Recommendation:

a) A Tier 3 service should be prioritised to provide extended treatment and rehabilitation for adolescents with severe and persistent mental illness.

3. Interim service provision if BAC closes and Tier 3 is not available is associated with risk

- Interim arrangements (after BAC closes and before Tier 3 is established) are at risk of offering sub optimal clinical care for the target group, and attention should be given to the therapeutic principles of safety and treatment matching, as well as efficient use of resources (e.g., inpatient beds).
- In the case of BAC being closed, and particularly if Tier 3 is not immediately available, a high priority and concern for the ECRG was the 'transitioning' of current BAC consumers, and those on the waiting list.
- Of concern to the ECRG is also the dissipation and loss of specialist staff skills and expertise in the area of adolescent extended care in Queensland if BAC closes and a Tier 3 is not established in a timely manner. This includes both clinical staff and education staff.

Recommendations:

a) Safe, high quality service provision for adolescents requiring extended treatment and rehabilitation requires a Tier 3 service alternative to be available in a timely manner if BAC is closed.

b) Interim service provision for current and 'wait list' consumers of BAC while Tier 3 service options are established must prioritise the needs of each of these individuals and their families/carers. 'Wrap-around care' for each individual will be essential.

c) BAC staff (clinical and educational) must receive individual care and case management if BAC closes, and their specialist skill and knowledge must be recognised and maintained.

4. Duration of treatment

- A literature search by the ECRG identified a weak and variable evidence base for the recommended duration of treatment for inpatient care of adolescents requiring mental health extended treatment and rehabilitation.
- Predominantly, duration of treatment should be determined by clinical assessment and individual consumer need; the length of intervention most likely to achieve long term sustainable outcomes should be offered to young people.
- As with all clinical care, duration of care should also be determined in consultation with the young person and their guardian. Rapport and engagement with service providers is pivotal.

Recommendation:

a) 'Up to 12 months' has been identified by the ECRG as a reasonable duration of treatment, but it was noted that this depends on the availability of effective step-down services and a

suitable community residence for the young person. It is important to note that like all mental health service provision, there will be a range in the duration of admission.

5. Education resource essential: on-site school for Tiers 2 and 3

- Comprehensive educational support underpins social recovery and decreases the likelihood of the long term burden of illness. A specialised educational model and workforce is best positioned to engage with and teach this target group.
- Rehabilitation requires intervention to return to a normal developmental trajectory, and successful outcomes are measured in psychosocial functioning, not just absence of psychiatric symptoms.
- Education is an essential part of life for young people. It is vital that young people are able to access effective education services that understand and can accommodate their mental health needs throughout the care episode.
- For young people requiring extended mental health treatment, the mainstream education system is frequently not able to meet their needs. Education is often a core part of the intervention required to achieve a positive prognosis.
- Band 7 school – add definition from KR

Recommendations:

a) Access to on-site schooling (including suitably qualified educators), is considered essential for Tiers 2 (day programs) and 3. It is the position of the ECRG that a Band 7 Specific Purpose School (provided by Department of Education, Training and Employment) is required for a Tier 3 service.

b) As an aside, consideration should also be given to the establishment of a multi-site, statewide education service for children/adolescents in acute units (hub and spoke model).

6. Residential Service: Important for governance to be with CYMHS; capacity and capability requires further consideration

- There is no true precedent set in Queensland for the provision of residential or bed-based therapeutic community care (by non-government or private providers) for adolescents (aged up to 18 years) requiring extended mental health care.
- The majority of ECRG members identified concerns with regard to similar services available in the child safety sector. These concerns were associated with:
  - Variably skilled/trained staff who often had limited access to support and supervision;
  - High staff turn-over (impacting on consumer trust and rapport); and
  - Variable engagement in collaborative practice with specialist services such as CYMHS.

Recommendations:

a) It is considered vital that further consultation and planning is conducted on the best service model for adolescent non-government/private residential and therapeutic services in community mental health. A pilot site is essential.

b) Governance should remain with the local CYMHS or treating mental health team.

c) It is essential that residential services are staffed adequately and that they have clear service and consumer outcome targets.

7. Equitable access to AETRS for all adolescents and families is high priority; need to enhance service provision in North Queensland (and regional areas)

- Equity of access for North Queensland consumers and their families is considered a high priority by the ECRG.

Recommendations:

a) Local service provision to North Queensland should be addressed immediately by ensuring a full range of CYMHS services are available in Townsville, including a residential community-based service.

b) If a decision is made to close BAC, this should not be finalised before the range of service options in Townsville are opened and available to consumers and their families/carers.

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----- Original Message -----
From: Trevor Sadler
To: Bill Kingswell
Cc: Sharon Kelly
Sent: Tuesday, May 21, 2013 6:26 PM
Subject: The efficacy of "Wraparound" services

Hello Bill,

My impression from the last Planning Group meeting was that you considered that the current patients, and those on the waiting list, could be managed alternatively via a wraparound service.

I write this email so that it is clearly on record.

The ECRG was charged with providing an evidenced based model. Wraparound services were considered, but specifically excluded. There is no evidence to support them as a stand alone service. We do however attempt to build in a wraparound component as part of our discharge planning for every adolescent.

Over the weekend I updated my literature search on wraparound services, and reviewed the literature. This term is almost solely used in literature emanating from the USA. Wraparound services arose in the mid 1980's after the collapse of the long stay, psychoanalytically oriented inpatient services which were used to treat inappropriately thousands of US adolescents until the late 1970's. Managed care brought an end to this practice. Wraparound was an appropriate response to the ensuing vacuum for those with moderate disorder, and inappropriate diagnoses and over medication a response to those with more severe disorder.

Wraparound is used as a service for populations of adolescents in child safety systems, juvenile justice and substance use systems and those with "serious emotional disorder" (a term unique to the USA used of young people with a mix of mild to moderate emotional and behavioural disorders).

Although we don't use the term, the concept is found in our own services. Evolve is a prime example. I did training sessions with Maroochydore and Cairns Evolve teams to help them consider specific components of a comprehensive wraparound process. In this case, the wraparound concept is a stand alone service. I did a workshop in Townsville last week to enable them to consider a comprehensive wraparound process as part of their day program. In this case, the wraparound service on its own would not be sufficient - it needs to be in the context of having a day program facility.

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

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

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

3. The more severe ones typically seen at Barrett would have repeated and prolonged admissions to acute inpatient units, with much poorer long term outcomes. Some would die. Many will face significant impairment including long term social exclusion.

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

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

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

Kind regards,

Trevor

Dr Trevor Sadler
Director
Barrett Adolescent Centre
The Park _ Centre for Mental Health
Locked Bag 500
Sumner Park BC
Queensland 4074
Ph
Fax
Email:

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STAFFING ISSUES AT BAC

In 1986, Barrett had

Nursing staff	Health Professionals	Medical Staff
28	6	3

All of these were fully funded positions. In addition 2 to 3 student nurses (equivalents of TNEPs) were attached to the unit in supernumerary positions. The roster was closed – all nursing staff were permanent, and none were required from other areas of the hospital.

Currently Barrett has

Nursing staff	Health Professionals	Medical Staff
20.9	4.5	1.8

Current staffing includes 3 TNEPs included in the nursing roster, the Speech and Language Pathologist, in covering the adult wards is only 0.25, and one of the Occupational Therapist positions has been abolished, but temporarily extended for another 3 months.

In summary, there has been greater than 25% reduction in staffing over the past 25 years. At the same time, there is a significant increase in acuity, complexity, severity and impairment with treatment of less severe cases with the expansion of community CYMHS clinics and the establishment of acute inpatient units.

By comparison, the 12 bed Walker unit in Sydney (our equivalent in NSW) has

Nursing staff	Health Professionals	Medical Staff
23	5	2.5

This is similar to the equivalent inpatient units in the UK, although a 12 bed unit there may have 20 – 23 nursing staff, and 4 Health Professionals.

Given that we are usually managing 15 – 20 adolescents (there are circumstances in which we will reduce numbers), our staffing is very lean by national or international comparisons. How have we managed this efficiency?

Over the years we have developed much more targeted treatment programs, and have articulated and developed a comprehensive rehabilitation program which I believe is world class. Roles have become more defined, and we truly use our multidisciplinary skills to maximum potential. I know from when I chaired the CYMHS Clinical Collaborative, that the number of face to face interventions each week provided by clinicians exceeds that of Community CYMHS clinicians. As we have become more rigorous in entering POS data, this will become quite evident.

The ratio of clinicians to adolescents has varied over the past 10 years. After a long period of bed block in 2008 – 2010, beds became available. Community CYMHS and acute inpatient units reduced their referrals, although this was identified as being associated with longer stays in acute inpatient units and poorer outcomes. (Acute inpatient units did not experience the same pressure on beds then as they do now, and had capacity to absorb this.) When beds did become available, there was a lag in referrals.

The second reason in late 2011 to the first quarter of 2012 was the level of high acuity among the adolescents – We had a reduced capacity to manage any more.

This coincided with the third reason, and a factor which definitely impacted on efficiency. During the same period, we lost several regular staff, and many staff were on short term contracts. On some shifts, only one regular staff member would be rostered on. The loss of staff who knew the patients, could recognise warning signs, who could appropriately intervene made it unsafe to try to admit more. Use of both prn medications and seclusion increased during this period – both unsatisfactory practices.

But the ratio of clinicians to patients is only one measure of efficiency. Another measure is a hypothetical "optimal time" an adolescent spends in the unit vs. the real time they spend. Of course, this can only be guessed at. I will link this to a third measure of efficiency – how long outcomes on discharge are sustained into the community.

There are two major staffing issues which impact on efficiencies in these areas – the numbers and experience/training of staff. I will address these issues specifically with respect to both Occupational Therapists and Nurses.

The role of the OT became more defined in the latter part of the 1990's. We were aware that the gains made during admission were not sustained during discharge. A clear rehabilitation focus was enunciated and developed that involved all staff in the day to day activities of the adolescent. In addition, OTs would assess an adolescent and develop a specific rehabilitation plan implementation by all staff, provide individualised rehabilitation activities which may be generalised to include other staff, as well as identify and implement multiple transitional activities to reintegrate an adolescent within a community. This is time consuming work. It is on top of the multiple other services provided by the OTs – providing sensory and perceptuomotor assessments and guiding staff on the day to day implications of any difficulties, developing the sensory room, and training staff in its use (we were at the forefront of using this intervention), assessing life skills, leisure skills and guiding staff in developing programs in to enhance these skills, developing physical activity programs which recently has become recognised as an essential intervention in young people with serious mental illness and developing, organising and facilitating the adventure therapy intervention which adolescents identify as a key experience in their recovery. It was clear by 1999 that we needed a second OT, and the position was created from a generic leisure activities co-ordinator.

The abolition of the second OT will severely limit the above activities. We will be compromised on all rehabilitation and transition interventions. Adolescents will stay longer. The evidence for this is from periods of time when there were limitations on filling an OT position, or when one has been on extended leave. The pressure on the remaining OT will almost inevitably lead to burn out.

Two OTs will be necessary whatever the future of the unit. It is the minimum if we continue as an inpatient service or we will require more if we transition to another type of service.

The second issue affecting the efficiency of treatment is the absence of the closed roster for Nursing staff. I described above the impact of this on the unit in early 2012. It also has a major impact on therapeutic efficiency. The situation has improved in recent months, but it is still sub-optimal. I have the highest regard for those nurses who put the care for the adolescent above their own future.

I recognise the difficulties in providing stability in this uncertain environment, but any possible future model that I can envisage must retain the current core of Nurses and enhance their skills. I know from conversations with senior Nurses in the acute adolescent inpatient units, from conversations with adolescents who have been to these units, and conversations with my psychiatrist colleagues that our Nurses have expertise which must be retained, expanded upon and enhanced for working with young people with severe and complex mental illness with severe impairment in whatever context they are cared for in the future. Any alternative model to that recommended by the ECRG will in fact require more nurses.

The Quality Network for Inpatient CAMHS (like an ACHS for inpatient adolescent units in the UK) publishes standards for inpatient units. The following two sections are highly relevant.

2.1.5 *The unit is staffed by permanent staff, and bank and agency staff are used only in exceptional circumstances e.g. in response to additional clinical need*
Guidance: A CAMHS inpatient unit is likely to have a problem with over-use of agency nurses if more than 15% of staff are agency staff during a week or if more than one member of staff on a shift are from an agency. Agency staff should not be used for more than two shifts in a day.
Ref 8, pg 19: 'Service user feedback reinforces the importance of a regular and stable workforce which enables the development of therapeutic relationship and trust in providing support at distressing times. The National Audit of Violence (HC 2005) found that lack of leadership, inexperienced ward staff combined with an over reliance on bank and agency staff can have a negative effect upon the continuity of care and overall safety of the acute inpatient ward.'

and 2.1.6

Where bank and agency staff are used, they are familiar with the service and experienced in working with young people with mental health problems.

I have observed some adolescents stalled for weeks because there are insufficient Nurses that they know to speak to on weekends and at night. It is an issue which the adolescents have brought up in the Business Unit Meeting, and parents have expressed their concerns.

In 2000 we had 21.9 regular staff + nurses in training. This consisted of the NUM, 4 CNs (including the Community Liaison Clinical Nurse) and 16.9 regular Registered Nurses. The reduction to 12 regular Registered Nurses really stretches the resources to provide care, treatment and rehabilitation activities, particularly when there may be long term sick leave, or any other type of leave.

I realise these are constrained times for budgets. However ensuring nursing staff stability and adequate numbers should be cost neutral, but a high priority in a patient focussed care system.

Minutes: Barrett Adolescent Centre Business Unit Meeting					
Date:	17 May 2013	**Commencement and Completion Time:**	0950 – 1120hrs	**Location:**	Family Therapy Room, BAC

Committee Members			Tick one box ✓			
Position	Name	Key	Present	Apology	Absent	Proxy/Comment
Chair	Dr Trevor Sadler	Director	✓			
	Graham Dyer	Nurse Manager	✓			
	Vanessa Clayworth	A/CN-CL	✓			
			✓			
	Kev Rodgers	Principal, BAC School	✓			
			✓			
	Elaine Ramsey	Minutes Secretary	✓			
	Laurence McDowell	Assistant Business Mgr		✓		

1.0	**Meeting Opening**			Responsible Officer
1.1	Apologies were noted			
1.2	No declaration of conflict of interest was received			
1.3	Previous Minutes			
	1.3.1	Minutes of the meeting held on 19 April 2013 were accepted as a true and accurate record of proceedings.		
	1.3.2	Business arising from the minutes		
		1.3.2.1	<u>Budget</u> As at end of April 2013 - $397,000 under budget Non-labour $37,000 under-expended <u>Action:</u> Budget liaison with Laurie McDowell	
		1.3.2.2	<u>PRIME Reports</u> Not discussed	

		1.3.2.3	Service Development/Future Planning Dr Sadler stated there was a planning group meeting held on 08.05.13 and the findings were to be presented to the Hospital Executive on 17.05.13. He further stated that there would be another meeting held on 22.05.13. Dr Sadler stated that a lot of the information was very positive. He said that there would be a final resolution and then feedback would be obtained from the adolescents and their parents and other Hospital and Health Service staff. The matter would also be referred to the Minister.	
		1.3.2.7	Staff Issues – not discussed	
		1.3.2.8	Quality Safety and Risk Graham stated that there was Child Safety Training and Mental Health Training available at the School of Mental Health Learning and he will ask Tania Yegdich to come to the Unit and discuss what was available for staff. Warren Storey came on 16.05.13 and talked to all staff about the LCT forms. Kev stated that professional development for staff was very important. [redacted] asked if a list of ward rules could be placed on the wall in the Day Area for both patients and staff to read to which Kev stated that the rules should be discussed at the Morning Meetings. Action: Graham to go through the rules with [redacted]	Graham Dyer
		1.3.2.9	Research Presentations – not discussed	
		1.3.2.10	School Report ▪ Kev stated that there has been no liaison between Health and Education on the Unit's future. The Education Dept would like to keep the School going. There are different degrees of angst amongst the teaching staff. Permanent staff have been promised jobs by the Department. ▪ The Music Teacher has been replaced ▪ Elayne Raisin will be back to work on 20.05.13 recovering from a work injury ▪ Janine Armitage has been off sick with the flu ▪ Five weeks before the school holidays commence ▪ 1st June is the Unit's 30th anniversary	

2.0	**Matters for Decision**			
Item	Title/ Item	Action	Officer	Due Date
2.1				

3.0	**Matters for Discussion**			
Item	Reference/ Discussion Topic	Action	Officer	Due Date
3.1	Consumer Report **Discussion:** Cleaning in the Ward [redacted] stated that [redacted] had sent a letter to the Minister concerning the cleaning of the Unit and the RSO hours but was redirected to the Executive Director of the Hospital. Pest Control - [redacted] has seen some dead bugs. Elaine (AO) explained that the Pest Control had sprayed quite recently. Vacuuming: Chore roster for the adolescents not commenced yet Invite Sandra Bolton (not Kerrie-Lee Thomas) to meet with the adolescents and discuss the cleaning. Showers: Mould still in them and the drains are blocked.	Work Order to be placed for both bathrooms to be cleaned thoroughly	Elaine Ramsey	As soon as possible
3.2	Consumer Report **Discussion:** Yoga on the Unit All the adolescents enjoyed yoga. Kev stated that the current Yoga teacher was quite expensive to employ as she charged $170 per hour and stated that if Yoga was to continue, someone cheaper would have to be found.			
3.3	Art Therapist Kate Partridge is trying to find an Art Therapist who would come to the Unit and give lessons.			
3.4	Board Games/Billiard Table Minutes Secretary will have to check with the OT's regarding the progress of the board games. The billiard table needs its pockets repaired.		Minutes Secretary (Elaine Ramsey)	As soon as possible

3.5	Thursday and Friday Outings Graham stated that Work Instructions for Outings needed to be drawn up. Vanessa asked if the First Aid Kit should be taken on outings to which Members replied in the affirmative. advised that the adolescents were a little annoyed about the outings process. stated that the adolescents who go on weekend leave would still like to go out on Thursday nights as they enjoy going out with their peers more than their parents.			
3.6	Holiday Program (June/July) stated that the OT's were still looking into the Holiday Program after having met with the adolescents to see what they would like to do.		OT's	As soon as possible
3.7	Hot House Program Vanessa stated that the Hot House Management were prepared to hold one session per term at no cost to the Unit.	Vanessa to followup	Vanessa Clayworth	As able
3.8	ADAWS Program Vanessa to follow up this program also.	Vanessa to followup	Vanessa Clayworth	As able
3.9	Homework Time asked if there could be a review done of homework time as most of the adolescents don't get much homework and it would be an ideal time for the adolescents to get together, chat and "chill-out". If it was done in an official period, then the nursing staff would not try and break the meeting up.	To be reviewed.		
3.8	Adventure Therapy Camp Kimmy has received a quote from The Outlook to the value of $1631 for the proposed camp from 11-14 June 2013. Elaine explained to Members that because the camp was over $1,000, approval had to be obtained from the Executive Director by way of a Business Case.	Kimmy to be advised to put in a Business Case for the Camp to the Executive Director as soon as possible to ensure a timely approval is given.	Kimmy Hoang	As soon as possible

3.9	No Screen Policy after 9.30pm [redacted] stated that this was a problem for some of the adolescents as they like to listen to their I-Pods whilst they go to sleep. [redacted] asked if the adolescents could keep their I-Pods until 10.30pm as other adolescents like to write in their journals before going to sleep. Dr Sadler stated that the Night Staff could be asked as to what times the adolescents actually go to sleep. Kev suggested that he could purchase more I-Pods and give them to the adolescents to take home and put their music on them and then bring them back, to which Graham suggested that Matt Beswick could do it on the ward for the adolescents.	Graham to discuss it with nursing staff with regard to the 10.30pm lights out and I-Pods off request. Graham to ask Matt Beswick to put music on the I-Pods that Kev supplies for the adolescents.	Graham Dyer Graham Dyer	As soon as possible As soon as possible

4.0	**Matters for Noting**
Item	Noted
4.1	The following correspondence was received < list correspondence tabled at meeting>
4.2	The following committee minutes were tabled <insert list of committee minutes tabled>
4.3	<list other matters that were tabled for noting at the meeting>

5.0	**Meeting Finalisation**	
Item		
5.1	List of action items were reviewed and responsible officer and due dates confirmed	
5.2	Meeting Evaluation	
5.3	**The next meeting will be held at BAC Family Therapy Room on Friday, 21 June 2013 from 9.30am**	
5.4	**The meeting closed at 11.20am**	

Minutes authorised by Chair as an accurate record of proceedings	
	17.05.13
Dr Trevor Sadler **Director**	**Date**

Queensland Government

Barrett Adolescent Strategy

Expert Clinical Reference Group

MINUTES

Chair:	Dr Leanne Geppert	**Date:**	13 March 2013
Executive Sponsor:	Chief Executive West Moreton HHS and A/Executive Director MHAODB	**Time:**	9.00 – 10.30am
Secretariat:	Vaoita Turituri		
Venue:	Level 2 Conference Room (Room 2.2 CR), 15 Butterfield St, Herston		
Tele/Videoconference Details	Local Dial in no. National Dial in no. Participant code:		
Attendees	▪ Amanda Tilse, Operational Manager, Alcohol Other Drugs and Campus Mental Health Services, Mater Children's Hospital ▪ Amelia Callaghan, State Manager Qld NT and WA, headspace ▪ Carer representative ▪ Dr James Scott, Consultant Psychiatrist, Early Psychosis Service Metro North HHS Mental Health Service ▪ Kevin Rodgers PSM, Principal, Barrett Adolescent Centre School, Education Queensland ▪ Dr Leanne Geppert, Director, Planning & Partnerships Unit, QH Mental Health Alcohol & Other Drugs Branch (MHAODB) ▪ Dr Trevor Sadler, Clinical Director, Barrett Adolescent Centre West Moreton HHS Mental Health Service		
Teleconference:	▪ Dr David Hartman Clinical Director, Child & Youth MHS Townsville HHS Mental Health Service ▪ Emma Hart, Nurse Unit Manager, Adolescent Inpatient Unit And Day Service, Child & Youth MHS Townsville HHS Mental Health Service ▪ Professor Philip Hazell, Director, Infant Child and Adolescent Mental Health Services, Sydney and South Western Sydney Local Health Districts		
Guests:			
Apologies:	▪ Kelly Bucknall, Consumer representative ▪ Josie Sorban, Director of Psychology, Child & Youth MHS Children's Health Qld HHS ▪ Dr Michelle Fryer Chair, QLD Branch of the Faculty Child & Adolescent Psychiatry (QFCAP), The Royal Australian and New Zealand College of Psychiatrists (RANZCP)		

Queensland Government

Barrett Adolescent Strategy

Expert Clinical Reference Group

Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
1.0	**Welcome, Apologies and Introductions**		
1.1	**Open and Welcome** ▪ Members present and on teleconference were welcomed by the Chair	Leanne Geppert	
1.2	**Previous minutes** ▪ The draft minutes of the last meeting (27.02.2013) were endorsed as an accurate record of proceedings by and Kevin Rodgers		
2.0	**Business arising**		
2.1 **Action Sheet**	**Outstanding actions to be addressed:** ▪ Nil of note ▪ Amanda Tilse to forward ADAWS model of service to secretariat for dissemination. **Action** Secretariat to disseminate ADAWS model to members.	Secretariat	
2.2 **Clarification of parameters and scope of proposed model**	▪ Clarification was sought in relation to determining whether the proposed service model should be an aspirational model that depicts the ideal without budgetary constraints. ▪ Funds to implement a proposed model will be limited to operational funds from the BAC and operational funds allocated to the cancelled Redlands facility. ▪ Agreement that only one model will be presented to the Planning Group. ▪ It was noted that there may be elements within the recommended model that may not be supported or implemented by the Planning Group e.g. inpatient beds or residential component.		
3.0	**Standing agenda**		
3.1 **Communication**	**Communication Log** ▪ No further communication received.		
3.2 **Updates**	▪ The e-petition has well over 1900 signatures and was tabled in Parliament on 5 March 2013. ▪ The Planning Group has not met since the last ECRG meeting, hence, nothing to report.		
4.0	**New Business**		
4.1 **Final meeting & write up**	▪ Agreement that the recommended service model will be presented to the Planning Group as a written report and power point presentation. ▪ A presentation by the ECRG will provide the ability to capture the nuances and complexities that are often difficult to convey in a text narrative.		
4.2 **Workshop**	▪ As in the previous meeting, a workshop format was used to work through the service description and critical elements of the service model. ▪ Feedback from current and past BAC clients indicates that there is a need for consistency in staffing. This is supported by carers and families.		

Queensland Government

Barrett Adolescent Strategy

Expert Clinical Reference Group

Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
	▪ Agreement that the proposed model should have an emphasis on: 1. flow through 2. family involvement 3. medium term therapy ▪ Inclusion of the Non Government sector as a component of the recommended model was not unanimously supported by members. The risks and benefits were robustly debated. **The risks were as follows:** 1. Noted that an NGO partnership arrangement with public services is a comparatively new concept to Queensland as compared to other states such as Victoria. 2. There was a concern that an NGO will not be able to manage the acuity and crises in this particular cohort. 3. In addition, there was concern regarding the 'quality' and stability of the NGO workforce given the traditionally lower pay scales. **The benefits were as follows:** 1. The NGO sector has indeed managed a high level of complexity with the support of the public sector and clinical teams 2. The public sector can support the NGO sector to maintain and improve the residential component and enable 24 hour support. 3. This is an opportunity to enhance the mental health component in the NGO sector and develop greater partnership and better flow and continuum of care to and from the community. 4. Will address the 'flow through' issues associated with existing CYMHS bed based services. ▪ Agreement that while contentious, the NGO option will be included in the proposed model. ▪ Noted that there were basically three components required for the NGO option to be viable: 1. balance – equity in pay rates 2. support within roles – from clinical services 3. culture and underlying philosophy ▪ Other options include capacity for families/carer/support worker to stay within the unit to support the adolescent. This option could be included in the inpatient/NGO component.		
4.3 **Closing discussions**	▪ The Chair reinforced the need to deliver a proposal for an alternative model at the earliest possible time so that BAC staff can access opportunities associated with the West Moreton HHS restructure and to lessen the impact on consumers and carers. ▪ Noted that an alternative and feasible model needs to be endorsed before BAC can close. There will no gaps in service delivery. ▪ Presentation will be developed by the Chair and Secretariat based on collated discussion and feedback. Will attempt to send out a draft presentation as soon as possible. Action Draft power point presentation to be developed and sent to members as		

Queensland Government

Barrett Adolescent Strategy

Expert Clinical Reference Group

Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
	soon as possible.	Leanne Geppert Secretariat	
5.0	▪ Forward Agenda Items		
5.1	1. Service model options 2. Budget and staffing profile		
Next Meeting:	**Date:** 27 March 2013 **Time:** 9.00 – 10.30 am **Venue:** Butterfield St Level 2 Conference Room (Room 2.2 CR) **Future dates:** 10 April (TBC)		

Queensland Government

Barrett Adolescent Strategy

Expert Clinical Reference Group

Expert Clinical Reference Group: Action Table – 2012 - 2013

Item	Actions	Accountable Officer/s.	Due Date	Status
19	Forward ADAWS model of service to secretariat for distribution to the group	Amanda Tilse	Asap	
20	Further development of service elements with reference to alternative models in preparation for discussion at the next scheduled meeting	Members	By next meeting	Revised service elements with reference to alternative models developed for discussion **27.02.2013** Members to work out of session to revise the service elements table. **13.03.2013** Workshop to progress service elements and model components
21	Develop a draft power point presentation of a proposed service model based on workshop discussions	Chair Secretariat		

[redacted]

3rd October, 2013

Dear Paul,

I write because I heard that you were to be asked to chair the Working Group on Workforce and Finance. My being stood aside means that I cannot be involve d in patient care, but I do believe I can advocate for staff.

The ECRG, in its full report stated "Of concern to the ECRG is also the dissipation and loss of specialist staff skills and expertise in the area of adolescent extended care in Queensland if BAC closes and a Tier 3 is not established in a timely manner. This includes both clinical staff and education staff." This does not come across as strongly in the recommendations. Professor Philip Hazell, the interstate expert on the ECRG was adamant on this point. All other members agreed.

I have had the opportunity to do locums with other services, including Mater and Logan acute inpatient units. I interact with many community colleagues. I am absolutely convinced that there is a skill set among many permanent (and some temporary) Barrett clinicians which is not routinely found elsewhere. They incorporate a strong rehabilitation focus as well as strong expertise in managing trauma, self harm, disordered eating behaviours, and extreme social anxiety - often in the context of Aspergers and other developmental disorders.

From the rate of referrals from various Districts (compared to the number of young people they see annually), the average community CYMHS clinician or private child psychiatrist would only see a young person of Barrett level severity every 3 - 5 years. Clinicians in acute inpatient units may see them yearly. Since over half of CYMHS clinicians are there less than 5 years, many will not have seen even one. Yet this level of severity is our bread and butter. I know from doing workshops with the Townsville and Toowoomba day programs, that the level of severity which they see is not comparable to even our day program young person. The level of expertise at Barrett is generally what one would expect in a Clinical Services Framework Level 6 service.

Outside the ECRG, this expertise is really quite devalued. There was no recognition of this in the last Transition Steering Committee meeting I attended on 9/9/2013.

This email is to list a number of precedents which could be referred to.

1. The current approach in the Queensland Children's Hospital is to recognise expertise in the Royal Children's and Mater Children's staff. I forget if they refer to the various levels as Tiers or Divisions. The second Tier - Directors of various Departments was an open merit selection process. The third Tier (equivalent to Team Leader, NUM or CNC) is a closed contestable process. The fourth Tier - ordinary clinicians like myself - is people slotting into equivalent positions, if there is no duplication of position, in which case there would be a closed merit selection process. Since Barrett is an add on service, which comes with its own funding, the same process could and should apply.

2. I would be interested to know what the process was when the Children's Cardiology service was transferred from Prince Charles to the Mater Children's. I cannot imagine that one would scrap expertise built up in children's cardiology, and the Mater (which is a private entity) bring in its own staff. That would devalue the whole service, and risk problems. Why should mental health be any different?
3. There was a smaller process when the gastroenterology department transferred from the Mater Children's to the Royal Children's. Apart from specialists, I don't know who else went across.
4. Finally I would be interested to know about the staffing of the Children's Emergency at Prince Charles. I am not sure if this comes under Metro North or Children's Health Queensland. If it is Metro North, were staff transferred from RCH (which would be the sensible first option), or did they employ totally new staff?

I am not writing out of self interest. Even if I was to be cleared of the allegations against me, the damage to my reputation is such that I doubt anyone in CHQ would be interested in having me. I am really concerned for two things.

1. Trying to maintain the best service for adolescents in whatever form that service takes. The time frames are incredibly short, and totally unrealistic. Adolescents were beginning to panic before I left because the future is so uncertain. Whatever service replaces Barrett, it will not be a CSCF Level 6 service. At best it will be between Levels 4 and 5. Young people will die. Some will be permanently impaired by their mental illness. The best hope of ameliorating the detrimental effects of this process is by maintaining the expertise of staff.
2. To maintain the expertise of staff. Through mentoring, selection of staff which show promise, and developing a strong team culture and ethos, as well as understanding of the processes of treatment and rehabilitation, I believe the team as a whole is unique. It is a total waste of experience to see that dissipated. Sure, it would be useful in community teams or acute inpatient units. Acute inpatient units have a very different focus, and will not utilise the skills at all. Community CYMHS functions as a team clinicians from individual disciplines, not as a multi-disciplinary team. Both of these settings will minimise the transfer of skills of our staff. Moreover, these skills will be totally underutilised because of the infreqeuncy of presentation of severe and longer term cases. They will therefore diminish with time. In addition, the significant feature of Barrett is that the contributions of every individual are integrated into the whole skill set of the team. This will not happen if they are dispersed.

I strongly implore you then to advocate for the retention of our staff into the new service(s), in the same way that the skills of staff from RCH and the Mater is recognised and will be incorporated into the new Queensland Children's Hospital.

I am also writing to Lorraine Dowell and Padraig McGrath who I understand were to be invited on to the Working Group.

Kind regards,

Trevor Sadler