program. In this case, the wraparound service on its own would not be sufficient - it needs to be in the context of having a day program facility.

Wraparound is essentially a CSCF Level 4/5 community based service. I had case based discussions as part of these workshops and understood the level of severity, complexity and impairment in adolescents for whom they were providing a service. It is clear that wraparound on its own is not a substitute for a CSCF Level 6 inpatient service.

If it is decided that a stand alone wraparound service will replace the current service as an interim measure, several issues need to be placed on record.

1. It will potentially be very expensive. The experience of Hengeller's MultiSystemic Therapy (MST) trial of MST as an alternative to inpatient admission for young people with acute self harm was that it was as expensive as hospitalisation, and outcomes equivalent. (MST is a very specific form of wraparound.) Their trial's would not have included patients of the severity seen at Barrett. To do so requires a prohibitive amount of support. Hengeller subsequently did not continue this trial, but he has done with a juvenile justice and substance using populations.
2. In 6 - 12 months, funding would be utilised to meet the needs of adolescents with levels of severity and complexity appropriate to wraparound.
3. The more severe ones typically seen at Barrett would have repeated and prolonged admissions to acute inpatient units, with much poorer long term outcomes. Some would die. Many will face significant impairment including long term social exclusion.

Bill, I find it very difficult to reconcile the occupancy figures you supplied to the Planning Group (50% or less - if any one says differently, either they are lying or HBCIS is lying) with figures supplied by the Directorate the next day - 67% for one adolescent unit based in the Greater Brisbane area, 76% for another and s in the 70+% range for the third. If a population of young people with repeated and prolonged admissions were to be placed in these beds, it would necessitate frequent transfer of Brisbane patients to the Gold Coast or Toowoomba or admissions to paediatric or acute adult inpatient beds.

Queensland and New South Wales are the leaders at meeting our obligations to adolescents under the *National Mental Health Plan*.

I am not living in the past about these matters. I live in the current reality of what is clinically possible for adolescents with severe and complex disorder, in the reality of the capacity of CYMHS services and what the implications are for our obligations are under the *National Mental Health Plan*.

Kind regards,

Trevor

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[redacted]