Ingrid Adamson - CE and Dept of Health Oversight Committee Papers for meeting on 17th October

From: Ingrid Adamson
To: CE & Dept of Health Oversight Committee
Date: 14/10/2013 4:08 PM
Subject: CE and Dept of Health Oversight Committee Papers for meeting on 17th October
Attachments: 20131017 Agenda.doc; CE DoH Oversight Committee TOR v1.2.doc; SW AETR Project Plan v0.4_Draft.doc; SW AETR Update Brief.doc

Good Afternoon,

Please find, attached, the agenda and papers for the upcoming Oversight Committee meeting on Thursday 17th October.

If you are unable to make the meeting this Thursday, please feel free to forward any comments or feedback to me to take to the meeting.

Thank you and warm regards,
Ingrid

Ingrid Adamson
Project Manager - SW AETR
Office of Strategy Management

Children's Health Queensland
Hospital and Health Service
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Royal Children's Hospital
HERSTON QLD 4029
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Children's Health Queensland Hospital and Health Service

Meeting Agenda

Chief Executive and Department of Health Oversight Committee

Date:	15th November 2013
Time:	7:00am
Venue:	Board Chair's Office, North Tower, RCH, Herston
Teleconference Details:	

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	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
	Ms Julia Squire	Health Service Chief Executive, Metro South HHS
	Ms Deb Miller	A/Executive Director, Office of Strategy Management, CHQ HHS
	Dr Bill Kingswell	Executive Director, Mental Health Alcohol & Other Drugs Directorate
	Mr Stephen Stathis	Clinical Director, CYMHS CHQ HHS
	Mrs Leanne Geppert	A/Director of Strategy, Mental Health and Specialised Services, West Moreton, HHS
Apologies:		
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	CHQ Communication Strategy	Chair

5. Matters for Discussion

Item no	Item	Action Officer
5.1	Draft SW AETR Service Model	SS

6. Standard Agenda Items

Item no	Item	Action Officer
6.1	**SW AETR Project Budget Status Update** • Project expenditure on track	IA
6.2	**Funding of Future Service Model** • Refer 5.1 above	SS
6.3	**Communication and Stakeholder Engagement** • Refer CHQ Communications Strategy • Parent Presentation to SW AETRS Steering Committee, followed by meeting with CHQ CE	IA SS
6.2	**Risk Management** • No risks for escalation	IA
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 – Oversight Committee

Date: 15/11/2013 **Time:** 7:00am **Venue:** Teleconference

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) Executive Director, Mental Health, Metro South HHS (DC) Executive Director, Mental Health Alcohol & Other Drugs Directorate (BK) 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	Health Service Chief Executive, Metro South HHS (RA) 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	**CHQ Communications Strategy** • LD noted the need to have close communication with consumers. WM HHS has determined weekly communication is needed. • PS has suggested a Consumer and Parent Reference Group, which will be discussed offline in a meeting between CHQ and WM HHS. • LG noted the need to include Department of Education in communication plan	Organise meeting to discuss the establishment of a C&P Reference Group Include Dept of Education in Action Plan	IA IA	29/11 18/11
5.	**Matters for Discussion**			
5.1	**Draft SW AETR Service Model** • SS provided an overview of the proposed SW AETR service model • Target age group was raised and it was noted			

Children's Health Queensland Hospital and Health Service

Item No	Topic	Action	Committee member	Due date
	that it needs to be extended beyond 17yo. Moving forward, half of Grade 12 students will be 18yo. Furthermore, the majority of mental health consumers typically repeat a year, extending them to 19yo. Additionally, many young people are not the same development age and may require longer in an adolescent service. The model may need to extend the age group to cater for young people up to the age of 21y.o. LD concurred. • BK noted that there is push to further develop services to the youth sector (16 to 25y.o.). • PS queried whether this is a consideration for the model or if it should be noted separately. • BK noted that three service options proposed target 16y.o. and over, so this age range is accommodated. • BK asked how *headspace* fits into the model. SS said it depends on whether headspace will expand their service to address more than just early psychosis and to include group therapy. • LD enquired on the interface between the subacute bed-based and acute inpatient units. SS noted that a bed-based unit is useful where an adolescent can be released back to the community but not necessarily back home; rather stepping them down from acute inpatient to 24hr care. It is most likely they are not well enough to go home or the home environment may not be supportive for recovery. • BK noted that the model looks like a sensible plan into the future. • LD, LG & Sharon Kelly met with BK to discuss what could be implemented in the interim and that would align with the future plan. • SS noted the quickest options to implement include the Assertive Treatment Services and Day Programs. • WM HHS is looking at establishing a day program with supported accommodation. They have to have something in place by 13th Dec for day program/assertive outreach. • The Committee raised the need to look at appropriate engagement with the Department of Education, emphasising the need to clarify the role of education within a contemporary therapeutic service. • MC stated that he and BK would make an appointment to see the Regional Director to discuss this further. • SS noted that Education's involvement will be added as an element to the Model Overview document. • LG asked if NGO partnerships could be considered across all service options. SS agreed that they could work within most service options with the exception of the subacute bed-based unit. • LD asked if this model will have an impact on	Meet with Education's Regional Director Add Education to Model Overview	MC IA	29/11 17/11

Children's Health Queensland Hospital and Health Service

Item No	Topic	Action	Committee member	Due date
	the number of acute inpatient beds in the state. SS said the bed-based unit could act as a step down unit from acute units, freeing up acute unit beds sooner. • It was noted that the Step Up/Step Down (SUSD) units could be delayed. PS noted a risk of removing the SUSD units could be pressure on the length of stay in the bed-based unit. • DC noted that finding appropriately skilled people may be challenging. He noted that Logan has not referred anyone to the BAC in some time – their young people are being treated out in the community with CYMHS support. Logan has asked their CYMHS staff to look at a "family model" for ages up to 25yo. • DC also noted that setting up these services will take a lot longer than anticipated. • LG noted the WM HHS transition plan integrates well with the proposed future model. WM HHS is proposing a phased process commencing with an activity-based program at the BAC (driven by clinical staff working with an NGO). At end of school holidays, WM HHS will then look to establish an Intensive Outreach Team and Day Program, negotiating a new education model to support that. WM HHS is also looking to establish supportive accommodation (comprising 3 or 4 beds) in partnership with an NGO. LD noted that these transitional services will remain in place until the future service options are available. They are not planned to continue past 12 months. • It was agreed that it is important these services fit in with the longer term model of care to ensure smooth transition into future service options. • Metro South have run transitional housing teams and noted that it has been difficult to accommodate people. The Department of Housing have closed two beds for mental health, and Four Walls have made it increasingly difficult to accommodate people. DC recommended active engagement with the Housing, commencing now so that adequate notice is provided to plan for housing options in the future. **Recommended** • PS concluded that three documents are required and must tie together: 1. WM HHS transition plan; 2. Service Overview Model (in more detail) and Implementation Plan, inclusive of business case; 3. An overarching document to bridge the two documents.	Commence engagement with Department of Housing Develop: 1. WM HHS transition plan 2. Service Overview Model and Implementation Plan 3. An overarching document	IA LG IA LG/IA	29/11 29/11 20/12 20/12

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Item No	Topic	Action	Committee member	Due date
6.	**Standard Agenda Items**			
6.1	**SW AETR Project Budget Status Update** • Noted project expenditure on track			
6.2	**Funding of Future Service Model** • Noted as on track			
6.3	**Communication and Stakeholder Engagement** • Noted in Item 4.1 above			
6.4	**Risk Management** • Nil risks to escalate			
6.5	**Progress of key milestones and deliverables** • Noted as on track			
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:

Ingrid Adamson - CE DoH Oversight Committee Agenda and Papers for teleconference on 15th November

From: Ingrid Adamson
To: CE & Dept of Health Oversight Committee
Date: 13/11/2013 7:39 PM
Subject: CE DoH Oversight Committee Agenda and Papers for teleconference on 15th November
CC: Judi Krause
Attachments: 20131115 Agenda.doc; 20131017 Minutes.doc; SW AETR Project Comms plan_v0.3.doc; Model of Care A3 Overview v0.3.doc; CE DoH Oversight Committee TOR Final.doc; SW AETR Project Plan v1.1.doc; SW AETR Project Plan Attachment 1.doc

Good Evening,

Please find, attached, the agenda and papers for the upcoming Oversight Committee teleconference at 7am on Friday 15th November.

Attached in order:

- The Agenda
- Minutes of the previous meeting (17th October)
- SW AETRS CHQ Communications Plan
- Draft SW AETR Model of Care (A3 Overview)

Also attached, for your records, are the final versions of:

- The Committee's Terms of Reference
- The SW AETRS Project Plan
- The SW AETRS Project Plan - Attachment 1

If you are unable to make the meeting this Thursday, please feel free to forward any comments or feedback to me to take to the meeting.

Thank you and warm regards,
Ingrid

Ingrid Adamson
Project Manager - SW AETR
Office of Strategy Management

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Ingrid Adamson - Fwd: CE DoH Oversight Committee Agenda and Papers for teleconference on 15th November

From: Ingrid Adamson
To: CE & Dept of Health Oversight Committee
Date: 14/11/2013 9:13 AM
Subject: Fwd: CE DoH Oversight Committee Agenda and Papers for teleconference on 15th November
CC: Judi Krause
Attachments: Model of Care A3 Overview v0.4.doc

Good Morning,

Please find, attached, an updated version of the Draft SW AETR Model of Care (A3 Overview) for your review - some minor amendments were made this morning.

Thank you and warm regards
Ingrid

Ingrid Adamson
Project Manager - SW AETR
Office of Strategy Management

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>>> Ingrid Adamson 13/11/2013 7:39 pm >>>
Good Evening,

Please find, attached, the agenda and papers for the upcoming Oversight Committee teleconference at 7am on Friday 15th November.

Attached in order:

- The Agenda
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- The Committee's Terms of Reference
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If you are unable to make the meeting this Thursday, please feel free to forward any comments or feedback to me to take to the meeting.

Thank you and warm regards,

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Ingrid Adamson
Project Manager - SW AETR
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Children's Health Queensland Hospital and Health Service

Meeting Agenda

Chief Executive and Department of Health Oversight Committee

Date:	22nd January 2014
Time:	9:00am
Venue:	Board Chair's Office, North Tower, RCH, Herston
Teleconference Details:	

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	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
	Ms Julia Squire	Health Service Chief Executive, Metro South HHS
	Ms Deb Miller	A/Executive Director, Office of Strategy Management, CHQ HHS
	Dr Bill Kingswell	Executive Director, Mental Health Alcohol & Other Drugs Directorate
	Mrs Leanne Geppert	A/Director of Strategy, Mental Health and Specialised Services, West Moreton, HHS
	Judi Krause	
Apologies:	Mr Stephen Stathis	Clinical Director, CYMHS CHQ HHS
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	Nil	

5. Matters for Discussion

Item no	Item	Action Officer
5.1	Barrett Adolescent Centre Closure and Transition Plans	LG
5.2	SW AETR Model of Care Budget and Funding Options	Chair

6. Standard Agenda Items

Item no	Item	Action Officer
6.1	**SW AETR Project Budget Status Update** • Project expenditure on track	IA
6.2	**Funding of Future Service Model** • Refer 5.2 above	
6.3	**Communication and Stakeholder Engagement** • Presentation to BAC Parents on future Model of Care • CHQ SW AETRS web page launched	IA
6.2	**Risk Management** • No new risks for escalation	IA
6.3	**Progress of key milestones and deliverables** • Refer to SW AETR Monthly Project Status Report and Clinical Care Transition Panel Monthly Report	IA
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: To be advised

Time:

Venue:

Children's Health Queensland Hospital and Health Service

Minutes

State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy – Oversight Committee

Date: 22/01/2013 **Time:** 9:00am **Venue:** Teleconference

Chair:	Health Service Chief Executive, CHQ HHS (PS)
Secretariat:	SW AETR Project Manager (IA)
Attendees	Health Service Chief Executive, West Moreton HHS (LD) Health Service Chief Executive, Metro South HHS (RA) Health Service Chief Executive, Townsville HHS (JS) Executive Director, Mental Health Alcohol & Other Drugs Directorate (BK) A/Executive Director, Office of Strategy Management, CHQ HHS (DM) Divisional Director, CYMHS CHQ HHS (JK) Executive Director of Strategy, Mental Health and Specialised Services, West Moreton HHS (SK)
Apologies	Deputy Director General, Health Service and Clinical Innovation Division (MC) Clinical Director, CYMHS CHQ HHS (SS) A/Director of Strategy, Mental Health and Specialised Services, West Moreton HHS (LG)
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 • PS acknowledged the efforts of Metro South and Townsville HHSs in working with West Moreton to transition consumers from BAC.	Below	Chair	
	Business			
3.	**Business Arising from Previous Meetings**			
3.1	• Nil			
4.	**Matters for Decision**			
4.1	•			
5.	**Matters for Discussion**			
5.1	**Barrett Adolescent Centre (BAC) Closure and Transition** • [redacted] as inpatients at the BAC. • [redacted] •			

Children's Health Queensland Hospital and Health Service

Item No	Topic	Action	Committee member	Due date
	• [redacted] • Department of Education are still decanting from BAC and will be completely offsite by the end of this week. • HR processes have been completed for all BAC staff with many being placed in vacancies within WM HHS, and the remaining becoming Employees Requiring Placement. • Complex communication processes are still ongoing with some parents and are being managed in collaboration between WM HHS and CHQ HHS. • LD raised that funding is required for redundancies; however, these redundancies have been delayed until an existing investigation process has concluded.			
5.2	**SW AETR Model of Care Budget and Funding Options** • PS proposed the committee re-endorse the 5 elements of the model. Committee supported this proposal. • Funding for services from February 1st is clear; however, now need a strategy to advocate for the remaining services to be implemented over time. • BK raised concerns regarding the Bed-Based option – JK confirmed this has been modelled off the National Mental Health Service Planning Framework. • PS advised that the structure of the unit will enable it to be modified to suit demand. • BK and LD confirmed that there is $2m from Redlands and $3.9m from BAC in recurrent operational funding. • BK is proposing that $1m of the Redlands Operational funding be re-allocated to the Step Up/Step Down Unit being constructed in Cairns. Cairns HHS will be providing in-kind operational funding and clinical resources to the Step Up/Step Down Unit. PS advised that this was different to what the Project Team had been working toward in regard to available operational funding. • PS proposed that he and BK speak with the DG regarding securing additional funding for the Step Up/Step Down Unit.	PS to meet with Mater to discuss and seek agreement re: interim bed-based option. Organise meeting between PS, BK and DG	IA to arrange IA	28/01 31/01
6.	**Standard Agenda Items**			
6.1	**SW AETR Project Budget Status Update** • Noted project expenditure on track			
6.2	**Funding of Future Service Model** • Refer above			

Children's Health Queensland Hospital and Health Service

Item No	Topic	Action	Committee member	Due date
6.3	**Communication and Stakeholder Engagement** • CHQ web page was launched on 6th December. • Transition Services and proposed Model of Care were presented to BAC parents on 11th December, which was well received. • LD advised that current WM HHS correspondence is predominantly from two families. As transition plans are implemented the amount of correspondence should reduce. • LD recommends WM HHS formerly advise the Minister of the BAC closure when the last consumer leaves and the centre closes. • PS suggested that the IA work with CHQ communications and WM communications areas to develop a message for the Minister.	Develop message for the Minister regarding BAC closure and future services	IA	31/01
6.4	**Risk Management** • Nil risks to escalate			
6.5	**Progress of key milestones and deliverables** • Noted as on track			
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:

Children's Health Queensland Hospital and Health Service

OVERSIGHT COMMITTEE PAPER January 2014

Agenda Item: 5.2
Agenda Title: Statewide Adolescent Extended Treatment and Rehabilitation Initiative Budget
Sponsor: Peter Steer, Chief Executive, Children's Health Queensland

Background:

At the November meeting, a proposed model of care outlining five service options for extended treatment and rehabilitation, was presented and included:

1. Assertive Mobile Youth Outreach Service (AMYOS) (note name change from *Assertive Community Treatment Service* to better reflect the scope of the service) – a new service option providing mobile interventions in community or residential settings; ideally resourced with a minimum of two full time employees per AMYOS team;
2. Day Program – an expansion of existing services with additional day program units proposed in the South-East Queensland region; treating up to 15 adolescents per day per unit;
3. Step Up / Step Down Unit – a new service option providing short-term residential treatment by mental health specialists in partnership with a non-government organisation (NGO); up to 10 beds per unit located where there is NGO support;
4. Subacute Bed-based Unit – a new service providing medium-term, intensive, hospital-based treatment in a secure and safe 4-bed unit located within the CHQ catchment; and
5. Residential Rehabilitation Unit – a new service providing long-term accommodation and recovery-oriented treatment in partnership with NGOs together with in-reach services provided by mental health specialists; 5 to 10 beds per unit located where there is NGO support.

By February 2014, a 5-bed residential rehabilitation unit at Greenslopes and an interim subacute bed-based unit at the Mater will be in place. At the same time, recruitment for the Statewide Panel, AMYOS Teams, and Psychiatrists will have commenced with the first appointments being made from March. The AMYOS Teams will be located in Metro North, Metro South, Townsville, Darling Downs, Gold Coast, and Redcliffe/Caboolture. And finally, a new Day Program Unit will be established in north Brisbane by June 2014.

A Business Case, including indicative implementation, has been developed, and a summary of this is provided in the table below. The first tier of implementation (2014 A in blue) identifies services recommended for implementation utilising existing operational funding. This is based on an estimate of what CHQ understands is available. This is awaiting confirmation of Barrett operational funds to transition from West Moreton Hospital and Health Service (WM HHS) and the Redlands Operational Funding to transition from the Mental Health, Alcohol and Other Drugs Branch.

uccessful implementation of the full model of care; however, is dependent upon new operational and capital funding. A proposed rollout plan for all services, from the end of 2014 B, 2015 and 2016, is provided below (highlighted in green, pink and yellow respectively). It is important to note that services identified from 2014 B onward will be dependent on the allocation of new funding by the Department of Health, including the subacute bed-based unit.

An estimate for capital costs has also been included. The Capital Fit-Out Costs are based on the assumption of leasing premises and adjusting these premises to be fit for purpose; whereas, the Construction Costs are based on the assumption of building fit-for-purpose premises. Where premises are constructed, operational costs will reduce by rent and other items accordingly. These capital figures are indicative only and require further analysis to determine more accurate costs.

Statewide Adolescent Extended Treatment and Rehabilitation Strategy Business Case Summary:

Service Funding Options		Commence	2013/14	2014/15	2015/16	2016/17
2014 A	Transition Case Management Panel	February	$144,533	$0	$0	$0
	Statewide Assessment Panel	February	$0	$0	$0	$0
	Residential Rehabilitation Unit + Activity Program	February	$592,767	$1,475,336	$1,588,214	$1,629,536
	Interim Subacute Bed-Based Unit	February	$200,000	$100,000	$0	$0
	AMYOS Psychiatrists x 2.4 + admin	April	$251,601	$995,387	$1,020,364	$1,045,968
	AMYOS x 6 Teams	March	$267,732	$1,675,204	$1,692,369	$1,735,320
	New Day Program (North Brisbane)	June	$333,780	$1,306,162	$1,340,375	$1,375,490
	TOTAL		**$1,790,413**	**$5,552,089**	**$5,641,322**	**$5,786,314**
2014 B	AMYOS Psychiatrists x 2	From	$0	$723,468	$733,160	$751,542
	AMYOS x 12 Teams (rest of Qld)	Jul-14	$0	$3,399,849	$3,384,739	$3,470,640
	TOTAL		**$0**	**$4,123,317**	**$4,117,899**	**$4,222,182**
2015	Subacute inpatient unit (4 bed unit)	From	$0	$577,027	$1,186,466	$1,216,644
	New Day Program (Logan)	Jan-15	$0	$676,359	$1,340,375	$1,375,490
	Resi Rehab Unit x 1 (North Cluster)		$0	$857,148	$1,588,214	$1,629,536
	Step Up/Step Down Unit x 1		$0	$1,731,515	$1,744,053	$1,790,780
	TOTAL		**$0**	**$3,842,049**	**$5,859,108**	**$6,012,450**
2016	New Day Program (Gold Coast)	From	$0	$0	$1,364,352	$1,375,490
	Resi Rehab Unit x1 (Central Cluster)	Jul-15	$0	$0	$1,685,817	$1,629,536
	Step Up/Step Down Units x 2		$0	$0	$1,778,002	$3,616,527
	TOTAL		**$0**	**$0**	**$4,828,171**	**$6,621,553**
	GRAND TOTAL		**$1,790,413**	**$13,517,455**	**$20,446,500**	**$22,642,499**

Capital Fit-Out Costs ($2,000/sqm)	2013-14	2014-15	2015-16	2016-17
Bed-base Fit Out (1 unit)		$ 150,000		
Day Program (3 units)	$ 450,000	$ 463,500	$ 477,405	
Step Up/Step Down Unit (3 units)		$ 2,400,000	$ 2,472,000	$ 2,546,160
Total	**$ 450,000**	**$ 3,013,500**	**$ 2,949,405**	**$2,546,160**
Capital Construction Costs ($3,200/sqm)				
Day Program (2 units)		$988,800	$1,018,464	
Step Up/Step Down Unit (3 units)		$5,120,000	$5,273,600	$5,431,808
Total		**$6,108,800**	**$6,292,064**	**$5,431,808**

The closure of the BAC is still on track for the 31st January and CHQ HHS is continuing to support WM HHS throughout the transition process. Any consumer who requires services, previously provided by the BAC, will be supported by wrap around services through their local HHS. These wrap around arrangements are supported and coordinated by the lead psychiatrist from BAC, who will continue to maintain oversight of the consumers under the governance of CHQ, post the January closure.

The next step for this initiative is to confirm the operational funds to transfer to CHQ HHS and the availability of new recurrent funding and capital funding to enable service implementation over a four year timeframe. Delivery of services identified in 2014 B onward will require new recurrent funding.

The following people have been involved in the preparation of this paper:

Name Position	Ingrid Adamson Project Manager, SW AETRS
Name Position	Stephen Stathis Clinical Director, CYMHS
Name Position	Judi Krause Divisional Director, CYMHS
Name Position	Deb Miller A/Executive Director, Office of Strategy Management, CHQ HHS

EXHIBIT 122

Page 359 redacted for the following reason:
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Confidential

Waitlist and Assessment List
The Panel is finalising follow up with the referring CYMHS of all young people on the BAC Waitlist and Assessment List.

Update:

- The Clinical Care Transition Panel was convened for the first time on 15 October 2013 and since then has met eight times.
- At present the Panel has reviewed all of 16 patients at BAC. The transition plans for all day and out patients has been finalised including the preparation of clinical documentation (eg. CIMHA) for handover to identified service providers.
- Work is still ongoing to finalise the transition plans for the inpatients as there have been a number of barriers particularly around sourcing appropriate accommodation for these patients. The Panel has escalated these issues and continues to seek appropriate solutions for these patients.
-
- The Panel continues to work finding solutions for the more complex cases including working alongside with other hospital and health services, government departments and non-government organisations.

Issues:

- Ongoing - the Panel has identified a number of challenges associated with the transition planning for the young people at BAC. This includes access to appropriate supported accommodation and mental health trained support workers. One strategy that has been identified to assist with this would be to provide strategic communication on what is happening at BAC to upper management of key organisations and government departments including meetings at the Director-General level. Another strategy identified was to invite the key NGO stakeholders to BAC to discuss what services they could potentially provide to the target group. This meeting was held on Monday 28 October 2013.

Risks:

- Please note this risk is unchanged - the Panel has identified significant clinical risks for BAC. The Panel is currently mitigating this by seeking expert opinion from statewide senior mental health clinicians. It should be noted that there may be some delays in the transition process for some of the more complex cases.

Prepared by:
Laura Johnson, Project Officer, West Moreton Hospital and Health Service.

Endorsed by:
Dr Anne Brennan, A/Clinical Director, West Moreton Hospital and Health Service.

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Children's Health Queensland Hospital and Health Service

Project Status Report

Project Name: Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy

Reporting Period: December 2013

Project Sponsor: Dr Peter Steer	
Signature:	Date:

Project Manager: Ingrid Adamson	
Signature:	Date:

Project at a Glance

Key Areas of Focus	Impact on Objectives	Key Comments
Project Milestones (Incl. Current / Future)		**Services Options Working Group (WG 1)** • Draft SW AETR Model of Care: o Endorsed, in principle, by the Steering and Oversight Committees and the CHQ Board. o Circulated to Working Group for input and feedback, which has now been incorporated. o Communicated to CYMHS Clinicians on 10th December and BAC Family members on 11th December. • Invited guest Sandra Radovini, Child and Adolescent Psychiatrist, presented to clinicians, BAC staff and families on adolescent mental health care services in Victoria over 10th/11th December. • Development commenced on a Business Case, including a high level implementation plan, for the proposed SW AETR Model of Care. • Concurrently, WM HHS has progressed plans for transitional services, including an activity-based program for the school holidays followed by establishment of supported accommodation for early 2014. Governance arrangements have been established and weekly meetings underway. **BAC Clinical Care Transition Panel** • Status Report attached
Budget and Cost Management		On target

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Key Areas of Focus	Impact on Objectives	Key Comments
Stakeholder Engagement and Participation	T	• BAC Fast Fact Sheet #11 issued. • CHQ SW AETRS web page went live.
Project Interdependencies	T	• Nil identified
Project Risks and Issues (incl. Escalation / Mitigation)	T	• Nil risks requiring management attention.
Other	N/A	

Legend:

C **Critical** – Issue is impacting on project objectives

S **Serious** – Issue COULD impact on project objectives

T **On track** – Issue able to be managed to maintain project objectives

Children's Health Queensland Hospital and Health Service

Terms of Reference

Statewide Adolescent Extended Treatment and Rehabilitation (SW AETR) Service Options Implementation Working Group

1. Purpose

The purpose of the SW AETR Service Options Implementation Working Group is to develop and implement contemporary service options, within a statewide model of service for adolescent mental health extended treatment and rehabilitation.

2. Guiding principles

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

3. Functions

The functions and objectives of the SW AETR Service Options Implementation Working Group include:

- Develop new and/or adapt service options across the continuum of care to meet the needs of adolescents requiring extended treatment and rehabilitation and produce a Service Options Paper.
- In liaison with the SW AETR Financial and Workforce Planning Working Group, identify financial and human resources for new service options.
- Develop a Statewide Model of Service for adolescent mental health extended treatment and rehabilitation.
- Develop an Options Paper for the Governance Model for SW AETR services under CHQ HHS.
- Develop an Implementation Plan for the statewide model of service, including staffing, contract management, where appropriate, and other resources.
- Facilitate expert discussion from clinician and consumer stakeholders around planning, developing, and implementing activities associated with SW AETR service options.
- Prepare and provide fortnightly Status Reports to the SW AETR Steering Committee, or as required.
- Manage risks associated with the development and implementation of SW AETR service options, and escalate where resolution is required to successfully implement SW AETR service options.
- Provide the Secretariat with information regarding risks, as they arise, for recording and management in the Project Risk Register.

4. Authority

Members are individually accountable for their delegated responsibility, and collectively responsible to contribute to recommendations to the SW AETR Steering Committee.

Decision making capability rests with the Chief Executive and Department of Health Oversight Committee.

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 Working Group. The Working Group will:

- Identify risks and mitigation strategies associated with the development and implementation of SW AETR service options; and
- Implement processes to enable the Working Group to identify, monitor, manage, and escalate critical risks as they relate to the functions of the Working Group.

Children's Health Queensland Hospital and Health Service

Meeting Agenda

Statewide Adolescent Extended Treatment and Rehabilitation Service Options Implementation Working Group Forum

Date:	Tuesday 1st October
Time:	10.30am to 3.00pm
Venue:	Training Room 1, Ground Floor, 15 Butterfield Street, Herston

Chair:	Leanne Geppert	Director Strategy, Mental Health and Specialised Services, West Moreton, HHS
Secretariat:	Ingrid Adamson	Project Manager SW AETRS, Office of Strategy Management, CHQ HHS
Attendees:	Amelia Callaghan	State Manager, Headspace
	Bernice Holland	Administration Officer, MHSS WM HHS
	Deb Miller	A/Executive Director, Office of Strategy Management, CHQ HHS
	Emma Hart	Team Leader, Adolescent Inpatient Unit And Day Service, Townsville HHS
	Erica Lee	CYMHS, Service Manager, Mater Hospital
	Gerry Howe	Team Leader, CYMHS, Fraser Coast Integrated Mental Health, Wide Bay HHS
	Ian Williams	Director of Adolescent Psychiatry, Adolescent Psychiatry Mental Health, RB&WH
	Jackie Bartlett-(proxy for Janet Martin)	Principal Project Officer, Clinical Governance, Office of the Chief Psychiatrist, MHOADB
	Janelle Bowra	Nursing Unit Manager, Metro South HHS
	Kerry Geraghty	Consumer Carer Representative
	Laura Johnson	SW AETRS Project Officer, MHSS West Moreton HHS
	Alison Jansen	Member and Community Relationships and Training Coordinator, Mental Illness Fellowship Queensland
	Michelle Fryer	A/Director, CYMHS, Gold Coast HHS
	Naysun Saeedi	Clinical Director CYMHS, Cairns HHS
	Raymond Ho	Clinical Services Program Manager, Metro South Addiction and Mental Health Service, Metro South HHS
	Vanessa Clayworth	A/Nurse Unit Manager, Barrett Adolescent Centre
Apologies:	Janet Martin	Manager, Clinical Governance Office of the Chief Psychiatrist, MHAODB
	Kimberly Curr	A/Manager, CYMHS Toowoomba HHA
	[redacted]	Consumer Representative
	Sean Hatherill	Child Psychiatrist, CYMHS Metro South HHS
	Shannon March	Consultant, CYMHS Toowoomba HHS
	Stephen Stathis	Clinical Director, CYMHS CHQ HHS

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The purpose of this Workshop is to explore the current and future service options for adolescent mental health extended treatment and rehabilitation in Queensland.

The aim of this platform of services is to provide medium term, recovery-oriented treatment and rehabilitation for young people aged 13 – 17 years with severe and persistent mental health problems, which significantly interfere with social, emotional, behavioural and psychological functioning and development

The target group:

- 13 - 17 years, with flexibility in upper age limit depending on presenting issue and developmental (as opposed to chronological) age.
- Severe and persistent mental health problems that significantly interfere with social, emotional, behavioural and psychological functioning and development.
- Treatment refractory/non responsive to treatment - have not been able to remediate with multidisciplinary community, day program or acute inpatient treatment.
- Mental illness is persistent and the consumer is a risk to themselves and/or others.
- Medium to high level of acuity requiring extended treatment and rehabilitation.

Workshop Agenda

Time	Item	Action Officer
10.30am	Morning Tea and Welcome	LG
10.45am	Introductions and Apologies Statement of Conflict/Interest	LG
10:55am	Session 1 – Current Service Options, including: • Geography • Exclusion criteria • Referral Source • Pathways in and out • Length of Stay • Treatment Modalities • Skills required • Environment of delivery Exploring the current strengths and weaknesses of the service options, and any gaps in the referral interface between service options.	LG IA LJ
12:15pm	Lunch	All
12:45pm	Session 2 – Future Service Options, including: • What could be included to provide a more comprehensive model of service to adolescents? • What evidence-based, best practices should we consider or research? • What are our counterparts in other states and countries doing? • What are appropriate service standards and benchmarks?	LG IA LJ

Children's Health Queensland Hospital and Health Service

Workshop Agenda

Time	Item	Action Officer
2:15pm	Afternoon Tea, where we will be joined by: • Dr Peter Steer, Health Service Chief Executive, CHQ HHS • Lesley Dwyer, Health Service Chief Executive, West Moreton HHS • Sharon Kelly, Executive Director, Mental Health and Specialised Services, West Moreton HHS • Bill Kingswell, Executive Director, Mental Health Alcohol and Other Drugs Branch	All
2:30pm	Workshop Debrief • Review of service options – current and future • Where to from here? • Next meeting	All IA IA
3.00pm	Workshop Conclusion	

P

Ingrid Adamson - Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy - BAC Consumer Transition Panel

From: Ingrid Adamson
To: SW AETR Working Group 2 BAC Transition
Date: 27/09/2013 11:05 AM
Subject: Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy - BAC Consumer Transition Panel
CC: Deborah Miller
Attachments: SW AETR Working Group_Consumer Transition_TOR FINAL.doc

Good Morning,

I am writing with regard to the Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy, which is to identify a new range of contemporary service options for the delivery of statewide adolescent mental health extended treatment and rehabilitation services. In addition to the Steering Committee, three Working Groups have also been established to deliver on various aspects of this initiative, and you have been nominated as your Mental Health Cluster Representative for Working Group 2 - Barrett Adolescent Centre (BAC) Consumer Transition. This Working Group was chartered to oversee the discharge process for existing consumers, and the waitlist group, in preparation for transfer to alternative services, where required.

Through further Steering Committee discussions, it has been decided to take a slightly different approach and the Working Group is now being formed as a consumer needs panel. The work of this panel will be driven by the individual needs of consumers currently at BAC or on the waitlist. Consequently, HHS involvement will be invited as each individual consumer is considered by the Panel rather than as a regular meeting of all representatives. The Chair of this Panel is Dr Anne Brennan, Acting Clinical Director of the Barrett Adolescent Centre. Anne, or a member of the Panel, will contact you as relevant individual cases are reviewed.

For your information, I have attached a copy of the Terms of Reference for the BAC Consumer Transition Panel.

In the meantime, if you have any questions or would like any other information, please feel free to contact me.

Warm regards,
Ingrid

Ingrid Adamson
Project Manager - SW AETRS
Office of Strategy Management

Children's Health Queensland Hospital and Health Service
E:
Royal Children's Hospital
HERSTON QLD 4029
www.health.qld.gov.au/childrenshealth

West Moreton Hospital and Health Service
Barrett Adolescent Centre Clinical Oversight Meeting

File / Meeting Note

Date/Location:	4pm, 12 December 2013. Meeting with teleconference option.
Attendees:	**CHQ*:** Assoc Prof Stephen Stathis (Clinical Director), Judi Krause (Executive Director, CYMHS), Dr Elisabeth Hoehn (Clinical Director) **West Moreton**: Sharon Kelly (ED, MHSS), Dr Anne Brennan (A/Clinical Director BAC), Dr Terry Stedman (Clinical Director, MHSS), Michelle Giles (Director Community MH and Allied Health), Dr Leanne Geppert (A/Director of Strategy) **MHAODB**: Dr Bill Kingswell (ED MHAODB) * Dr Peter Steer (CE, CHQ) joined first 15 mins of meeting
Discussion:	Confidential 5. BAC operational funding to transfer to CHQ upon closure of BAC. All decisions re use of BAC operational funding will be jointly considered from this point forward between WM and CHQ. 6. Identification of potential risk to providing ongoing safe care by familiar staff at BAC over next 6 weeks: a. Investigation completed and next HR steps commenced, resulting in increased staff stress and likely increase in leave/resignations b. Some staff indicating alternative job offers and indicating resignations. 7. BAC school finished today.
Action Taken / Decisions:	Confidential

	10. BAC Holiday Program to continue, even if no inpatients able to attend. 11. BAC remains open until 26/1/13. If all inpatients are discharged from BAC in alignment with their individual transition plans before 26/1/13, the Centre will continue to function as a day centre to support the delivery of the Holiday Program until the closure date.
Outcome:	Confidential **Leanne Geppert** 13. File note of this meeting. Confidential

West Moreton Hospital and Health Service
Barrett Adolescent Centre Consumer Meeting

Date / Location:	8:45am 18 December 2013. Meeting with teleconference option
Attendees:	**CHQ*:** Dr Peter Steer (CE), Assoc Prof Stephen Stathis (Clinical Director), Ingrid Adamson (Project Manager SWAETR) **West Moreton:** Linda Hardy (A/CE), Dr Leanne Geppert (A/ED, MHSS), Dr Anne Brennan (A/Clinical Director BAC)

Discussion:

1. [redacted]
2. [redacted]
3. [redacted]
4. [redacted]
5. [redacted]
6. [redacted]
7. Minister's Office (senior advisor) needs to be updated and briefed on discussions.
8. Urgent correspondence received from (Ms A Earls) through MD09 that needs to be addressed regarding young people being transitioned earlier then expected from BAC. Unanimous recommendation not to meet with Ms Earls – address via standard written correspondence pathway.
9. Key issues – a closure date was set as 2/2/14, however, clinical needs of inpatients will be the primary drivers associated with transition plans of individuals and it may be that there are no inpatients at a time prior to 2/2/14. The holiday program will be delivered as planned. There is no gap to service provision – the individual consumers are having their care needs met.

Action List:

10. [redacted]
11. Confidential
12. [redacted]
13. Linda Hardy and Leanne Geppert to provide briefing to Lesley Dwyer.
14. Linda Hardy and Leanne Geppert to seek options for joint CHQ and WM briefing of the Minister's Adviser as a matter of urgency and communicate options. Briefing to be provided on the rationale behind decisions regarding consumers at BAC.
15. West Moreton and CHQ to formulate a response to urgent correspondence (Ms A Earls). Leanne Geppert to forward correspondence to Peter Steer.

R

Children's Health Queensland Hospital and Health Service

Terms of Reference

Statewide Adolescent Extended Treatment and Rehabilitation (SW AETR) Financial and Workforce Planning Transition Working Group

1. Purpose

The purpose of the SW AETR Financial and Workforce Planning Working Group is to ensure effective workforce planning and the distribution of adolescent mental health service operational funds and resources to the Children's Health Queensland (CHQ) HHS with regard to future SW AETR service options.

2. Guiding principles

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

3. Functions

The functions and objectives of the SW AETR Financial and Workforce Planning Working Group include:

- Facilitate expert discussion from stakeholders to develop a workforce plan future SW AETR service options to be governed by CHQ HHS.
- In collaboration with the SW AETR Service Options Implementation Working Group, identify and define the funding sources for the new model of adolescent mental health services, in a Future State Financial Report.
- Develop a Plan for the allocation of funding and resources to the CHQ HHS.
- Prepare and provide fortnightly Status Reports to the SW AETR Steering Committee, or as required.
- Manage risks associated with AETR services to CHQ HHS, and escalate where resolution is required to successfully transition consumers.
- Provide the Secretariat with information regarding risks, as they arise, for recording and management in the Project Risk Register.

4. Authority

Members are individually accountable for their delegated responsibility, and collectively responsible to contribute to recommendations to the SW AETR Steering Committee.

Decision making capability rests with the Chief Executive and Department of Health Oversight Committee.

5. Frequency of meetings

Meetings will be held on a fortnightly basis, or as required. The Chair may call additional meetings as necessary to address any matters referred to the Working Group, or in respect of matters the Working Group wishes to pursue within the Terms of Reference.

Attendance can be in-person or via teleconference mediums.

The Working Group is life-limited for the duration of development and implementation of SW AETR service options to CHQ HHS. The Chair will advise Working Group members approximately one month prior to the dissolution of the Working Group.

6. Membership

Executive Director Finance and Business Services, West Moreton HHS
Executive Director Human Resources , West Moreton HHS
Executive Director, MH&SS, West Moreton HHS
Finance Director, West Moreton, HHS
Executive Director, Workforce, West Moreton HHS
A/Director, Workplace Relations, West Moreton HHS
Assistant Business Manager, Finance and Administration, MH &SS, West Moreton HHS
Allied Health and Nursing Representative, West Moreton HHS
2 x Mental Health Alcohol and Other Drugs Branch Representatives
Senior Director Finance, Children's Health Qld HHS
Director Clinical Costing, Children's Health Qld HHS
Executive Director, People and Culture, Children's Health Qld HHS
Allied Health and Nursing Representative, Children's Health Qld HHS
Project Manager, SW AETRS, Children's Health Qld HHS
Project Officer, SW AETRS, West Moreton HHS (as Secretariat)

Chair:
The Working Group will be chaired by Finance Director, West Moreton HHS, or their 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 Officer, SW AETRS WM HHS, or an alternate officer nominated by the Chair.

Proxies:
Proxies are not accepted for this Working Group, 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 Working Group. However, such persons do not assume membership or participate in any decision-making processes of the committee.

7. Quorum

As this is not a decision making group, a quorum is not applicable.

8. Performance and Reporting

The Secretariat is to circulate an Action Register to Working Group members within three business days of each Working Group meeting. Chair will determine the resolution of outstanding action items as they arise.

The Secretariat will coordinate the endorsement of fortnightly status reports, and other related advice to be provided as required, to the SW AETR Steering Committee.

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

Children's Health Queensland Hospital and Health Service

Terms of Reference

Young People's Extended Treatment and Rehabilitation Initiative (YPETRI) Governance Committee

1. Purpose and Functions

The purpose of the Young People's Extended Treatment and Rehabilitation Initiative (YPETRI) Governance Committee (Governance Committee) is to:

- Develop a pilot service model of residential rehabilitation for young people (16 – 18 years) with mental health problems that may benefit from extended mental health treatment care in a community setting.
- Contribute as relevant to the preparation of a contractual service agreement between service partners of YPETRI House.
- Provide strategic and operational governance for the ongoing delivery of services through YPETRI House, during the pilot period from February to December 2014, to ensure that milestones and key deliverables of the initiative are met in the required timeframes, and that all accountabilities are fulfilled.
- Establish a multidisciplinary Referral Panel that will receive and triage statewide referrals into YPETRI House.
- Provide governance to the risk management process and associated mitigation strategies of the pilot initiative, and escalate in a timely manner to the Adolescent Mental Health Extended Treatment Initiative (AMHETI) Steering Committee and/or Chief Executives of Children's Health Queensland and Aftercare.
- Prepare and provide update reports to the to the AMHETI Steering Committee and the Chief Executives of Children's Health Queensland and Aftercare, as required.
- Provide an escalation point for the resolution of issues and barriers associated with the delivery of quality services by YPETRI House.
- Prepare an evaluation of the pilot program following its conclusion in December 2014.

2. Guiding principles

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

3. Authority

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

The Committee will endorse all key deliverables for approval by the Chief Executives of Children's Health Queensland and Aftercare.

Decision Making:

- Recommendations of the Governance Committee will be by majority and will be made in writing to the AMHETI Steering Committee.
- If there is no group consensus in relation to critical matters, the co-Chairs will jointly escalate the issue/s to the AMHETI Steering Committee and/or Chief Executives of Children's Health Queensland and Aftercare (whichever is appropriate to the issue at hand).
- Decisions (and required actions) will be recorded in the minutes of each meeting.

4. Frequency of meetings

Meetings will be held fortnightly on Thursday from 3.30pm for one hour duration unless otherwise advised.

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

Attendance can be in-person or via teleconference.

The Governance Committee is life limited for the duration of the pilot of YPETRI House until December 2014. The Chair will advise the Committee members approximately one month prior to the dissolution of the Governance Committee.

5. Membership

Medical Director	CYMHS, CHQ HHS	Co Chair
National Operations Manager	Aftercare	Co Chair
Project Manager	AMHETI, CHQ HHS	Member
Service Manager	Aftercare	Member
A/Director of Strategy	MHSS, West Moreton HHS	Member
A/Director	Planning and Partnership Unit, MHAOD Branch	Member

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

Chair:
The Committee will be co-chaired by the Medical Director of CYMHS CHQ and the National Operations Manager of Aftercare (or their delegate). The delegate must be suitably briefed prior to the meeting and have the authority to make decisions on behalf of the Chair.

Each Chair will hold their seat for two quarters of the 12 month period – January, February, March (Aftercare) / April, May, June (CHQ HHS) / July, August, September (Aftercare) / October, November, December (CHQ HHS).

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

- Venue
- Agenda
- Minutes of previous meetings
- Briefs for any agenda items that require endorsement by the Chair three (3) working days prior to the meeting.

Proxies:
Proxies are not accepted for this Governance 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.

6. Quorum

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

7. Reporting

The Governance Committee provides the following:

- Reports (verbal and/or written) to the AMHETI Steering Committee and/or the Chief Executives of Children's Health Queensland and Aftercare, as required.

8. Performance and Reporting

Performance will be determined by the purpose and functions of this TOR being met within the required timeframes.

The Secretariat will coordinate the endorsement of status reports and other related advice to be provided to the AMHETI Steering Committee and to the Chief Executives of Children's Health Queensland and Aftercare, as required.

Members are expected to respond to out-of-session invitations to comment on reports and other advice within the timeframes outlined by the Secretariat. If no comment is received from a member, it will be assumed that the member has no concerns with the report/advice and it will be taken as endorsed.

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

Document history

Version	Date	Author	Nature of amendment
1.0	02/12/13	Senior Project Officer, MHSS, West Moreton HHS	Initial Draft
1.1	14/01/14	Senior Project Officer, MHSS, West Moreton HHS	Incorporated initial feedback
1.2	31/01/14	Senior Project Officer, MHSS, West Moreton HHS	Incorporated feedback
1.3	09/03/14	A/Director of Strategy, MHSS, West Moreton HHS	Transferred to CHQ template. Reflected changes in Committee roles and responsibilities, and establishment of Referral Panel.
Final	11/03/14	Secretariat, YPETRI Governance Committee	Finalisation of feedback.

Previous versions should be recorded and available for audit.

1

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

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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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EXHIBIT 122

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Confidential

EXHIBIT 122

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Thoughts from Meeting with Barrett Families and DG; 26.11.2014 1800-2000

Families there:

- [redacted]

1. Believe that through their learnt experience, all should be consulted and have expertise in providing advice on the establishment of services for adolescent and young people with severe, complex and longstanding mental health problems. On the other hand, most families/parents have developed a sense of learnt helplessness. (Parents have externalised their sense of being able to contain these children; *"what is Qld Health going to do about it". "We (parents) are all traumatised" – why has no-one supported us: "Teachers are all traumatised – "Why has Qld Health not supported them"*; etc.) . These polarising positions make it challenging to work with the families. Plus also may not understand the nature of consultation; the gov't may consult with you; does not necessarily mean they will implement your recommendations.
2. Gov't had not just closed down a mental health service, it has destroyed a community.
    a. Parents of children who have died are understandably united by grief and loss.
    b. Most parents there had children who were anxious/ASD
    c. They all stated that one of the most valuable therapeutic processes of the BAC was the sense of community that developed there
    d. This includes the connection with the teachers; One of the ex-BAC [redacted] is still being contacted by teachers, although [redacted]
    e. The parents/children/families that did not did not wish to engage with the BAC have probably dispersed.
    f. Historically, as this these sense of connectedness is built on dysfunction and ultimately is pathological, most families would have also dispersed. BAC parents at the meeting have no insight into this. On the contrary, as "that which unites is stronger than that which tears apart", the closing of the BAC has become a focal point that continues to strengthen and unite a small number of ex-BAC families. It is therefore not about the closing of a centre, but it is about the destruction of a community (albeit a dysfunctional one).
3. Given above, while the BAC families understand a Tier 3/Subacute beds do exists, they do not believe these supports are adequate, as they do not see two (or now four) beds as sufficient numbers to form a *community*. I gently questioned whether forming such a

'community' within BAC was therapeutic, or whether that would prevent re-integration back into the community. One of the parents stated this was a good example of why I "don't understand"; they see the development of such a community as critical to their child's well-being. This is what was lost with the closure of the Barrett. And at the core, this is what continues to unite these families.

a. In my view, this is one of the primary conscious or subconscious drivers for the ongoing rage, petitions, ministerials, and push to re-build a "Barrett".

b. That is why the name "Barrett" has such psychological strength

c. That is why it is so difficult to manage; these parents honestly believe given Qld Health destroyed a community, it is Qld's Health's job to rebuild a community.

4. Parents have idealised BAC processes before transition, demonised the whole transition process, and are nihilistic about future plans without Tier 3 beds which promote a sense of community.
5. Parents will therefore continue to push for some Tier 3 process
6. Parents were even critical of the ECRG – did not believe this process was consultative enough.
7. Parents want all YP re-assessed.
8. Was helpful to spend time with DG before meeting.

Plan:

- If required, strategically we have to connect with the individuals. Talking with these parents as a group only strengthens their view that they are a community, and increases their resolve to work together.
- Review current MOC for Subacute beds; we are going to do this. Subacute beds to be embedded within the continuum, not just form part of it.
- Would be willing to look at reassessing BAC YP (with parents' consent). Interesting to see what would be found. Who would do this? Funding? Independent to Qld Health? Private practitioner recommendations? Wait to see Coroner's recommendations – Coroner may recommend anyway?
- Ongoing, liaison with Ed Qld about current BAC students.
- Further liaison with DG (Ian is going to ask my advice on his letter, before he sends it out).

EXHIBIT 122

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From: Stephen Stathis
Sent: Thursday, 4 December 2014 5:24 PM
To: Ingrid Adamson
Subject: FW: BAC meeting follow up
Attachments: 20141204085657637.pdf

From: Scott Davies
Sent: Thursday, 4 December 2014 8:59 AM
To: Stephen Stathis; Cathie Schnitzerling
Cc: Bill Kingswell
Subject: BAC meeting follow up

G'day Stephen and Cathie,

I have got hold of Ian's notes from last weeks meeting – as you will see on page 2, he is seeking a letter back to families that covers four points:

1. Multidisciplinary support OT etc. how can this support be provided. Review of each patients care requirement and immediate action.
2. Support for parents – access to
3. Concession for 18 yo to be admitted to an adolescent ward – can this be given?
4. Consultation (not on a T3) / community engagement – wanting a collaborative process

Grateful if you can please draft a response for Ian's signature by 1200 tomorrow.

Thanks,
SD

Scott Davies
Senior Director
Office of the Director-General | Department of Health
Level 19, 147 Charlotte Street, Brisbane QLD 4000

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Meeting with

Mr Ian Maynard, Director-General, Queensland Health
and
Representative parents and caregivers of inpatients at the former Barrett Adolescent for Mental Health, Wacol

Wednesday, 26 November 2014
6.00pm – 7.30pm
Queensland Health Building, 147 Charlotte Street, Brisbane

Agenda

1. Feedback on Transition Report 10'
2. ✓ Impact of Barrett closure on adolescents, parents and concerned stakeholders (caregivers, staff etc) (Barrett parents) 30'
3. Request for a Commission ~~of Enquiry into the c~~losure of the Barrett Centre. 5' → not discussed.
4. ✓ Current issues with former patients (some who are at serious risk) and request for services and actions to safe-guard them. 15'
5. ✓ Request for practical support for parents/caregivers of former patients.

Where to now? Negotiating a constructive way forward → different models proposed.

6. ✓ Discussion about a consultation process with parents and key stakeholders to follow up on the ECRG report.
    a. The transition process and its legacy
    b. Parameters of a consultative model of engagement
    c. Levels of governance during the engagement process 20'

Barrett representatives will meet at 5pm at **Metro Arts** at 109 Edward St (just down from Charlotte St) – see attached google map.

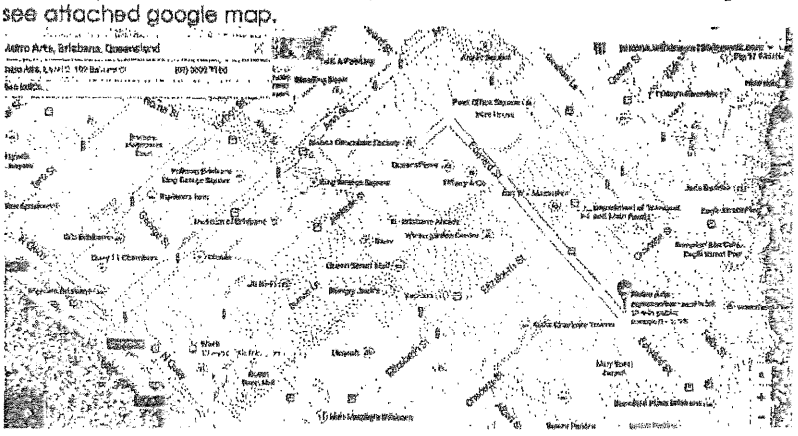

EXHIBIT 122

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From: Stephen Stathis
Sent: Thursday, 4 December 2014 5:26 PM
To: Ingrid Adamson; Judi Krause
Subject: FW: BAC meeting follow up

Importance: High

FYI

They want it tomorrow. Oh the joy.

SS

From: Stephen Stathis
Sent: Thursday, 4 December 2014 4:31 PM
To: Scott Davies; Cathie Schnitzerling
Cc: Bill Kingswell
Subject: RE: BAC meeting follow up
Importance: High

Thanks Scott

With all the commitments around LCCH, I unfortunately won't be able to get this letter to you by 1200 tomorrow. I'd rather Bill review the letter before it is signed off by the DG, as he is technically the only one who can 'direct' adolescent units to take over 18s and I don't want Bill or the DG to be put into an awkward position (the letter will certainly be table on the Save the Barrett web site).

Some other thoughts for the DG's consideration. Re:

1. To the best of my knowledge all these ex-Barrett patients are receiving some type of mental health support. Many declined CYMHS services, which is the publically funded multidisciplinary approach. I'd be hesitant to write in a letter that public funds be spent supporting these YP outside the current CYMHS system. Furthermore, we have no jurisdiction over patients within the private system. I understand that many of the parents expressed concerns that the YP required more than the 10-12 subsidised sessions available under ATAPS/Better Access. However, this is a systemic issue and funded federally. Other than parents paying for private care, there are few other options other than CYMHS, which many of these parents do not wish to engage with.
2. Support for parents. Unsure what is preventing the parents presenting to their GP requesting mental health support via the recognised pathways (ATAPS, Better Access programs etc.) Not sure if they are wanting funded group programs. I would not recommend this.
3. Concession re 18 year olds. See comments above.
4. Consultative process. This was mainly around moving adolescents with severe, longstanding and complex mental health problems from the adolescent into the adult/youth system. Interestingly, the Statewide Mental Health Alcohol and Other Drugs Clinical Network is meeting tomorrow from 0930-1130. I sit on the network as the rep for C&A mental health. The recent Barrett Report is to be tabled tomorrow at the Network for discussion. The Report noted that "the BAC process demonstrates positive learnings in relation to good quality transitional planning". The Report then recommended that "these learnings be considered for distillation into the development of a state policy (or review of the current transfer of care policy) that supports mental health transition for vulnerable young people". Interestingly, earlier this year the Network considered supporting a project to examine the transitional care of young people from the adolescent to adult system. The recommendations of the Barrett Report is timely. Should this project be endorsed by the Network, it could then be included in the DG's letter i.e. the need for consultation about improving the continuum of mental health care from the adolescent to adult system. Hence also why I would be reluctant to draft a letter before the 1200 deadline, given the Network meeting tomorrow. The Barrett families could then be consulted in this project.

Bill, I'd be interested in your thoughts.

I'll try to get a draft to the DG by COB Friday.

Cheers

Stephen

From: Scott Davies
Sent: Thursday, 4 December 2014 8:59 AM
To: Stephen Stathis; Cathie Schnitzerling
Cc: Bill Kingswell
Subject: BAC meeting follow up

G'day Stephen and Cathie,

I have got hold of Ian's notes from last weeks meeting – as you will see on page 2, he is seeking a letter back to families that covers four points:

1. Multidisciplinary support OT etc. how can this support be provided. Review of each patients care requirement and immediate action.
2. Support for parents – access to
3. Concession for 18 yo to be admitted to an adolescent ward – can this be given?
4. Consultation (not on a T3) / community engagement – wanting a collaborative process

Grateful if you can please draft a response for Ian's signature by 1200 tomorrow.

Thanks,
SD

Scott Davies
Senior Director
Office of the Director-General | Department of Health
Level 19, 147 Charlotte Street, Brisbane QLD 4000

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

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

Great State. Great Opportunity.

Background

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

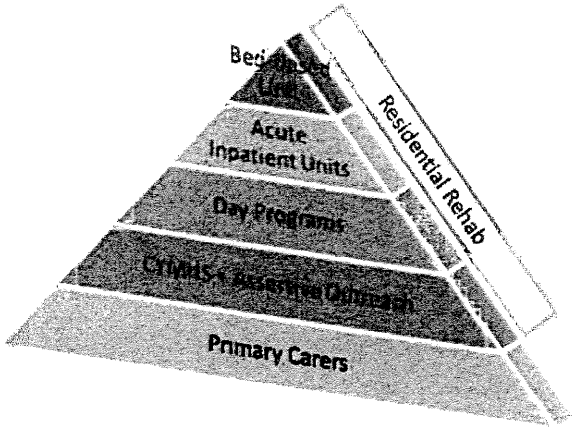
Our Consultation Process

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

ECRG Recommendations

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

Proposed Model of Care Options*



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

Proposed Assertive Community Treatment Service (Tier 2a)

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

For adolescents who may have...

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

Proposed Day Program (Tier 2a)

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

For adolescents who ...

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

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

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

For adolescents who ...

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

Proposed Residential Rehabilitation Unit (Tier 2b)

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

For adolescents who ...

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

Proposed Subacute Bed-Based Unit (Tier 3)

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

For adolescents who ...

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

Timeframes

Model of Care

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

Implementation

Needs to consider:

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

Some service options will be available earlier than others

For more information...

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

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

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

From:
Sent: Thursday, 20 February 2014 1:04 PM
To: Leanne Geppert; Stephen Stathis
Cc: Ingrid Adamson
Subject: RE: BAC waitlist

I will keep you all updated.
Ann
A/Clinical Director
Barrett Adolescent Centre
The Park-Centre for Mental Health
e
>>> Stephen Stathis 2/20/2014 12:50 pm >>>

I too had thought that would be the best option. However, it has just occurred to me you would not be credentialed to see patients in that HHS. MAJOR problem with not easy resolution.

I would suggest you organise an assessment at CYMHS. I realise that might be an imposition on the patient/family, given the distances involved, but I can't see a way around it. No point getting credentialed to see one person. The other option would be to arrange a videoconference. That could be done via the local CYMHS, if CYMHS team leader accepting. You would get around the credentialing issue then.

Stephen

From: Anne Brennan
Sent: Thursday, 20 February 2014 12:37 PM
To: Stephen Stathis; Leanne Geppert
Cc: Ingrid Adamson
Subject: RE: BAC waitlist

Late Thursday good at this stage. CYMHS clinicians access my diary and populate any spare time with consultations. Just claim a slot!!
If I offer assessments, where shall I do them? I assume the local CYMHS?
Anne

A/Clinical Director
Barrett Adolescent Centre
The Park-Centre for Mental Health

>>> Stephen Stathis 2/20/2014 12:32 pm >>>

No trouble, Anne.

Leanne and I had a very productive meeting working through young people: See attached.

I've cc'd Ingrid into this email, as she is the 'keeper of all documents'!!

Cheers

Stephen

From: Anne Brennan
Sent: Thursday, 20 February 2014 9:46 AM
To: Stephen Stathis; Leanne Geppert
Subject: Re: BAC waitlist

Hi
I am very sorry that I did not respond. I am not working Wednesdays and have no remote email access.
Available today if you are.
Anne

A/Clinical Director
Barrett Adolescent Centre
The Park-Centre for Mental Health

>>> Leanne Geppert 2/18/2014 7:55 pm >>>
ok, will wait to see if Anne ok with time, and i have asked jill to arrange tconf. will send thru details to you tomorrow am, L

Dr Leanne Geppert
Sent from my iPad

> On 18 Feb 2014, at 7:45 pm, "Stephen Stathis " wrote:
>
> That works fine 4 me. R u free then, Anne. Do we need to set up a teleconference or will the two of you ring in together?
>
> Sent from my iPhone
>
> On 18/02/2014, at 7:14 PM, "Leanne Geppert" wrote:
>
> Hi all
> I am doing interviews tomorrow until 3.30. Would 4pm be ok just to be safe? I think we may be in 3 different locations for the phone in - I can ask Jill (Berni is away tomorrow) to org tconf facility, and send through details to you if that suits.
> L
>
> Dr Leanne Geppert
> Sent from my iPad
>
> On 18 Feb 2014, at 5:30 pm, "Stephen Stathis wrote:
>
> Sounds like a very logical plan, Leanne. I fear this is driving me to become a risk-management beaurocrat rather than a clinician.
> Are you both free sometime tomorrow afternoon after 3PM? 15-20 minutes should do it.
> Stephen
>
> _____
> From: Leanne Geppert
> Sent: Tuesday, 18 February 2014 5:13 PM
> To: Stephen Stathis; Anne Brennan
> Subject: RE: BAC waitlist
>
> Hi to you both
> Might be worth reconvening over phone about this?
> As you say Anne, Kathy has contacted CYMHS and there are cases of long disengagement from the CYMHS. I am concerned about sending a letter directly to parents from BAC waitlist out of the blue, saying we are closed and to recontact local CYMHS if support needed - if the parents have an expectation that the referral is still active, it may not be the right way to share the information.
> I think it would be better if the referring CYMHS contacted the family - realistically, they should have withdrawn the BAC referral at the time they discharged the young person, and if the contact raises ongoing mental health issues, they would be the service to respond.
>
> Happy to touch base quickly for 10 mins sometime to discuss if you have time, L
>
> Dr Leanne Geppert
> Acting Director of Strategy
> Mental Health & Specialised Services
> _____
> West Moreton Hospital and Health Service
>
>
>
>
> The Park - Centre for Mental Health
> Administration Building, Cnr Ellerton Drive and Wolston Park Rd, Wacol, QLD 4076
> Locked Bag 500, Sumner Park BC, QLD 4074
> www.health.qld.gov.au<http://www.health.qld.gov.au/>
>

>
>
>>>> Anne Brennan 2/18/2014 3:54 pm >>>
> Hi Stephen and Leanne
> There seems to be a range of opinions as to how to deal with these final few on the waitlist.
> We concluded our teleconference 2 weeks ago with a plan that involved Kathy Stapley contacting the families. She preferred to contact the CYMHS clinics so we wrote letters to families and called the clinics.
>
> Those letters have been witheld and I understand from Berni that Leanne's preference is for CYMHS to contact families.
>
> Stephen, you are suggesting CYMHS clarify situation and then I offer assessment of needs. When we have called CYMHS they have informed us of long non-attendance but they have no indication of reasons for disengagement. Where they have had info, I have documented that to you both.
>
> I am happy to do whatever you both think best to finalise these cases. Let me know the plan.
> Anne
>
> A/Clinical Director
> Barrett Adolescent Centre
> The Park-Centre for Mental Health
>
>
>
>>>> Stephen Stathis 2/14/2014 5:09 pm >>>
> Thanks for all this follow up, Anne and Leanne.
> Anne, in your transitional role it would be wise to attempt to contact these families and find out what the reasons for disengagement were. We are unable to offer increased services at this time; they would need to be followed up at their local CYMHS or other appropriate local services. In your role, you could offer a reassessment to determine if their mental state had deteriorated and/or you still believe they need mental health support if so, broker a re-engagement with CYMHS (or other mental health services). We would need to let the local CYMHS know beforehand, to make certain they agree with the plan. Might be going overboard, but I am aware of the political sensitivities of these young people.
> Give me a call if you have other thoughts/questions.
> Cheers
> Stephen
> Ps. Thanks for your suggestions last night, Anne. Very helpful.
>
> _____
> From: Anne Brennan [mailto:Anne_Brennan@health.qld.gov.au]
> Sent: Friday, 14 February 2014 12:46 PM
> To: Leanne Geppert
> Cc: Stephen Stathis
> Subject: =?utf-8?B?UmU6IEJBQyB3YWl0bGlzdA====?>

> Anne
>
> A/Clinical Director
> Barrett Adolescent Centre
> The Park-Centre for Mental Health
> Ph 07
>
>
>>>> Leanne Geppert 2/14/2014 12:12 pm >>>
> thanks Anne
> so, are we confident that no one has fallen through the gaps? L

>
> Dr Leanne Geppert
> Acting Director of Strategy
> Mental Health & Specialised Services
> _____
> West Moreton Hospital and Health Service
> [redacted]
>
> The Park - Centre for Mental Health
> Administration Building, Cnr Ellerton Drive and Wolston Park Rd, Wacol, QLD 4076
> Locked Bag 500, Sumner Park BC, QLD 4074
> www.health.qld.gov.au<http://www.health.qld.gov.au/>
>
>
>
>>>> Anne Brennan 2/13/2014 4:56 pm >>>
> Hi Leanne and Stephen
> All consumers on BAC waitlist and assessment list have been contacted,or the referring service has been or in some cases both.
> Spreadsheet attached.
> Let me know if there is further action required.
> Anne
>
> A/Clinical Director
> Barrett Adolescent Centre
> The Park-Centre for Mental Health
> [redacted]

EXHIBIT 122

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6 January 2014 - 12 January 2014

January 2014

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February 2014

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6 Monday

11:00am 12:30pm Charters VC

12:30pm 5:00pm Private Practice

7 Tuesday

8:30am 12:00pm Ingrid

12:00pm 2:00pm Judi

2:30pm 5:00pm Keep Free

3:30pm 4:00pm Statewide Adolescent Initiative Update (CE Office, Level 1 North Tower) - Peter Steer

8 Wednesday

8:00am 11:30am Judi

1:00pm 3:30pm Judi

9 Thursday

8:00am 3:30pm Keep Free

3:30pm 4:30pm YPETRI Governance Committee (Conference Room N1.11, Level 1, Admin Building, The Park) - Bernice Holland

10 Friday

7:00am 5:00pm Keep Free

12:30pm 5:00pm Interview

1:00pm 2:00pm Executive Offices North Tower

11 Saturday

12 Sunday

13 January 2014 - 19 January 2014

January 2014

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February 2014

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13 Monday

6:00am 4:45pm LEAVE

9:00am 10:30am SW AETRS Steering Committee (Seminar Room, CYMHS, Cnr Roger and Water Streets, Spring Hill) - Ingrid Adamson

14 Tuesday

6:00am 4:45pm LEAVE

15 Wednesday

6:00am 4:35pm LEAVE

12:00pm 1:00pm CHQ Credentialing Committee - 2014 Meetings (Level 3, Surgical Services Meeting Room) - CHQ_Credentialing

16 Thursday

6:00am 4:45pm LEAVE

3:30pm 4:30pm YPETRI Governance Committee (Conference Room N1.11, Level 1, Admin Building, The Park) - Bernice Holland

17 Friday

6:00am 4:40pm LEAVE

18 Saturday

19 Sunday

20 January 2014 - 26 January 2014

January 2014

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February 2014

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20 Monday

6:00am 5:00pm LEAVE

6:00am 5:00pm LEAVE - Stephen Stathis

21 Tuesday

6:00am 5:00pm LEAVE

22 Wednesday

6:00am 4:45pm LEAVE

23 Thursday

6:00am 4:50pm LEAVE

3:30pm 4:30pm YPETRI Governance Committee (Conference Room M1.11, Level 1, Admin Building, The Park) - Bernice Holland

24 Friday

6:00am 4:50pm LEAVE

3:00pm 4:00pm Private Practice Governance Committee Meeting (Small Meeting Room, Level 1, North Tower) - CHQ_EDMS

25 Saturday

26 Sunday

27 January 2014 - 2 February 2014

January 2014

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February 2014

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24	25	26	27	28		

27 Monday

7:30am 5:05pm PUBLIC HOLIDAY

9:00am 10:30am SW AETRS Steering Committee (Seminar Room, CYMHS, Cnr Roger and Water Streets, Spring Hill) - Ingrid Adamson

28 Tuesday

2:00pm 2:30pm Stephen Stathis catch-up (North Tower) - Stephen Stathis

5:00pm 5:30pm Teleconf w Dr Peter Steer Re: Mater Interim Subacute Beds (Dr STeer to call Sean on [redacted] or alternatively [redacted] - Peter Steer

29 Wednesday

7:30am 9:30am Contracts & KPI's Planning Workshop (Meeting Room 3, Ground Floor, South Tower, RCH) - CHQ_EDMS

1:00pm 4:00pm Operations Committee

30 Thursday

10:30am 11:15am 10.40am Board Presentation (Cowlishaw Room) - Ingrid Adamson

3:30pm 4:30pm YPETRI Governance Committee (Conference Room N1.11, Level 1, Admin Building, The Park) - Bernice Holland

31 Friday

8:00am 10:00am Consultant Meeting (Spring Hill) - Stephen Stathis

1 Saturday

2 Sunday

Business Case

For the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation Model of Care

Children's Health Queensland Hospital and Health Service

April 2014

V 3.0

Version Control

Version	Date	Prepared By	Comments
0.1	27/11/13	Ingrid Adamson	Initial Draft
0.2	09/12/13	Ingrid Adamson	Incorporating comments from J. Krause and S. Stathis
0.3	06/01/14	Ingrid Adamson	Incorporating input from P. Steer, CE
0.4	15/01/14	Ingrid Adamson	Incorporating input from J. Krause, Divisional Director
0.5	22/01/14	Ingrid Adamson	Incorporating costing model updates
0.6	11/02/14	Ingrid Adamson	Incorporating input from L. Seamer, CFO
1.0	12/02/14	Ingrid Adamson	Final Version
2.0	14/02/14	Ingrid Adamson	Incorporating input from Executive Team
3.0	02/04/14	Ingrid Adamson	Incorporated input from Department of Health

**Drafts should use format vX.1 (eg. start at v0.1). Final versions should use format vX.0 (eg. v1.0).*

Approvals

Name	Title	Fu S
	Chief Executive and Department of Health Oversight Committee	Approve
	SW AETR Steering Committee	Endorse
Peter Steer	Chief Executive, CHQ HHS and Executive Sponsor	Feedback
Loretta Seamer	Chief Financial Officer, CHQ HHS	Feedback
Deborah Miller	A/Executive Director, Office of Strategy Management, CHQ HHS	Feedback
Judi Krause	Divisional Director CYMHS CHQ HHS	Feedback
Stephen Stathis	Clinical Director, CYMHS CHQ HHS	Feedback

** The values applicable to the function field are Review, Approve, For Information*

Note: There is a requirement for the Business Case to be managed in accordance with the Financial Management Practice Manual.

Should either funding requirements / benefit estimates vary or likely to vary by more than 10% for the next stage, it is viewed as a major change/risk to the validity of the original investment proposition and needs re-validation. For example, the business case must be updated to reflect the changes and re-submitted to the CHQ Executive for approval and advice to CFO. Additional funding approval must be sought from CHQ Executive.

Fundamentally any **major or significant change** from the approved business case position in regard to **timing, costs, benefits and/or risk** must be notified to the Executive Sponsor and CFO and may trigger a revision of the business case. The Executive Sponsor will accept responsibility for proposal oversight and will provide guidance in regard to this.

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1 Project Proposal

Children's Health Queensland Hospital and Health Service is leading the development and implementation of the Statewide Adolescent Extended Treatment and Rehabilitation (SW AETR) Strategy, which aims to ensure young people and their families across Queensland have access to quality mental health extended treatment and rehabilitation service options in the least-restrictive environment as close to their home and community as possible.

Work Unit: Child and Youth Mental Health Service (CYMHS)

Work Site: Children's Health Queensland Hospital and Health Service (CHQ HHS)

1.1 Strategic and Operational Alignment

This initiative aligns with *Strategic Direction 1: Leading the provision of quality health care for children and young people*.

1.2 Background

Queensland's public mental health system has undergone significant reform over the past ten years. The reform agenda includes a shift from institution-based service models, including extended treatment and rehabilitation, to more contemporary models of care that align with state and national policy. The impact of these important reforms has seen the care of consumers move primarily into community-based settings, where they are supported to engage in their own local neighbourhoods and facilities. This has been particularly vital for consumers requiring medium to longer-term care.

In alignment with the Queensland Plan for Mental Health 2007-17 (QPMH), a key area for reform within Mental Health and Specialised Services (MHSS) in the West Moreton Hospital and Health Service (WM HHS) is the development of The Park Centre for Mental Health (The Park) as an adult-only forensic and secure mental health campus. The high secure services have been expanded and, in July 2013, a new service option was established on campus, the Extended Forensic Treatment and Rehabilitation Unit.

In light of these significant changes, it is no longer safe or contemporary to provide long-term inpatient care for adolescents at the Barrett Adolescent Centre (BAC) on The Park campus. Compounding these changes at a service provision level, the existing infrastructure of the BAC is unable to be refurbished and the building will be decommissioned.

Through Stage 1 of the QPMH, an adolescent extended treatment unit was funded to replace the existing 15-bed BAC. The replacement service was to be located at Redlands within Metro South HHS, and had an indicative commissioning date of November 2013. Upon operation of the replacement 15-bed unit, the existing BAC would be decommissioned.

The Redlands adolescent extended treatment capital program encountered multiple delays and a significant budget over-run. There were unresolvable environmental barriers associated with the site, and the Department of Health ceased the development and redirected the capital funds toward other high priority health initiatives. Operational funding for the Redlands Facility, of approximately $1.8 million for 2013/14, has been retained and approved by the Department of Health to fund new adolescent mental health extended treatment and rehabilitation service options.

In December 2012, WM HHS initiated the Barrett Adolescent Strategy to identify new service options for adolescents requiring mental health extended treatment and rehabilitation in Queensland. An Expert Clinical Reference Group (ECRG) was convened, consisting of a consumer representative, a carer representative, an interstate Child and Adolescent Psychiatrist, multi-disciplinary Child and Youth Mental Health clinician representation (including north Queensland), a representative of BAC, a representative of the BAC School, and a Non-Government Organisation (NGO) representative. The ECRG was chaired by the Director of Planning and Partnerships Unit, Mental Health Alcohol and Other Drugs Branch (MHAODB). The ECRG reported up to the WM HHS via a Planning Group, which was chaired by the Executive Director of Mental Health & Specialised Services, WM HHS.

In May 2013, a preamble and seven recommendations were submitted by the ECRG and considered by the WM HHS Board (**Appendix 1**). This was followed by comprehensive consultation with the Minister for Health, the Queensland Mental Health Commissioner, CHQ HHS, Department of Education Training and Employment (DETE), and the Department of Health. The seven recommendations were accepted by the WM HHS Board.

On 6 August, 2013, the Minister for Health, the Honourable Lawrence Springborg MP made an announcement that adolescents requiring extended mental health treatment and rehabilitation will receive services through a new range of contemporary service options from early 2014. Young people receiving care from the Barrett Adolescent Centre at that time will be supported through their transition to other contemporary care options that best meet their individual needs.

Children's Health Queensland is leading the development and implementation of the Statewide Adolescent Extended Treatment and Rehabilitation Strategy.

1.3 Statement of Need

The closure of the BAC has provided an opportunity to review the model of care for adolescent extended treatment and rehabilitation to ensure young people receive contemporary, family-centred services in the least-restrictive environment as close to their home and community as possible.

The BAC represents just one service on a continuum of adolescent mental health care provided by the Queensland State Government. While the BAC provided care for 12 to 15 young people at any one time, Queensland Health is providing mental health care for a much larger cohort of young people across the state. Children's Health Queensland is now exploring the best way to enhance these current care options for young people, as well as the addition of new services, to address recognised service gaps in the continuum of care for adolescent mental health.

The goal is to ensure every adolescent in need of mental health care will receive the best support and treatment as close to their home and family as possible.

1.4 Objective/s

The objective of this initiative is to provide contemporary, evidence-informed treatment and rehabilitation care that treats young people in the least restrictive environment possible, recognises the need for safety and cultural sensitivity, and is provided with the minimum possible disruption to family, educational, social, and community networks.

Specifically, the initiative will:

1. Develop service options within a statewide mental health model of care for adolescent extended treatment and rehabilitation, within a defined timeline.
2. Develop an Implementation Plan to achieve the alternative model of care for adolescent mental health extended treatment and rehabilitation.
3. Ensure continuity of care for adolescents currently admitted to BAC, and on the wait list, through a supported discharge / transition process to the most appropriate care option/s that suit individual consumer needs, and that are located in (or as near to) their local community.
4. Oversee the redistribution of BAC operational funds, and other identified funding, to adolescent mental health service models to support the identified target group.
5. Develop a consistent and transparent Communication Plan regarding the implementation of the new service options.
6. Consider in all decision-making the key principles and recommendations as defined through the ECRG and Planning Group of the Barrett Adolescent Strategy.
7. Discharge all adolescents from the BAC facility by end January 2014, to enable finalisation of The Park campus as an adult-only forensic and secure mental health service facility, noting that this is a flexible date dependent upon the needs of the consumer group.

1.5 Scope

1.5.1 In Scope

- End-to-end recovery-oriented adolescent mental health extended treatment and rehabilitation services, that may be defined as a range of ambulatory mental health services that deliver mental health care to non-admitted patients, including services at non-hospital community mental health services, crisis or mobile assessment treatment services, and day programs. It may also include a small number of non-acute inpatient mental health services to admitted patients over a longer-term period and involve a specialist rehabilitation component to care.
- Linkages to other adolescent mental health services that do not meet the definition of mental health extended treatment and rehabilitation services (such as acute, forensic, and Community CYMHS)
- Linkages to Adult Mental Health Services in so far as to ensure smooth transition from Adolescent Mental Health Services
- Linkages to primary care service providers in so far as to ensure smooth transition to and from Adolescent Mental Health Services
- Governance and resource arrangements for the statewide adolescent mental health extended treatment and rehabilitation services, including, financial, workforce, and assets.
- The target consumer group is:
    - 13 - 18 years old, with flexibility in upper age limit depending on presenting issue and developmental age (as opposed to chronological age).
    - Severe and persistent mental health problems that may include co-morbid alcohol and other drug problems, which significantly interfere with social, emotional, behavioural and psychological functioning and development.

- Mental illness is persistent and the consumer is a risk to themselves and/or others.
- Medium to high level of acuity requiring extended treatment and rehabilitation.

1.5.2 Out of Scope

- Individual consumer clinical treatment plans
- Current BAC operations
- Decommissioning of the BAC building
- Any system requirements or enhancements for electronic consumers records
- Other adolescent mental health services that do not meet the definition of mental health extended treatment and rehabilitation services (such as acute, forensic, and Community CYMHS)
- Non-adolescent mental health services
- Primary care service providers and their processes

1.6 Dependencies

There are no project inter-dependencies identified.

1.7 Benefits and Outcomes

- High quality, effective extended treatment and rehabilitation mental health service options available to consumers that are based on contemporary models of care and take into account the wide geographical spread of Queensland.
- Increased access for adolescent consumers to their families, community and social networks by having greater access to more local mental health services.
- Reduced re-admission rates, emergency presentations, lengths of stay in acute adolescent inpatient units, and occupied bed days.
- Improved, strengthened inter-sectoral partnerships in delivering adolescent mental health care.
- Value for money in the delivery of care for adolescents requiring extended treatment and rehabilitation mental health care.

Achievement of project objectives and outcomes will be measured through:

- Consumer, family, and carer feedback reflecting quality, effectiveness, and accessibility of extended treatment and rehabilitation mental health service options.
- Service data demonstrating increased local access to extended treatment and rehabilitation mental health services, and demand management across Queensland.
- Service data outlining patient flow. Mental Health Performance Management Framework State key performance indicators would include 28 day re-admission rates and 1 to 7 day community follow up pre and post discharge. Other indicators would include service activity presentations to the

Department of Emergency Medicine, reduction in emergency examination orders, average length of stay, and occupied bed days.

- Staff feedback demonstrating improved service provision across Queensland.
- Feedback from service providers demonstrating improved, strengthened inter-sectoral partnerships in delivering adolescent mental health care.
- Financial assessment demonstrating value for money in the delivery of care for adolescents requiring extended treatment and rehabilitation mental health care.

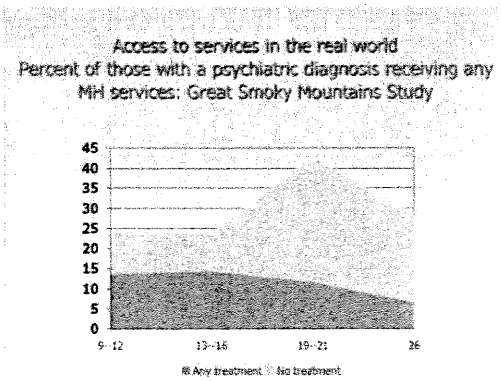
2 Demand for Services

Mental illness represents an estimated 11% of the disease burden worldwide. In Australia, mental illness is the largest cause of disability, accounting for 24% of the burden of non-fatal disease[1]. Furthermore, 75% of severe mental health problems emerge before the age of 25. Of the total population of young people aged between 13 and 18 years of age, it is estimated that 10% have mental health needs and 2.3% have a severe mental illness[2]. This equates to 35,044 young people with mental health needs and 8,060 with a severe mental health illness in Queensland[3].

The last national survey of child and youth mental health services was conducted in 1998 with a more recent study conducted from May through to December 2013. Results from the 2013 study will not be published until late 2014. As a consequence, there is no recent data regarding mental health services for young people in Australia at this time.

The National Mental Health Report 2013, commissioned by the Federal Government, did however find that the demand for services is on the rise, reflected in an increased rate of contact with primary mental health care by children and young people. This has increased three-fold from 2006-2007 to 2011-2012, where the increase was most marked for those aged 18-24 (rising from 2.2% to 7.5%) followed by those aged 12-17 (rising from 1.1% to 5.5%)[4].

It is also a well-known fact that young people are the most disengaged cohort along the mental health continuum, as demonstrated in the Great Smoky Mountains Study (Costello, et al, 1996) below. Consequently, the true extent of demand for services is difficult to quantify.



[1] *National Mental Health Report*, 2010, and *Mental Health Services In Brief*, 2011
[2] General Epidemiology data provided by the Mental Health, Alcohol and Other Drugs Branch
[3] Australian Bureau of Statistics, 2011, Census of Population and Housing
[4] Department of Health and Ageing, 2013, *National Mental Health Report 2013: tracking progress of mental health reform in Australia 1993-2011*. Commonwealth of Australia, Canberra

It has been identified by the Statewide Mental Health Network Child and Youth Advisory group, which comprises senior leaders in child and youth mental health across the state, that high risk, difficult-to-engage adolescents propose a significant risk factor for CYMHS. The Commission for Children and Young People and Child Guardian (CCYPCG) actively supports the sector's work in establishing best practice services to better meet the needs of these young people. The CCYPCG has also called on CYMHS to review current inter-Agency processes and services available to better meet the needs of these at-risk adolescents.

3 The Proposed Model of Care

The proposed Model of Care provides recovery-oriented treatment and rehabilitation for young people aged 13-18 years with severe and persistent mental health issues that may include co-morbid alcohol and other drug (AOD) problems, which significantly interfere with social, emotional, behavioural, and psychological functioning and development. It is anticipated that there will be flexibility in the upper age limit, dependent upon presenting issues and developmental age, as opposed to chronological age.

The proposed Model of Care has been developed based on the recommendations from the ECRG, who explored national and international models of service, and used evidence-based practices to inform their recommendations.

The proposed Model of Care has also been developed in accordance with the principles and services outlined in the current draft of the National Mental Health Services Planning Framework (NMHSPF). The NMHSPF aims to provide a population-based planning model for mental health that will better identify service demand and care packages across the sector in both inpatient and community environments. The NMHSPF, when completed toward the end of 2014, will allow for more detailed understanding of the need for and types of mental health services across a range of environments.

Further research for this initiative included site visits to the Departments of Health in NSW and Victoria and these findings were also used to inform development.

The above recommendations, information and findings have culminated in a Model of Care comprising five service elements for extended treatment and rehabilitation (refer **Appendix 2** and **3** for detailed service models for each element).

3.1 Assertive Mobile Youth Outreach Services (New Service)

The Assertive Mobile Youth Outreach Service (AMYOS) is a new service option providing mobile assertive engagement and prevention-focused interventions in a community or residential setting. The aims of this service are to assist adolescents who are high risk and difficult to engage; to manage crisis situations; and to reduce the need for inpatient bed-based care.

Ideally, each AMYOS team would be resourced with a minimum of two full-time employees, supported by psychiatrists in statewide roles. Establishing an AMYOS team in each HHS will increase capacity to case manage an additional 16 to 20 young people, at any one time, per team, per HHS. These would be young people who would have previously not engaged with mental health services and have therefore received no mental health input, increasing their risk of suicide and other adverse or life-threatening events. The approach places a strong emphasis on the development of inter-sectorial partnerships, working with other key service providers in the community to facilitate joint care planning and case management for the young people in care.

A literature search revealed that the Victorian Intensive Mobile Youth Outreach Service (IMYOS), on which AMYOS has been modelled, is viewed as a leading service in Australia. Results from a clinical audit show that IMYOS interventions were effective in significantly lowering the risk of harm to self and others, and in reducing the number of admissions and lengths of stay in hospitals. A subsequent study found that IMYOS involvement resulted in significant improvements in client engagement and sustained engagement in treatment.[5]

During a review of mental health services in Australia, the NOUS Group[6] identified that intensive case management models, such as assertive community treatment, can decrease rates and length of hospital stays, and produce cost savings. It was noted that "at the core of most successful models, and supported by a growing evidence base, is an intensive case management/care coordination function that helps patients to navigate their way through clinical and community services, thereby avoiding hospitalisation".

The inclusion of this service in the Model of Care will ensure:

- Greater flexibility to meet the needs of consumers, fostering greater participation in treatment;
- Decreased hospitalisation and lower admission rates;
- Decreased lengths of stay in acute inpatient units;
- Improvement in psychiatric symptoms and overall improved function; and,
- A more assertive approach to reducing high risk behaviours and self-harm.

3.2 Day Programs (Expanded Service)

Day Programs aim to reduce the severity of mental health symptoms and promote effective participation in areas such as schooling, social functioning, symptom management, and other life skills. They provide flexible and less restrictive treatment interventions that integrate with educational or vocational programs.

A recent evaluation of the Victorian Adolescent Day Programs suggests that they are an effective intervention for adolescents with mental health problems[7]. Adolescents reported significant improvements in peer relationships, school relationships, and overall mental health functioning with Day Program support.

It is proposed that existing Day Programs at the Mater Hospital, Toowoomba and Townsville be expanded through the addition of three new units in south-east Queensland, taking the total number to six Day Programs in Queensland. Each Day Program can treat up to 15 adolescents per day per unit. Expansion of these units would mean care could be provided for up to 45 additional adolescents per day, and an even greater number over the course of a week due to variations in individual care plans (most adolescents attend a day program 2 to 3 days per week).

Currently, there are only two day programs to service south east Queensland, where approximately 74% of the state's adolescent population reside. It has therefore been identified as a significant gap in service, with north Brisbane considered the most critical area.

[5] Schley, C., Radovini, A., Halperin, S., & Fletcher, K., 2011, *Intensive outreach in youth mental health: description of a service model for young people who are difficult-to-engage and high-risk*, Children and Youth Services Review, 33, p.1506-1514.
[6] Nous Group, 2013, *The Case for Mental Health Reform in Australia: A Review of Expenditure and System Design*, www.medibankhealth.com.au/Mental_Health_Reform
[7] Kennair, N., Mellor, D., & Brann, P., 2011, *Evaluating the outcomes of adolescent day programs in an Australian child and adolescent mental health service*, Clinical Child Psychology and Psychiatry, 16, 21-31.

3.3 Residential Rehabilitation Units (New Service)

The Residential Rehabilitation Units (Resi's) are a new service providing long-term accommodation and recovery-oriented treatment in partnership with non-government organisations (NGOs), with inreach services provided by mental health specialists. Each Resi can accommodate 5 to 10 beds per unit and would be established in areas where there is NGO support.

The Resi spans a gap in service for young people, aged 16 to 21 years, who do not have the skills or expertise for independent living, or a stable place of accommodation. This service focuses on supporting young people to:

- Improve their capacity to manage and be responsible for self-care;
- Enhance their adaptive coping skills and decrease self-harming behaviour;
- Enhance their social and daily living skills to improve their ability to live independently in the community; and
- Develop and maintain links with the community, family, and social networks, education and vocational opportunities.

It is well recognised across the sector that there is a significant lack of supported accommodation for adolescents with mental health and substance abuse issues, and who sit outside the child protection system. One of the findings from an external review of the Barrett Adolescent Centre in 2009 was the absence of supported accommodation to transition adolescents out of the centre and back into the community, where the young person was unable to return to their family of origin.[8] This finding was also evidenced by the increasing average length of stay in the centre, which rose from 3 months at opening in to 4 years at the time of the review in 2009.

In a Victorian study, people recovering from mental illness identified that stable and affordable housing as the most critical issue affecting quality of life and capacity for recovery. It is estimated that over 40% of young people with severe mental illness are homeless or housed in tenuous forms of accommodation, often interspersed with periods of hospitalisation and sometimes incarceration.[9] The Victorian Government consequently continues to invest $8 million per annum in youth residential rehabilitation services, providing 166 beds through 17 Resi's across the state.[10]

Queensland has 80% of the population of Victoria and yet seven times the geographic area to cover.[11] To produce the same outcomes as the Victorian service model, Queensland would require 14 Resi's providing up to 140 beds across the state. Due to funding limitations, however, it is proposed that a Resi be established in each Mental Health Cluster (North, Central, and South – three in total) until success of this service in Queensland can be evaluated, supporting the establishment of more units.

3.4 Step Up / Step Down Units (New Service)

The Step Up / Step Down Unit (SUSDU) is a new service option providing short-term residential treatment by mental health specialists in partnership with NGOs. These purpose-built units could have up to 10 beds per unit and be established in areas where there is NGO support.

[8] *Review of the Barrett Adolescent Centre*, 2009, commissioned by the CE, Darling Downs - West Moreton Health Service District
[9] Nous Group, 2012, *Review of the PDRSS Day Program, Adult Residential Rehabilitation and Youth Residential Rehabilitation Services for the Victorian Department of Health*
[10] Ibid.
[11] http://www.ga.gov.au/education/geoscience-basics/dimensions/area-of-australia-states-and-territories.html

The SUSDU are provided for young people who have recently experienced, or who are at increased risk of experiencing, an acute episode of mental illness. The young person usually requires a higher intensity of treatment and care to reduce symptoms and/or distress that cannot be adequately provided for in the community, but does not require the treatment intensity provided by acute inpatient units. It is therefore seen as a necessary and cost-effective addition to the continuum of care proposed.

These units are based on the Youth Prevention and Recovery Care (Y-PARC) services delivered in Victoria, which have anecdotally been proven effective at:

- Preventing further deterioration of a person's mental state and associated disability, and in turn reduced likelihood of admission to an acute inpatient unit (Step Up).
- Enabling early discharge from acute mental health inpatient units through the provision of an intensive safe and supportive sub-acute residential community program (Step Down).

There are currently three Y-PARCs in Victoria. Success of this service has created an impetus for the Victorian Government to explore the establishment of more, with the Victorian Minister for Mental Health stating, "This service has a critical role in caring for young people, providing intensive help earlier...it is particularly aimed at young people who need residential support as an alternative to inpatient care, or to help them transition from hospital back into the community."[12]

It is proposed that a SUSDU be established in each Mental Health Cluster (North, Central, and South – three in total) until success of this service in Queensland can be evaluated, supporting the establishment of more units.

3.5 Subacute Bed-based Unit (New Service)

The subacute bed-based unit is a new service providing medium-term, intensive, hospital-based treatment in a safe and structured environment for young people with severe or complex symptoms of mental illness and associated significant disturbance in behaviour that precludes them receiving treatment in a less restrictive environment.

Unlike acute inpatient units, this service is designed to undertake comprehensive assessments of issues, complicated by a high degree of complexity and chronicity, which young people and their families present with, particularly within a care-giving context. Organisation of ongoing care in these complex and chronic clinical presentations requires extensive collaboration and coordination that is beyond the scope and time available to acute inpatient units.

At this point in time, the demand for this service is unclear; however, it was noted by the ECRG that this service is an essential component of an overall model of care as there is a small group of young people whose needs cannot be safely and effectively met through alternative service types.[13]

CHQ has established an interim arrangement with the Mater Hospital to provide two subacute inpatient beds to meet the needs of the more high-risk end of the mental health spectrum, previously treated in BAC, to ensure there is no gap in service to adolescents. This arrangement is in place for a period of nine months, until November 2014, to assess demand for a longer term bed-based unit. While the level of need for this unit is determined, planning has commenced to allocate space for a four bed unit within the Lady Cilento Children's Hospital at South Brisbane.

[12] Department of Health news release, 2012, *New youth mental health service opens on Peninsula*, http://www.health.vic.gov.au/news/youth-mental-health-service-opens-on-peninsula.htm

[13] Expert Clinical Reference Group, 2013, *Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services*

It is important to note that the above Model of Care, and underpinning five service elements:

- Is supported by existing Community Child and Youth Mental Health Services and seven acute inpatient units located throughout Queensland (Royal Children's Hospital, Royal Brisbane and Women's Hospital, Mater, Logan, Robina, Toowoomba, and Townsville HHSs);
- Is based on evidence-informed services delivered in other States;
- Acknowledges the importance and role of education in all service options; and,
- Includes active engagement of the Non-Government Sector for service provision.

Delivering a range of services along a continuum of care provides:

- Greater choice in services for young people that will best meet their mental health recovery, and reduces the risk of disengaging from local mental health services;
- Ease of transition between services across the continuum;
- Reduced admissions into hospital-based services;
- Extended cover across the large, decentralised state of Queensland;
- Decreased risk of institutionalisation of young people by avoiding lengthy inpatient admissions away from their family home and/or community;
- Reduced reliance on bed-based options thereby increasing the capacity for families and support people to remain engaged in the young person's treatment; and
- Improved engagement and collaboration with service providers from other agencies and sectors.

The model of care improves on current service delivery through:

- Broader, comprehensive psychiatric input across the sector;
- Extended hours of service across the state; and,
- Speedier transition of young people back to their family and communities as a result of reduced lengths of stay at inpatient units and the provision of additional local support services, thereby reducing the risk of secondary disability as a consequence of institutionalisation, developmental arrest, deskilling, and disconnection from families, communities, and local mental health services.

Key stakeholders who were consulted on development of this Model of Care, including clinical experts, consumers, and their families, identified both the AMYOS and Residential Rehabilitation Units as priority services for implementation.

4 Issues

During development of the proposed Model of Care, the following issues were identified:

Age Limit

There is a need for flexibility in the upper age limit, which is currently set at 18 years of age. While eligible for adult mental health services, the developmental age of some adolescents is not reflective of their chronological age and more supportive and developmentally appropriate service options are needed for young people up to 21 years of age.

The Residential Rehabilitation Unit is currently the only service in the continuum that specifically accommodates an age range up to 21 years old. Whilst other services proposed would be able to service the same age range, it is not a supported mental health position in Queensland. Further consideration needs to be given to raising the age limit for all services in the proposed Model of Care.

Skilled Workforce

There is a current short fall in clinical child and youth mental health staff in Queensland. The 2017 target for full time equivalent (FTE) staff is estimated at 14 FTEs per 100,000 population[14]. As at June 2012, child and youth mental health FTEs were only at 58% of the total number of staff required. It is important to note that recruiting a suitably skilled workforce will be a significant critical success factor for service implementation.

Location of Services

A significant complexity for service delivery in Queensland is the geographic spread of consumers across the state. As demonstrated below, Queensland has the third highest population in Australia with the second largest land mass, over double the size of NSW and up to seven times that of Victoria.

State[15]	Population in millions	Square Kilometres in millions
New South Wales	7.407	0.801
Victoria	5.737	0.227
Queensland	**4.658**	**1.731**
Western Australia	2.517	2.529

The location and implementation of services will need to be prioritised against the demand for services based on population data. 2011 Census data estimates the adolescent population of Queensland (aged between 13 and 18 years of age) at 350,442[16], approximately 74% of which live in south-east Queensland. This data is presented in the tables below: the first table is sorted by population and the second table is sorted by mental health cluster.

[14] Community Mental Health Services Full Time Equivalent Report, Mental Health Alcohol and Other Drugs Branch, Qld Health

[15] http://www.ga.gov.au/education/geoscience-basics/dimensions/area-of-australia-states-and-territories.html

[16] Australian Bureau of Statistics, 2011, Census of Population and Housing

Table 1: Young Persons aged 13 to 18yo in Place of Usual Residence[17]

Geographical Catchment	Youth Pop'n	10% with Mental Health Needs[18]	2.3% with Severe Illness[19]
Metro North	43,958	4,396	1,011
Gold Coast	42,809	4,281	985
Logan/ Bayside/ Beenleigh	41,348	4,135	951
Metro South	39,961	3,996	919
Sunshine Coast	27,842	2,784	640
Darling Downs	26,067	2,607	600
Redcliffe/ Caboolture	23,095	2,310	531
Cairns and Hinterland	19,745	1,975	454
Central Queensland	18,657	1,866	429
Townsville	18,501	1,850	426
Wide Bay	16,199	1,620	373
West Moreton	14,056	1,406	323
Mackay	13,776	1,378	317
South West	1,779	178	41
Torres Strait-Northern Peninsula and Cape York	1,358	136	31
Central West	796	80	18
North West	495	50	11
TOTAL	**350,442**	**35,044**	**8,060**

[17] Australian Bureau of Statistics, 2011, Census of Population and Housing
[18] General Epidemiology data provided by the Mental Health, Alcohol and Other Drugs Branch, Queensland Health
[19] Ibid.

Table 2: Young Persons aged 13 to 18yo by Mental Health Cluster

Geographical Catchment	Youth Pop'n	10% with Mental Health Needs	2.3% with Severe Illness	By Cluster
Gold Coast	42,809	4,281	985	Southern
Logan/ Bayside/ Beenleigh	41,348	4,135	951	Southern
Metro South	39,961	3,996	919	Southern
Darling Downs	26,067	2,607	600	Southern
West Moreton	14,056	1,406	323	Southern
South West	1,779	178	41	Southern
TOTAL	**166,020**	**19,386**	**4,459**	
Metro North	43,958	4,396	1,011	Central
Redcliffe/ Caboolture	23,095	2,310	531	Central
Sunshine Coast	27,842	2,784	640	Southern
Central Queensland	18,657	1,866	429	Central
Wide Bay	16,199	1,620	373	Central
Central West	796	80	18	Central
TOTAL	**130,547**	**10,271**	**2,362**	
Cairns and Hinterland	19,745	1,975	454	Northern
Townsville	18,501	1,850	426	Northern
Mackay	13,776	1,378	317	Northern
Torres Strait-Northern Peninsula and Cape York	1,358	136	31	Northern
North West	495	50	11	Northern
TOTAL	**53,875**	**5,388**	**1,239**	

Non-Government Organisation Engagement

Two of the new services proposed are dependent upon NGO collaboration. It is important to note that the Queensland NGO market is relatively immature in the specialised field of adolescent mental health services. It is therefore acknowledged that NGOs will require time to build skills and capabilities to deliver services. Furthermore, time will be required to undertake robust procurement processes.

Service Governance

There is a risk that funding for adolescent mental health services may be reallocated to other services where appropriately skilled resources cannot be recruited. To mitigate this risk, governance and funding will be overseen by CHQ, as part of its statewide remit for children's health services. This will be managed through Service Level Agreements with respective Hospital and Health Services (HHS). Day-to-day reporting and management of positions under the AMYOS, Day Program, and SUSDU services will be the remit of the local HHS.

5 Financial Analysis

5.1 Current Funding Available

Current operational funding includes a reallocation of approximately $3.8m recurrent operational funding from the BAC. This amount has decreased since 2011/12 due to a 50% reduction in staffing at the BAC, removing approximately $2m from the adolescent mental health sector.[20]

In addition to the BAC operational funds, $2m recurrent operational funding will come from the ceased Redlands Project. This equates to a total of $5.8m for adolescent mental health extended treatment and rehabilitation services in Queensland.

It should be noted that there is no capital funding currently available to establish new services.

In contrast, the Department of Communities currently provides $18 million per annum to fund the Evolve program.[21] Evolve, a comparative service to the adolescent mental health service, provides therapeutic and behavioural support for children in out-of-home care with complex and severe needs who are under a child protection order (typically the top 3% of complex mental health cases requiring child protection). This would support the position that the current identified operational funds of $5.8m are insufficient to care for the much larger cohort of young people, outside the child protection system, with severe or complex mental health needs.

Additional recurrent operational and capital funding will be required to implement the proposed model of care and to realise the full benefits and outcomes that an enhanced continuum of services could provide.

5.2 Recurrent and Capital Cost Options

A phased approach to implementation has been developed with consideration of population, demand, and the local mental health service capacity to enhance services in the proposed locations. Consideration has also been given to local mental health service infrastructure, and their capacity to support the new services and integrate them within their existing team structures. It would be envisaged that the commencement of services in larger metropolitan and regional areas would ensure robust clinical and corporate governance systems, enable an integrated approach, and support the implementation of an evaluation framework, all of which will be critical to the success of the new services. These initial sites will help shape and promote the implementation of a sustainable and transferable model that can be adapted to the individual needs of the local HHS. The level of state-wide support required for more rural and remote areas could then be determined prior to implementation of more new services. Shared learnings would be used to inform the structures of new services in areas with less mental health capacity to ensure the optimal level of safe, appropriate, and effective care.

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

- Acknowledgement that all resources cannot be recruited at once;
- Recurrent funding sources need to be identified for new services;
- Service coverage in metro and regional areas will expand over time; and
- Telepsychiatry support from centralised CYMHS specialists will be a requirement to support clinical services in rural and remote areas.

[20] Child and Adolescent Mental Health FTE data, 2011-12, provided by the Mental Health, Alcohol, and Other Drugs Branch
[21] Department of Communities, Child Safety, and Disabilities 2012-13 Annual Report

5.2.1 Recurrent Costs

The proposed implementation, including budgeted expenditure, is outlined below. Detailed Costing Models, including assumptions, are provided at **Appendix 4**. It is anticipated that three new services could be funded through current identified operational funding, being a Residential Rehabilitation Unit, a new Day Program Unit, and seven AMYOS teams (highlighted in blue below). These services alone would treat up to 130 more young people per week than could be cared for had the BAC remained open.[22]

Statewide Adolescent Extended Treatment and Rehabilitation Strategy Business Case Summary

Service Funding Options	Service Commences	2013/14	2014/15	2015/16	2016/17
Statewide Assessment Panel (Coordinator)	February	$0	$75,311	$77,209	$79,155
Residential Rehabilitation Unit	February	$638,375	$1,476,844	$1,596,044	$1,637,662
Interim Subacute Bed-Based Unit	February	$76,813	$76,813	$0	$0
AMYOS Psychiatrists x 2 + coordinators	April	$217,938	$848,069	$869,332	$891,127
AMYOS x 7 Teams	April	$312,476	$1,970,233	$1,985,749	$2,036,198
New Day Program (North Brisbane)	May	$737,404	$1,423,272	$1,460,248	$1,498,190
TOTAL		**$1,983,006**	**$5,870,542**	**$5,988,582**	**$6,142,332**

The following table identifies new recurrent operational funding required to implement the full model of care.

Service Funding Options	Proposed Commence-ment	2013/14	2014/15	2015/16	2016/17
Subacute inpatient unit (4 bed unit)	From	$0	$665,397	$1,010,123	$1,035,686
AMYOS Psychiatrists x 2	Jul-14	$0	$719,320	$728,928	$747,183
AMYOS x 12 Teams (rest of Qld)		$0	$3,418,686	$3,404,141	$3,490,625
TOTAL		**$0**	**$4,803,403**	**$5,143,192**	**$5,273,494**
Day Program 2 (Logan)	From	$0	$0	$1,494,197	$1,498,190
Resi Rehab Unit 2 (North Cluster)	Jul-15	$0	$0	$1,676,672	$1,637,662
Step Up/Step Down Unit 1 (Central Cluster)		$0	$0	$3,587,810	$3,649,195
TOTAL		**$0**	**$0**	**$6,758,679**	**$6,785,047**
Day Program 3 (Gold Coast)	From	$0	$0	$0	$1,533,157
Resi Rehab Unit 3 (Central Cluster)	Jul-15	$0	$0	$1,676,672	$1,637,662
Step Up/Step Down Units 2 & 3 (North & Southern Clusters)		$0	$0	$3,587,810	$7,333,357
TOTAL		**$0**	**$0**	**$5,264,482**	**$10,504,176**
GRAND TOTAL		**$0**	**$4,803,403**	**$17,166,353**	**$22,562,717**

Implementation of the full Model of Care would mean that each week an additional 260 young people with serious and complex mental health problems such as suicidality, depression and psychosis, who would otherwise disengage or be unable to obtain mental health services, would receive appropriate care.[23]

[22] The Barrett Adolescent Centre was a 15 bed unit plus Day Program with 15 places – providing care for up to 30 young people at any one time.

[23] Figures are based on approximate caseload numbers per service and don't account for differences in care plans, duration of treatment and lengths of stay for individual consumers across the continuum of services.