escort for consumers attending appointments usually outside BAC. Nurses reported feeling anxious and unsupported having to remain alone with consumers in what is usually an unfamiliar environment.

COMMENTS:

The report accurately reflects the stress placed on nurses who are required to carry out 'continuous escorts' at local hospitals with patients who require medical interventions. This problem has been addressed in the following ways:

- Since 2009 nurses are relieved of escort duty after four hours instead of eight.
- Attempts to collaborate with local hospitals via Consultation Liaison teams with varying success (use: support, meal breaks, review of consumers mental state).
- Attempts to negotiate with medical teams to take over responsibility for continuous observation once the patient is admitted to another ward.
- Crisis Intervention Plans/ management plans individualised and made available to escort nurse and hospital.

Patient Journey

The "Report of the Site Options paper for the Development of the Barrett Adolescent Centre" identified a number of issues related to the patient journey of clients admitted to BAC. These included:

- The need for acute medical management at a local general hospital at regular intervals;
- Occasional need for more intensive acute psychiatric care;
- The need for intensive discharge planning at point of referral;
- Integration of BAC with services at the local community of origin;
- Partial hospitalisation as a method of transition from BAC to community management;
- The remoteness of referring services, making the above patients difficult to manage;

- Out of home care for increasingly older adolescents and young people who cannot return to their family of origin;
- Transitioning to suitable adult mental health services if the adolescent requires long term treatment and has reached an age where this transition is necessary.

The management or the difficulties in managing these issues has created some significant problems for BAC. The reviewers were advised that:

- Admissions to BAC are increasingly severe and complex;
- There is a perception that BAC has a limited choice over whom it accepts;
- There are referrals on from the CAMHS Acute Units if there is no obvious community placement option and that BAC becomes a treatment option of "last resort";
- A number of clients who are accepted are homeless;
- A number of clients are referred from very remote parts of Queensland – often by NGOs with little local CAMHS type support.

FACTS: It is unclear from where this information came.

- All patients are accepted on the basis of clinical need and evidence of response to the program at Barrett. At times, as clinical expertise has increased, we have extended admission to an adolescent who may have appeared on the borderline of what would be suitable. At times this has been to the benefit of the adolescent, at other times not.
- All community CYMHS are advised on referral as to the potential suitability of the referral. We are included in the orientation progam for new CYMHS clinicians, so they are aware of the Centre, the adolescents we take and appropriate referrals. We rarely have referrals simply as there are no community placement options.
- The Comment about taking a number of adolescents who may be homeless is perplexing. Admission is on the basis of clinical need whether or not the adolescent is homeless. This is in line with the UN Charter on the treatment of the mentally ill.

- In the past decade, there has been only one referral a town where there was only one CYMHS clinician, and four from towns where there were three or fewer CYMHS clinicians. These all had previous acute adolescent inpatient referrals as well as support from larger community teams which recommended the admission.

The concept of continuity of care is based around the notion of seamless transitions between treatment episodes, and this does not appear to be the case at BAC.

FACTS: Continuity of care has been an important principle for more than a decade. There is strong documentary evidence in the clinical records available to the Reviewers of ensuring seamless transitions where acute medical care is needed by letters of referral, direct communication between medical and nursing staff of the Centre and medical ward, liaison with clinical-liaison staff and often supply of nursing staff. There is clear evidence from two of the records of continued involvement of the referring agencies in bi-monthly intensive case workups which review progress and develop the care plan for the next two months, and email correspondence in the interim. In addition, there is other evidence that in the months prior to discharge, where the referring agency is longer be involved of planning to engage another service which can continue with the care of the young person on discharge to ensure a seamless transition.

While some of these issues will be addressed when the unit is relocated to a site adjacent to an acute hospital, there appear to be significant problems with all of: referral to the unit, waiting time to admission for accepted patients, length of stay, and discharge planning and discharge placement.

The BAC has 15 inpatient beds gazetted for use of adolescents with challenging mental health problems requiring medium to long term treatment. At the time of the visit, there were 9 inpatients. The nursing staff on duty were unable to clarify how the remaining beds were being utilised. [One of the clinical nurses performs the role of Clinical Liaison Officer, coordinating the intake activities of the service. The clinical liaison nurse informed the reviewing team that BAC has developed exclusion criteria that include: conduct disorder, predatory behaviour, criminal behaviour, aggression, substance misuse and moderate-severe intellectual impairment.]

COMMENTS: The Management Group of The Park – Centre for Mental Health were informed via the Business Unit Meeting of BAC that patient numbers would be low in January/February 2009 because:

- The high acuity of some of the adolescents meant that resources were stretched in managing their care
- A number of adolescents were actively supported by staff in being integrated back to their local schools as part of their transition planning.
- A number of experienced staff had resigned, and the unit needed to mentor new staff.
- We were running the Recovery Intensive (a workshop for CYMHS clinicians from throughout Queensland to consider aspects of managing adolescents with severe and complex disorders) in the February of the Review which involved many of the Senior nursing staff.

Thus, consumers are not necessarily discharged at 18 years of age and there appears to be a lack of clearly understood or communicated process to transition these young people to adult services.

FACTS: There is active debate in the Australian literature regarding the best models for transitions of services for young people. Traditionally CYMHS services have gone up to 18, and arranged transition to adult services. The Headspace model which is also endorsed[16], recommends treatment from 16 – 25 years. Indeed the Robina Adolescent Inpatient Unit envisaged treatment in co-located adolescent and young adult wards up until the age of 25.

The Barrett approach is very clear. If an adolescent is likely to require long term treatment and support for several years for a mental illness in which adult services

[16] Whiteford H. Groves A. (2009) Policy implications of the 2007 Australian National Survey of Mental Health and Wellbeing. *Australian & New Zealand Journal of Psychiatry. 43:644-51*

have expertise, the transition process begins well before their 18th birthday, if the adult service will accept the referral. Even so there can be a considerable delay, even when high level representations are made. On the other hand, if an adolescent is well engaged in treatment, and likely to respond more positively for a while in Barrett compared to transfer to an adult MHS at that stage, a decision it made to continue their admission beyond their 18th birthday. The transition is made when treatment is substantially completed or when they are sufficiently stabilised to benefit from the more limited treatments available in the relevant Adult MHS. This is more in line with the "Headspace model" than the "CYMHS model".

An assertively managed approach to admission and discharge will need to be adopted by BAC wherever it is located. The following recommendations can define the parameters of this approach.

FACTS: While many of the recommendations have merit (particularly 3, 4, 5, 10, 13, and 14), Recommendation 12 is part of current processes, Recommendation 6 has not identified the many problems the Centre has had to date with transitions, and minimises the complexities in establishing mechanisms to ensure they happen, Recommendations 7 and 11 have no evidence base, Recommendation 8 is contrary to evidence available to the Reviewers that the MHS service on discharge can be predicted – eg change of address, need to move from CYMHS to Adult MHS, and Recommendation 9 is contrary to the UN charter on the rights of the mentally ill.

***Recommendations*:**

1. *That referral forms for referring agencies be updated.*
2. *That service level agreements, Memoranda of Understanding or shared protocols be used as the basis of agreement for the transfer or sharing of care between BAC and other units. These would include but not be restricted to:*
3. *Agreements with local Acute Hospitals for assistance in the management of the physical sequelae of self harm.*
4. *Agreements with local Acute Hospitals for assistance in the management of the physical complications of eating disorders.*
5. *Agreements with local Acute Mental Health Facilities for assistance in the management of acute and extreme behavioural disturbances.*

6. *Agreements with local Acute Mental Health Facilities with regard to the transition of older adolescents from care at BAC to care in Adult Mental Health Services.*
7. *That the length of admission, and planned discharge date, for prospective admissions, be agreed upon by referrer and BAC staff prior to admission.*
8. *That there is firm agreement, prior to admission, about which service will have an ongoing role in the patient's management upon discharge (failure to agree on this will result in the patient not being admitted to BAC).*
9. *That homelessness in the absence of an identified and agreed upon strategy for accommodation at discharge be an exclusion criteria for admission to BAC.*
10. *That the concept of step up/step down facilities and halfway houses, possibly managed by NGOs, be explored as methods of transitioning clients back to the community, especially those clients who will require out of home care.*
11. *That a target for Length of Stay be set for BAC – this can be aspirational, but should be no more than 12 months. Any client that exceeds this target on clinical grounds should be identified and intensively managed to find alternative clinical placement including, for older clients, placement with Adult Mental Health Services.*
12. *That planning towards and documentation regarding a patient's discharge should be undertaken throughout the admission.*
13. *That regular (eg twice yearly) meetings of BAC staff with key referring agencies occur to improve the referral, treatment and discharge processes.*
14. *That data regarding referrals, wait times, lengths of admission etc be reviewed regularly and in different forums (eg at meetings of senior BAC staff and Park Hospital and Qld Mental Health)*

Treatment evaluation

There appears to have been negligible evaluation of treatments delivered by BAC.

FACTS:

1. BAC was one of the first CYMHS in Queensland to implement evaluation, using the HoNOSCA and CGAS since 2000.[17]
2. Throughout the clinical records available to the Reviewers, there were hard copy records of evaluation measures (HoNOSCA, CGAS, FIHS, SDQ) used in the regular bi-monthly care planning reviews. These are collectively scored by clinicians with contact with the adolescent at the intensive case workup so that they can be entered in to CIMHA.
3. Since the migration of OIS to CIMHA, we have been unable to access cumulative reports to understand changes in these evaluation measures. To do so is beyond our current resources.
4. A range of assessments are described in Appendix 2. A number of these form the basis of individual evaluation of change by a particular discipline. This is then reported to the treating team at the Intensive Case Workup.

Recommendations:

1. *Regular use of patient and parent/carer satisfaction surveys.*
2. *Affiliation with an academic unit to facilitate treatment evaluation.*
3. *Introduction of a regular meeting to specifically address the process of outcome measurement at BAC and the (outcome) results obtained for patients.*

Clinical leadership

One of the major problems of BAC relates to leadership and leadership structure. While several staff (e.g. psychiatrist, NUM, liaison nurse, senior allied staff) have considerable experience, there does not appear to be a clear Executive structure nor forum for the Executive to meet.

FACTS: All nursing staff are accountable to the Nurse Unit Manager who in turn is accountable to the Assistant Director of Nursing. All staff are accountable to the Director in clinical matters. All Allied Health staff are accountable to their Discipline

[17] Harnett PH. Loxton NJ. Sadler T. Hides L. Baldwin A. (2005) The Health of the Nation Outcome Scales for Children and Adolescents in an adolescent in-patient sample. *Australian & New Zealand Journal of Psychiatry. 39:129-35*

Seniors in operational matters. This was clearly outlined to the Reviewers on 26/2/3009.

A monthly Business Unit Meeting occurs on the 3rd Tuesday in the months February – November. It is a regular forum which includes the Director, Nurse Unit Manager, Senior Allied Health Professional, and School Principal from BAC, as well as the Assistant Director of Nursing from The Park and Finance Officer.. Other staff may attend. The meetings are minuted by the Centre's Administration Officer. The Centre reports to the Executive Management of The Park through both the Assistant Director of Nursing for BAC and the Nurse Unit Manager, who both attend Executive Meetings.

It was also emphasised at the time that while there is a clear management structure, that there is a strongly collaborative style of management which seeks to utilise the strengths of multiple staff members in developing processes in the unit, and which keeps them informed of decision making processes. This is in line with a Knowledge Management Framework.

In relation to nursing, while nursing staff reported that they weer all were very supportive of the relatively newly appointed Nurse Unit Manager, it was apparent that the Clinical Nurses were underutilised in their potential capacity as clinical leaders. It was not clear if regular nursing staff meetings were conducted, and the reporting lines were vague.

FACTS: The first part of this comment is again a broad generalisation with nothing in the way of criteria offered against which this is measured. At the time of the review, there were (and continue to be) multiple examples of opportunities to enhance the clinical leadership potential of Clinical Nurses. In the absence of criteria, it is impossible to know if this is what the Reviewers had in mind.

However, it is difficult to know on what basis the Reviewers could make this conclusion. At the time of the Review, there was only one permanent Clinical Nurse who was not on when the Reviewers came. One position was backfilled due to the absence of one Clinical Nurse on long Special Lease. Another position was unfilled because it had belonged to the recently appointed Nurse Unit Manager, and was being

advertised. A number of Registered Nurses had backfilled these two positions to develop experience in being Clinical Nurses.

Regular fortnightly nurses meetings are held on Tuesdays. The reporting lines were outlined in the previous "FACTS".

Similarly, it was unclear whether the Nurse Unit Manager and the Director attended regular meetings in their roles as providing the leadership group at BAC.
FACTS: Minutes of the Business Unit meetings for 2007 – 2008 (the two years prior to the Review) showed 100% attendance by the Nurse Unit Manger or the Acting NUM, and 95% attendance by the Director (on leave).

Recommendations:

1. *The Director should implement professional development seminars for all the staff and these should reflect the practice of other service providers. Examples of new and innovative therapies, presented by people external to BAC, should be included.*

   COMMENT: There is no doubt that there should be more enhancements to professional development. The Recovery Intensive which was run at the time of the Review was an example of a professional development seminar for new staff at the Centre. We currently do not have the budgetary capacity to invite in external speakers. However, as part of the CYMHS network, we receive regular information about upcoming Seminars and Workshops which are either run by CYMHS or external providers. This information is regularly disseminated to all staff. For those which are pertinent to the core business of the Centre, we have been able to make block bookings for multiple staff to attend.
2. *BAC should provide a regular (eg quarterly) report to Park Hospital and State mental health about its programs and use of both tested and innovative approaches.*

Staffing profiles (nursing)

BAC consists of a large multidisciplinary team; as with most inpatient services, the nursing establishment make up the bulk of this team. BAC currently maintains a nursing establishment of 23.9 FTE. Six nurses are rostered on each shift on weekdays. The nurses work continuously in 8 hour shifts. The nursing team is led by the Nurse Unit Manager and 4 Clinical Nurses, one of which holds an Intake/Community Liaison position.

As in all nursing teams, there are varying levels of clinical skill and experience amongst the individuals. At BAC, there are a number of staff who have been working there for many years and some staff who are relatively new to Child and Youth Mental Health (CYMH). Consultations with nursing staff present on the day of the visit suggested that there were no nurses who had experience with another CYMH service outside BAC. This indicates the team may be disadvantaged by a lack of current exposure to contemporary nursing practice within the CYMH speciality.
COMMENTS: This statement is true inasmuch as it states that the current nurses at Barrett have not worked in other CYMHS facilities. We have strongly advocated in the past the need to do 6 month rotations for staff willing to participate with other CYMHS inpatient facilities. We have had no support for this proposal.

However, it is not true in its implication that there is a benchmark of "contemporary nursing practice within the CYMH specialty". Apart from generic professional development activities open to all CYMHS staff, there are no processes to enhance CYMHS specific nursing development. A number of CYMHS inpatient units have a strong component of staff without a mental health background.

This is a systemic issue which we have attempted to address in the past e.g. through discussions with University of Queensland staff responsible for developing post graduate mental health courses, representation to the Queensland Centre for Mental Health Learning in its early days. We gained no support for the development of such courses, and have not recently pursued them.

While all nursing staff reported being very supportive of the relatively newly appointed Nurse Unit Manager, it was apparent that the Clinical Nurses were

underutilised in their potential capacity as clinical leaders. It was not clear if regular nursing staff meetings were conducted and the reporting lines were vague.
This paragraph in its entirety is a repeat of a previous paragraph. Objections to statements are noted under the previous paragraph.

Recommendations:

1. *More robust interactions between nursing staff of BAC and other CYMH services should be facilitated; one way to address this may be found in secondment activity negotiated between services.*

Nursing Staff Training and Education

Individual consultations with nursing staff during the visit identified a general desire for more educational/training opportunities, specifically in adolescent mental health. There appeared to some issue with the budget limiting nursing staff access to their professional development funds to pay for development activities.

The previous BAC review conducted by McDermott et al in 2003 recommended more training and education for staff on adolescent issues. It is clear from discussions with nursing staff that this education is still somewhat haphazard and limited.

Clinical supervision structures are problematic. The whole team attends group supervision with a specialist clinical supervisor, who is also a member of the team. Additionally, nursing staff identified a need for more clinical supervision.
FACTS: The Specialist Clinical Supervisor facilitates review sessions after critical incidents and days for team reflection. These are the only group activities. All other supervision is offered on an individual basis.

Over the years, Barrett has lost a senior nursing position (originally had the equivalent of a Nurse Unit Manger and a Clinical Nurse Consultant). After the loss of this position, the role of Clinical Nurse Consultant remained, while the roles of a Nurse Unit Manager was performed by a senior nurse for both BAC and the High Secure

Unit. Gradually the CNC assumed more of the role of the NUM until it was impossible to perform CNC duties. The loss of the CNC position has taken away an important avenue for supervision for nurses.

Recommendations:

1. *The use of professional development funds by nursing staff should not be compromised by budgetary constraints. The provision of the money to undertake development activities is an award condition.*
2. *Nursing staff would benefit from regular and relevant in-service, and a program or calendar of such in-service could be developed and then facilitated through rostering. There appears to be generous blocks of time that could be regularly quarantined for staff development during the time the young people are attending school.*
3. *Structures for group clinical supervision should be reviewed and strengthened by sourcing a clinical supervisor not currently working at BAC.*

Finally, while staff may understandably be unsettled by the prospect of significant changes as recommended in this report, the proposed rebuilding of the facility at a new location constitutes an unprecedented opportunity to reflect on BAC's purpose, mission, systems and work practices. With a motivated leadership team employing good change management skills, BAC and key stakeholders can seize this chance to review the service and maintain BAC's commendably long record of service provision to young people in Queensland.

APPENDIX 1 – DEVELOPING OBJECTIVE CRITERIA FOR REVIEWS

The Royal College of Psychiatrists (RCPsych) in the earlier part of this century set out to review the number and functions of child and adolescent inpatient units in the United Kingdom[18,19,20]. The Quality Network for Inpatient CAMHS (QNIC) developed out of this process. It is a multidisciplinary network funded by the RCPsych to support and monitor standards in inpatient CAMHS. QNIC hosts an internet discussion forum (of which staff from BAC have contributed), hosts yearly meetings to discuss issues relating to inpatient CAMHS.

It has developed, from extensive literature reviews, consultations with clinicians and Government guidelines, a set of standards. The fifth edition has just been published. It is anticipated that each inpatient unit will supply staff for a minimum of three site visits to other inpatient units to assess a unit against the standards. Participation is voluntary, but a high percentage of inpatient units are part of this process. Each unit has an annual review. The purpose is two-fold – to provide feedback to clinicians regarding their service, and to provide feedback to the local NHS Trust about resourcing issues. I have not been able to find a comparable process which is specific to CYMHS/CAMHS inpatient units in New Zealand, Canada, the USA, France or Switzerland.

I have reviewed the performance of Barrett Adolescent Centre against the 4th edition of these Standards[21], not only because were these the Standards in place at the time of the Review, but also because a subsequent Report[22] has been released which gives figures for the level of compliance with the Standards. Our performance is shown in the Table below, together with a measure of the QNIC average level of compliance.

Two factors emerge. Our level of compliance is comparable to QNIC rated adolescent inpatient units in five domains. It is clearly below in two – Staffing and Training and Access, Admission and Discharge

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[18] O'Herlihy, A., Worrall, A., Banerjee, S., Jaffa, T., Hill, P., Mears, A., Brook, H., Scott, A., White, R., Nikolaou, V. & Lelliott, P. (2001) National Inpatient Child and Adolescent Psychiatry Study (NICAPS). *Final Report to the Department of Health. London: Royal College of Psychiatrists' Research Unit*

[19] O'Herlihy A, Worrall A, Lelliott P, Jaffa T, Hill P, Banerjee S (2003) Distribution and characteristics of in-patient child and adolescent mental health services in England and Wales *The British Journal of Psychiatry 183: 547 - 551*

[20] McDougall T, Worrall-Davies A, Hewson L, Richardson G, Cotgrove A (2008) Tier 4 Child and Adolescent Mental Health Services (CAMHS) - Inpatient Care, Day Services and Alternatives: An Overview of Tier 4 CAMHS Provision in the UK *Child and adolescent Mental Health 13:173 – 180*

[21] Davies G, Thompson P, Landon G (Eds) (2007) Quality Network for Inpatient CAMHS 4th Edition Royal College of Pyschiatrists

[22] Solomon J, Thompson P (2010) QNIC A Quality Network for In-patient CAMHS Annual Report Review Cycle 7: 2007 – 2008

STANDARD	ESSENTIAL/ DESIRABLE	MET	NOT MET	N/R	% MET	QNIC %
1. Environment and Facilities	Essential	24	4	0	83%	85%
	Desirable	15	4			
2. Staffing and Training	Essential	47	11	3	74%	85%
	Desirable	13	10			
3. Access, Admission, Discharge	Essential	13	3	6	76%	85%
	Desirable	3	2			
4. Care and Treatment	Essential	37%	4%	1	87%	88%
	Desirable	15%	4%			
5. Information, consent confidentiality	Essential	24	2	2	89%	88%
	Desirable	25	3			
6. Young People's Rights	Essential	20	1	10	96%	92%
	Desirable	1	0			
7. Clinical Governance	Essential	17	1	15	84%	83%
	Desirable	11	4			
8. Location within a Public Health Context	Essential	7	0	16	N/A	N/A
	Desirable	9	6			

Below is are the criteria we failed to meet for Staffing and Training
Training

- Formal knowledge of aetiology, symptoms and a range of relevant conditions
- The nature and development of the therapeutic environment for children and young people and understanding of psychodynamic processes
- Managing relationships and boundaries between young people and staff, including appropriate touch
- The role of other services and the range of local services and activities
- Members of the nursing team including all newly appointed senior nurse managers, have undertaken further training in child and adolescent mental health
- Working with young people with learning disabilities alongside mental health problems
- Working with young people whom have visual impairment, hearing problems, physical disability and physical illness
- Working with young people with co-morbid substance abuse and mental health problems
- Audit and research skills
- Unit managers have had further training in management and team leadership
- All staff, including temporary staff, have a comprehensive induction which covers key aspects of care (e.g. observation, child protection) before they can have unsupervised access to the young people
- There is commitment and financial support to conduct service relevant research and academic activity, and to disseminate the findings and implications of studies widely
- Supervision is included in the job description of every member of the MDT
- The team have regular designated time to meet as a group to reflect upon the process and the impact of working with young people

- Units have a dedicated Human Resources contact who understands the nature of the service
- There is a minimum of two registered nurses, that have appropriate child and young people training, per day shift and one at night
- There is a minimum of two registered nurses, that have appropriate child and young people training, per day shift and one at night
- 0.5 WTE Psychotherapist input is provided in a typical 10-12 bed unit
- A written review of staffing needs is completed at defined intervals and when there are changes in service provision
- The team has off-site and informal 'away days' to facilitate team building and service development
- Training needs are informed through the skills needed within the unit, staff appraisal and individual development plans and support and supervision systems - all have been assessed in the last year

Some of these can be addressed immediately. Some should be noted as part of the redevelopment, so that they can be incorporated into staff training.

Below are the criteria we failed to meet for Access, Admission and Discharge.

- Young people do not experience delay in treatment that leads to deterioration in health
- Interpreters used by Specialist CAMHS have received training or guidance about mental health matters and recognise the importance of full and accurate translation
- Children's units have access to nearby facilities for parents to stay overnight when appropriate
- Young people have a named worker from the referring agency throughout their stay in the unit, who attends all CPA reviews and discharge planning meetings. The worker is the care coordinator unless the unit take on this role
- Young people and parents know the names of workers involved in follow-up after their discharge and have met them prior to discharge
- There is an agreement with the referring teams, regarding aftercare pathways, before admission

Although it should be possible to meet most of these, most relate to issues beyond the control of the Barrett Adolescent Centre. For example, one local Adult MHS will not accept a referral until a patient is discharged. This makes it difficult to meet a clinician prior to discharge.

Overall these Standards are an example of a valid reference point against which the unit can be measured. They do not prescribe a particular Model of Service Delivery, but ensure a set of basic Standards which should apply to all units. Most are highly relevant, although some Standards could not be translated to a Queensland Health context, and others needed to be adapted to suit our context.

Evaluation of an adolescent inpatient service against these standards could apply at local, State or National levels. One value of the QNIC process is the experience of staff visiting other services to review the other service. I am sure this has bi-directional effects.

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APPENDIX 2 – EVALUATION AND INTERVENTIONS

On admission to BAC, adolescents are given a comprehensive range of assessments (if they have not been given them recently) to enable a complete formulation of the issues and develop a management plan. Each discipline brings a range of assessment and observational skills. Each discipline conducts an initial interview as an integral part of the assessment before commencing discipline specific assessments.

The first section lists the range of standardised assessments and a limited number of non-standardised assessments. Standardised assessments are of two broad types. The first ascertains abilities and characteristics which are unlikely to change (e.g. intelligence), but which must be accommodated in a rehabilitation program. The second type of standardised assessment allows for testing after a period of time or on discharge as part of an evaluation of treatment and rehabilitation. These are marked with an *.

As the primary purpose of this Appendix is to outline additional areas of evaluation, a number of unstructured assessments (family, parent assessments, peer interactions, general behaviour etc.) are not described. These are nevertheless an important component of the formulation.

The second section describes a range of interventions which had been utilised in the twelve months preceding the Review. Literature referring to the evidence base for these interventions is included. It is noted in passing that the evidence base for interventions with many disorders in adolescents is limited.

SECTION 1: ASSESSMENTS

1. Psychology Assessments

Core psychological tests are administered following admission. The following are the most commonly used psychometric tests at BAC, shown to have good validity and reliability.

- *The Reynolds Adolescent Depression Scale, Second Edition (RADS-2)
- *The Revised Children's Manifest Anxiety Scale, Second Edition (RCMAS-2)
- *The Adolescent Anger Rating Scale (AARS)
- *The Eating Disorder Inventory-2 (EDI-2)
- *The Childhood Trauma Questionnaire (CTQ)

Where there is a direct concern surrounding cognitive and academic ability and a referral is made, the following measures may be used:

- *Intelligence* - The WISC-IV
- *Achievement/Academic* - The WIAT-II
- *Memory* – The Children's Memory Scale

A neuropsychology referral is made if necessary, to further assess attention and concentration, memory and executive functioning, or to determine capacity or decision-making competency.

2. Occupational Therapy Assessments

Adolescent

- *Activity Configuration (how adolescents occupy a 24 hour period)
- *Adaptive Behaviour Assessment System (ABAS - II)
- Adolescent/Adult Sensory Profile
- The Handwriting Speed Test (HST)
- Beery-Buktenica Developmental Test of Visual-Motor Integration
- *Canadian Occupational Performance Measure (COMP)
- *Living Skills Checklist
- *Interest Checklist
- *Barriers to Leisure and Leisure Hopes Checklist

Parent

- *Living skills Information – Initial Parent /Carer Interview
- (Adaptive Behaviour Assessment System (ABAS - II)
- Adolescent/Adult Sensory Profile
- *Living Skills Checklist

Ongoing Assessments

- Cooking assessment
- Vocational Education Interest Form
- Adventure Therapy Assessment

3. Speech Pathology Assessments

Specialist communication assessments.

- Test of Adolescent and Adult Language (TOAL -3/4)
- Children's Evaluation of Language Function – Revised (CELF-4)
- *Test of Problem Solving (TOPS)
- The Test of Auditory Processing Skills – 3rd Edition
- Test of Language Competence – Expanded edition (TLC-E)
- Language Processing Test – Revised edition
- The Children's Communication Checklist – second edition
- Test of Word Knowledge, Literacy Tests

4. Dietetic Assessments

All adolescents undergo an initial nutrition screening process[23] which may consist of one or more of the following:

- Medical and psychosocial History - reason for admission, medical history & medications, psychosocial history, socioeconomic status & history
- *Growth and development – height, weight, BMI plotted on CDC 2000 growth charts, weight and height history
- *Dietary intake, physical activity - meal and snacking patterns, appetite, food likes, dislikes, food allergies/intolerances, special dietary practices, nutrition supplement use, food security, alcohol consumption. physical activity levels
- Physical parameters – blood pressure, pulse, lipids, iron studies (females)

[23] Modified from Stang J, Story M (eds) Guidelines for Adolescent Nutrition Services (2005).

As well there may be indications for an in-depth nutrition assessment

- Medical and psychosocial history - medications known to have drug-nutrient interactions, depression or dysthymia, diagnosed eating disorder (AN, BN, EDNOS), at risk of re-feeding syndrome, disordered/fussy eating, ASD, developmental delay, chronic disease i.e. diabetes
- Growth and development - underweight, overweight, at-risk of overweight, short stature
- Dietary intake and physical activity - history of food insecurity, meal skipping, inadequate micronutrient intake, excessive intake of total or saturated fat, food allergy or intolerance, vegetarian diet, dieting, fasting, alcohol consumption, minimal/excessive sport/physical activity
- Physical observations and biochemistry – hypertension, hyperlipidaemia, iron deficiency anaemia

SECTION 2: INTERVENTIONS

Clinicians providing interventions at the time of the Review were contacted and asked to provide a list of:

- The range of interventions they provided at the time of the Review
- The evidence base for these interventions (including any reviews since the Review)

These interventions are listed in three categories

- Interventions Specific to a Disorder
- Treatment Interventions across Disorders
- Rehabilitation Interventions to Address Impairments across Disorders

1. Interventions Specific to a Disorder

School Refusal/Social Anxiety Disorder and Co-morbid Anxiety Disorders

- Behavioural Interventions – exposure individually or via groups

  Evidence Base

  Beidel DC, Turner SM, Morris TL. (2000) Behavioral treatment of childhood social phobia. *Journal of Consulting & Clinical Psychology 68:1072-1080*

  Borgeat F, Stankovic M, Khazaal Y, Rouget BW, Baumann MC, Riquier F, O'Connor K, Jermann F, Zullino D, Bondolfi G, (2009) Does the form or the amount of exposure make a difference in the cognitive-behavioral therapy treatment of social phobia? *Journal of Nervous and Mental Disease. 197:507-13,*

  Silverman WK, Pina AA, Viswesvaran C. (2008) Evidence-based psychosocial treatments for phobic and anxiety disorders in children and adolescents *Journal of Clinical Child and Adolescent Psychology. 37:105-30*

  Storch EA, Larson M, Adkins J, Geffken GR, Murphy TK, Goodman WK. (2008). Evidence-based treatment of pediatric obsessive-compulsive disorder. In: Handbook of evidence-based therapies for children and adolescents: Bridging science and practice. *Steele RG. (Ed.); Elkin TD (Ed.), Roberts MC. (Ed.); New York, NY, US: Springer Science + Business Media, 2008. pp. 103-120.*

- Social Skills Enhancement

  Evidence Base

  Beidel DC, Turner SM, Young BJ. (2006) Social effectiveness therapy for children: five years later. *Behavior Therapy 37:416-25*

  Cook CR. Gresham FM, Kern L, Barreras RB, Thornton S, Crews SD, (2008). Social skills training for secondary students with emotional and/or behavioral disorders: A review and

analysis of the meta-analytic literature. *Journal of Emotional and Behavioral Disorders 16:131-144.*
Herbert JD, Gaudiano BA, Rheingold AA, Myers VH, Dalrymple K Nolan, E M. (2005) Social Skills Training Augments the Effectiveness of Cognitive Behavioral Group Therapy for Social Anxiety Disorder. *Behavior Therapy. 36:125-138.*
Spence SH, Donovan C, Brechman-Toussaint M (2000) The treatment of childhood social phobia: The effectiveness of a SST-based cognitive-behavioural intervention, with and without parental involvement. *Journal of Child Psychology and Psychiatry 41:713-726*

- Cognitive Therapies

Evidence Base

King NJ, Heyne D, Ollendick TH (2005) Cognitive-behavioral treatments for anxiety and phobic disorders in children and adolescents: A review. *Behavioral Disorders. 30:241-257.*
Layne AE. Bernstein GA. Egan EA. Kushner MG. (2003) Predictors of treatment response in anxious-depressed adolescents with school refusal. *Journal of the American Academy of Child & Adolescent Psychiatry 42:319-26*

- Family Therapy

Evidence Base

Kendall PC. Hudson JL. Gosch E. Flannery-Schroeder E. Suveg C (2008) Cognitive-behavioral therapy for anxiety disordered youth: a randomized clinical trial evaluating child and family modalities. *Journal of Consulting & Clinical Psychology. 76:282-97*
Siqueland L, Rynn M, Diamond GS. (2005) Cognitive behavioral and attachment based family therapy for anxious adolescents: Phase I and II studies. *Journal of Anxiety Disorders. 19:361-81*

Depression, Dissociation and PTSD

- Trauma Focussed Cognitive Behaviour Therapy and Stress Inoculation Therapy

Evidence Base

Forbes D, Creamer M, Phelps A, Bryant R, McFarlane A, Devilly GJ, Matthews L, Raphael B, Doran C, Merlin T, Newton S. (2007) Australian guidelines for the treatment of adults with acute stress disorder and post traumatic stress disorder *Australian & New Zealand Journal of Psychiatry* 41:637-648
Cohen JA, Deblinger E, Mannarino AP, Steer R. (2004) A multisite, randomized controlled trial for children with sexual abuse related PTSD symptoms. *Journal of the American Academy of Child Adolescent Psychiatry. 43:393-402*
Foa EB, Chrestman KR, Gilboa-Schechtman E, (2009). Prolonged exposure therapy for adolescents with PTSD: Emotional processing of traumatic experiences: Therapist guide.; *New York, NY, US: Oxford University Press, 2009. xii, 206 pp*
Hembree EA, Foa EB (2003) Interventions for trauma-related emotional disturbances in adult victims of crime *Journal of Traumatic Stress 16:187-199.*
Hembree EA, Foa EB Dorfan NM, Street GP, Kowalski J, Tu X (2003) Do patients drop out prematurely from exposure therapy for PTSD? *Journal of Traumatic Stress. 16: 555-562*
Jonsson PV (2009) Complex trauma, impact on development and possible solutions on an adolescent intensive care unit *Clinical Child Psychology & Psychiatry. 14:437-54*
King NJ, Tonge BJ, Mullen P, Myerson N, Heyne D, Rollings S, Martin R, Ollendick TH (2000). Treating sexually abused children with posttraumatic stress symptoms: a randomized clinical trial. *Journal of the American Academy of Child Adolescent Psychiatry. 39: 1347-1355.*
Lewis C, Simons A, Silva S, Rohde P, Small D, Murakami J, High R, March J. 2009). The role of readiness to change in response to treatment of adolescent depression. *Journal of Consulting and Clinical Psychology. 77:422-428.*
Rauch SA, Cahill SP (2003) Treatment and Prevention of Posttraumatic Stress Disorder. Primary Psychiatry. 10:60-65.
Trowell J, Kolvin I, Weeranamthri T, Sadoski H, Berelowitz M, Glasser D Leitch I (2002) Psychotherapy for sexually abused girls: psychopathological outcome findings and patterns of change. *British Journal of Psychiatry160:234-247.*

Saunders BE, Berliner L, Hanson RF, eds. *Child Physical and Sexual Abuse: Guidelines for Treatment.* Revised Report: April 26, 2004. National Crime Victims Research and Treatment Center.
Spermon D, Gibney P, Darlington Y. (2009) Complex trauma, dissociation, and the use of symbolism in therapy. *Journal of Trauma & Dissociation. 10:436-50*
Weber S (2009) Treatment of trauma- and abuse-related dissociative symptom disorders in children and adolescents *Journal of Child & Adolescent Psychiatric Nursing. 22:2-6*

In addition, expressive therapies (art, sandplay) facilitate the expression of emotions and expression of traumatic events related to trauma focussed therapy.

Eating Disorders

- Integrated Management Program

  Evidence Base

  Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Anorexia Nervosa (2004) Australian and New Zealand clinical practice guidelines for the treatment of anorexia nervosa *Australian and New Zealand Journal of Psychiatry 2004; 38:659–670*
  National Collaborating Centre for Mental Health (2004) Eating Disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders *National Institute for Clinical Excellence Clinical Guideline*

- Dietetic Management

  Evidence Base

  Dietetic Management of Adolescents with Eating Disorders is based on existing guidelines and current literature. Including but not limited to:

  Golden HN. (2003)et al Eating disorders in adolescents: position paper of the Society for Adolescent Medicine. *Journal of Adolescent Health. 33:496-503.*
  Practice Recommendations for the Nutritional Management of Anorexia Nervosa in Adults http://www.daa.asn.au/index.asp?pageID=2145872887
  American Dietetic Association (2006) Position of the American Dietetic Association: Nutrition Intervention in the Treatment of Anorexia Nervosa, Bulimia Nervosa, and Other Eating Disorders. *Journal of the American Dietetic Association. 106: 2073-2082.*
  ANZAED The Role of Nutritional Management in the Treatment of Eating Disorders Position Paper. (2008) http://www.anzead.org.au/files/nutrition_position_paper.pdf
  Yager J, Devlin MJ, Halmi KA, Herzog DB, Mitchell JE, Powers P, Zerbe KJ, (2006) Practice guideline for the treatment of patients with eating disorders (3rd edition) Arlington *American Psychiatric Association.*
  Eating Disorder Toolkit - a practice-based guide to the inpatient management of adolescents with eating disorders, with special reference to regional and rural areas (2008) *MH-Kids Centre for Eating Disorders*
  Dietetic Association of Australia. Guidelines for paediatric nutrition support in health care facilities. (2001)
  Dietetic Association of Australia. Enteral Feeding Manual for Adults in Health Care Facilities. (2007)

  The Dietetic Association of Australia Eating Disorders Interest Group acknowledges that there is a gap literature regarding practice guidelines for the management of Anorexia Nervosa in Children and Adolescents. This is currently being addressed.

- Psychotherapies (including Motivational Enhancement and CBT-E) and Family Therapies. (Numerous articles up to the present outline[24,25,26] the poor

[24] Gowers S, Bryant-Waugh R. (2004) Management of child and adolescent eating disorders: the current evidence base and future directions. *Journal of Child Psychology and Psychiatry 2004; 45: 63–83.*
[25] Hay PPJ, Bacaltchuk J, Byrnes RT, Claudino AM, Ekmejian AA, Yong PY. Individual psychotherapy in the outpatient treatment of adults with anorexia nervosa. *Cochrane Database of Systematic Reviews 2003, Issue 4. Art. No.: CD003909.*
[26] Treasure J, Claudino AM, Zucker N (2010) Eating disorders *The Lancet 375:583-593*

Evidence Base for therapeutic interventions for anorexia nervosa, although the strongest to date is for the Maudsley Intervention. Where this is not suitable – e.g failure of the intervention already, or the adolescent is in unstable foster care, interventions are planned on a range of interventions described in the literature. These are listed below.)

Bowers W. (2002). Cognitive therapy for anorexia nervosa. *Cognitive and Behavioral Practice. 9:247-253.*
Bowers WA, Ansher LS (2008) The effectiveness of cognitive behavioural therapy on changing eating disorder symptoms and psychopathology of 32 anorexia nervosa patients at hospital discharge and one year follow up. *Annals of Clinical Psychiatry 20:79-86*
Eisler I, Simic, M, Russell GF Dare C (2007) A randomised control trial of two forms of family therapy in adolescent anorexia nervosa: a five year follow up *Journal of Child Psychology and Psychiatry and Allied Disciplines 49:552-60*
Fairburn CG, Cooper Z, Shafran R. (2003) Cognitive behaviour therapy for eating disorders: a "transdiagnostic" theory and treatment. Behavior *Research and Therapy 2003; 41: 509–28.*
Keel PK, Haedt A. Evidence-based psychosocial treatments for eating problems and eating disorders. *Journal of Clinical Child Adolescent Psychology 2008; 37: 39–61.*
Pearson, K., (2009). Cognitive behavior therapy and eating disorders. *British Journal of Psychology. 100:804-806.*
Robin AL, Siegel PT, Move AW, Gilroy M, Dennis AB, Sikand A (1999) A controlled comparison of family versus individual therapy for adolescents with anorexia nervosa *Journal of the American Academy of Child and Adolescent Psychiatry 38:1482 – 1489*
Tierney S, Fox JR (2009) Chronic anorexia nervosa: a Delphi study to explore practitioners' views *International Journal of Eating Disorders 42:62-67*
Townsend E. Hawton K. Altman DG. Arensman E. Gunnell D. Hazell P. House A. Van Heeringen K. (2001) The efficacy of problem-solving treatments after deliberate self-harm: meta-analysis of randomized controlled trials with respect to depression, hopelessness and improvement in problems. *Psychological Medicine. 31:979-88*

2. Treatment Interventions across Disorders

Individual Therapies

Evidence base

Young JF, Mufson L, Davies M (2006) 'Impact of Comorbid Anxiety in an Effectiveness Study of Interpersonal Psychotherapy for Depressed Adolescents', *Journal of the American Academy for Child and Adolescent Psychiatry 45:904-912.*
Castonguay LG, Beutler LE. (2006). Principles of therapeutic change: A task force on participants, relationships, and techniques factors. *Journal of Clinical Psychology,:631–638.*
Kaslow NJ, Thompson MP (1998) Applying criteria for empirically supported treatments to studies of psychosocial interventions for children and adolescents depression. *Journal of Clinical Child and Adolescent Psychology 27:146-155*
King, R. (1998) Evidence-based practice: where is the evidence? The case of cognitive behaviour therapy and depression. *Australian Psychologist*, 33, 83-88.

Family Therapies

Evidence base

Carr, A. (2009) 'The effectiveness of family therapy and systemic interventions for child-focused problems', *Journal of Family Therapy*, (31) 3-45.
Hayes AM, Laurenceau JP, Feldman G, Strauss JL, Cardaciotto (2007) Change is not always linear: the study of nonlinear and discontinuous patterns of change in psychotherapy. *Clinical Psychology Review27:715-723*
Larner, G. (2009) 'Integrating family therapy in adolescent depression: an ethical stance', *Journal of Family Therapy 31: 213-232.*

The following group interventions are adaptations of interventions described in the literature. Each group is described briefly.

Groups – Dialectical Behaviour Therapy

DBT is a therapy approach, with skills that can be used for any individual who has difficulty tolerating distress, regulating emotions and relating effectively with others. Four core skills learned in DBT: mindfulness, distress tolerance, emotional regulation, interpersonal effectiveness. It has been found that DBT is most successfully incorporated into the treatment program by a weekly group of one hour for all adolescent patients at BAC. One DBT skill is addressed each term. Outcomes are measured by evaluation of checklists of attendance, behaviour, participation and progress has generally shown a gradual improvement in group performance over each term. Changes in the cohort tend to alter group dynamics. Increased participation coincides with anonymous group participation and collective group activities.

Evidence base

Dimeff LA, Koerner K (2007). Dialectical behavior therapy in clinical practice: Applications across disorders and settings. *New York, NY, US: Guilford Press, 363 pp.*
James AC, Taylor A, Winmill L, Alfoadari K (2008). A preliminary community study of dialectical behavior therapy (DBT) with adolescent females demonstrating persistent, deliberate self-harm (DSH). *Child and Adolescent Mental Health 13:148-152.*
Bogels SM. Sijbers GFVM. Voncken M (2006) Mindfulness and task concentration training for social phobia: A pilot study *Journal of Cognitive Psychotherapy. 20:33-44.*
Nelson-Gray RO, Keane SP, Hurst RM, Mitchell JT, Warburton JB, Chok JT, Cobb AR. (2006). A modified DBT skills training program for oppositional defiant adolescents: Promising preliminary findings. *Behaviour Research and Therapy 44:1811-1820.*
Salbach-Andrae H, Bohnekamp I, Pfeiffer E, Lehmkuhl U, Miller AL. (2008). Dialectical behavior therapy of anorexia and bulimia nervosa among adolescents: A case series. *Cognitive and Behavioral Practice 15:415-425.*

Groups – Social Skills and Community Access Groups

Social Skills training - this group has been run in many formats, depending on staffing, consumer and resourcing capabilities. It is focused on developing key verbal and non-verbal communication skills, and interpersonal skills (for example negotiation, problem-solving, assertiveness.

Community Access - to develop skills enabling independence in the community e.g. Public Transport, accessing community facilities, purchasing and consuming meals in public planning leisure-based outings; to encourage development of organisational and planning skills; to improve social skills through participation in group processes; to provide exposure to reduce anxiety around food, socialising, talking to shop assistants and promoting safety whilst in public spaces; to be able to work well within a group setting.

These groups have both treatment and rehabilitation components.

Evidence Base

Beidel DC, Turner SM, Morris TL. (2000) Behavioral treatment of childhood social phobia. *Journal of Consulting & Clinical Psychology 68:1072-1080*
Davies S (2004) A group-work approach to addressing friendship issues in the treatment of adolescents with eating disorders *Clinical Child Psychology and Psychiatry 94:519-531*
Dirks MA, Treat TA, Weersing VR (2007) Integrating theoretical, measurement, and intervention models of youth social competence. *Clinical Psychology Review 27:327-347*
LaGreca AM, Santogrossi DA (1980) Social Skills Training with elementary school students: a behavioral group approach. *Journal of Consulting and Clinical Psychology 48:220-227*
Losel F, Beelman A (2003) Effects of child skills training in preventing antisocial behavior: A systematic review of randomized evaluations. *The Annals of the American Academy of Political and Social Science 587: 84-109*
Rao PA, Beidel DC, Murray MJ (2008) Social skills interventions for children and adolescents with Asperger's Syndrome or High-functioning autism: A review and recommendations. *Journal of Autism and Developmental Disorders 38:535-361*

Silverman WK, Pina AA, Viswesvaran C. (2008) Evidence-based psychosocial treatments for phobic and anxiety disorders in children and adolescents *Journal of Clinical Child and Adolescent Psychology. 37:105-30*
Spence SH (2003) Social skills training with children and young people: Theory, evidence and practice. *Child and Adolescent Mental Health 8:84-96*
Webster-Stratton C, Reid J, Hammond M. (2001) Social skills and problem-solving training for children with early-onset conduct problems: Who benefits? *Journal of Child Psychology and Psychiatry 42:943-952*

Groups – Adventure Therapy

Adventure therapy creates an environment of experiential learning where adolescents face challenges which enable them to learn to problem solve to overcome challenges; learn to identify emotions and cognitions associated with challenging situations and implement strategies to moderate. Adventure activities can facilitates experiential learning by providing a tool to enable adolescents to reflect, generalise and apply what they have learnt from an adventure based experience. It utilises communication skills and skills in group participation. The main components are problem solving activities, challenging activities and camping. Observation suggests that individual A-B-A research designs may be more valid than group evaluations because of the heterogeneity of the group and variations.

Evidence Base

Carlson KP, Cook M (2007) Challenge by choice: adventure-based counselling for seriously ill adolescents *Child and Adolescent Psychiatric Clinics of North America 16:909-919*
Cook EC (2008) Residential wilderness programs: the role of social support in influencing seld-evaluations of male adolescents *Adolescence 43:751-774*
Gillan MC, Balkin RS (2006) Adventure counselling as an adjunct to group counselling in hospital and clinical settings *Journal for Specialists in Group Work 31:153-164*
Jelalian E, Mehlenbeck R, Lloyd-Richardson EE, Birmaher V, Wing RR (2006) 'Adventure therapy' combined with cognitive-behavioral treatment for overweight adolescents *International Journal of Obesity 30:31-39*
Kelly VA (2006) Women of courage: a personal account of a wilderness based experiential group for survivors of abuse *Journal for Specialists in Group Work 31:99-111*

3. Rehabilitation Interventions to Address Impairments across Disorders

A range of group and individual interventions are aimed at improving function in adolescents with a range of developmental impairments.

There is a dearth of research into rehabilitation interventions for adolescents with severe and complex mental illness. This suggests either that adolescents with severe and complex mental illness

- do not suffer impairments in function secondary to severe and complex mental illness or
- that any functional impairments resolve on treatment of the disorders or
- that impairments in function are commonly overlooked by clinicians or
- that rehabilitation interventions to address functional impairments are not as easy to address in common research paradigms

The first two possibilities are not supported by clinical observation.

Groups – psycho-education

Psycho-education – delivered in a group process to foster acceptance and tolerance within the ward environment – reducing stigmatisation and bullying. The group enables adolescents to understand differences between people.

Groups – fitness and physical activity

Sporting group, gym group, bike riding group, walking group run in 8- 10 week programs. Most adolescents including those with anorexia nervosa and social anxiety engage in solitary leisure pursuits prior to admission and either solitary or no exercise. Engaging in leisure accounts for 50-57% of most young people's time. Leisure enhances competencies, self efficacy and self worth. Adolescents that feel less competent are more likely to choose solitary activities and use these opportunities to ruminate on their problems. Conversely there is evidence to support non-specific psychological effects of exercise

Evidence Base

Bracegirdle, H. (2002). Developing physical fitness to promote mental health. In J. Creek (Ed.), *Occupational Therapy in Mental health* (3rd ed.). (pp. 209-225). Sydney: Churchill Livingstone.

Davies, S. Parekh K, Etalapaa K, Wood, D, Jaffa T (2008) The inpatient management of physical activity in young people with anorexia nervosa *European Eating Disorders Review 16:334-340*

Henley R, Schweitzer I, De Gara F, Vetter S (2008) How psychosocial and sports programs help youth manage adversity: a review of what we know and what we should research *International Journal of Psychotherapy 12:53-61*

Tokumura M, Yoshiba S, Tanaka T, Nanri S, Watanabe H (2003) Prescribed exercise training improves exercise capacity of convalescent children and adolescents with anorexia nervosa *European Journal of Pediatrics 162:430-431*

Szabo CP, Green K (2002) Hospitalized anorexics and resistance training: impact on body composition and psychological well-being. A preliminary study *Eating and Weight Disorders 7:293 - 297*

Groups – cooking

Cooking groups involve planning balanced and varied meals, growing or purchasing food to preparation, developing simple to complex cooking skills, trialling new foods, and when consuming the meal, learning meal etiquette and socialising during meal time and learning the basics of eating out.

Evidence Base

Hinojosa, J., & Blount, M.L. (2004). *The texture of life; Purposeful activities in occupational therapy* (2nd ed.). Bethesda: AJOT

Zielinski-Grimm, E., Meus, J. S., Brown, C., Exley, M., & Manner, T. (2009). *OTJR: Occupation, Participation and Health.* Meal Preparation: Comparing Treatment Approaches to Increase Acquisition of Skills for Adults With Schizophrenic Disorders. 29:04.

Individual treatment and rehabilitation interventions – healthy eating (Dietitian + Nursing Staff)

The Dietitian meets with adolescents directly to identify priority areas for behaviour change. Graded dietary changes are developed with supportive meal therapy and Motivation Interviewing techniques where change is necessary. Meal plan developed for adolescents with eating disorders and for adolescents with specific dietary requirements that require support from staff for effective implementation. Special dietary requirements can be met by hospital foodservices.

Individual rehabilitation interventions - self care (Occupational Therapist + Nursing Staff)

- Personal care – showering, dressing, sleep patterns, basic first aid etc,
- Community management – road safety, public transport, budgeting etc.

- Vocational readiness – work interests and goals, motivation to find and work, job search resumes, time management etc.
- House management – chores and home duties, planning meals cooking and preparing simple and complex meal etc.
- School – attending school, addressing difficulties, managing work load, time
- Individualised dietary planning

Evidence base

Kopelowicz, A. & Liberman, R. P. (2003). Integration of Care: Integrating Treatment with Rehabilitation for Persons With Major Mental Illness. *Psychiatric Services 54, 1491-1498.*
Lloyd C, Waghorn G (2007) The importance of vocation in recovery for young people with psychiatric disabilities *British Journal of Occupational Therapy 70:50-59*
Loyd, C., Waghorn, G. (2010). The Importance of Vocation in Recovery for Young People with Mental Illness. In Loyd, C. *Vocational Rehabilitation and Mental Health* (pp. 115-151). United Kingdom: Wiley-Blackwell

Individual rehabilitation interventions - leisure activities (Occupational Therapist + Nursing Staff)

- Quiet relaxation – identifying and participating in interests, hobbies etc.
- Active relaxation – sports, outings, travel, exercise, fitness and health
- Socialisation – keeping in touch with family, friends, social participation etc.

Individual rehabilitation interventions – improved communication skills (Speech Pathologist + Nursing Staff)

- individual skills training for social interactions;
- development of self talk for self regulation;
- development and use of language underlying emotional literacy;
- development and use of language underlying for problem solving;
- development and acquisition of vocabulary and sentence construction skills to assist functional communication

APPENDIX 3 – RESEARCH PRESENTATIONS

All of the publications, presentations, current research projects and academic links are based on research conducted at BAC

Publications

Harnett PH. Loxton NJ. Sadler T. Hides L. Baldwin A. (2005) The Health of the Nation Outcome Scales for Children and Adolescents in an adolescent in-patient sample. *Australian & New Zealand Journal of Psychiatry. 39:129-35*

Clarke A, Soady D (2006) Social skills impairment impacts on behaviour in the school setting, Talkabout, Volume 19, 2006 (with Deborah Soady, Logan-Beaudesert CYMHS)

Clarke A (2008) Tourette's Syndrome: A comprehensive review of diagnosis, course, aetiology, assessment and treatment" *Talkabout 21*

Ward, D. (2009) Five messages every adolescent needs to hear, *Psychotherapy in Australia 15:48-54*

Presentations:

Harnett P, Sadler T (2003) Health of the Nations Outcome Scales for Children and Adolescents (HoNOSCA) in an adolescent inpatient centre *Queensland Health Mental Health Research Conference, Brisbane*

Sadler T (2004) Borderline Personality Disorder in Adolescence *Bi-National Grand Rounds, CYMHS Training Centre, Brisbane*

Sadler T (2005) Models of Care in Grief and Trauma *Child and Adolescent Psychiatry Grand Rounds, Brisbane*

Clarke A (2006) Charting a life: analysis of 50 adolescents in a long-stay mental health unit. *Speech Pathology Australia National Conference, Fremantle*

Clarke A (2006) Communication Profiling and masking Behaviours *Department of Child Psychiatry, University of Queensland/Royal Brisbane and Women's Hospital, State-wide Grand Rounds*

Clarke A (2006) Prevalence of Communication Disorders in Mental Health *Queensland Health and Medical Research Conference, Brisbane*

Corbett D, Clarke A (2006) Community Access and Socialisation Group *Australian Allied Health Conference, Hobart*

Sadler T (2006) Adolescent Trauma *Seminar: Trauma in Childhood and Adolescence, Toowoomba*

Clarke A (2006) Communication Profiling and masking Behaviours *Education Queensland, Training and Development Seminar (TADS), Brisbane*

Sadler T (2006) The role of attachment in professional interactions with traumatised adolescents *Brisbane North Interagency Forum, Brisbane*

Clarke A (2006) Charting a life: analysis of 50 adolescents in a long-stay mental health unit. *17th World congress of the International Association for Child and Adolescent Psychiatry and Allied Professionals. Melbourne*

Clarke A, Corbett D (2007) Community Access and Socialisation Group *Mater Kids in Mind Conference, Brisbane*

Clarke A (2007) Communication and Mental Health *Mater Kids in Mind Conference, Brisbane*

Clarke A, Corbett D (2007) Community Access and Socialisation Group *RANZCP Faculty of Child & Adolescent Psychiatry Annual Conference, Port Douglas*
Corbett D, Bruce K (2008) "Food Challenges" Community Access group for Adolescents with Eating Disorders. *RANZCP Faculty of Child & Adolescent Psychiatry Annual Conference, Port Douglas*
Sadler T (2008) Reflections on two decades of adolescent school refusal *Child and Adolescent Psychiatry Grand Rounds, Brisbane*
Corbett D, Ward D (2009) The BAC Community Access and Socialisation Group *Protecting Children Today Conference, Brisbane*
Hayes M, Clarke A (2009) The role of Occupational Therapy and Speech Pathology in managing children with complex trauma *Zonal Directors Statewide Meeting, Department of Child Safety, Brisbane*
Hoang K (2009) Benefits of adventure therapy in a mental health setting. *Victorian Outdoor Education Conference, Melbourne*

Current Research Projects:
Case review study, (first commenced in 2005 and continuing), compares communication disorders and psychiatric diagnoses. Results found common communication profile amongst eating disordered (anorexic) patients; identified the prevalence of communication impairment in the self-harming population. This project is currently being considered by the University of Queensland, Division of Speech Pathology and Audiology, for inclusion in the next round of Honour's and Master's students.
A proposal is currently before RCH Ethics Committee entitled: Communicate: an examination of the interface between self harming populations and communication impaired populations in child and youth mental health services.
Design, trial and evaluation of *BAC Adolescent Developmental Tasks Questionnaire* – a measure of the key adolescent developmental milestones to assess an adolescent's strengths and difficulties to assist care planning in a rehabilitation environment.

Academic Links:
Clarke A, (2005 – 2009) Invited lecturer: Communication profiles in mental health, engagement with adolescents, Specific diagnoses – ADHD, Aspergers, OCD, anxiety, depression *University of Queensland Division of Speech Pathology, School of Rehabilitation Sciences*
Corbett D (2006 – 2009) Invited lecturer: Clinical skills in adolescence *Masters and Doctorate of Clinical Psychology Postgraduate Program, Psychology Department, The University of Queensland*
Corbett D (2006 – 2009) Invited lecturer: The scientist practitioner model in action *Postgraduate Honours Psychology Program, Psychology Department, The University of Queensland*
Sadler T (1993 – 2010) Managing adolescents with severe and complex mental illness (4 sessions per year) *Queensland Advanced Trainee Registrar Program, RANZCP*

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

EXHIBIT 58

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.

EXHIBIT 58

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.

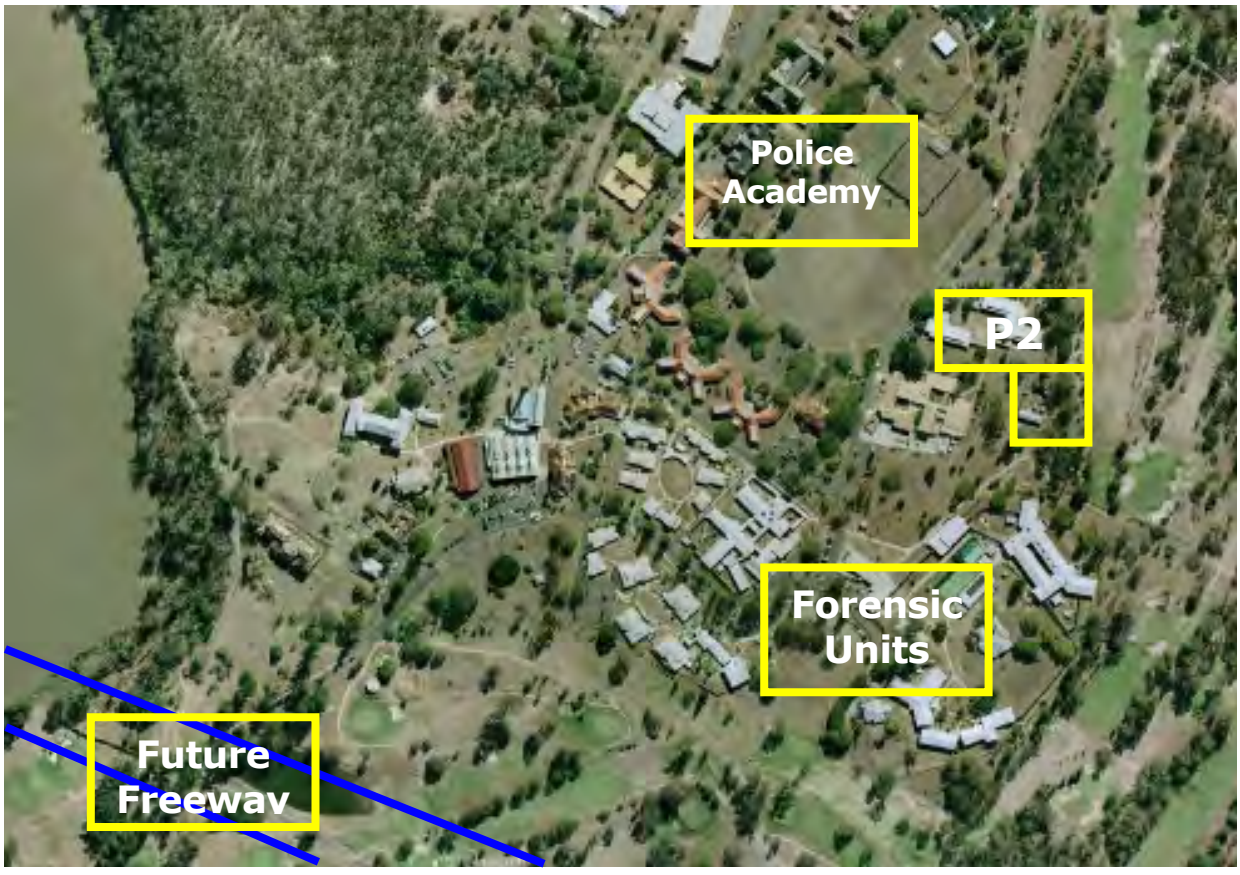
Koalas.

- 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.

EXHIBIT 58

Fig 3. Site P2 Stage 1 (Existing Site Redeveloped in 3 Stages) (Aerial View)

SITE OPTION 1 ON EXISTING SITE AT THE PARK - STAGE 1

Project No: 51426
Project Title: 15 Bed Adol. ETU, Day Centre and School

Scale 1:1000 @ A3

Note: Options diagrams are based on draft accommodation schedule and spatial relationships workshops only and are not intended to be used as sketch designs.

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Department of Public Works

EXHIBIT 58

Fig 4. Stage 2 Site P2 (Existing Site Redeveloped in 3 Stages) (Aerial View)

SITE OPTION 1 ON EXISTING SITE AT THE PARK - STAGE 2

Project No: 51426
Project Title: 15 Bed Addl. ETU, Day Centre and School

Scale 1:1000 @ A3

Note: Options diagrams are based on draft accommodation schedule and spatial relationships workshops only and are not intended to be used as sketch designs.

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Project Services
Department of Public Works
The State of Queensland 2010

Fig 5. Stage 3 Site P2 (Existing Site Redeveloped in 3 Stages) (Aerial View)

SITE OPTION 1 ON EXISTING SITE AT THE PARK - STAGE 3

Project No: 51426
Project Title: 15 Bed Addl. ETU, Day Centre and School

Scale 1:1000 @ A3

Note: Options diagrams are based on draft accommodation schedule and spatial relationships workshops only and are not intended to be used as sketch designs.

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Department of Public Works

5. Site Options Conclusion

Redland
According to the analysis provided in this report Redland appears to be the most suitable location for the redevelopment of the 15 Bed adolescent extended treatment unit.

This site measures favourably against the 'Essential' and 'Desirable' characteristics nominated in the revised 'Site Selection Criteria'. The local area affords considerable opportunity to access the natural environment, rehabilitation activities and community and primary care services. The area is adequately serviced by public transport, without being too busy or likely to become a thoroughfare.

The development of a 'green field' option will also avoid some of the logistical challenges and time and cost implications of redeveloped existing buildings.

Importantly, it is not compromised by the risks associated with co-location with forensic inpatient services.

The BAC Clinical Director has identified that the greatest challenge associated with this site is its distance from the existing service at Wacol. In addition, nurses operate under different awards at the two sites. Some senior and experienced staff from both Queensland Health and the Department of Education Training and the Arts definitely would not make a transition to Redland. Managing the retention of experienced staff is critical to avoid crossing a threshold of loss of experience at which all existing staff would seek employment elsewhere. Such a loss of specialised staff would render the unit inoperable. Clearly a human resource management plan would be required to mitigate these significant challenges.

One of the potential benefits of this site is its proximity to Redland Mental Health Service. There are plans to both redevelop and add new acute inpatient beds at Redland in the second half of the Queensland Plan for Mental Health 2007-2017. Initial discussions indicated that the additional beds could well be targeted as youth beds (age 18-25). There has also been suggestion that a child and youth service hub be developed with community and the extended service located at Redland. There could also be opportunity to model improved coordination and integration between adolescent and adult services. It has been noted that co-locating the unit with other mental health services is in the strategic interest of the service.

Among the potential advantages of co-location of this kind include meeting the challenge of staff recruitment and retention.

The Redland site is the preferred option.

The Park
Although the existing and planned forensic services at The Park significantly impact on the feasibility of this option, there are understandable incentives to retain the current adolescent centre location. The service has enjoyed the development of an experienced cohort of staff and the formulation of effective local partnerships. Both are critical to the service model. The key strength of redeveloping in the same location is the inherent support this offers in sustaining the existing culture, expertise and partnerships.

Alternate options that consider relocation and redevelopment must acknowledge the challenges of service development at another site.

Of the three sites identified at The Park, the option to redevelop on the site of the existing unit (P2) is the only option that could be pursued from an architectural/ site planning perspective. The Adolescent Centre Site Appraisal identifies how the redevelopment might be staged to minimise its impact on the provision of services. It is important to acknowledge that this staging process would have time and cost implications for the project. It also indicates that the overall site footprint would need to be reduced in order to be developed on this site.

The site measures well against other 'essential' and 'desirable' characteristics. Close proximity to the natural environment, public transport and the presence of a natural buffer are among the attributes of the location. However, its relative isolation from other child and youth or other (non forensic) mental health services may pose a challenge for service development in the longer term.

As stated the close proximity of the site to the growing high security and extended treatment forensic programs compromise this option. Redeveloping the unit in close proximity to mentally ill offenders is likely to pose clinical and practical challenges and may become a matter of public interest.

Appendix 1 – Site options Appraisal

Fig 1. Sites P1 A and P1B- The Park Centre for Mental Health (Aerial View)

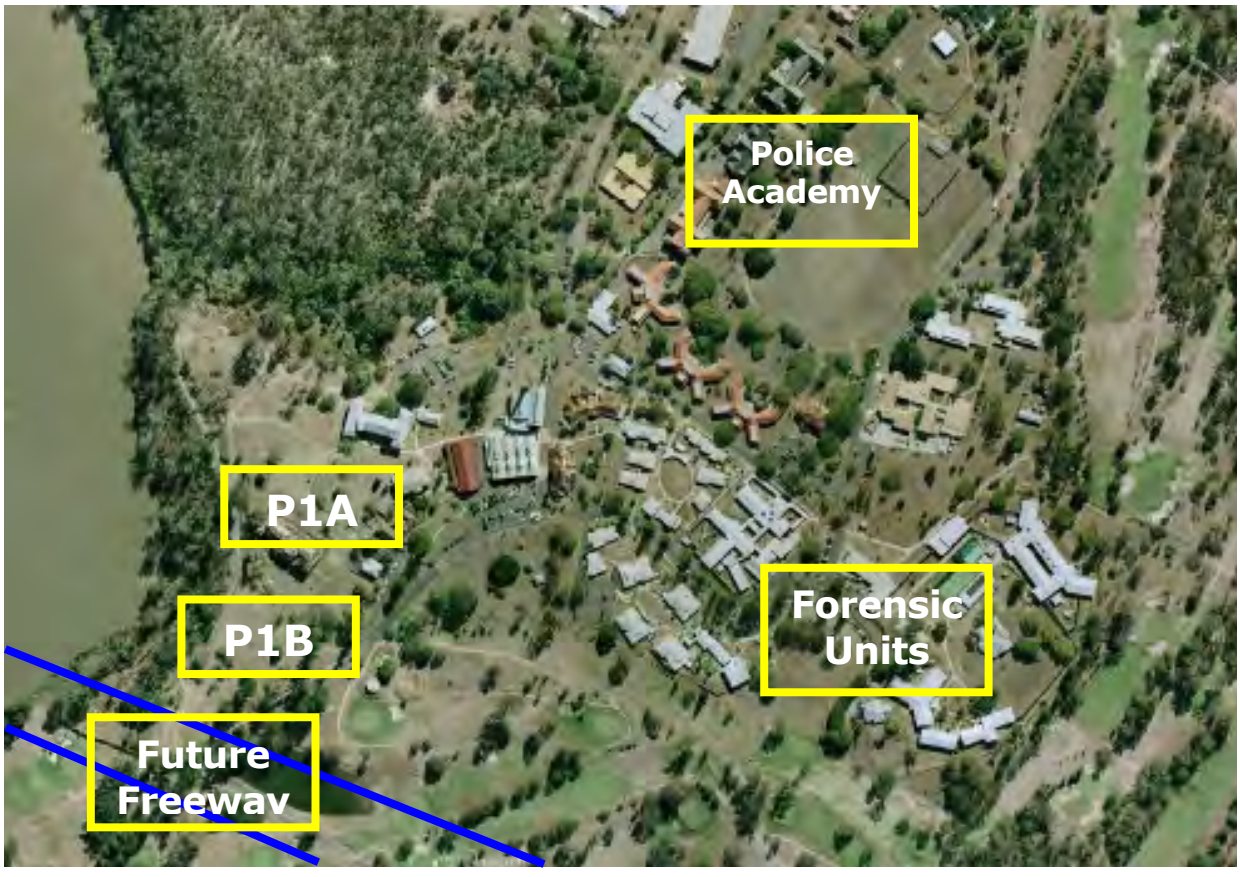

Fig 2. Site P1A (On Upper Side of Anderson House) (Scenic View)

Specific Site Considerations for P1A

- Old asylum buildings create an institutional ambience
- Proposed 110 km/hr freeway nearby with bridge over river.
- Close to forensic units affects “Undesirable Persons” & “Public perception & politics” aspects
- There is only about 5,000m2 of reasonably level site available, and this is only 33% of the 15,000m2 minimum
- Residents need to walk through forensic areas and across a golf course to reach the train station.

Conclusion
The size, topography and environment of the site make it unsuitable for the proposed Adolescent Unit.

Fig 3. Site P1B (On Lower Side of Anderson House) (Scenic View)

Specific Site Considerations for P1B

- Old asylum buildings create an institutional ambience.
- Proposed 110 km/hr 6 lane freeway adjacent with freeway bridge over river. Refer to Figure 1.
- Undesirable persons - Close to forensic units
- Level site area of only about 0.4 Ha (2 Ha preferred area / 1.5 Ha minimum)
- Residents need to walk through forensic areas and across a golf course to reach the train station.
- The proximity to forensic unit may influence Public Perception, Politics.
- High pressure water main across middle of site is likely to prevent development economically

Conclusion

The size, topography and environment of the site, plus the existing high pressure water main and possible future freeway make it unsuitable for the proposed Adolescent Unit.

Specific Site Considerations for Rogers St, Spring Hill

- Main roads and high rise buildings adjacent. Generally a busy inner-city location not compatible with the model of care.
- Too far from RBH
- Multiple physical hazards in the immediate vicinity.
- Numerous potential opportunities for contact with undesirable persons and activities in the Spring Hill and Fortitude Valley areas.
- No buffer space.
- Multiple escape routes and hiding places.
- Site is only 6684 square metres which is less than 50% of the 15,000 minimum.
- The existing buildings on site are unlikely to be suitable for the proposed new adolescent centre.
- Demolition of the buildings would be difficult to justify, given the quality and character of the buildings, and there may be heritage issues.
- There may also be heritage trees.

Conclusion

The size and environment of this site make it unsuitable for the Adolescent Unit as currently envisaged.

Specific Site Considerations for CAFTU

- Very steeply sloping site with existing buildings on three levels would not allow the kind of development required by the model of care.
- Site is adjacent to major hospital with high rise buildings.
- Site is near to main roads, a railway line, and high buildings, including multi-storey car parks.
- Limited buffer space, and multiple escape routes and hiding places
- Site area of under 5,000m2 is only about 30% of the minimum required.

Conclusion

The size, topography and environment of this site make it unsuitable for the Adolescent Unit as currently envisaged.

Appendix 2 – Site Tour Notes

THERAPEUTIC FACTORS				
External Views: Importance: 2 Desirable				
Desirable views: sky, trees, distant objects, grass, landscape, sports ovals. Sense of distance, calmness more important than people, but distant views of people engaged in gentle activities is desirable. Water is a bonus				
Undesirable views: anything that is too busy or intrusive; buildings				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Green field sight currently surrounded by bushland Located next to Redland hospital Commercial warehouse precinct adjacent separated from site by a road Future use of other vacant land unknown Some nearby reserve areas	Both sites afford greenery/sense of distance Views of the river possible in one site Sense of calmness might be inhibited by police training exercises including use of firearms and sniffer dogs Derelict ward may also compromise views from some angles	Relatively secluded location Some established trees and greenery Located on busy hospital campus No views of green spaces or water	Relatively quiet, leafy site Some established trees at the periphery Limited sense of distance eg views of horizon No immediate water features	Offers some nearby bush land and park areas. These are somewhat compromised by industrial area close by.

ACCESS TO NATURAL ENVIRONMENT				
Importance: 2 Desirable				
Desirable: Grass, trees, animals, water (as long as it is safe), gardens, getting back to nature				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Nature reserve readily accessible from site Bay is close by for arrange of other supervised activities Parks also in close proximity	Both sites afford some greenery/sense of distance Views of the river possible in one site Access without supervision may be compromised by safety issues eg accessing water alone and use of the campus in conjunction with other users of the grounds	Some established trees and greenery Victoria Park may be accessed under staff supervision	Some established trees at the periphery. Capacity to access Victoria Park precinct under staff supervision	Some potential amid existing green space.

ACCESS TO OUTDOOR ACTIVITIES				
Importance: 2 Desirable				
Desirable: Grass, trees, animals, water (as long as it is safe), gardens, getting back to nature				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Affords nearby nature reserves, readily accessible from site Bay is close by for other supervised activities Greenfield site may enable development of space for courtyards, games etc depending on exact land size	Some established trees and greenery Access to Victoria Park precinct under staff supervision Few other opportunities.	Some established trees and greenery Access to Victoria Park precinct under staff supervision Few other opportunities	Access Victoria Park precinct under staff supervision. Existing courtyard may be used for onsite for games etc	Site offers some potential for these spaces

EXHIBIT 58

EXTERNAL BUFFER SPACE & BOUNDARIES ESPECIALLY FOR NOISE MANAGEMENT				
Importance: Essential				
At least 50m away from houses is a minimum to reduce bad interactions with neighbours (both ways). There needs to be clearly defined boundaries but boundaries should be as invisible and unoppressive as possible. Good buffer spaces can reduce the need for fences				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Considerable buffer space with existing nature reserves Neighbouring hospital campus and adjacent commercial area may compromise aspects of this buffer Suitability of future use of land for this purpose is also unknown- unlikely to be factored into planning	Hospital campus and golf courses provide buffer. Compromised on some areas by steep slope of river bank, derelict ward and neighbouring services eg DSQ and Juvenile Justice Centre	Limited external buffer space apart from hospital	Some capacity to provide external buffer	Limited external buffer space apart from schools

TOPOGRAPHY				
Importance: Nice to Have				
An elevated site with long views and vistas into the distance is preferable, but the site of the facility must be reasonably level.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Site is undeveloped but natural topography is unlikely to afford long views to the distance	Site affords long views to the distance from some areas	Site does not offer long views into the distance.	Site does not offer long views into the distance	Site not elevated limited views

CLIMATE / ASPECT				
Importance: Nice to Have				
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				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Extent of breezes uncertain but proximity to the bay likely to be favourable in this regard	Significant breezes likely at sites overlooking the river Open spaces may contribute to breezes in other sites	Extent of cooling breezes difficult to determine Unlikely given buildings closely neighbouring the site	Unsure as to the extent of cooling breezes Established trees likely to offer shade	Level of cooling breezes difficult to gauge

EXHIBIT 58

SURROUNDING BUILT ENVIRONMENT				
Importance: Essential				
Avoid:- High rise and high density buildings. Overlooked sites. Main roads, railways, and other noisy busy areas. Intimidating, institutional or non-domestic general environment.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Site relatively free of high rise buildings Road in front of site does not currently have through access and therefore not a major thoroughfare Aspects of the neighbouring hospital site likely to be non-domestic Unsure about future uses of other neighbouring parcels of land	Natural environment is a real asset, but located in institutional (potentially intimidating) precinct-juvenile justice, high security unit, extended treatment forensic unit, medium secure unit, police academy etc	Nearby high rise buildings and close proximity of residential areas likely to be challenging aspect of this site Hospital campus location largely overcomes issues of busy roads, but campus itself might present intimidating non domestic feel.	Neighbouring school buildings may constitute a challenge Large Salvation Army facility overlooks site, but its windows are not oriented to where the service may be developed While the site is in an inner city location it appears reasonably protected from busy roads and thoroughfares	Some benefits in vacant land. Some semi industrial use nearby

PRIVACY				
Importance: Essential				
Privacy for the adolescent consumers is important, but the facility should not be too isolated. It is desirable for consumers to have opportunities to see people outside, but adolescents should not be “on display”. Contact with the public and families needs to be controlled. It is important that public thoroughfares do not happen through the facility site.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Undeveloped site and neighbouring reserves afford good potential to develop site in a manner that maintains privacy Impact of future use of vacant land unknown	Open spaces offer potential to maintain privacy but other users of the site and surrounds may create some challenges Not likely to be a thoroughfare although may be isolated	Neighbouring buildings on hospital campus and neighbouring residential buildings may create a challenge for maintaining privacy on the site Unlikely to be a public thoroughfare	Neighbouring schools and homeless shelter may create some challenges for maintaining privacy in this area. Location is not isolated	Private site

EXHIBIT 58

SAFETY – EMERGENCY BACKUP				
Importance: Essential				
Access to help for 'code blacks' is critical. These incidents require back up from psych nurses specifically trained in aggressive behaviour management. A response is needed within 5 minutes; therefore the adolescent facility needs to be located where appropriate help is available.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Proximity to the adult acute unit and hospital campus is favourable in this regard	Service currently receives code black support from ETR and Medium Secure staff High security service does not provide code black response Code black response might be compromised at Orford drive site As ETR is replaced by community care units and in time medium secure is downsized the maintenance code black response may not be assured	Code black response may be offered from hospital security Size of the campus makes fast code black response from adult mental health staff unlikely	After hours code black access to this site is an outstanding issue	Major weakness. Not near enough to mental health unit

PHYSICAL HAZARDS				
Importance: Nice to Have				
Avoid: bridges, high buildings, cliffs, multi-storey car parks, bridges, main roads, train lines				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Some main roads located in vicinity	Train line and abandoned buildings located in vicinity	Multistorey car park located on hospital campus Other physical hazards in the vicinity	Some high buildings and other physical hazards located in the vicinity	Some distance from these things

UNDESIRABLE PERSONS				
Importance: Essential				
Avoid opportunities for contact with 'undesirable persons'.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Site is not located near 'undesirable groups'	Growth in forensic programs particularly Extended Treatment Forensic programs makes this area problematic	May be some concern in the event consumer absconded to Fortitude Valley	May be somewhat of a challenge in Spring Hill and close proximity to homeless shelters	Site is not located near 'undesirable groups'

ABSCONDING				
Importance: Desirable				
A buffer of space around the facility is important – a buffer of 5 minutes walk (300m) to public transport to deter rapid absconding. Avoid potential hiding places. Multi-purpose games court (tennis, basket ball, volleyball).				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Site likely to offer reasonable buffer for accessing public transport. Neighbouring nature reserve may be a challenge in the event of an absconding attempt	Site has about a 300m buffer between it and public transport.	Hospital campus may act as a buffer to accessing public transport but may not deter rapid absconding.	Closest bus stop about 450 metres May not deter absconding due to building density	

EXHIBIT 58

SITE PLANNING FACTORS				
On Site Activities Multi-purpose games court (tennis, basket ball, volleyball).				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Potential for on campus sporting options	Site has about a 300m buffer between it and public transport.	Limited on campus sports and activity options	Some opportunity to have some onsite sporting and other activities	

Vehicle Access & Parking				
Importance: Nice to Have Need space for car and mini-bus access to front of building and truck / ambulance / police access to rear. Must adhere to QHealth and building code requirements.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Not likely to be problematic on site	Not likely to be a problem on site	Might be a challenge on site	Not likely to be problematic on site	

Access to Facilities				
Importance: Desirable Access to Gymnasium				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Land size may permit larger design	Land size may permit larger design Access to large open grassed area	Land may not permit entire gymnasium, but exercise room may be	Land may not permit entire gymnasium, but exercise room may be possible.	Land size may permit larger design
Importance: Essential Access to Large Open Grassed Area				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Footprint may be larger on this site	Footprint may be larger on this site	Large open grassed area unlikely on site	Large open grassed area unlikely on site	Footprint may be larger on this site
Importance: Nice to Have Access to a small swimming pool with spa and swim jets				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Site unlikely to prohibit this feature	Site unlikely to prohibit this feature	Site unlikely to prohibit this feature	Site unlikely to prohibit this feature	Site unlikely to prohibit this feature
Importance: Desirable Access to a full size swimming pool				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Site within 5 minutes drive of local aquatic centre	Site within 5 minutes drive of Goodna Pool	Site within 5 minutes drive of centenary pool	Site within 5 minutes drive of centenary pool	?
Importance: Desirable Access to a Sports Oval or park				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Site within reasonable distance of sporting facilities	Site located close to cricket oval	Site within reasonable distance of Victoria Park precinct	Site within reasonable distance of Victoria Park precinct	Close proximity to sporting facilities
Importance: Desirable Access to adventure training and water sports				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Bay is accessible to site	Brisbane river accessible to site	Accessible to 'Riverlife' at Kangaroo point and Rock Climbing at Fortitude Valley	Accessible to 'Riverlife' at Kangaroo point and Rock Climbing at Fortitude Valley	Reasonable proximity to activities

EXHIBIT 58

Public Transport				
Importance: Essential Need access to good public transport. Trains are preferred as being more reliable in timetable and less intimidating. (See attached summary)				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Not likely to be problematic on site	Not likely to be problematic on site	Might be a challenge on site	Not likely to be problematic on site	

Shops				
Importance: Desirable Need access to a variety of shops via public transport. There is graded use of shops in rehabilitation starting with smaller, less dense and closer shops and progressing on to large shopping malls. Ideally there should be a corner store within walking distance, and a major shopping centre a train ride away.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Some shopping available at Cleveland	Variety of shops accessible from Ipswich line	Variety of shops available in Brisbane City/Fortitude Valley/ New Farm	Variety of shops available in Brisbane City	Some shopping available at Logan

Other Facilities				
Importance: Desirable It is desirable to have other types of social activities available in the community such as:- churches, youth groups, sporting groups, dancing classes etc. (these are examples only – it is not important to have a particular type of community activity, group, club available).				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
May be able to access these activities and opportunities in the Cleveland area	May be able to access some activities in the Goodna/ Gailes area	Lack of isolation increases likelihood of accessing community activities in local area	Lack of isolation increases likelihood of accessing community activities in local area	Access to some activities likely

On-site independent accommodation units				
Importance: Essential Future proof for on-site independent accommodation units (for family visits and for consumers preparing to leave). Note: This is not in current scope of works but should be considered in future construction.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Site size unlikely to prohibit provision of this space	Site size unlikely to prohibit provision of this space	Size of site may make future proofing a challenge	Size of site may make future proofing a challenge	Site size unlikely to prohibit provision of this space

Hospitals & Doctors				
Importance: Essential Hospital emergency department within a 20 minute drive of the facility. A good working relationship with a local hospital is important.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Located at Redland Hospital	Ipswich Hospital closest available emergency facility	Located at RBH	Within 20 minutes of RBH	Within 20 minutes of Logan
Importance: Essential Proximity to the Qld Children's hospital is desirable				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Considerable distance from Qld Childrens Hospital close proximity to other mental health services	Some distance from Qld children's hospital, some distance from other child and youth services. Close proximity to forensic mental health services and medium secure staff.	Reasonable proximity to Qld Childrens Hospital close proximity to other C&Y mental Health Services	Reasonable proximity to Qld Childrens Hospital close proximity to other C&Y mental Health Services	Considerable distance from Qld Childrens Hospital close proximity to other mental health services

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Importance: Desirable Proximity to an 'after hours' GP clinic is desirable.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Significant number of General Practitioners in Cleveland area with opening hours to 7pm.	Access to General Health Service- The Park	Some options in reasonable proximity	Some options in reasonable proximity	Access to Logan Clinics

Public Transport				
Importance: Essential Hospital emergency department within a 20 minute drive of the facility. A good working relationship with a local hospital is important.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Located at Redland Hospital	Ipswich Hospital closest available emergency facility	Located at RBH	Within 20 minutes of RBH	Within 20 minutes of Logan

Access for Families & Visitors				
Importance: Nice to Have Local external accommodation for families such as motels and hotels with good public transport access to the facility.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
'Holiday style' accommodation available in close proximity	Limited accommodation options at Darra.	May be some local options with existing partnerships eg Ronald McDonald House.	Variety of temporary accommodation options in Spring Hill.	Some options available

Police				
Importance: Desirable 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.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Close proximity to local police station	Reasonable proximity to Mt Ommaney police station	Reasonably close to Valley Police Station	Reasonably close to Valley Police Station	Reasonable proximity to police station

Staff Access				
Importance: Nice to Have Staff recruitment and retention are important factors. Consider metropolitan location.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
45 minute drive from CBD may be a challenge for some staff. May also be a challenge for existing staff. May be some benefit from co-location with other services.	Advantages associated with retaining existing location and staffing group- some concern in the future about the isolation of the service from other child and youth services.	Centrally located. May be some advantages in being located with other mental health services.	Centrally located. May be some advantages in being located with other C&Y services	Some distance from existing service. Serviced by Logan and Pacific Motorways

EXHIBIT 58

Site Acquisition & Development				
Importance: Essential What are the cost and time implications of site acquisition?				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
	Applicable to all sites Sites on The Park Campus QHealth Land. Orford Drive site may not be Q Health land.	Applicable to all sites- Q Health Land	Applicable to all sites- Q Health Land	Applicable to all sites

Site Development				
Importance: Essential Includes:- Obtaining development approvals. Providing site infrastructure (power, water, roads, sewers, drains, phones). Site preparation costs (earthmoving, site drainage). Foundation costs (does the site have problem ground?). Are there any existing facilities/services which need to be decanted (budget, timelines and other impacts)? Is the site large enough, now and in the future? Any heritage or indigenous issues? What are the time and cost implications of the above? Will any of these factors affect the use of the facility now and in the future?				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Applicable to all sites	Applicable to all sites	Applicable to all sites	Applicable to all sites	Applicable to all sites

EXHIBIT 58

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

EXHIBIT 58

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

EXHIBIT 58

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.

EXHIBIT 58

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

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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.

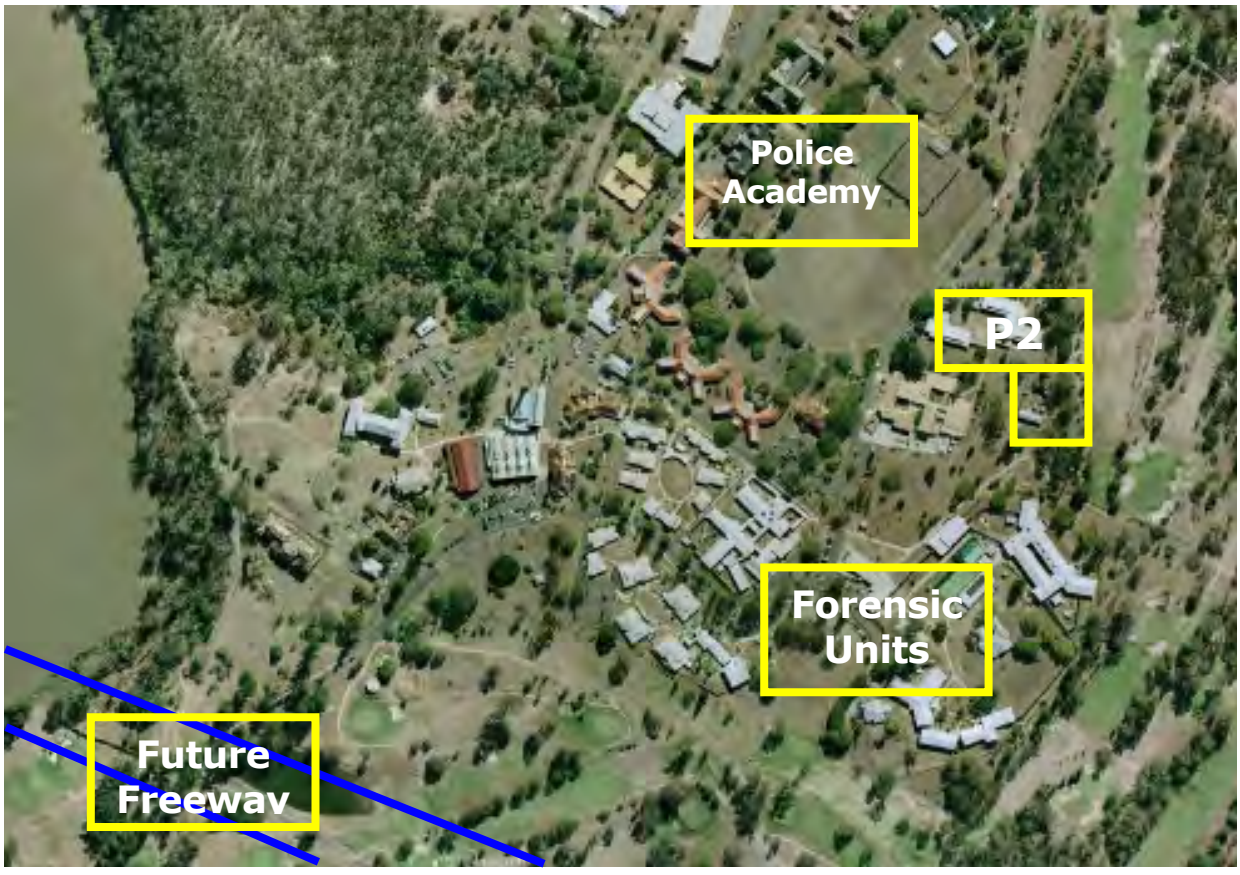
Koalas.

- 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.

EXHIBIT 58

Fig 3. Site P2 Stage 1 (Existing Site Redeveloped in 3 Stages) (Aerial View)

SITE OPTION 1 ON EXISTING SITE AT THE PARK - STAGE 1

Project No: 51426
Project Title: 15 Bed Adol. ETU, Day Centre and School

Scale 1:1000 @ A3

Note: Options diagrams are based on draft accommodation schedule and spatial relationships workshops only and are not intended to be used as sketch designs.

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EXHIBIT 58

Fig 4. Stage 2 Site P2 (Existing Site Redeveloped in 3 Stages) (Aerial View)

SITE OPTION 1 ON EXISTING SITE AT THE PARK - STAGE 2

Project No: 51426
Project Title: 15 Bed Adol. ETU, Day Centre and School

Scale 1:1000 @ A3

Note: Options diagrams are based on draft accommodation schedule and spatial relationships workshops only and are not intended to be used as sketch designs.

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EXHIBIT 58

Fig 5. Stage 3 Site P2 (Existing Site Redeveloped in 3 Stages) (Aerial View)

SITE OPTION 1 ON EXISTING SITE AT THE PARK - STAGE 3

Project No: 51426
Project Title: 15 Bed Addl. ETU, Day Centre and School

Scale 1:1000 @ A3

Note: Options diagrams are based on draft accommodation schedule and spatial relationships workshops only and are not intended to be used as sketch designs.

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5. Site Options Conclusion

Redland
According to the analysis provided in this report Redland appears to be the most suitable location for the redevelopment of the 15 Bed adolescent extended treatment unit.

This site measures favourably against the 'Essential' and 'Desirable' characteristics nominated in the revised 'Site Selection Criteria'. The local area affords considerable opportunity to access the natural environment, rehabilitation activities and community and primary care services. The area is adequately serviced by public transport, without being too busy or likely to become a thoroughfare.

The development of a 'green field' option will also avoid some of the logistical challenges and time and cost implications of redeveloped existing buildings.

Importantly, it is not compromised by the risks associated with co-location with forensic inpatient services.

The BAC Clinical Director has identified that the greatest challenge associated with this site is its distance from the existing service at Wacol. In addition, nurses operate under different awards at the two sites. Some senior and experienced staff from both Queensland Health and the Department of Education Training and the Arts definitely would not make a transition to Redland. Managing the retention of experienced staff is critical to avoid crossing a threshold of loss of experience at which all existing staff would seek employment elsewhere. Such a loss of specialised staff would render the unit inoperable. Clearly a human resource management plan would be required to mitigate these significant challenges.

One of the potential benefits of this site is its proximity to Redland Mental Health Service. There are plans to both redevelop and add new acute inpatient beds at Redland in the second half of the Queensland Plan for Mental Health 2007-2017. Initial discussions indicated that the additional beds could well be targeted as youth beds (age 18-25). There has also been suggestion that a child and youth service hub be developed with community and the extended service located at Redland. There could also be opportunity to model improved coordination and integration between adolescent and adult services. It has been noted that co-locating the unit with other mental health services is in the strategic interest of the service.

Among the potential advantages of co-location of this kind include meeting the challenge of staff recruitment and retention.

The Redland site is the preferred option.

The Park
Although the existing and planned forensic services at The Park significantly impact on the feasibility of this option, there are understandable incentives to retain the current adolescent centre location. The service has enjoyed the development of an experienced cohort of staff and the formulation of effective local partnerships. Both are critical to the service model. The key strength of redeveloping in the same location is the inherent support this offers in sustaining the existing culture, expertise and partnerships.

Alternate options that consider relocation and redevelopment must acknowledge the challenges of service development at another site.

Of the three sites identified at The Park, the option to redevelop on the site of the existing unit (P2) is the only option that could be pursued from an architectural/ site planning perspective. The Adolescent Centre Site Appraisal identifies how the redevelopment might be staged to minimise its impact on the provision of services. It is important to acknowledge that this staging process would have time and cost implications for the project. It also indicates that the overall site footprint would need to be reduced in order to be developed on this site.

The site measures well against other 'essential' and 'desirable' characteristics. Close proximity to the natural environment, public transport and the presence of a natural buffer are among the attributes of the location. However, its relative isolation from other child and youth or other (non forensic) mental health services may pose a challenge for service development in the longer term.

As stated the close proximity of the site to the growing high security and extended treatment forensic programs compromise this option. Redeveloping the unit in close proximity to mentally ill offenders is likely to pose clinical and practical challenges and may become a matter of public interest.

Appendix 1 – Site options Appraisal

Fig 1. Sites P1 A and P1B- The Park Centre for Mental Health (Aerial View)

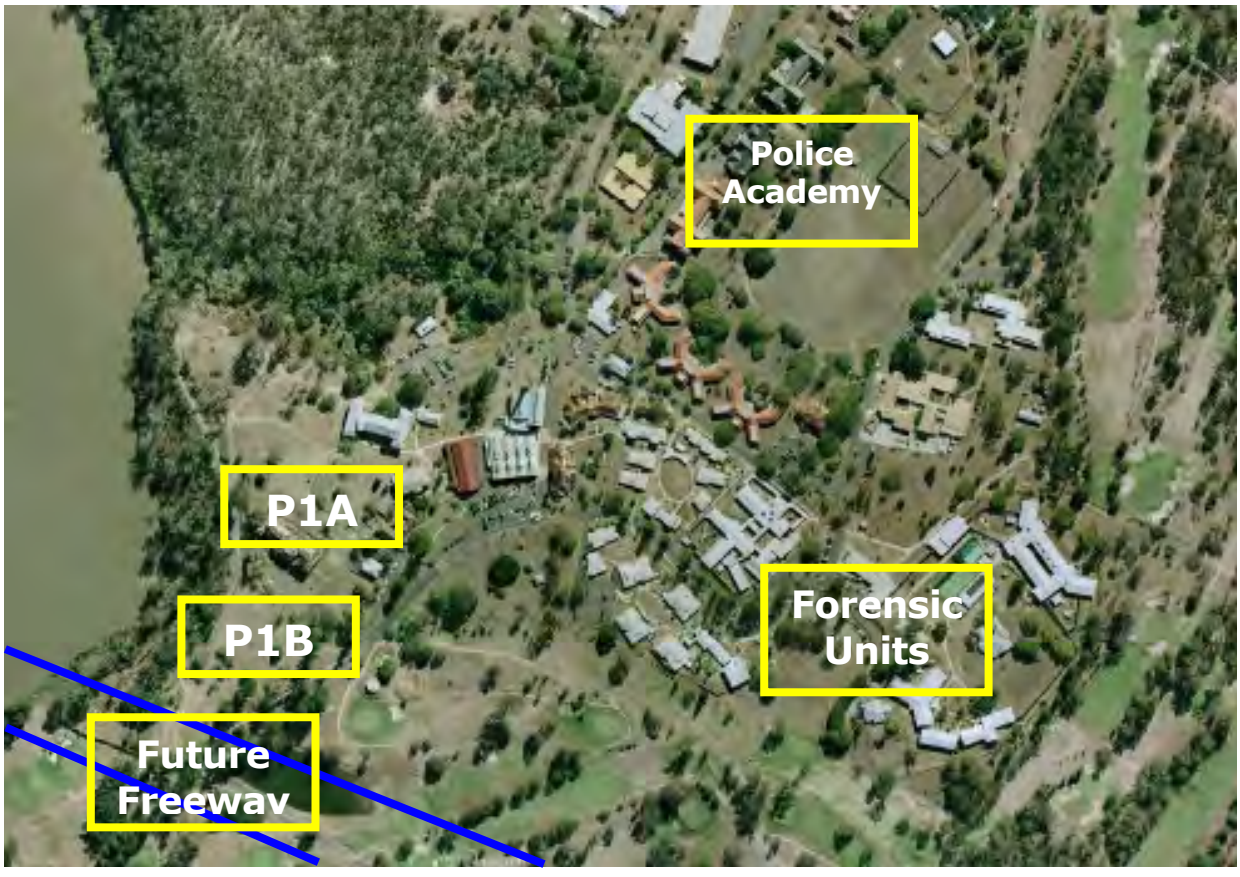

Fig 2. Site P1A (On Upper Side of Anderson House) (Scenic View)

Specific Site Considerations for P1A

- Old asylum buildings create an institutional ambience
- Proposed 110 km/hr freeway nearby with bridge over river.
- Close to forensic units affects “Undesirable Persons” & “Public perception & politics” aspects
- There is only about 5,000m2 of reasonably level site available, and this is only 33% of the 15,000m2 minimum
- Residents need to walk through forensic areas and across a golf course to reach the train station.

Conclusion
The size, topography and environment of the site make it unsuitable for the proposed Adolescent Unit.

Fig 3. Site P1B (On Lower Side of Anderson House) (Scenic View)

Specific Site Considerations for P1B

- Old asylum buildings create an institutional ambience.
- Proposed 110 km/hr 6 lane freeway adjacent with freeway bridge over river. Refer to Figure 1.
- Undesirable persons - Close to forensic units
- Level site area of only about 0.4 Ha (2 Ha preferred area / 1.5 Ha minimum)
- Residents need to walk through forensic areas and across a golf course to reach the train station.
- The proximity to forensic unit may influence Public Perception, Politics.
- High pressure water main across middle of site is likely to prevent development economically

Conclusion

The size, topography and environment of the site, plus the existing high pressure water main and possible future freeway make it unsuitable for the proposed Adolescent Unit.

Specific Site Considerations for Rogers St, Spring Hill

- Main roads and high rise buildings adjacent. Generally a busy inner-city location not compatible with the model of care.
- Too far from RBH
- Multiple physical hazards in the immediate vicinity.
- Numerous potential opportunities for contact with undesirable persons and activities in the Spring Hill and Fortitude Valley areas.
- No buffer space.
- Multiple escape routes and hiding places.
- Site is only 6684 square metres which is less than 50% of the 15,000 minimum.
- The existing buildings on site are unlikely to be suitable for the proposed new adolescent centre.
- Demolition of the buildings would be difficult to justify, given the quality and character of the buildings, and there may be heritage issues.
- There may also be heritage trees.

Conclusion

The size and environment of this site make it unsuitable for the Adolescent Unit as currently envisaged.

Specific Site Considerations for CAFTU

- Very steeply sloping site with existing buildings on three levels would not allow the kind of development required by the model of care.
- Site is adjacent to major hospital with high rise buildings.
- Site is near to main roads, a railway line, and high buildings, including multi-storey car parks.
- Limited buffer space, and multiple escape routes and hiding places
- Site area of under 5,000m2 is only about 30% of the minimum required.

Conclusion

The size, topography and environment of this site make it unsuitable for the Adolescent Unit as currently envisaged.

Appendix 2 – Site Tour Notes

THERAPEUTIC FACTORS				
External Views: Importance: 2 Desirable				
Desirable views: sky, trees, distant objects, grass, landscape, sports ovals. Sense of distance, calmness more important than people, but distant views of people engaged in gentle activities is desirable. Water is a bonus				
Undesirable views: anything that is too busy or intrusive; buildings				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Green field sight currently surrounded by bushland Located next to Redland hospital Commercial warehouse precinct adjacent separated from site by a road Future use of other vacant land unknown Some nearby reserve areas	Both sites afford greenery/sense of distance Views of the river possible in one site Sense of calmness might be inhibited by police training exercises including use of firearms and sniffer dogs Derelict ward may also compromise views from some angles	Relatively secluded location Some established trees and greenery Located on busy hospital campus No views of green spaces or water	Relatively quiet, leafy site Some established trees at the periphery Limited sense of distance eg views of horizon No immediate water features	Offers some nearby bush land and park areas. These are somewhat compromised by industrial area close by.

ACCESS TO NATURAL ENVIRONMENT				
Importance: 2 Desirable				
Desirable: Grass, trees, animals, water (as long as it is safe), gardens, getting back to nature				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Nature reserve readily accessible from site Bay is close by for arrange of other supervised activities Parks also in close proximity	Both sites afford some greenery/sense of distance Views of the river possible in one site Access without supervision may be compromised by safety issues eg accessing water alone and use of the campus in conjunction with other users of the grounds	Some established trees and greenery Victoria Park may be accessed under staff supervision	Some established trees at the periphery. Capacity to access Victoria Park precinct under staff supervision	Some potential amid existing green space.

ACCESS TO OUTDOOR ACTIVITIES				
Importance: 2 Desirable				
Desirable: Grass, trees, animals, water (as long as it is safe), gardens, getting back to nature				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Affords nearby nature reserves, readily accessible from site Bay is close by for other supervised activities Greenfield site may enable development of space for courtyards, games etc depending on exact land size	Some established trees and greenery Access to Victoria Park precinct under staff supervision Few other opportunities.	Some established trees and greenery Access to Victoria Park precinct under staff supervision Few other opportunities	Access Victoria Park precinct under staff supervision. Existing courtyard may be used for onsite for games etc	Site offers some potential for these spaces

EXHIBIT 58

EXTERNAL BUFFER SPACE & BOUNDARIES ESPECIALLY FOR NOISE MANAGEMENT				
Importance: Essential				
At least 50m away from houses is a minimum to reduce bad interactions with neighbours (both ways). There needs to be clearly defined boundaries but boundaries should be as invisible and unoppressive as possible. Good buffer spaces can reduce the need for fences				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Considerable buffer space with existing nature reserves Neighbouring hospital campus and adjacent commercial area may compromise aspects of this buffer Suitability of future use of land for this purpose is also unknown- unlikely to be factored into planning	Hospital campus and golf courses provide buffer. Compromised on some areas by steep slope of river bank, derelict ward and neighbouring services eg DSQ and Juvenile Justice Centre	Limited external buffer space apart from hospital	Some capacity to provide external buffer	Limited external buffer space apart from schools

TOPOGRAPHY				
Importance: Nice to Have				
An elevated site with long views and vistas into the distance is preferable, but the site of the facility must be reasonably level.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Site is undeveloped but natural topography is unlikely to afford long views to the distance	Site affords long views to the distance from some areas	Site does not offer long views into the distance.	Site does not offer long views into the distance	Site not elevated limited views

CLIMATE / ASPECT				
Importance: Nice to Have				
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				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Extent of breezes uncertain but proximity to the bay likely to be favourable in this regard	Significant breezes likely at sites overlooking the river Open spaces may contribute to breezes in other sites	Extent of cooling breezes difficult to determine Unlikely given buildings closely neighbouring the site	Unsure as to the extent of cooling breezes Established trees likely to offer shade	Level of cooling breezes difficult to gauge

EXHIBIT 58

SURROUNDING BUILT ENVIRONMENT				
Importance: Essential				
Avoid:- High rise and high density buildings. Overlooked sites. Main roads, railways, and other noisy busy areas. Intimidating, institutional or non-domestic general environment.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Site relatively free of high rise buildings Road in front of site does not currently have through access and therefore not a major thoroughfare Aspects of the neighbouring hospital site likely to be non-domestic Unsure about future uses of other neighbouring parcels of land	Natural environment is a real asset, but located in institutional (potentially intimidating) precinct-juvenile justice, high security unit, extended treatment forensic unit, medium secure unit, police academy etc	Nearby high rise buildings and close proximity of residential areas likely to be challenging aspect of this site Hospital campus location largely overcomes issues of busy roads, but campus itself might present intimidating non domestic feel.	Neighbouring school buildings may constitute a challenge Large Salvation Army facility overlooks site, but its windows are not oriented to where the service may be developed While the site is in an inner city location it appears reasonably protected from busy roads and thoroughfares	Some benefits in vacant land. Some semi industrial use nearby

PRIVACY				
Importance: Essential				
Privacy for the adolescent consumers is important, but the facility should not be too isolated. It is desirable for consumers to have opportunities to see people outside, but adolescents should not be “on display”. Contact with the public and families needs to be controlled. It is important that public thoroughfares do not happen through the facility site.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Undeveloped site and neighbouring reserves afford good potential to develop site in a manner that maintains privacy Impact of future use of vacant land unknown	Open spaces offer potential to maintain privacy but other users of the site and surrounds may create some challenges Not likely to be a thoroughfare although may be isolated	Neighbouring buildings on hospital campus and neighbouring residential buildings may create a challenge for maintaining privacy on the site Unlikely to be a public thoroughfare	Neighbouring schools and homeless shelter may create some challenges for maintaining privacy in this area. Location is not isolated	Private site

EXHIBIT 58

SAFETY – EMERGENCY BACKUP				
Importance: Essential				
Access to help for 'code blacks' is critical. These incidents require back up from psych nurses specifically trained in aggressive behaviour management. A response is needed within 5 minutes; therefore the adolescent facility needs to be located where appropriate help is available.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Proximity to the adult acute unit and hospital campus is favourable in this regard	Service currently receives code black support from ETR and Medium Secure staff High security service does not provide code black response Code black response might be compromised at Orford drive site As ETR is replaced by community care units and in time medium secure is downsized the maintenance code black response may not be assured	Code black response may be offered from hospital security Size of the campus makes fast code black response from adult mental health staff unlikely	After hours code black access to this site is an outstanding issue	Major weakness. Not near enough to mental health unit

PHYSICAL HAZARDS				
Importance: Nice to Have				
Avoid: bridges, high buildings, cliffs, multi-storey car parks, bridges, main roads, train lines				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Some main roads located in vicinity	Train line and abandoned buildings located in vicinity	Multistorey car park located on hospital campus Other physical hazards in the vicinity	Some high buildings and other physical hazards located in the vicinity	Some distance from these things

UNDESIRABLE PERSONS				
Importance: Essential				
Avoid opportunities for contact with 'undesirable persons'.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Site is not located near 'undesirable groups'	Growth in forensic programs particularly Extended Treatment Forensic programs makes this area problematic	May be some concern in the event consumer absconded to Fortitude Valley	May be somewhat of a challenge in Spring Hill and close proximity to homeless shelters	Site is not located near 'undesirable groups'

ABSCONDING				
Importance: Desirable				
A buffer of space around the facility is important – a buffer of 5 minutes walk (300m) to public transport to deter rapid absconding. Avoid potential hiding places. Multi-purpose games court (tennis, basket ball, volleyball).				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Site likely to offer reasonable buffer for accessing public transport. Neighbouring nature reserve may be a challenge in the event of an absconding attempt	Site has about a 300m buffer between it and public transport.	Hospital campus may act as a buffer to accessing public transport but may not deter rapid absconding.	Closest bus stop about 450 metres May not deter absconding due to building density	

EXHIBIT 58

SITE PLANNING FACTORS				
On Site Activities Multi-purpose games court (tennis, basket ball, volleyball).				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Potential for on campus sporting options	Site has about a 300m buffer between it and public transport.	Limited on campus sports and activity options	Some opportunity to have some onsite sporting and other activities	

Vehicle Access & Parking				
Importance: Nice to Have Need space for car and mini-bus access to front of building and truck / ambulance / police access to rear. Must adhere to QHealth and building code requirements.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Not likely to be problematic on site	Not likely to be a problem on site	Might be a challenge on site	Not likely to be problematic on site	

Access to Facilities				
Importance: Desirable Access to Gymnasium				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Land size may permit larger design	Land size may permit larger design Access to large open grassed area	Land may not permit entire gymnasium, but exercise room may be	Land may not permit entire gymnasium, but exercise room may be possible.	Land size may permit larger design
Importance: Essential Access to Large Open Grassed Area				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Footprint may be larger on this site	Footprint may be larger on this site	Large open grassed area unlikely on site	Large open grassed area unlikely on site	Footprint may be larger on this site
Importance: Nice to Have Access to a small swimming pool with spa and swim jets				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Site unlikely to prohibit this feature	Site unlikely to prohibit this feature	Site unlikely to prohibit this feature	Site unlikely to prohibit this feature	Site unlikely to prohibit this feature
Importance: Desirable Access to a full size swimming pool				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Site within 5 minutes drive of local aquatic centre	Site within 5 minutes drive of Goodna Pool	Site within 5 minutes drive of centenary pool	Site within 5 minutes drive of centenary pool	?
Importance: Desirable Access to a Sports Oval or park				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Site within reasonable distance of sporting facilities	Site located close to cricket oval	Site within reasonable distance of Victoria Park precinct	Site within reasonable distance of Victoria Park precinct	Close proximity to sporting facilities
Importance: Desirable Access to adventure training and water sports				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Bay is accessible to site	Brisbane river accessible to site	Accessible to 'Riverlife' at Kangaroo point and Rock Climbing at Fortitude Valley	Accessible to 'Riverlife' at Kangaroo point and Rock Climbing at Fortitude Valley	Reasonable proximity to activities

EXHIBIT 58

Public Transport				
Importance: Essential Need access to good public transport. Trains are preferred as being more reliable in timetable and less intimidating. (See attached summary)				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Not likely to be problematic on site	Not likely to be problematic on site	Might be a challenge on site	Not likely to be problematic on site	

Shops				
Importance: Desirable Need access to a variety of shops via public transport. There is graded use of shops in rehabilitation starting with smaller, less dense and closer shops and progressing on to large shopping malls. Ideally there should be a corner store within walking distance, and a major shopping centre a train ride away.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Some shopping available at Cleveland	Variety of shops accessible from Ipswich line	Variety of shops available in Brisbane City/Fortitude Valley/ New Farm	Variety of shops available in Brisbane City	Some shopping available at Logan

Other Facilities				
Importance: Desirable It is desirable to have other types of social activities available in the community such as:- churches, youth groups, sporting groups, dancing classes etc. (these are examples only – it is not important to have a particular type of community activity, group, club available).				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
May be able to access these activities and opportunities in the Cleveland area	May be able to access some activities in the Goodna/ Gailes area	Lack of isolation increases likelihood of accessing community activities in local area	Lack of isolation increases likelihood of accessing community activities in local area	Access to some activities likely

On-site independent accommodation units				
Importance: Essential Future proof for on-site independent accommodation units (for family visits and for consumers preparing to leave). Note: This is not in current scope of works but should be considered in future construction.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Site size unlikely to prohibit provision of this space	Site size unlikely to prohibit provision of this space	Size of site may make future proofing a challenge	Size of site may make future proofing a challenge	Site size unlikely to prohibit provision of this space

Hospitals & Doctors				
Importance: Essential Hospital emergency department within a 20 minute drive of the facility. A good working relationship with a local hospital is important.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Located at Redland Hospital	Ipswich Hospital closest available emergency facility	Located at RBH	Within 20 minutes of RBH	Within 20 minutes of Logan
Importance: Essential Proximity to the Qld Children's hospital is desirable				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Considerable distance from Qld Childrens Hospital close proximity to other mental health services	Some distance from Qld children's hospital, some distance from other child and youth services. Close proximity to forensic mental health services and medium secure staff.	Reasonable proximity to Qld Childrens Hospital close proximity to other C&Y mental Health Services	Reasonable proximity to Qld Childrens Hospital close proximity to other C&Y mental Health Services	Considerable distance from Qld Childrens Hospital close proximity to other mental health services

EXHIBIT 58

Importance: Desirable Proximity to an 'after hours' GP clinic is desirable.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Significant number of General Practitioners in Cleveland area with opening hours to 7pm.	Access to General Health Service- The Park	Some options in reasonable proximity	Some options in reasonable proximity	Access to Logan Clinics

Public Transport Importance: Essential Hospital emergency department within a 20 minute drive of the facility. A good working relationship with a local hospital is important.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Located at Redland Hospital	Ipswich Hospital closest available emergency facility	Located at RBH	Within 20 minutes of RBH	Within 20 minutes of Logan

Access for Families & Visitors Importance: Nice to Have Local external accommodation for families such as motels and hotels with good public transport access to the facility.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
'Holiday style' accommodation available in close proximity	Limited accommodation options at Darra.	May be some local options with existing partnerships eg Ronald McDonald House.	Variety of temporary accommodation options in Spring Hill.	Some options available

Police Importance: Desirable 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.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Close proximity to local police station	Reasonable proximity to Mt Ommaney police station	Reasonably close to Valley Police Station	Reasonably close to Valley Police Station	Reasonable proximity to police station

Staff Access Importance: Nice to Have Staff recruitment and retention are important factors. Consider metropolitan location.				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
45 minute drive from CBD may be a challenge for some staff. May also be a challenge for existing staff. May be some benefit from co-location with other services.	Advantages associated with retaining existing location and staffing group- some concern in the future about the isolation of the service from other child and youth services.	Centrally located. May be some advantages in being located with other mental health services.	Centrally located. May be some advantages in being located with other C&Y services	Some distance from existing service. Serviced by Logan and Pacific Motorways

EXHIBIT 58

Site Acquisition & Development				
Importance: Essential What are the cost and time implications of site acquisition?				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
	Applicable to all sites Sites on The Park Campus QHealth Land. Orford Drive site may not be Q Health land.	Applicable to all sites- Q Health Land	Applicable to all sites- Q Health Land	Applicable to all sites

Site Development				
Importance: Essential Includes:- Obtaining development approvals. Providing site infrastructure (power, water, roads, sewers, drains, phones). Site preparation costs (earthmoving, site drainage). Foundation costs (does the site have problem ground?). Are there any existing facilities/services which need to be decanted (budget, timelines and other impacts)? Is the site large enough, now and in the future? Any heritage or indigenous issues? What are the time and cost implications of the above? Will any of these factors affect the use of the facility now and in the future?				
REDLAND	**THE PARK**	**CAFTU**	**ROGERS ST**	**MEAKIN PARK**
Applicable to all sites	Applicable to all sites	Applicable to all sites	Applicable to all sites	Applicable to all sites

EXHIBIT 58 'AG-14'

Queensland Plan for Mental Health 2007–2017

Four Year Report
October 2011

Queensland Government

EXHIBIT 58

Four Year Report on the Queensland Plan for Mental Health 2007–2017
(October 2011)

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For more information contact:
Mental Health Alcohol and Other Drugs Directorate, Queensland Health, PO Box 2368, Fortitude Valley BC QLD 4006,
email **MHIU-admin@health.qld.gov.au**

An electronic version of this document is available at **www.health.qld.gov.au/mentalhealth**

All artwork has been supplied in collaboration with the Mental Illness Fellowship of Queensland (MIFQ).

Featured artists exhibited their artwork in the 2009 and 2010 Schizophrenia Awareness Week Annual Art Exhibition, an initiative of MIFQ. For more information on this annual event or to view more artwork, please visit www.mifq.org.au

Photography: Michael Marston, Thinkstock.

Ministers' Message

In June 2008, the Queensland Government announced a 10-year plan to reform and develop the mental health system—the *Queensland Plan for Mental Health 2007–2017*. This plan reflects the Government's commitment to providing a world-class mental health system that delivers world-class results for all Queenslanders.

The plan outlined our vision for mental health care and positions mental health services to better respond to demand and implement new and innovative approaches to meet consumer and carer needs. The plan is complemented by *Supporting Recovery: Mental Health Community Services Plan 2011–2017*. This plan reflects the government's commitment to strengthening the community mental health sector and builds on the achievements to date assisting and supporting people with mental illness to live full and meaningful lives in the community under priority 3 of the *Queensland Plan for Mental Health 2007–2017*.

The Queensland Government has supported the plan with record investments in mental health totalling more than $632 million. Combined with existing funding, this brings the Government's investment to more than $1 billion every year, to deliver improved mental health services.

A rigorous evaluation strategy has also been implemented to measure the plan's impact and outcomes. Evaluation results are used to ensure our resources and efforts remain aligned to our goals, and will also provide insights into how our efforts are improving the mental health system.

The information presented in this report shows:

- we have invested (as planned) in more staff and better inpatient facilities, increasing the capacity of mental health services
- we have improved the quality of the mental health system, with better links between mental health services and community supports, and more sustainable treatment for consumers
- mental health services are reaching more people living with mental illness, who value the services that they receive.

These results demonstrate our strong progress towards achieving the aims and targets set out in the plan.

However, there is more work to do. Further investment and reform is planned, to manage significant challenges in the years ahead. The Queensland Government is committed to supporting the mental health of all Queenslanders. That's why we will take a further major step in transforming the state's mental health system, by establishing an independent Queensland Mental Health Commission from July 2012. Queensland can and will do better in providing a more person-centred, recovery-oriented, community-based, co-ordinated and human rights-focused mental health system for Queenslanders.

We look forward to continuing to implement our vision for mental health in Queensland.

Geoff Wilson MP
Minister for Health

Curtis Pitt MP
Minister for Disability Services, Mental Health and Aboriginal and Torres Strait Islander Partnerships

My Roots
Marina Pavlakis
2009 Schizophrenia Awareness Week Art Exhibition

Overview

The *Queensland Plan for Mental Health 2007–2017* outlines the Queensland Government's vision to reform and improve mental health services over a 10-year period. The plan challenges the government, private sector and non-government organisations to work together to provide recovery-oriented, consumer-focused mental health services that:

- promote mental health and wellbeing
- prevent mental health problems and mental illness, where possible
- reduce the impact of mental illness on individuals, their families and the community
- promote recovery and build resilience
- enable people who live with a mental illness to participate meaningfully in society.

The plan was supported by a record increase in mental health funding—and brought the Queensland Government's investment to nearly $530 million in the 2007–08 budget. This represented the largest investment in mental health in Queensland's history. The Government has since invested further in mental health—bringing total plan funding to more than $632 million.

The reform directions outlined in the plan are grouped around five priority areas:

Priority area 1 Promotion, prevention and early intervention	Strengthen collaborative action to: • build individual and community resilience and wellbeing • effectively target key risk and protective factors • facilitate early intervention in known high risk groups for mental illness.
Priority area 2 Integrating and improving the care system	Enhance and develop the continuum of clinical mental health treatment and care for consumers, families and carers. This system will promote resilience and recovery.
Priority area 3 Participation in the community	Build capacity to assist and support people with mental illness to live full and meaningful lives in the community.
Priority area 4 Coordinating care	Facilitate the linkage of a range of services to provide an integrated system of care to consumers, families and carers.
Priority area 5 Workforce, information quality and safety	Enhance and strengthen the capacity of services to provide high quality, safe and evidence-based mental health care.

Our results

Priority area 1
Promotion, prevention and early intervention

The Queensland Government has invested in promotion, prevention and early intervention activities to help more Queenslanders avoid mental disorders and the need for more intensive mental health interventions. These initiatives aim to strengthen collaborative action to build individual and community resilience and wellbeing, effectively target key risk and protective factors, and facilitate early intervention in known high risk groups for mental illness.

Summary of achievements

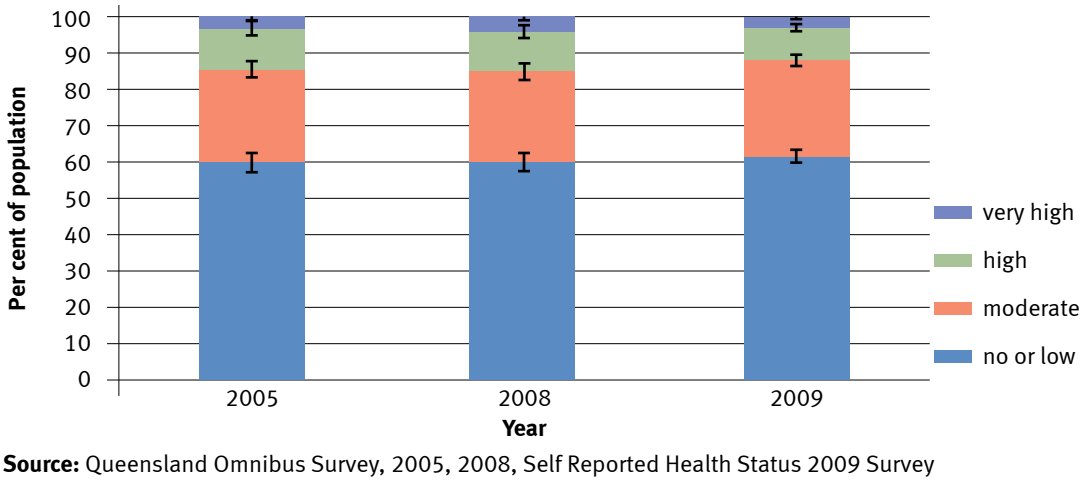
- invested $10.6 million to deliver promotion, prevention and early intervention initiatives with a further $7.3 million planned investment remaining for the stigma reduction social marketing campaign, commencing late 2011
- established the Queensland Centre for Mental Health Promotion, Prevention and Early Intervention, and beyondblue Queensland Chapter
- trained 10,000 front-line police, ambulance and Queensland Health workers to effectively deal with people experiencing mental health crisis
- provided targeted programs to Aboriginal and Torres Strait Islanders, people from culturally and linguistically diverse backgrounds and other at-risk groups
- established the Ed-LinQ initiative, which works with schools to identify and treat mental health problems and disorders affecting children and young people at an early stage

Psychological distress in the general community

High levels of psychological distress are often associated with poor mental health. In Queensland, population based mental health surveys have shown a downward trend in the reports of high or very high levels of psychological distress since 2007. These results demonstrate that sustained effort can contribute to better mental health outcomes in the population.

However, these positive results may decline in future surveys, due to the unprecedented natural disasters experienced by Queenslanders in the summer of 2010–11. In the 2011–12 budget, the Queensland Government invested funding, in partnership with the Commonwealth Government, to recruit 126 additional community mental health staff for disaster-affected areas.

Figure 1 Queenslanders reporting no/low, medium, high or very high levels of psychological distress, 2005–2009



Source: Queensland Omnibus Survey, 2005, 2008, Self Reported Health Status 2009 Survey