Meeting Agenda

Adolescent Mental Health Extended Treatment Initiative Steering Committee

Date:	4th August 2014
Time:	9am – 10.30am
Venue:	CYMHS Board Room Citilink Building 2, Foyer 4, Level 2, 153 Campbell Street, Bowen Hills
Video/ Teleconference Details:	**Teleconference Details:** *** Please advise secretariat if you want to dial in***

Chair/s:	Judi Krause	Divisional Director CYMHS CHQ HHS
	Stephen Stathis	Clinical Director CYMHS CHQ HHS
Secretariat:	Susan Hunt	AMHETI Project Officer, CHQ HHS
Attendees:		
Video Conf.	Leanne Geppert	A/Director of Strategy, Mental Health & Specialised Services, WM HHS
Parking req'd	Raymond Ho	Clinical Services Program Manager, Metro South Addiction and Mental Health Service, Metro South HHS
	Josie Sorban	Director of Psychology, CHQ HHS
	Emma Foreman	Proxy for A/Director Planning and Partnership Unit, MHAODB
	Deborah Miller	A/Executive Director Office of Strategy Management, CHQ HHS
Video Conf.	Cara McCormack	Program Manager Rural, Remote and Indigenous Mental Health Services & Child, Adolescent and Young Adult Services/ Assistant Director of Allied Health, Mental Health Service Group, Townsville Hospital and Health Service
Teleconference	Amelia Callaghan	State Manager Headspace
Parking req'd		Carer Representative
		Consumer Representative
Apologies:	Ingrid Adamson	AMHETI Project Manager, CHQ HHS
	Marie Kelly	A/Director Planning and Partnership Unit, MHAODB
	Amanda Tilse	Operational Manager Alcohol, other Drugs & Campus, Mater Hospital
Guests:		

* Attachments accompany this item; papers to be tabled if available

1. Presentations

Item no	Item	Action Officer
1.0	• Nil	

2. Meeting Opening

Item no	Item	Action Officer
2.1	Welcome and Apologies	Chair
2.2	Statement of Conflict/Interest	Chair

2.3	Confirmation of the minutes from the previous meeting *(attached)*	Chair

3. Business Arising from previous minutes

Item no	Item	Action Officer
3.1	• Informing CCYMHS staff of AMHETI Services	Chair
	• Resi footage to promote service	SS
	• Service Evaluation and BAC Review Update	Chair

4. Matters for Decision

Item no	Item	Action Officer
4.1	• Endorse Resi Service Evaluation Plan	Chair

5. Matters for Discussion

Item no	Item	Action Officer
5.1	• Nil	

6. Standard Agenda Items

Item no	Item	Action Officer
6.1	**Service Implementation Update**	Chair
	• AMYOS recruitment	
	• Resi Rehab operations	
	• Day Program establishment	
	• Subacute inpatient beds	
6.2	**Consumer Update**	
	• Status Update	SS
6.3	**Risk Management**	
	• No new risks or change to existing risks.	Chair
6.4	**Progress of key milestones and deliverables**	
	• Refer Monthly Project Status Report	Chair
6.5	**Other business**	
	•	

7. Matters for Noting

Item no	Item	Action Officer
7.1	**Major correspondence**	
	• Increased correspondence following Estimates and recent sentinel event	SS

8. For Information (papers only)

Item no	Item	Action Officer
8.1	•	

Next Meeting

Date: 1st September 2014
Time: 9am – 10.30am
Venue: CYMHS Board Room, Citilink Building 2, Foyer 4, Level 2, 153 Campbell Street, Bowen Hills

Children's Health Queensland Hospital and Health Service
Statewide Adolescent Extended Treatment & Rehabilitation Implementation
Steering Committee Action Item Register
(Status Indicators: Red = Significant delay, Amber = Slight delay, Green = On Track and Blue = Completed)

Meeting Date	Action Item #	Previous Meeting Reference	Action Item	Action Officer	Due Date	Status Update	Status
30/06/2014	3.1	Business from Previous Meetings	Follow up with JK regarding approach to reaching CCYMHS staff	Stephen Stathis Ingrid Adamson	11/07/14	Completed - update at next Steering Committee	
30/06/2014	5.1	Service Evaluation and BAC Review	Follow up with WM HHS about progressing the BAC Review	Leanne Geppert	04/07/14	Completed - review on hold	
30/06/2014	5.1	Service Evaluation and BAC Review	Investigate length of stays in adolescent inpatient units for consumers who may be suitable for the subacute beds or Resi	Stephen Stathis	11/07/14	Completed	
30/06/2014	5.1	Service Evaluation and BAC Review	MHAODB to provide letter of support for evaluation	Marie Kelly	11/07/14	Completed	
30/06/2014	5.1	Service Evaluation and BAC Review	Raise the idea of obtaining Resi footage with YPETRI Governance Committee - for use in promoting the service with CCYMHS staff	Stephen Stathis Ingrid Adamson	04/07/14	Awaiting confirmation from YPETRI Service Manager	
30/06/2014	6.1	AMYOS	Update Metro South's Service Agreement for AMYOS location	Ingrid Adamson	04/07/14	Completed	
30/06/2014	6.1	AMYOS	Follow up Darling Downs in regard to their Service Agreement	Stephen Stathis	04/07/14	Completed	

Children's Health Queensland Hospital and Health Service

Minutes

Adolescent Mental Health Extended Treatment Initiative Steering Committee

Date: 04/08/2014 **Time:** 09:00am **Venue:** Boardroom, CitiLink Building, Bowen Hills

Chair:	Medical Director CYMHS CHQ HHS (SS)
Secretariat:	AMHETI Project Officer (SH)
Attendees:	A/Executive Director Office of Strategy Management, CHQ (DM) A/Director of Strategy, Mental Health & Specialised Services WM HHS (LG) Clinical Services Program Manager, Metro South Addiction and Mental Health Service (RH) Director of Psychology, CHQ HHS (JS) Carer Representative State Manager Headspace (AC) Program Manager Rural, Remote and Indigenous Mental Health Services & Child, Adolescent and Young Adult Services/ Assistant Director of Allied Health, Mental Health Service Group, Townsville Hospital and Health Service (CM)
Apologies:	Divisional Director CYMHS CHQ HHS (JK) Operational Manager Alcohol, other Drugs & Campus, Mater (AT) AMHETI Project Manager (IA) A/Director Planning & Partnership Unit MHAODB (MK) Consumer Representative
Guests:	

Item No	Topic	Action	Comm'ee member	Due date
1.	**Presentations**			
	Nil			
2.	**Meeting opening**			
2.1	Welcome and Apologies	Nil	Chair	
2.2	Statement of Conflict/Interest	Nil	Chair	
2.3	Confirmation of Minutes	Confirmed	MK	
	Business			
3.	**Business Arising from Previous Meetings**			
3.1	• Obtaining Resi footage with YPETRI Governance Committee for use in promoting the service with CCYMS staff • Service Evaluation and BAC Review			
4.	**Matters for Decision**			
4.1	• Nil			
5.	**Matters for Discussion**			
5.1	Service Evaluation Plan and BAC Review: • Meetings have taken place with WM HHS and CHQ regarding whether or not to proceed with the BAC Review. Advantages and disadvantages of the review have been explored. There are concerns that a review could raise concerns for consumers, families and staff by raising the closure. It was noted that the views of stakeholders have already	LG to draft a document noting the decision to discontinue the BAC review - for submission to CEs of WM HHS and CHQ.	LG	29/08

Item No	Topic	Action	Comm'ee member	Due date
	been heard and documented. • It was agreed that the BAC review will not be progressed due to the recent serious adverse events. Matters could also become blurred between any coronial inquiries, and an external evaluation of the BAC Closure.	SH to email LG information about discussions to date regarding the BAC Review.	SH	10/08
	• Resi Service Evaluation Plan was discussed. Feedback from members indicates further consideration and discussion about the methodology and purpose of the evaluation is required; e.g. consider whether we need to narrow the evaluation as the measures are too broad; measuring cost effectiveness against what; etc.	Members to email their feedback on the Resi Service Evaluation to SS	All	22/08
6.	**Standard Agenda Items**			
6.1	**Service Implementation Update** • **AMYOS**: Referrals to this service commenced this week. A management plan for intake has been developed. Dr Michael Daubney is now leading the AMYOS teams. In July, MD visited the IMYOS teams in Victoria to learn more about the service. • Service Level agreements have been signed by most HHSs, and recruitment has commenced. • [redacted] • **Day Program**: Six sites have been viewed to date. The Stafford site was suitable but subsequently advised that it had been sold. Another site viewed at Kedron looks promising, but needs to be rezoned by Brisbane City Council to proceed. Advice indicates this could take between 3 – 6 months. CHQ continues to search for a suitable site. • **Subacute Beds**: One young person is likely to be referred to a bed but there have been no other referrals to date. • SS is flying to Cairns to review the TOHI and the continuum of care in Far North Queensland. • **BAC Closure** – The recent sentinel events are very serious and sad. Brisbane Times media coverage of these deaths is concerning given the level of inaccurate reporting and non-compliance with code of conduct regarding the reporting of suicide and mental illness. Such media has potential to increase the suicide risk of other ex-Barrett consumers. • Documentation of facts has occurred, and Dr Peter Steer has communicated concerns about recent media coverage to the Minister. • A meeting is scheduled with Brisbane Times	AC to circulate link to 'Mindframe', which has resources and information on reporting suicide and mental illness. Media release to be circulated to	AC SH	04/08 26/08

Item No	Topic	Action	Comm'ee member	Due date
	tomorrow. SS will discuss facts, incorrect reporting, and raise awareness of risks associated with reporting suicide, including code of conduct for journalists.	members with minutes.		
6.2	**Consumer Update** • Nil update			
6.3	**Risk Management** • No new risks have been identified and no change to existing risks.			
6.4	**Progress of key milestones and deliverables** • Presented Monthly Status Report and Project Gantt.			
6.5	Other Business • Nil			
7.	**Matters for Noting**			
7.1	Major correspondence • Nil			
8.	**For Information**			
8.1	• Nil			
Next meeting: Monday 1st September 2014, 9am – 10.30am CYMHS Board Room, Citilink Building 2, Foyer 4, Level 2, 153 Campbell Street, Bowen Hills				

Children's Health Queensland Hospital and Health Service

Meeting Agenda

Adolescent Mental Health Extended Treatment Initiative Steering Committee

Date:	1st September 2014
Time:	9am – 10.30am
Venue:	CYMHS Board Room Citilink Building 2, Foyer 4, Level 2, 153 Campbell Street, Bowen Hills
Video/ Teleconference Details:	Teleconference Details: ** Please advise secretariat if you want to dial in**

Chair/s:	Judi Krause	Divisional Director CYMHS CHQ HHS
	Stephen Stathis	Clinical Director CYMHS CHQ HHS
Secretariat:	Ingrid Adamson	AMHETI Project Manager, CHQ HHS
Attendees:	Deborah Miller	A/Executive Director Office of Strategy Management, CHQ HHS
	Leanne Geppert	A/Director of Strategy, Mental Health & Specialised Services, WM HHS
	Raymond Ho	Clinical Services Program Manager, Metro South Addiction and Mental Health Service, Metro South HHS
	Josie Sorban	Director of Psychology, CHQ HHS
	Marie Kelly	A/Director Planning and Partnership Unit, MHAODB
Video Conf.	Vicki Hopkins	A/Program Manager Rural, Remote and Indigenous Mental Health Services & Child, Adolescent and Young Adult Services/ Assistant Director of Allied Health, Mental Health Service Group, Townsville Hospital and Health Service
	Amanda Tilse	Operational Manager Alcohol, other Drugs & Campus, Mater Hospital
	Amelia Callaghan	State Manager Headspace
		Carer Representative
		Consumer Representative
Apologies:	Cara McCormack	Program Manager Rural, Remote and Indigenous Mental Health Services & Child, Adolescent and Young Adult Services/ Assistant Director of Allied Health, Mental Health Service Group, Townsville Hospital and Health Service
Guests:		

* Attachments accompany this item; papers to be tabled if available

1. Presentations

Item no	Item	Action Officer
1.0	• Nil	

2. Meeting Opening

Item no	Item	Action Officer
2.1	Welcome and Apologies	Chair

2.2	Statement of Conflict/Interest	Chair
2.3	Confirmation of the minutes from the previous meeting *(attached)*	Chair

3.	**Business Arising from previous minutes**	
Item no	**Item**	**Action Officer**
3.1	• Resi Service Evaluation Plan – feedback from Committee	Chairr

4.	**Matters for Decision**	
Item no	**Item**	**Action Officer**
4.1	• Nil	

5.	**Matters for Discussion**	
Item no	**Item**	**Action Officer**
5.1	• Nil	

6.	**Standard Agenda Items**	
Item no	**Item**	**Action Officer**
6.1	**Service Implementation Update**	Chair
	• AMYOS recruitment	
	• Resi Rehab operations	
	• Day Program establishment	
	• Subacute inpatient beds	
6.2	**Consumer Update**	
	• Health Service Investigation	SS/LG
	• Acknowledgement of Headspace support	SS/LG
6.3	**Risk Management**	
	• No new risks or change to existing risks.	Chair
6.4	**Progress of key milestones and deliverables**	
	• Refer Monthly Project Status Report.	Chair
6.5	**Other business**	
	•	

7.	**Matters for Noting**	
Item no	**Item**	**Action Officer**
7.1	**Major correspondence**	
	•	SS

8.	**For Information (papers only)**	
Item no	**Item**	**Action Officer**
8.1	•	

Next Meeting

Date: 6th October 2014

Time: 9am – 10.30am

Venue: CYMHS Board Room, Citilink Building 2, Foyer 4, Level 2, 153 Campbell Street, Bowen Hills

Children's Health Queensland Hospital and Health Service
Statewide Adolescent Extended Treatment & Rehabilitation Implementation
Steering Committee Action Item Register
(Status Indicators: Red = Significant delay, Amber = Slight delay, Green = On Track and Blue = Completed)

Meeting Date	Action Item #	Previous Meeting Reference	Action Item	Action Officer	Due Date	Status Update	Status
30/06/2014	5.1	Service Evaluation and BAC Review	Raise the idea of obtaining Resi footage with YPETRI Governance Committee - for use in promoting the service with CCYMHS staff	Stephen Stathis Ingrid Adamson	04/07/14	Awaiting confirmation from YPETRI Service Manager	
4/08/2014	5.1	Service Evaluation and BAC Review	LG to draft a document, noting the decision to discontinue the BAC Review, for submission to the CEs of WM HHS and CHQ HHS	Leanne Geppert	29/08/14		
4/08/2014	5.1	Service Evaluation and BAC Review	Susan Hunt to send LG information about discussions to date regarding the BAC review	Susan Hunt	10/08/14	Completed	
04/08/14	5.1	Service Evaluation and BAC Review	Members to email feedback on the Resi Service Evaluation Plan to Chair	All	22/08/14		
04/08/14	6.1	Service Implementation Update	Amelia Callaghan to circulate link to Committee on 'Mindframe', which has resources and information on reporting suicide and mental illness.	Amelia Callaghan	04/08/14	Completed	
04/08/14	6.1	Service Implementation Update	Media release to be circulated to Committee, together with minutes.	Susan Hunt	26/08/14	Completed	

Children's Health Queensland Hospital and Health Service

Minutes

Adolescent Mental Health Extended Treatment Initiative Steering Committee

Date: 01/09/2014 **Time:** 09:00am **Venue:** Boardroom, CitiLink Building, Bowen Hills

Chair:	Medical Director CYMHS CHQ HHS (SS)
Secretariat:	AMHETI Project Manager (IA)
Attendees:	A/Executive Director Office of Strategy Management, CHQ (DM) A/Director of Strategy, Mental Health & Specialised Services WM HHS (LG) Clinical Services Program Manager, Metro South Addiction and Mental Health Service (RH) Director of Psychology, CHQ HHS (JS) Operational Manager Alcohol, other Drugs & Campus, Mater (AT) A/Director Planning & Partnership Unit MHAODB (MK) A/Program Manager Rural, Remote and Indigenous Mental Health Services & Child, Adolescent and Young Adult Services/ Assistant Director of Allied Health, Mental Health Service Group, Townsville Hospital and Health Service (VH) Consumer Representative Carer Representative State Manager Headspace (AC)
Apologies:	Divisional Director CYMHS CHQ HHS (JK) Program Manager Rural, Remote and Indigenous Mental Health Services & Child, Adolescent and Young Adult Services/ Assistant Director of Allied Health, Mental Health Service Group, Townsville Hospital and Health Service (CM)
Guests:	

Item No	Topic	Action	Comm'ee member	Due date
1.	**Presentations**			
	Nil			
2.	**Meeting opening**			
2.1	Welcome and Apologies	Nil	Chair	
2.2	Statement of Conflict/Interest	Nil	Chair	
2.3	Confirmation of Minutes	Confirmed		
	Business			
3.	**Business Arising from Previous Meetings**			
3.1	• Resi Service Evaluation Plan – feedback has been received from Remainder of committee asked to submit feedback.	Provide feedback on Resi Service Evaluation Plan	Committee	19/09
4.	**Matters for Decision**			
4.1	• Nil			
5.	**Matters for Discussion**			
5.1	• Nil			
6.	**Standard Agenda Items**			
6.1	**Service Implementation Update** • **AMYOS**: Three Service Level agreements have			

Item No	Topic	Action	Comm'ee member	Due date
	been signed by HHSs, with Metro South and North still to be received. Recruitment for the remaining Brisbane-based positions has commenced. • [redacted] • **TOHI update:** In early August, SS visited the Time Out House Initiative (TOHI) in Cairns. This is run in collaboration with Aftercare. We were under the impression they were looking after young people with mild to moderate mental health problems between 22 and 25 years of age. SS discovered the cohort was quite severe and complex. The safety and care of these young people is of key concern and needs to be addressed with extra staffing. CHQ has asked Aftercare to provide a quote for an increase in staffing, and an increase in salary to attract a high level of skill for the house manager. Also looking at a review of the referral pathway, age of the cohort, and for the TOHI to provide a life skills program – bringing the TOHI more into line with the Resi. Aftercare has provided a quote which CHQ will fund through 2013/14 service underspend. This can only be provided for the 2014/15 financial year. Future funding for the TOHI will need to be revisited prior to June 2015. SS has a meeting with Aftercare/ TOHI next Tuesday to discuss this further, and look at modifying into a Resi AC noted that there is a working party looking at referral pathways in Cairns. SS is hoping this group could be the governance party for referrals into the TOHI. • **Day Program:** CHQ continues to search for a suitable site. In the interim, the plan is to establish the day program at the Child and Family Therapy Unit (CAFTU) on the Royal Children's (RCH) campus. The unit will become available from end of November when staff move across to the Lady Cilento. This will provide an interim facility until a more permanent site can be located. CAFTU will also be used to house the AMYOS teams. Some minor works will be required to refurbish CAFTU. The plan is to find a large enough space to house the AMYOS teams and Day Program. JS queried whether CAFTU could be used longer term. SS noted that ideally the day program is located further north so it is not the best site, and the entire campus will be unavailable from June 2015.			

Item No	Topic	Action	Comm'ee member	Due date
	• [redacted]			
6.2	**Consumer Update** • The DG of Health has called an external health service investigation into the transition planning for consumers who were at the Barrett. CHQ has provided documentation as provided to the Steering Committee and CE Oversight Committee. • WM HHS welcomes the investigation and notes that all information provided through the investigation is highly confidential. The final report is due by mid-September but it is anticipated that it could take longer. • SS noted that there has been a cluster of three deaths and the Coroner will investigate, to make a determination as to the cause of death. CHQ has contacted treating teams of ex-BAC consumers to inform them of the third death. • SS acknowledged the support being provided by Headspace of both ex-BAC consumers and current consumers. It is sincerely appreciated. • SS is confident that it will be found that the transition plans prior to the closure of the Barrett were as good as could be expected with the resources available at that time. SS acknowledges that it has been a difficult time for people. • [redacted] asked if there is information on what we have researched and put in place. [redacted] noted that there is a lot of negative communication on Facebook due to the lack of information on new services and how these were arrived at. SS noted that there have been newspaper articles and the 7.30 Report, where SS has discussed what we have done however very little of this information makes it into those articles or the 7.30 report. The media have only chosen minimal detail. • It was noted that the current website information does not include references to services in other states that were researched in the preparation of the Qld service – that similar services are being successfully delivered in other states. IA will follow up with the CHQ Media and Comms team to improve the information presented on the AMHETI web page. [redacted] has offered to put a link up on Facebook. RH suggested also putting out a message to consumer consultants.	Speak to CHQ Media and Comms regarding improved information on web page – send link to committee for circulation.	IA	26/09
6.3	**Risk Management** • No new risks have been identified and no change to existing risks.			

Item No	Topic	Action	Comm'ee member	Due date
6.4	**Progress of key milestones and deliverables** • Presented Monthly Status Report and Project Gantt.			
6.5	**Other Business** • Nil			
7.	**Matters for Noting**			
7.1	**Major correspondence** • There has been quite a bit of correspondence in response to the recent sentinel events. • SS noted the opposition (Labour Party) has released a statement about services they would establish if successfully voted in, including establishment of a 22 bed Barrett Centre, and a review the AMYOS and Resi services.	Circulate link to the opposition's report.	IA	05/09
8.	**For Information**			
8.1	• Nil			
Next meeting: Monday 20th October 2014, 9am – 10am CYMHS Board Room, Citilink Building 2, Foyer 4, Level 2, 153 Campbell Street, Bowen Hills				

Meeting Agenda

Adolescent Mental Health Extended Treatment Initiative Steering Committee

Date:	20th October 2014
Time:	9am – 10am
Venue:	CYMHS Board Room Citilink Building 2, Foyer 4, Level 2, 153 Campbell Street, Bowen Hills
Teleconference Details:	

Chair/s:	Judi Krause	Divisional Director CYMHS CHQ HHS
	Stephen Stathis	Clinical Director CYMHS CHQ HHS
Secretariat:	Ingrid Adamson	AMHETI Project Manager, CHQ HHS
Attendees:		
Tele Conf.	Bretine Curtis – Proxy for L Geppert	A/Director of Strategy, Mental Health & Specialised Services, WM HHS
	Deborah Miller	A/Executive Director Office of Strategy Management, CHQ HHS
	Raymond Ho	Clinical Services Program Manager, Metro South Addiction and Mental Health Service, Metro South HHS
	Josie Sorban	Director of Psychology, CHQ HHS
	Marie Kelly	A/Director Planning and Partnership Unit, MHAODB
Tele Conf.	Cara McCormack	Program Manager Rural, Remote and Indigenous Mental Health Services & Child, Adolescent and Young Adult Services/ Assistant Director of Allied Health, Mental Health Service Group, Townsville Hospital and Health Service
	Amanda Tilse	Operational Manager Alcohol, other Drugs & Campus, Mater Hospital
		Carer Representative
		Consumer Representative
Apologies:	Amelia Callaghan	State Manager Headspace
	Leanne Geppert	A/Director of Strategy, Mental Health & Specialised Services, WM HHS
Guests:		

* Attachments accompany this item; papers to be tabled if available

1. Presentations

Item no	Item	Action Officer
1.0	• Nil	

2. Meeting Opening

Item no	Item	Action Officer
2.1	Welcome and Apologies	Chair
2.2	Statement of Conflict/Interest	Chair
2.3	Confirmation of the minutes from the previous meeting *(attached)*	Chair

3.	**Business Arising from previous minutes**	
Item no	**Item**	**Action Officer**
3.1	• Improved information on website – update	IA

4.	**Matters for Decision**	
Item no	**Item**	**Action Officer**
4.1	• Nil	

5.	**Matters for Discussion**	
Item no	**Item**	**Action Officer**
5.1	• Nil	

6.	**Standard Agenda Items**	
Item no	**Item**	**Action Officer**
6.1	**Service Implementation Update** • AMYOS recruitment • Resi Rehab operations • Day Program establishment • Subacute inpatient beds	Chair
6.2	**Consumer Update** • Health Service Investigation	SS/LG
6.3	**Risk Management** • No new risks or change to existing risks.	Chair
6.4	**Progress of key milestones and deliverables** • Refer Monthly Project Status Report.	Chair
6.5	**Other business** •	

7.	**Matters for Noting**	
Item no	**Item**	**Action Officer**
7.1	**Major correspondence** •	SS

8.	**For Information (papers only)**	
Item no	**Item**	**Action Officer**
8.1	•	

Next Meeting

Date: 8th December 2014
Time: 9am – 10am
Venue: To be advised

Children's Health Queensland Hospital and Health Service

Children's Health Queensland Hospital and Health Service
Statewide Adolescent Extended Treatment & Rehabilitation Implementation
Steering Committee Action Item Register
(Status Indicators: Red = Significant delay, Amber = Slight delay, Green = On Track and Blue = Completed)

Meeting Date	Action Item #	Previous Meeting Reference	Action Item	Action Officer	Due Date	Status Update	Status
30/06/14	5.1	Service Evaluation and BAC Review	Raise the idea of obtaining Resi footage with YPETRI Governance Committee - for use in promoting the service with CCYMHS staff	Stephen Stathis Ingrid Adamson	04/07/14	Support given - now to be raised with CHQ Media and Comms	
04/08/14	5.1	Service Evaluation and BAC Review	LG to draft a document, noting the decision to discontinue the BAC Review, for submission to the CEs of WM HHS and CHQ HHS	Leanne Geppert	29/08/14		
04/08/14	5.1	Service Evaluation and BAC Review	Members to email feedback on the Resi Service Evaluation Plan to Chair	All	22/08/14	Completed - Two responses received	
01/09/14	6.2	Consumer Update	Speak to CHQ Media and Comms regarding improved information on web page – send link to committee for circulation.	IA	26/09/14	Content completed - awaiting publishing by Media and Comms	

Children's Health Queensland Hospital and Health Service

Minutes

Adolescent Mental Health Extended Treatment Initiative Steering Committee

Date: 20/10/2014 **Time:** 09:00am **Venue:** Boardroom, CitiLink Building, Bowen Hills

Chair:	Medical Director CYMHS CHQ HHS (SS)
Secretariat:	AMHETI Project Manager (IA)
Attendees:	Clinical Services Program Manager, Metro South Addiction and Mental Health Service (RH) A/Director Planning & Partnership Unit MHAODB (MK) Program Manager Rural, Remote and Indigenous Mental Health Services & Child, Adolescent and Young Adult Services/ Assistant Director of Allied Health, Mental Health Service Group, Townsville Hospital and Health Service (CM) Carer Representative
Apologies:	Divisional Director CYMHS CHQ HHS (JK) A/Director of Strategy, Mental Health & Specialised Services WM HHS (LG) A/Executive Director Office of Strategy Management, CHQ (DM) Director of Psychology, CHQ HHS (JS) Operational Manager Alcohol, other Drugs & Campus, Mater (AT) State Manager Headspace (AC) Consumer Representative
Guests:	

Item No	Topic	Action	Comm'ee member	Due date
1.	**Presentations**			
	Nil			
2.	**Meeting opening**			
2.1	Welcome and Apologies	Nil	Chair	
2.2	Statement of Conflict/Interest	Nil	Chair	
2.3	Confirmation of Minutes	Confirmed	MK	
	Business			
3.	**Business Arising from Previous Meetings**			
3.1	• Resi Service Evaluation Plan – feedback has been received by two committee members and will be incorporated. • Improved information on AMHETI web page – link on Facebook – held up with LCCH web site update – will circulate link to new page when available.	Circulate link to Committee, when available	IA	
4.	**Matters for Decision**			
4.1	• Nil			
5.	**Matters for Discussion**			
5.1	• Nil			
6.	**Standard Agenda Items**			
6.1	**Service implementation Update** • AMYOS: Recruitment – now fully recruited in Brisbane north, south and Red/Cab.			

Item No	Topic	Action	Comm'ee member	Due date
	• Townsville have interviewed (have 1 FTE and some part time interest in the clinicians). Will be delivering the 0.2 out of existing psychiatry hours. SS offered additional support from Brisbane if needed. • Logan has just received confirmation that recruitment can progress to advertising. 0.2 psychiatry time will be absorbed by current resources. • Toowoomba and Gold Coast have yet to update on their recruitment activities. • **Resi:** The Resi is now at full capacity, with a small waiting list. There is growing awareness in the community CYMHS clinics regarding the service. • SS advised that the lease on the current Resi house expires at the end of December. CHQ has decided to extend the current contract until 30 June 2015. Aftercare will attempt to extend the current lease for 6 months but if unsuccessful, he will lease for 12 months. • [redacted] asked whether consent will be sought from consumers and their guardians prior to resi footage being filmed. IA confirmed this would definitely be part of the process. • **TOHI** update: MK advised that they have been progressing the contract with Aftercare. Recruitment has commenced. TOHI funding is still only available until June 2015. MK will follow up with Aftercare regarding the expiry date of the house lease for this service. • MK advised that the Step Up/Step Down proposal is still under consideration by Treasury and there is no guarantee of approval. Won't have an outcome until March 2015. • **Day Program:** CHQ continues to search for a suitable site. A site at Chermside was inspected last Thursday. IA advised that the barriers to finding an appropriate site is predominantly due to inappropriate size (too large or too small) or inappropriate zoning (e.g. residential or industrial). • In the interim, the plan is to establish the day program at the Child and Family Therapy Unit (CFTU) on the Royal Children's (RCH) campus. Plan B would be to extend the use of CFTU beyond 30 June 2015; however, unclear who will own the property at that time. • In the meantime, all staff have been recruited for the Day Program. • **Subacute Beds**: We are of the understanding (informally informed) that [redacted] young people are now in the beds. The Mater is not strictly following the referral approach; however, with the Lady Cilento opening in 5 weeks, CHQ feels focus is better placed on developing a detailed model of service for when the beds transition to LCCH.			

Item No	Topic	Action	Comm'ee member	Due date
6.2	**Consumer Update** • The external health service investigation is continuing and the due date for the final report has been extended to end of October. CHQ doesn't expect to see the report until November.			
6.3	**Risk Management** • No new risks have been identified and no change to existing risks.			
6.4	**Progress of key milestones and deliverables** • Presented Monthly Status Report and Project Gantt.			
6.5	**Other Business** • **Nil**			
7.	**Matters for Noting**			
7.1	**Major correspondence** • Nil			
8.	**For Information**			
8.1	• Nil			
Next meeting: 15th December 9am – 10am; venue to be confirmed				

Children's Health Queensland Hospital and Health Service

Meeting Agenda

Adolescent Mental Health Extended Treatment Initiative Steering Committee

Date:	15th December 2014
Time:	9am – 10am
Venue:	To Be Confirmed
Teleconference Details:	

Chair/s:	Judi Krause	Divisional Director CYMHS CHQ HHS
	Stephen Stathis	Clinical Director CYMHS CHQ HHS
Secretariat:	Ingrid Adamson	AMHETI Project Manager, CHQ HHS
Attendees:		
	Leanne Geppert	A/Director of Strategy, Mental Health & Specialised Services, WM HHS
	Deborah Miller	A/Executive Director Office of Strategy Management, CHQ HHS
	Raymond Ho	Clinical Services Program Manager, Metro South Addiction and Mental Health Service, Metro South HHS
	Josie Sorban	Director of Psychology, CHQ HHS
	Marie Kelly	A/Director Planning and Partnership Unit, MHAODB
	Cara McCormack	Program Manager Rural, Remote and Indigenous Mental Health Services & Child, Adolescent and Young Adult Services/ Assistant Director of Allied Health, Mental Health Service Group, Townsville Hospital and Health Service
	Amanda Tilse	Operational Manager Alcohol, other Drugs & Campus, Mater Hospital
	Amelia Callaghan	State Manager Headspace
		Carer Representative
		Consumer Representative
Apologies:		
Guests:		

* Attachments accompany this item; papers to be tabled if available

1. Presentations

Item no	Item	Action Officer
1.0	• Nil	

2. Meeting Opening

Item no	Item	Action Officer
2.1	Welcome and Apologies	Chair
2.2	Statement of Conflict/Interest	Chair
2.3	Confirmation of the minutes from the previous meeting *(attached)*	Chair

3.	**Business Arising from previous minutes**	
Item no	**Item**	**Action Officer**
3.1	• Improved information on website – update	IA

4.	**Matters for Decision**	
Item no	**Item**	**Action Officer**
4.1	• Nil	

5.	**Matters for Discussion**	
Item no	**Item**	**Action Officer**
5.1	• Nil	

6.	**Standard Agenda Items**	
Item no	**Item**	**Action Officer**
6.1	**Service Implementation Update** • AMYOS recruitment • Resi Rehab operations • Day Program establishment • Subacute inpatient beds	Chair
6.2	**Consumer Update** • Health Service Investigation	SS/LG
6.3	**Risk Management** • No new risks or change to existing risks.	Chair
6.4	**Progress of key milestones and deliverables** • Refer Monthly Project Status Report.	Chair
6.5	**Other business** •	

7.	**Matters for Noting**	
Item no	**Item**	**Action Officer**
7.1	**Major correspondence** •	SS

8.	**For Information (papers only)**	
Item no	**Item**	**Action Officer**
8.1	•	

Next Meeting

Date: To be advised
Time: 9am – 10am
Venue: To be advised

Children's Health Queensland Hospital and Health Service

Children's Health Queensland Hospital and Health Service Statewide Adolescent Extended Treatment & Rehabilitation Implementation Steering Committee Action Item Register (Status Indicators: Red = Significant delay, Amber = Slight delay, Green = On Track and Blue = Completed)							
Meeting Date	**Action Item #**	**Previous Meeting Reference**	**Action Item**	**Action Officer**	**Due Date**	**Status Update**	**Status**
30/06/14	5.1	Service Evaluation and BAC Review	Raise the idea of obtaining Resi footage with YPETRI Governance Committee - for use in promoting the service with CCYMHS staff	Stephen Stathis Ingrid Adamson	04/07/14	Support given - now to be raised with CHQ Media and Comms	
04/08/14	5.1	Service Evaluation and BAC Review	LG to draft a document, noting the decision to discontinue the BAC Review, for submission to the CEs of WM HHS and CHQ HHS	Leanne Geppert	29/08/14		

Children's Health Queensland Hospital and Health Service

Minutes

Adolescent Mental Health Extended Treatment Initiative Steering Committee

Date: 15/12/2014 **Time:** 09:00am **Venue:**

Chair:	Medical Director CYMHS CHQ HHS (SS) Divisional Director CYMHS CHQ HHS (JK)
Secretariat:	AMHETI Project Manager (IA)
Attendees:	A/Director of Strategy, Mental Health & Specialised Services WM HHS (LG) A/Executive Director Office of Strategy Management, CHQ (DM) Director of Psychology, CHQ HHS (JS) Clinical Services Program Manager, Metro South Addiction and Mental Health Service (RH) A/Director Planning & Partnership Unit MHAODB (MK) Program Manager Rural, Remote and Indigenous Mental Health Services & Child, Adolescent and Young Adult Services/ Assistant Director of Allied Health, Mental Health Service Group, Townsville Hospital and Health Service (CM) Operational Manager Alcohol, other Drugs & Campus, Mater (AT) State Manager Headspace (AC) Consumer Representative Carer Representative
Apologies:	
Guests:	

Item No	Topic	Action	Comm'ee member	Due date
1.	**Presentations**			
	Nil			
2.	**Meeting opening**			
2.1	Welcome and Apologies	Nil	Chair	
2.2	Statement of Conflict/Interest	Nil	Chair	
2.3	Confirmation of Minutes	Confirmed	MK	
	Business			
3.	**Business Arising from Previous Meetings**			
3.1	• Improved information on AMHETI web page –			
4.	**Matters for Decision**			
4.1	• Nil			
5.	**Matters for Discussion**			
5.1	• Nil			
6.	**Standard Agenda Items**			
6.1	**Service Implementation Update** • **AMYOS**: Recruitment • Townsville have interviewed (have 1 FTE and some part time interest in the clinicians). Will be delivering the 0.2 out of existing psychiatry hours. SS offered additional support from Brisbane if needed.			

Item No	Topic	Action	Comm'ee member	Due date
	• Logan has just received confirmation that recruitment can progress to advertising. 0.2 psychiatry time will be absorbed by current resources. • Toowoomba and Gold Coast have yet to update on their recruitment activities. • **Resi:** The Resi is now at full capacity, with a small waiting list. There is growing awareness in the community CYMHS clinics regarding the service. • SS advised that the lease on the current Resi house expires at the end of December. CHQ has decided to extend the current contract until 30 June 2015. Aftercare will attempt to extend the current lease for 6 months but if unsuccessful, he will lease for 12 months. • asked whether consent will be sought from consumers and their guardians prior to resi footage being filmed. IA confirmed this would definitely be part of the process. • **TOHI** update: MK advised that they have been progressing the contract with Aftercare. Recruitment has commenced. TOHI funding is still only available until June 2015. MK will follow up with Aftercare regarding the expiry date of the house lease for this service. • MK advised that the Step Up/Step Down proposal is still under consideration by Treasury and there is no guarantee of approval. Won't have an outcome until March 2015. • **Day Program:** CHQ continues to search for a suitable site. A site at Chermside was inspected last Thursday. IA advised that the barriers to finding an appropriate site is predominantly due to inappropriate size (too large or too small) or inappropriate zoning (e.g. residential or industrial). • In the interim, the plan is to establish the day program at the Child and Family Therapy Unit (CFTU) on the Royal Children's (RCH) campus. Plan B would be to extend the use of CFTU beyond 30 June 2015; however, unclear who will own the property at that time. • In the meantime, all staff have been recruited for the Day Program. • **Subacute Beds:** We are of the understanding (informally informed) that young people are now in the beds. The Mater is not strictly following the referral approach; however, with the Lady Cilento opening in 5 weeks, CHQ feels focus is better placed on developing a detailed model of service for when the beds transition to LCCH.			
6.2	**Consumer Update** • The external health service investigation is continuing and the due date for the final report has been extended to end of October. CHQ doesn't expect to see the report until November.			

Item No	Topic	Action	Comm'ee member	Due date
6.3	**Risk Management** • No new risks have been identified and no change to existing risks.			
6.4	**Progress of key milestones and deliverables** • Presented Monthly Status Report and Project Gantt.			
6.5	**Other Business** • Nil			
7.	**Matters for Noting**			
7.1	Major correspondence • Nil			
8.	**For Information**			
8.1	• Nil			
Next meeting: XX 2015, 9am – 10am, venue to be confirmed				

Ingrid Adamson - Phone Number for Monday's Steering Committee Meeting

From: Ingrid Adamson
To: [redacted]
Date: 1/11/2013 9:49 AM
Subject: Phone Number for Monday's Steering Committee Meeting

Good morning [redacted] and thank you for your time on the phone yesterday.

As promised, here is the phone number for the CYMHS unit, where the Steering Committee meeting is being held Monday. The phone number is: [redacted]

Should you be running late, or your flight delayed, please phone and let the receptionist know and they will get your message to the Steering Committee.

Again, I just want to reassure you that the Steering Committee will move the agenda around to accommodate the parents' presentation, so that you have the full time scheduled.

In the meantime, if you have any other questions, please let me know.

Warm regards,
Ingrid

Ingrid Adamson
Project Manager - SW AETRS
Office of Strategy Management

Children's Health Queensland Hospital and Health Service
E: [redacted]
Level 1, North Tower
Royal Children's Hospital
HERSTON QLD 4029
www.health.qld.gov.au/childrenshealth

EXHIBIT 122

Page 280 redacted for the following reason:
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Confidential

EXHIBIT 122

Page 281 redacted for the following reason:
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Confidential

EXHIBIT 122

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Confidential

EXHIBIT 122

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Confidential

EXHIBIT 122

Page 284 redacted for the following reason:
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Confidential

Queensland Government

West Moreton Hospital and Health Service

Enquiries to: Laura Johnson
Telephone:
Facsimile:
Our Ref:

Dear Parents and Carers

The statewide project for the Adolescent Extended Treatment and Rehabilitation (SW AETR) Implementation Strategy has commenced under the governance of Children's Health Queensland, and the Steering Committee has met three times since 26 August 2013. As part of the statewide project, two Working Groups and a Clinical Panel have also recently been defined to deliver on various aspects of this initiative. Working Group 1 is the SW AETR Service Options Implementation Working Group, which will build on the work surrounding service models completed by the Expert Clinical Reference Group earlier this year. Working Group 2 will focus on financial and staffing requirements. Finally, the Clinical Panel will consist of a team of clinicians led by Dr Anne Brennan (A/Clinical Director of the Barrett Adolescent Centre) that focuses on identifying and supporting the ongoing care needs of and future options for the adolescents currently at Barrett or on the waiting list.

The SW AETR Service Options Implementation Working Group will be meeting for the first time on 1 October 2013, when a Forum will be held. A second Forum will be delivered within a month after this period. This Working Group comprises of a range of multi-disciplinary clinicians and service leaders from statewide Child and Youth Mental Health Services (CYMHS), consumer and carer representation, and non government organisation representation.

We invite you to (or you may wish to collectively as a group) prepare a written submission for the consideration of Working Group 1. Our aim is to ensure you have direct input into the work of the statewide project, and that you have an opportunity to contribute to the development of the new service options moving forward. The key questions that we would appreciate you addressing in your submission are:

1. What components of the current service options available in Queensland best meet the care requirements of adolescents with complex mental health needs?
2. What are the gaps of the current mental health service options available in Queensland?
3. What opportunities are there for new and/or enhanced services for these adolescents in Queensland?

This feedback will be valuable in providing insight into the planning of future service options for adolescent mental health extended treatment and rehabilitation. Please send your submission to Laura Johnson, Project Officer, Mental Health and Specialised Services, West Moreton Hospital and Health Service via by Friday 18 October 2013. Your de-identified submission will be utilised by the SW AETR Service Options Implementation Working Group in their second Forum (date to be confirmed).

Yours sincerely

Lesley Dwyer
Chief Executive
West Moreton Hospital and Health Service
30/09/2013

Office
The Park - Centre for Mental Health
Administration Building,
Cnr Ellerton Drive and
Wolston Park Road,
Wacol, Qld 4076

Postal
Locked Bag 500, Sumner Park
BC, Qld 4074

Phone **Fax**

Prepared by:	Laura Johnson Project Officer MH&SS [redacted] 30/09/2013
Submitted through:	Dr Leanne Geppert Director MH&SS [redacted] 30/09/2013
Submitted through:	Sharon Kelly Executive Director MH&SS [redacted] 30/09/2013
Cleared by:	Lesley Dwyer Chief Executive West Moreton Hospital and Health [redacted] date

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The Park - Centre for Mental Health
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Cnr Ellerton Drive and
Wolston Park Road,
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Locked Bag 500, Sumner Park
BC, Qld 4074

Phone [redacted] **Fax**

Statewide Adolescent Extended Treatment And Rehabilitation Strategy Parents' Presentation

Hello and thank you for your submission regarding the Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy (SW AETRS). Your input and comments are sincerely appreciated.

We would now like to extend an invitation to parents and carers of adolescents currently admitted at the Barrett Adolescent Centre to present this submission to the SW AETRS Steering Committee.

Meeting Details:

9.30am – 10am (*please arrive a little earlier to be signed in*)
Monday 4th November 2013
Child and Youth Mental Health Services Unit
Corners Roger and Water Streets Spring Hill (*parking is available via the Roger St entrance*)

Frequently Asked Questions

Question 1: What is the purpose of the Statewide Adolescent Extended Treatment and Rehabilitation Strategy Steering Committee?

The purpose of the SW AETRS Steering Committee is to oversee the implementation of the Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy, and provide a decision-making, guidance, and leadership role with respect to mental health service planning, models of care, workforce planning, financial management and consumer needs associated with future adolescent extended treatment and rehabilitation services.

Question 2: What is the purpose of the Parents' Presentation?

The Parents' Presentation is an opportunity for parents of adolescents currently admitted at the Barrett Adolescent Centre to engage with the Steering Committee. This forms part of a broader engagement strategy to gather input for the design and development of improved mental health service options for adolescents.

The Committee are very interested to hear your submission to raise their understanding of your experience and perspective, and to inform an enhanced child and family centric model of care for the future. All due respect and consideration will be given to your family's privacy and personal situation.

Question 3: How long will I have for the presentation?

You will have 30 minutes with the Steering Committee, commencing at 9.30am. We would like to suggest you allocate 20 minutes for the presentation and 10 minutes for questions and answers from the Steering Committee to clarify any points of the presentation.

We will also undertake a debriefing session with you immediately following the presentation which could take from 10 – 20 minutes. We will be guided by you on the duration of this debriefing session.

Question 4: Will all of my suggestions be implemented?

A range of stakeholders from across the state, and interstate, have been consulted on adolescent mental health services and contemporary models of care. This has included mental health clinicians across nursing, allied health and medical professions, non-government organisations, carers, consumers, and

families. The aim of this extensive consultation is to consolidate input from all stakeholders, together with evidence-based research, to create a service model to best meet the needs of youth across Queensland. Your submission will absolutely be considered as part of this process, however, it must be noted that some of your suggestions may not be implemented.

Question 5: Does my adolescent need to attend the presentation?
No, your adolescent does not need to attend the presentation. Again, we understand that this could be a potentially unsettling and emotional process for you. Even though we will make every attempt to create a relaxed environment when talking with the Committee, and make you feel as comfortable as possible, it might be a little daunting for a child.

Question 6: Will my adolescent's clinical care team be attending the presentation?
No, your child's clinical care team from the Barrett Adolescent Centre will not be in attendance at the presentation. The current clinical care of your adolescent remains the responsibility of West Moreton Hospital and Health Service and is not the focus of this presentation.

Question 7: Who else will be at the presentation?
Only Steering Committee members and the invited parents associated with your submission will be present during your presentation.

Question 8: What if I freeze up during the presentation?
At any time during your presentation, should you wish to take a break, freeze up, or finish the presentation, please indicate to the Committee Chair, Judi Krause, and she will immediately cease the presentation. A separate break out room will be available for you to move to should this be required.

Question 9: Do I need to prepare anything or do I just turn up and start talking?
You are not required to undertake any preparation for the presentation unless you would like to. If you would feel more comfortable with some notes to prompt your thinking in the presentation then please feel free to do so. The Committee will have read your written submission prior to the presentation, so they will be familiar with the content.

Question 10: Is it up to me to take the lead in the presentation or will someone else assist?
The Steering Committee Chair, Judi Krause, will take the lead in the presentation. When you are ready, you will then be invited to lead on from there.

Question 11: Can I ask questions of the Steering Committee?
The purpose of this presentation is for you to have an opportunity to present your submission to the Steering Committee. The Committee will not, however, enter into discussions regarding future adolescent mental health service options. This initiative is still in a consultation phase and no decisions have yet been made regarding the future model of service.

Question 12: How will you support me through this process?
We understand that this could be a potentially unsettling and emotional process for you. Our aim is to provide every available support to you at the Committee meeting and directly after. Prior to the committee meeting we will contact you to ensure you are clear about the purpose of the Parent Presentation and to identify any support services that you may require. During the presentation, the Chair, Judi Krause will introduce you to the Committee and be a moderator throughout the presentation. Immediately following the presentation, Stephen Stathis, the Clinical Lead on this initiative, will undertake a debriefing session with you. At the end of this debriefing session, we will discuss whether you think you might like any additional support assistance and, if required, we will make the appropriate arrangements. Finally, and if agreed by you, we will contact you one week after the presentation to see how you are. It is at this time that further support services can also be arranged if required.

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

6 AUGUST 2013

PARENTS/CARERS OF CURRENT BARRETT PATIENTS PHONED BY WMHHS MANAGEMENT

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

6 AUGUST 2013

RADIO INTERVIEW WITH REBECCA LEVINGSTON ON 612 ABC BRISBANE

HEALTH MINISTER LAWRENCE SPRINGBORG

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

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

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

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

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

6 AUGUST 2013

QUEENLAND GOVERNMENT MEDIA STATEMENT

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

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

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

6 AUGUST 2013
QUEENLAND GOVERNMENT FAQ SHEET

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

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

7 AUGUST 2013
FIRST SESSION OF THE FIFTY-FOURTH PARLIAMENT

HEALTH MINISTER LAWRENCE SPRINGBORG

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

7 AUGUST 2013
RADIO INTERVIEW WITH STEPHANIE SMAIL ON 'THE WORLD TODAY', ABC RADIO

HEALTH MINISTER LAWRENCE SPRINGBORG

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

7 AUGUST 2013
THE AUSTRALIAN

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

7 AUGUST 2013
THE BRISBANE TIMES (TONY MOORE)

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

HEALTH MINISTER LAWRENCE SPRINGBORG

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

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

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

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

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

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

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

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

7 AUGUST 2013
EMAIL TO ALISON EARLS, INITIATOR OF SAVE THE BARRETT CENTRE PETITION

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

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

8 AUGUST 2013
THE QUEENSLAND TIMES

HEALTH MINISTER LAWRENCE SPRINGBORG

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

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

8 AUGUST 2013

4ZZZ RADIO INTERVIEW

WEST MORETON HOSPITAL & HEALTH SERVICE CHIEF EXECUTIVE, LESLEY DWYER

I need to be really clear – we will continue as West Moreton Hospital & Health Service to provide care at the Barrett Adolescent Service until there is an agreed statewide model for adolescent mental health services.

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

9 AUGUST 2013

EMAIL TO [redacted] OF BARRETT CENTRE PATIENT

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

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

22 AUGUST 2013

FIRST SESSION OF THE FIFTY-FOURTH PARLIAMENT

HEALTH MINISTER LAWRENCE SPRINGBORG

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

EDUCATION MINISTER JOHN-PAUL LANGBROEK

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

23 AUGUST 2013

WEST MORETON HOSPITAL & HEALTH SERVICE 'FAST FACTS' 6

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

28 AUGUST 2013

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

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

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

12 SEPTEMBER 2013

THE BRISBANE TIMES (TONY MOORE)

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

HEALTH MINISTER LAWRENCE SPRINGBORG

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

30 SEPTEMBER 2013

RADIO INTERVIEW WITH REBECCA LEVINGSTON ON 612 ABC BRISBANE

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

QUEENSLAND MENTAL HEALTH COMMISSIONER, LESLEY VAN SCHOUBROECK

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

HEALTH MINISTER LAWRENCE SPRINGBORG's STATEMENTS ON MENTAL HEALTH

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

August 2012, Speech to Health Media Club

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

25 March 2013, Queensland Times

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

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

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

providing that. There is significant dislocation for families who have to take their young family member to access those particular services and sometimes for a long period of time. When I became the Minister for Health I was not impressed by the decision of the previous government to close the Barrett centre and simply to seek to replace it with a centre at Redlands. I put that on hold pending further advice and consideration of the matter involving the Queensland Mental Health Commissioner. It makes sense that we take a service like this and expand it across the state so it can be provided closer to where the young person lives. The reality is that we do have a growing demand. There has been the establishment of a clinical expert committee that involves psychiatrists and psychologists from within Queensland and interstate, residents of the Barrett centre and parents of residents of the Barrett centre. We take our advice from them. Anyone in Queensland who can say today that we have properly and adequately met the needs of young people with complex mental health needs by the utilisation of the current system is absolutely ignoring the fact that it is falling short of what we need. That expert panel is working towards a final decision on the model of care for the early part of 2014 and the transition of those young people into that particular model of care which may involve in-patient, complex treatment and support from the department of education for the educational needs of those young people with complex mental health needs. I can assure this House that none of those young clients currently there will be left in the lurch. They will be properly accommodated and looked after, and there will be additional capacity for others—

7 August 2013, First Session of the Fifty-Fourth Parliament

The simple reality is this; (the Barrett Centre) is a youth mental health facility and we are trying to build more mental health facilities for our young people around Queensland.

1 September 2013, Brisbane Times

Queensland's whole-of-government approach to mental health and substance misuse combined with widespread community input is delivering better outcomes for patients and their families. Health Minister Lawrence Springborg said at the start of Mental Health Week it was important to highlight the role communities across Queensland would play in the future direction of mental health. "On 1 July 2013 we established an independent Queensland Mental Health Commission (QMHC) to allow us to deliver better services," *Mr Springborg said.* "The theme of Mental Health Week this year is 'We're all in this together' and Queensland's Mental Health Commissioner Dr Lesley van Schoubroek has been travelling the state to hear people's thoughts how we can better support those living with mental illness. I'm really pleased communities are taking a leadership role, and appreciate their efforts to support people with mental illness and help keep them well. The future of mental health in Queensland will reflect this community spirit, while ensuring resources and frontline government services are where they need to be." *Mr Springborg said Queensland communities were remarkably resilient, and the government would continue to focus on strengthening frontline services, while recognising the importance of housing, education and employment services, as well as social inclusion. While discussions about new directions are underway, the government is continuing to provide resources to improve existing services including: • $130.35 million capital funding for 17 projects to improve and upgrade mental health facilities • strengthening prevention and early intervention by working with three new Headspace centres in Queensland • more facilities for people who need treatment, with a $10 million mental health care facility for Cairns and more Community Care Units across the state • a review of the Mental Health Act.*

8 October 2013, My Sunshine Coast

We all know the devastating impacts mental health can have on the community, particularly in rural areas. We all know the statistics. We can't say this publication *[Glovebox guide to mental health]* is going to change all that but if it helps one person suffering from a mental illness then it will all be worthwhile.

23 October 2013, Goondiwindi Argus

Health Minister Lawrence Springborg said more could be done to help people who live with mental health concerns. I think we can do a lot more than we are currently doing. The statistics are very scary. We want Queenslanders to know it is okay to seek help. Collectively we need to take our support to a whole new level and this website goes along way to achieving that.

31 October 2013, Northern Star

It should be noted that the Qld Health web pages dedicated to mental health (www.health.qld.gov.au/mentalhealth/) don't seem to contain ANY statements on mental health by the current Minister OR the current Premier. The previous government's Plan for Mental Health 2007 - 2017 is available, as is the previous government's four year progress report on that, but there is nothing from Mr Springborg indicating that he believes this area of healthcare to be one of any level of importance.

PREMIER CAMPBELL NEWMAN's STATEMENTS ON MENTAL HEALTH

Hospital in the Home, the practice of providing home-based care at hospital standards, is another priority, as is the creation of an **independent*** Mental Health Commission for Queensland.

February 2013, Premier's Message, Blueprint for Better Healthcare in Queensland

p17 of the Blueprint again states that "Queensland's first ***independent**** *Mental Health Commission will be established."*

** (It should be noted that under the Qld Mental Health Commission Act 2013, that the QMHC was set up NOT as an* ***Independent*** *body but* ***under the direct control of the Health Minister*** *i.e.*
Division 2 Functions and powers
13 Ministerial direction
(1) The commissioner is subject to the directions of the Minister in performing the commissioner's functions under this Act.
(2) The commissioner must comply with a direction given by the Minister.)

Please be assured that I, along with the WMHHS, am committed to ensuring Queensland's adolescents have access to the mental health treatment and care they need.

15 March 2013, Letter to Alison Earls, Initiator of 'Save Barrett' petition

... the government is establishing the Queensland Mental Health Commission (QMHC) for commencement by mid-2013. The QMHC will drive mental health reform in Queensland and will work to achieve better health outcomes for people with mental

illness. The QMHC will support greater cooperation across the government and on-government sectors, along with an increased focus on outcomes, recovery, and community wellbeing. It will also be empowered to recommend changes or improvements to make sure out mental health services are delivering the right support where it is needed.

24 April 2013, Letter to Alison Earls, Initiator of 'Save Barrett' petition

....what we are doing in Health. We have a blueprint for Health that we released back in February this year. ... Why are we doing these things? Because we want the best free public health and hospital system in the nation. Nothing but the best will do for this government. That is what we are doing for Queenslanders. I am afraid that at the moment it appears that the message is not quite out there in the Queensland community.

31 October 2013, First Session of the Fifty-Fourth Parliament

We support the national reform agenda to ensure young people are treated closer to their homes in the least restrictive environment, and with minimum possible disruption to their families, educational, social and community networks.
The National Mental Health Service Planning Framework clearly recommends community-based and non-acute care settings for the care of mental health consumers, particularly young people*. What is important to understand is that the Barrett Centre building is very old and was not really designed to house a school or adolescent's accommodation. The Australian Council of Health Care Standards has recommended that the Barrett Adolescent Centre does not meet current standards or future standards for contemporary models of care for young people*. We are working to strengthen the mental health sector. Queensland Health spends approximately $1.0 Billion per year on mental health services. It's an extremely important area.

Premier's Team on Campbell Newman's Facebook Page

** Brian Woods, Project Director of the NMHSPF has actually stated that "It has been recognised that to remain relevant in a comprehensive health care system, it is likely the model of extended inpatient care of adolescents will continue to evolve with a clear focus on adolescents with severe and complex mental health disorders. International guidelines have indicated that inpatient care is regarded as necessary only for the most severe and complex young people and the emphasis is on intensive day patient, community-focussed programs and step-up/step-down youth mental health care." This statement supports the Barrett model. In addition, the current ACHS National Standards for Mental Health Service including nothing that would lead anyone to conclude that a, extended inpatient facility like Barrett "does not meet current standards or future standards for contemporary models of care for young people". In fact, it states that there should be "access to a range of evidence based treatments and facilitates access to rehabilitation and support programs which address the specific needs of consumers and promotes their recovery" They do state that "The MHS provides the least restrictive and most appropriate treatment and support possible. Consideration is given to the consumer's needs and preferences, the demands on carers, and the availability of support and safety of those involved" And this again supports the Barrett model as it IS the least restrictive and most appropriate treatment and support possible for this group of young sufferers*

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

Laura Johnson - Project Officer

Mental Health and Specialised Services

West Moreton Hospital and Health Services

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

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

Introduction

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

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

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

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

(i) Education: Onsite Schooling.

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

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

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

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

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

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

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

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

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

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

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

(ii) Services away from home:

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

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

(iii) Combined Inpatient/Day-patient capacity:

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

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

(iv) Community:

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

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

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

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

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

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

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

(i) No/insufficient service available:

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

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

(ii) Lack of recognition of developmental theory:

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

(iii) Failure to access service:

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

(iv) Lack of networking and collaboration between services:

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

(v) Lack of recognition of genuine family support

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

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

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

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

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

(i) E-health/E-Therapy:

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

(ii) Family Units:

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

(iii) Mobile Services

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

(iv) Clinical Case Management Advisory Teams:

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

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

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

Refer to attachment

(v) How did they get here?

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

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

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

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

4. Other comments for consideration.

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

Recommendation 10

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

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

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

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

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

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

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

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

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

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

Queensland Government

Enquiries to: Ingrid Adamson, Steering Committee Secretariat
Email:
Your Ref: CHQB130197

Children's Health Queensland
Hospital and Health Service

Dear and

I would like to express my personal thanks to you for agreeing to share your experience with myself and the other Steering Committee members. Your personal time commitment and involvement is sincerely appreciated.

Early feedback received from the Committee members indicates how much each member took away from your positive and personal engagement with them. They also appreciate the insights you provided into the complexities facing families with children who have complex care needs.

The Committee will be considering the issues you have raised at our next meeting and as part of ongoing service model developments.

Once again, thank you for your invaluable contribution.

Kind regards

Judi Krause
Divisional Director, CYMHS

Stephen Stathis
Clinical Director, CYMHS

Co-Chairs of the Statewide Adolescent Extended Treatment and Rehabilitation Strategy Steering Committee, Children's Health Queensland Hospital and Health Service

11 / 11 / 2013

Level 1 – North Tower
Royal Children's Hospital,
Herston Road,
HERSTON Q 4029
GPO Box 48, Brisbane Q 4001
Telephone
Facsimile
ABN 62 254 746 464

Ingrid Adamson - Sent on behalf of the SW AETRS Steering Committee

From: Ingrid Adamson
To: [redacted]
Date: 12/11/2013 5:13 PM
Subject: Sent on behalf of the SW AETRS Steering Committee
Attachments: Thank You Letter_Signed.pdf

Hello [redacted] and [redacted] and I hope my email finds you [redacted] well.

Please find, attached, a letter from the Co-Chairs of the Statewide Adolescent Extended Treatment and Rehabilitation Strategy Steering Committee, expressing our appreciation for your time last week and the information you shared with us.

Warm regards,
Ingrid

Ingrid Adamson
Project Manager - SW AETR
Office of Strategy Management

Children's Health Queensland
Hospital and Health Service
E: [redacted]
Level 1, North Tower
Royal Children's Hospital
HERSTON QLD 4029
www.health.qld.gov.au/childrenshealth

Queensland Government

Children's Health Queensland Hospital and Health Service

Enquiries to: Ingrid Adamson, Steering Committee Secretariat
Email:
Your Ref: CHQB130197

Dear [redacted] and [redacted]

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Early feedback received from the Committee members indicates how much each member took away from your positive and personal engagement with them. They also appreciate the insights you provided into the complexities facing families with children who have complex care needs.

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Once again, thank you for your invaluable contribution.

Kind regards

[redacted]

Judi Krause
Divisional Director, CYMHS

[redacted]

Stephen Stathis
Clinical Director, CYMHS

Co-Chairs of the Statewide Adolescent Extended Treatment and Rehabilitation Strategy Steering Committee, Children's Health Queensland Hospital and Health Service

11 / 11 / 2013

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

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

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

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

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

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

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

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

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

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

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

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

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

Commissions of Inquiry Order (No.4) 2015

Barrett Adolescent Centre Commission of Inquiry

CERTIFICATE OF EXHIBIT

Exhibit L to X to the Affidavit of Stephen Stathis affirmed on 5 November 2015.

[redacted]

Deponent

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

JUSTICE OF THE PEACE (QUALIFIED) DEPT. OF JUSTICE & ATTORNEY-GENERAL Reg. No. 84680

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

Commissions of Inquiry Order (No.4) 2015

Barrett Adolescent Centre Commission of Inquiry

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L

Children's Health Queensland Hospital and Health Service

Terms of Reference

Chief Executive and Department of Health Oversight Committee

1. Purpose

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

2. Guiding principles

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

3. Functions

The functions and objectives of the Oversight Committee include:

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

4. Authority

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

Decision Making:

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

5. Frequency of meetings

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

Attendance can be in-person or via teleconference mediums.

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

6. Membership

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

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

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

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

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

7. Quorum

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

8. Performance and Reporting

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

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

9. Confidentiality

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

10. Risk Management

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

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

Document history

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

Previous versions should be recorded and available for audit.

Children's Health Queensland Hospital and Health Service

M

Meeting Agenda

Chief Executive and Department of Health Oversight Committee

Date:	17th October 2013
Time:	12.30pm to 2pm
Venue:	Boardroom, Level 5, Woolworths Building, RCH, Herston
Teleconference Details:	*** Please advise secretariat if you are using T/C***

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

1. Presentations

Item no	Item	Action Officer
1.0	Nil	

2. Meeting Opening

Item no	Item	Action Officer
2.1	Welcome and Apologies	Chair
2.2	Statement of Conflict/Interest	Chair
2.3	Confirmation of the minutes from the previous	Chair
2.4	Statement of achievements	Chair

3. Business Arising from previous minutes

Item no	Item	Action Officer
3.1	Nil	

4.	**Matters for Decision**	
Item no	**Item**	**Action Officer**
4.1	Oversight Committee Terms of Reference	Chair
4.2	SW AETRS Project Plan (endorsing amendments to timeframes)	Chair
4.3	Communication Strategy	Chair

5.	**Matters for Discussion**	
Item no	**Item**	**Action Officer**
5.1	SW AETR Service Options Update Brief	SS
5.2	Previous proposal regarding Logan Hospital site as an interim bed-base option	SS

6.	**Standard Agenda Items**	
Item no	**Item**	**Action Officer**
6.1		
6.2	**Risk Management**	
6.3	**Progress of key milestones and deliverables**	
6.4	**Other business**	

7.	**Matters for Noting**	
Item no	**Item**	**Action Officer**
7.1	**Major correspondence**	

8.	**For Information (papers only)**	
Item no	**Item**	**Action Officer**
8.1		

Next Meeting

Date:
Time:
Venue:

Children's Health Queensland Hospital and Health Service

Minutes

State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy

Date:	17/10/2013	Time:	12:30pm	Venue:	Boardroom, Level 5, Woolworths Building, RCH, Herston

Chair:	Health Service Chief Executive, CHQ HHS (PS)
Secretariat:	SW AETR Project Manager (IA)
Attendees	Deputy Director General, Health Service and Clinical Innovation Division (MC) Health Service Chief Executive, West Moreton HHS (LD) Health Service Chief Executive, Metro South HHS (RA) A/Executive Director, Office of Strategy Management, CHQ HHS (DM) Clinical Director, CYMHS CHQ HHS (SS) A/Director of Strategy, Mental Health and Specialised Services, West Moreton HHS (LG)
Apologies	Executive Director, Mental Health Alcohol & Other Drugs Directorate (BK) Health Service Chief Executive, Townsville HHS (JS)
Observers/ Guests:	Nil

Item No	Topic	Action	Committee member	Due date
1.	**Presentations**			
	Nil	Nil		
2.	**Meeting opening**			
2.1	Welcome and Apologies	Nil	Chair	
2.2	Statement of Conflict/Interest	Nil	Chair	
2.3	Confirmation of Minutes	Nil	Chair	
2.4	Statement of achievements	Below	Chair	
	Business			
3.	**Business Arising from Previous Meetings**			
3.1	Nil			
4.	**Matters for Decision**			
4.1	**Terms of Reference** • Include the Boards Act 2011 under *Guiding Principles* • The Committee had no other changes to the Terms of Reference **Recommendation:** • Endorse Terms of Reference **SW AETRS Project Plan** • Committee noted the project timeframes as outlined under Key Deliverables. • Committee noted AETR service model should be consistent with other statewide plans. • MC advised that the Minister prefers service plans on a double sided A3 page. • HIV AIDS plan was recommended as a good example.	Adjust ToR Note reference to statewide plans in Quality Management Section of Project Plan	IA IA	18/10 18/10

Queensland Government

Children's Health Queensland Hospital and Health Service

Item No	Topic	Action	Committee member	Due date
	• Committee made no other changes **Recommendation:** • Endorse SW AETR Project Plan • Add *Project Budget Status Update* as standing agenda item. • Note engagement of Mental Health Commissioner for review of service model when developed. **Communication Strategy** • PS noted WM HHS' extraordinary communication efforts with families and consumers throughout the initiative to date. • Regular communication from parent of a current BAC consumer, was noted. • LD noted that some therapeutic support is needed for families, which sits outside the scope of this project. • LD also noted that 2 to 3 families would like to present their feedback to the Service Options Implementation Working Group.	Add standard agenda item Note MH Commissioner in Communications Strategy Noted families will present to the SW AETRS Steering Committee	IA IA	25/10 25/10
5.	**Matters for Discussion**			
5.1	**SW AETR Service Options Update Brief** • PS commented that Anne Brennan and Elisabeth Hoehn's involvement with the BAC has been valuable and provided new insights on the AETR services. • It was noted that the future service model must be developed in line with the National Mental Health Framework; however, a copy of this is not currently available. LG confirmed that Marie Kelly from MHAODB has escalated a request to access a draft. • PS recommended that the service model be developed for consumer need, as a priority, with consideration of funding models at a later stage. • MC proposed the *Funding of the Future Service Model* as a standing agenda item. • LD queried the education component of the model. SS advised that it is in scope and that education will be part of the service options. • MC offered to make contact with the DG, DETE regarding progress and/or future service model. • PS asked the level of engagement with DETE be increased for joint communications. • LD noted that there is a current issue in regard to an Education staff member. WM HHS is going to ask DETE to participate in the resolution of this matter. • It was noted that engagement is also needed with other Departments. This will form part of the Communications Strategy. • PS noted that a bed-based option forms part of the proposed service model. • Discussion was had regarding the use of Acute	Draft Framework to be accessed Add standard agenda item	LG IA	01/11 25/10

Item No	Topic	Action	Committee member	Due date
	Inpatient Units or NGOs as an alternative to a bed-based option. • SS noted that Acute Inpatient Units do not provide an appropriate environment for extended treatment and rehabilitation. It was noted that there will be a small group of adolescents requiring a bed-based service over and above what Day Program Units can provide. • It was also noted that the NGO sector is not as mature in adolescent services at this stage. • SS advised that in terms of economies of scale and expertise, it makes sense to have one bed-based facility in Queensland, but not in isolation from residential solutions. Discharge planning would occur prior to consumers being admitted to the facility to keep the consumer engaged with services in their community and from their local HHS. • PS queried how transition care needs could be managed until future services options were available. • One option explored was that of an HHS setting aside 4 to 5 beds specifically for extended treatment and rehabilitation until longer term solutions were established. • PS advised that the Mater inpatient unit may become available in November, which could be a longer term option but would require further exploration. • Discussion was had about the possibility of outsourcing beds and in-reach CYMH services • PS said that further investigation into options for a bed-based is needed. • MC suggested that Bill Kingswell, Stephen Stathis and Harvey Whiteford could explore it further. • LG suggested that three current complex cases at BAC be used to test the thinking around the model. **Recommended:** • A draft model of service be available for review at the next Oversight Committee meeting. **Previous Proposal regarding Logan Hospital** • It was agreed that Logan is not a suitable solution for the interim needs of BAC consumers.	Further investigation into options for bed-based options	SS	01/11
6.	**Standard Agenda Items**			
6.1	• Communication and Stakeholder Engagement was recommended as standing agenda item.	Add standard agenda item	IA	25/10
6.4	**Risk Management** • Noted in project plan			
6.5	**Progress of key milestones and deliverables** • Noted in project plan			

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Item No	Topic	Action	Committee member	Due date
6.6	Other Business • Nil			
7.	Matters for Noting			
7.1	Major correspondence • Nil			
8.	For Information			
8.1	• Nil			
Next meeting: To Be Advised				

ENDORSED BY:

Signature: **Date:** / /13

Name:
Position: