The payroll legacy

The 2012 report by the accountancy firm KPMG made it clear the legacy of the $1.25 billion health payroll debacle will have a lasting impact on Queensland's HHSs, even as Queensland Health works to restore efficiency and overall capacity.

The process of payroll repair is slow and time-consuming given the enormous complexity of awards and entitlements that apply within Queensland Health.

In addition, the government has:

- ended the moratorium that stopped the recovery of payroll overpayments
- changed the employee pay date to provide more time for processing
- ended ancient pay claims by employees (some lodged years later).

At its peak, the health payroll system required 1032 full-time administrative employees. This disproportionate allocation required support drawn from the health budgets of communities across the state.

Today, 854 full-time payroll employees remain. They engage in a difficult task and do a great job, but the high cost of payroll stability remains a problem. At the frontline of health delivery it denies access to resources sufficient to employ hundreds of additional nurses or health workers. Significant administrative lessons arising from these problems are well learned.

At the very top, healthcare system decision-makers must not lose sight of community goals. The huge collaborative capacity of the entire Queensland healthcare system must remain at the focus of attention for the government and its health agencies.

The ability to mount a diverse, articulated, sector-wide campaign to confront and overcome entrenched problems in health is what separates this new system from that which went before.

The facts of the failed payroll system and its $1.25 billion cost will be determined by a Commission of Inquiry being led by the Hon. Richard Chesterman QC.

Right of Private Practice Review

All health dollars must be spent properly and wisely. Fraudulent practice will not be tolerated by this government.

Medical practitioners employed by the public healthcare sector are given the opportunity to participate in private practice arrangements as part of their employment. Participating medical staff must declare their income when treating private patients in public hospital facilities.

Serious matters relating to questionable billing practices by senior medical officers in Queensland Health were raised by the Crime and Misconduct Commission (CMC) in late 2012. The CMC review indicated that some doctors and specialists may not be doing the right thing in billing and reporting private practice, and that this behaviour may be a systemic problem.

At the Minister for Health's request, the Auditor-General is undertaking a comprehensive audit of private practice arrangements in the public healthcare sector. The health and financial benefits of the right of private practice scheme are being scrutinised. So too is the way in which the scheme is administered, and whether senior medical officers participating in the scheme are doing so in full compliance with their contractual conditions.

Any potential cases of illegal activity identified during the audit will be referred by the Auditor-General to the CMC for investigation. The Auditor-General's recommendations are due to be delivered to government by mid–2013.

Greenslopes Hospital success story

The rebirth of Greenslopes Private Hospital in the mid-nineties is one of the great success stories of effective cooperation between the public and private sectors of the healthcare system in Queensland.

For many decades, Greenslopes was a military and repatriation hospital operated by the Department of Veterans' Affairs, Australian Government. In the late 1980s, options for the future of the facility, including privatisation or transfer into the control of Queensland Health, were raised.

The eventual decision, in January 1995, saw the former veterans' hospital transferred into the management of Ramsay Health Care, one of Australia's largest non-government health providers.

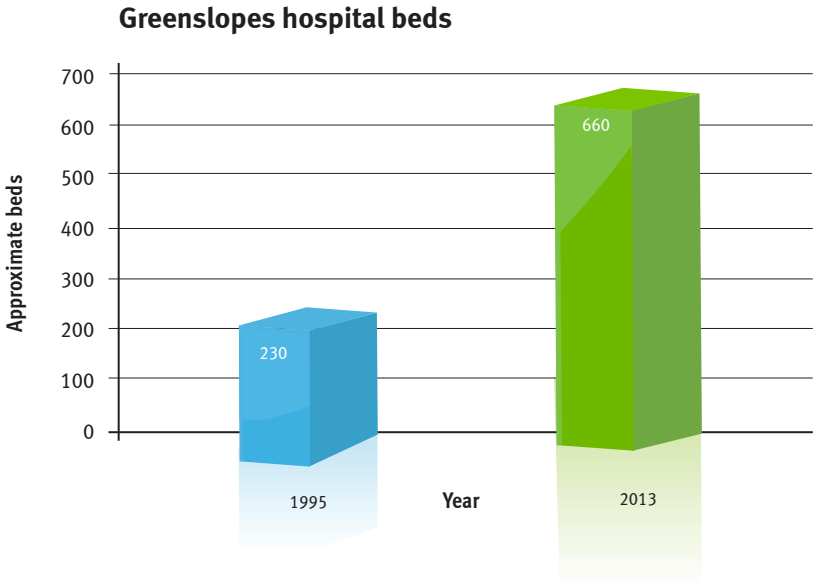
The decision transformed Greenslopes into Australia's largest private hospital whilst maintaining and respecting its tradition of providing care to entitled veterans and war widows. Although Greenslopes gained the right to admit private patients, Queensland's veteran community would continue to receive the quality and diversity of services provided prior to the sale.

Now known as Greenslopes Private Hospital, it has since grown from approximately 230 beds to a 660 bed facility offering a comprehensive and complex range of health care services including cardiac surgery and neurosurgery. In 2013, the hospital will open maternity services.

During the past 17 years, Greenslopes Private Hospital has developed a reputation for delivering the highest quality and standards of care, winning many awards and accolades across the country. Initial fears about privatisation, held by veterans, failed to come to fruition.

Today the ex-service community is a great supporter of Greenslopes Private Hospital and continues to participate in the development of services and to provide feedback to Ramsay Health Care through hospital consumer groups and committees.

Despite its growth and development, the private owners have retained and enhanced the features of the hospital that have ensured it remains a special place in the personal and national histories of those heroic generations of men and women who have served their country.



Greenslopes Private Hospital

section four

Investing, innovating and planning for the future

- **A lasting commitment to collaborative effort and improvement will provide Queenslanders with a world-class healthcare system.**
- **A simplified employment and industrial relations environment.**
- **A highly-skilled, capable and sustainable workforce with access to flexible opportunities for employment.**
- **New opportunities to promote and review infrastructure investment.**

The level of care in Brisbane is really good. I wish I could get the same care back home.

Delivering the best patient care

Delivering a healthcare system that Queenslanders can be proud of requires the commitment and expertise of many people working in partnership with the government.

To address underlying reasons for growing waiting lists in the past, we need to think and act differently to reduce the pressure on public hospitals and the healthcare system. The traditional default to building more hospitals and opening more beds is not always the best approach.

The design of clinical health systems, processes and services and health planning will be constantly revised. At all times, Queensland's healthcare system will provide access to the most clinically effective and cost-efficient service settings and models of care.

The experience, judgement and expertise of HHSs and the health workforce will be integrated with research findings, audits and surveys to inform future health planning and policy.

HHSs will work to improve the emergency department patient journey and will be accountable for emergency department performance. This will support the improvement of timely access for ambulance patients into emergency departments, as highlighted in the August 2012 MEDAI Report.

In banning ambulance bypass from 1 January 2013, the government expects all HHSs to effectively manage emergency department demand.

The Queensland Ambulance Service has implemented a MEDAI matrix to improve patient delivery times. No ambulance is to be redirected by one hospital to another.

Workforce reform

The foundation of quality service delivery is the health workforce, whether the jobs are in the public, private or not-for-profit sectors.

The government's commitment to reforming industrial relations in the public healthcare sector incorporates better wages and better conditions for employees, as well as greater choice.

Since its election, the greatest single health investment of this government was its $1.35 billion investment in pay-rises for Queensland Health employees over three years. This comprised:

- **3 per cent increase for nurses and midwives—an extra $592 million**
- 2.5 per cent increase for medical officers—an extra $300 million
- 3 per cent increase for employees under the Queensland Public Health Sector Certified Agreement—an extra $466 million.

Queensland Health will move away from the restrictive and centralised decision-making processes that currently exist. A flexible, easy to understand employment and industrial relations system that facilitates local decision-making is the goal.

The government and its agencies will work with employees to position Queensland's healthcare system to meet demands. There will be a simplified award system for health employees; one that protects the wages and conditions of workers; and where only one set of conditions applies to each category of employee.

Today, there are nine awards, six agreements and 189 human resources policies, covering more than 80 000 health staff. Complexity creates duplication and unnecessary disputes that impede productivity and flexibility. Currently, employees doing similar work at the same level of classification are subject to different pay rates, allowances and conditions because of historical quirks within award coverage.

The use of awards to cover senior roles will end. For professional categories of employment awards, they impose restrictive and outdated conditions that were eliminated in the private sector long ago. Consistent with best practice employers, flexible, simplified employment contracts will be become the norm in the public healthcare sector.

The productivity of the medical workforce will be improved through best use of expertise and skills. Queensland needs highly skilled clinicians, nurses and allied health professionals, to provide services and to reach their full potential in a flexible industrial environment.

In remote areas and in other critical settings, a flexible workforce model can enable highly-skilled advanced practice nurses to provide services that meet community needs. Appropriately trained nurses can be employed in procedures, such as endoscopy, to help reduce waiting lists for patients.

Awards and agreements

Our workforce awards and agreements are unnecessarily complex. The combination of nine awards and six enterprise agreements results in a possible 24 000 permutations of payments, which have to be processed each and every pay run.

For example, 32 000 nurses are covered by one award which contains six separate sets of conditions. Two nurses, working side-by-side, doing the same thing can take home different pay.

Nurses who work at Baillie Henderson in Toowoomba are on a different set of conditions to nurses who work in the Toowoomba Hospital. Many staff need to work in both areas—creating an administrative nightmare for managers.

Administration staff working in corporate office are employed under the Public Service Award, whereas administration staff in HHSs are employed under the District Health Services Award. The awards contain different pay levels and hours of work. There is regular movement between the areas and this causes an unnecessary administrative burden.

In the administration stream, employees over the level of AO8 are no longer subject to award conditions and do not receive overtime for any extra hours or weekend work. Their wage level is up to $115 000 per year. Our senior doctors are earning in excess of $300 000 per year, many earn a lot more, and they are still covered by an award and receive overtime payments and allowances in a system that is meant to benefit lower paid workers.

Health and medical research

Queensland Health acknowledges the major public benefit of research undertaken in public health organisations. Research leads to better healthcare practices, less disease and improvements to quality and longevity of life. It also helps to tackle the burgeoning pressures facing the public healthcare sector.

To ensure a strong and vibrant research base, the best and brightest innovators will be supported through the Office of Health and Medical Research. Support for our Senior Clinical Research Fellowships will be retained.

Specialised services will be contracted to identify and commercialise intellectual property generated within Queensland research hospitals. Our research hospitals will be required to articulate their investment strategy for research so that it integrates with the clinical environment to improve clinical outcomes.

Established in 1945 by the Queensland Government, the Queensland Institute of Medical Research (QIMR) is one of the largest and most successful medical research institutes in Australia, and is recognised worldwide for the quality of research, both fundamental and translational.

1950s—tropical diseases studied

1963—Ross River fever discovered

1968—discovery that the Epstein-Barr Virus (which causes glandular fever) can immortalise white blood cells. These cells can then be used for an endless source of DNA and is now performed thousands of times a day, all over the world

1970s—research into melanoma begins

1990s—cancer research accelerates

2009—two new genes discovered that together double a person's risk of developing melanoma

2011—discovery of two new genes linked to glaucoma which opens the pathway to developing completely new ways of treating glaucoma patients that could delay disease progression and prevent blindness.

An Australian first initiative, Translational Research Institute (TRI) brings together four leading research institutes and a co-located biopharmaceutical manufacturer to discover, produce, test and manufacture new treatments and vaccines in one location.

Combining the research intellect of The University of Queensland, Queensland University of Technology, Mater Medical Research Institute and Queensland Health together with Biopharmaceutical Australia's (BPA) facility operated by DSM Biologics, TRI represents the future of excellence in biomedical research in Australia.

TRI's capacity to translate potential treatments into therapeutic solutions will directly result from the collaborated research of over 650 researchers, made possible through funding from the Australian and Queensland Governments, The Atlantic Philanthropies, The University of Queensland and Queensland University of Technology. The benefits of TRI are:

- local investment and commercialisation of Australian medical breakthroughs
- shorter time to market of laboratory discovery to practical treatments and therapeutics
- long-term development for the Australian medical and research industries
- synergistic collaboration through disease-focussed global research networks of clinicians and researchers
- better health for the global community, courtesy of new medical treatments and therapeutics.

Non-commercial activities in public health, health services research and hospital services will also be supported to improve efficiency and reduce the cost of clinical care. This blueprint recognises that the vast repositories of clinical and workforce data held in Queensland provide new ground for further strategic research. The government will encourage health researchers to express their interest in using this data.

To make sure conditions are right to attract private sector research investment into the state, clinical trials processes will continue to be strengthened. The approach to bio-banking (through existing stores of biological samples) will be coordinated to reduce red tape for researchers investigating the next best health treatments.

Enabling technologies

To improve the efficiency and effectiveness of the healthcare system and to ensure patients have the best available treatment, clinicians need access to patient information that is accurate and timely.

Today the information and communications technology (ICT) systems of Queensland Health are inadequate to fully support clinicians and help patients. In the past, systems have been created or purchased with little regard to value for money and measureable benefits for clinicians and patients.

ICT systems need to be improved and integrated to provide the government with value for money and benefits that are clearly articulated. New ICT projects will be closely scrutinised and managed.

Program governance, monitoring, oversight and benefit realisation for major ICT projects will be strengthened. But ICT systems will not be funded unless clear benefits can be articulated and measured.

The obligation of Queensland Health is to deliver the best ICT infrastructure in a highly competitive environment where uneven technology and problematic linkages to other jurisdictions are among current difficulties.

The core challenge is to advance reliable support for our staff and our patients through a trusted and reputable integrated system.

A review of the department's Health Services Information Agency to ensure that procurement processes are open and transparent and the most appropriate governance arrangements are in place has commenced.

Infrastructure and assets

Current and future infrastructure development, assets and capital works projects will be tailored to suit service delivery to local communities through HHSs. ICT infrastructure will be incorporated into works for new projects or major refurbishments to maximise operational effectiveness and cost efficiency.

There is a growing body of evidence that the cost of delivering public sector infrastructure is significantly higher than similar works in the private sector.

A total of $1.886 billion will be invested in health infrastructure and capital grants projects in 2012–2013. Of this amount, approximately five or six per cent will be delivered by government agencies. The great majority will be provided through arrangements with the private sector.

Gold Coast University Hospital

To ensure the uniform and robust treatment of new health business opportunities involving the private and non-government sectors, the Ministerial Health Infrastructure Council will serve as a new portal for contact with project proponents.

Modern infrastructure standards that are practical and flexible will be maintained to support the delivery of innovative clinical services, research and education. Hospital projects, such as the Gold Coast and Sunshine Coast University Hospitals, will be delivered at the lowest cost while preserving longevity.

Expressions of interest will soon be called for the redevelopment of the Royal Children's Hospital site.

A focus on improving the business processes and efficiency of health services also extends to how assets are being used. For example, across Queensland, public hospital parking arrangements are failing to provide efficient and equitable hospital access for patients, visitors and staff. A statewide assessment of hospital car parking arrangements is underway.

Consultation with HHSs will determine local needs and the best ways to improve current business models and access to facilities.

The government will improve and upgrade previously neglected health facilities in regional and remote areas, including the Atherton, Sarina, Emerald and Thursday Island hospitals, and attend to the degraded foundations of block C at Mount Isa Hospital. An extra 84 beds will be delivered at Ipswich Hospital. At Cairns, additional funding of $15 million over four years will enable the recruitment of specialists to revitalise frontline services.

Artist impression of the Sunshine Coast University Hospital

Ending ambulance bypass: new plan to improve emergency department performance in major Queensland Hospitals

When the report of the Metropolitan Emergency Department Access Initiative (MEDAI) project was tabled by the Minister for Health in Parliament on 2 August 2012, the government pledged full support for its implementation.

MEDAI was initiated to minimise 'ambulance ramping' and improve patient access to emergency departments (EDs) in Queensland metropolitan hospitals.

MEDAI involved staff from Hospital and Health Services (HHSs) and Queensland Ambulance Service (QAS) in a quest for recommendations based on mutual agreement.

The report found:

- internal hospital processes for the management of ED capacity issues were inconsistent
- ambulance diversion or bypass was an unacceptable mechanism to manage ED demand
- triage and Patient Off Stretcher Time (POST) varied
- roles and responsibilities between HHS and QAS staff were not clearly defined
- processes for inter-hospital transfers resulted in the inappropriate use of EDs
- HHS/QAS integration in ED planning was inadequate.

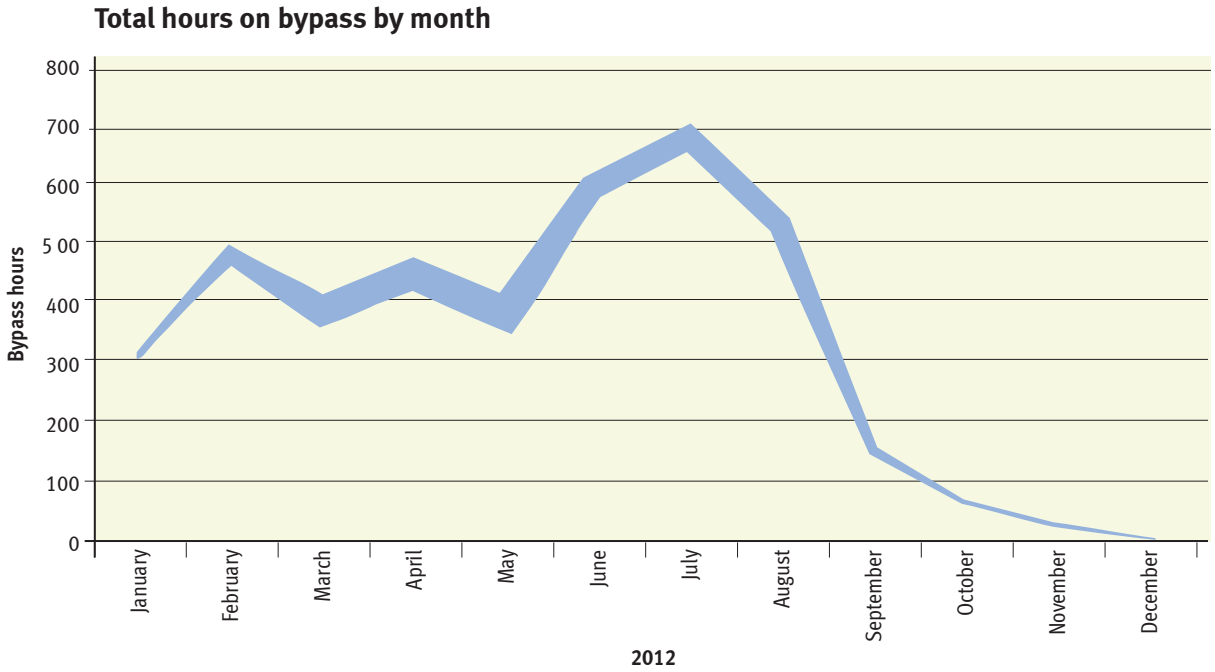
MEDAI listed 15 recommendations to correct deficiencies and an implementation oversight committee was established.

Key corrective work by Queensland Health and QAS includes:

- Health Service Directive banning bypass as a mechanism for managing hospital demand Service protocols have been developed including *Capacity Escalation Response Protocol, Patient Off Stretcher Time (POST) Protocol, Inter Hospital Transfers (IHT) Protocol* and Guideline for the Implementation of the Clinical Initiatives Nurse Role in Emergency Departments
- QAS and the department now provide local and statewide input to improve their communications interface
- Improved education clarifying roles and responsibilities between QAS and triage staff
- Information technology under development to enable real-time reporting of POST times.

The most recent POST data shows a steady improvement in performance. In six months from July 2012, the proportion of patients transferred off-stretcher within 30 minutes has improved from 75 per cent to 86.3 per cent.

Ending ambulance bypass



In line with the MEDAI report on emergency department access, the government imposed a ban on the practice of ambulance bypass. The ban was implemented first in the Metro South Hospital and Health Service in October 2012. The ban took effect statewide from 1 January 2013.

section five

Queensland's Hospital and Health Services

Hospital and Health Service	Chair
Cairns and Hinterland	Mr Robert Norman
Cape York	Ms Louise Pearce (Acting)
Central Queensland	Mr Charles Ware
Central West	Mr Edward Warren
Children's Health Queensland	Ms Susan Johnston
Darling Downs	Mr Mike Horan
Gold Coast	Mr Ian Langdon
Mackay	Mr Colin Meng
Metro North	Dr Paul Alexander AO
Metro South	Mr Terry White AO
North West	Mr Paul Woodhouse
South West	Dr Julia Leeds
Sunshine Coast	Emeritus Professor Paul Thomas AM
Torres Strait–Northern Peninsula	To be announced
Townsville	Mr John Bearne
West Moreton	Dr Mary Corbett
Wide Bay	Mr Gary Kirk

Hospital and Health Services by Queensland Health Facilities

6 How is my hospital and health service performing?

The government will hold Hospital and Health Services (HHSs) accountable for their performance.

Through a robust performance management and reporting framework, HHSs will be recognised for excellence, and poor performance will be addressed in a timely way.

Regular monitoring and assessment of performance against clearly identified targets will mean that local communities will be able to hold their HHS to account.

All Hospital and Health Boards will publically report on six statewide targets on a quarterly basis from 1 July 2013.

Shorter stays in emergency departments

Reducing the length of time Queenslanders spend in emergency departments is shown to improve the patient journey and experience, reduce delays and increase access to services, and ensure best clinical practice. Through 2013, Queensland emergency departments are aiming for 77 per cent of patients to have departed the ED within four hours of their arrival.

Hospital and Heath Service	2012 quarter performance Jul–Sep	Oct–Dec
Cairns and Hinterland	58%	70%
Central Queensland	76%	78%
Children's Health Queensland	85%	88%
Darling Downs	64%	73%
Gold Coast	58%	68%
Mackay	74%	79%
Mater Health Services	70%	74%
Metro North	54%	63%
Metro South	58%	67%
North West	86%	87%
Sunshine Coast	66%	73%
Townsville	64%	71%
West Moreton	61%	82%
Wide Bay	78%	79%
All HHSs	**64%**	**72%**

Percentage of emergency department patients whose length of stay in ED was within four hours.

Shorter waits for elective surgery

Elective surgery patients are categorised according to the urgency of their treatment. It is clinically recommended that Category 3 patients are treated within 12 months to optimise their clinical outcome. Through 2013, Queensland public hospitals are aiming for 94 per cent of Category 3 patients to have their surgery within 12 months from being wait-listed.

Hospital and Heath Service	2012 quarter performance Jul–Sep	Oct–Dec
Cairns and Hinterland	71%	84%
Central Queensland	100%	100%
Children's Health Queensland	100%	100%
Darling Downs	74%	82%
Gold Coast	98%	94%
Mackay	98%	88%
Mater Health Services	99%	99%
Metro North	86%	75%
Metro South	87%	85%
North West	100%	100%
Sunshine Coast	94%	93%
Townsville	60%	65%
West Moreton	68%	61%
Wide Bay	82%	81%
All HHSs	**89%**	**88%**

Percentage of Category 3 elective surgery patients treated whose waiting time was within 12 months.

Shorter waits for specialist outpatient clinics

Patients referred to a specialist clinic in a public hospital are categorised according to the urgency of their need.

It is clinically recommended that Category 3 patients are seen by a specialist within 12 months. Queensland public hospitals are aiming for 90 per cent of Category 3 patients to be seen within 12 months from the time they were referred.

Hospital and Heath Service	2012 quarter performance Jul–Sep	Oct–Dec
Cairns and Hinterland	70%	67%
Central Queensland	61%	75%
Children's Health Queensland	58%	67%
Darling Downs	45%	48%
Gold Coast	57%	55%
Mackay	54%	59%
Metro North	55%	45%
Metro South*	44%	45%
North West	58%	53%
Sunshine Coast	55%	54%
Townsville	50%	46%
West Moreton	62%	67%
Wide Bay	52%	49%
All HHSs	**52%**	**53%**

Percentage of Category 3 specialist outpatients waiting for their first appointment whose waiting time was within 12 months.

*Excludes Princess Alexandra Hospital

EXHIBIT 43

MSS.900.0002.0150

These six targets, along with those identified at a national level, will form a key part of the service agreement between Queensland Health and each HHS.

Not all hospitals are required to report on data so some HHSs may not be included in the data sets. In addition, some of the data sets are not applicable to certain HHSs, for example there are no babies born at Children's Health Queensland.

Increased support for families with newborns

More parents of newborns are supported by a home visiting program in the first month following birth.

All families will be able to access two home visits and four community clinic consultations with an experienced maternal and child health professional during their baby's first year of life.

Hospital and Heath Service	July 2011–June 2012
Cairns and Hinterland	2328
Central Queensland	1066
Central West	76
Darling Downs	1547
Gold Coast	3405
Mackay	1559
Metro North	6004
Metro South	10 877
North West	283
Sunshine Coast	1065
South West	131
Townsville	4505
West Moreton	2283
Wide Bay	2336
All HHSs	**37 182**

Number of in-home visits by an experienced maternal and child health professional.

Fewer hospital acquired infections

We are working hard to to reduce all hospital acquired infection rates in public hospitals. Infection rates are routinely collected in reporting hospitals as part of infection control surveillance in Queensland. Where there are multiple reporting hospitals within a service the results have been combined, and individual hospital rates can be found on the MyHospitals website.

Hospital and Heath Service	2012 quarter performance: Jan–Mar SAB Rate	Apr–June SAB Rate
Cairns and Hinterland	0.82	0.27
Central Queensland	0	0.41
Children's Health Queensland	1.68	1.57
Darling Downs	0.43	1.21
Gold Coast	0.67	0.57
Mackay	1.21	0
Mater Health Services	0	0
Metro North	0.96	1.1
Metro South	1.12	1.75
North West	0	0
Sunshine Coast	0.26	0.74
Townsville	1.43	1.03
West Moreton	0.37	0.38
Wide Bay	0.83	1.89

Healthcare associated Staphylococcus aureus (including MRSA) infections/10 000 acute public hospital patient days.

Better value for money

We are working to create better value for money in healthcare. A standard national measurement provides a way of comparing each HHS' average cost for admitted patient services. The table below lists the average cost for admitted patient services in the cost column. These figures have then been compared to the national average of $4141, which will be the target for each HHS. It also shows the percentage difference between the national average and each HHS' average costs.

Hospital and Heath Service	$ cost	Percentage difference
Cairns and Hinterland	4,025	-2.8
Central Queensland	4,560	10.1
Children's Health Queensland	4,650	12.3
Darling Downs	4,600	11.1
Gold Coast	4,633	11.9
Mackay	5,147	24.3
Metro North	4,887	18.0
Metro South	4,644	12.1
North West	5,129	23.9
Sunshine Coast	4,396	6.2
Townsville	4,251	2.7
West Moreton	4,175	0.8
Wide Bay	4,517	9.1
State average	**4,614**	**11.4**

Based on national weighted activity units (NWAUs)—a measure of health service activity expressed as a common unit. It provides a way of comparing and valuing hospital services. Figures are derived from unpublished estimates by the Independent Hospital Pricing Authority (IHPA) and relate to acute admitted patients only. Expenditure data derived by IHPA from several sources, including National Hospital Cost Data Collection (NHCDC) and National Public Hospital Establishments Database (NPHED).

Glossary of terms

AM	Member of the Order of Australia
AO	Officer of the Order of Australia
BPA	Biopharmaceutical Australia
CMC	Crime and Misconduct Commission
ED	Emergency department
GP	General practitioner
HHS	Hospital and Health Service
ICT	Information and communications technology
IHPA	Independent Hospital Pricing Authority
IHT	Inter hospital transfers
MEDAI	Metropolitan Emergency Department Access Initiative
MRSA	Methicillin Resistant Staphylococcus aureus
NEAT	National emergency access target
NEST	National elective surgery target
NHCDC	National Hospital Cost Data Collection
NPHED	National Public Hospital Establishments Database
NWAUs	National weighted activity units
POST	Patient off stretcher time
QAS	Queensland Ambulance Service
QC	Queen's Council
QIMR	Queensland Institute of Medical Research
TRI	Translational Research Institute
TS–NP HHS	Torres Strait–Northern Peninsula Hospital and Health Service

EXHIBIT 43

MSS.900.0002.0152

David Crompton

From: David Crompton
Sent: Wednesday, 7 August 2013 11:16 AM
To: Dianne Bickhoff
Subject: Fwd: progression of the Barrett Adolescent Strategy
Attachments: WMHHS-CHQ BAC 130805.pdf; FAQ BAC.pdf; Expert Clinical Reference Group Recommendations July 2013.pdf

As discussed

Executive Support for Associate Professor David Crompton, Executive Director
Metro South Addiction and Mental Health Services
Metro South Hospital and Health Service
www.health.qld.gov.au/metrosouthmentalhealth

Po Box 6046, Upper Mt Gravatt, QLD 4122

>>> Sharon Kelly 7/08/2013 11:11 am >>>
Good morning,

I wish to provide you with further information in regards to the progression of the Barrett Adolescent Strategy following announcements last evening.

The West Moreton Hospital and Health Board considered the documentation put forward by the Planning Group in May 2013 and all seven recommendations made by the Expert Clinical Reference Group (ECRG) with the additional comments from the planning group were accepted. Further key stakeholder consultation was then conducted with the Department of Health, the Queensland Mental Health Commissioner, the Department of Education Training and Employment, and Children's Health Queensland.

The work of the ECRG, the Planning Group and the subsequent consultation process has enabled us to progress the Strategy to the next phase. As identified in an announcement yesterday, adolescents requiring extended mental health treatment and rehabilitation will receive services through a new range of contemporary service options from early 2014. Young people receiving care from Barrett Adolescent Centre at that time will be supported to transition to other contemporary care options that best meet their individual needs.

Importantly, our goal in West Moreton Hospital and Health Service continues to be to ensure that adolescents requiring mental health extended treatment and rehabilitation will receive the most appropriate care for their individual needs. We will also continue to provide information and support as needed to staff at the Barrett Adolescent Centre. The transition process will be managed carefully to ensure that there is no gap to service provision.

For further information about Barrett Adolescent Centre and the planning for new statewide service options in adolescent mental health extended treatment and rehabilitation, please find attached a media statement, a copy of the ECRG recommendations submitted to the West Moreton Hospital and Health Board, and a FAQ sheet.

If you have any further queries, please do not hesitate to contact me on

[redacted]

Regards
Sharon
Sharon Kelly
Executive Director
Mental Health and Specialised Services

West Moreton Hospital and Health Service

[redacted]

The Park - Centre for Mental Health
Administration Building, Cnr Ellerton Drive and Wolston Park Road, Wacol, Qld 4076
Locked Bag 500, Sumner Park BC, Qld 4074

www.health.qld.gov.au

EXHIBIT 43

MSS.900.0002.0154

File

Queensland Government
Queensland Health

MEMORANDUM

To: Dr David Theile, Clinical CEO, Metro South

Ms Pam Lane, Clinical CEO, Darling Downs-West Moreton

Copies to: Dr David Crompton, A/Chair Metro South Health Service District

Dr Bill Kingswell, Executive Director Mental Health, Southside Health Service District

Ms Monica O'Neil, A District Director Mental Health Services, West Moreton-South Burnett

From: Dr Aaron Groves, Senior Director, Mental Health Branch

Contact No:
Fax No:

Subject: Adolescent Extended Treatment- Site Selection

File Ref:

ACTIONS:

- It is recommended that the District CEOs provide preliminary endorsement of the recommendation of the Site Evaluation Subgroup to redevelop the Barrett Adolescent Centre (BAC) at the site identified adjacent to Redland Hospital outlined in the *Report of the Site Evaluation Subgroup.*
- It is further recommended that the District CEOs provide the Site Evaluation Subgroup with the authority to consult with sector stakeholders on the preferred option. Feedback gathered in the course of consultation will be provided to the District CEOs to inform their final decision on site selection.

BACKGROUND:

The replacement of the BAC is one of 17 capital works projects associated with the *Queensland Plan for Mental Health 2007-17*, and is identified in the *Outline of the 2007-08 State Budget Outcomes for Mental Health.*

An initial working group was formed comprising staff members involved in the existing BAC and Project Services architects to consider the redevelopment of the unit and provide advice on the service model and design specification.

Making a determination about a preferred location for the unit is contentious and likely to be subject to public scrutiny.

A previous attempt to close the unit was strongly resisted by staff, consumers and carers.

This redevelopment of the unit at an alternate site should not be resisted as strongly as closure, but may still attract adverse comment.

Redevelopment on the existing site is problematic for a number of reasons outlined in the site options paper, primarily its collocation with forensic services for mentally ill offenders.

The "Site Evaluation Sub Group" was convened on the advice of the Area General Managers to provide advice on site options identified by Area Health Services.

The consensus of the Site Evaluation Subgroup is that a vacant site adjacent to Redland Hospital constitutes the most appropriate option for the redevelopment of the unit.

The Executive Director of Capital Works and Asset Management Branch has provided in principle support for this proposal.

The group has identified a number of challenges associated with the implementation of this option that are likely to become clearer during the course of consultation including:

- planning for the relocation of services from a human resource perspective;
- establishing governance arrangements for the service and in particular its relationship with Metro South and or the Queensland Children's Hospital; and
- negotiation with Education Queensland regarding the operation of the school at the preferred location.

Consultation is planned to occur with the following:

- existing staff and consumers and carers of BAC;
- the Child and Youth Mental Health subgroup; and
- the Child and Youth Inpatient Design reference group.

Following further consultation and the final selection of an appropriate site by the CEOs, a local user group will be formed to manage the project.

Dr Aaron Groves
Senior Director, Mental Health Branch
28/10/2008

EXHIBIT 43

MSS.900.0002.0156

Queensland Government
Queensland Health

Mental Health Plan Implementation Team
Mental Health Branch
Division of the Chief Health Officer
12th Floor, Forestry House
160 Mary St,
Brisbane Qld 4000

Report of the site evaluation subgroup

Site Options Paper for the redevelopment of the Barrett Adolescent Centre

October 2008

TABLE OF CONTENTS 2

Executive Summary

The Queensland Plan for Mental Health 2007-2017 provides significant funding to support mental health service improvement and reform. The plan includes investment in new and upgraded inpatient services.

This report of the Site Evaluation Subgroup includes an appraisal of the options explored for the redevelopment of the Barrett Adolescent Centre (BAC).

At the request of the Area General Managers of the former Southern and Central Area Health Services, the following sites were considered as options for the redevelopment of the BAC:

- Rogers Street Spring Hill;
- CAFTU- RBH;
- Land adjacent to Redland Hospital;
- Meakin Park – 3 km from Logan Hospital Site (precise land parcel unknown- assume bushland between Queens Rd and Beal St); and
- The Park Centre for Mental Health (3 site options on campus considered).

The report finds Redland and The Park as the only architecturally viable options if the service is to be redeveloped as currently envisaged.

It identifies redevelopment at Redland as the preferred option.

The report identifies the need for further consultation on this option with the current Barrett service providers, consumers, carers and the broader Child and Youth Mental Health Sector to inform a final decision.

The Barrett School is a critical component of the service and must be included in the redevelopment of the service at any site. Therefore, negotiation with the Department of Education, Training and the Arts is required in the process of deciding the preferred option.

A final decision for the service location will be made by the District CEOs of Metro South and Darling Downs West Moreton Health Service Districts. It is recommended that the District CEOs provide the Site Evaluation subgroup with the authority to consult these relevant stakeholders on the preferred option. Subject to approval consultation could consider the following identified issues:

- Review of transport options, including duration and cost of journeys. A comparison of the accessibility of the sites particularly for consumers accessing the day program and for consumers and carers travelling from rural, regional and remote areas who require the service.
- Consideration of the impact of the surrounding built environment at Redland. This should take account of the surrounding bushland and include some consideration of risk management strategies associated with bushfires, wildlife and proximity to other infrastructure including the sewage treatment plant.
- Further analysis of the impact of the built environment at The Park and associated risk management strategies. This may include consideration of the implications of having vacant buildings on the site. It could further identify the challenges and opportunities associated with the proximity of the service to the new Police Academy site.
- Further consideration of the cost and time implications should a staged redevelopment at the existing site be pursued.
- Consultation with police to establish whether Redland site may subject the unit to risk from 'undesirable persons' and consideration about how such a risk might be managed.
- Consideration of the implications of the implementation of the Clinical Services Capability Framework (CSCF) and the assignment of a level to the service. In particular, this may further clarify the specialised requirements of the unit including the need for specialist human resources and the advantages of being co-located with 24 hour medical care.

- Further clarification of plans for service expansion in the second half of the plan to provide 5 additional beds for the adolescent unit in the development of step down units and further consideration of accommodation options for family and carers.
- Clarifying the governance arrangements should the unit be located at Redland. In particular the service's reporting relationships to Metro South and/or the Queensland Children's Hospital.
- Further examination of the potential advantages of co-locating the service near the Brisbane Youth Detention Centre at Wacol, Child and Youth Forensic Outreach Service (CYFOS), Mental Health Alcohol Tobacco and Other Drugs Service (MHATODS) given the overlap of demographics and some characteristics of clients seen by each of these services. This requires some consultation with MHATODS and CYFOS to determine whether co-location of this kind is consistent with the service development intentions of these services.

It is proposed that the Site Evaluation Subgroup report on the outcome of this consultation to the District CEOs to support a final decision concerning the site for redevelopment of the Centre.

Dr Aaron Groves
Senior Director, Mental Health Branch
28/10/2008

Introduction

The purpose of this paper is to support decision making associated with the selection of a site for the replacement of the Barrett Adolescent Centre (BAC).

It considers the sites below, which were identified by Area Health Services as potentially suitable for replacement of the centre:

- Rogers Street Spring Hill
- CAFTU- RBH
- Redland Hospital
- Meakin Park – 3 km from Logan Hospital Site (precise land parcel unknown- assume bushland between Queens Rd and Beal St)
- The Park Centre for Mental Health (3 site options on campus considered)

The report includes:

- a brief description of the project;
- a summary of the model of service for BAC;
- a description of site requirements and;
- a site appraisal of the two architecturally viable sites- prepared by Project Services.

Appendix One includes the rationale for finding two of the three site options at The Park, CAFTU and Rogers Street to be architecturally unviable. Advice from Southside Health Service District subsequent to the site options tour indicated the option at Logan was no longer available or viable; therefore an appraisal of this site has not been undertaken.

Appendix Two is a collection of 'Site Tour Notes' providing a summary of some of the key issues considered by Site Evaluation subgroup during site visits by the subgroup on 5 August 2008.

The report identifies the need for further elaboration of some of the challenges and opportunities of the two architecturally viable sites to support a final decision concerning the redevelopment of the unit.

The report concludes that Redland appears to be the preferred option for the redevelopment of the service subject to further consultation with the sector.

1. Project Description

Replace Barrett Adolescent Centre with a new 15 bed adolescent extended treatment unit.

Background:

- Decision concerning the location for the redevelopment of the Adolescent unit is contentious
- Redevelopment at The Park is problematic because of the expansion of forensic services being undertaken on the site
- This expansion includes the development of a further 40 extended treatment forensic beds over the next 10 years
- Advantage of the current site is the existing service with highly skilled staff.
- No optimal location for the unit identified by Child and Youth clinicians
- "Site Evaluation Sub Group" established to assist in determining an appropriate site for the unit at the direction of the Area General Managers (participants identified below)
- Subgroup reviewed the site selection criteria and accommodation schedule produced by Project Services in collaboration with BAC staff
- Ranking of site selection criteria reviewed
- Scope for reducing footprint identified in accommodation schedule
- Alternate sites identified in discussion with Area Health Services
- Sub Group visited the following sites on 5 August 2008:

Rogers Street Spring Hill

CAFTU- RBH

Redland Hospital

Meakin Park – 3 km from Logan Hospital Site (precise land parcel unknown- assume bushland between Queens Rd and Beal St)

The Park Centre for Mental Health (3 site options on campus considered)

- Sub Group agreed to consider the site options on the basis that they may:
    - serve the clinical objectives of the service
    - satisfy the criteria nominated in the 'Site Selection Criteria'
    - meet the design requirements identified in the accommodation schedule

Participants:

Ms Denisse Best	Executive Director	Child & Youth Mental Health Service, Royal Children's Hospital & Health Services Districts, Chair Child & Youth Sub Group
Mr Kevin Fjeldsoe	Director	Mental Health Plan Implementation Team
Dr Trevor Sadler	Clinical Director	Barrett Adolescent Centre
Dr Brett McDermott	Director	Mater Child & Youth Mental Health Service
Ms Linda Ryan	Principal Project Officer	Southern Area Health Service
Ms Karen Ryan	Manager	Rural Service Planning Unit, Southern Area
Ms Erica Lee	Manager	Child and Youth Mental Health Service
Mr Paul Clare	Principal Project Officer	Mental Health Plan Implementation Team
Mr John Quinn	Manager	Mental Health Plan Implementation Team
Ms Jenny Stone	Assistant Director	(Southern) Program Coordination Unit LWAMB
Mr Chris Hollis	Network Coordinator	Mental Health - Central Area
Mr Mark Wheelehan	Area Team Leader	Central Area
Ms Elisabeth Roberts	Principal Project Officer	Southern Area

Additional invitees to site options tour:

Dr Terry Carter	Project Manager,	Mental Health Capital Works Program
Mr David Pagendam	Senior Architect	Project Services
Ms Karen Reidy	Architect	Project Services

Apologies for the site tour:

Dr Bill Kingswell	Director	Mental Health Services - Logan
Ms Karen Ryan	Manager	Rural Service Planning Unit, Southern Area
Mr Chris Hollis	Network Coordinator	Mental Health - Central Area
Mr Mark Wheelehan	Area Team Leader	Central Area
Ms Elisabeth Roberts	Principal Project Officer	Southern Area
Mr David Pagendam	Senior Architect	Project Services

2. Brief Summary of the Adolescent Extended Treatment Model of Service

Service integration

The Adolescent Extended Treatment and Rehabilitation Service is an integral part of Child and Youth Mental Health network of services in Queensland. Child and Youth Mental Health Services (CYMHS) include:

- community clinics throughout Queensland
- specialised therapeutic services to children and adolescents in the care of the Department of Child Safety (Evolve teams)
- acute inpatient services in Metro South, Metro North, Mater and Gold Coast Health Districts
- a day program at the Mater Children's Hospital, with proposals to develop further day programs at Townsville and the Sunshine Coast.
- a Child and Youth Forensic Outreach Service (CYFOS)
- a visiting service to the Brisbane Youth Detention Centre

An adolescent of high school age is referred to the Adolescent Extended Treatment and Rehabilitation Service if severe mental illness and impairment persist after extended treatments in one or more of these other settings. It is both a tertiary and quaternary referral service, depending on the severity and complexity of illness and range of settings for intervention prior to referral. Referrals are accepted from throughout Queensland. On occasions it is appropriate to accept referrals from northern New South Wales and the Northern Territory. Referrals may also be made by private child and adolescent psychiatrists or psychologists.

Adolescents usually will be placed on the waiting list, and managed by the referring service until admission is possible. Throughout the admission, ongoing linkages with the referrer will occur via videoconference and case management.

It is proposed that the Adolescent Extended Treatment and Rehabilitation Service be a Level 6 service in the Clinical Services Capability Framework being developed by the Mental Health Branch.

Target population:

Adolescents accepted for referral have severe, persistent, co-morbid mental illnesses associated with a range of impairments. Mental illnesses most commonly diagnosed include:

- depression
- eating disorders
- social and other anxiety disorders
- obsessive compulsive disorder
- dissociative disorders

- post traumatic stress disorder
- psychotic disorders
- organic disorders
- co-morbid disorders of development

The Health of the Nations Outcome Scale for Children and Adolescents (HoNOSCA) is an assessment tool used by mental health services across Australia to assess levels of symptom severity, impairment and family function. Compared with the national average of those admitted to acute adolescent inpatient units, those admitted to the Adolescent Extended Treatment and Rehabilitation Service show similarly high levels of symptoms and acuity (e.g. emotional distress, self harm, perceptual disturbances), but significantly higher levels of impairment (e.g. schooling, self care, peer relationships, impaired concentration) and family dysfunction.

Treatment of many disorders requires the active participation of the adolescent. Frequently they are not contemplating change, but continue with an illness seriously affecting health and their functioning. Both symptom severity and impairment are likely to persist for decades into adult life without adequate intervention.

Service description:

The core of the service is the provision of a wide range of intensive interventions for integrated treatment and rehabilitation. (Unlike many areas of physical medicine in which there is a definitive treatment followed by rehabilitation, effective outcomes in adolescent mental health require an integrated approach to treatment and rehabilitation over months.)

Core approaches to treatment and rehabilitation include:

- utilising standard biological mental health treatments (medication, ECT), although the effectiveness of these is limited
- utilising a wide range of psychological interventions for adolescents with often limited verbal skills and limited understanding of psychological issues
- utilising a wide range of life skill and activity based interventions to address developmental tasks in both treatment and rehabilitation
- providing of a range of comprehensive education and pre-vocational activities through the Department of Education, Training and the Arts
- continuing support of, liaison with and therapy for the family
- maintaining strong community linkages
- safely managing a range of life threatening behaviours
- effectively managing a range of dysfunctional behaviours
- maintaining a ward environment which promotes therapeutic interactions

Depending on levels of acuity and impairment, adolescents access this program at a number of levels:

- as inpatients (full or partial hospitalisation) for those with high to extreme levels of acuity and severe impairment. Up to 15 beds are available for this purpose.
- as day patients for those with severe impairment but lower acuity for those who can access the service.

A comprehensive extended treatment and rehabilitation program for a Statewide service would also include:

- a therapeutic residential unit for those who have severe levels of impairment, low to medium levels of acuity and cannot access the service as a day patient
- a transitional residential facility (step-down) service for those who have moved from high to lower levels of acuity, continue to have moderate to severe impairment, and cannot return to their family home.

- a family stay residential facility to provide intensive family interventions or family interventions with adolescents with extreme acuity.

Legislative framework and Policy Directions:

In common with other Mental Health Services in Queensland,

- adolescents are admitted either as voluntary patients or under the Mental Health Act.
- consumer, and where possible, carer participation is essential to providing service.
- a Recovery framework is clearly articulated, although it differs in concept to adult mental health services.
- adolescents are managed in the least restrictive manner appropriate to safety. (This creates challenges on an open unit.)
- minimising seclusion and restraint is associated with better outcomes, but requires more intensive staffing.
- outcomes are routinely measured utilising a nationally standard suite of scales - the HoNOSCA, Children's Global Assessment Scale (CGAS) and Factors Influencing Health Scale (FIHS).

Pathways of service delivery once admitted

Transfer

- acute medical management at local general hospital occurs at regular intervals.
- rarely acute psychiatric care at referring acute unit may be required.

Discharge

- intensive discharge planning requires considerable integration with the local community of origin (including local schools)
- the adolescent often transitions from full inpatient admission to periods of partial hospitalisation prior to discharge.
- the lack of appropriately supervised accommodation in the NGO sector is a problem for adolescents who cannot return to their family of origin.
- remoteness of referring services makes follow up referral linkage sometimes difficult to sustain
- occasionally it is difficult to access support in adult mental health services if the adolescent requires further long term treatment.

Managing risk

Managing self harm, suicide attempts, absconding and aggression are major risk issues in patient safety in both adolescent and adult sectors. However, there are particular issues in the genesis and management of these risks in adolescents.

- adolescents do not often possess good verbal skills and their distress is manifest instead in a range of behaviours
- adolescents generally are fitter and have fewer problems with mobility (whether secondary to the type of illness or medications). This enables them to abscond.
- adolescents are more likely to encourage a peer to join them in absconding or to copy another with self harm – the so called "contagion effect".
- adolescents are more sensitive to adverse changes in the family environment. Although distant, this may be a potent effect on behaviours within the unit.
- adolescents are often more impulsive, especially in relation to negative life events to which they are more sensitive.
- adolescents have less experience at assessing safety in the community

- adolescents are more likely to react negatively to a perceived closed environment than an open one. There is a complex interaction between built environment and safety which will be described in the next section

Staffing structure and composition:

- Intensive levels of staffing required for intensive interventions and high levels of acuity
- Staff must have training and/or substantial experience in child and adolescent mental health
- Specialist skill sets in a range of psychological, activity based and life skills interventions required
- Clinical and educational multidisciplinary bio psycho social approach
- Maintenance of ongoing professional development and supervision of staff required
- Range of resources to support the necessary range of interventions

Performance, quality and safety:

- consumer and carer satisfaction
- ongoing workplace health and safety monitoring due to nature of service
- outcomes monitoring

3. Site Requirements

THE IMPACT OF BUILT ENVIRONMENT AND EXTENDED ADOLESCENT TREATMENT

1. The Rationale to Develop Guiding Principles for the Built Environment

Adolescents admitted to the Extended Treatment and Rehabilitation unit are likely to spend up to twelve months or more in hospital. (Hospital is acknowledged to be the most restrictive setting in mental health.) About half will at some stage be on an Involuntary Treatment Order. Initially most adolescents do not contemplate the need for change. Many adolescents believe they should be independent and exercising freedoms they see in their peers, These factors have the potential to actively work against the fact that most treatments require the active participation of the adolescent. There is considerable potential for adolescents them to react strongly against treatment, the staff and hospitalisation. This is manifest in two of the risk factors associated with the unit – absconding and aggression.

Clearly identifiable factors can minimise these tensions and their attendant risk factors. Broadly they can be divided into staff attitudes/skills and the impact of built environment. Guiding Principles 1 – 3 below have been extracted from surveys of adolescents who have been asked about the impact of the change of environment from the constricted environment of an acute inpatient setting to the more open environment of the extended treatment unit has had on their attitudes to being in treatment.

Built environment also has numerous other impacts:

- Adolescents on admission range widely in their fitness levels, co-ordination abilities and participation in physical activity. Providing for a range of physical activity addresses a number of impaired tasks of adolescent development. (Principles 2 and 3).
- Adolescents interact intensively with a limited range of peers over a long period. Adequate external and internal spaces achieve a balance between privacy and a range of peer interactions. (Principles 2,3 and 6)
- Adolescents can utilise external spaces to help them regulate emotional distress and aggressive impulses. (Principles 1 and 2)
- Many adolescents have had very limited interactions with peers or areas outside their home prior to admission. Time in acute inpatient units is in enclosed environments. It is initially helpful to spend time outside without the feeling of being on view to the public. (Principles 2 and 3)
- A number of adolescents often talk in therapy in an activity in the grounds. They are uncomfortable in a room with the expectation they should talk. (Principle 2)

The built environment must also be considered within the broader context of the neighbourhood in which it is located.

- An open unit offers more chances to abscond. Adolescents are at risk then of mishap from nefarious persons, or from themselves by accessing of heights or other means to attempt suicide. (Principles 4,5)
- It is essential for rehabilitation that community public transport, sporting, community and recreational facilities are available within reasonable distance to prepare an adolescent for integration into their own communities. (Principle 6)
- Either sufficient recreational space and facilities are located within the grounds of the unit, or within close proximity (less than 1 minute) to afford opportunities for acutely unwell adolescents to access these in safety, or for staff return to attend to crises on the unit. (Principle 1, 2 and 6)

2. Guiding Principles

Six Principles can be derived from the above observations to guide the location and design of the Centre.

Principle 1.
Minimising visual restrictions in the environment enable adolescents to cope better with legislative and behavioural restrictions and the restrictions their illness imposes on them.

Principle 2.
The grounds surrounding the building must have sufficient room for multiple purpose activities – recreation, fitness, socialisation, private areas, areas for emotional regulation and areas to enhance therapies to be undertaken safely.

Principle 3.
Adolescents should not feel they are on display to the public, nor should the public have cause to stigmatise the unit.

Principle 4.
The chances of absconding successfully can be reduced by consideration of factors in the immediate neighbourhood of the Unit.

Principle 5.
The chances of an adverse event following an absconding can be reduced by attention to the immediate neighbourhood of the Unit.

Principle 6.
The neighbourhood in which the unit is located should afford opportunities to practice skills for rehabilitation and community integration which can be generalised to the community in which the adolescent lives.

3. Application of the Principals to Design

3.a Characteristics of the Site

3.a.i external views – desirable:

- Sky, trees, distant objects, grass, landscape, sports ovals. (Principles 1,2)
- Sense of distance, calmness more important than people, but distant views of people engaged in gentle activities is desirable. (Principle 1,2)
- Water views a bonus. (Principle 2)

3.a.ii External views – undesirable

- Anything that is too busy or intrusive; buildings. (Principles 1,2 and 5)

3.a.iii Access to natural environment

- Grass, trees, animals, water (as long as it is safe), gardens, getting back to nature. (Principles 1,2)

3.a.iv Access to outdoor activities

- Safe place for walking and riding (not on main roads), playing outdoor games and sports, and just "getting away". (Principles 2, 6)

3.a.v External buffer space and boundaries

- At least 50m away from houses is a minimum to reduce bad interactions with neighbours (both ways). (Principle 3)
- There needs to be clearly defined boundaries but boundaries should be as invisible and unoppressive as possible. (Principles 1,4)
- Good buffer spaces can reduce the need for fences. (Principles 1,4)

3.a.vi Topography

- An elevated site with long views and vistas into the distance is preferable, but the site of the facility must be reasonable level. (Principles 1,2)
- Slopes can be used to hide fences. (Principles 1,4)

3.a.vii Schools

- The facility will have an on-site school which contributes 60% of rehabilitation.

3.a.viii Privacy

- Privacy for the adolescent consumers is important, but the facility should not be too isolated. (Principles 3,6)
- It is desirable for consumers to have opportunities to see people outside, but adolescents should not be "on display". (Principle 3)
- Contact with the public and families needs to be controlled. (Principles 2,3,4 and 5)
- It is important that public thoroughfares do not happen through the facility site. (Principle 3)

3.a.ix Total site area

- 2 Ha preferred area. (Principles 1,2 and 3)
- 1.5 Ha minimum.

3.b. Characteristics of the Immediate Neighbourhood

3.b.i Surrounding built environment

Avoid:-

- High rise and high density buildings. (Principles 1,2 and 5)
- Sites that other buildings look down on. (Principle 3)
- Main roads, railways, and other noisy busy areas. (Principles 3,4 and 5)
- Intimidating or industrial general environment (Principles 2, 3)

3.b.ii Physical hazards

- Avoid bridges, high buildings, cliffs, multi-storey car parks, bridges, main roads, train lines. (Principles 4,5)

3.b.iii Absconding

- A buffer of open space around the facility is important to keep sight of an absconder (Principles 4,5)
- A buffer of 500m to public transport to deter rapid absconding. (Principles 4,5)
- Avoid potential hiding places. (Principle 4)

3.b.iv Schools

- The facility will have an on-site school which contributes 60% of rehabilitation.
- It is a Band-7 school (special education) but not all consumers attend this school, therefore access to other schools (particularly high schools) is necessary. (Principle 6)

- Need plenty of good schools within short driving distance including good ones with varying socio-economic levels. (Principles 3,6)
- Avoid areas where there are "tough" schools where there might be bullying. (Principle 3, 6)

3.b.v Recreational facilities in close proximity

- Recreational-size swimming pool. (Principles 1,2)
- Sports oval or park. (Principles 1,2)
- Adventure therapy components (Principles 1,2)

3.b.vi Undesirable persons

- Avoid opportunities for contact with undesirable persons. (Principle 2)
- Avoid close proximity to forensic units (Principle 2)

3.c. Characteristics of the Broader neighbourhood

3.c.i Sports locally off site

- Full-size swimming pool. (Principle 6)
- Sports oval or park. (Principle 6)
- Bike riding and recreational walking
- Water sports. (Principle 6)

3.c.ii Activities off site (remote)

- Reasonable access to adventure therapy activities. (Principle 6)

3.c.iii Public Transport

- Need access to good public transport. Trains are preferred as being more reliable in timetable and less intimidating. (Principle 6)

3.c.iv Shops

- Need access to a variety of shops via public transport. (Principle 6)
- There is graded use of shops in rehabilitation starting with smaller, less dense and closer shops and progressing on to large shopping malls. (Principle 6)
- Ideally there should be a corner store within walking distance, and a major shopping centre a train ride away. (Principle 6)

3.c.v Other facilities

- It is desirable to have other types of social activities available in the community such as:-
  - churches, (Principle 6)
  - youth groups, (Principle 6)
  - sporting groups, (Principle 6)
  - dancing classes etc. (Principle 6)
- (These are examples only – it is not important to have a particular type of community activity, group, club available).

4. Other General Considerations

4.i Staff access

- Staff recruitment and retention are important factors.
- Existing staff have a highly specialised background, and mostly live within easy reach of the Barrett Adolescent Centre.
- A location which is convenient to existing staff is important.
- Numbers and staff on the unit will be insufficient to meet every psychiatric and medical emergency which may arise.

4.ii Emergency Backup

- Access to help for 'code blacks' is critical. These incidents require back up from mental health trained nurses who have completed aggressive behaviour management training.
- A response is needed within 5 minutes; therefore the adolescent facility needs to be located within 500m of a hospital of other mental health facility where appropriate help is available.

4.iii Hospitals and Doctors

- Hospital emergency department within a 20 minute drive of the facility. (Principle 8)
- The existing Barrett Adolescent Centre has enjoyed good relationships with the Mater / Qld Children's Hospital to date, so proximity to there is desirable. (Principle 8)
- Proximity to an 'after hours' GP clinic is desirable. (Principle 8)

4.iv Access for families and visitors.

- Local external accommodation for families are desirable such as motels and hotels with good public transport access to the facility.
- On-site independent accommodation units (for family visits and for consumers preparing to leave).

4.v Police

- Police do not need to be close, but a relationship with a small local police station is good, more for consumer education and contact **than to handle emergency situations.**

4.vi. Climate / Aspect

- Good cooling breezes are desirable for personal comfort and to reduce the need for air-conditioning.
- Site must allow buildings to predominantly face north and south to maximise opportunities for natural cooling and light.

4.vii Public Perception, Politics

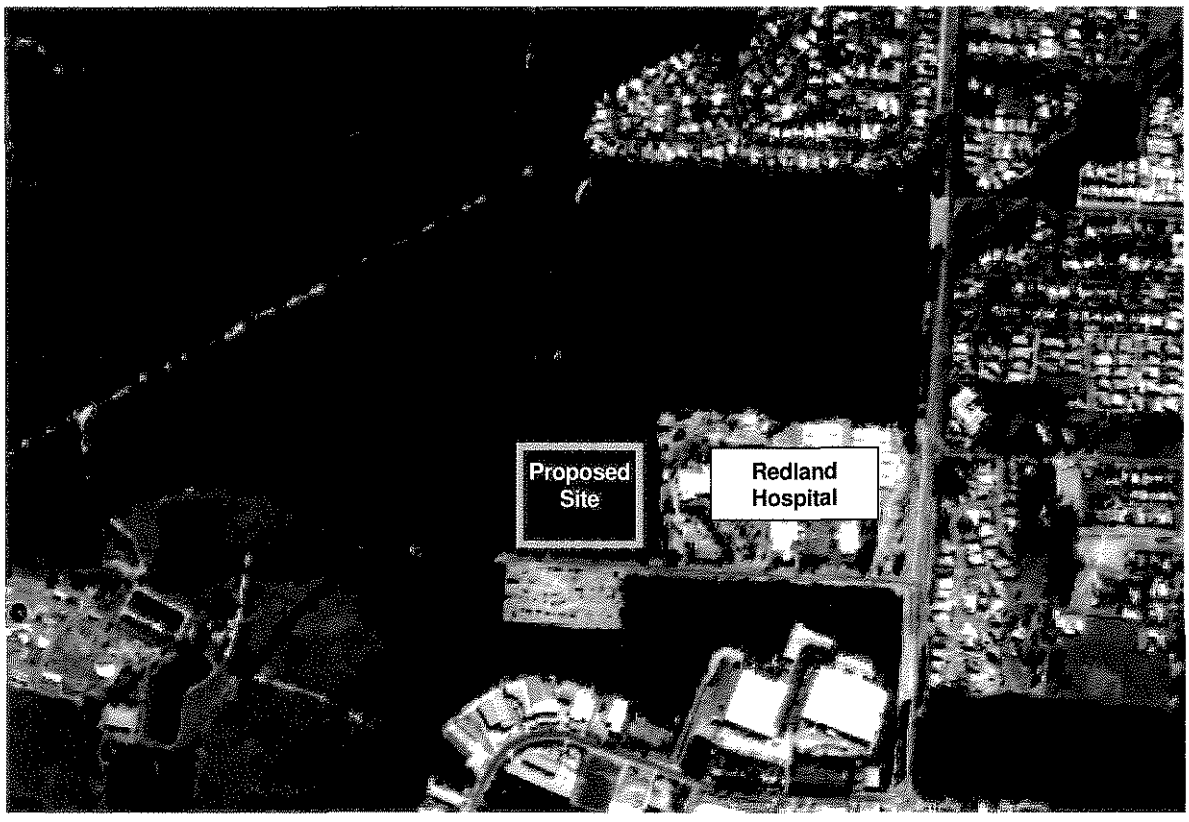
- Avoid close proximity to a high security adult mental health facility or prison.
- Avoid suburban areas where 'not in my backyard' syndrome may cause problems.

4.viii Site acquisition & Development

- Possible in reasonable cost and time
- Are there heritage, environmental, indigenous issues affecting the site.

4. Site Options Appraisal

Fig 1. Redland Hospital Site (Aerial View)



4.1 Specific Site Considerations for Site Next to Redland Hospital

- Site features
  - Potentially excellent bushland setting satisfactory for views, access to natural environment and access to outdoor activities.
  - No houses in vicinity or likely to be. Site is large enough to allow for adequate buffers. Site is surrounded by hospital, bush and industry.
  - Level site.
  - Distant views may be possible.
  - Sea breezes.
  - Site large enough to allow optimum orientation of buildings.
  - Surrounding built environment is potentially good, if it can be separated from the hospital.
  - Privacy is potentially good, if it can be separated from the hospital.
  - Reasonably close to existing mental health inpatient unit with possibility of closer location in future.
  - There are no physical hazards as per site considerations in the vicinity.
  - If site can be suitably separated from hospital and the public the propensity for interaction with undesirable persons will be limited.
  - 5 minutes walk to nearest bus stop, and being at the end of the bus and train line might make catching of absconders easier (there is only one way to get out of Cleveland)
  - Total site area of 5 Ha - 2 Ha preferred area.

- Local entertainment and sporting facilities
    - Aquatic centre (5 pools plus a spa) in Russell St Cleveland with skate park adjacent. Approx 3 km.
    - Chandler Aquatic Centre approx 10km.
    - Beaches, boating and creeks near.
    - Redland Youth Plaza, a large skateboard facility in Capalaba.
    - Social & community activities are catered for by Redland Shire Council – their web site lists numerous and varied organisations in the area.
- Public transport
    - Buses from Redland Hospital to Cleveland train station. 25 buses in each direction every day from 6 am to 11:30 pm. Veolia bus lines routes 258 and 272. Approx 10 minute ride.
    - 45 trains per day into Brisbane city and back.
- Shopping
    - Snack bar and kiosk in main hospital.
    - Small convenience shopping centre at corner of Bay Street and Wellington Road (approx 750 metres with one road to cross)
    - Good medium size shopping centre at Cleveland (10 minutes by bus)
    - Larger shopping centre at Capalaba (approx 8km)
    - Major shopping centre at Carindale (approx 15km)
    - Brisbane CBD shops accessible by train (approx 1 hour)
- Schools
    - Carmel College (Catholic High School) approx 5km
    - Faith Lutheran College (prep to year 12) approx 7 km
    - Redland District Special School and Thornlands Primary School approx 2 km.
    - Cleveland District High School approx 2km (on bus route)
    - Cleveland Primary approx 3 km
    - Ormiston Primary approx 4km
    - Ormiston College (private non-denominational prep to year 12 school) approx 5 km.
- Supplementary accommodation
    - As a tourist centre, Cleveland has a number of accommodation options for families from $70 per night.
    - The site is large enough to accommodate independent units.
- External services
    - Hospital emergency department is immediately adjacent.
    - Numerous medical practices in and around Cleveland, including Medeco Medical Centre which operates 24 hours out of central Cleveland and bulk bills children under 16.
    - Large police station in central Cleveland, close to train station.
- Staff
    - Existing staff can access the Redland site which is approximately 40km from the existing Barrett site.
    - The attractions of Redland area (particularly the coastal climate as compared with the Ipswich-Goodna area) might attract existing staff to move or new staff to join.
- Public perception

- Caters to Public perception and politics whereby there is no proximity to a high security adult mental health facility or prison - we are not aware of any such facility anywhere near.

Site acquisition.

- It is understood that the land is State Government owned and is available for purchase from Dept of Infrastructure.

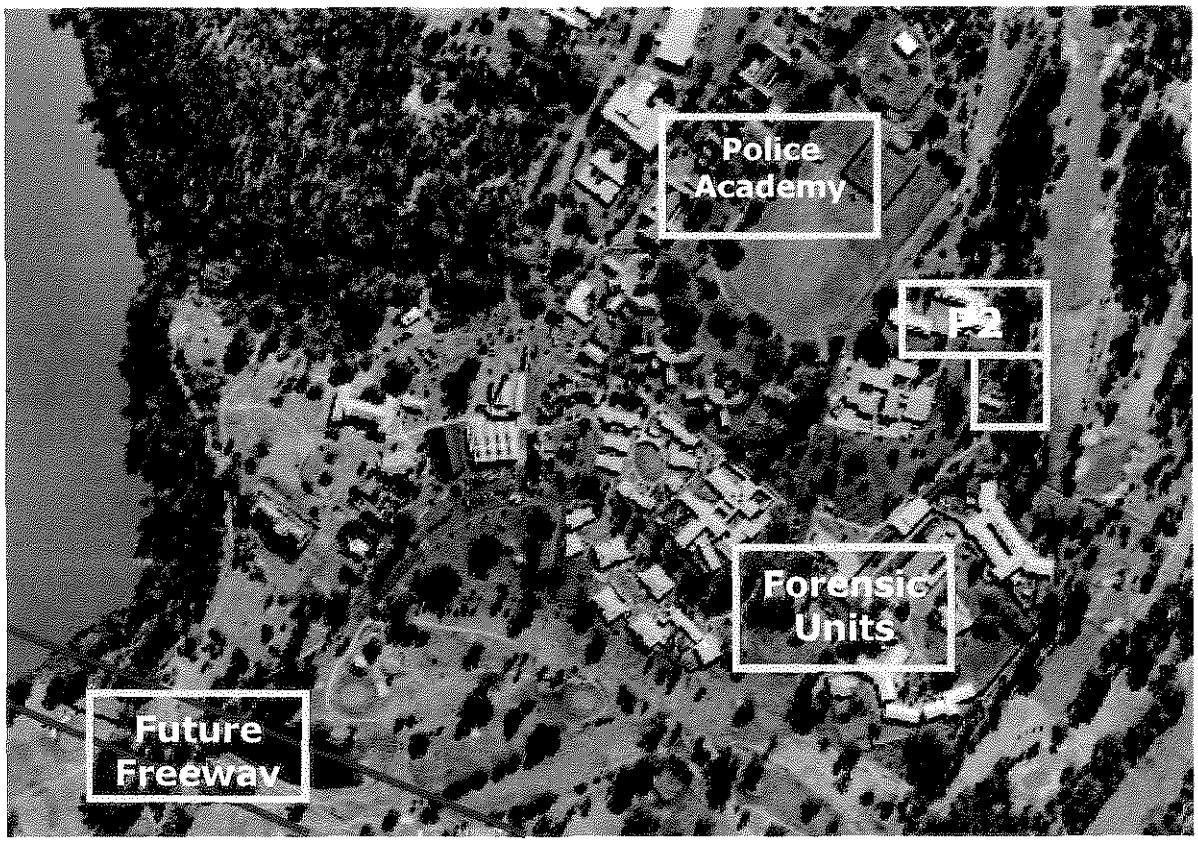
Koalas.

- The site is marked as an Urban Koala Area, which is the least onerous of the three types of Koala Habitat areas.
- It is adjacent to a large Koala Sustainability Area.
- Advice from Project Services Environmental section is that development on this site should not be a problem. It is just a matter of applying a Koala Management Plan, which will cover such items as retention and planting of suitable trees and appropriate fencing. The type of development proposed should be compatible with these requirements.
- Development on this site has not been costed, however, being a "green field" site should have some time and cost advantages.

Conclusion – Redland Site

The information currently at hand, indicates that this site would be suitable for the proposed Adolescent Unit.

Fig 2. P2- The Park Centre for Mental Health – (Aerial View)



4.2 Specific Site Considerations for P2 – The Park

The existing location has been found to be satisfactory in many respects however the following issues need to be taken into consideration

- The Wacol location tends to be hotter in summer and colder in winter than sites closer to the coast.
- The close proximity of the high secure forensic unit could be a drawback.
- Undesirable persons - Open forensic unit nearby
- 2 Ha preferred area, 1.5 Ha minimum - About 1.5 Ha available.
- Existing oval may no longer be available once it is taken over by Police Academy.
- Access for families and visitors - No space available on site.
- Site development possible in stages while maintaining existing service is possible, but there may be a time and cost penalty in a staged development. Figures 3, 4 & 5 illustrate how such a staged development might be achieved while keeping the unit functioning.

Conclusion – P2 – The Park

If the continued proximity of the forensic unit and a compact site can be accepted, the site appears to be suitable for the re-development of the adolescent unit.