STATUTORY DECLARATION OF TERRY STEDMAN

INDEX OF EXHIBITS

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TJS-5	Queensland Health – Project Services, Department of Public Works – Options Study for Barrett Adolescent Centre at The Park Centre for Mental Health dated December 2004	WMS.6000.0002.02774	116-139
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TJS-8	Queensland Government – Queensland Plan for Mental Health 2007-2017 dated June 2008	WMS.5000.0011.00001	242-281
TJS-9	Email from Sharon Kelly to Logan Steele, Terry Stedman and William Brennan, copied to Lesley Dwyer and Mark Kearin dated 29 August 2012, attaching: • Email from MD09-WestMoreton-HSD to Lesley Dwyer and Sharon Kelly dated 29 August 2012	WMS.5000.0016.00001 WMS.5000.0016.00002 WMS.5000.0016.00003 WMS.5000.0016.00004	282-285

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Terry Stedman

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Witness

	• Email to HIO-Correspondence to MD09-WestMoreton-HSD dated 29 August 2012 • Queensland Health Memorandum – Cancellation of Capital Delivery Project dated 28 August 2012		
TJS-10	Email from Lesley Dwyer to Terry Stedman, copied to Alice Gaston, Linda Hardy, Mark Kearin, Sharon Kelly, Logan Steele, William Brennan and Lesley Dwyer dated 31 August 2012 Email from Terry Stedman to unknown recipients including Lesley Dwyer dated 31 August 2012 Email from Sharon Kelly to Logan Steele, Terry Stedman and William Brennan dated 29 August 2012	WMS.5000.0006.00107	286-287
TJS-11	West Moreton Hospital and Health Service Memorandum from Sharon Kelly to Executive Directors and Clinical Directors, Mental Health Services dated 22 October 2013	WMS.0011.0001.00074	288
TJS-12	West Moreton Hospital and Health Service Barrett Adolescent Centre Clinical Oversight Meeting – File/Meeting Note dated 12 December 2013	WMS.1000.0035.00004	289-290
TJS-13	West Moreton Hospital and Health Service Barrett Adolescent Centre Transition Care Planning Meeting minutes dated 11 December 2013	WMS.3003.0001.00024	291-292
TJS-14	Email from Bernice Holland to Elisabeth Hoehn, Anne Brennan, Leanne Geppert, Michelle Giles, Sharon Kelly, Terry Stedman and William Brennan dated 28 January 2014 Document entitled 'BAC Weekly Update Meeting Issues Register', undated West Moreton Hospital and Health Service Barrett Adolescent Centre (BAC) Update Meeting Minutes dated 22 January 2014	WMS.3003.0001.00011 WMS.3003.0001.00017 WMS.3003.0001.00019 WMS.3003.0001.00016	293-300

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Terry Stedman **Witness**

	West Moreton Hospital and Health Service Barrett Adolescent Centre Update Meeting Agenda dated 29 January 2014		
TJS-15	Email from Terry Stedman to Sharon Kelly dated 5 December 2013	WMS.1001.0075.00010	301
TJS-16	West Moreton Hospital and Health Service – Briefing for the Director-General, Department of Health and Director-General, Department of Communities, Child Safety and Disability Services Meeting dated 22 January 2014	WMS.1000.0042.00001	302-304
TJS-17	Briefing Note for Noting or Approval to Deputy Director – General, Health Service and Clinical Innovation Division dated 18 December 2013	WMS.0016.0001.16763	305-307
TJS-18	Email from Sharon Kelly to George Plint, Anand Choudhary, Brett Emmerson, Brett McDermott, Catherine Oelrichs, David Crompton, Ed Heffernan, Erica Lee, Fraun Flerchinger, Gail Robinson, Jacinta Powell, Janet Bayley, Jason Kidd, Jenny Flynn, Jeremy Hayllar, Jill Mazdon, Joe Petrucci, Judi Krause, Karlyn Chettleburgh, Keryn Fenton, Kevin McNamara, Linda Bailey, Lindsay Farley, Lisa Fawcett, Loma Bunton, Mark Fairbairn, Mark Fakes, Matira Taikato, Melanie Kaplun, Mike Coward, Monica O'Neill, Naeem Jhetam, Neeraj Gill, Sandra Kennedy, Shirley Wigan, Stephen Stathis, Terry Stedman, Thomas John, Tonya Plumb and Vikas Moudgil, copied to Bill Kingswell, Michael Cleary, Leanne Geppert, Lesley Dwyer, Marie Kelly and Sharon Kelly dated 7 August 2013, attaching: • West Moreton Hospital and Health Service and Children's Health Queensland Hospital and Health Service Frequently Asked Questions, undated • West Moreton Hospital and Health Service – Expert Clinical Reference Group Recommendations Barrett	WMS.0011.0001.03828 WMS.0011.0001.03712 WMS.0011.0001.03769 WMS.0011.0001.03847	308-320

	Adolescent Strategy dated July 2013 • West Moreton Hospital and Health Service and Children's Health Queensland Hospital and Health Service Media Statement – Statewide focus on adolescent mental health, dated 6 August 2913		

CURRICULUM VITAE

Terry Jon Stedman
Work Details:
The Park-Centre for Mental Health
Treatment Education and Research
WACOL Q 4076

Employment History

1979	MBBS Graduated 1979 University of Queensland
1980/81	Resident Medical Officer – Royal Brisbane Hospital
1982-1987	Psychiatry trainee
May 1986	Completed Part I RANZCP examination
May 1987	Elected FRANZCP
Sept 1987 - 1997	Psychiatrist Wolston Park Hospital
June 1997 -2013	Director of Clinical Services, Wolston Park Hospital and subsequently The Park- Centre for Mental Health
2013	Clinical Director, Division of Mental Health and Specialised Services, West Moreton Hospital and Health Service

RESEARCH

Publications

Stedman TJ The effects of discharge from hospital on the quality of life of chronic psychiatric patients. Dissertation for Fellowship Royal Australian and New Zealand College of Psychiatrists.

Stedman TJ and Price J. Two Cases of Papillary Carcinoma of the Thyroid Associated with Psychosis and Violence. Australian and New Zealand Journal of Psychiatry; 22(2), 202-207, 1988.

Stedman TJ and Whiteford HA. L-Tryptophan is natural perhaps even rational but is it effective? Australian Prescriber;12(1), 3-4, 1989.

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Stedman T, Welham J: Quality of Life Research: Helping differing people make different decisions. The Australian Occupational Therapy Journal 1993;40:83-84.

Eyles DW, Whiteford HA, Stedman TJ, Pond SM: Determination of haloperidol and reduced haloperidol in the plasma and blood of patients on depot haloperidol. Psychopharmacology (Berl) 1992;106:268-274.

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Whiteford HA, Stedman TJ, Welham J, Csernanzky JG, Pond SM: Placebo controlled, double blind study of the effects of proglumide in the treatment of schizophrenia. Journal of Clinical Psychopharmacology 1992;12:337-340.

Stedman TJ, Welham JL: The distribution of adipose tissue in female inpatients receiving psychotropic drugs. British Journal of Psychiatry 1993;162:249-250.

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Eyles D, Stedman T, Pond S. Nonlinear relationship between circulating concentrations of reduced haloperidol and haloperidol: evaluation of possible mechanisms. Psychopharmacology 1994;161-166.

McGrath J, Stedman T. A mental illness which has far-reaching consequences. Australian Doctor 1994;28 October:I-VIII.

Keks N, McGrath JJ, Lambert T, Catts S, Vaddadi K, Burrows G, Varghese F, George T, Hustig H, Burnett P, Kerr K, Stedman TJ et al. The Australian multicentre double-blind comparative study of remoxipride and thioridazine in schizophrenia. Acta Psychiatr Scand 1994;90:358-365.

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Whiteford H, Stedman T, McGrath J, Welham J, Pond S. An open label study of famotidine as a treatment for schizophrenia. Psychiatry and Neuroscience 1995;239-240.

Stedman T, Welham J. Are single figure generic quality of life measures sensitive to change with mental health interventions? European Neuropsychopharmacology 1996;8 Supp 3, 167.

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Eyles DW, Avent KM, Stedman TJ, Pond SM. Two pyridinium metabolites of haloperidol are present in the brain of patients at postmortem. Life Sci 1997;60(8):529-34.

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Welham, Joy; Haire, Mary; Mercer, Dianne; Stedman, Terry. A gap approach to exploring quality of life in mental health. Quality of Life Research: an International Journal of Quality of Life Aspects of Treatment, Care & Rehabilitation. Vol 10(5) 2001, 421-429.

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Sharpe J-K, Stedman TJ, Byrne NM, Hills AP. Low-fat oxidation may be a factor in obesity among men with schizophrenia. Acta Psychiatr Scand 2009: 119(6):451-6

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Meehan T, Stedman T, Wallace J. Consumer strategies for coping with antipsychotic medication side effects. Australasian Psychiatry. 201:119(1):74-7.

Green, B; Stedman, T; Chapple, B and Griffin, .C (2010). Criminal Justice Outcomes of Those Appearing before the Mental Health Tribunal: A Record Linkage Study. Psychiatry, Psychology and Law, 18, 573-587.

Meehan T. Stedman T; Trends in the use of Emergency Examination Orders in Queensland since the implementation of the Mental Health Intervention Project. Australasian Psychiatry. 20(4):287-90, 2012 Aug.

Meehan T. Stedman T. Robertson S. Drake S. King R. Does supported accommodation improve the clinical and social outcomes for people with severe psychiatric disability? The Project 300 experience. Australian & New Zealand Journal of Psychiatry. 45(7):586-92, 2011 Jul.

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Scott R; Goel V; Neillie D; Stedman T; Meehan T. Unauthorised absences from leave from an Australian security hospital. Australasian Psychiatry: Vol. 22 (2), pp. 170-3; 2014

Grants

With Dr HA Whiteford. NH&MRC Grant 1990. "Clinical and Neuroendocrine Correlates of Neuroleptic Withdrawal" - $35,955.19.

NH&MRC Commissioned Research 1990. Development of A Quality of Life Scale - $4000.

Stedman T, Rebecca L Cooper Foundation 1991 Ölfactory Agnosia in Schizophrenic Patients" $1500.

Stedman TJ, Haire MC, Welham JL. NH&MRC Public Health Research and Development Project Grants 1991-1993 "Quality of Life and Tertiary Prevention for the Chronically Mentally Ill" $33093.

Stedman TJ, Haire MC, Welham JL. Mayne Bequest Fund 1991 "Quality of Life and Tertiary Prevention for the Chronically Mentally Ill" $1923

Whiteford HA, Stedman TJ, McGrath JJ, Pond SM. British Red Cross Society Trust Fund 1991 "Famotidine in the treatment of schizophrenia" $4900.

Stedman TJ, Rebecca L Cooper Foundation 1994 "Instrumental Measurement of Drug-induced Parkinsonism" $6000

Haire MC, Welham JL, Stedman TJ. The Prince Charles Hospital Foundation "Qualitative aspects of the quality of life of the seriously mentally ill".

Finnane M, Fjeldsoe K, Stedman T and Swendson C. 1999 Australian Research Council Grant Mental Illness Asylum and Community: A History of Wolston Park Hospital, Queensland 1865–2000 $36000.

Meehan T, Stedman T and Swendson C. Relocation to Community Care Units Evaluating the Impact on Clients. 2000 Queensland Health Grant to evaluate the relocation of patients from three psychiatric hospitals – Baillie Henderson Hospital, Mosman Hall and Wolston Park Hospital $95000.

Stedman T, Coulton R, Sharp, J-K, 2002 Novartis CPMS plus A program for prevention of clozapine associated weight gain. $20000

Meehan T, Drake S, Stedman T 2004 Eli Lilly Five year follow-up evaluation of Project 300 Clients. $60000

Meehan T, Stedman T et al 2003 Queensland Health Evaluation of the Mental Health Outcomes Initiative in Queensland $207000

Meehan T, Stedman t et al 1999 Evaluating the relocation of patients to Nursing Homes from stand alone psychiatric hospitals

Callan V, Fjeldsoe K, Lacey P, Stedman T et al 1999 ARC-SPIRT Industry Partnership with UQ graduate School of Management to investigate effects of large scale redevelopment and downsizing.

Meehan, T Stedman, T Burgess, P 2007 Qld Police- Evaluation of the Mental Health Intervention Training Program for. $200000 4 yrs

Meehan, T, Stedman, T, Campbell I I. Janssen-Cilag-The management of medication side-effects as perceived by consumers. $35000

Meehan, T Stedman T, Robinson S 2006 Eli-Lilly Seven year follow-up evaluation of 'Project 300' clients. $60000

Consultancies

Stedman TJ, Mellsop GM, Yellowlees PM "Field testing of Selected Consumer Outcome Measures in Mental Health" Commissioned Research by the Mental Health Branch of the Commonwealth Department of Human Services and Health for the National Mental Health Strategy $208000.

Positions

External Reviewer Australian and New Zealand Journal of Psychiatry, Comprehensive Psychiatry and Schizophrenia Research, Acta Psychiatrica Scandinavia

External Examiner Royal Australian and New Zealand College of Psychiatrists 1996 to present

Accredited Examiner Royal Australian and New Zealand College of Psychiatrists 2009- present

Member of Committee for Examinations Royal Australian and New Zealand College of Psychiatrists writing group for written examination 2006- present

Director of Advanced Training Addiction Psychiatry- Queensland Branch Training Committee 2006- 2010

Chair of Queensland Rotation and Training Program (Subcommittee of Queensland Branch Training Committee) 2006 to present

Associate Professor, Department of Psychiatry, University of Queensland 2009-present

Queensland Government
Queensland Health

Job Ad Ref: H07WM
Closing Date: Monday
Status:

Comment [TS]: Medium

WEST MORETON SOUTH BURNETT HEALTH SERVICE DISTRICT
ROLE DESCRIPTION

POSITION TITLE:	**Director of Clinical Services**
DIVISION/BRANCH/SECTION:	**Executive Management** **The Park: Centre for Mental Health**
LOCATION:	**West Moreton Health Service District**
CLASSIFICATION LEVEL:	**MO2**
POSITION NUMBER:	**026474**
AWARD:	**Medical Officers' (Queensland Health) Certified Agreement (No.1) 2005, Medical Officers' (Queensland Health) Memorandum of Understanding 2005 and Regional Health Authorities Senior Medical Officers' and Resident Medical Officers Award – State**
DATE OF REVIEW:	**September 2007**

PURPOSE OF POSITION

To provide psychiatric oversight for the clinical activities of The Park: Centre for Mental Health.

ORGANISATIONAL ENVIRONMENT

The West Moreton South Burnett Health Service District is responsible for the provision of health services to the community and is committed to achieving continuous quality improvement in client service within a Quality Management Framework.

The District covers approximately 19,460km2 to the West of Brisbane and extends from the New South Wales border to the town of Proston to the North. In 2001, the population of WMSB HSD was 200,558. This has grown to 218,172 in 2006, and is projected to increase to 240,875 in 2011. Throughout this time, the population of West Moreton South Burnett Health Service District has remained constant at approximately 5.5% of the total Queensland population.

The West Moreton South Burnett Health Service District provides services to the communities of Boonah, Cherbourg, Esk, Ipswich, Kingaroy, Laidley, Murgon, Nanango and Wondai.

The Park- Centre for Mental Health is a tertiary mental health facility. Ipswich Hospital is the main acute facility. Community Health services are provided across the district.

The Park: Centre for Mental Health philosophy emphasises the importance of extending to the consumers of this service dignity, autonomy and respect as an individual and as a member of the community. Opportunities that would normally be available to a member of the wider community will also be available to those who reside on this site with respect to clinical, rehabilitation and legal considerations.

The service comprises District services that include Extended Treatment and Rehabilitation Clinical Program (51 beds), Extended Secure Clinical Program (34 beds) and Dual Diagnosis Clinical Program (31 beds). These District oriented services are provided to clients of the Logan/Beaudesert, West Moreton, Princess Alexandra Hospital and Bayside Health Districts. Each of the programs is integrated into the District Mental Health Service thus creating a seamless service. Using a similar premise, the Extended Secure Clinical Program will be the tertiary service of the Gold Coast District Mental Health Service. The Adolescent (Rehabilitation) Clinical program provides services to all Health Districts in Queensland. The

High Security Clinical Program offers in-patient mental health services in a high security environment for Health Districts south of Mackay.

REPORTING RELATIONSHIP

This position reports directly to the Executive Manger for on-site clinical services.

EDUCATIONAL QUALIFICATIONS

Fellowship of the RANZCP or qualifications recognised by the Award as a specialist qualification.

POSITION REQUIREMENTS (WORKPLACE BEHAVIOURS, DUTIES AND RESPONSIBILITIES ASSOCIATED WITH THE POSITION)

Queensland Health is committed to achieving its mission of promoting a healthier Queensland and our vision to be leaders in health – partners for life. We recognise that Queenslanders trust us to act in their interest at all times. To fulfil our mission and sustain this trust we share four core values of: quality and recognition: professionalism: teamwork: and performance accountability. In addition we will be successful in promoting a healthier Queensland through the following five strategic intents: healthier staff: healthier partnerships: healthier people and communities: healthier hospitals and healthier resources. The primary duties and assessment criteria outlined in the job description reflect the commitment to our mission, vision, values and strategic intents which are required by this position.

DUTIES AND COMPETENCIES ASSOCIATED WITH THE POSITION

The following competencies are considered of primary importance to the position:

- Customer Service Orientation
- Motivating Others
- Providing Direction
- Judgement
- Problem Analysis
- Concern for Excellence
- Strategic Perspective
- Technical Skills and Competence
- Policy Awareness: knowledge and application of the following legislative requirements and Queensland Health policies – employment equity anti-discrimination ethical behaviour quality Queensland Health Code of Conduct and Workplace Health & Safety.

The following competencies are considered of compliment any importance to the position:

- Integrity
- Career and Self Development
- Persuasiveness
- Teamwork
- Organisational awareness
- Cross Cultural Awareness
- Cross Functional Awareness
- Self Confidence
- Execution

These competencies are associated with the following roles/responsibilities of the position (in summary only):

- Provide clinical leadership in the process of continuing performance improvement of the mental health services provided including the achievement of accreditation.
- Develop a range of initiatives which will contribute an enhanced quality of life and care for adolescent and adult consumers.
- Teaching may be required for medical undergraduates, as well as medical postgraduates enrolled in the training scheme for the RANZCP.
- Ensure that the service complies with the provisions of the Mental Health Act (1974).
- Undertake the role of Medical Superintendent as specified in the Mental Health Act (1974).

Comment [TS]: Also Prison Mental Health Service which provides mental health care to prisoners in all prisons ion South East Queensland.
Could also note that The Park included Queensland Centre for Mental Health Research, Queensland Centre for Mental Health Learning

Comment [TS]: Should also have point about clinical leadership and direction to the clinical programs as well the rest of this point.

- Support, and participate in where appropriate, inter-district, inter-agency and/or intersectoral partnerships that promote positive consumer outcomes.

Workplace Behaviours

Clinical Expertise	**INSERT DEFINITION OF CLINICAL EXPERTISE REQUIRED FOR THIS POSITION**
Patient Focus	Provides patient care by displaying personal qualities of respect, politeness and empathy as well as involving patients and carers in the care process.
Communication	Demonstrates effective communication skills by actively listening, providing relevant and timely information and adapting their style to suit others.
Financial Management	Demonstrates effective financial decision making, prioritising effectively and understanding the impacts of their decisions.
Staff Management	Manages staff in relation to patient care by setting clear expectations, by recognizing good performance and providing constructive feedback on poor performance
Continuous Improvement	Promotes a safe and quality focused work environment by demonstrating safe work practices, reviewing practices, identifying areas of improvement and acting accordingly, and participating in quality audits and risk management activities.
Continuous Learning	Committed to own ongoing professional development and actively contributes to professional memberships and networks.
Team Focus	Becomes part of and engenders a team environment by showing respect, acknowledging and validating other team members.
Work Values	Demonstrates honesty, integrity and respect for all patients, carers and staff.

MANDATORY

Fellowship of the RANZCP or qualifications recognised by the Award as a specialist qualification.

A criminal history check may be conducted on the recommended person for this job.

Please note that as per Queensland Health policy, it is mandatory that you have been vaccinated against Hepatitis B or have commenced a course of vaccination. You must provide documentary evidence of this vaccination prior to commencement of your employment.

ASSESSMENT CRITERIA

Applicants should submit a covering letter and resume (written responses to the assessment criteria is not required).

Shortlisting and selection will be based upon these assessment criteria.

1. Clinical Expertise
2. Patient Focus
3. Communication
4. Financial Management
5. Staff Management
6. Continuous Improvement
7. Continuous Learning
8. Team Focus
9. Work Values

For further enquiries, please contact XXXXXXX on 3810 XXXX

How do I submit my application?	
Online:	Visit www.health.qld.gov.au/workforus to search for your preferred job and APPLY ONLINE from there.
Postal:	Human Resource Management Recruitment Services PO Box 73 Ipswich Q 4305
Street:	Ipswich Hospital Tower Block Chelmsford Avenue IPSWICH Q 4305
Need assistance:	• Read the Applicant Information Kit • Contact Recruitment Services on [redacted] or • Voice Mail on [redacted]

Role Description o Approved	..... Dated: ..... Supervisor

ADDITIONAL FACTORS

This position may be subject to pre-employment history checks including a working with children suitability check (Blue Card), criminal history, identity or previous discipline history checks for the preferred applicant.

The West Moreton Health Service District is an equal opportunity employer and adopts a no smoking policy in all Health Service buildings.

Hepatitis B Vaccination

Health Care Workers in Queensland Health whose occupation poses a potential risk of exposure to blood or body fluids must be immunised against Hepatitis B according to the National Health and Medical Research Council Australian Immunisation Handbook 8th edition and the Queensland Health Infection Control Guidelines.

Hepatitis B immunisation is a condition of employment for Health Care Workers in Queensland Health who have direct patient contact (eg. Medical officers, nurses and allied health staff), as well as those staff who, in the course of their work, may be exposed to blood or body fluids, for example by exposure to contaminated sharps e.g. (but not confined to) plumbers.

Proof of vaccination must be provided to the Human Resource Management Department upon acceptance of appointment. Proof of vaccination can be provided via a letter from a general practitioner, infection control or occupational health department.

Probation Requirements

All new permanent employees to Queensland Health will be required to undertake a period of probation upon commencement of duty. This period will be 6 months in length with a possible 3 month extension if performance objectives are not met.

No Smoking Policy

The Queensland Government "NO Smoking Policy" prohibits the smoking of cigarettes within all Queensland Government buildings, corridors, passageway, walkways and balconies. Smoking is also prohibited immediately outside external entrances to buildings and within government owned motor vehicles. Smoking is only permitted in designated areas.

Queensland Government

West Moreton Hospital and Health Service

Job ad reference:	
Role title:	Director of Clinical Services, West Moreton Mental Health and Specialised Services
Status:	Permanent Full Time
Unit/Branch:	Mental Health and Specialised Services
Division/District:	West Moreton Hospital and Health Service
Location:	The Park – Centre for Mental Health
Classification level:	
Salary level:	
Closing date:	
Contact:	Sharon Kelly, Executive Director Mental Health and Specialised Services
Telephone:	(07)
Email Applications:	If you are unable to apply via email, please contact Statewide Recruitment Services on
Deliver application:	Hand delivered applications will not be accepted

About our organisation

Queensland Health's purpose is to provide safe, sustainable, efficient, quality and responsive health services for all Queenslanders. Our behaviour is guided by Queensland Health's commitment to high levels of ethics and integrity and the following **five core values**:

- **Caring for People:** We will show due regard for the contribution and diversity of all staff and treat all patients and consumers, carers and their families with professionalism and respect.
- **Leadership:** We will exercise leadership in the delivery of health services and in the broader health system by communicating vision, aligning strategy with delivering outcomes, taking responsibility, supporting appropriate governance and demonstrating commitment and consideration for people.
- **Partnership:** Working collaboratively and respectfully with other service providers and partners is fundamental to our success.
- **Accountability, efficiency and effectiveness:** We will measure and communicate our performance to the community and governments. We will use this information to inform ways to improve our services and manage public resources effectively, efficiently and economically.
- **Innovation:** We value creativity. We are open to new ideas and different approaches and seek to continually improve our services through our contributions to, and support of, evidence, innovation and research.

Purpose

- The Director of Clinical Services provides clinical and professional leadership and directs clinical governance activities for the services of the Division of Mental Health and Specialised Services (MH&SS), West Moreton Hospital and Health Service (HHS).
- All medical staff within the Division report operationally and professionally via the relevant Clinical Director to the Director of Clinical Services.
- This position reports operationally to the Executive Director MH&SS and professionally to the Executive Director Medical Services and Ipswich Hospital, West Moreton HHS.

Your key responsibilities

- Fulfil the responsibilities of this role in accordance with Queensland Health's core values, as outlined above.
- Provide clinical leadership and governance to the process of continuing reform and service improvement of the mental health services.
- Lead, manage and coordinate clinical and psychiatric services within the Division of Mental Health and Specialised Services (MH&SS), West Moreton Hospital and Health Service (HHS).
- Contribute as a member of the West Moreton MH&SS Leadership Team to the planning and delivery of the range and scope of mental health services provided by West Moreton HHS.
- Provide authoritative advice and guidance on the strategic planning and delivery of quality contemporary psychiatric services through a detailed understanding of national and state mental health policy directives.
- Work collaboratively with the MH&SS Leadership team to provide Clinical Governance to the Division in keeping with the Queensland Health Clinical Governance Policy and Implementation Standards, and the clinical governance imperatives of the HHS. This will include oversight of activities in relation to clinical standards, clinical direction, evidence based practice, policies and procedures, safety and quality, professional development, working collaboratively with and directing the activities of relevant staff to achieve desired outcomes.
- Actively participate in the Division's strategic and operational management, including financial management, human resource management, information management, quality management and education and training.
- Provide clinical leadership in evidence-based practices which ensure that the overall quality of clinical services delivered by multidisciplinary clinical staff in the Division is in line with current and relevant mental health standards and legislation.
- Provide direct clinical assessment and treatment services including participation in the psychiatrist's on-call roster.
- Implement procedures to promote and optimise continuity of care in the Service between service components, when staff change, or when consumers move, and between the Service and other relevant agencies/clinicians (including general practitioners).
- Lead the operational management of the medical workforce to meet service requirements, including recruitment, orientation and retention activities
- Ensure the organisation of educational activities in the Division including:
    - The training and supervision of registrars and other medical staff (inclusive of IMGs).
    - An appropriate form of continuing medical education for senior medical staff within the services including other Staff Specialist.
    - Medical Student teaching and learning.
    - The training of other clinical staff, in consultation with professional seniors and service managers.
- Provide leadership to promote a work culture that supports:
    - The participation of consumers and carers in the development, delivery and evaluation of the service
    - A sound value base of trust and respect for clients and their families
    - The development of employee abilities and competencies and
    - Innovation and change within the organisational service improvement framework.
- High level knowledge of, and compliance with:
    - *Queensland Mental Health Act 2000*, Queensland Health Consumer Complaints Management Policy and Standards, any local procedures relating to this policy, the Health Quality and Complaint Commission Standard, Queensland Health's Integrated Risk Management Policy, Workplace Health and Safety, Equal Employment Opportunity and Antidiscrimination requirements, and ensuring any staff reporting to this position are also aware of these policies, procedures and standards.
- Represent as part of the MH&SS Leadership Team, relevant HHS, State and National Mental Health committees and forums as required.

Qualifications/Professional registration/Other requirements

- Appointment to this position requires proof of qualification and/or registration with the appropriate registration authority, including any necessary endorsements, to be provided to the employing service prior to the commencement of duty.

- MBBS or equivalent registrable with the Australian Health Practitioner Regulation Agency (AHPRA); and Fellowship of the Royal Australian and New Zealand College of Psychiatrists (FRANZCP) or equivalent qualification as recognised by the College; and be able to be registered as a Specialist in Psychiatry with AHPRA.
- This position is appointed to the Division of MH&SS and may be required to work from a number of Divisional sites. The position will also be required to participate in the Consultant Psychiatrists' rostered on-call duties.
- Knowledge of current national and state mental health policies and plans, legislation and standards, with respect to provision of contemporary mental health care, including the *Queensland Mental Health Act 2000* would be an advantage. The position will be required to undertake roles and functions in accordance with the Mental Health Act 2000 as delegated.
- Licence to Operate Vehicle: This position requires the incumbent to operate a class C motor vehicle and an appropriate licence endorsement to operate this vehicle is required. Proof of this endorsement must be provided prior to the commencement of duty.
- Hepatitis B Vaccination: Health Care Workers in Queensland Health whose occupation poses a potential risk of exposure to blood or body fluids must be immunised against Hepatitis B according to the National Health and Medical Research Council Australian Immunisation Handbook and the Queensland Health Infection Control Guidelines.

Are you the right person for the job?
You will be assessed on your ability to demonstrate the following key attributes. Within the context of the responsibilities described above, the ideal applicant will be someone who can demonstrate the following:

- Demonstrated clinical expertise and management experience consistent with a leadership role in a comprehensive mental health service.
- Demonstrated knowledge and application of the Queensland and National Mental Health policies and priorities and commitment to their implementation, including clinical governance, quality improvement, risk management and service evaluation.
- Demonstrated ability to facilitate changes to clinical work practices, knowledge and experience in improvement science, clinical redesign and demonstrated commitment to research, service improvement and quality activities.
- Demonstrated effective communication, consultation and negotiation skills including the ability to work effectively with multidisciplinary teams, other components of the mental health service, other agencies and consumer groups.
- Demonstrated ability to develop and implement high quality teaching and educational initiatives at an undergraduate and post-graduate level (including multidisciplinary education and training), in research leadership and achievement, and in advancing the objectives of the relevant professional organisation.

How to apply
Please provide the following information to the panel to assess your suitability:

- **Your current CV or resume, including referees.** You must seek approval prior to nominating a person as a referee. Referees should have a thorough knowledge of your work performance and conduct, and it is preferable to include your current/immediate past supervisor. By providing the names and contact details of your referee/s you consent for these people to be contacted by the selection panel. If you do not wish for a referee to be contacted, please indicate this on your resume and contact the selection panel chair to discuss.
- **A short response** (maximum 1-2 pages) on how your experience, abilities, knowledge and personal qualities would enable you to achieve the key responsibilities and meet the key attributes.
- **Application form** (only required if not applying online).

WEST MORETON
About West Moreton Hospital and Health Service
West Moreton Hospital and Health Service (WMHHS) comprises of four local government areas Scenic Rim Regional Council, Lockyer Valley Regional Council, Somerset Regional Council and Ipswich City Council.

Ipswich is the major city of the region. Esk, Laidley, Gatton, Boonah and Wacol are townships spread throughout the service area.

The WMHHS services a population of approximately 249,000 people. The region's demographics are diverse and include metropolitan and small rural community settings.

The service has a major teaching role, providing both undergraduate and postgraduate clinical experience for members of the multidisciplinary healthcare team. The service currently employs over 2 600 staff.

WMHHS is home to one medium sized hospital, Ipswich Hospital, four rural facilities, Boonah Rural Health Service (RHS), Esk RHS, Gatton RHS, and Laidley RHS.

Based at Gailes are The Brisbane Youth Detention Centre Health Service and The Park-Centre for Mental Health, Treatment, Research and Education which also hosts the state-wide service of Queensland Centre for Mental Health Learning and Queensland Centre for Mental Health Research.

Wacol Women's Correctional Offender Health Service (including Helana Jones at Albion), Wolston Correctional Offender Health Service, Brisbane Correctional Offender Health Service became a part of West Moreton Hospital and Health Service on 1 July 2012 as part of the state-wide health reform.

Community Health Services operate from both the Ipswich Health Plaza and Goodna Community Health Centre and provides an outreach service to the rural area.

Oral Health services are provided in 18 fixed clinics and 12 mobile dental clinics across the region, coordinated to provide comprehensive adult and school based services. The main oral health clinic is the Ipswich Community Dental Clinic based in the Limestone Street Centre.

By 2031 it is projected that the WMHHS population will more than double to approximately 580,000, making the Hospital and Health Service the fastest growing in the state.

Additional information on the Hospital and Health Service is available on QHEPS site via www.health.qld.gov.au

Mental Health and Specialised Services
The MH&SS currently consists of:

- Integrated Mental Health Services (IMHS),
- The Park- Centre for Mental Health (The Park)
- Offender Health Services (OHS) and
- The Drug Court Program (which will cease by 30 June 2013)

Since 1 July 2012, Offender Health Services have been devolved to Hospital and Health Services. Historically, the mental health services within WMHHS have functioned and been managed and resourced as distinct separate services. A revised integrated organisational structure for MH&SS has been implemented. It is planned that into the future, the program areas of Brisbane Youth Detention Centre (BYDC) and Alcohol, Tobacco and other drug services (ATODs) will also be aligned into the division.

Pre-employment screening
Pre-employment screening, including criminal history and discipline history checks, may be undertaken on persons recommended for employment. The recommended applicant will be required to disclose any serious disciplinary action taken against them in public sector employment. In addition, any factors which could prevent the recommended applicant complying with the requirements of the role are to be declared.

Roles providing health, counselling and support services mainly to children will require a Blue Card, unless otherwise exempt. Please refer to the Information Package for Applicants for details of employment screening and other employment requirements.

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

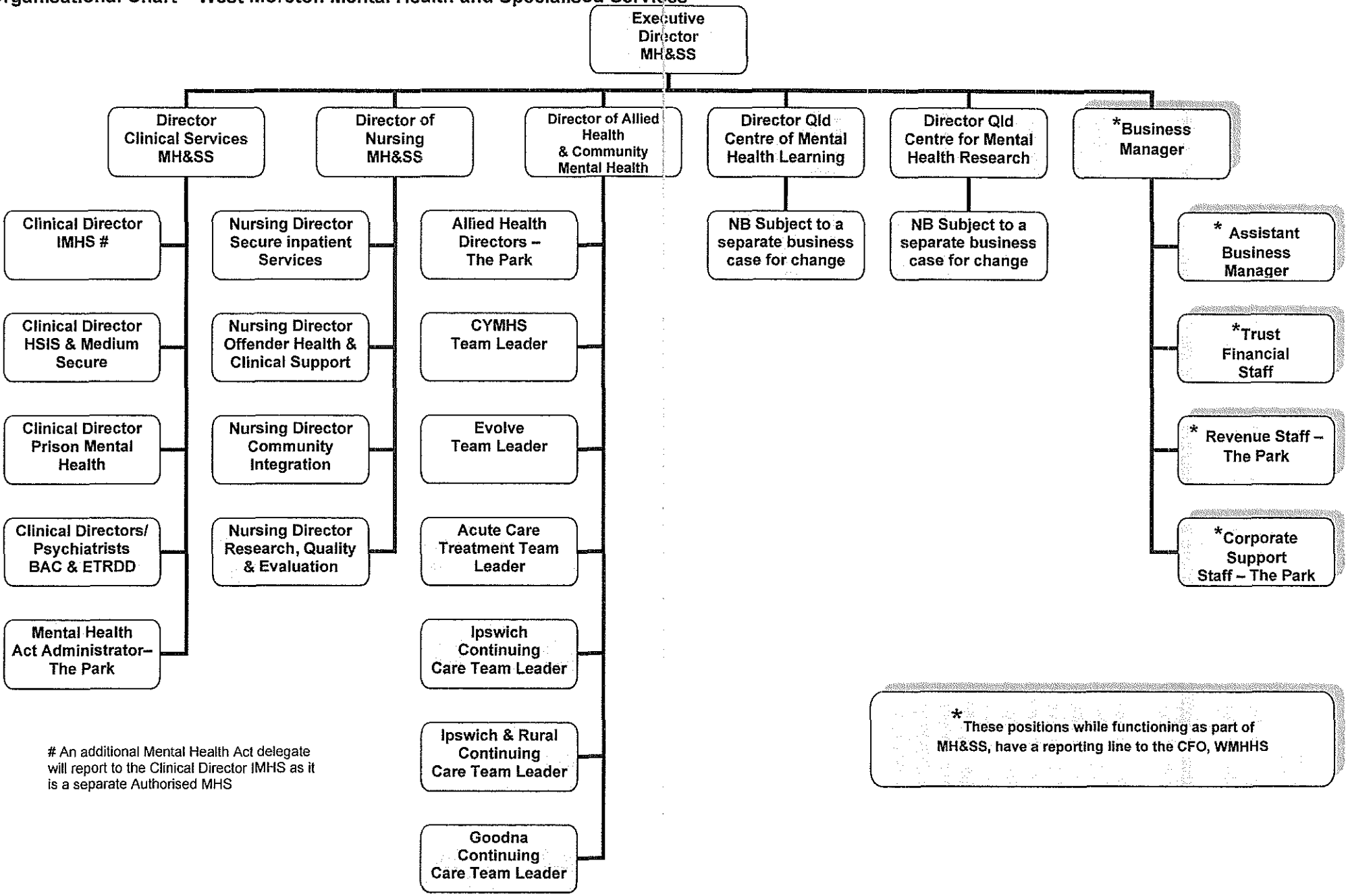
All relevant health professional are also responsible for the maintenance of their level of capability in the provision of health care and their reporting obligations in this regard.

Salary Packaging
To find out whether or not your work unit is eligible for the Public Hospital Fringe Benefits Tax (FBT) Exemption Cap please refer to the Salary Packaging Information Booklet for Queensland Health employees available from the Queensland Health Salary Packaging Bureau Service Provider - RemServ at http://www.remserv.com.au. For further queries regarding salary packaging RemServ's Customer Care Centre may be contacted via telephone on 1300 30 40 10.

Disclosure of Previous Employment as a Lobbyist
Applicants will be required to give a statement of their employment as a lobbyist within one (1) month of taking up the appointment. Details are available at http://www.psc.qld.gov.au/library/document/policy/lobbyist-disclosure-policy.pdf.

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

Organisational Chart – West Moreton Mental Health and Specialised Services



Kids in Mind
Mater Child and Youth Mental Health Service

BARRETT ADOLESCENT CENTRE

CONSULTATION on AGGRESSION and VIOLENCE at the BAC

August 2003

Consult on Aggression & Violence 2003

McDermott
Gullick
Powell
Kyte

TES4005

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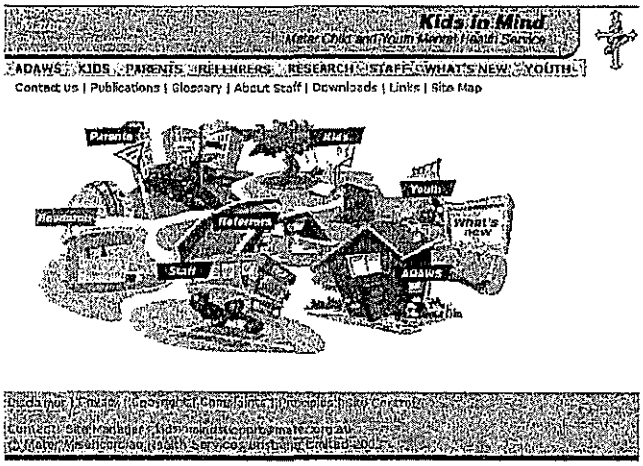
Disclaimer

The opinions expressed in this report are those of the authors and are not necessarily those of any of the existing Barrett Adolescent Centre workers, CYMHS Team Leaders, or Queensland Health. Information in this report is from a combination of new data obtained from the Barrett Adolescent Centre and interviews with Queensland Health staff. The evaluation team are responsible for the methodology, data collection, analysis and conclusions drawn from this data. We thank the Barrett Adolescent Centre for their cooperation with this process, the many discussions around their endeavours and the data made available. Any similar process is fraught with omissions; events, forms, sheets, and questionnaires. We have attempted to minimise such loss, but note it will occur to some degree with this type of project.



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Acknowledgements

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Kids in Mind

Mater Child and Youth Mental Health Service

CONTENTS

Executive Summary

The Barrett Adolescent Centre (BAC) has been providing medium to long term therapy for Queensland adolescents for 20 years. Of itself, this is a commendable record of continuous service provision to a group considered by many parents and professionals to be extremely challenging. In recent times it is likely the client group of the unit has changed with admission of more individuals with challenging, predominantly externalising behaviour, more individuals with broad internalising and externalising behaviour and more serious self harm. This brief review considered the impact of critical incidents at the BAC from a multi-domain perspective: the current risk on the BAC from the perspective of the BAC clientele, BAC management practices, staff, environment and systemic issues, as well as a review of BAC responses to critical incidents.

The review found that there is a significant burden of critical incidents at the BAC across issues dealing with aggression and assault, self harm and being away from the unit without permission. Less prominent incidents included property damage and injuries. The major critical incidents co-occurred in vulnerable individuals. This means that if a patient was involved in an assault they were more likely to be involved in both future assaults as well as self harm incidents. Additionally, it appears that girls were likely to be involved in aggressive behaviour at rates higher than the societal norms.

The review team identified areas for the BAC management to consider in a broad response to critical incidents. Recommendations include consideration of the group most likely to benefit from care at the BAC, more structured and clear admission criteria, greater inclusion of risk management assessment in the clinical care pathway, more scrutiny of the usefulness and application of the risk assessment tool and consideration of staff and environment issues. Changes should include consideration of the current relationship with other service units at The Park as well as BAC responses.

To invest in significant program revision, and policy and procedural change requires enthusiasm and motivation. The review team feel that this is impeded by the current uncertainty about the future of the BAC. In a broad sense, securing certainty about the BAC is an outcome that has a clear implication for improved risk management at the BAC.

RECOMMENDATIONS

The recommendations section is structured as:

(1) General recommendations relating to the BAC target group, clinical care pathway and interventions,

(2) Recommendations pertaining to specific risk management issues,

(3) Over arching recommendations that relate to the continuation of funding of the BAC and the motivation and enthusiasm of staff to implement change. The overarching recommendations should be seen as fundamental to, and equally important to 1 & 2.

(1) General recommendations relating to the BAC target group, clinical care pathway and interventions:

1. In the absence of other forms of outcome measurement, a qualitative and experiential review of the usual clientele admitted to the BAC should be undertaken with a specific objective of considering the most suitable target group for the BAC.

2. The "have a go" ethos of admitting individuals to the BAC should be stopped and all potential referrals should be considered against strict and mutually accepted criteria.

3. BAC admission criteria should be more clearly operationalised.

4. Risk assessment should be specifically included in the BAC referral form and additional referral information obtained.

5. An inclusion of risk assessment should be made in the determination of whether an individual is accepted by the BAC. Issues around risk management should be included in information promulgated by the BAC about its program.

6. It should be more clearly annunciated to referrers, patients, families and staff whether there is a 2 week assessment period at the beginning of a BAC admission.

7. Analysis of risk assessment should be included in the determination of the effectiveness of the two week trial and whether the patient should remain at the BAC.

8. BAC staff should consider programming in the after school and early evening period as a risk management strategy.

9. The BAC should consider smaller groups size for therapeutic and recreational groups.

10. The BAC should consider a restructure of its program into smaller functional units including the possibility of having 2 home groups rather than a larger single cohort of adolescents on the unit.

(2) Recommendations pertaining to specific risk management issues

11. The BAC management should review the use of the risk assessment tool in the adolescence population: whether the tool is valid, the clinical use of the assessment tool findings in the BAC and the evaluation of the assessment tool over time.

12. There are policies related to risk management that have not been reviewed at the BAC for many years, the BAC management should review such policies.

13. The BAC management should instigate a critical and formal process of risk analysis following incidents where there was actual or potential significant morbidity or potential mortality.

14. The appropriateness of the A1-A7 system should be reviewed in light of contemporary changes in patient presentations at the BAC.

15. Consideration of the appropriateness of the category red system in view of the new clientele should be reviewed.

16. All BAC staff should have regular inservice training about risk management.

17. Orientation of new staff should include risk management.

18. There should be clarity about the status of the unit in relation to it being an open (and therefore unlocked) unit; such changes to the status of the unit will have legal implications.

(3) Over arching recommendations that relate to the continuation of funding of the BAC and the motivation and enthusiasm of staff to implement change.

It is the opinion of the review team that a significant amount of money is required to be spent on the BAC environment. Further significant emotional investment in changes of policies and practices is required. Given this burden:

19. Senior BAC and Park management should, as a matter of some urgency, advance with Queensland Health the issue of the continued funding and support of the BAC. Whilst the current work environment of the BAC may be therapeutic to adolescents, the staff milieu is not promoting motivation and enthusiasm to review risk management and other procedures at the BAC.

20. With contemporary understanding of the burden of youth homelessness and school exclusion, the BAC provides an excellent opportunity for youth with mental health and challenging behaviour to live in a safe environment and receive high quality educational and psychological input. For these reasons the review team recommend advocacy for the BAC.

21. However the review team recommend further work in the delineation of the BAC in the continuum of care of adolescent mental health services in SE Queensland. Tasks include the current evidence base for adolescent inpatient care and whether the current broad admission brief should not be changed to focus on a more limited diagnostic range or alternatively to focus on particular challenging behaviours such as individuals with internalising conditions

and mild externalising behaviour or individuals with severe and ongoing suicidality and self harm.

1. BACKGROUND

1.1 HISTORICAL CONTEXT OF THE BAC

The BAC was established in 1983. The unit was established with an overarching treatment ethos of milieu therapy and this has been a unifying treatment theme over the last 20 years. The last 5 years have seen a significant expansion in the number of inpatient child & youth mental health beds across south east Queensland. This includes the opening of inpatient units at The Royal Brisbane Hospital, Mater Children's Hospital, Logan, Gold Coast and Toowoomba, as well as a significant expansion in the community CYMHS clinics. It should be noted that for the new inpatient beds were conceptualised as acute beds, aimed at providing brief admissions around clarification of an individual's mental health diagnosis, the initiation of treatment and movement of the patient back to the community with follow-up by a CYMHS clinic or private practitioner. No other inpatient unit for adolescents has been established with a long stay brief. The Day Program of Mater CYMHS is potentially long stay (1 to 2 school terms) and includes the ability to attend the Mater Children's Hospital school, but has no residential capacity.

With the increase in inpatient beds in south east Queensland the commitment to fund the Barrett Adolescent Centre has become less certain, and indeed at one point it was widely thought the BAC would close. Whilst this clearly did not happen it is true that there is significant ongoing apprehension amongst BAC staff about the continuing funding of the BAC. Further there is considerable discussion amongst staff about how, if it is to continue, the BAC will function within the current South East Queensland continuum of adolescent mental health care.

1.2 Terms of Reference of the current review

- To review the incident profile of the unit over the last four years and to consider the nature and extent of the risk associated with the profile
- To consider the relationship between risks and the current target population, associated diagnostic profile and service model
- To consider the organisational response to the incidents

- To consider the risk management approach in terms of individual risk identification and response efficacy
- To suggest strategies which may reduce the likelihood of further serious incidents.

2. VIOLENCE AND AGGRESSION: DEFINITIONS, PREVALENCE, DETERMINING FACTORS AND IMPACT ON STAFF.

Definitions of Aggression: Multiple definitions for aggression have been suggested. Definitions include 'any threatening verbal or physical behaviour directed toward self or others,' (Owen, 1998), "an act whose goal-response is injury to another organism," (Dollar et al., 1989). Many authors have subdivided aggression type, including O'Leary-Kelly and colleagues. In a review of the literature, they found that terms such as hostile aggression, violent aggression, affective aggression, angry aggression, bullying, emotional and instrumental aggression, impulsive and reactive aggression, environmental aggression and enraged aggression or enraged violence dominate the literature (1996); the schema of Rippon states, "aggression can be physical or verbal, active or passive, and can be focused on the victim(s) directly or indirectly" (2000). Several authors have noted instrumental aggressive "does not have strong emotional basis and yet can be extremely violent" (Buss, 1961).

Definitions of Violence: Steinmetz (1986) defined violence as, 'an act carried out with the intention, or perceived as having the intention, of physically hurting another person". Steinmetz included a broad range of incidents from minor common assault to premeditated murder as violent acts. Others including Strasburg (1978) included legal concepts in a definition of violent behaviour, 'illegal use or threat of force against a person'. Strasborg included a range of crimes such as assault, robbery, sexual impositions and sexual assault, arson, threatening behaviour, kidnapping, burglary and murder. Rippon stated that "by definition, violence is synonymous with aggression", then went on to suggest a distinction by severity, "however, violence is reserved for those acts of aggression that are particularly intense, and are more heinous, infamous irreprehensible" (2000). The Department of Employment, Training and Industrial Relations, in its April 1999 brochure on 'Violence at Work' defined violence as 'the unwarranted or unjust use of force or power'.

In summary, the literature in this area is hampered by significant differences in the definitions of the core constructs. One useful theme is that violence is the act or the behaviour that often follows aggression, whereas aggression is the intent to commit a violent act or forms of behaviour. Examples of these include verbal abuse and physical intimidation that fall short of a physical act against another person.

The following discussion briefly considers violence and aggression prevalence, determining factors and impact on staff. The current literature in this area is predominantly derived from studies of adult mental health units. Generalising these findings to child and adolescent units requires caution.

Prevalence: Many studies have reported the prevalence of mental health staff being involved in acts of violence and aggression. The US Department of Justice statistics report (1992-1996) that 79.5 out of 1000 mental health workers have experienced nonfatal workplace violence. The British Columbia workers compensation board received 600 claims from nurses and health care workers for time lost from acts of violence or force, 10 times more than that from any other occupation. More than half of these are injuries suffered by nurses, care aides and other health care workers while working in long term care facilities, psychiatric hospitals, group homes and acute care hospitals. (Duxbury 2002).

Verbal aggression and threats of violence appear more prevalent than acts of violence, although research reports vary widely. Duxbury (2002) reported that incidents of patient aggression (an expression of hostility or intent to do harm) accounted for 70% of incidents (n= 157) and involved verbal abuse and verbal threats in total, whilst violence accounted for only 13.5% (n=30) of the incidents recorded. However, Nolan et al (1999) reported that 18% of staff had been threatened verbally and that 50% of psychiatric staff have been physically assaulted at some time during their careers. Similarly, Ruben et al., (1980) and Madden et al., (1976) concluded that approximately 50% of psychiatrists had been assaulted during the course of their work and in a multinational survey Poster (1996) found that 75% of mental health nurses had been physically assaulted at least once in their careers. The Poster report is in accordance with Whittington and Wykes (1994) who found 65% of nurses in their study had been violently assaulted by patients and led to their conclusion that there is overwhelming evidence that nurse are more likely to be physically

assaulted, threatened or verbally abused that any other health professional group. (Whittington et al 1996).

Clearly not all patients are violent, indeed, Weiser (1994) estimated that approximately 10% of psychiatric patients are violent towards staff. This includes perpetrating the most serious acts of violence with several documented cases of mental health clinicians being murdered in Australia by current or former patients. There is a poverty of research on aggression and violence by child and adolescent mental health clients, with most studies focusing on adults.

Determining Factors: Studies of adults with mental illness finds a range of illnesses associated with an increase in aggression and violence, including mania (Lion et al, 1981,) schizophrenia (Pearson et al., 1986), borderline personality disorder (Hansen, 1996) antisocial personality disorders and psychotic disorders (Whittington 1997). Other factors include male gender (Duxbury, 2002; Morrison et al,2002), age ranging from 15 to 30 (James et al; Noble and Rogers, 1989; West, 1974), a previous history of violence (Flannery et al., 1994; Whittington, 1998; Owen et al., 1998 b) and patients who were on a high level of medications (Duxbury, 2002; Lion et al., 1981; Pearson et al., 1986; Finke 2001). Others report substance abuse (Lanza, 1988; Flannery et al 1994; Royal College of Psychiatrists, 1988) as a key indicator for potential for violence.

Length of stay has been reported as being an influential factor with long stay adult patients most likely to be violent (Morrison et al., 2002; Barber, Hundley, Kellogg, 1988). Studies on adolescents concur with these findings (Finke, 2001; Owen et al., 1998). Involuntary status under a mental health act was found to be a factor in patients most likely to be violent. Other precursors to violence and aggression were confusional states, non-compliance with medication (Whittington et al., 1996) and short hospital stays in overcrowded wards (Edwards and Reid).

Staff factors were seen to be important by Duxbury, "Factors including staff gender, experience, training and grade are also believed to have some impact upon the incidence of patient aggression and violence" (2002). Vanderslott found that male nursing staff were more commonly attacked than female staff, possibly because they are frequently involved in containing aggressive outbursts (1998). Hatch and colleagues postulated that, "female staff might also use non-aggressive strategies to de-escalate tension and aggression rather than the traditional male, "police-like"

techniques that could generate a power struggle instead of diffuse anger" (2002). This opinion has not been universally replicated with some studies suggesting that women are at higher risk (Binder, Ednie, Lanza and Wykes). However, in a general a review the consensus appears to be that women in mental health care settings are not at increased risk for patient assault.

A caveat may be the pregnant female staff member. Binder (1991) reviewed this literature and concluded that pregnancy remains a significant mental health work-related issue. The literature repeatedly reports instances of patients experiencing envy, abandonment, rejection maternal transference and aggression toward the therapist, including fantasies of hurting or killing both the therapist and the infant. Overall the literature in this area points to pregnancy as a significant risk factor for women, particularly in violence prone environments such as acute care wards, emergency rooms and forensic settings.

Research supporting the argument that staff grade may be correlated with the incidence of patient aggression or that less senior nursing staff are more commonly the victims of aggression and violence is inconclusive. Hodgkinson and colleagues 1985 found that student nurses were assaulted more often than trained or qualified staff (1985). Vanderslott reported that care assistants who are most at risk (1998). Other studies suggest students are at greater risk. In one study student nurses student nurses making up 19% of staff, but sustaining 24% of assault caused injury (doc 15). In another study physical assaults were higher among student nurses especially those with no training in conflict resolution (Grenade and Macdonald 1995). Nursing seniority may confer protection through experience and competent. Alternatively less senior staff may spend more time with patients and this in turn may make them more vulnerable to acts of violence and aggression. (Whittington and Wykes 1994b; Vanderslott 1998). With psychiatrists age and experience also appear to be linked with risk; younger clinicians with less experience were at a significantly greater risk for patient assault than older more experienced psychiatrists.

When: The literature is varied as to when violent and aggressive incidents occur. Results differ markedly with reports showing time periods for incidents are across the day (Cottrell, 1980; Whittington and Wykes, 1994b; Vanderslott 1998), with fewer incidences at lunch or after midnight. Low levels of staffing, such as when handovers occur (Carmel & Hunter 1993) and when staff are handing out medication and around meal times (Owen et al., 1998; Carmel & Hunter, 1993) are other predictive factors for increases in violence and aggression.

Where: Issues that have been examined include building deficits such as limited space or provisions for privacy, overcrowding, hospital shifts, the timing of assaults, raised temperature and additional poor environmental provisions (Nijman et al 1999). However, Blair and New argue that most studies in this area are inconclusive (1991). Recent guidelines by the royal college of psychiatrists (1998) recommend that hospital environments should be comfortable, safe, private, homely and free from noxious environmental factors as far as possible. Staff most commonly identified factors contributing to the development of patient aggression as problematic interactions and restrictive environments. The latter was deemed to cause over one-quarter of all incidents reported. High-risk areas, include bathrooms and bedrooms, ward corridors and dayrooms.

Why: Human resource issues are a common theme. Reduced numbers of staff, and an overuse of casual staff (Turnbull and Patterson 1999), inexperience, increased workload and low levels of training are probable factors. Management of the milieu has been implicated, mediated by numerous factors: the impact of varying staff, controlling styles, negative interactions, poor or limited communication and interaction with patients, authoritarian management approaches, and punitive management and interventions (Morrison, 2002; Anderson & Roper 1991; Garrison et al., 1990; Goren, Singh & Best, 1993).

The issue of negative staff interactional styles and limited communication skills is a cause for concern, particularly given the evidence of staff lack of awareness about the impact of these deficits. In one research project (staff) when surveyed did not view their interaction with patients to be problematic despite finding that almost one fifth of incidents of the incidents in practice (MSOAS) were reported to be the direct result of staff-patient interaction. Concomitant with poor staff insight may be lack of training in precursors to patient aggression such as self presentation and self awareness (Farrell and Gray 1992) to limited interaction with patients prior to incidents (Whittington and Wykes 1994a, 1994b.)

Impact on staff: There is an ever prevailing theme of a cultural acceptance of violence and aggression in mental health facilities. Most nurses believe that violence and assault are part of the job, and also that workplace violence has a normative effect, meaning that violent acts and aggression become accepted as a normal part of the workplace culture (Erikson & Williams Evans, 2000; Thomas, 1995; Scott, 1999). One reason for denial may be that mental health care

provider's overestimate their ability to remain objective toward their patients in the face of personally disturbing incidence and deal with their assault at a cognitive rather than emotional level. (Wykes & Whittington 1998)

Workplace violence literature notes that the issues of cost to the organization remains of paramount concern (Wykes & Whittington 1998). Cost is typically conceptualized in terms of the individual worker (physical/physiological and mental/emotional issues) and the organization. At the individual level, physical cost refer to consequences of workplace violence such as disrupted sleep, cardiopulmonary problems, fatigue, hypertension, and susceptibility to illness, while emotional costs encompass issues such as depression, loss of self esteem, family conflict, cynicism, anger and impaired coping. At the organizational level, costs are associated with decreased worker productivity and morale, lost working days, legal liability costs, employee turnover and resources allocated to rehiring and retraining. (Barrett et al., 1997).

Wykes & Whittington (1998) found that of the psychiatric intensive care nurses who had reported being recently assaulted, 25% reported feeling jumpier, overly alert, and bothered by recurrent thoughts about the incident. One third of the assaulted nurses indicated they experienced significant psychological distress and anger following the incident. Assault victims see themselves as weak and often continue to fear the patient after the assault. Threats were reported to be as likely to cause psychological distress and disruption of service delivery in staff as were physical or sexual assaults (Flannery et al., 1995). There is evidence that increasing numbers of nursing and other health professionals are suffering the effects of PTSD (Rippon 2000), anxiety, impaired work performance (Robbins, 1997) and difficulties with sleep as a result of hostility and violence in the workplace (Fisher et al., 1995).

3. INTRODUCTION TO THIS CONSULTATION

The review team consisted of Melissa Kyte, consumer consultant at the Barrett Adolescent Centre, Ms Karen Gullick, Manager of The Hollywood Clinic, Hollywood Private Hospital in Perth, Western Australia and Dr Jacinta Powell from the Mental Health Unit, Queensland Health. Associate Professor McDermott, Director of the Mater Child and Youth Mental Health Service was the Chair of the Review Team. Context expertise in child and adolescent mental health was provided by members Gullick and McDermott. Ms Gullick has many years experience in various roles within child and adolescent mental health, and for 7 years managed an inpatient child and adolescent mental health unit. Dr Powell has extensive experience in reviews of risk management including recent reviews of adult mental health units. Melissa Kyte's consumer experience of child and adolescent mental health services included admission at the Barrett Adolescent Centre.

3.1 Staff and consumers consulted

The review team worked for three days at the BAC, and during this period, consultation time was offered to all staff members. Staff appeared very interested in the review and were open and helpful during the process. They were consulted individually and in small groups and whilst no staff member requested confidentiality per se, the review team consider it more appropriate to indicate the professional background of staff consulted rather than a list of individual staff members.

Table 3.1: Professions of staff consulted.

BAC Medical Director
BAC Nursing Practice Coordinator
Senior nursing practitioner (level 3) ?Nursing Unit Manager
Nursing staff (level 2)
Specific nurses involved in critical incidents
Community Liaison Officer
Adventure therapy coordinator
School teachers
Occupational Therapist
Consumers (specifically consulted by the consumer representative of the review team)
Police liaison officer
Social worker

The consultation included two meetings with the Executive Director and Clinical Director of The Park.

3.2 Access to documentation

Access to policy manuals, orientation information, standard forms and patient records was provided as requested by the review team.

The review team specifically considered the patient medical records of four critical incidents. These incidents were considered by staff to have conferred a high degree of risk to staff and/or patients of the BAC. Such charts were reviewed initially against BAC polices and procedures as given by existing BAC documentation and then against current best practice (as agreed by the review team). A number of charts randomly drawn from current BAC patients were also considered.

3.3 Access to Data

Summary data on critical incidents presented in graphical form was made available to the review team and is included in the appendices of this report.

The review team were interested in the whether the critical incident data was of sufficient quality for more detailed analysis. All critical incident forms completed at the BAC were obtained from 2000 until June 2003, entered and analysed. Details of this analysis are in section 4.1.b.

4. CURRENT STATUS OF RISK ON THE BAC

4.1. Client Profile of the BAC

The review team were informed that the current bed platform of the BAC was 15 beds with an additional 5 outpatient places. Occasionally there are more inpatients and indeed during the week of the consultation, there were 16 patients. A presentation from the Director of the BAC delineated the type of clientele seen at the BAC. Diagnoses of patients attending the BAC are listed below.

Table 4.1: Range of diagnostic groups admitted to the BAC

Psychosis,
Depressive disorders,
Avoidant anxious disorders,
OCD,
Tourette's Syndrome,
Eating disorders
Traumatic stress disorders,
Asperger's Syndrome.

From this presentation it was noted that the BAC accepted a wide range of individuals with a wide range of presentations and would generally give many individuals "a go" to see whether they could use the therapy offered at the BAC. This philosophy was stated by most senior clinicians, and they were clear that the admission criteria were quite open, i.e. from 13 to 17 years of age with a clear psychiatric illness, and suitable to be on an open unit and with evidence of client and family commitment. Individuals with substance abuse, with a diagnosis of only conduct disorder or who had moderate or severe intellectual handicap were excluded from the BAC.

There was a clear perception from all levels of clinical and management staff that the type of clients seen at BAC has changed over recent years. Many clinical staff noted there was a mismatch of recently referred adolescents with the original treatment philosophy at the unit, mainly manifest by an increase in the amount of disturbed behaviour including increased client histories of aggression and social problems. Some clinicians felt there were more patients with co-morbid drug and alcohol problems or adolescents from geographically remote locations, including Darwin. Some clinicians noted that the recent occurrence of finding several patients in possession of weapons was very unusual in the long history of the BAC. Lastly, many staff felt that the unit was under increasing pressure from external stakeholders to accept children whose presentations did not meet the admission criteria for the unit, and who in fact would previously have been excluded because of those presentations. Examples included adolescents on remand from the Brisbane Youth Detention Centre.

4.2 Risk Profile: Review of existing data analysis

The review team were provided with a powerpoint presentation of the incident profile of the BAC from January 2001 to March 2003. This information is found in Appendix 1, Figure A1 The Adolescent Incident Profile 2001-03, in which incidents have been aggregated into aggressive incidents, absent without leave (AWOL), self harm and 'other' incidents. In the 28 months graphically represented, 12 months have incidents from all 4 different categories recorded. Ten months have 3 different types of incidents, 6 months have only 2 types of incidents, no month has only one type of incident. There is no month at the BAC without a recorded incident. The range of incidents over this period is from 26 incidents occurring in June 02 and March 03 to a low of 3 incidents occurring in February 03. There is no significant seasonal variation with all types of incidents evenly spread across the reporting period. The most frequent type of incident by month was aggression and self harm. Both categories were represented in 24 of the 28 month reporting period, followed by 'other' (22 of 28 months) and AWOL (20 of 28 months).

Some analysis is provided in the BAC briefing material. The relationship between assault and aggression and absconding can be found also in Appendix 1 page 2. It is reported that 17 of 19 adolescents who absconded from the unit were also involved in aggression. Reasons for

absconding varied. Some absconding behaviour was driven by suicidal intent, peer pressure and a desire to obtain drugs. Six of 19 individuals used alcohol or substances when they absconded. Some comment is also included on page 3 of the relation to prior aggression stating that the group with the highest incidence of aggression prior to admission were a group who were reported as "violent at home", had perpetrated "physical attacks on parents" or demonstrated "excessive violence towards siblings". However, it was reported that only one of this group was involved in aggression at BAC. Nine of 34 adolescents involved in incidents of aggressive assault had antecedent conduct disturbance. The analysis does not mention the type of statistical test employed or the level of significance of the finding.

4.3 Risk profile: new data analysis

Critical incident reports were available on 93 patients. The mean patient age during the admission was 15.37 years (SD 1.25yrs), ages ranged from 13 to 18 years. There was a non significant over-representation of female patients (52.1% versus 47.9%). The majority of patients involved in critical incidents were Australian born (94.5%), all spoke English in the family home. No patient in this sample identified their ethnicity as Aboriginal or Torres Strait Islander.

Table 4.1:

total number of incidents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00	42	45.2	45.7	45.7
	2.00	14	15.1	15.2	60.9
	3.00	5	5.4	5.4	66.3
	4.00	5	5.4	5.4	71.7
	5.00	4	4.3	4.3	76.1
	6.00	3	3.2	3.3	79.3
	7.00	2	2.2	2.2	81.5
	8.00	3	3.2	3.3	84.8
	9.00	1	1.1	1.1	85.9
	10.00	2	2.2	2.2	88.0
	11.00	2	2.2	2.2	90.2
	13.00	2	2.2	2.2	92.4
	16.00	2	2.2	2.2	94.6
	18.00	1	1.1	1.1	95.7
	19.00	1	1.1	1.1	96.7
	29.00	1	1.1	1.1	97.8
	37.00	1	1.1	1.1	98.9
	70.00	1	1.1	1.1	100.0
	Total	92	98.9	100.0	
Missing	System	1	1.1		
Total		93	100.0		

An important consideration about this analysis is that the results presented are indicative only. The analysis does not at present meet a research standard, given the need to further review and clean the data. Most variables have between 5-15% of missing data and this could be improved with further work. Further, most analyses were run without the results of one patient, an individual who was a significant statistical outlier. This person was responsible for 70 critical incidents whilst at the BAC, approximately 16 times the average incidents per patient in the CI sample.

Table 4.1 above highlights that out of 463 incidents 45.7 percent of patients accounted for only one incident, 60.9 percent account for 2 incidents. However, there is a substantial minority of patients would are involved in repetitive critical incidents, and indeed 12% of this sample were involved in 10 or more incidents.

Figure 4.1: Relative frequency of Critical Incident Type

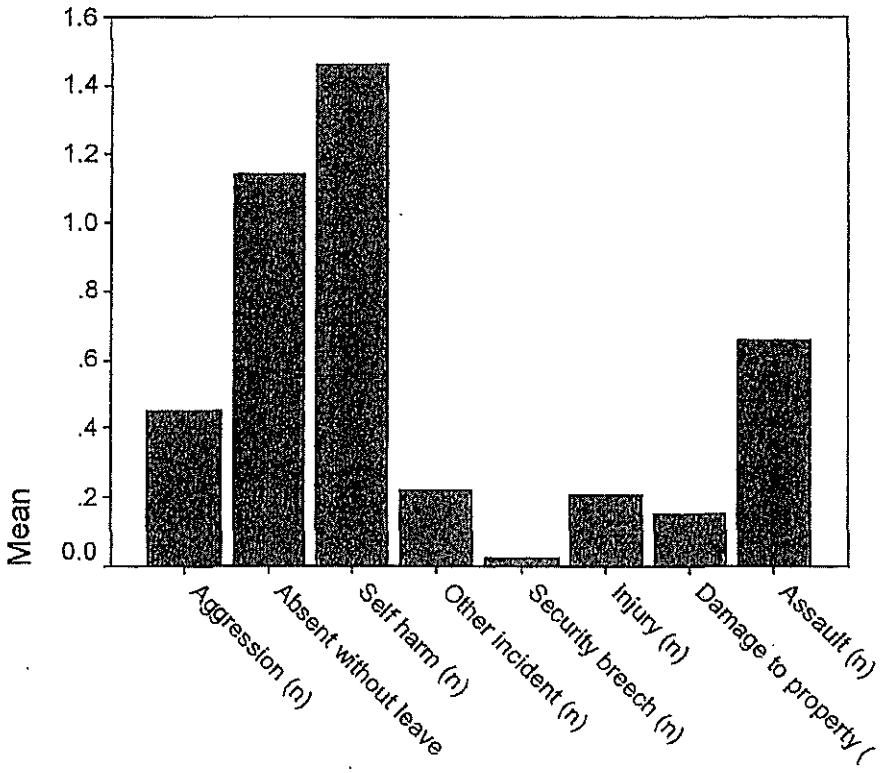
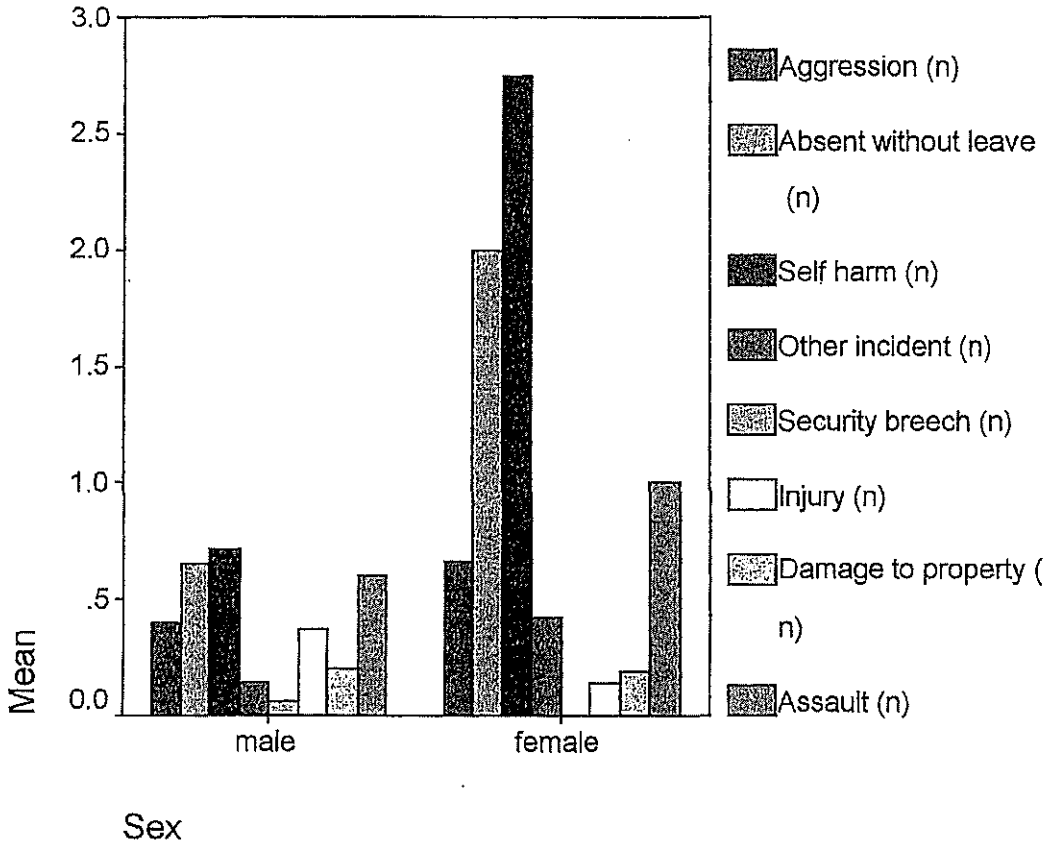


Figure 4.1 above depicts critical incident by incident type.

Self-harm was the most common critical incident occurring at the BAC. During this reporting period there were 134 incidents of self harm occurring in 33.7% of the critical incident patient sample. If self-harm occurred the patient was likely to do so on multiple occasions, given only 10.4% of the self harm group did so on only one occasion. In contrast approaching half of the sample (43.3%) of the self-harm group did so on 10 or more times. Self harm was significantly more likely to be perpetrated by female patients (female mean self harm = 2.703, male = 0.714, T_{70} =-2.232, p = .029). There was no correlation between patient age and number of self harming incidents. Self harm by gender is graphically represented in Figure 4.2.

Figure 4.2 Critical Incident category by Gender



An **absent without leave (AWOL)** critical incident was recorded 104 times during the reporting period. 41 individuals were involved in one or more AWOL incidents, 22.2% of the CI sample had at least one AWOL incident. AWOL incidents were less likely to be multiple than self harm incidents: 54% of AWOL patients did so on only one occasion, 83% between 1 and 3 occasions and only 15% on more than 6 occasions. Significantly more female patients were involved in AWOL incidents (mean female AWOL = 2.000, male = 0.657, $T_{69} = -2.470$, $p = 0.016$). There was a trend ($p = .076$) for AWOL incidents to involve older patients.

An incident of **assault** was recorded 50 times during the reporting period. 33 individuals were involved in one or more assault incidents, 25.3% of the CI sample had at least one assault

incident. Similar to the AWOL data, multiple incidents of assault was uncommon, 69% of patients were involved in one assault incident rapidly declining to 12% involved in two assaults and 18% in more than 2 assaults. The data suggests some tolerance to an act of assault: 2 patients were involved in 4 assaults, 3 patients in 5 assaults, 1 patient in 6 assaults. There was no gender or age difference in patients involved in assault incidents.

An incident of **aggression** was recorded 41 times during the reporting period. 24 individuals were involved in one or more aggressive incidents, 17.4% of the CI sample had at least one assault incident. Similar to the AWOL and assault data, multiple incidents of aggression was uncommon, 67% of patients were involved in one aggressive incident declining to 21% involved in two assaults and 12% in more than 2 assaults. Three individuals accounted for 4, 5 and 6 aggressive incidents respectively. There was no gender or age difference in patients involved in assault incidents.

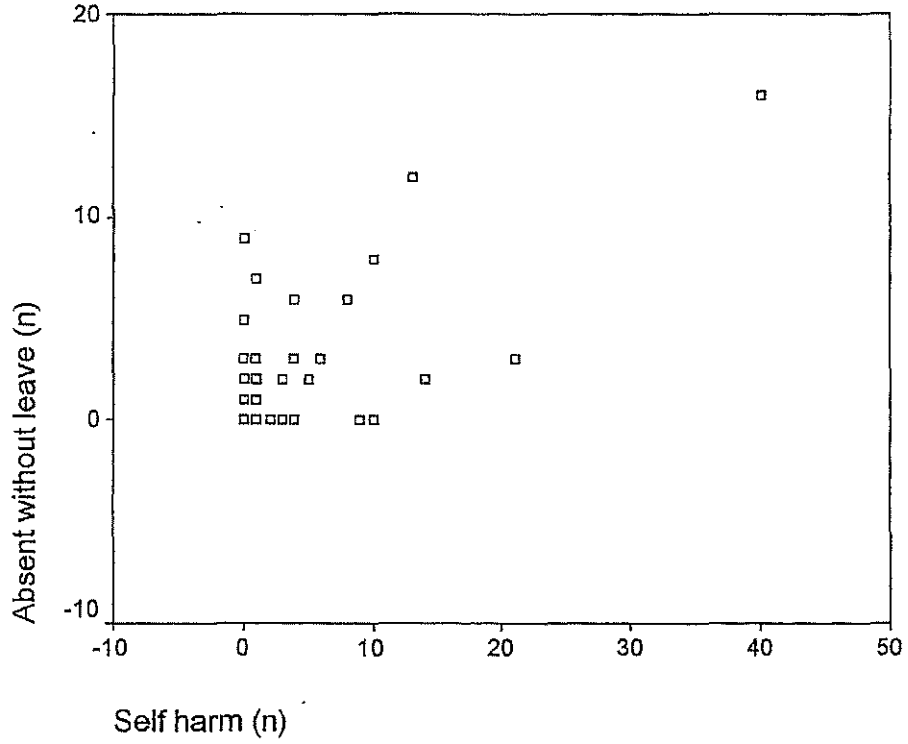
No separated analysis was performed on low prevalence incidents such as injury (n = 20, 4.3% of all incidents), 'other' (n = 20, 4.3% of all incidents), property damage (n = 19, 4.1% of all incidents) and security breach (n = 2, 0.4% of all incidents).

Table 4.2 below, highlights the significant relationship between the most common variables with significant bivariate correlations between incidents reported as aggression and assault, AWOL and self harm, assault and AWOL and self harm and AWOL. The example of self harm and AWOL is graphical depicted in Figure 4.3. Whilst a higher order factor such as gender may be found following multivariate analysis with a larger sample size these results suggest that multiple forms of critical incidents cluster in individuals. The clinical implication is that if a patient is involved in one form of critical incident, the clinical staff should be aware of the potential for further incidents in that as well as in other domains of critical incidents.

Table 4.2 Summary of Bivariate analyses (Pearson's correlation) of the four most common critical incidents

	Aggression	Assault	AWOL	Self harm
Aggression: p (2-tailed)		.000	.000	.000
Assault			.033	NS (.183)
AWOL				.000

Figure 4.3 Simple Scattergram of AWOL versus Self-harm incidents



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4.4 Current service delivery model

The BAC model was described to the review team as a milieu therapy model with adjunctive therapy mainly in the form of adventure therapy, individual therapy and psychopharmacology. The medical support to the BAC and hence the medication prescribers were the BAC Director and a psychiatry registrar. Individual therapy was provided formally primarily by allied health professionals. The form of individual therapy depended on the therapist: cognitive – behavioural and psychodynamic approaches were cited. It was not clear whether all adolescents were offered individual therapy, and on what grounds it was offered. The nursing case management role is also central to the therapeutic process, and during the course of an admission, would constitute a significant long term relationship for the adolescents admitted. Several staff members noted the current limited family therapy capacity due to an unfilled allied health position.

Certain aspects of the therapy programme seemed unclear to some staff. An example of this is the two week assessment period. Several staff were unsure about whether that still happened or not. In any case, there did not appear to be a formal review following the two week assessment, and nor was the outcome made overt to any of the relevant parties.

4.5 Current Admission Pathway

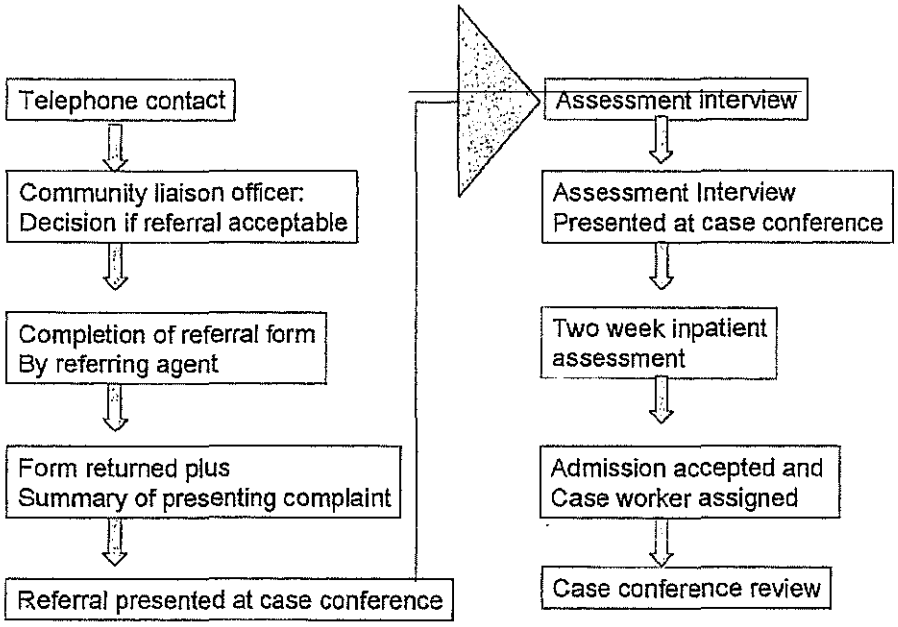
Figure 4.4 below, highlights the BAC clinical and administrative pathway from the first telephone contact with the BAC until a patient is accepted for an inpatient treatment stay.

Central to this process is the Community Liaison Officer's role. The role includes (1) Triaging telephone referrals, including the initial decision as to whether the patient seems acceptable, (2) presenting the case at the referral meeting, (3) completing the assessment interview with the registrar and (4) presenting the case at case the conference. The centrality of this worker clearly provides some consistency to the process, but may at some level not be appropriate. Issues include potential differences in the understanding of suitable referrals between the Community Liaison Officer and nursing staff or senior clinical staff.

Secondly, there is the potential for idiosyncratic practices or detailed understanding of systemic issues and processes residing in one individual and not generalising to the broader clinical team.

Another issue noted by several staff was that referrals were often considered at the end of the case conference. The identified problems arising from this process included staff having to

Figure 4.4: BAC Referral and Admission acceptance pathway



leave the meeting prior to discussing new referrals, time constraints on this item of discussion and fatigue at the end of an otherwise busy meeting. Given the importance of selecting appropriate adolescents for the milieu, it would appear that this process needs to be managed differently.

4.6 Treatment Model

Most staff stated that the BAC had an over-arching theme of working in a milieu therapy model with an adjunctive individual, group, family and adventure based therapy. A recent staff vacancy had diminished the availability family therapy. It was the opinion of the reviewing team that a more indepth understanding of the milieu model was not easily accessible either from staff or from the documentation provided. It was also apparent that whilst the senior and long serving

members of the team appeared to have a common understanding of the meaning of this model, newer staff felt that they hadn't been orientated to this, and felt that they were expected to learn on the job. Given the importance of staff roles in 'maintaining the milieu', this would need to be addressed.

4.7 Specific risk strategies

The **A1-A7 programs** are a series of behaviour management programs employed at the BAC. They are well documented, available to all staff as typed sheets and have been in use for many years. The review team noted the programs were developed before the current clientele with the more recent emphasis on externalising behaviour and consider the relevance of these programs to this client group is untested and there is no documented evidence that these programs change/effect behaviour. The programs could be seen to create a consistent response to behaviour, however, individual patients contexts differ, and a patient centred response that requires an adolescent to accept responsibility and participate in negotiating consequences may be useful. The review team felt that compliance with the 'A' program could be erroneously seen as the young person accepting responsibility.

Programs are a very 'public' response to behaviours. Some programs require restrictions to be in place for up to 48 hours. The review team were unsure that this fits with 'short, sharp and meaningful' consequences to behaviour. Further, the program would be 'monitored' by a number of staff over that period, leaving it open to interpretation. Indeed, some staff mentioned that they make modifications to the programmes when implementing them. Some consequences seem dissonant with the 'offence'; for instance a 48-hour response for a consistently untidy bedroom (A3).

More broad responses (other than A1-7) include '**suspension**' from BAC. Staff were of the opinion this was used more in the past, but homelessness and patients from geographically isolated areas make that impossible in some instances. Suspension was seen as a valuable response to some situations, as it allowed some "cooling off" and reflection on the part of the adolescent, and enabled a re-negotiation of expectations on return. The other advantage was that

family members were involved, and their support in the process had the potential to strengthen the relationship between them and the BAC.

4.8 Staff issues

An overarching staff issue was the concerns by BAC staff that the ongoing funding uncertainty hampered the capacity of the BAC to recruit and retain high quality staff. Many staff members felt that staff would preferentially move to or apply to units with a more certain future.

There were a range of staff issues that individual BAC staff members felt were related to critical incidents on the unit. Certainly there appears to be a growing lack of confidence in the BAC and Park's ability to respond in a timely and safe way to unexpected incidents, and this is affecting morale. There is a current position open for a family therapist, and staff felt that this position would not only increase the range of therapy available at the BAC but also the skills of a family therapist in thinking systemically were also valued. The position remains unfilled due to the need to fund the increased staff required when a category red is in place. Staff noted that the gym equipment available at the BAC was presently not able to be used because of the lack of a qualified trainer who could supervise the use of this equipment. Staff noted that this was a source of frustration for many patients who enjoyed using gym equipment and this form of exercise was a pro-social use of energy.

There review team also heard many positive comments about the internal peer support within the BAC. However, there was a sense of resignation to the continuation of the untenable position of being uncertain about the future.

4.9 Environmental issues

Maintaining a safe environment includes the need to ensure that all equipment (including furniture) is well maintained, especially in high-risk areas. This is fundamental modelling, in that it gives the adolescents a clear message about the importance of living in a clean and functional environment. It also impacts on staff morale.

The review team noted that whilst the main dining/ recreation areas appeared to be very clean, tidy and light, there did appear to be a lot of 'clutter' in other areas, including broken and unused equipment.

Added to this, the majority of staff cited concerns about the physical environment of the BAC. All staff stated that of the two accommodation corridors presented a considerable risk, especially the corridor furthest from the nursing station, which was not in line of sight of nurses. The other corridor was visible to nursing staff, however, the bedrooms at the far end of the corridor were still reasonably inaccessible. Staff also noted that the age of the building and the style of the building made for many small and out of the way spaces that were potential places for an individual to self harm or to hide belongings that were not allowed on the BAC and indeed this has been their experience.

The staff involved in the critical incident in which a [redacted] were very clear in their concerns about the extensive amount of glass in the unit. The likelihood is that this glass is not of a suitable strength to be in this type of unit, nor is it covered by a protective film that would stop the glass breaking into shards. It was of interest to note that the police liaison officer, who has some experience in matters related to physical safety of environments, has ongoing concerns about the safety of the environment at the BAC. It was the opinion of the review team that the building looked dated and that it would benefit from a process that established whether it could be improved by significant modifications or a new type of facility was required. A major advantage to the BAC was the space and parkland around the unit. However, this was not itself without problems in that the review team was told that the access to the oval had been recently restricted because of the oval being sold. In addition access to a nearby auditorium that had been fairly extensively used by BAC for badminton and other activities had also been stopped.

4.10 Systemic issues

The relationship between BAC and the Park: Staff cited considerable uncertainty about the ability and willingness of staff members from other Park areas to be of assistance to the BAC during critical incidents. Indeed several examples were given including one response by other staff members of The Park to a critical incident, where the response included a 'drive by' and the discovery that a serious incident was occurring only happened fortuitously. Some staff noted that The Park redevelopment and the creation of more discreet service entities, in their opinion, diminished the ability of units to cooperate on the campus. Other staff noted, in their opinion, a campus wide lack of appreciation of both the type of patients seen at the BAC and the potential for dangerousness of the BAC patient group.

The relationship between BAC and the other CAMHS units: this was difficult to assess given comments were only available from BAC staff. It was stated by staff that the BAC received referrals from CYMHS teams in all regions and that suitable working relationships existed with other CYMHS units.

Staff team relationships: Staff reported excellent communication between school and nursing and allied staff, and the teaching staff reported that they feel very well supported by nursing staff if there is a problem. Teachers reported 'useful' things as being: peer support from other teachers; nurses on duty in the school; they don't ever feel that people are critical; they have regular meetings to discuss issues; they have regular meetings with the nurses to handover info; the common understanding that 'we're all here to help the kids'.

The BAC and the Brisbane Youth Detention Centre (BYDC): there had been several individuals referred from the Brisbane Youth Detention Centre which is geographically close to the BAC. Whilst there was an overall ethos of the BAC of giving youth "a go" and seeing who could benefit from the program, given the types of offence that have led individuals to be in the Brisbane Youth Detention Centre it is likely that this group is at greater risk of creating critical incidents on the BAC. In-reach services would seem to be more appropriate, but this issue is outside the scope of this review.

Geographically isolated patients: It was the opinion of many staff that current patients were increasingly likely to be admitted from geographically very distant areas. Clear problems with such a regime included the decreased probability of visiting from friends and relatives, the diminished possibility of going on outings away from the unit with friends and relatives and the psychological implications of being dislocated from your local social network. In this regard there was some degree of double jeopardy: (a) you are going to a new residential environment which involves group living that the adolescent may have not experienced before and (b) this new residential experience is far from the normal place of abode and social networks. It was the opinion of staff that such individuals were more likely to be distressed through this process and this was a possible risk factor for critical incidents.

4.11 Risk Management Related Training

All Park staff attend compulsory training in manual handling, CPR, fire procedures and aggression management training (PART program, 3 days duration followed by refresher program). All staff spoken to believed that the PART program was both useful and relevant. Apart from the compulsory training, there does not appear to be any BAC unit based training.

4.12 Orientation of new staff

An orientation manual and checklist for new staff exists. This process covers all administrative requirements for new staff coming into the BAC, however there was some difficulty obtaining a copy of the manual, and it appears that the information needs updating in some areas. Several newer staff reported that they had not in fact been orientated to the unit.

5. CURRENT RESPONSES BY THE BAC

Current responses to escalating issues include the use of the various behaviour management plans, and include completing documented risk management ratings. The review team noted that there was little coherence between documented risk and management plans on occasion. It was difficult to establish what the management plan was apart from the typed multidisciplinary plan, which prescribed generic interventions. Documentation of management plans following case conferences varied greatly in the notes reviewed.

Recent events have left several staff feeling very unsupported, and indeed with unresolved stress related issues. Whilst all staff who spoke to the review team felt that there was very good internal and informal support following incidents, the lack of formal review process and subsequent changes to policy, practice or procedure left staff feeling that there was little between then and the next incident. Recently there has been use of an external facilitator on two occasions, however, their role appeared more debriefing than process analysis.

5.1 Review of case notes

Rather than provide outlines of individual cases and reported critical incidents, this section will details themes across the cases reviewed, including issues from case files and issues that arose when discussing cases with staff.

The review team found little evidence either documented or from staff report that a review of process related to critical incidents takes place. Risk management is not a theme that is easily found in case notes apart from the risk assessment forms. It was difficult to find specific and individualised plans that relate to self harm, aggression of AWOL incidents. This extended to the individual care plans, which were often not ungraded in general as well as specifically about

risk. From a review of some notes, the level of risk assessed did not appear to influence decision-making in some instances.

AWOL was specifically mentioned in case notes with case note information and Staff report suggesting that the "retrieval from AWOL rate" is very high. Verbal report indicates that staff, with the aid of security staff, pursue young people in the local area, and will use physical methods to return young person to the BAC. If this occurred with a voluntary patient, the review team were unsure of the legality of such a procedure. Clearly a negative of the physical environment is the amount of open space that can be used to abscond too. It seems that many patients undertake a 5-minute walk across parkland to train station.

5.2 Review of Policies and procedures

It is a BAC policy to complete risk assessment relating to absconding, self harm and aggression: (1) prior to admission by the referring agent, (2) on admission, (3) reviewed at case conference and (4) post-incident.

The review team identified several issues with the risk assessment protocols. The risk assessment tools did not clearly indicated how to score or interpret the results of the assessment, and staff reported that they were not trained in its use. There was no clear pathway between assessment and a proactive management plan with the exception of placing the patient on a CAT RED. There was no available evidence that the risk assessment tool was relevant to or had an evidence-base in the adolescent population

Some risk assessment and management polices and procedures appeared overly universal for instance searching bags and rooms, locking bedrooms during the day, searching day patient's bags. Whilst such activities may have uncovered prohibited weapons or substances there was no evidence of the efficacy of such activities, no obvious audit of this practice and in the opinion of the review team, it has the potential to create a culture of mistrust. "Living up" to this mistrust may increase\the overall risk in the unit.

Many staff demonstrated confusion between critical incident stress debriefing (CISD) and a risk review and management process. When CISD was mentioned the 'informal' nature of the debriefing was cited by some staff as useful.

A brief review of the adventure therapy programme manual was undertaken, as well as informal discussion with the coordinator. The standards set by several outside organisations in relation to adventure therapy, and the components of it, are adhered to in this programme. The low critical incident rate whilst adolescents (and indeed staff) are participating in the programme is testament to the adherence to those standards, and to the carefully planned and managed events. The philosophy of adventure therapy as explained to the review team and would appear to contribute to the risk management in this programme. The maintenance of equipment and emergency plans also contributes. Nevertheless, involving a group of adolescents presenting with psychiatric and behavioural problems does increase the risk factor. The fitness level of staff may present a risk at another level.

5.3 Review of Critical Incident process

The review team found little evidence that a review of processes related to critical incidents takes place in any consistent or meaningful way. Indeed many staff confused this question with the opportunity for staff support and debriefing following an incident, citing that an external facilitator has been used recently after a critical incident.

The review team are of the opinion the BAC needs to establish a process whereby incidents considered to have potentially major consequences are investigated.

The review team are of the opinion The Park needs to consider updating incident forums for the risk assessment to include looking at the

(1) actual outcome,
(2) potential outcome,
(3) likelihood of the event re-occurring and then
(4) looking in-depth at the responses. (A root cause analysis or similar process)

This process needs to become the basis for change in practice as it related to risk and critical incidents. Such an analysis would include what happened, why and how it happened, what opportunities are there to prevent further occurrence. A response should consider communication, training and experience, fatigue and rostering, environment and equipment, rules, policies and procedures, and other barriers that become the evident. It will assist the staff to identify deficits in policy, procedure, education and skills of staff etc.

For example a review of the incident when the would have inevitably lead to an urgent need to ensure that all glass is replaced or protected in some way, as well as a change to the Park wide response process when a 'Code Black' is called. It may also have lead to changes in protocol related to outings and pro-active communication with others on the Park site prior to outings occurring. The failure to look at potential risk management issues resulting from service incidents could be seen as negligent.

5.4 Wider Park issues

It appears that issues related to **budgetary** processes are not necessarily transparent, and may not reflect the level of activity and risk profile of the BAC. Staff reported accruing extremely high numbers of TOIL hours, and felt they had little possibility of being able to take that time. Costs for provision of Category Red care need to be acknowledged, as there is an assumption that not filling staffing positions is to save money for cat reds. The belief is that the programme is compromised as a result of this. Capital works funding is an issue and is mentioned in the recommendation section.

5.5 Response to Codes

The review team noted an absence of an enforced protocol about who makes up the response team, and the timeliness and process of their response. Any review of critical incidents should include looking at whether this protocol was observed. There needs to be opportunities to practice this on a regular basis, and a process of review afterwards.

6. POSSIBLE IMMEDIATE ACTIONS

Possible immediate actions are also detailed in the report recommendations. Whilst specific actions will be discussed the overarching need for a secure future for the BAC is an important action with a direct relationship to risk management.

6.1 Clinical Issues

6.1.1 **More clear admission criteria.** The review team felt the BAC should undertake a purposeful process to determine which patients are most likely to receive benefit from the BAC program, and how this fits with the current continuum of client care across SE Queensland. The review team were surprised with both the range of potential diagnoses of individuals at the BAC and the often stated ethos by all levels of staff of "having a go" with most types of presenting problems. A review of the target group need not only be diagnosis driven. For example a role for individuals with severe, persisting self-harm (therefore problem based) may be equally as valuable.

6.1.2 **Regular program review.** The BAC should consider closing the program for 1-2 days twice a year to invest time in management, procedure and training issues. Other inpatient units have been able to schedule regular program reviews. The potential benefits of this would significantly outweigh the costs.

6.1.3 **Structure.** The review team were interested in the relative absence of critical incidents at the BAC school, and on the adventure therapy programme. Small group size and highly structured time seem important determinants. Based on this observation the BAC staff should consider more structure in the after school and evening time.

6.1.4 **Group size.** Following on from 6.1.3 above the therapy group size seems very large and division of the group should be considered.

6.1.5 **"Home groups" within the BAC.** To further impart structure, control and a sense of belonging, the BAC staff should consider two home groups within the BAC program rather than one larger group of adolescents.

6.1.6 **Drug and Alcohol detoxification**. Given greater numbers of youth with dual diagnosis, the BAC staff should consider developing a relationship with the Adolescent Drug & Alcohol Withdrawal Service to up-skill BAC staff in contemporary drug withdrawal management, as well as the possibilities of additions to the BAC therapeutic program on drug and alcohol issues.

6.2 Policies & Procedures

The review team identified a range of BAC policies that were several years over the documented time for review, or had been created more than 4 years ago and had not obvious review schedule. The BAC should invest in a quality activity to review and where appropriate update all policies. Policies should be written from a patient centred, risk management, point of view, and should be separate from procedures.

6.3 Risk Assessment Tool

The Park risk assessment tool does not clearly indicate how to score or interpret data. Further there is no available evidence that the risk assessment tool is relevant to the adolescent population. The review team feel that there should be greater scrutiny of the tool as it relates to the prediction of further critical incidents and the more general outcome of that individual at the BAC. Note that part of this increased scrutiny is the new data analysis included in this report. Other analysis is possible with the BAC collection of HoNOSCA and CBCL data.

6.4 Decisions following on from the risk management process

Some risk management strategies seem to be universal at the BAC, for example searching bags and rooms, locking bedrooms during the day and searching day patient's bags. The danger of

universal interventions is engendering a culture of "mistrust" in response to risk management, which in turn affects interactions and relationships between staff and patients. Policies such as these should be reviewed by the team.

Specific issues, highlighted by case note review, include the review team feeling that there should be increased clarity of the pathway between risk assessment and a pro-active management plan, including placing the patient on CAT RED. The review team feel a more formal process review should occur after significant incidents. Documented care plans do not appear to be updated during the adolescents stay in response to risk assessment outcomes. . The requirement to have a multidisciplinary care plan does not disallow a nursing care plan, or a behavioural management plan being written and updated on a regular basis.

If programmed responses such as the A1-7 and Cat Red processes to risk taking behaviour are to continue, the review team are of the opinion BAC staff need to:
(1) review current programs and update them in relation to current patients,
(2) Document patient compliance and responses to the program,
(3) Monitor usefulness overall of such programs in modifying behaviour and
(4) Give consideration to a process whereby the adolescent and staff member sit down together to discuss and agree on logical consequences following risk taking behaviours. Age and developmental maturity may influence the outcomes.

6.5 BAC Management issues relating to critical incidents

BAC staff need to establish a process whereby incidents considered to have potentially major consequences are investigated. Park needs to consider updating incident forms to include risk assessment of the incident looking at the actual and potential outcomes rather than as primarily a reporting tool. Simple categories could include; What happened, Why and how did it happen, What opportunities are there to prevent a further occurrence?

A broad BAC response would include better communication about risk and risk management, more focused training, consideration of fatigue and rostering issues, environment and equipment needs, reviewing relevant rules/policies/procedures and other barriers that become evident. This process needs to become the basis for changes in practice. For example a review of the [redacted] would have inevitably led to the urgent need to ensure that BAC glass is replaced or in some other way the clients are protected. A failure to look at potential risk management issues resulting from serious incidents could be seen as negligent.

6.6 Training, Education and Orientation for all staff

Many staff stated there was no regular inservice program or training days programmed at the BAC or for BAC staff. The review team feel that regular and ongoing training for BAC staff, in risk management and other issues should be mandatory. Such training should be consistent with the severity of problems that BAC patients present and the issues around intense medium to long term admissions for adolescents. A special focus should be training and education for new staff on adolescent issues. This currently appears to be ad hoc, with some staff reporting they were not offered any training opportunities related to working with adolescents or developing their understanding of adolescence. It was clear that opportunities for personal clinical supervision should also be explored and incorporated into the BAC processes.

Example of potential risk management training would be regular participation in a program of local critical incident response training, which would include:

(1) Fire evacuation,
(2) Managing aggression,
(3) Managing a medical emergency (eg an adolescent who looses a significant amount of blood after cutting themselves; or where an adolescent is found unconscious, with several empty pill packets next to them)
(4) Secluding a patient.
(5) CPR

Orientation: the review team feel the orientation process and documentation should be improved, specifically:

(1) The manual needs to be updated, and several copies need to exist.

(2) All new staff need to be orientated including casual staff. Consideration be given to developing a competency based orientation programme, where staff need to be able to demonstrate skills and understanding of processes, developmental issues and therapies.

(3) Consider making up a 'cheat sheet' orientation for casual staff with the absolutely essential information to manage for a shift on it.

7. LONG TERM ISSUES THE CONTINUING ROLE OF THE BAC

This report has focused on critical incidents and risk management at the BAC. However, a pervasive theme amongst staff, and in the review teams opinion a significant barrier to change at the BAC is the uncertainty of the unit.

The review team encourage The Park and BAC management to activity pursue clarity of this issue. In doing so the review team note contemporary themes, not necessarily core to mental health but clearly related to adolescent mental health, that are reasons why the BAC offers a unique opportunity to severely troubled youth. Firstly most BAC clients have been serially suspended or excluded from the education system. Cessation of schooling confers a further and serious impairment to this client group. The BAC provides a unique educational opportunity for this group, with good evidence of major academic gains being made by clients during their BAC stay.

Secondly, youth homelessness is unacceptably high and the BAC clients are at the severe end of the spectrum of risk factors that lead to homelessness. Without the BAC many of this client group will become homeless and denied a place of safety, therapy and education. In brief without the BAC many of this group will still need accommodation somewhere, but alternative accommodation could not provide the possibility of restoration and rehabilitation which the BAC staff work so hard to provide to a very disenfranchised group of adolescents.

All services should change over time, and the BAC has this challenge. Precipitous action such as closure of the unit without a process of re-orientation with other SE Queensland service units could remove a part of the continuum of care that is extremely difficult to replace and simply transfers the burden to other areas of the wider system.

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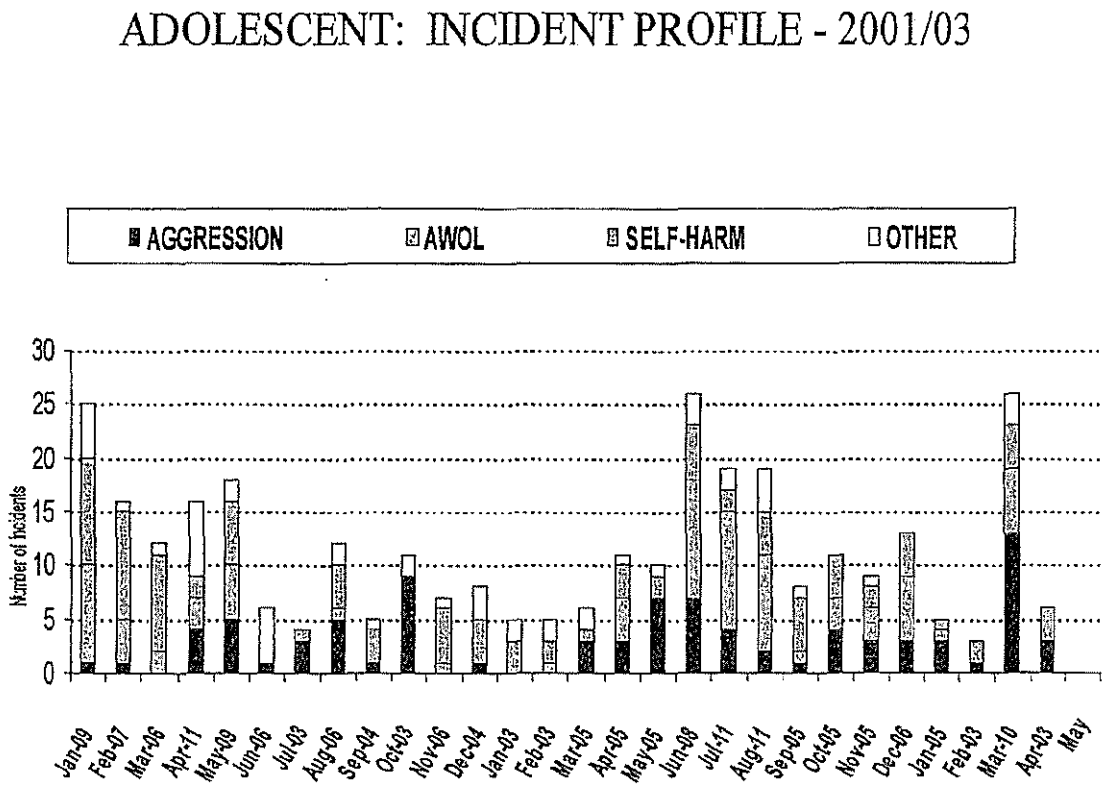
Appendix I: Information provided by the BAC

Figure A1: Summary of Critical Incident by Incident Month.



Queensland Government
Queensland Health

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

December 2004

Prepared By

Project Services
Queensland Government
Department of Public Works

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SUMMARY AND RECOMMENDATIONS

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

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

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

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

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

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

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

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

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

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

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

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

1. BACKGROUND

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

The residents attend school in an adjacent building.

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

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

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

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

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

2. SCOPE OF THIS REPORT

There are two types of problem with the building:-

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

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

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

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

Advice has been obtained from building specialists including:-

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

The report includes:-

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

The report excludes:-

- block C (the adjacent school building)

3. THE EXISTING FACILITY

3.1 The building.

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

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

3.2 Floor plan

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

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

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

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

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

3.3 Use and function

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

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

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

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

Toilets are a favourite place for self-harm.

3.4 Siting, access and external areas.

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

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

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

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

The site is not fully fenced.

3.5 Aesthetics

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

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

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

3.6 Condition

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

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

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

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

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

3.7 Plans and photographs

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

4. SOME IDENTIFIED PROBLEMS

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

4.1 Resident behaviour

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

4.2 General Environment

Problems with the general environment include:-

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

4.3 Functionality

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

4.4 Safety / Security

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

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

4.5 Building deterioration

Problems identified include:-

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

5. SUGGESTED REMEDIES

5.1 Generally

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

5.2 Priorities

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

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

5.3 High-Dependency Unit (HDU)

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

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

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

5.4 Other user suggestions

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

5.5 The three options

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

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

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

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

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

More detail of each option follows.

6. OPTION 1

6.1 Scope

Option 1 consists of the following refurbishment work.

Building work

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

Electrical

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

Electronic

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

Mechanical

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

Fire engineering

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

Other

- Minor repairs and maintenance items as necessary.

6.2 Cost

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

6.3 Advantages

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

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

6.4 Disadvantages

Disadvantages of Option 1 include:-

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

7. OPTION 2

7.1 Scope

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

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

A plan showing Option 2 is attached as Appendix C

7.2 Cost

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

7.3 Advantages

The main advantages of Option 2 are:-

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

7.4 Disadvantages

Disadvantages of Option 2 include:-

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

8. OPTION 3

8.1 Scope

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

8.2 Cost

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

8.3 Advantages

The main advantages of Option 3 are:-

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

8.4 Disadvantages

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

9. COST ESTIMATES

9.1 Capital Costs

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

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

9.2 Gross project costs

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

9.3 Exclusions

Estimates exclude:-

- Escalation from today's prices
- Temporary accommodation and re-location
- GST
- Demolition of existing building (option 3)
- Abnormal site conditions
- Site works (eg roads, footpaths, landscape) or external services for Options 1 or 2.

- Loose furniture and equipment
- Information technology

9.4 Limitations

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

9.5 Recurrent Costs

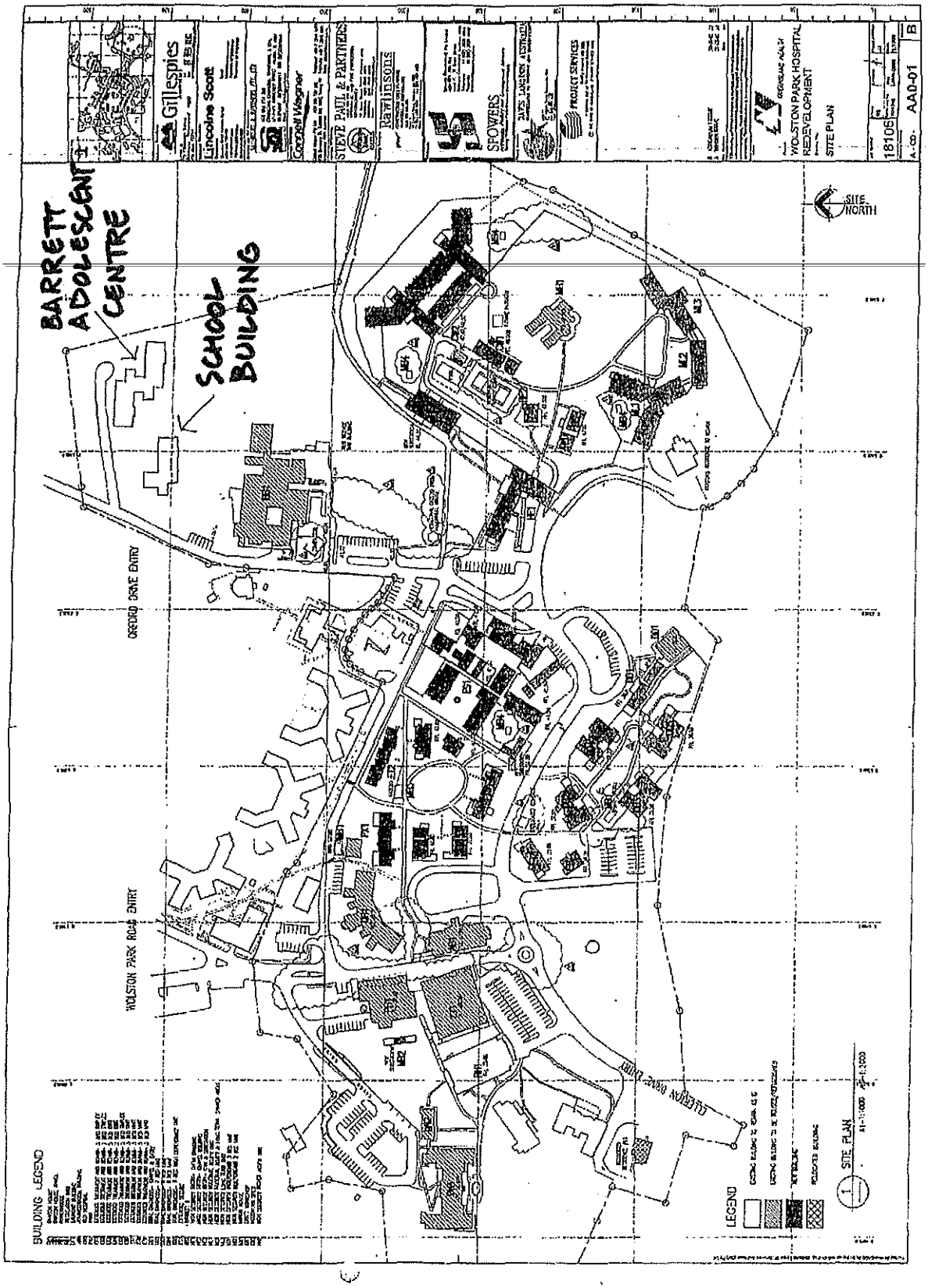
Recurrent costs have not been considered at this stage.

10. PROGRAM

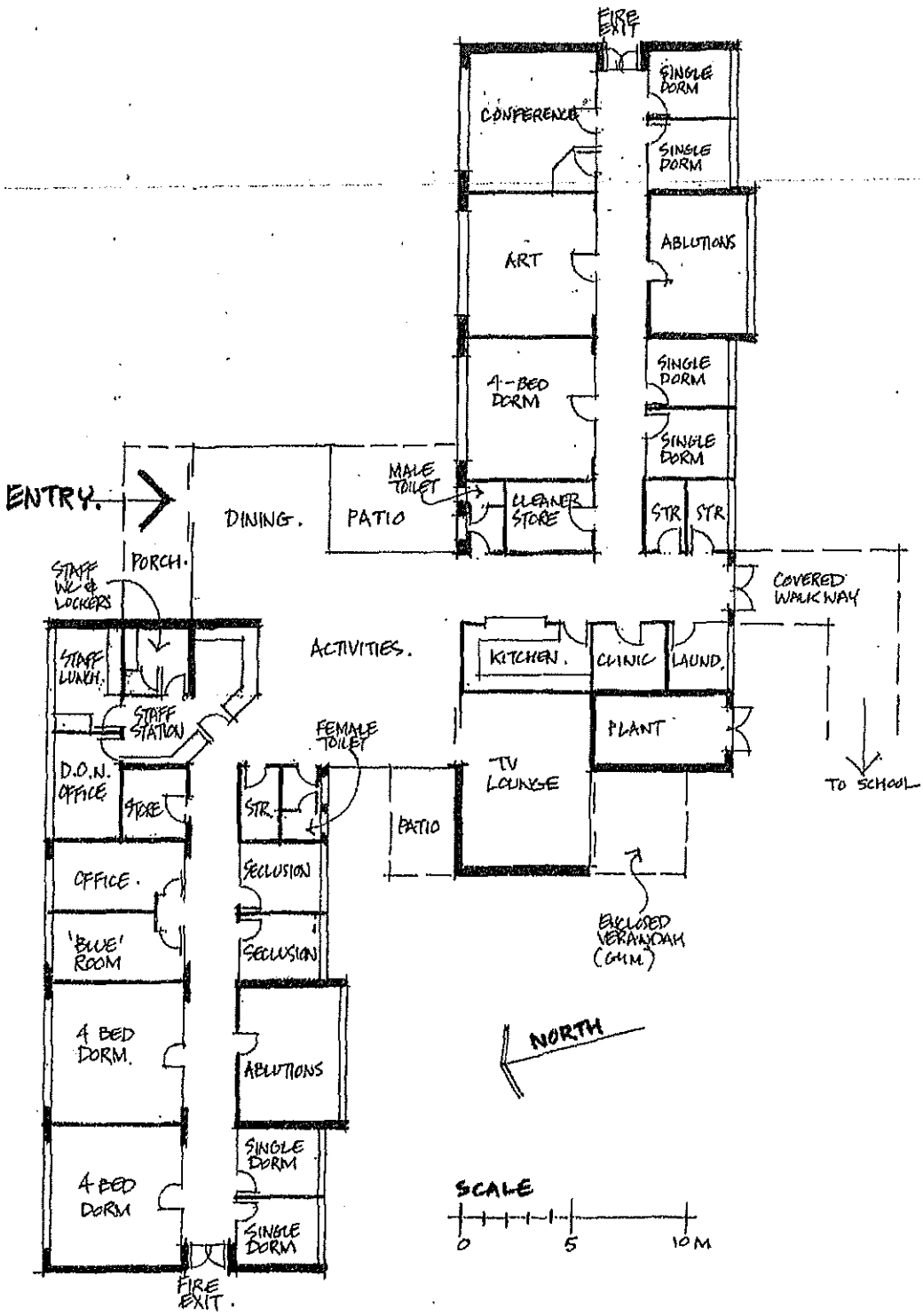
The Project Program is contained in Appendix D, which shows that completion of construction could be achieved by late August 2006.

APPENDICES

Appendix A – Plans of existing facility

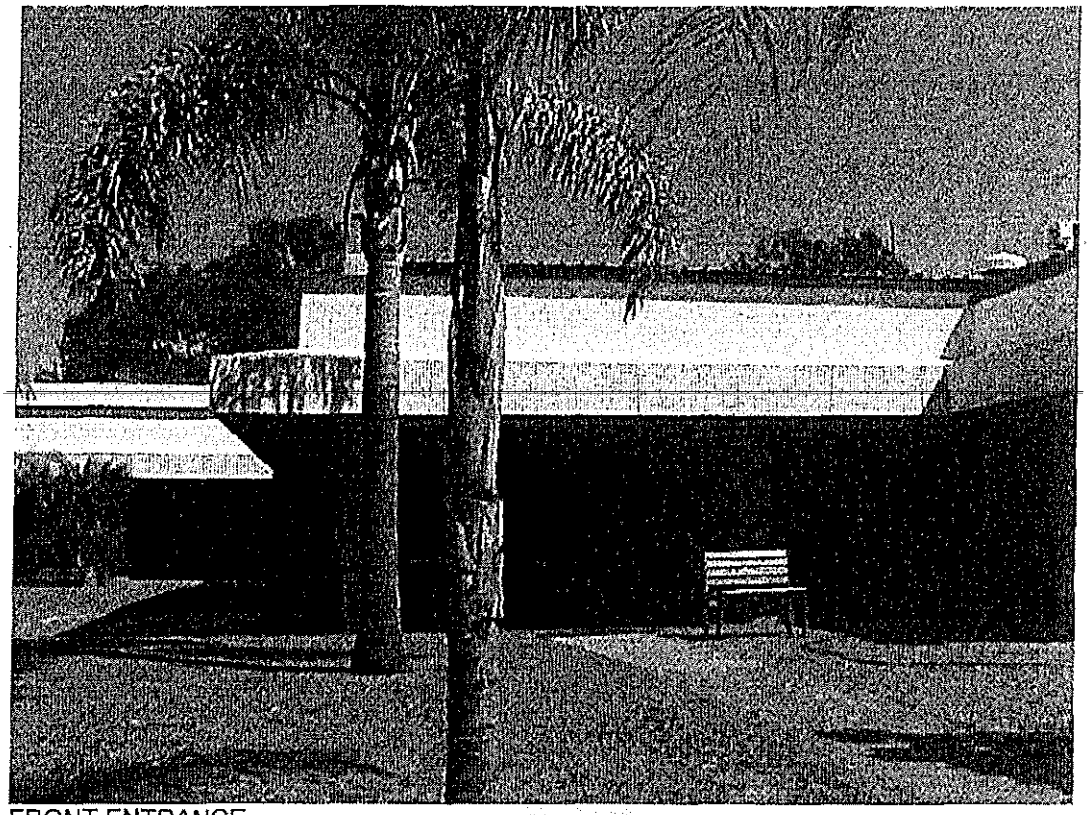

BARRETT ADOLESCENT CENTRE
SCHOOL BUILDING
SITE NORTH
OXFORD DRIVE ENTRY
WOLSTON PARK ROAD ENTRY
QUEENS DRIVE ENTRY
BUILDING LEGEND
LEGEND
SITE PLAN
WOLSTON PARK HOSPITAL REDEVELOPMENT
SITE PLAN
18106
AA0-01
Gillespies
Lincolne Scott
Cooper Wagner
STEVE PAUL & PARTNERS
Rawlinsons
SPOWERS
JAMES LARSON ASSOCIATES
PROJECT SERVICES

SITE PLAN

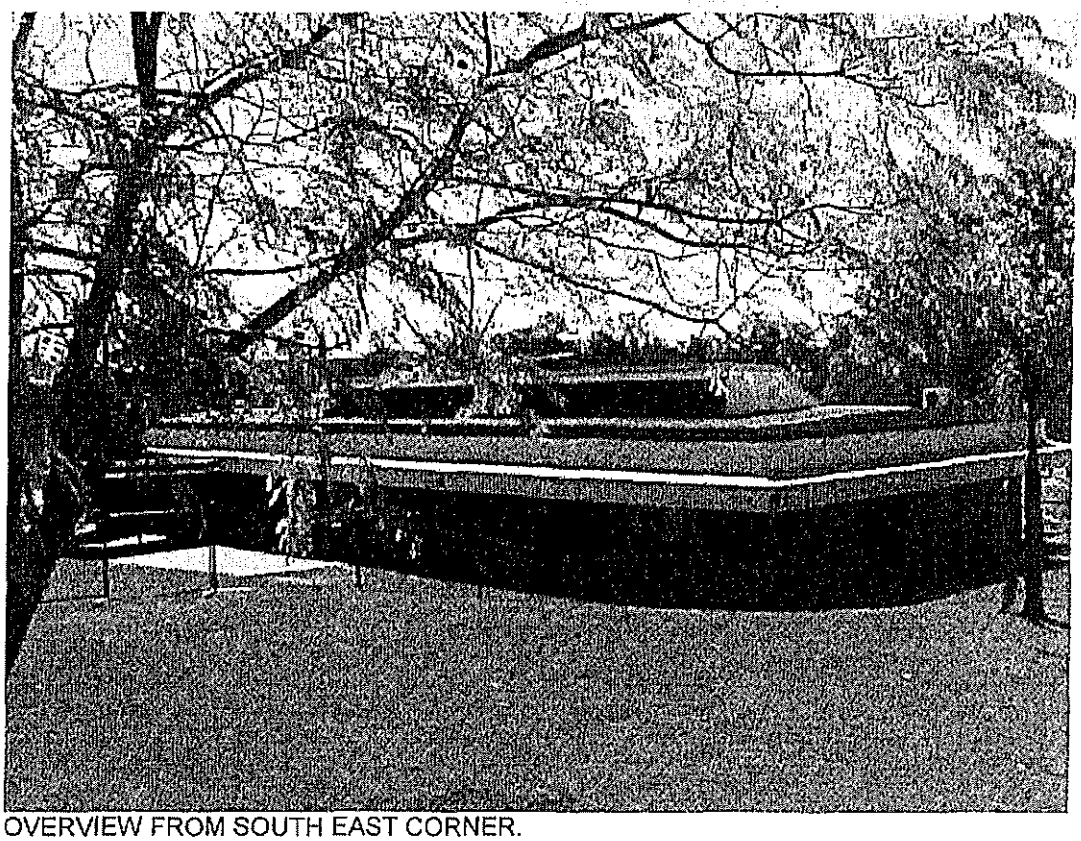


BARRETT ADOLESCENT CENTRE
FLOOR PLAN AS EXISTING.
DECEMBER 2004

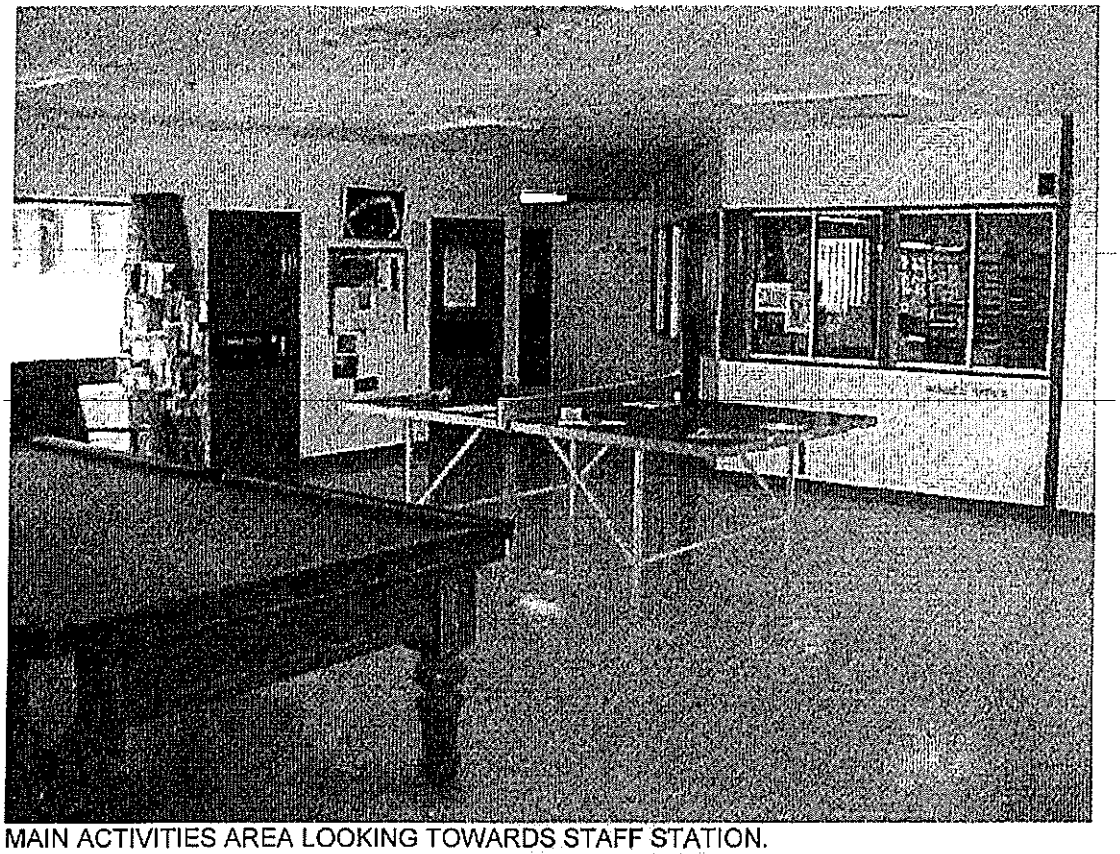
Appendix B - Photographs



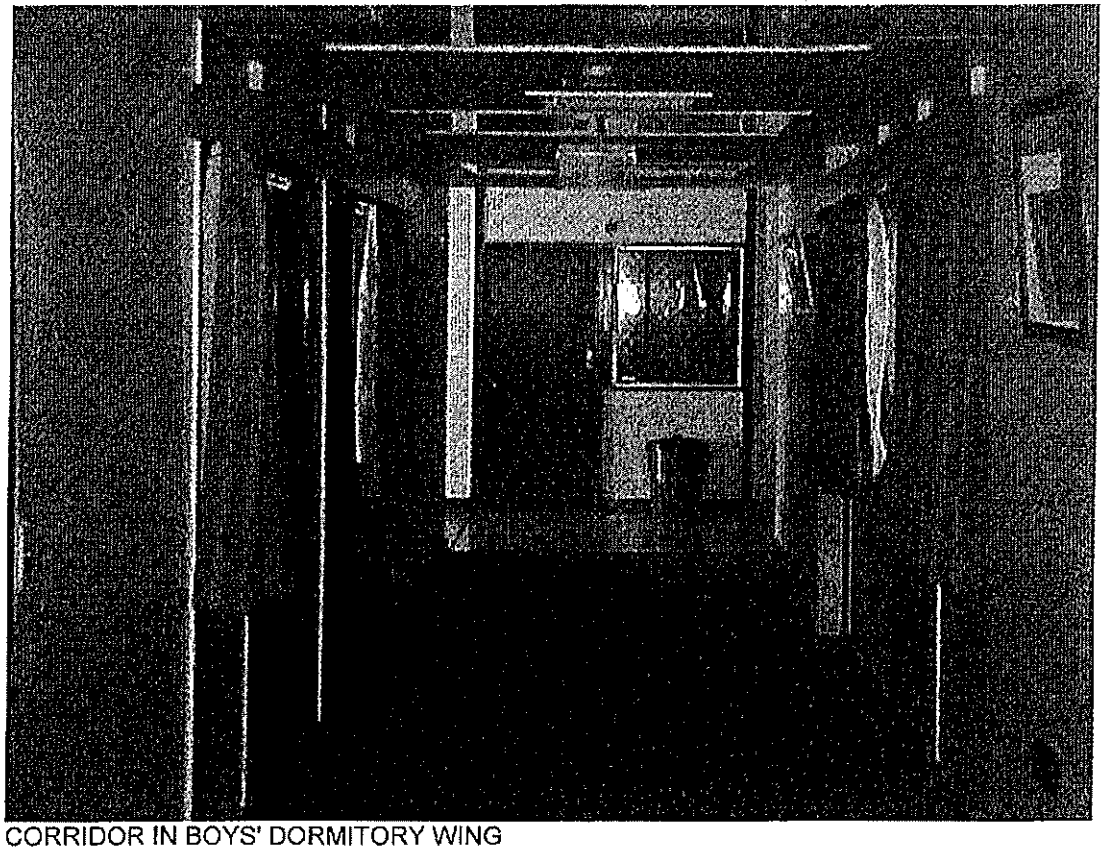
FRONT ENTRANCE.



OVERVIEW FROM SOUTH EAST CORNER.

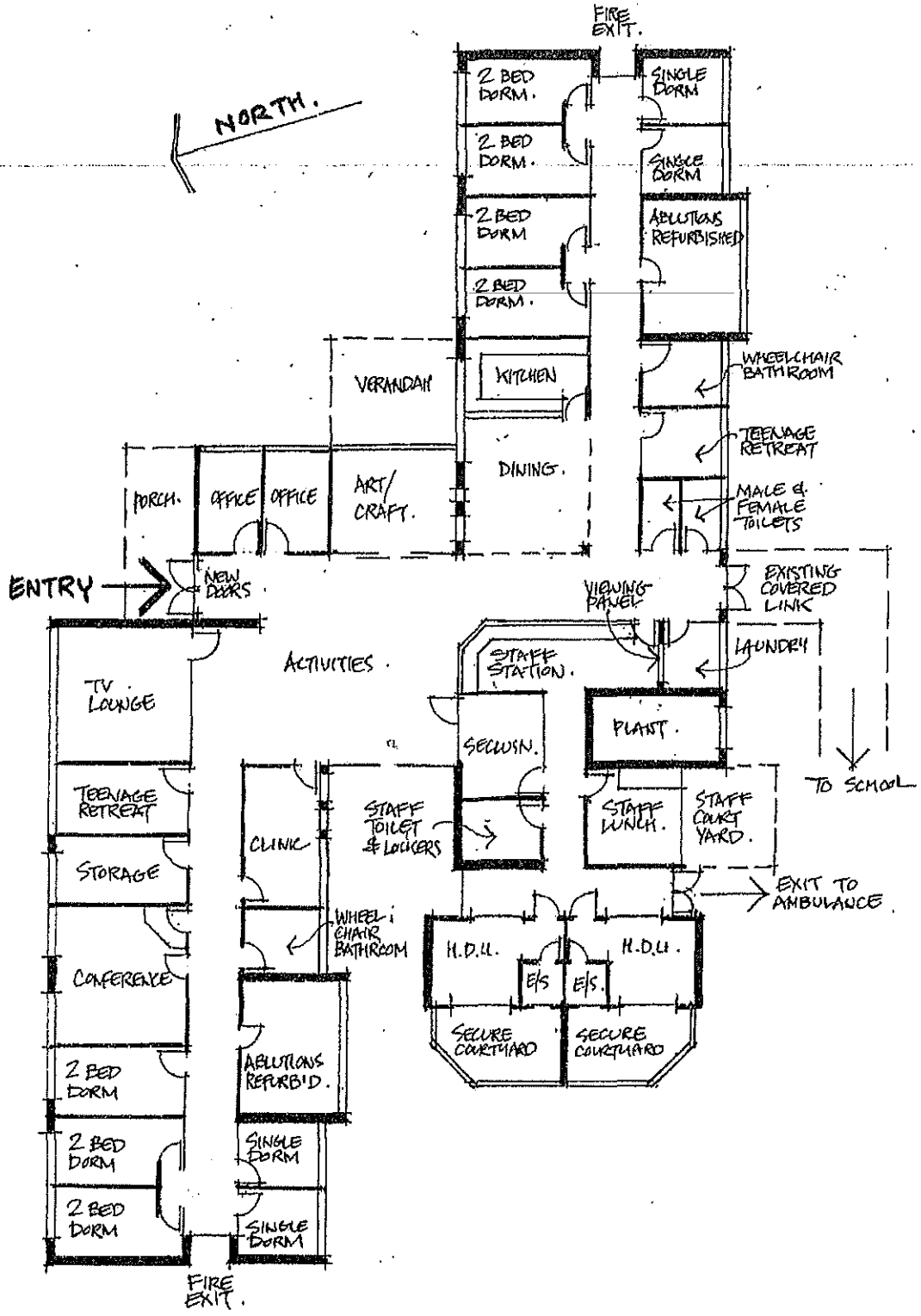


MAIN ACTIVITIES AREA LOOKING TOWARDS STAFF STATION.



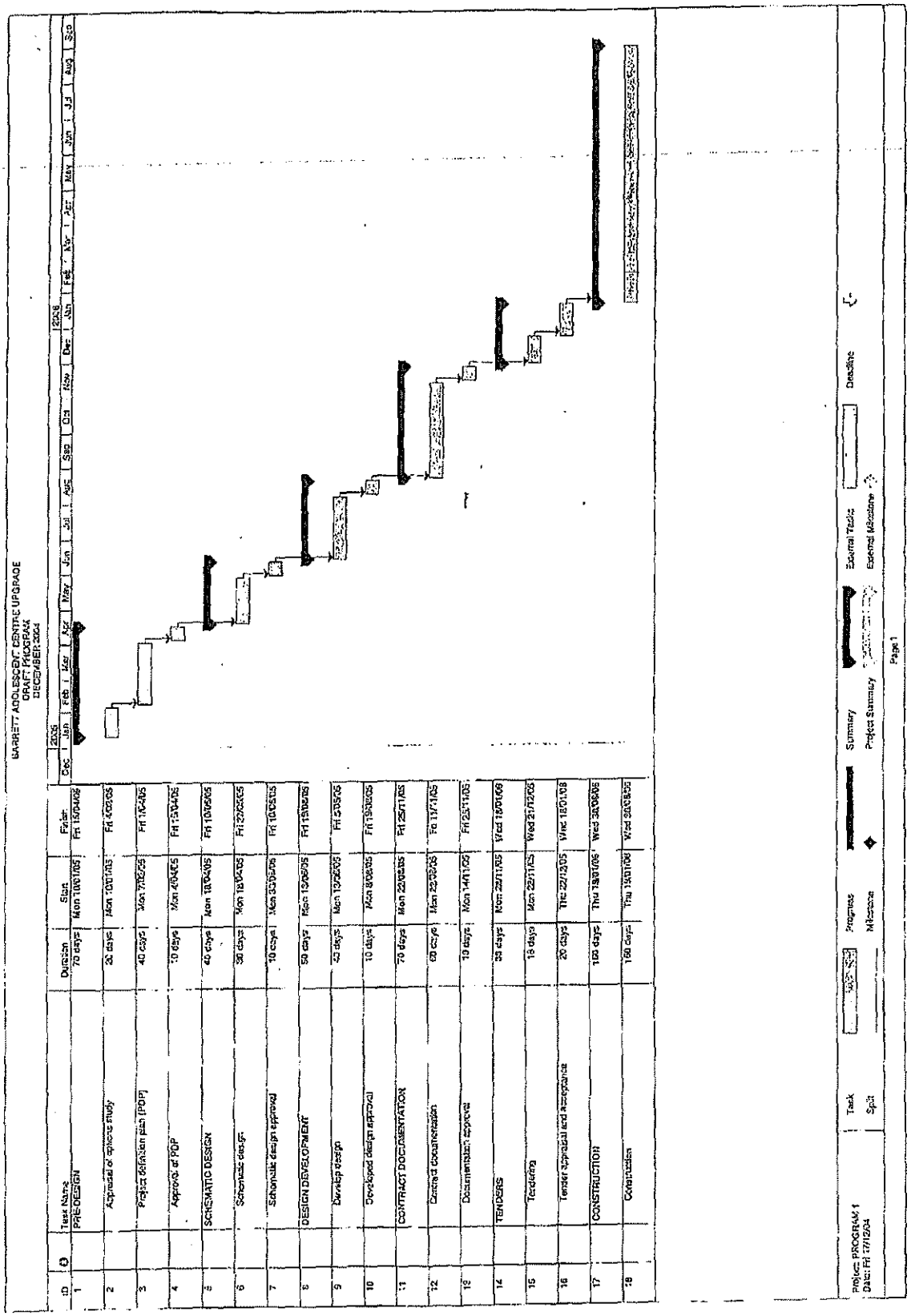
CORRIDOR IN BOYS' DORMITORY WING

Appendix C - Sketch plan of Option 2



BARRETT ADOLESCENT CENTRE.
FLOOR PLAN AS PROPOSED.
OPTION 2

Appendix D - Preliminary program



ID	Task Name	Duration	Start	Finish
1	PRE-DESIGN	70 days	Mon 10/01/05	Fri 15/04/05
2	Appraisal of options study	20 days	Mon 10/01/05	Fri 4/02/05
3	Project definition plan (PDP)	40 days	Mon 7/02/05	Fri 1/04/05
4	Approval of PDP	10 days	Mon 4/04/05	Fri 15/04/05
5	SCHEMATIC DESIGN	40 days	Mon 18/04/05	Fri 10/06/05
6	Schematic design	35 days	Mon 18/04/05	Fri 27/05/05
7	Schematic design approval	10 days	Mon 30/05/05	Fri 10/06/05
8	DESIGN DEVELOPMENT	50 days	Mon 13/06/05	Fri 19/08/05
9	Develop design	45 days	Mon 13/06/05	Fri 5/08/05
10	Developed design approval	10 days	Mon 8/08/05	Fri 19/08/05
11	CONTRACT DOCUMENTATION	70 days	Mon 22/08/05	Fri 25/11/05
12	Contract documentation	60 days	Mon 22/08/05	Fri 11/11/05
13	Documentation approval	10 days	Mon 14/11/05	Fri 25/11/05
14	TENDERS	35 days	Mon 28/11/05	Wed 18/01/06
15	Tenderers	15 days	Mon 28/11/05	Wed 21/12/05
16	Tender appraisal and acceptance	20 days	Thu 22/12/05	Wed 18/01/06
17	CONSTRUCTION	180 days	Thu 19/01/06	Wed 28/06/06
18	Construction	180 days	Thu 19/01/06	Wed 28/06/06

QUEENSLAND HEALTH

CHILD AND YOUTH MENTAL HEALTH PLAN

2006-2011

EXECUTIVE SUMMARY

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

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

Workforce Enhancements

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

Intensive Treatment Enhancements

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

Continuing Care Enhancements

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

Infant and Early Childhood Mental Health Enhancements

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

Emergency Psychiatry Enhancements

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

Intersectoral Collaboration Enhancements

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

Eating Disorders Enhancements

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

Promotion, Prevention, Early Intervention Enhancements

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

Forensic Mental Health Enhancements

- Southern/Central Child and Youth Forensic Outreach Service – 7 x FTEs
- Northern Child and Youth Forensic Outreach Service – 4 x FTEs
- Southern and Central Area MHATODS – 6.5 x FTEs + 0.5 FTE psychiatrist
- Northern Area MHATODS – 3.5 x FTEs + 0.5 FTE psychiatrist
- Statewide Child and Adolescent Forensic Psychiatrist – MO2
- MST Teams (S1m) x 3
- 12-bed unit for adolescents with mental health issues and high risk behaviours, involved in the juvenile justice system

Dual Diagnosis Enhancements

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

Indigenous Mental Health Enhancements:

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

Capital Works Requirements

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

Corporate Governance Enhancements

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

INTRODUCTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MODEL OF SERVICE DELIVERY

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

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

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

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

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

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

Age Range:

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

Services

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

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

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

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

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

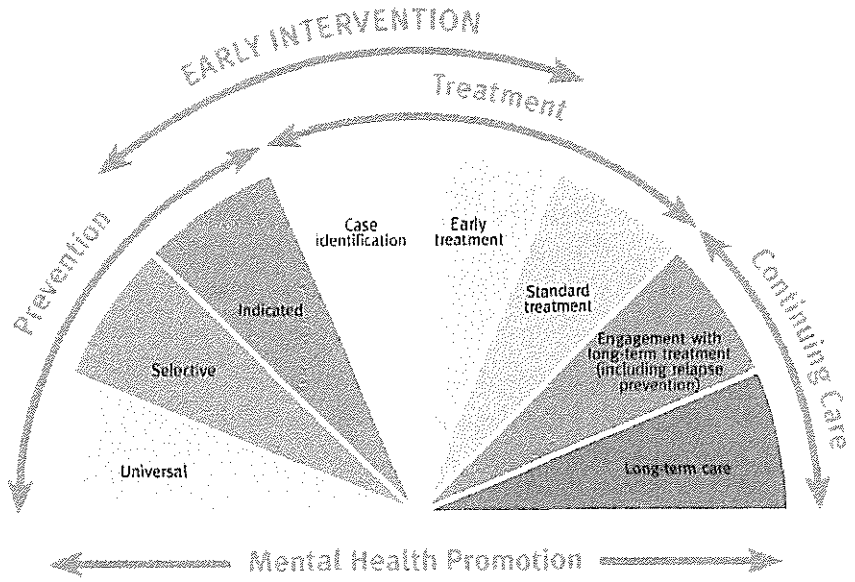


Figure 1: The spectrum of interventions for mental health problems and mental disorders
(Adapted from the Mrazek & Haggerty 1994 Mental Health Intervention Spectrum for Mental Disorders)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Components of Service Delivery

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

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

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

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

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

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

Vital "enablers" for CYMHS service delivery include:

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

SERVICE ENHANCEMENT AND EXPANSION

1. Promotion, Prevention, Early Intervention

1.1 Social Promotion

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

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

1.2 Primary Mental Health Promotion and Prevention

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

References:

1.3 Infant and Early Childhood Mental Health

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

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

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

References:

Infant and Early Years Mental Health Plan (Attachment 2)

1.4 Children of Parents with Mental Illness

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

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

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

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

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

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

Bayside has established a COPMI program for children and adolescents.

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

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

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

References:

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

1.5 Universal, Selected, and Indicated Interventions

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

References:

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

1.6 Consultation/Liaison Services

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

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

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

1.7 Cross-Agency Promotion, Prevention, Early Intervention

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

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

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

References:

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

Promotion, Prevention, Early Intervention Enhancements

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

2. Emergency Psychiatry and Acute Care

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

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

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

2.1 Emergency Psychiatry

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

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

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

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

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

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

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

2.2 Mobile Acute Care Teams

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

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

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

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

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

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

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

- Gladstone & Banana 1.0 FTE
- Southern Downs 1.0 FTE

References:

Emergency Mental Health Subgroup Report 2006

2.3 Accommodation Network

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

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

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

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

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

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

References

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

Emergency Psychiatry Enhancements

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

3. Intensive Treatment

3.1 Acute Inpatient Treatment

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

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

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

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

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

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

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

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

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

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

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

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

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

3.1.1 Acute Inpatient Treatment – Child

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

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

3.1.2 Mental Health Admissions to Paediatric Wards

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

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

3.1.3 Acute Inpatient Treatment - Adolescent

Townsville

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

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

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

Gold Coast

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

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

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

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

Logan-Beaudesert

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

Toowoomba

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

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

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

3.2 Day Programs

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

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

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

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

Expansion will be undertaken for the day programs at:

- Mater Children's Hospital
- Barrett Adolescent Centre.

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

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

Indicative Staffing for 12-place Day Program

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

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

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

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

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

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

3.3 Extended Inpatient Treatment

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

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

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

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

Inpatient Program

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

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

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

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

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

Indicative staffing for the redeveloped BAC is as follows:

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

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

Day Program

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

Independent Living Units

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

Components needed to support the clinical program

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

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

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

References:

Barrett Adolescent Centre presentations

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

4. Continuing Care

4.1 Community Mental Health Service Enhancement

4.1.1 Young Adults

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

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

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

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

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

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

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

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

4.1.2 Occupational Therapy

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

4.1.3 Speech Pathology

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

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

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

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

4.1.3 Psychiatry

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

4.1.4 Targets

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

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

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

4.2 e-CYMHS

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

Year 1

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

Year 3 (additional)

0.5FTE x Psychiatrist
1.00 FTE x PO3 Mental Health Professional

Year 4 (additional)

1.0 FTE x Registrar

Summary of Costs: e-CYMHS service

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

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

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

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

Summary of Costs: e-CYMHS service

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

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

References:

Child and Youth Staffing Ratios
e-CYMHS RCH Costing

Continuing Care Enhancements

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

5. Specialist Services

5.1 Infant and Early Childhood Mental Health

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

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

Required Enhancements:

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

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

mental health services by disseminating information and establishing networks

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

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

Budget

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

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

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

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

5.2 Eating Disorders

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

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

Stage One:

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

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

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

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

Stage Two:

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

Child/Adolescent Hubs:

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

Hub Teams:

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

- 1.0 FTE x Administration Officer

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

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

Stage Three:

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

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

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

Inpatient Services

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

Day patient Programs

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

References:
Eating Disorders Subgroup Report, 2006

Eating Disorders Enhancements

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

5.3 Dual Diagnosis (Mental Health/Substance Abuse Issues)

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

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

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

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

Other strategies to be considered include:

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

Dual Diagnosis Enhancements

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

5.3 Forensic Issues

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

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

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

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

2007-2008

Statewide

MO2 Child and Adolescent Psychiatrist – Clinical Leader

Southern and Central Area Community Forensic Outreach Service (CYFOS)

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

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

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

Northern Area MHATODS

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

2008-2009

Southern and Central Area CYFOS

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

Northern Area CYFOS

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

Southern and Central Area MHATODS

1.0 x FTE Mental Health Professional

Northern Area MHATODS
1.0 x FTE Mental Health Professional

2009-2010

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

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

2010-2011

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

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

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

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

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

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

References:

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

Forensic Mental Health Enhancements

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

5.4 Transcultural Mental Health

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

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

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

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

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

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

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

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

References:

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

5.5 Indigenous Mental Health

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

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

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

Indigenous Mental Health Enhancements:

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

5.6 Child Safety Therapeutic Support

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

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

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

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

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

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

References:

Child Safety Unit, Queensland Health 2006

6. Workforce

6.1 Competencies

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

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

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

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

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

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

6.2 Gaps in the workforce

6.2.1 Entry Level Traineeships

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

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

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

6.2.2 Nurse Education

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

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

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

6.2.3 Co-ordinated CYMHS Education Program

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

- Royal Children's Hospital
- Mater CYMHS

- Townsville

6.2.4 Co-ordination of Student Placements

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

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

6.2.5 Enhanced Allied Health Career Structure

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

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

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

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

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

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

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

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

Logan-Beaudesert
- 1 x new Professional Senior position PO4

Sunshine Coast
- 1 x new Professional Senior position PO4

West Moreton
- 1 x new Professional Senior position PO4

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

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

6.2.6 Enhanced Administrative Support

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

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

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

6.2.7 Service Development Officers

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

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

6.2.8 Team Leader Review

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

6.2.9 New Workforce

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

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

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

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

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

Staffing:

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

Total budget: $487 197 (Attachment 3)

6.3 Consumer and carer participation

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

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

Consumer consultants are required for the following CYMHS Services:

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

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

Workforce Enhancements

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

References:

Workforce Subgroup, Mental Health Plan 2006

7. Intersectoral Collaboration

7.1 Partnership Facilitators

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

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

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

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

7.2 Non-government organizations

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

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

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

7.3 Education Queensland

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

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

7.4 Department of Child Safety

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

7.5 General Practitioners

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

7.6 Joint Assessment Services

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

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

The mental health component of each team will consist of:

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

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

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

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

Intersectoral Collaboration Enhancements

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

8. Information Management

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

9. Research

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

10. Capital Works

10.1 Office Accommodation for Community Mental Health Staff

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

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

10.2 Accommodation for rural and remote staff

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

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

10.3 Redevelopment of acute inpatient units

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

10.4 Modifications to paediatric wards

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

10.5 Day programs

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

10.6 Future inpatient facilities

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

10.7 Redevelopment of Barrett Adolescent Centre

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

10.8 Specialist unit for adolescents in juvenile justice system

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

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

Capital Works Requirements

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

11. Corporate Governance

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

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

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

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

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

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

Corporate Governance Enhancements
AO6 Senior Project Officer

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

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

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

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

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

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

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

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

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

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

Background

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

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

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

Closing the Gaps

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

Innovations

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

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

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

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

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

Implementation Components (See Table in Appendix)

Sustainable Partnerships

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

Workforce Implications

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

Capital Works Implications

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

Budget

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

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

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

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

Time Frame

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

Working Group

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

Appendices

- Implementation Components Table
- Future Families Framework

References

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

FTE requirements

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

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

Queensland Government
Queensland Health

Clinical Practice Improvement Centre

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

1. Description of the Problem

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

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

2. Size of the Problem

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

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

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

3. Description of the Proposed Intervention

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

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

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

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

Project Plan

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

4. Details of Supporting Evidence

- Workforce Data
- Recovery Policy
- CYMHS Future Directions Policy

5. Measurement of Impact

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

6. Support

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

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

Total budget: $487 197

2009 REVIEW OF BARRETT ADOLESCENT CENTRE

(Final Report)

Reviewers: Garry Walter, Martin Baker, Michelle George

BACKGROUND

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

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

PREVIOUS REVIEWS AND REPORTS

ACHS Review

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

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

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

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

DOH Brief

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

McDermott Review

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

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

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

Community Visitors Report

This report noted that:

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

Queensland Nurses Union

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

CRITICAL INCIDENTS

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

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

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

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

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

OBSERVATIONS AND *RECOMMENDATIONS*

Governance

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

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

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

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

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

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

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

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

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

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

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

Recommendations:

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

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

Clinical Model

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Recommendations:

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

Nursing Model of Care

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

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

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

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

Recommendations:

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

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

Patient Journey

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

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

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

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

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

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

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

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

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

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

***Recommendations*:**

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

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

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

Treatment evaluation

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

Recommendations:

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

Clinical leadership

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

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

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

Recommendations:

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

Staffing profiles (nursing)

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

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

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

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

Recommendations:

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

Nursing Staff Training and Education

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

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

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

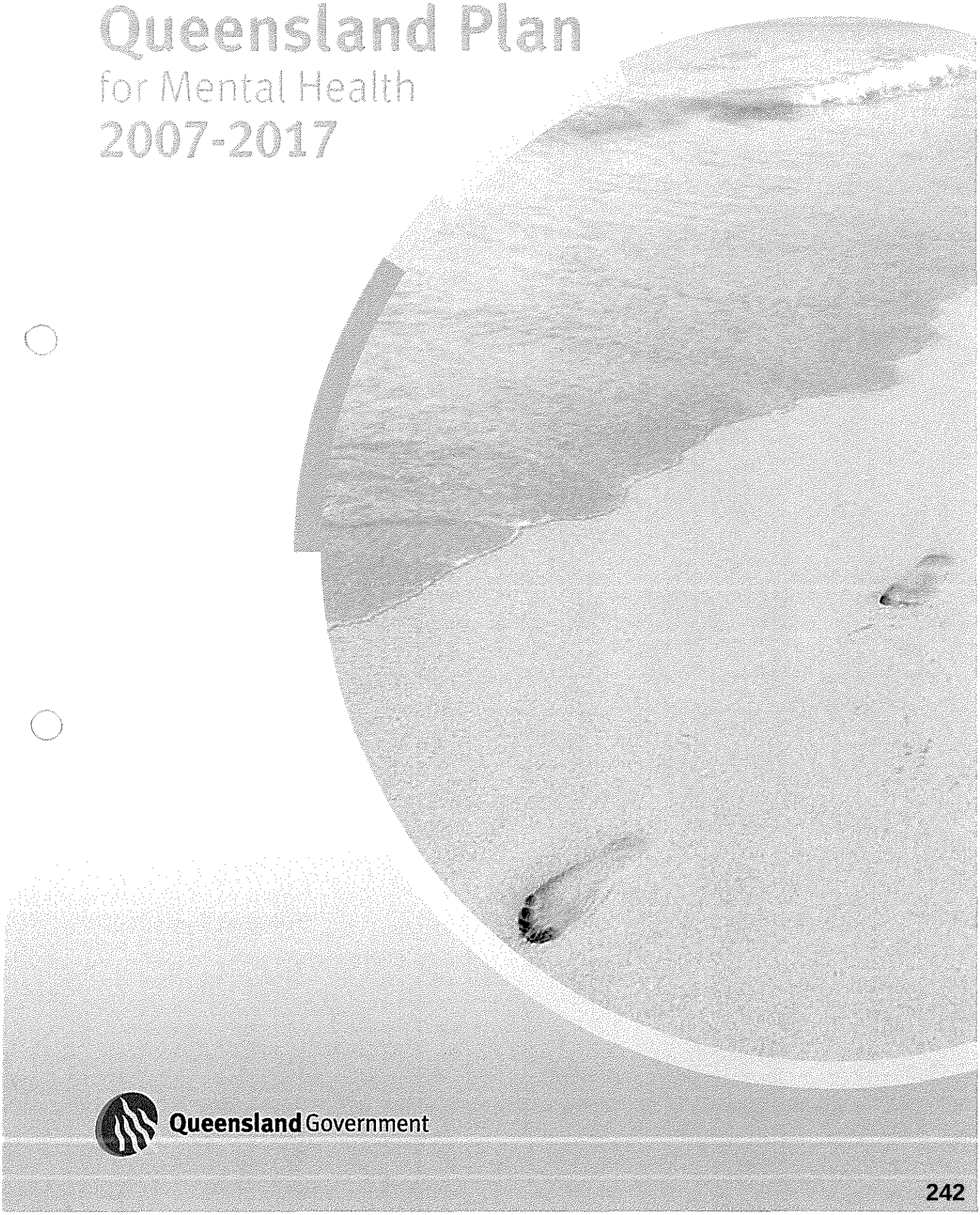
Clinical supervision structures are problematic. The whole team attends group supervision with a specialist clinical supervisor, who is also a member of the team. Additionally, nursing staff identified a need for more clinical supervision.

Recommendations:

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

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

Queensland Plan for Mental Health 2007-2017



Queensland Government

The Queensland Plan for Mental Health 2007-2017

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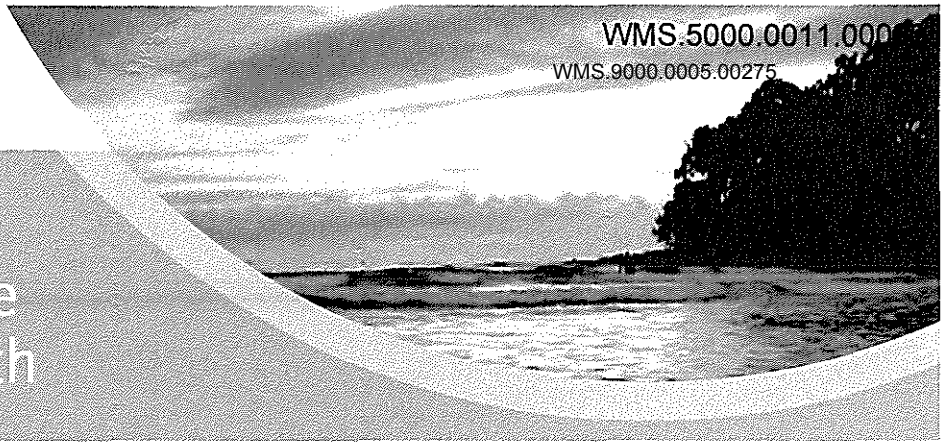

Message from the Minister for Health

I am very pleased to present the *Queensland Plan for Mental Health 2007-2017*. The plan outlines priorities for the reform and development of mental health care over the next ten years.

The demand for treatment and support for people with mental illness continues to grow. Currently one in five adult Australians experience a mental illness in any one year. Depression is predicted to rise from the fourth to the second greatest cause of global disease burden over the next twenty years.

As part of the 2007-08 State Budget the Queensland Government committed a record $528.8 million over four years to improve Queensland's mental health system. This unprecedented level of funding, the largest investment in mental health in Queensland's history, reflects the Government's deep commitment to delivering a better quality of life for people who live with mental illness, their families and carers.

In 2008-09 a further $88.63 million has been allocated over four years to continue implementation of this Plan bringing the total Government commitment since July 2007 to $617.43 million.

The *Queensland Plan for Mental Health 2007-2017* provides a blueprint for reform and will inform future investment in mental health services across the State. The directions outlined in the Plan establish a framework for the development of a more responsive system of services to better meet the needs of people who live with a mental illness.

Public mental health services will continue to play a major role, with the contribution of other sectors involved in the delivery of mental health care clearly highlighted. There is a much stronger role for non-government organisations, and major contributions from all levels of government.

The *Queensland Plan for Mental Health 2007-2017* has been informed by extensive consultations undertaken with mental health consumers, carers, service providers and key stakeholders.

Five priority areas for action have been identified. These priorities position mental health services to be better able to respond to existing and future demand for care, by building on the strengths of the current system, developing an appropriate mix and level of services and implementing new and innovative approaches to consumer and carer needs.

The priorities are:

- promotion, prevention and early intervention
- improving and integrating the care system
- participation in the community
- coordinating care
- workforce, information, quality and safety.

Effective partnerships around mental health care are essential. Improving collaboration between the public sector, private sector, non-government organisations, other agencies and departments and the broader community to respond to the needs of people who live with a mental illness, their families and carers is a prime aspect of the *Queensland Plan for Mental Health 2007-2017*. The reform of mental health care over the next ten years relies on these partnerships and the participation of the broader community.

I look forward to working with you as we further develop and implement our vision for mental health in Queensland.

Stephen Robertson MP
Minister for Health

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