 22 January 2014 or 22 January 2013. The Commission understands that you were acting in Dr Stephen Stathis' position at the time you attended this Oversight Committee meeting. The Commission also understands that you were acting in Dr Stephen Stathis' position between 13 January 2014 and 28 January 2014. During this period, please confirm whether you attended any other meetings as a proxy for Dr Stephen Stathis and the extent to which you carried out any of his other duties which may be relevant to the Commission's Terms of reference.

The meeting was held on 22 January 2014. I was a proxy for Dr Stephen Stathis and not acting in his position at any time. To the best of my recollection, I did not attend any other meetings as proxy for Dr Stathis during this time nor did I carry out any duties on his behalf relevant to the Commission's Terms of Reference.

12. The Commission understands that the model of service presented to the Oversight Committee meeting on 22 January 2014 or 22 January 2013 was modelled on the National Mental Health Service Planning Framework. Please provide a copy of the National Mental Health Service Planning Framework and explain how the model of service presented to the Oversight Committee was modelled on the National Mental Health Service Planning Framework.

I do not have a copy of the draft National Mental Health Service Planning Framework (NMHSPF). I understand that this document has not been publically released. An extract of the document was used for planning purposes. **Exhibit H** to this affidavit is a copy of this extract.

The draft National Mental Health Service Planning Framework service categories were reviewed and used as a guide for staffing profiles and service descriptions for each of the AMHETI services – outlined in the table below:

NMHSPF Service Category	AMHETI Service
Intensive Community Treatment Service	Assertive Mobile Youth Outreach Service
Day Program	Day Program

Step Up/Step Down – Youth (Residential)	Step Up/Step Down AND Youth Residential Rehabilitation Unit
Sub-acute Intensive Care Service	Sub-acute Beds

13. Under what circumstances was responsibility for correspondence with members of the Save the Barrett group was transferred from WMHHS to CHQHHS after the BAC closed in January 2014?

Children's Health Queensland responded to all correspondence received from the community, as directed by the Department of Health, which may have included correspondence from members of the Save the Barrett Group. It is my understanding that any correspondence related to the Barrett Adolescent Centre, their clients, or its closure were directed to West Moreton, even after the Centre had closed in January 2014. I do not have any formal record of this.

14. On what date and under what circumstances were you first made aware that a specific closure date in January 2014 had been chosen for the BAC?

The specific date, 26 January 2014, as a potential closure date was raised at the Barrett Adolescent Centre Clinical Oversight Meeting which I attended on 12 December 2013 (Exhibit T to my original affidavit). This was dependent upon all clients being successfully transitioned from the Barrett Adolescent Centre.

15. In paragraph 48 of your statement, you state that "Tier 3 services is a term used in the United Kingdom, it is not commonly used in Australia". Explain to the best of your knowledge and understanding:

(a) What (if any) equivalent of a Tier 3 system exists within Queensland's Clinical Services Capability Framework and Australia's draft National Mental Health Framework.

The Tier 3 system within the United Kingdom has no direct correlation to the Tier 3 services referred to by the Expert Clinical Reference Group. The Expert Clinical Reference Group reference to Tier 3 denote sub acute extended treatment adolescent inpatient beds. The Queensland Clinical Services Capability Framework in Section 2 Child and Youth Services Subsection 2.3 – Non – Acute Inpatient Service (page 40) outlines *'a service capable of providing medium to long term inpatient mental health care to low, moderate and high risk/*

complexity voluntary and involuntary mental health patients up to 18 years, 24 hours per day'. Barrett Adolescent Centre would have been characterised as a Non-Acute Inpatient Service. **Exhibit I** to this affidavit is a copy of the Clinical Services Capability Framework.

Sub Acute beds (residential and hospital) are mentioned in the draft National Mental Health Services Planning Framework 2013 (Exhibit H to this affidavit).

This service type includes Step Up Step Down services, rehabilitative services and sub acute intensive care services for people 16 to 65 years, with unremitting and severe symptoms of mental illness and an associated significant disturbance in behaviour which precludes them from receiving support in a less restrictive environment. Barrett Adolescent Centre is referred to as an example service of sub acute rehabilitation co-located on a hospital campus and the Y-PARC in Victoria is mentioned as an example of the Step Up Step Down Model of sub acute care.

(b) How each of the AHMETI models of service fit into the Tier system used in Queensland (as you understand that system to be).

As previously stated, there is no Tier system used in Queensland. We have aligned the AMHETI services to the Tiers outlined by the Expert Clinical Reference Group for the purposes of clarity/consistency of communication only.

The Expert Clinical Reference Group developed a service element document which proposed four tiers of service provision for adolescents requiring extended mental health treatment and rehabilitation:

Tier 1 – Public Community Child and Youth Mental Health Services (existing) – this correlates with our existing Child and Youth Mental Health Services community services and was outside the scope of the AMHETI.

Tier 2a – Adolescent Day Program Services (existing and new) – one new day program has been established under AMHETI in North Brisbane and the Assertive Mobile Youth Outreach Service (AMYOS) a number of which have been established across Queensland (7 services under AMHETI).

Tier 2b – Adolescent Community Residential Service/s (new) – we currently have two Resi's established under AMHETI in Cairns and Greenslopes. Step-up Step-down services also fit into this category.

Tier 3 – State-wide Adolescent Inpatient Extended Treatment and Rehabilitation – the sub-acute beds were made available via the Mater Child and Youth Mental Health Service and post November 2014 at the Lady Cilento Children's Hospital (Lady Cilento).

I have also provided further information below on how the AMHETI was aligned with the Expert Clinical Reference Group Recommendations in their entirety:

1. *Broader consultation and formal planning processes are essential in guiding the next steps required for service development, acknowledging that services need to align with the National Mental Health Service Planning Framework.*

Children's Health Queensland undertook broad consultation and planning processes, and ensured alignment with the National Mental Health Services Planning Framework.

2. *Inpatient extended treatment and rehabilitation care (Tier 3) is an essential service component.*

Children's Health Queensland has implemented Tier 3 subacute beds as part of the service continuum. These beds were available at the Mater shortly after closure of the Barrett Adolescent Centre and transitioned to the Lady Cilento in November 2014. These Tier 3 beds have access to onsite schooling at the Lady Cilento.

3. *Interim service provision if BAC closes and Tier 3 is not available is associated with risk.*

Detailed transition planning for each young person was undertaken and implemented to ensure that the young people requiring ongoing care were well supported during transition to alternative care options. These plans were developed by West Moreton in close consultation with the young people and their families, and tailored to individual needs and care requirements.

To confirm the appropriateness of transition planning undertaken, the Department recently appointed an external health service investigator to review the transition and care planning process. This investigation culminated in a report, titled Transitional Care for Adolescent Patients of the Barrett Adolescent Centre. The report has concluded that the Barrett Adolescent Centre clinical team "undertook an exhaustive and meticulous process of clinical review and care planning with each individual young person's best interests at the core of the process."

4. Duration of Treatment

It is acknowledged that the duration of treatment is dependent upon the nature of the mental health service being delivered and the complexity and severity of the mental health problems being treated. The service elements in the proposed model of care range in duration from short term stay (up to 4 weeks) in the Step Up/Step Down Units through to long term stay (up to 12 months) in the Youth Resi.

5. Education resource essential: on-site school for Tiers 2 and 3.

Children's Health Queensland has engaged with the Department of Education and Training to ensure appropriate education options are available to all services. Educators are onsite in all Day Programs and the subacute beds have access to the special purpose school at the Lady Cilento.

6. Residential Service: Important for governance to be with CYMHS; capacity and capability requires further consideration.

The Youth Resi service has been established in partnership with a Non-Government Organisation (NGO) and governance has been clearly articulated in the overarching model of service. The model of service recognises that clinical governance of consumers remains with their treating Child and Youth Mental Health Service team. Statewide governance and funding of this service remains with Children's Health Queensland. Operational and strategic governance of Youth Resi's are managed through a Statewide Governance Panel established in partnership with the NGO.

7. Equitable access to AETRS for all adolescents and families is high priority; need to enhance service provision in North Queensland (and regional areas).

In January 2014, Townsville Hospital and Health Service opened a new adolescent inpatient unit and day program service. Since then, Children's Health Queensland has worked with Townsville and Cairns to expand services with the establishment of an AMYOS team in Townsville, and the conversion of the Cairns TOHI into a Youth Resi.

Equitable access to all state-wide services is ensured through the establishment of a state-wide panel, which will include representation from North, Central and Southern mental health clusters. This panel will have oversight of all referrals into services to ensure the most appropriate service option is made available to consumers.

16. With reference 16 to paragraph 48 of your statement:

(a) Please provide further details about what is meant by "low occupancy" of the subacute beds that were made available at the Mater Children's Hospital and Lady Cilento Children's Hospital.

To date there have only been referrals to the sub acute beds, of which occurred and of these, after review by the State-wide panel only clients have required admission into the sub acute beds. Of the clients not admitted,

(b) What is your understanding or opinion in relation to why the subacute beds at the Lady Cilento Children's Hospital (and the Mater Children's Hospital prior to its closure) have had a "low occupancy" since the closure of the Barrett Adolescent Centre?

Children's Health Queensland has promoted the AMHETI services within multiple forums across the Queensland mental health sector (see Exhibits Q and S to my original affidavit - minutes of meetings from the State-wide Child and Youth Mental Health Alcohol and Other Drugs Clinical Group and the Central Cluster Mental Health Committee). In my opinion the provision of alternative services such as day programs and AMYOS services appear to have reduced the need for sub acute admissions for some young people. Other young people may have elected to utilise mental health services closer to their homes.

(c) Did the model of service for the sub-acute beds change when the Mater Children's Hospital closed and was replaced by the Lady Cilento Children's Hospital?

The model of care for sub acute beds is individualised for the client. This individual approach did not change when the Mater Child and Youth Mental Health Service transitioned to the Lady Cilento.

(d) Are the sub-acute beds at the Lady Cilento Children's Hospital part of the acute inpatient unit? If so, explain to the best of your knowledge and understanding:

(i) What are the difficulties with treating subacute patients in an acute inpatient ward, and how have these difficulties been mitigated in this model of care?

Yes, the sub acute beds are part of the acute adolescent inpatient unit. Anticipated challenges are the difference in acuity of the young people accessing the sub acute beds and the different focus of the care. The individualised treatment plan for the sub acute clients has focussed more on a rehabilitative approach which has included a variety of evidence informed therapeutic interventions such as cognitive remediation for unrelenting psychosis, intensive psychoeducation, re-integration into vocational education or schooling and family therapy.

Both clients had detailed risk assessments incorporated into their individual care plan. Acute presentations focus more on immediate acute symptom reduction, providing safety and containment, diagnostic clarification and review of psychopharmacology if appropriate. Longer term individual and family therapy is usually done within a community setting post discharge.

(ii) What is the basis for delivering Tier 3 services recommended by the ECRG in this way? In particular, have any elements of the BAC model of care been adopted or modified in the model of care for the subacute bed-based service? What other models of care have influenced this model of care?

Children's Health Queensland was only able to establish the sub-acute beds in the acute inpatient unit as there was no dedicated funding to establish a standalone unit. There was no defined model of service for the Barrett Adolescent Centre upon which to model the sub-acute

bed service, nor had the 2010 draft model of service developed for the Redland Facility been progressed. Therefore, the model of care was modelled on the National Mental Health Services Planning Framework and outlines individualised treatment programs for the young person and their family to meet their rehabilitative and recovery mental health needs.

(iii) What is the difference between the treatment provided to patients occupying these subacute beds, compared to patients occupying the acute beds?

As aforementioned in response to 16(d), the difference is the focus of the individualised care is rehabilitative as opposed to acute.

(e) Describe your understanding of any differences between the current subacute beds model at the Lady Cilento Children's Hospital and the Barrett Adolescent Centre model.

In my understanding the most significant differences would be the age of the clients; at the Lady Cilento that is under 18, the admission process is via a state-wide multi-disciplinary panel, there is clear discharge planning at time of admission, the length of stay is under six months. There is individualised treatment planning for the Lady Cilento clients with evidence based interventions and less emphasis on a group approach to therapy such as milieu or adventure therapy. There is also a strong focus on family involvement and family therapy.

(f) Describe your understanding of any similarities between the current subacute beds model at the Lady Cilento Children's Hospital and the Barrett Adolescent Centre model.

There is onsite schooling for the young people, there is a focus on rehabilitation administered via a multidisciplinary team, there is 24 hour access to clinical staff, and the option of attending elements of the onsite Day Program.

(g) Describe your understanding of a typical:

(i) Care plan for a patient admitted to the subacute beds at the Lady Cilento Children's Hospital (and the Mater Children's Hospital prior to its closure).

These are individualised to the client so there is no 'typical' care plan. Areas of focus would include risk profile, recovery principles, family and client psychoeducation, intensive family therapy, development of improved activities of daily living skills, linkages to vocational/educational activities, re-integration into social activities and developmentally appropriate community participation in a graded approach.

(ii) Day and week for a patient admitted to the subacute beds at the Lady Cilento Children's Hospital (and the Mater Children's Hospital prior to its closure).

There is no 'typical' day or week for young people with mental illness. All care and treatment plans are individually drafted and implemented flexibly to meet the needs of the young person at the relevant time.

17. With reference to paragraph 52 of your statement:

(a) Explain the circumstances under which you were asked or offered to nominate senior staff to join panels to assist with transition planning.

As far as I recall I was requested by Dr Leanne Geppert, A/Director of Strategy, Mental Health & Specialised Services, West Moreton, to nominate some senior staff members to participate in the complex care review panel. **Exhibit J** to this affidavit is a copy of an email from Dr Leanne Geppert dated 28 October 2013 at 5:24pm attaching the Terms of Reference for the Complex Care Review Panel and a template used by the panel.

(b) Identify the senior staff whom you nominated and the panels which they joined to assist with transition planning.

From memory, I nominated the following Child and Youth Mental Health Staff - Ms Tania Withington, Director of Social Work, Mr Richard Litster, Senior Social Worker, Ms Penny Knight, Clinical Nurse Consultant and Dr Ray Cash, Consultant Psychiatrist.

Ms Knight was unavailable and I do not recall whether Ms Withington, Dr Cash or Mr Litster attended any of the panels as I had no further involvement with client transition arrangements.

(c) Explain the circumstances under which you were asked or offered to suggest service and care options for individual transition clients.

I was only consulted by Dr Stephen Stathis about broad community based services that may be suitable for clients.

(d) Identify the service and care options and the individual clients.

See response above.

18. The Commission understands from exhibit Z to your statement, the Project Plan for the Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy (the SWAETRIS), that the Mental Health, Alcohol and Other Drugs Branch (the MHAODB) provided "temporary bridging funds to support the transition process from the current service model to the newly defined service options". The Commission also understands from paragraph 53 of your statement that after the BAC closed, its operational funds were transferred to CHQHHS and that you had delegation and accountability for the release of the operational funds. Explain your knowledge and understanding of the "temporary bridging funds" controlled by the MHAODB and when these funds would be used to support transitioning patients compared to when the operational funds controlled by the CHQHHS would be used to support transitioning patients. Please provide examples, if possible.

My understanding is that the bridging funds mentioned in the Project Plan were never required. Any transition care required was funded by Children's Health Queensland from the operational funds provided upon closure of the Barrett Adolescent Centre. Details of transition funding requests have been previously submitted to the Commission.

19. The Commission understands from exhibit T to your statement, that during a Barrett Adolescent Centre Clinical Oversight Meeting on 12 December 2013, it was decided that "all decisions regarding use of operational funding will be jointly considered from this point forward between WMHHS and CHQHHS". Please provide further details about the joint decision making process for the release of operational funds.

It is my recollection that decision making was made via email and memos from West Moreton and/or other Hospital and Health Services. All requested funds were released by CHQ. Details of transition funding requests have been previously submitted to the Commission.

20. With reference to exhibit U to your statement, what is your understanding of the circumstances surrounding being contacted to provide support for In particular, please provide details in relation to:

(a) The conversation which you and Dr Stephen Stathis had with on in relation to

My recollection is that the of had researched this and had, in consultation with this client, determined that would provide a more useful intervention than the intervention being provided (at that time) by

I do not recall the specifics of the conversation with Dr Stephen Stathis and and do not have any notes from this conversation.

Dr Stephen Stathis made contact with Children's Health Queensland subsequently entered into a contract for support care to be provided to this client.

(b) On what basis was "identified as providing the most suitable solution" as stated on page 372 of your statement.

This was the organisation of choice of the nominated client and Children's Health Queensland, after further discussion with supported this choice.

21. With reference to paragraph 55 of your statement, please:

(a) Clarify whether the assistance you provided to Dr Stephen Stathis in relation to waitlist patients was limited to discussing service options for the patients or whether you also assisted him to communicate with the patients to enquire about their welfare.

It was limited to discussing the range of service options available to young people.

(b) **Identify which waitlist patients you discussed or communicated with and provide details or the discussions or communications, to the best of your recollection.**

As far as I can recall it was generalised conversations about service options broadly. I was not involved in discussing specifics of transition.

22. **With reference to paragraph 65 of, and exhibit Y to, your statement:**

(a) **The Commission understands that most of the work of the group who reviewed the MOSD BAC was "done via email or out of session as finding times for the working group to meet proved difficult". Please provide copies of any email correspondence or notes of phone conversations in relation to the work of the group who reviewed the MOSD BAC.**

From memory, much of the work was done directly onto the draft Model of Service Delivery document during the teleconference meetings and email suggestions were incorporated via track changes directly on to the draft Model of Service Delivery by the secretariat (Fiona Cameron, A/Principal Project Officer Child and Youth Mental Health Service). **Exhibit K** to this affidavit is a bundle of draft documents and correspondence, accessed from my email account, relating to the Model of Service Delivery document.

(b) **The Commission understands that on 4 March 2010, you provided a draft of the reviewed MOSD BAC to Dr David Crompton, Executive Director of Clinical Services, Metro South Mental Health Service. Did you or, to your knowledge, any other members of the group who reviewed the MOSD BAG, work on the draft of the reviewed MOSD BAG after 4 March 2010? Was the draft of the reviewed MOSC BAG ever finalised? If so, please provide a copy of the final version.**

Dr David Crompton, Executive Director Mental Health, Metro South Health Service District (as it was formerly known), at the The Mental Health Capital Works Program; Facility Project Team Meeting – (Redland Project) dated 24 June 2010, requested that the expert Child and Youth Mental Health Service working group re-convene to revise the draft Model of Service Delivery in lieu of decisions made to not progress with the day program component and the 'parents' retreat' due to funding constraints. Dr Crompton followed up this request in a Memo dated 30 June 2010. **Exhibit L** to this affidavit is a copy of this memo.

The group reviewed the draft Model of Service Delivery and the newly proposed design of the Redlands site in July 2010. I was on leave overseas for seven weeks from mid July returning in late September, 2010. Ms Erica Lee, Executive Manager, Mater Child and Youth Service, chaired the State-wide Child and Youth Advisory Group in my absence. According to email correspondence, contained in Exhibit K to this affidavit, the expert panel reviewed the draft Model of Service Delivery during this time and the draft Model of Service Delivery was presented to the State-wide Child and Youth Advisory Group and endorsed on 26 August 2010. **Exhibit M** to this affidavit is a copy of the agenda and minutes of the meeting of the State-wide Child and Youth Advisory Group on 26 August 2010.

I forwarded the endorsed draft Model of Service Delivery to Dr David Crompton and Ms Shirley Wigan on 30 September 2010. I do not recall having any further involvement in the draft Model of Service Delivery. The agenda of the Facility Project Team meeting on 16 February 2012 notes that the draft Model of Service Delivery had not been forwarded to the Facility Project Team. **Exhibit N** to this affidavit is a copy of the agenda for the meeting of the Facility Project Team on 16 February 2012 (meeting number 18). I do not have any further documentation about the Model of Service Delivery being tabled at the Facility Project Team meeting. I was advised of the Redland Project being ceased on 26 August 2012 (Exhibit H to my original affidavit).

Information circulated to the Facility Project Team from Katie Eckersley, Manager, Bayside Mental Health Service, on 25 July 2011 advised that the Facility Project Team meetings had been cancelled for July and August 2011 and the bed capacity for the Redlands Project had been reduced to 15. A confidential Briefing Note to the Minister for Health was attached to this email outlining environmental issues with the Redlands site which potentially could delay the progress of the project and advice that the project was over budget and changes would occur to the Schematic Design scope to reduce the overall project costs. **Exhibit O** to this affidavit are copies of this email from Katie Eckersley on 25 July 2011 and the attached Briefing Note.

An email from David Pagendam dated 29 September 2011, gave an overview of the reduced footprint of the design. **Exhibit P** to this affidavit are copies of this email and the attached plan.

23. The Commission understands from paragraph 71 of your statement that two parents of BAC patients presented their lived experience to the SWAETRIS Steering Committee on 4 November 2013 and that "their input and suggestions

aligned with the recommendations of the ECRG". You have also stated in paragraph 71 of your statement that "these recommendations were the foundation of the SWAETRIS Steering Committee's redevelopment of replacement services." Please explain in detail how the input and suggestions of [redacted] who attended the SWAETRIS Steering Committee meeting on 4 November 2013 aligned with the ECRG recommendations. In particular:

(a) Identify the specific ECRG recommendations which aligned with the input and suggestions of [redacted]

[redacted] provided a submission to the Steering Committee outlining their suggestions for specialised adolescent extended treatment and rehabilitation services for adolescents. **Exhibit Q** to this affidavit is a copy of the submission which outlines their input.

Key points from the [redacted] submission which align with the Expert Clinical Reference Group recommendations are outlined below.

1. *Broader consultation and formal planning processes are essential in guiding the next steps required for service development, acknowledging that services need to align with the National Mental Health Service Planning Framework.*
   Aligns with [redacted] submission: refer 'Lack of networking and collaboration' between services and 'Other Comments' section.

2. *Inpatient extended treatment and rehabilitation care (Tier 3) is an essential service component.*
   Aligns with [redacted] submission: refer combined inpatient/day patient capacity section.

3. *Interim service provision if the Barrett Adolescent Centre closes and Tier 3 is not available is associated with risk.*
   Aligns with [redacted] concerns expressed at various points within their submission and during their verbal presentation to the Steering Committee.

4. *Duration of Treatment*
   This was not addressed directly by the [redacted]

5. *Education resource essential: on-site school for Tiers 2 and 3.*

Aligns with the submission refer 'Education, On Site Schooling' section.

6. *Residential Service: Important for governance to be with Child and Youth Mental Health Services; capacity and capability requires further consideration.*
did not directly address this issue.

7. *Equitable access to Adolescent Extended Treatment and Rehabilitation Services for all adolescents and families is high priority; need to enhance service provision in North Queensland (and regional areas).*
Aligns with concerns expressed in 'Gaps within the current mental health service options available in Queensland'.

(b) Which ECRG recommendations were most influential in the SWAETRIS Steering Committee's redevelopment of replacement services? To what extent did the most influential ECRG recommendations align with the input and suggestions of the

See response to 15(b) above.

24. In paragraph 29(b) of your statement, you mention that the development of services by SWAETRIS Steering Committee/AMHETI Steering Committee was undertaken by visiting sites such as the Y-PARC (Youth Prevention and Recovery Care) and residential rehabilitation units in Victoria (the Y-PARC model). The Commission understands that the Y-PARC model informed the proposal for the Step Up, Step Down Unit (SUSDU). State whether this is correct and if so, explain, to the best of your knowledge and understanding:

(a) The elements of the Y-PARC model which have been adopted in the proposal for the SUSDU.

The Youth Prevention and Recovery Care (Y-PARC) model did help inform the proposal for the Step Up Step Down (SUSDU). The elements that have been adopted are the result of collaboration and joint governance with the NGO sector, some design features and locations (embedded in the community as opposed to on a hospital site). Limited on site schooling as the focus is for young people to be linked back with their home schools/ vocational educational options or employment.

(b) The elements of the Y-PARC model which have been modified in the proposal for the SUSDU.

Elements that have been modified include the age range, reduced from 16 to 25 to 16 to 21 (with flexibility in the lower age range to not exclude young people from 13 to 15). The staffing ratios would be proposed to be increased due to the focus on the younger age range. An increased focus on family visiting spaces and an increased therapeutic focus on family therapy interventions.

(c) What other models of care have influenced the proposal for the SUSDU?

As I recall there were limited documented models of care for an adolescent step up step down that were able to be sourced. It is important to note that the AMHETI was not tasked to complete an exhaustive literature review of all service models available nationally and internationally for adolescent extended treatment and rehabilitation. It was my understanding that the Expert Clinical Reference Group had undertaken this foundation work although I do not recall them specifically referencing Y-PARC's in their Tier 2b element.

The majority of the detail supporting the Step Up Step Down Model of Service under AMHETI was sourced from the National Mental Health Service Planning Framework and site visits to Victoria.

25. The Commission understands from paragraph 27 of your statement that the SWAETRIS Steering Committee/AMHETI Steering Committee met between August 2013 and December 2014. The Commission also understands that the SWAETRIS Steering Committee/AMHETI Steering Committee did not meet after December 2014 because the establishment of the new services was underway. What governance structure is now responsible for overseeing the new services and what is your involvement in that structure?

Mental Health Alcohol and Other Drugs Branch and Children's Health Queensland governance oversees the development of the new Youth Resi services. Regular briefings are sent to the Deputy Director General of Health and the Minister for Health.

Children's Health Queensland has service level agreements with other Hospital and Health Services for the establishment of new AMYOS services as funding becomes available. The

AMYOS teams are operationally managed by the respective Hospital and Health Services. The North Brisbane Day Program is part of the Children's Health Queensland Child and Youth Mental Health Service. The governance of the state-wide panels for the Sub Acute beds and the Resi's is governed by Children's Health Queensland Child and Youth Mental Health Service as are the Sub Acute beds within Lady Cilento. The Cairns Step Up Step Down will be governed by Cairns Hospital and Health Service. I am responsible for oversight of the AMHETI suite of services that Children's Health Queensland Child and Youth Mental Health Service administer. Children's Health Queensland Executive and Board are briefed regularly on the progress of the new services.

26. With reference to exhibit Z to your statement, the Project Plan for the SWAETRIS states that one of the objectives of the SWAETRIS was to ensure "continuity of care for adolescents currently admitted to BAC, and on the wait list, through a supported discharge/ transition process to the most appropriate care option/s that suit individual consumer needs, and that are located in (or as near to) their local community". However, one of the "constraints" identified by the Project Plan for the SWAETRIS was that "alternative service options for BAC consumer must be available by early 2014". Explain, to the best of your knowledge and understanding, how the SWAETRIS Steering Committee/AHMETI Steering Committee achieved this objective within the identified "constraint, and provide details of the activities you undertook as part of the SWAETRIS Steering Committee/AHMETI Steering Committee to ensure the achievement of this objective within the identified "constraint".

The Project Plan was endorsed by the Steering Committee on 21 October 2013 which was prior to the closure of the Barrett Adolescent Centre and thus the transition of current clients was included as part of this plan. West Moreton who were members of the Steering Committee, had complete responsibility for the discharge and transition process for the Barrett Adolescent Centre clients (including those clients on the waiting list) to appropriate services. For many of the clients these were adult services as they were over 18 or close to 18 in age. This is clearly articulated in the Communication and Management section of the previously exhibited Project Plan (page 18) which states West Moreton comprising of The Board, Chief Executive and Executive Director of Mental Health Services have responsibility for 'Clinical Care for current BAC and wait list clients'.

It further articulates on page 15 under Risk Event and Impact, that critical incidents involving adolescents transitioning from Barrett Adolescent Centre are the responsibility of the West Moreton and the local Hospital and Health Service that the young person has transitioned to. As articulated in the Steering Committee minutes dated 9 September 2013, the Consumer Transition Working Group was chartered with the guiding and overseeing of the progress of safe consumer transition planning. It was not the role of the Steering Committee to develop individual consumer discharge/ transition plans. Note this group changed names as per minutes of the Steering Committee dated 23 September 2013, to Barrett Adolescent Centre Transition Panel which involved only Barrett Adolescent Centre staff with other Hospital and Health Service staff involved only on an 'as needs' basis.

This panel was chaired by Dr Anne Brennan who was Acting Clinical Director, Barrett Adolescent Centre. As noted in the minutes of the Steering Committee dated 9 October 2013, Ms Leanne Geppert, A/Director of Strategy, Mental Health and Specialised Services, West Moreton, advised that the Barrett Adolescent Centre Transition Panel had been converted to a Clinical Care Panel and remained a West Moreton driven panel.

27. The Commission encloses a copy of the AMHETI Business Case. In relation to the AMHETI Business Case, please answer the following questions:

(a) In section 1.5 (Scope), it states "[l]inkages to Adult Mental Health Services in so far as to ensure smooth transition from Adolescent Mental Health Services" were within the scope of the AHMETI. Explain to the best of your knowledge and understanding what linkages were established and how these linkages are designed to improve the transition from adolescent to adult mental health services.

The AMHETI services build on the existing linkages across the Queensland mental health sector and rely upon processes within Child and Youth Mental Health Services and Adult Mental Health services to ensure a smooth transition. The AMHETI suite of services was widely promoted including to the State-wide Mental Health Leadership Forum and the State-wide Mental Health Clinical Network, by Dr Stephen Stathis. The audience at these forums include Directors and Managers of mental health and drug and alcohol services throughout Queensland so these integrated services which comprise of both Child and Youth Mental Health Services and Adult services are mindful of the potential transition challenges.

The AMHETI business case in Section 4 'Issues' notes that the age range for child and youth services within Queensland does not typically extend to young people over the age of 18. Adult mental health services do not accept young people under 18. This remains an outstanding issue for the Queensland Mental Health Sector and has been raised at the State-wide Clinical Network Meeting as an opportunity for further service improvement.

(b) In relation to the Residential Rehabilitation Units (the Resi) in section 3.3 and the SUSDU in section 3.4, please answer the following questions to the best of your knowledge and understanding:

(i) What are the key differences in the model of service for a SUSDU and a Resi apart from length of stay?

The key differences are, apart from the length of stay, the acuity of the clients, the staffing model and the focus of care.

Step Up Step Down – Length of stay up to 28 days with extensions determined by a multidisciplinary team of mental health clinical staff and Non Government Organisation (NGO) staff. Clients have more acute mental health issues that require intensive mental health support from staff and may require a secure facility. They are clients who may be deteriorating in the community setting but do not respond well to, or are not unwell enough for, an acute inpatient admission or clients who are well enough to be discharged from the acute unit/ not responding well to the acute inpatient unit, but not yet fully ready to go home. The staffing model is a combination of mental health clinical staff and NGO staff who work collaboratively. The focus of care is on returning the client to optimal functioning and reducing symptomatology of mental health issues.

Resl – Length of stay up to 12 months with review from a State-wide multidisciplinary panel, clients have lower acuity and are unable to live at home with their families at the present time. The Resi is operated and staffed with NGO staff and the focus of care is rehabilitative not clinical in nature and seeks to foster independence with a lower staff to client ratio. Young people are supported to develop skills of daily living, access their nominated community mental health supports and to re-connect with community based vocational, educational and pro-social activities.

(ii) What are similarities and differences in the type and level of clinic care provided in a SUSDU and a Resi?

Refer response above - 27(b)(i).

(iii) The model of care for the SUSDU as outlined in section 3.4 indicates that each SUSDU client will have a designated consultant psychiatrist. Will each Resi client also have a designated consultant psychiatrist?

No, young people accessing a Resi are linked into their individual primary health care provider or community mental health services. The Resi model is not designed to provide therapeutic clinical services on site.

(iv) What are the similarities and differences in the staffing profile for a SUSDU and a Resi?

Refer response above - 27(b)(i).

(v) What type of clients is a Resi model of service most effective for?

Young people with mental health issues who require support with transitioning to independent living and for whatever reason cannot live within the family home. The aim is for these young people to access mental health therapeutic services independent from the Resi.

(vi) What type of clients is a Resi model of service least effective for?

Young people who require a more secure facility and young people actively using/abusing substances.

(c) In section 4 (Issues), it states:

(i) "[w]hilst other services proposed would be able to service the same age range; it is not a supported mental health position in Queensland. Explain what the AHMETI Business Case means by this.

Current Queensland Child and Youth Mental Health services cater for young people from 0 up until their 18th birthday. There is no policy direction for Queensland supporting any changes to this approach at the present time.

(ii) **"[i]t is important to note that the Queensland NGO market is relatively immature in the specialised field of adolescent mental health services. It is therefore acknowledged that NGOs will require time to build skills and capabilities to deliver services." The AHMETI appears to draw heavily on models implemented in Victoria, which the Commission understands has a more developed non-government sector than Queensland. Explain to the best of your knowledge and understanding how the AHMETI proposes to address this.**

It is not directly within the scope of the AMHETI project to address this issue. However, tender processes for the Resi's have been broadly advertised and interstate applicants (MIND Australia and Aftercare) have been successful in securing the tender for all four Resi's. These NGOs have extensive experience within the mental health sector. As a result of that extensive experience interstate these NGO's have demonstrated expertise in delivering the required services with the necessary skills and capabilities.

28. **In paragraph 29(b) of your statement, you mention the Walker Unit and Rivendell in New South Wales. Explain to the best of your knowledge, whether either of these models informed, or has been incorporated into, the development of services by the SWAETRIS Steering Committee/AMHETI Steering Committee and the AMHETI Business Case. If not, why?**

Elements of these units are incorporated into the AMHETI models, such as:

(a) specialist on site schooling provided for both the Day Program and subacute beds;

(b) the provision of day programs for young people requiring more intensive services than community Child and Youth Mental Health Services can provide;

(c) State-wide multidisciplinary panels established to determine eligibility for admission;

(d) a range of evidence based interventions for young people accessing day programs and inpatient beds.

Neither the Walker Unit or Rivendell services was totally suitable to model AMHETI services from.

The Rivendell model was five days per week only and necessitated families from NSW to provide interim accommodation for the weekends or transport young people home for the weekends. This was a difficult concept to promote in a geographically diverse state such as Queensland. The Walker Unit had a high proportion of developmentally delayed young people with concurrent mental health issues that were difficult to place back into their community. This was not the typical profile of Barrett Adolescent Centre clients.

In discussions with management from both units they identified that a lack of community based services precluded them from timely discharge from their units and they felt the introduction of alternative services within the continuum of care for Child and Youth Mental Health Services would be helpful.

29. With reference to paragraph 75 of your statement,

30. With reference to paragraph 76 of, and exhibit BB to, your statement, confirm that you only attended the following Young Person's Extended Treatment and Rehabilitation Initiative Governance Committee (YPETRIGC) meetings:

(a) 9 January 2014;

(b) 15 January 2014;

(c) 23 January 2014;

(d) 22 May 2014; and

(e) 5 June 2014.

This is correct.

31.

32.

33. Confirm that the discussion paper referred to in paragraph 87 of your statement is being prepared by Sophie Morson. If so, in what capacity she is preparing the discussion paper and why? If not, who is preparing the discussion paper, in what capacity, and why? When do you expect that the discussion paper referred to in paragraph 87 of your statement will be finalised and provided to the Commission?

Sophie Morson has authored the internal Children's Health Queensland discussion paper on Sub Acute Beds at my direction. The discussion paper is currently being reviewed by senior Children's Health Queensland staff and should be finalised and available to be provided to the Commission by the end of January 2016.

All the facts sworn to in this affidavit are true to my knowledge and belief except as stated otherwise.

Sworn by Judith Krause on 19 January)
2016 at Brisbane in the presence of:)
)

JUSTICE OF THE PEACE (QUALIFIED) DEPT. OF JUSTICE & ATTORNEY-GENERAL Reg.No.: 118609

A Justice of the Peace, C.Dec., Solicitor

In the matter of the *Commissions of Inquiry Act 1950*

Commissions of Inquiry Order (No.4) 2015

Barrett Adolescent Centre Commission of Inquiry

CERTIFICATE OF EXHIBIT

Exhibits A - Q to the Affidavit of Judith Krause sworn on 19 January 2016.

JUSTICE OF THE PEACE (QUALIFIED) Reg. No. 118609 MINISTRY OF JUSTICE & ATTORNEY-GENERAL

Deponent

A J.P., C.Dec., Solicitor

In the matter of the *Commissions of Inquiry Act 1950*
Commissions of Inquiry Order (No.4) 2015
Barrett Adolescent Centre Commission of Inquiry

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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:
  - 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
  - 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.

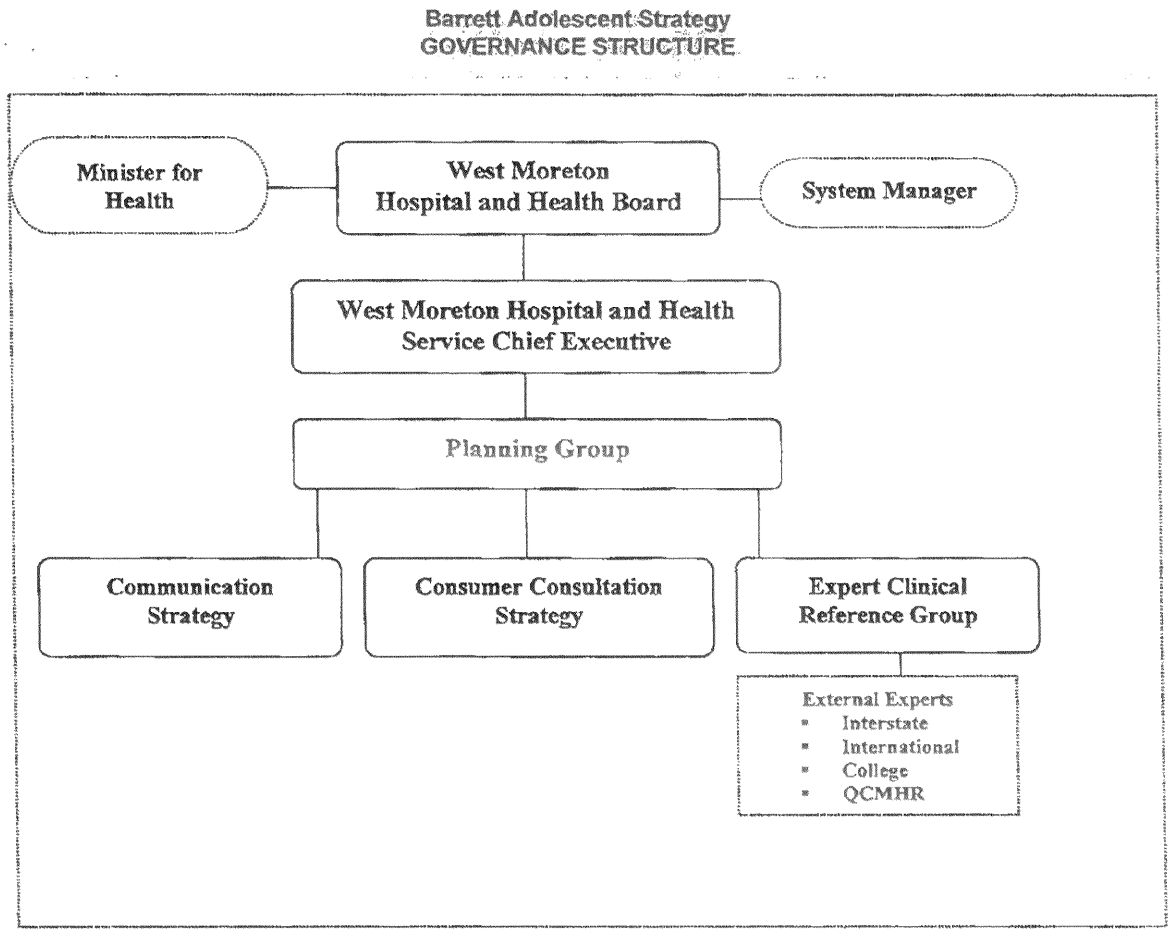
OBJECTIVES	• Through the formation of a planning group, with input from a multidisciplinary expert clinical reference group:
	  o alternative contemporary, statewide model(s) of care will be developed to replace the services currently provided by BAC;
	  o an implementation plan will be developed to 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:

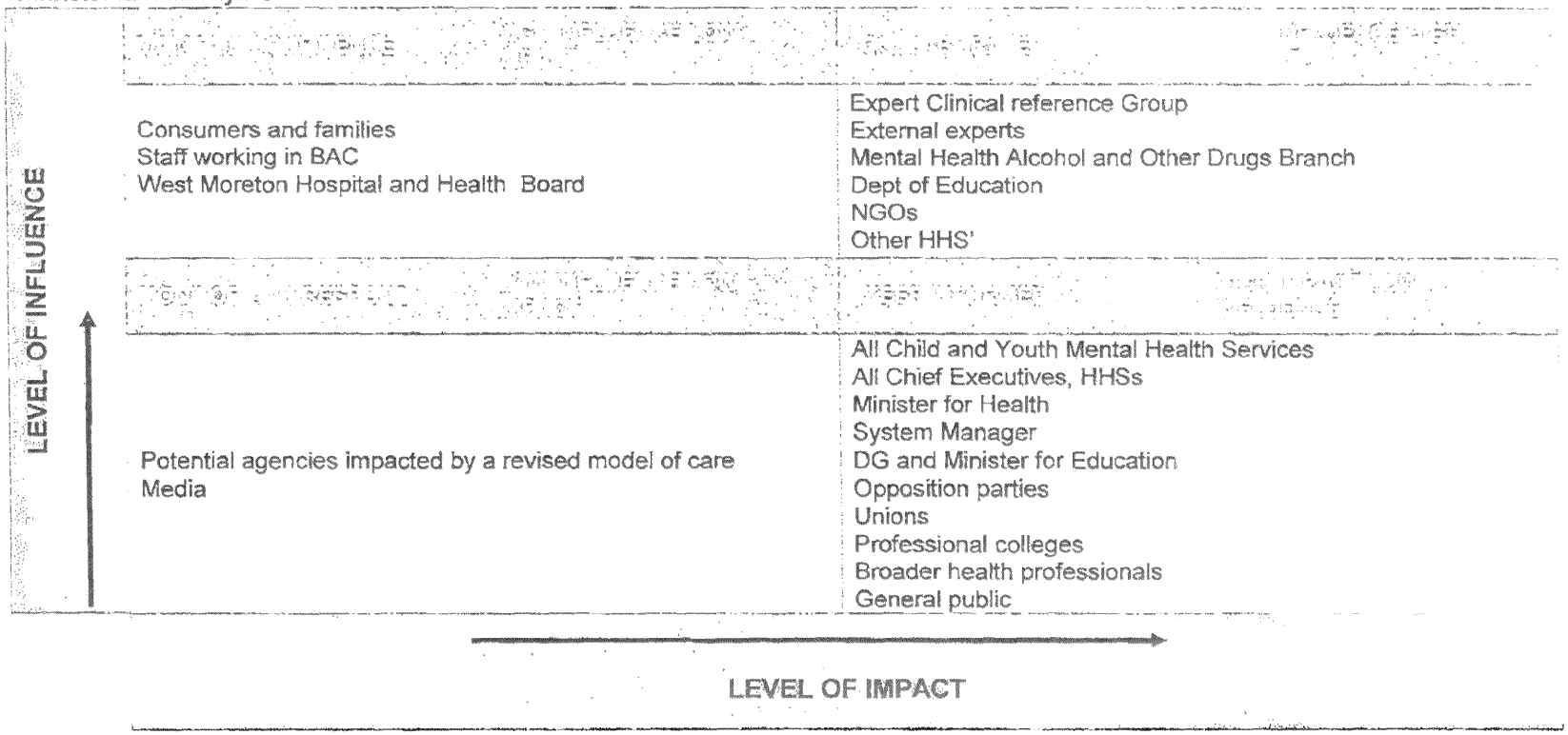
- WMHHS Board, Executive and Senior Management Team
- Clinicians, other staff and management working within WMHHS
- Health Minister and key advisors
- Queensland Health Director-General, Deputy Directors-General and Executive Directors (including Mental Health Alcohol and Other Drugs Branch)
- Senior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



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 recuired	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 available)	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.

QUEENSLAND HEALTH
MENTAL HEALTH CAPITAL WORKS PROGRAM

Agenda

Queensland Government
Queensland Health

Project(s)	Redland – New 15 Bed Adolescent ETU, Day Centre & School	Project(s) No	5126
Meeting	Formation of Facility Project Team Meeting (FPTM) and User Group Meeting (UGM)	Meeting No	1
Held at	Conference Room 1 & 2, Redland Hospital	Date	20 August 2009
Author	Glenn Gibson, A/Executive Support Officer	Time	3.30pm – 4.30pm

Confirmed

Name	Role	Company	Telephone/Mobile	Email
Assoc. Prof David Crompton	Executive Director	Division of Mental Health, Metro South		
Assoc. Prof Brett McDermott	Executive Director	Mater Child & Youth Mental Health Service		
Dean Luton		Project Services		
Debbie Samuels	A/Manager Operational Support Services	Operational Support Services		
Emma Page	Psychologist	Child & Youth Mental Health		
Janelle Bowra	Nurse Unit Manager	Mental Health		
John Quinn	Chairman/Director	Vascular Surgery		
Kevin Fjeldsoe	Director	Mental Health Plan Implementation		
Michael Daubney	Psychiatrist	Child & Youth Mental Health		
Neil Pratt	Director of Nursing	Logan-Beaudesert Mental Health Service		
Paul Clare	Principal Project Officer	Mental Health Branch		
Peter Trevathan	Building & Engineering Manager	BEM		
Sanjib Baruah	Clinical Director	Bayside Mental Health, Metro South		
Sue Leggate	Director, Corporate Services	Corporate Services		
Tamara Madsen	Carer Liaison Representative	Logan-Beaudesert Mental Health Service		
Terry Carter	Project Manager	Capital Works & Asset Management Branch		
Trevor Sadler	Psychiatrist	The Park Centre for Mental Health		

Apologies

Name	Role	Company	Telephone/Mobile	Email
Professor Brett Emmerson	Executive Director	Mental Health Services		
Ms Veronica Casey	Executive Director of Nursing	Metro South HSD		
Ms Elizabeth Powell	Director Strategic Policy Unit	Mental Health Branch		
Dr Aaron Groves	Senior Director	Division on the Chief Health Officer		

Item	Topic	PN 51414 New 20 Bed CCU	Action By
1.0	Procedural Issues Welcome FPTM format TOR Agenda items Dates & times MHPIT		
2.0	Model of Service Delivery (MOSD) 1. MOSD Current Status & Progress Report		
3.0	Land & Legals 1. Site Acquisition & Property Issues 2. Adjoining Owners & Existing Tenants		
4.0	Authorities 1. Site designation 2. Building application 3. Statutory authorities 4. Heritage 5. Asbestos		
5.0	Master Programme 1. Progress Report 2. Upcoming milestones 3. Delivery methodology		
6.0	PDP/Design 1. Site Planning Issues 2. Progress Report 3. TCP/ID		
7.0	Financial		

Item	Topic	PN 51414 New 20 Bed CCU	Action By
	2. Expenditure 3. Variations 4. Art-Built In Budget/Cost 5. FF&E & IT Budget/Cost		
8.0	Decanting 1. Decanting strategy		
9.0	Construction 1. Progress Report 2. General 3. Industrial Relations & Safety 4. Contractual 5. Quality 6. Forecast practical completion		
10.0	Risk Analysis & Value Management 1. Peer Review 2. Project Services		
11.0	FF&E 1. Progress Report 2. Budget 3. Expenditure		
12.0	Operational /Commissioning 1. Staffing 2. Commissioning		
13.0	Communications (Media) 1. Communication Plan 2. Consultation		
14.0	Recurrent Costs 1. Building Operation & Maintenance Costs 2. Staff/Other recurrent costs		
15.0	New Business		

Item	Topic	PN 51414 New 20 Bed CCU	Action By

Next Meeting

TBA

C

Notes from Sandra Radovini's Visit

10th December 2013

Timeframe for BAC has increased from 4mths in 1994, to 10 months in 2006, and then to 17 months in 2013

ACTS offers flexible and extended hours of support and acts as the coordination point for a range of community services, such as NGOs, education, justice, housing, etc.

Current in Victoria, there are 17 Resis looking after 166 young people

Statewide Admissions Panel will provide transparency and equity of access to the bed-based subacute unit across the state. Local HHSs will fund families to travel town to the unit for family-based therapy.

Have we thought of creating an annex to acute inpatient units for youth beds, e.g. 2 beds that can be sectioned off.

Sandra suggested the paediatric acute units. In Victoria, they don't have a BAC – they built inpatient beds as part of the paediatric units that acted as swing beds. They then ensured the staff had expertise to accommodate young people – noted that you do need a child & adolescent psychiatrist on hand.

Sandra suggested talking to headspace about co-locating day programs – there would be less stigma

IMYOS Services in Victoria
The metro services looked different to the rural services – in the rural setting the function spread across team where more people did outreach. They also experienced an issue with services being watered down and funds spent elsewhere when positions weren't filled. Need a mechanism to safe guard the funding. Found that it was important to bring the IMYOS workers together once or twice a year to create a team environment and provide for cross sharing of learnings and development

Specifically targeted at difficult to engage, high risk youths
They found that clients really liked the outreach model – it was more collaborative
Important IMYOS workers have a low case load to increase collaboration on each case, i.e. 8 to 10 cases each – linking up with other service providers was very time consuming
They typically worked 9am to 5pm and had an after-hours team, who would work up to 11pm and weekends
Average length of stay with the services was 12 to 14 months
Found the diagnostic profile didn't matter
Found that the teams could best work within a 1.5hr driving radius – safer for clinicians and optimised their time

Benefits of the service (from a file audit):

- Greater flexibility to meet the needs of the consumer – consequently fewer treatments missed
- Decreased hospitalisation – lower admissions
- Decreased length of stay in acute inpatient units
- Improvement in psychiatric symptoms and overall better function
- Less risky behaviours and self-harm

- Remarkably low level of suicides over a 10 year period – 4 deaths, 3 of which were not thought to be suicide related, i.e. accidental

Important to manage the safety of the young person and the workers – always worked in pairs until the person was known and had a point of referral in the event of violence or drug use. They didn't treat if it wasn't safe.
They were creative in working together, e.g. on verandas, in public places, etc.
They would also work with other agencies, e.g. child protection, youth workers, etc.
Services were needs-led

The disposition of the worker was more important than skill set, e.g.:

- Have to like working with tricky young people
- Be ok with being on the road (and not office-based)
- There is a lot of training that can be done to up-skill people
- Would attempt to have a nurse as part of the team, to issue medication, etc.

They found transitioning someone into Adult Mental Health services was fraught with issues
They would often work with a consumer up until 25yo before transitioning to adult services
Would

11th December 2013

Attending:

- Terry Steadman, WMHHS
- Laura Johnson, WMHHS
- Leanne Geppert, WMHHS
- Stephen Stathis, CHQ HHS
- Ingrid Adamson, CHQ HHS
- Sandra Radovini, Victoria
- [redacted]

Leanne covered off on the transition plan for services.
Parents initially raised concern that their children wouldn't access the holiday program – i.e. won't travel
A mobile team would be one solution; alternatively, change up the activities to occur closer to where each of the consumers reside.

Stephen then went on to present the proposed future model of care – Sandra interjected with information about IMYOS in Victoria.
Parents noted that the spectrum seemed comprehensive – concern now is getting the funding to roll these out.

Sandra suggested a language change from *extended treatment and rehabilitation* to *extended treatment and recovery*
Leanne noted *rehabilitation* is an adult-specific term