EXHIBIT 618

Business Case

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

Children's Health Queensland Hospital and Health Service

July 2014

V 4.0

Version Control

Version	Date	Prepared By	Comments
0.1	27/11/13	Ingrid Adamson	Initial Draft
0.2	09/12/13	Ingrid Adamson	Incorporating comments from J. Krause and S. Stathis
0.3	06/01/14	Ingrid Adamson	Incorporating input from P. Steer, CE
0.4	15/01/14	Ingrid Adamson	Incorporating input from J. Krause, Divisional Director
0.5	22/01/14	Ingrid Adamson	Incorporating costing model updates
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1.0	12/02/14	Ingrid Adamson	Final Version
2.0	14/02/14	Ingrid Adamson	Incorporating input from Executive Team
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4.0	16/07/14	Ingrid Adamson	Update service name and financials

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

Approvals

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

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

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

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

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

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1 Project Proposal

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

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

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

1.1 Strategic and Operational Alignment

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

1.2 Background

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

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

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

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

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

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

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

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

Children's Health Queensland is leading the development and implementation of the statewide Adolescent Mental Health Extended Treatment Initiative.

1.3 Statement of Need

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

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

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

1.4 Objective/s

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

Specifically, the initiative will:

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

1.5 Scope

1.5.1 In Scope

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

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

1.5.2 Out of Scope

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

1.6 Dependencies

There are no project inter-dependencies identified.

1.7 Benefits and Outcomes

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

Achievement of project objectives and outcomes will be measured through:

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

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

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

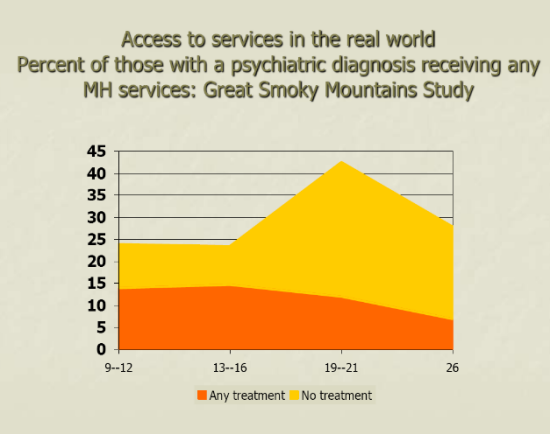
2 Demand for Services

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

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

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

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



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

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

3 The Proposed Model of Care

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

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

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

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

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

3.1 Assertive Mobile Youth Outreach Services (New Service)

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

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

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

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

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

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

3.2 Day Programs (Expanded Service)

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

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

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

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

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

3.3 Residential Rehabilitation Units (New Service)

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

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

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

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

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

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

3.4 Step Up / Step Down Units (New Service)

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

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

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

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

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

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

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

3.5 Statewide Subacute Beds (New Service)

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

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

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

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

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

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

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

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

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

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

The model of care improves on current service delivery through:

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

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

4 Issues

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

Age Limit

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

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

Skilled Workforce

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

Location of Services

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

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

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

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

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

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

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

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

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

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

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

Non-Government Organisation Engagement

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

Service Governance

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

5 Financial Analysis

5.1 Current Funding Available

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

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

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

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

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

5.2 Recurrent and Capital Cost Options

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

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

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

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

5.2.1 Recurrent Costs

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

Statewide Adolescent Extended Treatment and Rehabilitation Strategy Business Case Summary

Service Funding Options v4.0	Service Commences	2014/15	2015/16	2016/17
Residential Rehabilitation Unit	February	$1,379,025	$1,488,212	$1,527,111
Interim Statewide Subacute Beds	February	$76,813	$0	$0
Statewide Assessment Panel (Coordinator)	From July	$79,539	$81,542	$83,597
AMYOS Psychiatrists x 2 + coordinators	From July	$939,060	$928,872	$952,218
AMYOS x 7 Teams	From July	$1,955,843	$2,165,549	$2,220,493
New Day Program (North Brisbane)	From July	$1,456,001	$1,494,066	$1,533,134
TOTAL		**$5,886,281**	**$6,158,241**	**$6,316,553**

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

Service Funding Options	Commence	2014/15	2015/16	2016/17
Statewide Subacute Beds (4 beds)	From	$661,455	$1,005,880	$1,031,317
AMYOS Psychiatrists x 2	Jul-14	$756,079	$734,131	$752,639
AMYOS x 12 Teams (rest of Qld)		$3,719,396	$3,712,369	$3,806,559
TOTAL		**$5,136,930**	**$5,452,380**	**$5,590,515**
Day Program 2 (Logan)	From	$0	$1,528,015	$1,568,101
Resi Rehab Unit 2 (North Cluster)	Jul-15	$0	$1,570,550	$1,527,111
Step Up/Step Down Unit 1 (Central Cluster)		$0	$3,586,651	$3,648,007
TOTAL		**$0**	**$6,685,216**	**$6,743,219**
Day Program 3 (Gold Coast)	From	$0	$0	$1,568,101
Resi Rehab Unit 3 (Central Cluster)	Jul-15	$0	$1,570,550	$1,527,111
Step Up/Step Down Units 2 & 3 (North & Southern Clusters)		$0	$3,586,651	$7,330,981
TOTAL		**$0**	**$5,157,201**	**$10,426,193**
GRAND TOTAL		**$5,136,930**	**$17,294,797**	**$22,759,927**

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

5.2.2 Capital Costs

The following capital estimates are based on fit out and building estimates for the construction of similar bed-based units in Queensland, and are an indication of the type of capital investment that would be required. The accuracy of these estimates would need to be verified by an appropriately qualified quantity surveyor.

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

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

Capital Fit-Out Costs ($2,000/sqm)	2014-15	2015-16	2016-17
Day Program (2 units)		$501,272	$516,310
Step Up/Step Down Unit (3 units)		5,092,320*	$ 2,622,545
Total	**$0**	**$5,593,592**	**$3,138,855**
Capital Construction Costs ($3,200/sqm)			
Day Program (2 units)		$1,612,568	$1,660,945
Step Up/Step Down Unit (3 units)		$10,863,616*	$5,594,762
Total	**$0**	**$12,476,184**	**$7,255,707**

* Cost for establishing two Step Up/Step Down Units in 2015/16.

Due to the complexity of individual mental health care provided to young people, it is not possible to calculate an accurate cost per consumer for each service. Care plans, duration of treatment, and length of stay will differ for each individual consumer across the continuum of care.

6 Recommended Option

To deliver a robust and comprehensive model for adolescent mental health care, it is strongly recommended that the full spectrum of services be funded. It is important that each service element is not viewed as a stand-alone component of the model but rather as a necessary integrated element along a continuum.

If these services are not funded, gaps in delivery and care will remain. In the absence of appropriate community care, there is an increased risk of recurrence in mental illness, self-harm, and suicide upon discharge from acute inpatient units, greater number of admissions into acute inpatient units, and longer lengths of stay in acute inpatient units. The ability for consumers, and their families, to navigate their way through clinical and community services will continue to be challenging and difficult without the support of intensive case management and coordination. Furthermore, without appropriate funding, adolescent mental health services in rural and regional areas will remain limited. Young people will need to be removed from their families and communities in order to receive appropriate mental health treatment. Risks of institutionalisation and deskilling as a result of lengthy hospital inpatient admissions will continue, and the follow up and recovery of consumers on discharge will be compromised.

Following the closure of the BAC, and the increased public scrutiny into adolescent mental health treatment, any gaps in the continuum of care that result in poor mental health outcomes, including the risk of significant self-harm or suicide, exposes the Government and CHQ to significant reputational risk.

7 Risk

Significant key risks to the implementation of the proposed Model of Care are listed below:

Risk Event & Impact	Rating	Treatment	Owner
Poor quality of service options developed	Medium	• Undertake sufficient research to inform service option development, and to instil confidence in the service model • Manage timeframes to allow quality development of service options • Consult with stakeholders to test validity of service model • Pilot service options with current BAC and wait list consumers • Engage with other Departments and organisations to ensure comprehensive service model (e.g. DETE, Child Safety, Housing, headspace, etc.)	CHQ HHS
Low level of support for new service options/service model	High	• Clear communication strategies regarding impact of change and benefits • Training, education and support for staff	CHQ HHS
Absence of capital and growth funding to support services	High	• Utilise existing operational funds • Explore operational expenditure options versus capital intensive options • Advocate for additional recurrent funding to support service options • Remain within ABF Scope	CHQ HHS
Critical incident with an adolescent prior to availability of new or enhanced service options	High	• Appropriate Consumer Clinical Care Plans • Clear communication strategies with service providers regarding the development and rollout of service options • Develop an escalation process for referral of consumers whose needs fall outside of existing service options	Local HHS CHQ HHS
Reputational Risk			
Reputational and political implications from any adverse incidents or media	High	• Clear communication strategies regarding impact of change and benefits • Proactive workforce and community engagement • Regular communication to Premier, Minister, and CEs regarding initiative, to keep fully informed of progress and issues	WM HHS and CHQ HHS

8 Stakeholder Engagement

Throughout development of the statewide Adolescent Mental Health Extended Treatment Initiative, CHQ has engaged with young people, families, and carers to explore care options. CHQ has encouraged submissions from parents and carers, including a presentation to the accountable Steering Committee, participation on various working groups, and one-to-one meetings with parents.

CHQ has also engaged with mental health experts and care providers from other Hospital and Health Services, and across Australia, to learn about and explore alternative, progressive approaches to adolescent extended treatment and rehabilitation care.

CHQ continues to work in close partnership with West Moreton Hospital and Health Service to support them in the continuity of mental health care for young people following closure of the BAC in January 2014.

Key stakeholders involved in this initiative are identified below:

Stakeholders	Commitment to the project
DDG Health Services and Clinical Innovation	Strategic oversight
Qld Mental Health Commissioner – Lesley van Schoubroeck	Strategic oversight
CHQ HHS: The Board CE – Peter Steer ED – Deb Miller	Project Sponsor Responsible for: • Governance of the project • Development of the future model of service • Provision of information and support to staff impacted by new service options • Communications and media regarding the future model of service • Achievement of project objectives
WM HHS: The Board CE – Lesley Dwyer ED – Sharon Kelly	Project Partner Responsible for: • Clinical care for current BAC and wait list consumers • Transition of BAC operational funding • Provision of information and support to BAC staff • Communications and media regarding BAC • Achievement of project objectives
Mental Health, Alcohol and Other Drugs Branch ED – Bill Kingswell	Project Partner Responsible for: • Funding for the project and identified service options • Provision of national and state information and data regarding policy and service planning as relevant to the project • Participate in statewide negotiations and decision-making
Divisional Director, CHQ CYMHS - Judi Krause	Steering Committee Co-Chair
Medical Director, CHQ CYMHS - Stephen Stathis	Steering Committee Co-Chair

Stakeholders	Commitment to the project
Other HHSs with acute inpatient units and MHSS	• Service provision to consumers • Participate in discussions and negotiations relevant to the service options being considered • Work collaboratively to support the transition of consumer care back to 'home' HHS as relevant to individual consumer needs
Mental Health Executive Directors, Clinicians and other staff	• Service provision to consumers • Participate in discussions and negotiations relevant to the service options being considered • Work collaboratively to support the transition of consumer care back to 'home' HHS as relevant to individual consumer needs
Department of Employment, Training, and Education	Service provision to consumers Adapt current service delivery to suit new service options identified
Mater Hospital	Service provision to consumers
NGOs	Service provision to consumers Work collaboratively to support the transition of consumer care back to 'home' HHS as relevant to individual consumer needs
Carer Representatives	Impact on the consumer/s they are representing
Families	Direct impact on their family
Existing and Potential Consumers	Direct personal impact
Interstate Mental Health Counterparts	Participate in discussions regarding contemporary service options
Media	Influence on community perception of initiative and public image of Qld Health

Consultation undertaken:

An **Expert Clinical Reference Group** (ECRG) was convened, consisting of a consumer representative, a carer representative, an interstate Child and Adolescent Psychiatrist, multi-disciplinary Child and Youth clinician representation (including north Queensland), a representative of BAC, a representative of the BAC School, and a Non-Government Organisation (NGO) representative. The ECRG was chaired by the Director of Planning and Partnerships Unit, Mental Health Alcohol and Other Drugs Branch (MHAODB). The ECRG reported up to the WM HHS via a **Planning Group**, which was chaired by the Executive Director of Mental Health & Specialised Services, WM HHS.

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

In August 2013, the Statewide Adolescent Extended Treatment and Rehabilitation Strategy (now known as the Adolescent Mental Health Extended Treatment Initiative or AMHETI) was established. The **AMHETI Steering Committee** met for the first time on 26th August. The purpose of the AMHETI Steering Committee is to oversee the implementation of AMHETI, and provide a decision-making, guidance, and leadership role with respect to mental health service planning, models of care, workforce planning, financial management and consumer needs associated with future adolescent extended treatment and rehabilitation services. The

committee is co-chaired by the Divisional Director and Medical Director of the CHQ Child and Youth Mental Health Service (CYMHS). Membership includes representatives from Mental Health (Metro South, Mater, Townsville, and West Moreton HHS), the CHQ HHS, MHAODB, headspace, and a consumer and carer.

On 1st October, the **Service Options Implementation Working Group** was convened. The purpose of this group was to develop contemporary service options, within a statewide model of service, for adolescent mental health extended treatment and rehabilitation. The group was chaired by the Manager, Clinical Governance Office of the Chief Psychiatrist – the Mental Health, Alcohol, and Other Drugs Branch (MHAODB), and comprised of representatives from across the state and Hospital and Health Service Districts, including mental health clinicians across nursing, allied health and medical professions, a carer representative, and a non-government organisation representative.

Supporting References and Project Documentation:

- Adolescent Mental Health Extended Treatment and Rehabilitation Model of Care (**Appendix 2**) and Detailed Service Elements (**Appendix 3**)
- Adolescent Mental Health Extended Treatment Initiative Project Plan
- Victorian Site Visit Report, 2013
- NSW Site Visit Report, 2013
- Queensland Plan for Mental Health 2007-2017
- COAG National Action Plan on Mental Health 2006-2011
- COAG Roadmap for National Mental Health Reform 2012-2022
- National Mental Health Report 2013: tracking progress of mental health reform in Australia 1993-2011. Commonwealth of Australia, Canberra
- Mental Health Services In Brief, 2011
- National Mental Health Report, 2010
- Community Mental Health Services Full Time Equivalent Report (2012), for the Mental Health Alcohol and Other Drugs Branch
- Intensive Mobile Youth Outreach Service (IMYOS) Information Sheet (2012), Victorian Department of Health
- Youth Prevention and Recovery Care (Y-PARC) Model of Care, Victorian Department of Health
- Adult Prevention and Recovery Care (PARC) Services Framework and Operational Guidelines (2010), Victorian Department of Health
- Intensive outreach in youth mental health, 2011, Children and Youth Services Review, Vol. 33, 1506-1514
- Review of the PDRSS Day Program, Adult Rehabilitation and Youth Residential Rehabilitation Services (2011), for the Victorian Department of Health, Nous Group
- The Case for Mental Health Reform in Australia: a Review of Expenditure and System Design, Nous Group

9 Approval of Recommendation and Decision-Making

Recommendation			
To deliver a robust and comprehensive model for adolescent mental health care, it is strongly recommended that the full spectrum of services be funded and implemented.			
Next Steps	**Prepared By**	**Name:**	Ingrid Adamson
		Work Unit/ Site:	Office of Strategy Management, CHQ HHS
		Date:	
	Cleared By (Project Sponsor)	**Name:**	Peter Steer
		Position:	Chief Executive, CHQ HHS
		Signed:	
		Date:	
		Comments:	

Approval / Decision (Higher Authority)			
Next Step	☐ Progress to Planning and Definition phase – complete Project Plan ☐ Revise Business Case and resubmit ☐ Undertake further options analysis ☐ Cease *Comments:* Submit business case to Department of Health Policy and Planning Branch for consideration.		
Governance	**Project Manager**	Ingrid Adamson	
	Project Sponsor	Peter Steer	
Resources for Next Step	☐ Approved ☐ Not approved ☐ N/A		
	Amount	$ { FORMTEXT }	Perm FTE:
Approved By	**Name:**	Peter Steer	
	Position:	Chief Executive, CHQ HHS	
	Signed:	{ FORMTEXT }	
	Date:		

Appendix 1: ECRG Recommendations

Proposed Service Model Elements
Adolescent Extended Treatment and Rehabilitation Services (AETRS)

Preamble

Mental health disorders are the most prevalent illnesses affecting adolescents today. Of particular note is the considerable evidence that adolescents with persisting and severe symptomatology are those most likely to carry the greatest burden of illness into adult life. Despite this, funding for adolescent (and child) mental health services is not proportional to the identified need and burden of disease that exists.

In the past 25 years, a growing range of child and youth mental health services have been established by Queensland Health (and other service providers) to address the mental health needs of children and adolescents. These services deliver mental health assessment and treatment interventions across the spectrum of mental illness and need, and as a service continuum, provide care options 24 hours a day, seven days a week. No matter where an adolescent and their family live in Queensland, they are able to access a Child and Youth Mental Health Service (CYMHS) community clinic or clinician (either via direct access through their Hospital and Health Service, or through telehealth facilities). Day Programs have been established for adolescents in South Brisbane, Toowoomba and Townsville. Acute mental health inpatient units for adolescents are located in North Brisbane, Logan, Robina, South Brisbane and Toowoomba, and soon in Townsville (May/June 2013). A statewide specialist multidisciplinary assessment, and integrated treatment and rehabilitation program (The Barrett Adolescent Centre [BAC]) is currently delivered at The Park Centre for Mental Health (TPCMH) for adolescents between 13 and 17 years of age with severe, persistent mental illness. This service also offers an adolescent Day Program for BAC consumers and non-BAC consumers of West Moreton Hospital and Health Service.

Consistent with state and national mental health reforms, the decentralisation of services, and the reform of TPCMH site to offer only adult forensic and secure mental health services, the BAC is unable to continue operating in its current form at TPCMH. Further to this, the current BAC building has been identified as needing substantial refurbishment. This situation necessitates careful consideration of options for the provision of mental health services for adolescents (and their families/carers) requiring extended treatment and rehabilitation in Queensland. Consequently, an Expert Clinical Reference Group (ECRG) of child and youth mental health clinicians, a consumer representative, a carer representative, and key stakeholders was convened by the Barrett Adolescent Strategy Planning Group to explore and identify alternative service options for this target group.

Between 1 December 2012 and 24 April 2013 the ECRG met regularly to define the target group and their needs, conduct a service gap analysis, consider community and sector feedback, and review a range of contemporary, evidence-based models of care and service types. This included the potential for an expanded range of day programs across Queensland and community mental health service models delivered by non-government and/or private service providers. The ECRG have considered evidence and data from the field, national and international benchmarks, clinical expertise and experience, and consumer and carer feedback to develop a service model elements document for Adolescent Extended Treatment and Rehabilitation Services in Queensland. This elements document *is not a model of service* – it is a conceptual document that delineates the key components of a service continuum type for the identified target group. As a service model elements document, it will not define how the key components will function at a service delivery level, and does not incorporate funding and implementation planning processes.

The service model elements document proposes four tiers of service provision for adolescents requiring extended mental health treatment and rehabilitation:

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

The final service model elements document produced was cognisant of constraints associated with funding and other resources (e.g. there is no capital funding available to build BAC on another site). The ECRG was also mindful of the current policy context and direction for mental health services as informed by the National Mental Health Policy (2008) which articulates that *'non acute bed-based services should be community based wherever possible'.* A key principle for child and youth mental health services, which is supported by all members of the ECRG, is that young people are treated in the least restrictive environment possible, and one which recognises the need for safety and cultural sensitivity, with the minimum possible disruption to family, educational, social and community networks.

The ECRG comprised of consumer and carer representatives, and distinguished child and youth mental health clinicians across Queensland and New South Wales who were nominated by their peers as leaders in the field. The ECRG would like to acknowledge and draw attention to the input of the consumer and carer representatives. They highlighted the essential role that a service such as BAC plays in recovery and rehabilitation, and the staff skill and expertise that is inherent to this particular service type. While there was also validation of other CYMHS service types, including community mental health clinics, day programs and acute inpatient units, it was strongly articulated that these other service types are not as effective in providing safe, medium-term extended care and rehabilitation to the target group focussed on here. It is understood that BAC cannot continue in its current form at TPCMH. However, it is the view of the ECRG that like the Community Care Units within the adult mental health service stream, a design-specific and clinically staffed bed-based service is essential for adolescents who require medium-term extended care and rehabilitation. This type of care and rehabilitation program is considered life-saving for young people, and is available currently in both Queensland and New South Wales (e.g., The Walker Unit).

The service model elements document (attached) has been proposed by the ECRG as a way forward for adolescent extended treatment and rehabilitation services in Queensland.

There are seven key messages and associated recommendations from the ECRG that need to underpin the reading of the document:

1. Broader consultation and formal planning processes are essential in guiding the next steps required for service development, acknowledging that services need to align with the National Mental Health Service Planning Framework

- The proposed service model elements document is a conceptual document, not a model of service. Formal consultation and planning processes have not been completed as part of the ECRG course of action.
- In this concept proposal, Tier 2 maps to the Clinical Services Capability Framework for Public and Licensed Private Health Facilities Version 3.1 (CSCF) Level 5 and Tier 3 maps to CSCF Level 6.

Recommendations:

a) Further work will be required at a statewide level to translate these concepts into a model of service and to develop implementation and funding plans.
b) Formal planning including consultation with stakeholder groups will be required.

2. Inpatient extended treatment and rehabilitation care (Tier 3) is an essential service component

- It is understood that the combination of day program care, residential community-based care and acute inpatient care has been identified as a potential alternative to the current BAC or the proposed Tier 3 in the following service model elements document.
- From the perspective of the ECRG, Tier 3 is an essential component of the overall concept, as there is a small group of young people whose needs cannot be safely and effectively met through alternative service types (as represented by Tiers 1 and 2).
- The target group is characterised by severity and persistence of illness, very limited or absent community supports and engagement, and significant risk to self and/or others. Managing these young people in acute inpatient units does not meet their clinical, therapeutic or rehabilitation needs.
- The risk of institutionalisation is considered greater if the young person receives medium-term care in an acute unit (versus a design-specific extended care unit).

- Clinical experience shows that prolonged admissions of such young people to acute units can have an adverse impact on other young people admitted for acute treatment.
- Managing this target group predominantly in the community is associated with complexities of risk to self and others, and also the risk of disengaging from therapeutic services.

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.

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.

Appendix 2: Proposed Model of Care

Recovery oriented treatment and rehabilitation for young people, aged 13 – 18 years*, with severe and persistent mental health problems

Step Up to Acute Inpatient Care (out of scope)					
Service Element	**Assertive Mobile Youth Outreach Service**	**Day Program**	**Step Up/Step Down Unit**	**Statewide Subacute Beds**	**Residential Rehabilitation Unit**
Overview	Provides ongoing recovery-oriented assessment, assertive treatment, and care through intensive mobile interventions in a community or residential setting.	Provides a flexible range of intensive therapy, extended treatment and rehabilitation options within a therapeutic milieu.	Provides short-term residential treatment with services from specialist trained mental health staff with NGO support.	Provides medium-term intensive hospital-based treatment and rehabilitation services in a secure, safe, structured environment.	Provides longer-term accommodation and recovery-oriented treatment with inreach services from specialist trained mental health staff with NGO support.
Primary Referral	CYMHS	CYMHS	CYMHS / Acute Inpatient Unit	Statewide Admission Panel	CYMHS or Adult Mental Health Services
Profile	Supportive intensive services required out of hours. No fixed address or living in residential accommodation. High risk of disengagement from treatment services. Absence of bed-based or day program options in local community.	Home environment is supportive enough to ensure safety and/or access to CYMHS. Does not require inpatient care. History of school exclusion or refusal. Poor social skills requiring group-based work. Live within a geographical area in proximity to the day program.	Young person requires increased intensity of treatment to prevent admission into acute inpatient units (Step Up). Enables early discharge from acute/sub-acute inpatient units (Step Down). Safety not ensured at home. Does not allow for involuntary detention as not gazetted MH facility.	Level of acuity or risk requires inpatient admission. Improvement in mental health not expected to occur within short term: measured in weeks/months. Requires therapeutic milieu not provided by acute inpatient unit. Allows for involuntary detention.	16-21 year olds who are able to consent to treatment (Gillick competent). Home environment is not supportive enough to ensure safety and/or facilitate access to mental health services. Requires additional support to develop independent living skills. Does not require inpatient care.
Hours of Operation	Flexible, with capacity for extended hours	Business hours, Monday to Friday, with capacity for some extended hours.	24 x 7	24 x 7	Mental Health: Flexible, with capacity for extended hours. Residential: up to 24 x 7
Length of Stay	Case-by-case basis	120 days; maximum of 180 days	28 days	120 days; maximum of 180 days	Up to 365 days
Unit Size	Ideally 2 staff per AMYOS team	10-15 adolescents per day	Up to 10 beds	2 - 4 beds; seclusion room	5 - 10 beds
Education Options	Support local schooling	In-reach; On-site; Distance Education and/or support local schooling	In-reach; Distance Education and/or support local schooling	On-site and/or Distance Education	Support local schooling
Location	Community CYMHS	Hospital campus or gazetted community mental health facility	Residential area located close to an acute mental health unit	Lady Cilento Children's Hospital	Residential area
Governance	Local. Some with CHQ HHS oversight	Local HHS	Local HHS with CHQ HHS Oversight	CHQ HHS	Local HHS with CHQ HHS Oversight NGO operated
Existing in Qld	Nil	Mater; Toowoomba; Townsville	Nil	Nil	Nil
Proposed sites with implementation taking place over 4 years, subject to funding**	North Brisbane Logan Redcliffe-Caboolture Toowoomba Bundaberg/Wide Bay Mackay Cairns Central West Qld South Brisbane Gold Coast Ipswich Sunshine Coast Rockhampton Townsville Mt Isa South West Qld	North Brisbane (critical) South Brisbane (Logan) Gold Coast	North Brisbane South Brisbane North Qld [Dependent upon NGO sector appetite; provider agnostic]	1 SSB in CHQ catchment	Cluster based (North/Central/Southern) [Dependent upon NGO sector appetite; provider agnostic]
Evidence-Informed	Intensive Mobile Youth Outreach Services (IMYOS), Victoria Mobile Intensive Team (Adult), Qld Wraparound System of Care	Existing Qld Day Programs – endorsed statewide Model of Service Adolescent Drug and Alcohol Withdrawal Service (ADAWS)	Y-PARC, Frankston and Dandenong, Victoria	Walker Unit, Concorde Hospital, NSW	Time Out House Initiative (TOHI), Cairns Therapeutic Residentials (DCCSDS) Victorian Youth Residential Models, Nous Group Report Evaluation of the Therapeutic Residential Care Pilot Program, VERSO (2011)
Underpinned by Community CYMHS (out of scope)**					

* Age range includes all young people completing high school

** A phased approach to service implementation is proposed.

*** CYMHS staffing is currently at 58% of FTE target capacity (by 2017) as noted by the Qld Mental Health Plan (NB: Mental health planning will adopt an outputs-based approach in future).

Appendix 3: Detailed Service Elements

MODEL of SERVICE for ASSERTIVE MOBILE YOUTH OUTREACH SERVICE	
What does the service intend to achieve? (Key functions – description)	Assertive Mobile Youth Outreach Services (AMYOS) form part of an integrated continuum of care for adolescents requiring mental health treatment in Queensland. AMYOS are delivered by multidisciplinary teams, who provide ongoing recovery-oriented assessment and assertive treatment and care, aimed at improving the quality of life for young people with complex mental health needs, through intensive mobile interventions in a community or residential setting. AMYOS will work within a collaborative partnership model with other community service providers, including other health care providers, education, child safety, housing, police, and youth justice services. A range of individual, family, and group-based assessment, treatment, and rehabilitation programs will be offered, aimed to treat mental illness, reduce emotional distress, and promote function within the community. This will include recovery-orientated treatment and discharge planning that will support the safe transition to more functional or independent living. The AMYOS model is a strength based, family centred approach with focuses on the client's individual strengths. AMYOS clinicians work as mental health case managers and a core role is working collaboratively with other local community services and linking young people into appropriate wraparound care options. Each clinical recovery plan is tailored to the individual and developed in collaboration with key stakeholders. The AMYOS model may be adapted to reflect local service requirements or systems. The service will meet and exceed National Standards for Mental Health Services and the Equip National Safety Standards.
Who the service is for? (Target group)	Diagnostic Profile: Adolescents aged 13-18 who are difficult to engage, exhibit high risk behaviour or risk of deterioration, and may have a diagnosis of a psychotic illness, severe mood or anxiety disorders, or complex trauma with significant deficits in psychosocial functioning. Other diagnostic profiles would include adolescents presenting with marked social avoidance or severely disorganised behaviour characterised by impaired impulse control, substance misuse, emerging personality vulnerabilities, complex disruptive behavioural disorders, risk of self-harm, or difficulties managing activities of daily living. Many will experience chronic family dysfunction, which serves to exacerbate the severity and persistence of the disorder and associated disabilities.
What does the service do? **The key functions:** • Provide assertive engagement with adolescents and their families.	

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- Provide intensive, developmentally-appropriate, community-centred, mental health interventions and ongoing assessment for adolescents who require higher intensity (level and mode of contact and range of interventions/services, including risk assessment, crisis management, and safety planning) treatment, rehabilitation, and support to recover from mental illness.
- Minimise the impact of mental illness on adolescents, their family, friends, support people, and carers by providing a range of multi-systemic interventions.
- Provide outreach mental health case management to facilitate access to a range of clinical and non-clinical services to enable adolescents to establish or re-establish a meaningful life.
- Work with the adolescent, and their networks, to develop personal support systems and a sense of self-efficacy, and encourage increased participation in their community.
- Oversight of AMYOS will be provided by dedicated psychiatry services that will provide individualised specialist assessment and treatment advice, and workforce development to suit the specific requirements of the local HHS.
- Ensure engagement with other primary care and specialist service providers to enable access to a range of early interventions and timely treatment.
- Partner with other primary care and specialist services providers to tailor evidence-informed, community or residential-based treatment interventions to alleviate or treat distressing symptoms and promote recovery.
- Partner with other primary care and specialist service providers to assist progression in developmental tasks, which may be arrested secondary to the mental illness.

AMYOS have an assertive engagement, early intervention, and prevention focus to assist adolescents to manage crisis situations and reduce the need for inpatient care. The approach places a strong emphasis on the development of inter-sectorial partnerships, and AMYOS will work with other key service providers to facilitate joint care planning and case management.

Partnership programs will include a range of community-based therapeutic, educational/vocational interventions, and comprehensive activities to assist in the development and recovery of the adolescent. The program will follow structured phases incorporating establishing a therapeutic alliance, comprehensive biopsychosocial, developmental and risk assessments, collaborative development of realistic therapeutic goals incorporating a range of community services, and assertive discharge planning to facilitate ongoing engagement with community support and treatment services.

AMYOS are mobile and delivered by multidisciplinary teams at residences and/or community settings appropriate for engagement with the adolescent. The approach has an emphasis on recovery, rehabilitation, and community integration and will likely be provided over a number of months.

The AMYOS will:

- Provide safe, high quality triage, assessment, and treatment interventions that demonstrate best practice principles and reflect evidence-informed care.
- Assertively engage with adolescents at high risk of disengaging from or not accessing treatment services.
- Provide information, advice, and support to adolescents and their families/carers.
- Offer information and advice to other health service providers on the provision of mental health care for young people and their families/carers.
- Establish effective, collaborative partnerships with other Queensland Health mental health

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services/teams, local health services/teams, and external service providers and stakeholders, including Medicare Locals, General Practitioners (GPs), educational/vocational services, non-government organisations (NGOs), and community groups. • Respond and adapt to the changing state and national health context over time. • Establish a detailed understanding of local resources for the support of adolescents with mental health problems, and their families/carers. • Appropriately involve adolescents and their families/carers in all phases of care, and support them in their navigation of the mental health system. • Support/uphold the rights of adolescents and their families/carers to make informed decisions and actively participate in their care plans. • Convey hope, optimism, and a belief in recovery from mental health problems and disorders to adolescents, their families/carers, and their community. • Promote and advocate for improved access to general health care services for adolescents and their families/carers. • Support health promotion, prevention, and early intervention strategies. • Link with other Statewide Adolescent Extended Rehabilitation and Treatment Services to provide a continuum of care for adolescents requiring more intense services.	
Referral /Access	• In most cases, AMYOS will operate as part of a Community Child and Youth Mental Health Service (CCYMHS). • AMYOS may work in conjunction with eCYMHS in areas, where access to CYMHS psychiatry services is not easily accessible, or as negotiated with local HHSs. • All new service referrals will be via a single point of entry at each AMYOS site. • Triage and intake assessment will be undertaken by a dedicated AMYOS team member/s. • Parental/carer consent to referral must be noted on the intake form. Adolescents presenting independently will be asked to provide informed consent, where able. • The adolescent will be encouraged to involve parents/carers in knowledge of treatment; however, the interests of the adolescents are placed above any parental right to be informed. • When a person is referred to AMYOS without his/her knowledge or consent, triage will proceed as clinically indicated, and according to the mental health statement of rights and responsibilities and the *Mental Health ACT 2000.* • Timeframes for assessments will be formulated according to the documented risk assessment. • A clinical decision is made at intake regarding the most appropriate services (AMYOS and/or other) to meet the needs of the adolescent and family/carers. • Referral agencies will be supported to remain actively involved during the assessment process. • Suitability for entry to AMYOS will be undertaken by the local AMYOS

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	multidisciplinary team (MDT). • A multi-agency wraparound approach will be utilised to allow for assertive, collaborative management and discharge planning across multiple service providers, and to promote whole of government partnerships across the sector. • On acceptance into AMYOS, the adolescent will be assigned a Case Manager, who will be responsible for organising admission, case co-ordination, and ongoing liaison across the sector.
Assessment	**Mental Health Assessments** • AMYOS will complete a comprehensive, bio-psychosocial, developmental, and risk assessment with each adolescent and their family/carers. Ongoing assessments will be timely, reflecting the clinical needs of the adolescent and their families/carers. • The Case Manager will obtain a detailed assessment of the nature of mental illness, their behavioural manifestations, impact on function and development, and the course of the mental illness. This assessment will begin with the referral and continues throughout treatment. • Initial and ongoing assessments will include both risk assessment, and drug and alcohol use assessment. • Assessments will initiate a discussion of treatment and recovery goals, including the adolescent's goals, strengths, and capacity for self-management. The assessment will also entail the collection of information from family/carers and other service providers, including GPs and schools. • Same day crisis response assessments will be provided. **Family/Carer Assessment** • A Family Assessment is considered essential where possible. The Case Manager will obtain a detailed history of family structure and dynamics, or a history of care if the adolescent is in care. This process will begin with the referral and continues throughout treatment. • If parent/carer mental health needs are identified, the Case Manager will attempt to meet these needs and, if necessary, refer to an adult mental health service. **Developmental/Educational** • Educational or vocational goals and life skills are a key feature of the assessment process. Linkages to school or vocational-based interventions will be a key component of the adolescent's recovery. • The Case Manager will obtain a comprehensive understanding of any developmental, cognitive, speech and language, or learning disorders and their impact on the adolescent's mental health and schooling. This process begins with available information on referral and during treatment. **Physical Health** • Physical and oral health will be routinely assessed, managed, and documented. This may be conducted by a health service provider external to AMYOS, but needs to be considered as part of an AMYOS assessment.

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	• The outcome of assessments will be communicated to the adolescent, family/carer, and other stakeholders in a timely manner. **Risk Assessment** • Risk assessments will be conducted on admission and as clinically indicated in all phases of care provision. • A risk assessment will be documented prior to transfer or discharge. • Risk assessments will include a formalised suicide risk assessment and assessment of risk to others. • Risk assessments will be conducted in accordance with the statewide standardised clinical documentation. **Alcohol and other Drugs** • Assessments of alcohol and other drug use will be conducted during the referral process, on admission, and routinely throughout treatment. **Child Safety** • Child safety concerns will be addressed in accordance with legislative mandatory reporting requirements.
Recovery Planning and Clinical Interventions: *** Service Inclusions**	AMYOS intake and referral meetings will be held weekly. Urgent cases will be reviewed as clinically indicated. All cases will be reviewed as per National Mental Health Standards (90 days) or as clinically indicated. As the designated mental health case manager, the AMYOS clinician will organise regular care co-ordination meetings with other relevant community service providers. A Recovery Plan will be developed in consultation with the adolescent and their family/carers, the referrer/s, and other relevant agencies at completion of the assessment phase. Adolescents will have access to a range of least restrictive, therapeutic, educational and recreational interventions determined by evidence-informed practice, and developmentally appropriate programs to optimise their rehabilitation and recovery. The adolescent's progress against their Recovery Plan is regularly reviewed through collaboration between the treating team, the adolescent, their family/carer, the referrer/s, and other relevant agencies. **Clinical Interventions will include:** Behavioural and psychotherapeutic: • Individual and group-based interventions will be developed according to the adolescent's treatment needs. This will include a range of therapeutic and supportive verbal and non-verbal modalities and frameworks. Family Interventions: • Supportive family interventions will be integrated into the overall therapeutic approaches to the adolescent, where possible. This will include psycho-education for the parents and carers. Where possible, family therapy will also be integrated into overall therapeutic approaches. The AMYOS will offer a range of interventions to promote appropriate development in a safe and validating environment.

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	Pharmacological: • Administration will occur under the direction of a consultant psychiatrist. • Regular administration and supervision of psychotropic medications will include monitoring for efficacy and adverse effects of psychotropic medications. • Education will be given to the adolescent and parent(s)/carer about medication and potential adverse effects.
Clinical Intervention: *** Service Exclusions**	• Adolescents who do not present with severe and complex mental health problems. This decision will take into account: the nature of the presenting problem; the acuity and severity of the disturbance; the complexity of the condition (including co- morbidity); the extent of functional impairment; the level of distress experienced by the adolescent and/or family/carers; and the availability of other appropriate services. • A written referral will be provided for direct referrals from AMYOS to all other service providers (e.g. GPs, NGOs, community health, other mental health services).
Care Co-Manager / Continuity	• The Case Manager will monitor the adolescent's level of risk, mental state, and function in developmental tasks throughout treatment. • The Case Manager will act as the primary liaison person for the parent(s)/carer and external agencies throughout the young person's contact with the service. • The Case Manager will continue to co-ordinate a multi-agency wraparound approach that allows for assertive, collaborative management planning across multiple service providers, and promotion of whole of government partnerships across the sector. • The Case Manager and/ or other members of the MDT will provide therapeutic input over the course of treatment.
Discharge/Transition Planning	• Discharge planning should begin at time of admission, with key stakeholders being actively involved. Discharge planning will address potential significant obstacles such as accommodation, engagement with other child and youth mental health services, and transition to adult mental health services. • Discharge planning will involve multifactorial components that attend to therapeutic needs, developmental tasks, and reintegration into the family if appropriate. • The AMYOS team will work collaboratively with educational/vocational systems to establish linkages, or facilitate school re-integration, as appropriate.
Frequency of activity	• AMYOS will operate during business hours with capacity for extended hours. • AMYOS are mobile and delivered by multidisciplinary teams at residences and/or in community settings.

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Average Length of Stay	Determined on a case-by-case basis.
Hours of Operation	Flexible with capacity for extended hours.
Unit Size / Facility Features	Dependent upon local resources and community needs. Minimum of two staff per AMYOS team.
Staffing/Workforce	• The staffing profile will include a child and adolescent consultant psychiatrist and mental health nursing, psychology, social work, or other specialist CYMHS multi-disciplinary staff. The staffing profile may include a psychiatry registrar. The registrar position will be accredited for basic or advanced training by the Royal Australian and New Zealand College of Psychiatrists. • While there is a typical staff establishment, this will be flexible and responsive to levels of acuity and the need for specific therapeutic skills. • Administrative support is essential for the efficient operation of the AMYOS. • All appointed members of the AMYOS team are (or are working towards becoming) authorised mental health practitioners. • Caseload sizes need to consider a range of factors, including complexity of need, current staff resources within the team, and the available skill mix of the team. It is recommended that each one FTE case manager has a caseload of no more than 10 consumers at any one time. Under normal circumstances, case management will not be provided by students or staff appointed less than 0.5 FTE. • The effectiveness of the AMYOS is dependent upon an adequate number of appropriately trained clinical and non-clinical staff. The complexity of the mental health needs of adolescents suggests the need to provide staff with continuing education and professional development programs, clinical supervision, mentoring, and other appropriate staff support mechanisms. AMYOS will undertake recruitment and retention strategies, such as providing clinical placements for students, encouraging rotations through the unit of staff from other areas of the integrated mental health service, and supporting education and research opportunities.
Geographic Location	AMYOS is a mobile service working from local CYMHS. Regional and Rural AMYOS may be supported by eCYMHS.
Funding	Funding is dependent on team size. Recommended: • Ideally two clinicians per team: HP4 and/or NG7 • Psychiatrist: 4.0 FTE (psychiatrist cover spread across all AMYOS) • Psychologist: 0.5 FTE • Administration Officer: 1.0 FTE
Governance	The AMYOS will operate under the governance of the local Hospital and Health Service, where the Community CYMHS is located. The AMYOS form part of the Queensland statewide adolescent extended treatment and rehabilitation service continuum. As part of its statewide remit,

MODEL of SERVICE for ASSERTIVE MOBILE YOUTH OUTREACH SERVICE	
	Children's Health Queensland Hospital and Health Service (CHQ HHS) will provide oversight of some AMYOS via e-CYMHS.
Related Services / Other Providers	The AMYOS will operate in a complex, multi-system environment. Services are integrated and co-ordinated with partnerships and linkages to other agencies and specialist mental health services for adolescents, to ensure continuity of care across the service system and through the adolescent developmental transitions. Mechanisms for joint planning, developing, and co-ordinating services are developed and maintained. AMYOS will develop linkages with services, including but not limited to: • Strong operational and strategic links to the CYMHS network, including community child and youth mental health services; specialist child and youth mental health services (e.g. forensic services and evolve therapeutic services); and acute child and youth mental health inpatient services; • Adult mental health services; • Alcohol, tobacco and other drug services (ATODS); • Medicare Locals; • headspace services; • Community pharmacies; • Local educational providers/schools, guidance officers, and Ed-LinQ co-ordinators; • Indigenous Mental Health Workers; • Primary health care providers and networks (including those for Aboriginal and Torres Strait Islander health), local GPs and paediatricians; • Private mental health service providers; • Child and family health and developmental services; • Department of Communities, Child Safety and Disability Services; • Youth Justice services; • Government and non-government community-based youth and family counselling and parent support services; • Housing and welfare services; and • Transcultural and Aboriginal and Torres Strait Islander services. The AMYOS will: • Provide education and training to health professionals within CYMHS on the provision of comprehensive mental health care to adolescents with severe and complex disorder within community settings; • Develop the capacity to benchmark with other similar adolescent assertive outreach services; • Develop and monitor key performance indicators to reflect clinical best practice outcomes; and, • Drive research and publish on effective interventions for young people with severe and complex mental health disorders who require adolescent

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	assertive outreach services. Consumers and carers will contribute to continued practice improvement through the following mechanisms: • Participation in collaborative treatment planning • Feedback tools (e.g. surveys, suggestion boxes) • Inform workforce development Consumer and carer involvement will reflect the National Mental Health Standards and the Equip National Safety Standards.

MODEL of SERVICE for a MENTAL HEALTH DAY PROGRAM	
What does the service intend to achieve? (Key functions – description)	Mental Health Day Programs (MHDP) form part of a continuum of care for adolescents requiring extended mental health treatment and rehabilitation in Queensland. MHDP will be used as part of an overall treatment strategy and/or as an alternative to inpatient care. MHDP have a goal to reduce the severity of mental health symptoms and promote effective participation in areas such as schooling, social functioning, symptom management, and other life skills. MHDP aim to support the young person in achievement of their recovery goals by utilising a flexible approach that enables work with family/carers, peers, community support people, and other agencies (i.e. education). MHDP are time limited. They provide targeted treatment interventions in the least restrictive environment, while recognising the need for safety, with minimal disruption to family, friends, educational/vocational, social, community, and support networks. MHDP for adolescents have a focus on the developmental context and specific requirements for family involvement and include integration with educational or vocational programs. MHDP are ideally integrated with mental health inpatient and CYMHS community based services. MHDP form part of a continuum of child and youth mental health care and provide a flexible range of intensive therapy, extended treatment and rehabilitation options to maximise recovery within a therapeutic milieu. The MHDP model may be adapted to reflect local service requirements or systems. The service will meet and exceed National Standards for Mental Health Services and the Equip National Safety Standards.
Who the service is for? (Target group)	Diagnostic profile: Young people aged 13-18 with extreme anxiety, chronic depression, eating disorders, early psychosis, Post Traumatic Stress Disorder (PTSD), and co-morbid developmental disorders that are linked to school refusal and social exclusion. Symptoms may include a history of early childhood trauma characterised by sexual, physical, emotional abuse and neglect. They may have a history of parental separation, chaotic family environments, and/or parental mental illness/substance abuse. The level of acuity is such that the adolescent does not require inpatient stay; the living environment is supportive enough to ensure safety and facilitate attendance on a daily basis. If acuity levels increase, the adolescent may require admission to an acute inpatient unit.
What does the service do? **The key functions:** • Provide multidisciplinary and collaborative consultation, diagnostic assessment, treatment, and a range of evidence-informed interventions, including recovery and discharge planning. • Provide an alternative to acute hospital admission for young people with severe and complex mental health issues, who require additional support due to difficulties engaging in mainstream services,	

MODEL of SERVICE for a MENTAL HEALTH DAY PROGRAM

including schooling.

- Coordinate and support access to a range of integrated services to ensure seamless service provision.

Treatment programs will include an extensive range of therapeutic, educational/vocational interventions, and comprehensive activities to assist in the development and recovery of the adolescent. The MHDP will follow structured phases incorporating assessment, establishment of therapeutic alliances, development of realistic therapeutic goals, treatment, and assertive discharge planning to facilitate reintegration back to community-based treatment.

Programs will include:

- Phased treatment programs that are developed in partnership with adolescents and where appropriate, their parents or carers.
- Targeted treatment incorporating a range of therapeutic interventions delivered by appropriately trained staff.
- Access to schooling within the hospital campus or unit.
- Access to Indigenous and transcultural support services.
- Flexible and targeted programs that can be delivered in a range of contexts including individual, family, group, school, and community.
- Assertive discharge planning to integrate the adolescent back into their community, including appropriate local mental health treatment, education or vocational services, and accommodation.

Referral /Access	• Referrals to the MHDP are made by services providing specialist child and youth mental health services. • It is anticipated that young people referred to the MHDP will have the capacity to attend on a daily basis. For young people outside the HHS catchment, this may involve temporary re-location with parents/relatives /alternative accommodation options. It will be the responsibility of the family to fund any alternative accommodation arrangements. • All referrals are received through a designated intake process. There will be a single point of entry for each day program. This single point of referral ensures consistent collection of adequate referral data and immediate feedback on appropriateness. Referrals will be triaged and prioritised according to documented clinical need and risk assessment. • Priorities for admission into the MHDP will be determined on the basis of levels of acuity, the risk of deterioration, the current mix of adolescents in the program, the potential impact on the adolescent and others, length of time on the waiting list, and age at time of referral. • Responsibility for the clinical care of the adolescent remains with the referring HHS until the adolescent is admitted to the MHDP. • Referral agencies will be supported to remain actively involved during MHDP service provision and continue their role as a major service provider following discharge (unless another appropriate referral is made). • Suitability for entry to the MHDP will be undertaken by a Multidisciplinary Intake Panel (MIP) that will consist of: a Consultant Psychiatrist and Registrar; Designated Intake Officer; Team Leader/Coordinator/NUM; Allied Health Representative; and Education representative.

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	• The MIP will assign a Case Manager to each adolescent accepted into the MHDP. • A pre-admission assessment of the adolescent and family (if appropriate) will be incorporated into the referral process. The pre-admission assessment enables the adolescent and parents/carers to meet staff and negotiate their expectations regarding treatment and discharge planning. It also allows further determination of the potential for therapeutic benefit from admission, the impact of being with other adolescents, and some assessment of acuity and risk.
Assessment	**Mental Health Assessment** • The Case Manager will obtain a detailed assessment of the nature of mental illness, their behavioural manifestations, impact on function and development, and the course of the mental illness. This assessment will begin with the referral and continues throughout the admission. **Family/Carer Assessment** • Assessment of family structure and dynamics will continue during the course of admission to the MHDP. This process will begin with the referral and continues throughout the admission. • If parent/carer mental health needs are identified, the Case Manager will attempt to meet these needs and, if necessary, refer to an adult mental health service **Developmental/Educational** • School-based interventions, to promote learning, educational or vocational goals, and life skills, are a key feature of the assessment process and treatment plan. Access to on-site schooling will be available to all young people admitted into the MHDP. • The Case Manager will obtain a comprehensive understanding of any developmental, cognitive, speech and language, or learning disorders and their impact on the adolescent's mental health and schooling. This process begins with available information on referral and during the admission. **Physical Health** • Physical examination will occur on admission and be monitored throughout admission, where clinically indicated. • Appropriate investigations will be completed as necessary. **Risk Assessment** • A key function of the MIP will be to assess risk of harm to self and others prior to admission. • Risk assessments will be initially conducted on admission. Ongoing risk assessments will occur at a frequency as recommended by the treating team and updated at case review. • Risk assessments will be conducted in accordance with the statewide standardised clinical documentation. **Alcohol and other Drugs** • Assessments of alcohol and other drug use will be conducted during the

MODEL of SERVICE for a MENTAL HEALTH DAY PROGRAM	
	referral process, on admission, and as clinically indicated. **Child Safety** • Child safety concerns will be addressed in accordance with legislative mandatory reporting requirements.
Recovery Planning and Clinical Interventions: *** Service Inclusions**	All adolescents will have a designated consultant psychiatrist. A Recovery Plan will be developed in consultation with the adolescent and their family/carers on admission. Adolescents will have access to a range of least restrictive, therapeutic interventions determined by evidence-informed practice, and developmentally appropriate programs to optimise their rehabilitation and recovery. The adolescent's progress against their Recovery Plan is regularly reviewed through collaboration between the treating team, the adolescent, their family/carer, the referrer/s, and other relevant agencies. **Clinical Interventions will include:** Behavioural and psychotherapeutic: • Individual and group-based interventions will be developed according to the adolescent's treatment needs. This will include a range of therapeutic and supportive, verbal and non-verbal modalities and frameworks. Family Interventions: • Supportive family interventions will be integrated into the overall therapeutic approaches to the adolescent, where possible. This will include psycho-education for the parents and carers. Where possible, family therapy will also be integrated into the overall therapeutic approaches to the adolescent during admission and as part of their discharge plan. Tasks to Facilitate Adolescent Development and Schooling: • The MHDP will offer a range of interventions to promote appropriate development in a safe and validating environment. • School-based interventions to promote learning, educational or vocational goals, and life skills. • Individual and group-based interventions to promote aspects of adolescent development, which may include local adventure-based and other recreational activities. Pharmacological: • Administration will occur under the direction of a consultant psychiatrist. • Regular administration and supervision of psychotropic medications will include monitoring for efficacy and adverse effects of psychotropic medications. • Education will be given to the adolescent and parent(s)/carer about medication and potential adverse effects.
Clinical Intervention: *** Service Exclusions**	• Young people who are substance-dependent. • Young people who are assessed as being at an unacceptably high level of risk to self or others.

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Care Co-Manager / Continuity	• The Case Manager will monitor the adolescent's level of risk, mental state, and function in developmental tasks throughout admission. • The Case Manager will act as the primary liaison person for the parent(s)/carer and external agencies on admission and during the discharge process. • Depending on their skill set, the Case Manager will provide or co-ordinate therapeutic input over the course of admission.
Discharge/Transition Planning	• Discharge planning should begin at time of admission, with key stakeholders being actively involved. • Discharge planning will involve multifactorial components that attend to therapeutic needs and developmental tasks. • The school linked to the MHDP will have primarily responsibility for school reintegration, and /or vocational options, and the support required during this process.
Frequency of activity	Average attendance of 5 supervised hours per day (up to 25 hours per week per client) with an emphasis on flexibility. Of these, 2 hours per day will be in individual therapy and 3 hours per day in group therapy.
Average Length of Stay	120 days (one school term) with an expected maximum stay of less than 180 days (two school terms).
Hours of Operation	Business hours, Monday to Friday. Some flexibility will be available to accommodate extracurricular and recreational activities.
Unit Size / Facility Features	Gazetted. Some young people may be subject to community treatment orders or forensic orders. • 10-15 adolescents per day. • 1 clinician per 5 clients in group work. (Based on 15 clients per day requiring 75 direct contact hours, which includes 30 hours in individual therapy and 45 hours in group therapy. This converts to 39 direct contact hours per day or 2.6 hours direct contact per client per day).
Staffing/Workforce	• The staffing profile will comprise of a multidisciplinary team of clinical and non-clinical staff providing a variety of recovery and resilience-oriented interventions for adolescents. • Treatment and care will be provided by clinical mental health workers including psychiatrists and psychiatry registrars, nurses, and allied health staff (including music and art therapists) as well as a range of non-clinical staff (including indigenous mental health workers, diversional and recreational therapists, and allied health assistants). The registrar position will be accredited for basic or advanced training by the Royal Australian and New Zealand College of Psychiatrists. • While there is a typical staff establishment, this may be altered according to levels of acuity and the need for specific therapeutic skills.

MODEL of SERVICE for a MENTAL HEALTH DAY PROGRAM	
	• The multidisciplinary team will be supported by administrative and operational staff who will assist with the day-to-day operations of the MHDP. • All permanently appointed medical, allied health, or senior nursing staff are (or are working towards becoming) authorised mental health practitioners. • Caseload sizes need to consider a range of factors, including complexity of need, current staff resources within the team, and the available skill mix of the team. Under normal circumstances, case management will not be provided by students or staff appointed less than 0.5 FTE. • The effectiveness of the MHDP is dependent upon an adequate number of appropriately trained clinical and non-clinical staff. The complexity of the mental health needs of children and adolescents suggests the need to provide staff with continuing education and professional development programs, clinical supervision, mentoring, and other appropriate staff support mechanisms. MHDP will undertake recruitment and retention strategies, such as providing clinical placements for students, encouraging rotation of staff from other areas of the integrated mental health service through the unit, and supporting education and research opportunities.
Geographic Location	The MHDP will be located on a hospital campus or in a gazetted community mental health facility that has access to educational services onsite or with capacity to in-reach.
Funding	Recommended clinical staffing per 15 client MHDP: • Psychiatrist: 0.5 FTE • Register: 0.5 FTE • Nursing: 1.0 FTE • Psychologist: 2.0 FTE • Social Worker: 1.0 FTE • Occupational Therapist: 1.0 FTE • Other CYMHS therapists: 1.0 FTE (speech pathology, music, art, etc.) • Administration Officer: 1.0 FTE • Operational Officer: 1.0 FTE
Governance	The MHDP will operate under the governance of the local Hospital and Health Service, where the MHDP is located.
Related Services / Other Providers	The MHDP will operate in a complex, multi-system environment. Services are integrated and co-ordinated with partnerships and linkages to other agencies and specialist mental health services for adolescents, to ensure continuity of care across the service system and through the adolescent developmental transitions. Mechanisms for joint planning, developing, and co-ordinating services are developed and maintained. The MHDP will develop linkages with services, including but not limited to: • Strong operational and strategic links to the CYMHS network, including community child and youth mental health services; specialist child and

MODEL of SERVICE for a MENTAL HEALTH DAY PROGRAM	
	youth mental health services (e.g. forensic services and evolve therapeutic services); and acute child and youth mental health inpatient services. • Adult mental health services; • Alcohol, tobacco and other drug services (ATODS); • Medicare Locals; • headspace services; • Community pharmacies; • Local educational providers/schools, guidance officers, and Ed-LinQ co-ordinators; • Indigenous Mental Health Workers; • Primary health care providers and networks (including those for Aboriginal and Torres Strait Islander health), local GPs and paediatricians; • Private mental health service providers; • Child and family health and developmental services; • Department of Communities, Child Safety and Disability Services; • Youth Justice services; • Government and non-government community-based youth and family counselling and parent support services; • Housing and welfare services; and, • Transcultural and Aboriginal and Torres Strait Islander services. The MHDP will: • Provide education and training to health professionals within CYMHS on the provision of comprehensive mental health care to adolescents with severe and complex disorder requiring extended treatment and rehabilitation; • Develop the capacity to benchmark with other similar adolescent mental health day programs; • Develop and monitor key performance indicators to reflect clinical best practice outcomes; and, • Drive research and publish on effective interventions for young people with severe and complex mental health disorders within the continuum of care. Educational resources are essential to adolescent extended treatment and rehabilitation services. Access to on-campus/in-reach schooling (including suitably qualified educators) will be offered as an integral part of the MHDP. All educational services will need to be evaluated and provided by the Department of Education, Training and Employment (DETE). Consumers and carers will contribute to continued practice improvement through the following mechanisms: • Participation in collaborative treatment planning • Feedback tools (e.g. surveys, suggestion boxes)

MODEL of SERVICE for a MENTAL HEALTH DAY PROGRAM	
	• Inform workforce development Consumer and carer involvement will reflect the National Mental Health Standards and the Equip National Safety Standards.

MODEL of SERVICE for RESIDENTIAL REHABILITATION UNIT	
What does the service intend to achieve? (Key functions – description)	The Residential Rehabilitation Units (Resi's) form part of an integrated continuum of care for young people requiring extended mental health treatment and rehabilitation in Queensland. It is envisaged that the Resi will be operated by Non-Government Organisations (NGOs) in partnership with local Hospital and Health Services (HHS) Child and Youth and Adult Mental Health Services. The Resi will provide accommodation and recovery-oriented support and rehabilitation for young people whose needs are associated with severe and complex mental illness, complicated by unresolved psychosocial or functional disability. Staffing is on-site for up to 24 hours a day to deliver recovery-oriented psychosocial rehabilitation and support to achieve agreed outcomes identified in an individualised recovery plan, inclusive of support to build links within the community to sustain community integration and social connectedness. These services offer ongoing development of skills and strategies for managing mental and general health, promoting wellbeing, sustainable community living, and meaningful engagement in social, recreational, and vocational activities of choice. Services will also include clinical support and treatment such as specialist medical psychiatric review and support of young people receiving involuntary community treatment under the provision of the *Mental Health Act 2000*. A range of individual, family and group-based assessment, treatment, and rehabilitation programs will be offered, aimed to treat mental illness, reduce emotional distress, and promote functioning and wellbeing within the community. This will include recovery-orientated support and discharge planning that will support the safe transition to more functional or independent living. The Resi model may be adapted to reflect local service requirements or systems. The service will meet and exceed residential care industry standards. The specialist mental health provisions will be compliant with National Standards for Mental Health Services and the Equip National Safety Standards.
Who the service is for? (Target group)	Diagnostic Profile: Young people aged 16-21 with a diagnosis of a psychotic illness, severe mood disorder, or complex trauma with significant deficits in psychosocial functioning. Other diagnostic profiles would include young people presenting with marked social avoidance or severely disorganised behaviour characterised by impaired impulse control, substance misuse, emerging personality vulnerabilities, complex disruptive behavioural disorders, risk of self-harm, or difficulties managing activities of daily living. Many will experience chronic family dysfunction, which serves to exacerbate the severity and persistence of the disorder and associated disabilities.

MODEL of SERVICE for RESIDENTIAL REHABILITATION UNIT

What does the service do?
The key functions:

- Resi's are provided as congregate living arrangements in which young people share living spaces such as the kitchen, dining room or family room, and may have their own bedrooms and bathrooms.
- Services will provide flexible staffing arrangements inclusive of 24x7support.
- Resi's facilitate access to a range of clinical and non-clinical services to enable people to establish or re-establish a meaningful life.
- Initial mental health support will be provided through case management from the local CCYMHS.
- Mental health staff (Case Manager) will collaborate with the Resi staff to facilitate assertive engagement with young people and (where appropriate) their families.
- The Case Manager will be capable of providing developmentally appropriate and community-centred mental health assessments and interventions for those young people who require higher intensity (level and mode of contact, range of interventions/services including risk assessment, crisis management, and safety planning) treatment, rehabilitation, and support to recover from mental illness. Services may be provided at the residential site or in other settings.
- Case Managers will minimise the impact of mental illness on young people, their family, friends, support people, and carers by providing a range of multi-systemic interventions.
- Case Managers will work with the young person, and their networks, to develop personal support systems and a sense of self-efficacy, and encourage increased participation in their community.
- Case Managers will work collaboratively with the residential staff to provide seamless care for the young person.
- Case Managers will ensure engagement with other primary care and specialist service providers to enable ongoing access to a range of mental health interventions and timely treatment.
- Case Managers will partner with other primary care and specialist services providers to tailor evidence-informed community or residential-based treatment interventions to alleviate or treat distressing symptoms and promote recovery.
- Case Managers will partner with other primary care and specialist services providers to assist progression in developmental tasks, which may be arrested secondary to the mental illness.

Resi mental health Case Managers work within multidisciplinary teams. Services to Resi's are mobile and capable of being delivered at residential and/or community settings as appropriate for engagement with the young person. The approach has an emphasis on recovery, rehabilitation, and community integration and will likely be provided over a number of months.

Mental health services for Resi's are primarily provided in business hours, though they may be provided over extended hours to meet particular needs. Services aim to assist the residential staff and young people to manage crisis situations and reduce the need for inpatient care.

Resi mental health Case Managers will partner with residential staff and other key service providers to facilitate care planning and case management. Partnership programs will include a range of community-based therapeutic, educational/vocational interventions, and comprehensive activities to assist in the development and recovery of the young person. The program will follow structured phases incorporating establishing a therapeutic alliance, comprehensive biopsychosocial, developmental and risk assessments, collaborative development of realistic therapeutic goals, and assertive discharge planning to facilitate ongoing engagement with community support and treatment services.

MODEL of SERVICE for RESIDENTIAL REHABILITATION UNIT	
Mental Health Clinicians in-reaching to Resi's will be able to: • Provide safe, high quality assessment and treatment interventions that demonstrate best practice principles and reflect evidence-informed care. • Assertively engage with young people at high risk of disengaging from or not accessing treatment services. • Provide information, advice and support to young people and their families/carers. • Offer information and advice to residential staff, and other health service providers, on the provision of mental health care for young people and their families/carers. • Establish effective, collaborative partnerships with other Queensland Health mental health services/teams, local health services/teams, and external service providers and stakeholders, including Medicare Locals, General Practitioners (GPs), educational/vocational services, non-government organisations (NGOs), and community groups. • Respond and adapt to the changing state and national health context over time. • Establish a detailed understanding of local resources for the support of young people with mental health problems, and their families/carers, that facilitate independent living options. • Appropriately involve young people and their families/carers (if appropriate) in all phases of care, and support them in their navigation of the mental health system. • Support/uphold the rights of young people and their families/carers to make informed decisions and to actively participate in their care plans. • Convey hope, optimism, and a belief in recovery from mental health problems and disorders to young people, their families/carers, and the wider community. • Promote and advocate for improved access to general health care services for young people. • Support health promotion, prevention, and early intervention strategies.	
Referral /Access	• Resi's will work collaboratively with the local Community Child and Youth Mental Health Service (CCYMHS) and, in some areas, adult mental health services. • The young person will be a client of a local/ cluster CCYMHS or adult mental health service. • Assessment of suitability for entry to a Resi will be undertaken by a multidisciplinary panel including CYMHS and the NGO service provider. • A multi-agency wrap around approach will be utilised to allow for assertive, collaborative management and discharge planning across multiple service providers, and promote whole of government partnerships across the sector. • All new service referrals to a Resi will be via a single point of entry via the aforementioned panel. • Young people will be asked, where capable, to provide informed consent. The young person will be encouraged to involve partners/parents/carers in their treatment. • Treatment will proceed as clinically indicated, and in accordance with the mental health statement of rights and responsibilities and the *Mental Health ACT 2000.* • On acceptance into a Resi, the young person will be assigned a Case

MODEL of SERVICE for RESIDENTIAL REHABILITATION UNIT	
	Manager from the referring CCYMHS. If this is not feasible, a local CCYMHS Case Manager will be assigned. The Case Manager will be responsible for organising ongoing mental health treatment and liaison across the sector.
Assessment	**Mental Health Assessments** • The designated Resi Case Manager will review or undertake a comprehensive, bio-psychosocial, developmental, and risk assessment with each young person and their family/carers. Ongoing assessments will be timely, reflecting the clinical needs of the young person. • The Case Manager will obtain or undertake a detailed assessment of the nature of mental illness, their behavioural manifestations, impact on function and development, and the course of the mental illness. This assessment will begin with the referral and continues throughout the admission. • Initial and ongoing assessments will include both risk assessment, and drug and alcohol use assessment. • Assessments will initiate a discussion of treatment and recovery goals, including the young person's goals, strengths, and capacity for self-management. The assessment will also entail the collection of information from family/carers and other service providers, including GPs and schools. • The outcome of assessments will be communicated to the young person, family/carer, and other stakeholders in a timely manner. • Same day crisis response assessments will be provided. **Family/Carer Assessment** • A Family Assessment is considered essential where possible. The Case Manager will review or undertake a detailed history of family structure and dynamics, or a history of care if the young person is in care. This process will begin with the referral and continues throughout the admission. • If parent/carer mental health needs are identified, the Case Manager will attempt to meet these needs and, if necessary, refer to adult mental health services. **Developmental/Educational** • Educational or vocational goals and life skills are a key feature of the assessment process. Linkages to school or vocational-based interventions will be a key component of the young person's recovery. • The Case Manager will review or undertake a comprehensive understanding of any developmental, cognitive, speech and language or learning disorders, and their impact on the young person's mental health and schooling or vocational needs. This process begins with available information on referral and during treatment. **Risk Assessment** • Risk assessments will be conducted on admission and as clinically indicated in all phases of care provision. • A risk assessment will be documented prior to transfer or discharge. • Risk assessments will include a formalised suicide risk assessment and

MODEL of SERVICE for RESIDENTIAL REHABILITATION UNIT	
	assessment of risk to others. • Risk assessments will be conducted in accordance with the statewide standardised clinical documentation. **Alcohol and other Drugs** • Assessments of alcohol and other drug use will be conducted during the referral process, on admission, and routinely throughout treatment.
Recovery Planning and Clinical Interventions: *** Service Inclusions**	All new cases will be discussed at a clinical review meeting, and at the Multidisciplinary Team (MDT) Review meetings at the relevant CCYMHS. This may include collaboration with residential staff. Review cases will be discussed as clinically indicated, though all cases will be presented at a minimum of every 90 days. A Recovery Plan will be developed in consultation with the young person at completion of the assessment phase. Young people will have access to a range of least restrictive, therapeutic interventions determined by evidenced-informed practice, and developmentally appropriate programs to optimise their rehabilitation and recovery. The young person's progress toward their Recovery Plan is regularly reviewed through collaboration between the treating team, residential staff, young person, family/carers, the referrers, and other relevant agencies. **Clinical Interventions will include:** Behavioural and psychotherapeutic: • Individual and group-based interventions will be developed according to the young person's treatment needs. This will include a range of therapeutic and supportive, verbal and non-verbal modalities and frameworks. Family Interventions: • Supportive family interventions are integrated into the overall therapeutic approaches to the young person, where possible. This will include psycho-education for the parents and carers. Where possible, family therapy will also be integrated into the overall therapeutic approaches. The Case Manager will offer a range of interventions to promote appropriate development in a safe and validating environment. Pharmacological: • Administration will occur under the direction of a consultant psychiatrist. • Regular administration and supervision of psychotropic medications will include monitoring for efficacy and adverse effects of psychotropic medications. • Education will be given to the young person and parent(s)/carer about medication and potential adverse effects. In addition to the Case Manager, it is recommended that Resi mental health clinicians be appointed to the local CCYMHS to support each Resi. Depending upon local CCYMHS requirements, the Resi mental health clinicians will provide clinical services in collaboration with, or independent to, the local CCYMHS.

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	These positions will also provide education and training to residential staff on the provision of comprehensive mental health care to adolescents with severe and complex disorders requiring youth residential services.
Clinical Intervention: *** Service Exclusions**	• Young people who do not present with severe and complex mental health problems, and do not require intensive residential support. This decision will take into account: the nature of the presenting problem; the acuity and severity of the disturbance; the complexity of the condition (including co-morbidity); the extent of functional impairment; the level of distress experienced by the young person; and the availability of other appropriate services.
Care Co-Manager / Continuity	• The Case Manager will oversee the young person's level of risk, mental state, and function in developmental tasks throughout treatment. • The Case Manager will act as the mental health primary liaison person for the parent(s)/carer and external agencies throughout the young person's contact with the service. • The Case Manager and/ or other members of the MDT will provide therapeutic input over the course of treatment, in collaboration with residential staff, as appropriate.
Discharge/Transition Planning	• Discharge planning should begin at time of admission, with key stakeholders being actively involved. Discharge planning will address potential significant obstacles such as ongoing accommodation needs and engagement with other mental health services and community support agencies. • Discharge planning will involve multifactorial components that attend to therapeutic needs, developmental tasks, and reintegration into the family, if appropriate. • The Case Manager and residential staff will work collaboratively with the educational/ vocational systems to establish linkages, or facilitate school re-integration, or vocational options or employment, as appropriate.
Frequency of activity	• The Case Manager will operate during business hours, though ideally will have extended hours capacity. • Residential staff will facilitate Life Skills Programs that will operate five days per week and include recovery support for mental health consumers.
Average Length of Stay	Up to 365 days.
Hours of Operation	Residential service is staffed 6 to 24 hours per day, 7 days per week.
Unit Size / Facility Features	5 to 10 beds, dependent upon local resources and community needs.
Staffing/Workforce	• Oversight will be provided by a consultant psychiatrist working within the CCYMHS MDT. • Case Managers could be health practitioners or nursing officers.

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	• It is envisaged that the residence will be operated and staffed by the NGO sector, utilising mental health trained staff, including youth and support workers. • Administrative support is essential for the efficient operation of the Resi service and would be the responsibility of the NGO. • All appointed CCYMHS Case Managers are (or are working towards becoming) authorised mental health practitioners. • Caseload sizes need to consider a range of factors, including complexity of need, current staff resources within the team, and the available skill mix of the team. Under normal circumstances, case management will not be provided by students or staff appointed less than 0.5 FTE. • All staff will be provided with continuing education and professional development programs, clinical supervision, mentoring, and other appropriate staff support mechanisms. This will be the shared responsibility of the NGO service administrating the Resi and the CCYMHS.
Geographic Location	Case Managers are based with the local CCYMHS and residential staff are based at the Resi.
Funding	Funding for Case Managers will be absorbed by their substantive CCYMHS. In addition to Case Managers, it is recommended: • Consultant Psychiatrist support (approximately 0.1 FTE) • Community Support Workers: 7.0 FTE • Community Support Team Leader: 1.0 FTE • Administration Officer: 0.2 FTE This Model of Service is for young people aged 16 to 21 living in a Resi. Under this model, CCYMHS may need to negotiate with local adult mental health services and Mental Health and Other Drugs Branch (MHAODB) to fund ongoing case management for young people aged 18 years or older.
Governance	The Resi will operate under the governance of the local Hospital and Health Service, where CCYMHS is located.
Related Services / Other Providers	Resi services will operate in a complex, multi-system environment. Services are integrated and co-ordinated with partnerships and linkages with other agencies and specialist mental health services, to ensure continuity of care across the service system and through the young person's developmental transitions. Mechanisms for joint planning, developing, and co-ordinating services are developed and maintained. Resi mental health services will develop linkages with services, including but not limited to: • Strong operational and strategic links to the CYMHS network, including community child and youth mental health services; specialist child and youth mental health services (e.g. forensic services and evolve therapeutic services); and acute child and youth mental health inpatient services;

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	• Adult mental health services; • Alcohol, tobacco and other drug services (ATODS); • Medicare Locals; • Community pharmacies; • Local educational providers/schools, guidance officers, and Ed-LinQ co-ordinators; • Indigenous Mental Health Workers; • Primary health care providers and networks (including those for Aboriginal and Torres Strait Islander health), local GPs and paediatricians; • Private mental health service providers; • Child and family health and developmental services; • Department of Communities, Child Safety and Disability Services; • Youth Justice services; • Government and non-government community-based youth and family counselling and parent support services; • Housing and welfare services; and, • Transcultural and Aboriginal and Torres Strait Islander services. The Resi mental health team will: • Provide education and training to health professionals and other service providers, on the provision of comprehensive mental health care to adolescents with severe and complex disorders requiring youth residential services; • Develop the capacity to benchmark with other similar youth residential services; • Develop and monitor key performance indicators to reflect clinical best practice outcomes; • Drive research and publish on effective interventions for young people with severe and complex mental health disorders, who require youth residential services. Consumers and carers will contribute to continued practice improvement through the following mechanisms: • Participation in collaborative treatment planning • Feedback tools (e.g. surveys, suggestion boxes) • Inform workforce development Consumer and carer involvement will reflect the National Mental Health Standards and the Equip National Safety Standards.

MODEL of SERVICE for a STEP UP / STEP DOWN UNIT	
What does the service intend to achieve? (Key functions – description)	Subacute Step-Up/Step-Down Units (SUSDU) form part of a continuum of care for adolescents requiring mental health treatment in Queensland. SUSDU are subacute residential units that are defined as bed-based facilities delivered in partnership and/or collaboration between clinical services and the NGO/ community support sector. SUSDU will provide overnight care and short-term residential treatment from specialist and non-specialist trained mental health staff. Vocational qualified mental health workers will be available on site 24 hours per day. There will be capacity for in-reach specialist mental health services. A SUSDU aims to: • Prevent further deterioration of a person's mental state and associated disability, and in turn reduce the likelihood of admission to an acute inpatient unit (*Step Up*). • Enable early discharge from acute mental health inpatient units through the provision of an intensive safe and supportive sub-acute residential community program (*Step Down)*. The SUSDU are provided for young people who have recently experienced, or who are at increased risk of experiencing, an acute episode of mental illness. The young person usually requires a higher intensity of treatment and care to reduce symptoms and/or distress that cannot be adequately provided for in the community, but does not require the treatment intensity provide by acute inpatient units. The SUSDU takes an integrated approach to clinical recovery and psychosocial interventions with a focus on stabilisation and management of illness, and engagement or re-engagement in positive and supportive social, family, educational, and vocational connections. A range of individual, family and group-based assessment, treatment and rehabilitation programs will be offered, aimed at treating mental illness, reducing emotional distress, and promoting functionality within the community. This will include recovery-orientated treatment and discharge planning, which will support the safe transition to more functional or independent living. The SUSDU model may be adapted to reflect local service requirements or systems. The service will meet and exceed National Standards for Mental Health Services and the Equip National Safety Standards.
Who the service is for? (Target group)	Diagnostic Profile: Young people aged 13-18 who meet the criteria for admission to a mental health service inpatient unit but whose level of risk is such that they can be safely supported in a less restrictive environment than an acute inpatient unit. Primary diagnoses are likely to be psychotic illness, severe mood disorder, or complex trauma with deficits in psychosocial functioning.

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	Other diagnostic profiles would include adolescents presenting with social avoidance or disorganised behaviour characterised by impaired impulse control, emerging personality vulnerabilities, risk of self-harm, or difficulties managing activities of daily living. Some may experience chronic family dysfunction, which serves to exacerbate the severity and persistence of the disorder and associated disabilities.

What does the service do?
The key functions:

- Services are located in the community and delivered in a community residential environment.
- Services are delivered through partnerships between, and in collaboration with, clinical services and the community support sector.
- There is a strong focus on early and active engagement of family/friend/support persons or carers in an adolescent friendly environment.
- Services provide individually tailored evidence-informed treatment interventions to alleviate or treat distressing symptoms and promote recovery.
- Services will operate as a component of an integrated, cluster-wide child and youth mental health system.

Treatment programs will include a range of therapeutic, educational/vocational interventions, and life-skill activities to assist in the development and recovery of the adolescent. The program will follow structured phases incorporating assessment, establishment of therapeutic alliances, development of realistic therapeutic goals, trauma and evidence-informed treatment, and assertive discharge planning to facilitate reintegration back to community-based treatment programs.

Programs will include:

- Phased treatment programs that are developed in partnership with adolescents and, where appropriate, their parents or carers.
- Targeted treatment incorporating a range of therapeutic interventions delivered by appropriately trained staff.
- Flexible and targeted programs that can be delivered in a range of contexts including individual, family and group therapy.
- 24-hour inpatient care for adolescents in a safe, structured, highly supervised, and supportive environment.
- Access to on-site or out-reach schooling to support educational and vocational goals.
- Access to Indigenous and transcultural support services as required.
- Assertive discharge planning to integrate the adolescent back into their community of choice, including appropriate local mental health treatment, education or vocational services, and accommodation.

Referral /Access	• *Step Up*: Queensland CYMHS services such as community CYMHS (CCYMHS) and day programs will function as the referral agencies. • *Step Down:* Acute Adolescent Inpatient Units • All referrals will be processed through a designated intake officer. This single point of referral ensures consistent collection of adequate referral data and immediate feedback on appropriateness. It also expedites a pre-

MODEL of SERVICE for a STEP UP / STEP DOWN UNIT	
	assessment interview and liaison with the referrer if there is a wait time until the adolescent can be admitted. • As a cluster-based subacute service, referrals will be assessed for admission via a formal Admission Panel. The Panel will be chaired by the Clinical Director of the SUSDU, and may include a CHQ Complex Care Co-ordinator, and representatives from Mental Health and the community support sector managing the SUSDU. Other representatives, such as Education, Child Safety, and Housing, may be invited onto the Panel as required. This transdisciplinary approach will allow for assertive pre-discharge planning across multiple service providers and promote whole of government partnerships across the sector. • On acceptance, the adolescent will be assigned a Case Manager, who will be responsible for organising admission and ongoing liaison with the referring CYMHS service. • Responsibility for the clinical care of the adolescent remains with the referring CYMHS unit until the adolescent is admitted to the SUSDU. It is anticipated that adolescents in community CYMHS or day programs will remain actively engaged with local mental health services prior to, and during the course of, their admission into the SUSDU. • Priorities for admission will be determined on the basis of levels of acuity, the risk of deterioration, the current mix of admitted adolescents, the potential impact on the adolescent and others, length of time on the waiting list, and age at time of referral. • A pre-admission assessment of the adolescent and family (if appropriate) will be incorporated into the referral process. This may be done in person or via videoconference. The pre-admission assessment enables the adolescent and parents/carers to meet staff and negotiate their expectations regarding treatment and discharge planning. It also allows further determination of the potential for therapeutic benefit from the admission, the impact of being with other adolescents, and further assessment of acuity and risk.
Assessment	**Mental Health Assessment** • The Case Manager will obtain a detailed assessment of the nature of mental illness, their behavioural manifestations, impact on function and development, and the course of the mental illness. This assessment will begin with the referral and continues throughout the admission. **Family/Carer Assessment** • A Family Assessment is considered essential. The Case Manager will obtain a detailed history of family structure and dynamics, or a history of care if the adolescent is in out-of-home care. This process will begin with the referral and continues throughout the admission. • It is expected that the family will be available to complete a comprehensive family assessment and that parents/carers will remain involved in the mental health care of the adolescent as much as possible. A significant effort will be made to support the involvement of parents/ carers. Negotiations will be undertaken to cover the cost of transport,

MODEL of SERVICE for a STEP UP / STEP DOWN UNIT	
	accommodation, meals, and incidentals by the referring HHS. • If parent/carer mental health needs are identified, the Case Manager will attempt to address these needs as appropriate and, if necessary, refer to an adult mental health service provider. **Developmental/Educational** • School-based interventions, to promote learning, educational or vocational goals, and life skills, are an important feature of the assessment process and treatment plan. Access to on-site or out-reach schooling or vocational options will be available to all inpatients. • The Case Manager will obtain a comprehensive understanding of any developmental, cognitive, speech and language, or learning disorders and their impact on the adolescent's mental health and schooling. This process begins with available information on referral and during admission. **Physical Health** • Routine physical examination will occur on admission and be monitored throughout admission. • Appropriate investigations will be completed as necessary. **Risk Assessment** • A key function of the Statewide Admission Panel will be to assess the risk of harm to self and others prior to admission. • Risk assessments will be conducted on admission. Ongoing risk assessments will occur at a frequency as recommended by the treating team and updated at clinical case review meetings. • Risk assessments will be conducted in accordance with the statewide standardised clinical documentation. **Alcohol and other Drugs** • Assessments of alcohol and other drug use will be conducted during the referral process, on admission, and routinely throughout treatment. **Child Safety** • Child safety concerns will be addressed in accordance with legislative mandatory reporting requirements.
Recovery Planning and Clinical Interventions: *** Service Inclusions**	All adolescents will have a designated consultant psychiatrist. A Recovery Plan will be developed in consultation with the adolescent and, where appropriate, their family/carers on admission. Adolescents will have access to a range of least restrictive, therapeutic interventions determined by evidenced-informed practice, and developmentally appropriate programs to optimise their rehabilitation and recovery. The adolescent's progress toward individual recover goals is regularly reviewed through collaboration between the treating team, the adolescent, their family/carers, the referrer/s, and other relevant agencies.

MODEL of SERVICE for a STEP UP / STEP DOWN UNIT	
	Clinical Interventions will include: Behavioural and psychotherapeutic: • Trauma-informed individual and group-based interventions will be developed according to the adolescent's treatment needs. This will include a range of therapeutic and supportive verbal and non-verbal modalities and frameworks. Family Interventions: • Supportive family interventions will be integrated into the overall therapeutic approaches for the adolescent, where possible. This will include psycho-education for the parents and carers. Tasks to Facilitate Adolescent Development and Schooling: • The SUSDU will offer a range of interventions to promote appropriate development and enhancement of life skills in a safe and validating environment. • School-based interventions to promote learning, educational or vocational goals, and life skills. Pharmacological: • Administration will occur under the direction of a consultant psychiatrist. • Regular administration and supervision of psychotropic medications will include monitoring for efficacy and adverse effects of psychotropic medications. • Education will be given to the adolescent and parent(s)/carer about medication and potential adverse effects.
Clinical Intervention: *** Service Exclusions**	• Secure forensic beds are not offered as part this service. • SUSDU are not gazetted, though adolescent may be subject to community treatment orders or forensic orders. • SUSDU are not specifically an alcohol and other drugs detoxification service. Adolescents may also be excluded if their clinical and recovery requirements are assessed as being at a level of acuity or risk where the SUSDU is unable to meet their treatment needs. Suicidal thoughts and self-harm are associated with many mental health disorders. Acceptance into a SUSDU may be determined by the extent of this risk, the adolescent's behaviour, their capacity to engage with service providers, and compliance with treatment.
Care Co-Manager / Continuity	• The Case Manager will monitor the adolescent's level of risk, mental state, and function in relation to developmental tasks throughout admission. • The Case Manager will act as the primary liaison person for the parent(s)/carer and external agencies on admission and during the discharge process. • The Case Manager and/or another member of the clinical team will provide therapeutic input over the course of admission.

MODEL of SERVICE for a STEP UP / STEP DOWN UNIT	
Discharge/Transition Planning	• Discharge planning will begin at time of admission, with key stakeholders actively involved. Discharge planning will address potential significant obstacles, such as engagement with other child and youth mental health services and/or other community support services, or transition to adult mental health services. • Discharge planning will involve multifactorial components that attend to therapeutic needs, developmental tasks, and reintegration into the family if appropriate. • The school linked to the SUSDU will have primary responsibility for school reintegration, and /or vocational options, and the support required during this process.
Frequency of activity	• Access to a multidisciplinary team will be provided weekdays during business hours. • Nursing staff will be rostered to cover day and evening shifts, 7 days a week. • Vocational qualified staff will be rostered to cover shifts 24 hours, 7 days a week. • For acute mental health or medical assessment, the adolescent will be transported to the most appropriate hospital, where an on-call consultant child and adolescent psychiatrist, with registrar support, will be available 24 hours, 7 days per week.
Average Length of Stay	28 days
Hours of Operation	24 x 7
Unit Size / Facility Features	Up to 10 beds. Not gazetted, though adolescent may be subject to community treatment orders or forensic orders.
Staffing/Workforce	• Services are delivered in collaboration between specialist clinical and community support sector services, with staff available on site 24 hours per day. • The staffing profile will incorporate the child and adolescent expertise and skills of psychiatry (consultant psychiatrist and psychiatry registrar), mental health nursing, psychology, social work, occupational therapy, other specialist CYMHS staff, and community sector workers. The registrar position will be accredited for basic or advanced training by the Royal Australian and New Zealand College of Psychiatrists. • While there is a typical staff establishment, this may be altered according to levels of acuity and the need for specific therapeutic skills. • Administrative support is essential for the efficient operation of the SUSDU. • All permanently appointed medical, allied health and senior nursing staff are (or are working towards becoming) authorised mental health practitioners. • Caseload sizes need to consider a range of factors, including complexity of need, current staff resources within the team, and the available skill mix of the team. Under normal circumstances, case management will not be provided by students or staff appointed less than 0.5 FTE.

MODEL of SERVICE for a STEP UP / STEP DOWN UNIT	
	• The effectiveness of the SUSDU is dependent upon an adequate number of appropriately trained clinical and non-clinical staff. The complexity of the mental health needs of children and adolescents suggests the need to provide staff with continuing education and professional development programs, clinical supervision, mentoring, and other appropriate staff support mechanisms. The SUSDU will undertake recruitment and retention strategies, such as providing clinical placements for students, encouraging rotation of staff from other areas of the integrated mental health service through the unit, and supporting education and research opportunities.
Geographic Location	The SUSDU will be located in a residential area of the Children's Health Queensland catchment (Brisbane).
Funding	Recommended Clinical Staff per 10 bed unit: • Psychiatrist: 0.5 FTE • Registrar: 0.6 FTE • Total Nursing: 6.4 FTE • Psychologist: 1.0 FTE • Social Work: 1.0 FTE • Occupational Therapist: 0.5 FTE • Other CYMHS therapists: (speech therapy, art, music, etc.) 1.5 FTE • Community Support Worker: 4.6 FTE • Community Support Team Leader: 1.0 FTE • Administration Officer: 1.0 FTE
Governance	• The SUSDU will operate under the governance of Children's Health Queensland Hospital and Health Service (CHQ HHS), within a statewide mental health service. • Operational governance will occur through the SUSDU Clinical Director reporting directly to the Divisional Director, CYMHS CHQ HHS, or via a Memorandum of Understanding between CHQ HHS and the community support sector service. • Clinical governance will occur through the SUSDU Clinical Director reporting directly to the Divisional Medical Director, CHQ HHS. • Interim line management arrangements may be required.
Related Services / Other Providers	The SUSDU will operate in a complex, multi-system environment. Services are integrated and co-ordinated with partnerships and linkages to other agencies and specialist mental health services for adolescents, to ensure continuity of care across the service system and through the adolescent developmental transitions. Mechanisms for joint planning, developing, and co-ordinating services are developed and maintained. The SUSDU will develop linkages with services, including but not limited to: • Strong operational and strategic links to the CYMHS network, including community child and youth mental health services; specialist child and youth mental health services (e.g. forensic services and evolve therapeutic services); and acute child and youth mental health inpatient services;

MODEL of SERVICE for a STEP UP / STEP DOWN UNIT	
	• Adult mental health services; • Alcohol, tobacco and other drug services (ATODS); • Medicare Locals; • headspace services; • Community pharmacies; • Local educational providers/schools, guidance officers, and Ed-LinQ co-ordinators; • Indigenous Mental Health Workers; • Primary health care providers and networks (including those for Aboriginal and Torres Strait Islander health), local GPs and paediatricians; • Private mental health service providers; • Child and family health and developmental services; • Department of Communities, Child Safety and Disability Services; • Youth Justice services; • Government and non-government community-based youth and family counselling and parent support services; • Housing and welfare services; and, • Transcultural and Aboriginal and Torres Strait Islander services. The SUSDU will: • Provide education and training to health professionals within CYMHS on the provision of comprehensive mental health care to adolescents with severe and complex disorders requiring step-up or step-down services; • Develop the capacity to benchmark with other similar subacute adolescent inpatient units; • Develop and monitor key performance indicators to reflect clinical best practice outcomes; and, • Drive research and publish on effective interventions for young people with severe and complex mental health disorders, who require step-up or step-down treatment. Educational resources are essential to adolescent extended treatment and rehabilitation services. Access to on-campus or out-reach schooling (including suitably qualified educators) will be offered as an integral part of the SUSDU. All educational services will need to be evaluated and provided by the Department of Education, Training and Employment (DETE). Consumers and carers will contribute to continued practice improvement through the following mechanisms: • Participation in collaborative treatment planning • Feedback tools (e.g. satisfaction surveys, suggestion boxes) • Inform workforce development • Active engagement with the CHQ CYMHS Youth and Carer Advisory Groups and Consumer Carer Network

MODEL of SERVICE for a STEP UP / STEP DOWN UNIT	
	Consumer and carer involvement will reflect the National Mental Health Standards and the Equip National Safety Standards.

MODEL of SERVICE for the STATEWIDE SUBACUTE BEDS	
What does the service intend to achieve? (Key functions – description)	The statewide subacute beds (SSB) form part of a continuum of care for adolescents requiring extended mental health treatment and rehabilitation in Queensland. As a statewide subacute service, the SSB will provide medium-term, intensive, hospital-based treatment and rehabilitation services in a safe, structured environment for young people with severe or complex symptoms of mental illness and associated significant disturbance in behaviour that precludes them receiving treatment in a less restrictive environment. A range of individual, group and family-based assessment, treatment and rehabilitation programs will be offered, aimed to treat mental illness, reduce emotional distress, and promote functioning and wellbeing within the community. This will include recovery-orientated treatment and discharge planning that will support the safe transition to more functional or independent living. The service will meet and exceed National Standards for Mental Health Services and the Equip National Safety Standards.
Who the service is for? (Target group)	Diagnostic Profile: Young people aged 13-18 with a diagnosis of schizophrenia or other psychotic illness, severe mood disorder, or complex trauma with significant deficits in psychosocial functioning. Other diagnostic profiles would include adolescents presenting with marked social avoidance or severely disorganised behaviour characterised by impaired impulse control, emerging personality vulnerabilities, risk of self-harm, or difficulties managing activities of daily living. Many will experience chronic family dysfunction, which serves to exacerbate the severity and persistence of the disorder and associated disabilities.

What does the service do?
The key functions:

- Build upon existing comprehensive assessment of the adolescent (utilising the thorough treatment history obtained from service providers and carers) to assess the likelihood of therapeutic gains by attending the SSB.
- Provide individually tailored evidence-informed treatment interventions to alleviate or treat distressing symptoms and promote recovery.
- Provide a range of interventions to assist progression in developmental tasks which may be arrested secondary to the mental illness.
- Provide a 3 - 6 month targeted and phased treatment program that will ultimately assist recovery and reintegration back into the community.

Treatment programs will include an extensive range of therapeutic, educational/vocational interventions and comprehensive activities to assist in the development and recovery of the adolescent. The program will follow structured phases incorporating assessment, establishment of therapeutic alliances, development of realistic therapeutic goals, treatment, and assertive discharge planning to facilitate reintegration back to community-based treatment.

MODEL of SERVICE for the STATEWIDE SUBACUTE BEDS	
Programs will include: • Phased treatment programs that are developed in partnership with adolescents and, where appropriate, their parents or carers. • A comprehensive family assessment completed within the first 4 weeks of admission. • Targeted treatment incorporating a range of therapeutic interventions delivered by appropriately trained staff. • Access to schooling within the hospital campus. • Access to Indigenous and transcultural support services. • 24-hour inpatient care for adolescents in a safe, structured, highly supervised, and supportive environment. • Flexible and targeted programs that can be delivered in a range of contexts including individual, family, group, school, and community. • Assertive discharge planning to integrate the adolescent back into their community of choice, including appropriate local mental health treatment, education or vocational services, and accommodation.	
Referral /Access	• Referral to the SSBs will be through the Statewide Assessment Panel. • On acceptance, the adolescent will be assigned a Case Manager, who will be responsible for organising admission and ongoing liaison with the referring HHS. • Responsibility for the clinical care of the adolescent remains with the referring HHS until the adolescent is admitted to the SSB. It is anticipated that adolescents will also remain actively engaged with local mental health and other support services prior to, and during the course of, their admission into the SSB. • Priorities for admission will be determined on the basis of levels of acuity, the risk of deterioration, the current mix of admitted adolescents, the potential impact on the adolescent and others, length of time on the waiting list, and age at time of referral. • A pre-admission assessment of the adolescent and family (if appropriate) will be incorporated into the referral process. This may be done in person or via videoconference. The pre-admission assessment enables the adolescent and parents/carers to meet staff and negotiate their expectations regarding treatment and discharge planning. It also allows further determination of the potential for therapeutic benefit from the admission, the impact of being with other adolescents, and some assessment of acuity and risk.
Assessment	**Mental Health Assessment** • The Case Manager will obtain a detailed assessment of the nature of mental illness, their behavioural manifestations, impact on function and development, and the course of the mental illness. This assessment will begin with the referral and continues throughout the admission. **Family/Carer Assessment** • A Family Assessment is considered essential. The Case Manager will obtain a

MODEL of SERVICE for the STATEWIDE SUBACUTE BEDS	
	detailed history of family structure and dynamics, or a history of care if the adolescent is in care. This process will begin with the referral and continues throughout the admission. • It is expected that the family will be available to complete a comprehensive family assessment and that parents/carers will be involved in the mental health care of the adolescent as much as possible. A significant effort will be made to support the involvement of parents/ carers. As part of this comprehensive assessment, families will be expected to travel to Brisbane for up to a week. The organisation and cost of transport, accommodation, meals, and incidentals will be covered by the referring HHS. • If parent/carer mental health needs are identified, the Case Manager will attempt to meet these needs and, if necessary, refer to an adult mental health service or other appropriate supports. **Developmental/Educational** • School-based interventions, to promote learning, educational or vocational goals, and life skills, are a key feature of the assessment process and treatment plan. Access to on-site schooling will be available to all inpatients. • The Case Manager will obtain a comprehensive understanding of any developmental, cognitive, speech and language, or learning disorders and their impact on the adolescent's mental health and schooling. This process begins with available information on referral and during admission. **Physical Health** • Routine physical examination will occur on admission and be monitored throughout admission. • Appropriate investigations will be completed as necessary. • The SSB will have access to local tertiary paediatric consultation services if required. **Risk Assessment** • Risk assessments will be conducted on admission. Ongoing risk assessments will occur at a frequency as recommended by the treating team and updated at case review. • Risk assessments will be conducted in accordance with the statewide standardised clinical documentation. **Alcohol and other Drugs** • Assessments of alcohol and other drug use will be conducted during the referral process, on admission, and routinely throughout treatment. **Child Safety** • Child safety concerns will be addressed in accordance with legislative mandatory reporting requirements.
Recovery Planning and Clinical Interventions: *** Service Inclusions**	All adolescents will have a designated consultant psychiatrist. A Recovery Plan will be developed in consultation with the adolescent and their family/carers on admission. Adolescents will have access to a range of least restrictive, therapeutic interventions determined by evidence-informed

MODEL of SERVICE for the STATEWIDE SUBACUTE BEDS	
	practice, and developmentally appropriate programs to optimise their rehabilitation and recovery. The adolescent's progress against their Recovery Plan is regularly reviewed through collaboration between the treating team, the adolescent, their family/carer, the referrer/s, and other relevant agencies. **Clinical Interventions will include:** Behavioural and psychotherapeutic: • Individual and group-based interventions will be developed according to the adolescent's treatment needs. This will include a range of therapeutic and supportive verbal and non-verbal modalities and frameworks. Family Interventions: • Supportive family interventions will be integrated into the overall therapeutic approaches to the adolescent, where possible. This will include psycho-education for the parents and carers. Where possible, family therapy will also be integrated into the overall therapeutic approaches to the adolescent during admission and as part of their discharge plan. This may include videoconference family therapy support to local mental health services. Tasks to Facilitate Adolescent Development and Schooling: • The SSB will offer a range of interventions to promote appropriate development in a safe and validating environment. • School-based interventions to promote learning, educational or vocational goals, and life skills. • Individual and group-based interventions to promote aspects of adolescent development, which may include local adventure-based and other recreational activities. Pharmacological: • Administration will occur under the direction of a consultant psychiatrist. • Regular administration and supervision of psychotropic medications will include monitoring for efficacy and adverse effects of psychotropic medications. • Education will be given to the adolescent and parent(s)/carer about medication and potential adverse effects.
Clinical Intervention: *** Service Exclusions**	• Secure forensic beds are not offered as part this service. • It is also not anticipated that young people with a primary diagnosis of an eating disorder will be accepted into the SSB.
Care Co-Manager / Continuity	• The Case Manager will monitor the adolescent's level of risk, mental state, and function in developmental tasks throughout admission. • The Case Manager will act as the primary liaison person for the parent(s)/carer and external agencies on admission and during the discharge process. • Depending on their skill set, the Case Manager will provide therapeutic input over the course of admission.

MODEL of SERVICE for the STATEWIDE SUBACUTE BEDS	
Discharge/Transition Planning	• Discharge planning should begin at time of admission, with key stakeholders being actively involved. Discharge planning will address potential significant obstacles, such as accommodation, engagement with other child and youth mental health services, and transition to adult mental health services. • Discharge planning will involve multifactorial components that attend to therapeutic needs, developmental tasks, and reintegration into the family if appropriate. • The school linked to the SSB will have primary responsibility for school reintegration, and /or vocational options, and the support required during this process.
Frequency of activity	• Access to the full multidisciplinary team will be provided weekdays during business hours. • Nursing staff will be rostered to cover shifts 24 hours, 7 days a week. • An on-call consultant child and adolescent psychiatrist, with Registrar support, will be available 24 hours, 7 days per week.
Average Length of Stay	90 days with an expected maximum stay of less than 180 days.
Hours of Operation	24 x 7
Unit Size / Facility Features	Gazetted. 2 to 4 beds. Seclusion room.
Staffing/Workforce	• The staffing profile will incorporate the child and adolescent expertise and skills of psychiatry (consultant psychiatrist and psychiatry registrar), mental health nursing, psychology, social work, occupational therapy, speech pathology, and other specialist CYMHS staff. The registrar position will be accredited for basic or advanced training by the Royal Australian and New Zealand College of Psychiatrists. • While there is a typical staff establishment, this may be altered according to levels of acuity and the need for specific therapeutic skills. • Administrative support is essential for the efficient operation of the SSB. • All permanently appointed medical, allied health, and senior nursing staff are (or are working towards becoming) authorised mental health practitioners. • The effectiveness of the SSB is dependent upon an adequate number of appropriately trained clinical and non-clinical staff. The complexity of the mental health needs of children and adolescents suggests the need to provide staff with continuing education and professional development programs, clinical supervision, mentoring, and other appropriate staff support mechanisms. The SSB will undertake recruitment and retention strategies, such as providing clinical placements for students, encouraging rotation of staff from other areas of the integrated mental health service through the unit, and supporting education and research opportunities.
Geographic Location	The SSB will be located on a hospital campus in Children's Health Queensland catchment (Brisbane).

MODEL of SERVICE for the STATEWIDE SUBACUTE BEDS	
Funding	Recommended Clinical Staff per 4 beds: • Psychiatrist: 0.2 FTE • Registrar: 0.4 FTE • Total Nursing: 5.1 FTE • Psychologist: 0.2 FTE • Social Work: 0.2 FTE • Occupational Therapist: 0.2 FTE • Speech Therapist: 0.2 FTE • Recreational Officer: 2.2 FTE • Administration Officer: 0.2 FTE
Governance	• The SSB will operate under the governance of Children's Health Queensland Hospital and Health Service (CHQ HHS), within a statewide integrated mental health service. • Clinical and operational governance will occur through the SSB Clinical Director reporting directly to the Divisional Director, CYMHS CHQ HHS. • Interim line management arrangements may be required.
Related Services / Other Providers	The SSB will operate in a complex, multi-system environment. Services are integrated and co-ordinated with partnerships and linkages to other agencies and specialist mental health services for adolescents, to ensure continuity of care across the service system and through the adolescent developmental transitions. Mechanisms for joint planning, developing, and co-ordinating services are developed and maintained. The SSB will develop linkages with services, including but not limited to: • Strong operational and strategic links to the CYMHS network, including community child and youth mental health services; specialist child and youth mental health services (e.g. forensic services and evolve therapeutic services); and acute child and youth mental health inpatient services; • Adult mental health services; • Alcohol, tobacco and other drug services (ATODS); • Medicare Locals; • headspace services; • Community pharmacies; • Local educational providers/schools, guidance officers, and Ed-LinQ co-ordinators; • Indigenous Mental Health Workers; • Primary health care providers and networks (including those for Aboriginal and Torres Strait Islander health), local GPs and paediatricians; • Private mental health service providers; • Child and family health and developmental services; • Department of Communities, Child Safety and Disability Services; • Youth Justice services; • Government and non-government community-based youth and family

MODEL of SERVICE for the STATEWIDE SUBACUTE BEDS	
	counselling and parent support services; • Housing and welfare services; and, • Transcultural and Aboriginal and Torres Strait Islander services. The SSB will: • Provide education and training to health professionals within CYMHS on the provision of comprehensive mental health care to adolescents with severe and complex disorders requiring extended treatment and rehabilitation; • Develop the capacity to benchmark with other similar subacute adolescent inpatient units; • Develop and monitor key performance indicators to reflect clinical best practice outcomes; and, • Drive research and publish on effective interventions for young people with severe and complex mental health disorders, who require extended treatment and rehabilitation inpatient treatment. Educational resources are essential to adolescent extended treatment and rehabilitation services. Access to on-campus schooling (including suitably qualified educators) will be offered as an integral part of the SSB. All educational services will need to be evaluated and provided by the Department of Education, Training and Employment (DETE). Consumers and carers will contribute to continued practice improvement through the following mechanisms: • Participation in collaborative treatment planning • Feedback tools (e.g. surveys, suggestion boxes) • Inform workforce development Consumer and carer involvement will reflect the National Mental Health Standards and the Equip National Safety Standards.

Statewide Panel Coordinator - Input Sheet

KPIs	Beds/Consumers	0
	Utilisation %	100
	m2	4
Budget Phasing		
Days/year	July	23
	August	20
	September	22
	October	22
	November	19
	December	21
	January	20
	February	20
	March	22
	April	19
	May	21
	June	21
		250
On-costs		%
	Super	12.75
	Rec Leave loading	1.7
	Long Service Leave levy	1.75
	Work cover	1.5
		17.7

LABOUR COSTS

	Pay Level	Base salary	FTE	Salaries	All other allowances Option A,PD, MV etc	IT Req	FFE Req
Managerial and Clerical							
Administration Officer	AO3-4	64952	1.00	64,952		1	1
				64,952			
Medical							
Registrar	L13	137517		-			
Psychiatrist	L23	180107		-	0		
				-			
Nursing							
Enrolled Nurse	NG3(4)	54073		-	0		
Registered Nurse	NG5(6)	76896		-	0		
Clinical Nurse	NG6(2)	80522		-	0		
Clinical Nurse	NG6(3)	82393		-	0		
Nurse Unit Manager	NG7(2)	104388		-	0		
				-			
Operational							
Domestic & other staff	OO2(4)	49676		-			
				-			
Professional							
Community Support Worker	PO3(3)	81428		-			
				-			
Health Practitioners							
MH Therapist	HP3(5)	78672		-			
Psychologist	HP3(5)	78672		-			
Social Worker	HP3(5)	78672		-			
Comm Supp Team Leader	HP4(3)	99504		-			
MH Therapist	HP4(3)	99504		-			
Occupational Therapist	HP4(3)	99504		-			
Psychologist	HP4(3)	99504		-			
Social Worker	HP4(3)	99504		-			
Speech Pathologist	HP4(3)	99504		-			
				-			
				64,952	-		
Headcount			1			1	1

NON-LABOUR COSTS

Staff Development	annual cost per FTE	500	
Vehicle costs	lease cost/month/vehicles No of vehicles		
Fuel costs	monthly cost/vehicle		
Vehicle running costs	monthly cost/vehicle		
Rent	annual cost per m2		based on commercial rent rate
Property service charge	% of rent		Includes gardening, external paint, maintenance of guttering, etc.
Utilities	annual cost 10c/kw.		270kw/annum/m2
ICT	annual cost per FTE	2500	
Catering	per bed day/consumer		
Linen	per bed day/consumer		
Domestic Services	monthly cost		
Consumables and Staff amenities	monthly cost		
Therapeutic programs	per annum		
Therapeutic equipment	per annum		
Drugs	per bed day/consumer		
Clinical Supplies	per bed day/consumer		
Repairs and Maintenance	monthly cost		

ESTABLISHMENT COSTS (YR 1 ONLY)

ICT	per applicable ee	2600	2600	
FFE	per applicable ee	1400	1400	4000
Fitout	cost per m2			
Construction	cost per m2			

Statewide Panel Coordinator
Budget 2013-17

											Labour inflation		0.0%	2.5%	2.5%
											Non-labour inflation		3.0%	3.0%	3.0%
Days in Period:	**23**	**20**	**22**	**22**	**19**	**21**	**20**	**20**	**22**	**19**	**21**	**21**	**250**		
													2014-15	**2015-16**	**2016-17**
	July	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**	**Total**	**Total**	**Total**
Managerial and Clerical	*5,976*	*5,196*	*5,716*	*5,716*	*4,936*	*5,456*	*5,196*	*5,196*	*5,716*	*4,936*	*5,456*	*5,456*	*64,952*	*66,576*	*68,240*
Medical	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Nursing	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Operational	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Professional	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Health Practitioners	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Base	5,976	5,196	5,716	5,716	4,936	5,456	5,196	5,196	5,716	4,936	5,456	5,456	64,952	66,576	68,240
Super and work cover (on total base)	1,058	920	1,012	1,012	874	966	920	920	1,012	874	966	966	11,497	11,784	12,079
Other allowances	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Labour	**7,033**	**6,116**	**6,727**	**6,727**	**5,810**	**6,422**	**6,116**	**6,116**	**6,727**	**5,810**	**6,422**	**6,422**	**76,449**	**78,360**	**80,319**
Drugs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Clinical Supplies	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Staff Development	42	42	42	42	42	42	42	42	42	42	42	42	515	530	546
Vehicle costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Fuel costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Vehicle maint costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Rent	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Property Service charges	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Utilities	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
ICT costs	208	208	208	208	208	208	208	208	208	208	208	208	2,575	2,652	2,732
Catering	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Linen	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Domestic Services	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Consumables	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Therapeutic Programs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Therapeutic Equipment	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
R&M	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
ICT & FFE establishment cost	4,000														
Total Non-Labour	**4,250**	**250**	**250**	**250**	**250**	**250**	**250**	**250**	**250**	**250**	**250**	**250**	**3,090**	**3,183**	**3,278**
TOTAL OPERATING COST	**11,283**	**6,366**	**6,977**	**6,977**	**6,060**	**6,672**	**6,366**	**6,366**	**6,977**	**6,060**	**6,672**	**6,672**	**79,539**	**81,542**	**83,597**

AMYOS Team - Input Sheet - NG7 Costing

KPIs	Beds/Consumers	8	16 to 20 consumers in caseload per team
	Utilisation %	100	
	m2	8	
Budget Phasing			
Days/year	July	23	
	August	20	
	September	22	
	October	22	
	November	19	
	December	21	
	January	20	
	February	20	
	March	22	
	April	19	
	May	21	
	June	21	
		250	
On-costs		%	
	Super	12.75	
	Rec Leave loading	1.7	
	Long Service Leave levy	1.75	
	Work cover	1.5	
		17.7	

LABOUR COSTS

	Pay Level	Base salar	FTE	Salaries	All other allowances Option A,PD, MV etc	Public Holiday/ Weekend rates	IT Req	FFE Req
Managerial and Clerical								
Administration Officer	AO3	64952		-				
				-				
Medical								
Registrar	L13	137517		-				
Psychiatrist	L23	180107		-	0			
				-				
Nursing								
Enrolled Nurse	NG3(4)	54073		-	0			
Registered Nurse	NG5(6)	76896		-	0			
Clinical Nurse	NG6(2)	80522		-	0			
Clinical Nurse	NG6(3)	82393		-	0			
Nurse Unit Manager	NG7(3)	106996	2.19	234,568	3288		2	2
				234,568				
Operational								
Operational staff	OO2(4)	49676		-				
				-				
Professional								
Community Support Worker	PO3(3)	81428		-				
				-				
Health Practitioners (Teams)								
Psychologist	HP4(3)	99504		-		-		
				-				
Health Practitioners								
MH Therapist	HP3(5)	78672		-				
Psychologist	HP3(5)	78672		-				
Social Worker	HP3(5)	78672		-				
Comm Supp Team Leader	HP4(3)	99504		-				
MH Therapist	HP4(3)	99504		-				
Occupational Therapist	HP4(3)	99504		-				
Psychologist	HP4(3)	99504		-				
Social Worker	HP4(3)	99504		-				
Speech Pathologist	HP4(3)	99504		-				
				-				
				234,568	**3,288**	**-**		
Headcount			2.19				2	2

NON-LABOUR COSTS

Staff Development	annual cost per team	4000	
Vehicle costs	lease cost/month	507	based on QFLeet Toyota Sedan
	No of vehicles	1	
Fuel costs	monthly cost/vehicle	300	
Vehicle running costs	monthly cost/vehicle	250	
Rent	annual cost per m2		
Property service charges	% of rent		
Utilities	annual cost 10c/kw.		270kw/annum/m2
ICT	annual cost per FTE	2500	
Catering	per bed day/consumer		
Linen	per bed day/consumer		
Domestic Services	monthly cost		
Consumables and Staff amenities	monthly cost		
Therapeutic programs			
Therapeutic equipment			
Drugs	per bed day/consumer		
Clinical Supplies	per bed day/consumer		
Repairs and Maintenance	monthly cost		

ESTABLISHMENT COSTS (YR 1 ONLY)

ICT	per person	2600	5200	
FFE	per person	1400	2800	8000
Kitchen fitout	cost per m2			
Fitout	cost per m2			
Construction	cost per m2			

AMYOS Team Summary
Budget 2013-17

	Labour	0.0%	2.5%	2.5%	0.0%	2.5%	2.5%
	Non-Labour	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
	Teams 2013-14 Total	**Teams 2014-15 (7) Total PHASED**	**Teams 2015-16 (7) Total**	**Teams 2016-17 (7) Total**	**Teams 2014-15 (12) Total**	**Teams 2015-16 (12) Total**	**Teams 2016-17 (12) Total**
Managerial and Clerical	-	-	-	-	-	-	-
Medical	-	-	-	-	-	-	-
Nursing	-	1,474,965	1,683,027	1,725,102	2,814,818	2,885,188	2,957,318
Operational	-	-	-	-	-	-	-
Professional	-	-	-	-	-	-	-
Teams	-	-	-	-	-	-	-
Health Practitioners	-	-	-	-	-	-	-
Total Base	-	1,474,965	1,683,027	1,725,102	2,814,818	2,885,188	2,957,318
Super and work cover (on total base)	-	261,069	297,896	305,343	498,223	510,678	523,445
Other allowances	-	20,678	23,595	24,185	39,462	40,448	41,459
Total Labour	**-**	**1,756,711**	**2,004,517**	**2,054,630**	**3,352,502**	**3,436,315**	**3,522,223**
Drugs	-	-	-	-	-	-	-
Clinical Supplies	-	-	-	-	-	-	-
Staff Development	-	26,093	29,705	30,596	49,440	50,923	52,451
Vehicle costs	-	39,688	45,182	46,537	75,198	77,454	79,778
Fuel costs	-	23,484	26,735	27,537	44,496	45,831	47,206
Vehicle maint costs	-	19,570	22,279	22,947	37,080	38,192	39,338
Rent	-	-	-	-	-	-	-
Property servicing	-	-	-	-	-	-	-
Utilities	-	-	-	-	-	-	-
ICT costs	-	32,617	37,132	38,245	61,800	63,654	65,564
Catering	-	-	-	-	-	-	-
Linen	-	-	-	-	-	-	-
Domestic Services	-	-	-	-	-	-	-
Consumables	-	-	-	-	-	-	-
Therapeutic Programs	-	-	-	-	-	-	-
Therapeutic Equipment	-	-	-	-	-	-	-
R&M	-	-	-	-	-	-	-
ICT & FFE establishment cost	-	57,680			98,880		
Total Non-Labour	**-**	**199,132**	**161,032**	**165,863**	**366,894**	**276,055**	**284,336**
TOTAL OPERATING COST	**-**	**1,955,843**	**2,165,549**	**2,220,493**	**3,719,396**	**3,712,369**	**3,806,559**

AMYOS Budget 2013-14	FTE Teams												
	1	5	7	7	7	7	7	7	7	7	7	7	
Days in Period:	**23**	**20**	**22**	**22**	**19**	**21**	**20**	**20**	**22**	**19**	**21**	**21**	**250**
	July	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**	**Total**
Managerial and Clerical	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Medical	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Nursing	*21,580*	*93,827*	*144,494*	*144,494*	*124,790*	*137,926*	*131,358*	*131,358*	*144,494*	*124,790*	*137,926*	*137,926*	***1,474,965***
Operational	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Professional	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Teams	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Health Practitioners	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Total Base	21,580	93,827	144,494	144,494	124,790	137,926	131,358	131,358	144,494	124,790	137,926	137,926	**1,474,965**
Super and work cover (on total base)	3,820	16,607	25,575	25,575	22,088	24,413	23,250	23,250	25,575	22,088	24,413	24,413	**261,069**
Other allowances	302.54	1,315	2,026	2,026	1,749	1,934	1,842	1,842	2,026	1,749	1,934	1,934	**20,678**
Total Labour	**25,703**	**111,750**	**172,095**	**172,095**	**148,628**	**164,273**	**156,450**	**156,450**	**172,095**	**148,628**	**164,273**	**164,273**	**1,756,711**
Drugs	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Clinical Supplies	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Staff Development	333	1,667	2,333	2,333	2,333	2,333	2,333	2,333	2,333	2,333	2,333	2,333	**25,333**
Vehicle costs	507	2,535	3,549	3,549	3,549	3,549	3,549	3,549	3,549	3,549	3,549	3,549	**38,532**
Fuel costs	300	1,500	2,100	2,100	2,100	2,100	2,100	2,100	2,100	2,100	2,100	2,100	**22,800**
Vehicle maint costs	250	1,250	1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,750	**19,000**
Rent	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Property service charge	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Utilities	-	-	-	-	-	-	-	-	-	-	-	-	**-**
ICT costs	417	2,083	2,917	2,917	2,917	2,917	2,917	2,917	2,917	2,917	2,917	2,917	**31,667**
Catering	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Linen	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Domestic Services	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Consumables	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Therapeutic Programs	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Therapeutic Equipment	-	-	-	-	-	-	-	-	-	-	-	-	**-**
R&M	-	-	-	-	-	-	-	-	-	-	-	-	**-**
ICT & FFE establishment cost	8,000	32,000	16,000	-	-	-	-	-	-	-	-	-	**56,000**
Total Non-Labour	**9,807**	**41,035**	**28,649**	**12,649**	**12,649**	**12,649**	**12,649**	**12,649**	**12,649**	**12,649**	**12,649**	**12,649**	**193,332**
TOTAL OPERATING COST	**35,510**	**152,785**	**200,744**	**184,744**	**161,277**	**176,922**	**169,099**	**169,099**	**184,744**	**161,277**	**176,922**	**176,922**	**1,950,043**

AMYOS Budget 2013-14	FTE Teams												
	12	12	12	12	12	12	12	12	12	12	12	12	
Days in Period:	**23**	**20**	**22**	**22**	**19**	**21**	**20**	**20**	**22**	**19**	**21**	**21**	**250**
	July	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**	**Total**
Managerial and Clerical	-	-	-	-	-	-	-	-	-	-	-	-	-
Medical	-	-	-	-	-	-	-	-	-	-	-	-	-
Nursing	*258,963*	*225,185*	*247,704*	*247,704*	*213,926*	*236,445*	*225,185*	*225,185*	*247,704*	*213,926*	*236,445*	*236,445*	*2,814,818*
Operational	-	-	-	-	-	-	-	-	-	-	-	-	-
Professional	-	-	-	-	-	-	-	-	-	-	-	-	-
Teams	-	-	-	-	-	-	-	-	-	-	-	-	-
Health Practitioners	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Base	258,963	225,185	247,704	247,704	213,926	236,445	225,185	225,185	247,704	213,926	236,445	236,445	2,814,818
Super and work cover (on total base)	45,836	39,858	43,844	43,844	37,865	41,851	39,858	39,858	43,844	37,865	41,851	41,851	498,223
Other allowances	3,630.46	3,157	3,473	3,473	2,999	3,315	3,157	3,157	3,473	2,999	3,315	3,315	**39,462**
Total Labour	**308,430**	**268,200**	**295,020**	**295,020**	**254,790**	**281,610**	**268,200**	**268,200**	**295,020**	**254,790**	**281,610**	**281,610**	**3,352,502**
Drugs	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Clinical Supplies	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Staff Development	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	**48,000**
Vehicle costs	6,084	6,084	6,084	6,084	6,084	6,084	6,084	6,084	6,084	6,084	6,084	6,084	**73,008**
Fuel costs	3,600	3,600	3,600	3,600	3,600	3,600	3,600	3,600	3,600	3,600	3,600	3,600	**43,200**
Vehicle maint costs	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	**36,000**
Rent	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Property service charge	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Utilities	-	-	-	-	-	-	-	-	-	-	-	-	**-**
ICT costs	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	**60,000**
Catering	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Linen	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Domestic Services	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Consumables	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Therapeutic Programs	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Therapeutic Equipment	-	-	-	-	-	-	-	-	-	-	-	-	**-**
R&M	-	-	-	-	-	-	-	-	-	-	-	-	**-**
ICT & FFE establishment cost	96,000	-	-	-	-	-	-	-	-	-	-	-	**96,000**
Total Non-Labour	**117,684**	**21,684**	**21,684**	**21,684**	**21,684**	**21,684**	**21,684**	**21,684**	**21,684**	**21,684**	**21,684**	**21,684**	**356,208**
TOTAL OPERATING COST	**426,114**	**289,884**	**316,704**	**316,704**	**276,474**	**303,294**	**289,884**	**289,884**	**316,704**	**276,474**	**303,294**	**303,294**	**3,708,710**

AMYOS Psychiatrists (2.0+Admin) - Input Sheet

KPIs	Beds/Consumers	0
	Utilisation %	100
	m2	32

Budget Phasing

Days/year	July	23
	August	20
	September	22
	October	22
	November	19
	December	21
	January	20
	February	20
	March	22
	April	19
	May	21
	June	21
		250

On-costs		%
	Super	12.75
	Rec Leave loading	1.7
	Long Service Leave Levy	1.75
	Work cover	1.5
		17.7

LABOUR COSTS

	Pay Level	Base salary	FTE	Salaries	All other allowances Option A,PD, MV etc	IT Req	FFE Req
Managerial and Clerical							
Administration Officer	AO3-4	64952	1.00	64,952		1	1
				64,952			
Medical							
Registrar	L13	137517		-			
Psychiatrist	L27	200731	1.20	240,877	197739	2	2
Psychiatrist	L23	180107	0.80	144,086	96203	4	4
				384,963			
Nursing							
Enrolled Nurse	NG3(4)	54073		-	0		
Registered Nurse	NG5(6)	76896		-	0		
Clinical Nurse	NG6(2)	80522		-	0		
Clinical Nurse	NG6(3)	82393		-	0		
Nurse Unit Manager	NG7(3)	106996		-	0		
				-			
Operational							
Domestic & other staff	OO2(4)	49676		-			
				-			
Professional							
Community Support Worker	PO3(3)	81428		-			
				-			
Health Practitioners							
MH Therapist	HP3(5)	78672		-			
Psychologist	HP3(5)	78672		-			
Social Worker	HP3(5)	78672		-			
Comm Supp Team Leader	HP4(3)	99504		-			
MH Therapist	HP4(3)	99504		-			
Occupational Therapist	HP4(3)	99504		-			
Psychologist	HP4(3)	99504	0.50	49,752		1	1
Social Worker	HP4(3)	99504		-			
Speech Pathologist	HP4(3)	99504		-			
				49,752			
				499,667	**293,941**		
Headcount			6.7			8	8

NON-LABOUR COSTS

Staff Development	annual cost per FTE	500	
Vehicle costs	lease cost/month/vehicles		
	No of vehicles		
Fuel costs	monthly cost/vehicle		
Vehicle running costs	monthly cost/vehicle		
Rent	annual cost per m2		based on commercial rent rate
Property service charge	% of rent		Includes gardening, external paint, maintenance, etc.
Utilities	annual cost 10c/kw.		270kw/annum/m2
ICT	annual cost per FTE	2,500	
Catering	per bed day/consumer		
Linen	per bed day/consumer		
Domestic Services	monthly cost		
Consumables and Staff amenities	monthly cost		
Therapeutic programs	per annum		
Therapeutic equipment	per annum		
Drugs	per bed day/consumer		
Clinical Supplies	per bed day/consumer		
Repairs and Maintenance	monthly cost		

ESTABLISHMENT COSTS (YR 1 ONLY)

ICT	per applicable ee	2600	20800	
FFE	per applicable ee	1400	11200	32000
Fitout	cost per m2			
Construction	cost per m2			

AMYOS Psychiatrists (2+Admin)
Budget 2013-17

											Labour inflation		0.0%	2.5%	2.5%
											Non-labour inflation		3.0%	3.0%	3.0%
Days in Period:	**23**	**20**	**22**	**22**	**19**	**21**	**20**	**20**	**22**	**19**	**21**	**21**	**250**		
													2014-15	**2015-16**	**2016-17**
	July	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**	**Total**	**Total**	**Total**
Managerial and Clerical	*5,976*	*5,196*	*5,716*	*5,716*	*4,936*	*5,456*	*5,196*	*5,196*	*5,716*	*4,936*	*5,456*	*5,456*	*64,952*	*66,576*	*68,240*
Medical	*35,417*	*30,797*	*33,877*	*33,877*	*29,257*	*32,337*	*30,797*	*30,797*	*33,877*	*29,257*	*32,337*	*32,337*	*384,963*	*394,587*	*404,452*
Nursing	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Operational	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Professional	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Health Practitioners	*4,577*	*3,980*	*4,378*	*4,378*	*3,781*	*4,179*	*3,980*	*3,980*	*4,378*	*3,781*	*4,179*	*4,179*	*49,752*	*50,996*	*52,271*
Total Base	45,969	39,973	43,971	43,971	37,975	41,972	39,973	39,973	43,971	37,975	41,972	41,972	499,667	512,158	524,962
Super and work cover (on total base)	8,137	7,075	7,783	7,783	6,722	7,429	7,075	7,075	7,783	6,722	7,429	7,429	88,441	90,652	92,918
Other allowances	27,043	23,515	25,867	25,867	22,340	24,691	23,515	23,515	25,867	22,340	24,691	24,691	293,941	301,290	308,822
Total Labour	**81,149**	**70,564**	**77,620**	**77,620**	**67,036**	**74,092**	**70,564**	**70,564**	**77,620**	**67,036**	**74,092**	**74,092**	**882,049**	**904,100**	**926,703**
Drugs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Clinical Supplies	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Staff Development	279	279	279	279	279	279	279	279	279	279	279	279	3,451	3,554	3,661
Vehicle costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Fuel costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Vehicle maint costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Rent	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Property Service charges	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Utilities	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
ICT costs	1,667	1,667	1,667	1,667	1,667	1,667	1,667	1,667	1,667	1,667	1,667	1,667	20,600	21,218	21,855
Catering	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Linen	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Domestic Services	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Consumables	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Therapeutic Programs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Therapeutic Equipment	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
R&M	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
ICT & FFE establishment cost											32,000		32,960		
Total Non-Labour	**1,946**	**1,946**	**1,946**	**1,946**	**1,946**	**1,946**	**1,946**	**1,946**	**1,946**	**1,946**	**33,946**	**1,946**	**57,011**	**24,772**	**25,515**
TOTAL OPERATING COST	**83,094**	**72,510**	**79,566**	**79,566**	**68,982**	**76,038**	**72,510**	**72,510**	**79,566**	**68,982**	**108,038**	**76,038**	**939,060**	**928,872**	**952,218**

AMYOS Psychiatrists (2.0) - Input Sheet

KPIs	Beds/Consumers	0
	Utilisation %	100
	m2	40

Budget Phasing

Days/year	July	23
	August	20
	September	22
	October	22
	November	19
	December	21
	January	20
	February	20
	March	22
	April	19
	May	21
	June	21
		250

On-costs		%
	Super	12.75
	Rec Leave loading	1.7
	Long Service Leave Levy	1.75
	Work cover	1.5
		17.7

LABOUR COSTS

	Pay Level	Base salary	FTE	Salaries	All other allowances Option A,PD, MV etc	IT Req	FFE Req
Managerial and Clerical							
Administration Officer	AO3	64952		-			
				-			
Medical							
Registrar	L13	137517		-			
Psychiatrist	L23	180107	2.00	360,214	262,107	10	10
				360,214			
Nursing							
Enrolled Nurse	NG3(4)	54073		-	0		
Registered Nurse	NG5(6)	76896		-	0		
Clinical Nurse	NG6(2)	80522		-	0		
Clinical Nurse	NG6(3)	82393		-	0		
Nurse Unit Manager	NG7(3)	106996		-	0		
				-			
Operational							
Domestic & other staff	OO2(4)	49676		-			
				-			
Professional							
Community Support Worker	PO3(3)	81428		-			
				-			
Health Practitioners							
MH Therapist	HP3(5)	78672		-			
Psychologist	HP3(5)	78672		-			
Social Worker	HP3(5)	78672		-			
Comm Supp Team Leader	HP4(3)	99504		-			
MH Therapist	HP4(3)	99504		-			
Occupational Therapist	HP4(3)	99504		-			
Psychologist	HP4(3)	99504		-			
Social Worker	HP4(3)	99504		-			
Speech Pathologist	HP4(3)	99504		-			
				-			
				360,214	**262,107**		
Headcount			10			10	10

NON-LABOUR COSTS

Staff Development	annual cost per FTE	500	
Vehicle costs	lease cost/month/vehicles No of vehicles		
Fuel costs	monthly cost/vehicle		
Vehicle running costs	monthly cost/vehicle		
Rent	annual cost per m2		based on commercial rent rate
Property service charge	% of rent		Includes gardening, external paint, maintenance, etc.
Utilities	annual cost 10c/kw.		270kw/annum/m2
ICT	annual cost per FTE	2500	
Catering	per bed day/consumer		
Linen	per bed day/consumer		
Domestic Services	monthly cost		
Consumables and Staff amenities	monthly cost		
Therapeutic programs	annual cost		
Therapeutic equipment	annual cost		
Drugs	per bed day/consumer		
Clinical Supplies	per bed day/consumer		
Repairs and Maintenance	monthly cost		

ESTABLISHMENT COSTS (YR 1 ONLY)

ICT	per applicable ee	2600	26000	
FFE	per applicable ee	1400	14000	40000
Fitout	cost per m2			
Construction	cost per m2			

AMYOS Psychiatrists (2)
Budget 2013-17

											Labour inflation		0.0%	2.5%	2.5%
											Non-labour inflation		3.0%	3.0%	3.0%
Days in Period:	**23**	**20**	**22**	**22**	**19**	**21**	**20**	**20**	**22**	**19**	**21**	**21**	**250**		
													2014-15	**2015-16**	**2016-17**
	July	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**	**Total**	**Total**	**Total**
Managerial and Clerical	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Medical	*33,140*	*28,817*	*31,699*	*31,699*	*27,376*	*30,258*	*28,817*	*28,817*	*31,699*	*27,376*	*30,258*	*30,258*	*360,214*	*369,219*	*378,450*
Nursing	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Operational	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Professional	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Health Practitioners	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Base	33,140	28,817	31,699	31,699	27,376	30,258	28,817	28,817	31,699	27,376	30,258	30,258	360,214	369,219	378,450
Super and work cover (on total base)	5,866	5,101	5,611	5,611	4,846	5,356	5,101	5,101	5,611	4,846	5,356	5,356	*63,758*	65,352	66,986
Other allowances	24,114	20,969	23,065	23,065	19,920	22,017	20,969	20,969	23,065	19,920	22,017	22,017	*262,107*	268,660	275,376
Total Labour	**63,119**	**54,886**	**60,375**	**60,375**	**52,142**	**57,631**	**54,886**	**54,886**	**60,375**	**52,142**	**57,631**	**57,631**	**686,079**	**703,231**	**720,812**
													-		
Drugs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Clinical Supplies	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Staff Development	417	417	417	417	417	417	417	417	417	417	417	417	*5,000*	5,150	5,305
Vehicle costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Fuel costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Vehicle maint costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Rent	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Property Service charges	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Utilities	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
ICT costs	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	*25,000*	25,750	26,523
Catering	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Linen	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Domestic Services	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Consumables	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Therapeutic Programs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Therapeutic Equipment	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
R&M	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
ICT & FFE establishment cost										40,000			*40,000*		
Total Non-Labour	**2,500**	**2,500**	**2,500**	**2,500**	**2,500**	**2,500**	**2,500**	**2,500**	**2,500**	**42,500**	**2,500**	**2,500**	**70,000**	**30,900**	**31,827**
TOTAL OPERATING COST	**65,619**	**57,386**	**62,875**	**62,875**	**54,642**	**60,131**	**57,386**	**57,386**	**62,875**	**94,642**	**60,131**	**60,131**	**756,079**	**734,131**	**752,639**

Day Program - Input Sheet

KPIs	Beds/Consumers	15	
	m2	475	based on Stafford Site
	Utilisation %	100	
Budget Phasing			
Days/year	July	23	
	August	20	
	September	22	
	October	22	
	November	19	
	December	21	
	January	20	
	February	20	
	March	22	
	April	19	
	May	21	
	June	21	
		250	
On-costs		%	
	Super	12.75	
	Rec Leave loading	1.7	
	Long Service Leave Levy	1.75	
	Work cover	1.5	
		17.7	

LABOUR COSTS

	Pay Level	Base salary	FTE	Salaries	All other allowances Option A,PD, MV etc	IT Req	FFE Req
Managerial and Clerical							
Administration Officer	AO3-4	64952	1.04	67,225		1	1
				67,225			
Medical							
Registrar	L13	137517	0.52	71,234			
Psychiatrist	L23	180107	0.52	93,295	62291	1	1
				164,529			
Nursing							
Enrolled Nurse	NG3(4)	54073		-	0		
Registered Nurse	NG5(6)	76896		-	0		
Clinical Nurse	NG6(2)	80522		-	0		
Clinical Nurse	NG6(3)	82393		-	0		
Clinical Nurse Consultant	NG7(2)	104388	1.16	121,508	1746	1	1
				121,508			
Operational							
Operational staff	OO3(3)	51164	1.04	52,955		1	1
				52,955			
Professional							
Community Support Worker	PO3(3)	81428		-			
				-			
Health Practitioners							
MH Therapist	HP3(5)	78672	1.04	81,426		1	1
Psychologist	HP3(5)	78672		-			
Social Worker	HP3(5)	78672		-			
Comm Supp Team Leader	HP4(3)	99504		-			
MH Therapist	HP4(3)	99504		-			
Occupational Therapist	HP4(3)	99504	1.04	102,987		1	1
Psychologist	HP4(3)	99504	1.04	102,987			
Social Worker	HP4(3)	99504	1.04	102,987		1	1
Psychologist	HP5(2)	99504	1.04	102,987		1	1
				493,372			
				899,589	**64,037**		
Headcount			9.45			8	8

NON-LABOUR COSTS

Staff Development	annual cost per FTE	500	
Vehicle costs	lease cost/month/vehicles	747	This is for 12-seater and Corolla Sedan (QFLeet lease costs)
	No of vehicles	2	
Fuel costs	monthly cost/vehicle	150	
Vehicle running costs	monthly cost/vehicle	100	
Rent	annual cost per m2	300	based on Salvation Army rent
Property service charge	% of rent	10	Includes gardening, external paint, maintenance, etc.
Utilities	annual cost 10c/kw.	2700	270kw/annum/m2
ICT	annual cost per FTE	2500	
Catering	per bed day/consumer	14	
Linen	per bed day/consumer		
Domestic Services	monthly cost	900	
Consumables and Staff amenities	monthly cost	353	used oncology day ward 12-13 actuals as benchmark 15 patients/day + 11 staff
Therapeutic programs	per consumer per month	100	
Therapeutic equipment	per consumer per month	100	
Drugs	per bed day/consumer	0	
Clinical Supplies	per bed day/consumer	0	
Repairs and Maintenance	annual % of fit out	2.5%	

ESTABLISHMENT COSTS (YR 1 ONLY)

ICT	per applicable ee	2600	20800		
FFE	per applicable ee	1400	11200	32000	
Fitout	cost per m2	995	Original budget was $1,500/315sqm = $995/475sqm		
R&M	annual % of build	2.5%			
Construction	cost per m2	3200			

Day Program - Roster

Demand	Monday to Friday service - 8 hours per day
	15 places; School days only but may include school holiday program or some after hours /
Indicators	Occupancy 100%; LOS 120 to 180 days

24 hr Roster Construct

			Mon	Tues	Wed	Thur	Fri	Sat	Sun	Total Hrs	Total FTE
AM	Clinical Nurse	NO Gr6								0.00	0.00
	Registered Nurse	NO Gr5								0.00	0.00
	Rec Officer	OO / HP								0.00	0.00
		Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.00**	**0.00**

			Mon	Tues	Wed	Thur	Fri	Sat	Sun	Total Hrs	Total FTE
PM	Registered Nurse	NO Gr5								0.00	0.00
	Rec Officer	OO / HP								0.00	0.00
		Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.00**	**0.00**

			Mon	Tues	Wed	Thur	Fri	Sat	Sun	Total Hrs	Total FTE
Night	Registered Nurse	NO Gr5								0.00	0.00
		NO								0.00	0.00
		Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.00**	**0.00**
		Daily Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.00**	**0.00**

Other roster construct

Title	**Grade**	**Mon**	**Tues**	**Wed**	**Thur**	**Fri**	**Sat**	**Sun**	**Total Hrs**	**Total FTE**	
Operational	OO3	7.6	7.6	7.6	7.6	7.6	0.0	0.0	38.00	1.00	1.00
Admin	AO3	7.6	7.6	7.6	7.6	7.6	0.0	0.0	38.00	1.00	1.00
	HP3	7.6	7.6	7.6	7.6	7.6	0.0	0.0	38.00	1.00	
Speech pathology	HP4	7.0	0.0	6.0	0.0	6.0	0.0	0.0	19.00	0.50	
OT	HP4	7.0	0.0	6.0	0.0	6.0	0.0	0.0	19.00	0.50	
Social Worker	HP4	7.6	7.6	7.6	7.6	7.6	0.0	0.0	38.00	1.00	
Psychologist	HP4	7.6	7.6	7.6	7.6	7.6	0.0	0.0	38.00	1.00	
	HP5	7.6	7.6	7.6	7.6	7.6	0.0	0.0	38.00	1.00	5.00
	NO5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.00	0.00	
CNC	NO7	7.6	7.6	7.6	7.6	7.6	0.0	0.0	38.00	1.00	1.00
Psychiatrist	MO	4.0	4.0	4.0	4.0	3.0	0.0	0.0	19.00	0.50	
Registrar	MO	4.0	4.0	4.0	4.0	3.0	0.0	0.0	19.00	0.50	1.00
	Total	**75.2**	**61.2**	**73.2**	**61.2**	**71.2**	**0.0**	**0.0**	**342.00**	**9.00**	

FTE Allocations

Level	Productive FTE	Sick Leave (3.5%)	Professional Development Leave	Organisational Education	Mandatory Training (Award Entitlement)	Recreational Leave (Award Entitlement)			
OO3	1.0	0.04						1.04	
AO3	1.0	0.04						1.04	
HP3	1.0	0.04						1.04	
Speech pathology	0.5	0.02						0.52	
OT	0.5	0.02						0.52	
Social Worker	1.0	0.04						1.04	
Psychologist	1.0	0.04						1.04	
HP5	1.0	0.04						1.04	
NO5 RN	0.0	0.00						0.00	Taken out of roster
NO7 CNC	1.0	0.04	0.01		0.02	0.10	5 wk	1.16	
MO - con	0.5	0.02						0.52	
MO - reg	0.5	0.02						0.52	
Total FTE	**9.00**	**0.3**	**0.0**	**0.00**		**0.1**		**9.44**	
Productive FTE					**9.3**	**9.1**			
Funded FTE									
Employable FTE									

Day Program Budget 2013-17

											Labour inflation		0.0%	2.5%	2.5%	0.0%	2.5%	2.5%
											Non-labour inflation		3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
													1st Day Program				Additional Day Programs		
Days in Period:	**23**	**20**	**22**	**22**	**19**	**21**	**20**	**20**	**22**	**19**	**21**	**21**	**May-Jun 2013-14 Total**	**2014-15 Total**	**2015-16 Total**	**2016-17 Total**	**2014-15 Total**	**2015-16 Total**	**2016-17 Total**
	July	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**							
Managerial and Clerical	*6,185*	*5,378*	*5,916*	*5,916*	*5,109*	*5,647*	*5,378*	*5,378*	*5,916*	*5,109*	*5,647*	*5,647*	*11,294*	*67,225*	*68,906*	*70,629*	*67,225*	*68,906*	*70,629*
Medical	*15,137*	*13,162*	*14,479*	*14,479*	*12,504*	*13,820*	*13,162*	*13,162*	*14,479*	*12,504*	*13,820*	*13,820*	*27,641*	*164,529*	*168,642*	*172,859*	*164,529*	*168,642*	*172,859*
Nursing	*11,179*	*9,721*	*10,693*	*10,693*	*9,235*	*10,207*	*9,721*	*9,721*	*10,693*	*9,235*	*10,207*	*10,207*	*20,413*	*121,508*	*124,545*	*127,659*	*121,508*	*124,545*	*127,659*
Operational	*4,872*	*4,236*	*4,660*	*4,660*	*4,025*	*4,448*	*4,236*	*4,236*	*4,660*	*4,025*	*4,448*	*4,448*	*8,896*	*52,955*	*54,279*	*55,636*	*52,955*	*54,279*	*55,636*
Professional	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Health Practitioners	*45,390*	*39,470*	*43,417*	*43,417*	*37,496*	*41,443*	*39,470*	*39,470*	*43,417*	*37,496*	*41,443*	*41,443*	*82,887*	*493,372*	*505,706*	*518,349*	*493,372*	*505,706*	*518,349*
Total Base	82,762	71,967	79,164	79,164	68,369	75,565	71,967	71,967	79,164	68,369	75,565	75,565	151,131	899,589	922,079	945,131	899,589	922,079	945,131
Super and work cover (on total base)	14,649	12,738	14,012	14,012	12,101	13,375	12,738	12,738	14,012	12,101	13,375	13,375	*26,750*	*159,227*	*163,208*	*167,288*	*159,227*	*163,208*	*167,288*
Other allowances	5,891	5,123	5,635	5,635	4,867	5,379	5,123	5,123	5,635	4,867	5,379	5,379	*10,758*	*64,037*	*65,638*	*67,279*	*64,037*	*65,638*	*67,279*
Total Labour	**103,303**	**89,828**	**98,811**	**98,811**	**85,337**	**94,320**	**89,828**	**89,828**	**98,811**	**85,337**	**94,320**	**94,320**	**188,639**	**1,122,854**	**1,150,925**	**1,179,698**	**1,122,854**	**1,150,925**	**1,179,698**
Drugs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Clinical Supplies	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Staff Development	394	394	394	394	394	394	394	394	394	394	394	394	*787*	*4,864*	*5,010*	*5,160*	*4,864*	*5,010*	*5,160*
Vehicle costs	1,494	1,494	1,494	1,494	1,494	1,494	1,494	1,494	1,494	1,494	1,494	1,494	*2,988*	*18,466*	*19,020*	*19,590*	*18,466*	*19,020*	*19,590*
Fuel costs	300	300	300	300	300	300	300	300	300	300	300	300	*600*	*3,708*	*3,819*	*3,934*	*3,708*	*3,819*	*3,934*
Vehicle maint costs	200	200	200	200	200	200	200	200	200	200	200	200	*400*	*2,472*	*2,546*	*2,623*	*2,472*	*2,546*	*2,623*
Rent	13,110	11,400	12,540	12,540	10,830	11,970	11,400	11,400	12,540	10,830	11,970	11,970	*23,940*	*146,775*	*151,178*	*155,714*	*146,775*	*151,178*	*155,714*
Property service charges	1,311	1,140	1,254	1,254	1,083	1,197	1,140	1,140	1,254	1,083	1,197	1,197	*2,394*	*14,678*	*15,118*	*15,571*	*14,678*	*15,118*	*15,571*
Utilities	225	225	225	225	225	225	225	225	225	225	225	225	*450*	*2,781*	*2,864*	*2,950*	*2,781*	*2,864*	*2,950*
ICT costs	1,667	1,667	1,667	1,667	1,667	1,667	1,667	1,667	1,667	1,667	1,667	1,667	*3,333*	*20,600*	*21,218*	*21,855*	*20,600*	*21,218*	*21,855*
Catering	4,830	4,200	4,620	4,620	3,990	4,410	4,200	4,200	4,620	3,990	4,410	4,410	*8,820*	*54,075*	*55,697*	*57,368*	*54,075*	*55,697*	*57,368*
Linen	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Domestic Services	900	900	900	900	900	900	900	900	900	900	900	900	*1,800*	*11,124*	*11,458*	*11,801*	*11,124*	*11,458*	*11,801*
Consumables	353	353	353	353	353	353	353	353	353	353	353	353	*705*	*4,358*	*4,489*	*4,623*	*4,358*	*4,489*	*4,623*
Therapeutic Programs	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	*3,000*	*18,540*	*19,096*	*19,669*	*18,540*	*19,096*	*19,669*
Therapeutic Equipment	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	*3,000*	*18,540*	*19,096*	*19,669*	*18,540*	*19,096*	*19,669*
R&M	984	984	984	984	984	984	984	984	984	984	984	984	*1,969*	*12,167*	*12,532*	*12,908*	*12,167*	*12,532*	*12,908*
IT and FFE establishment											32,000		*32,000*				*32,960*	*33,949*	*34,967*
Total Non-Labour	**28,767**	**26,256**	**27,930**	**27,930**	**25,419**	**27,093**	**26,256**	**26,256**	**27,930**	**25,419**	**59,093**	**27,093**	**86,186**	**333,147**	**343,142**	**353,436**	**366,107**	**377,090**	**388,403**
TOTAL OPERATING COST	**132,070**	**116,084**	**126,741**	**126,741**	**110,756**	**121,413**	**116,084**	**116,084**	**126,741**	**110,756**	**153,413**	**121,413**	**274,826**	**1,456,001**	**1,494,066**	**1,533,134**	**1,488,961**	**1,528,015**	**1,568,101**

Resi Rehab Unit - Input Sheet

KPIs	Beds/Consumers	6	
	Utilisation	100	
	m2	490	
Budget Phasing			
Days/year	July	31	
	August	31	
	September	30	
	October	31	
	November	30	
	December	31	
	January	31	
	February	28	
	March	31	
	April	30	
	May	31	
	June	30	
		365	0
On-costs		%	
	Super	12.75	
	Rec Leave loading	1.7	
	Long Service Leave Levy	1.75	
	Work cover	1.5	
		17.7	

LABOUR COSTS

	Pay Level	Base salary	FTE	Salaries	All other allowances Option A,PD, MV etc	Penalty payments	IT Req	FFE Req
Managerial and Clerical								
Administration Officer	AO3-4	64952	0.20	13,250			1	1
				13,250				
Medical								
Registrar	L13	137517		-				
Psychiatrist	L27	200731	0.11	22,080	42840			
Psychiatrist	L23	180107		-	0			
				22,080				
Nursing								
Enrolled Nurse	NG3(4)	54073		-	0			
Registered Nurse	NG5(6)	76896		-	0			
Clinical Nurse	NG6(2)	80522		-	0			
Clinical Nurse	NG6(3)	82393		-	0			
Nurse Unit Manager	NG7(2)	104388		-	0			
				-				
Operational								
Operational staff	OO2(4)	49676		-				
				-				
Professional								
Community Support Worker	PO3(3)	81428	6.97	567,797		247,678	1	1
				567,797				
Health Practitioners								
MH Therapist	HP3(5)	78672		-				
Psychologist	HP3(5)	78672		-				
Social Worker	HP3(5)	78672		-				
Comm Supp Team Leader	HP4(3)	99504	1.04	102,987			1	1
MH Therapist	HP4(3)	99504		-				
Occupational Therapist	HP4(3)	99504		-				
Psychologist	HP4(3)	99504		-				
Social Worker	HP4(3)	99504		-				
Speech Pathologist	HP4(3)	99504		-				
				102,987				
				706,115	**42,840**	**247,678**		
Headcount			8.32				3	3

NON-LABOUR COSTS

Staff Development	annual cost per FTE	500	
Vehicle costs	lease cost/month	747	This is for 14-seater and Corolla Sedan (QFLeet lease costs)
	No of vehicles	2	
Fuel costs	monthly cost/vehicle	150	NGO estimate for 11 mths
Vehicle running costs	monthly cost/vehicle	98	NGO estimate for 11 mths
Rent	monthly cost	4,136	NGO estimate for 12 mths - lease signed for 12 mths
Utilities	monthly cost	535	NGO estimate for 11 mths
ICT	monthly lease	333	within NGO Ohds charge
Catering	Monthly cost	1752	NGO estimate for 11 mths
Linen	per bed day/consumer		within NGO Client Support Services
Cleaning	monthly cost	904	NGO estimate for 11 mths
Consumables and Staff amenities	monthly cost	907	NGO estimate for 11 mths
Therapeutic programs	annual costs	23995	NGO annual estimate
Therapeutic equipment	annual costs	6656	NGO estimate for 11 mths
Drugs	per bed day/consumer		
Clinical Supplies	per bed day/consumer		
Building maintenance	monthly cost	594	NGO estimate for 11 mths
NGO Overheads	annual costs	138511	NGO estimate for 11 mths

ESTABLISHMENT COSTS (YR 1 ONLY)

ICT	per applicable ee	2600	7800	
FFE	per applicable ee	1400	4200	12000

Resi Rehab Unit - Roster

Demand	7 days per week & 24 hours per day
	5 beds stand alone
Indicators	transition to residential living, 16 to 21 yo, up to

											15%	50%	100%	150%	
											WEEKLY PENALTY HRS				
24 hr Roster Construct											**Shift**	**Saturday**	**Sunday**	**Public**	**TOTAL**
			Mon	**Tues**	**Wed**	**Thur**	**Fri**	**Sat**	**Sun**	**Total Hrs**	**Total FTE**	**Allowance**	**Allowance**	**Allowance**	**Holidays**	
AM	Community Support Workers							16.0	16.0	32.00	0.84		8	16	0.00	
	Total		**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**16.0**	**16.0**	**32.00**	**0.84**					
			Mon	**Tues**	**Wed**	**Thur**	**Fri**	**Sat**	**Sun**	**Total Hrs**	**Total FTE**					
PM	Community Support Workers	PO3	12.0	12.0	12.0	12.0	12.0	12.0	12.0	84.00	2.21	12.6	6	12	4.15	
	Total		**12.0**	**12.0**	**12.0**	**12.0**	**12.0**	**12.0**	**12.0**	**84.00**	**2.21**					
			Mon	**Tues**	**Wed**	**Thur**	**Fri**	**Sat**	**Sun**	**Total Hrs**	**Total FTE**					
Night	Community Support Workers	PO3	20.0	20.0	20.0	20.0	20.0	20.0	20.0	140.00	3.68	21	10	20	6.92	
	Total		**20.0**	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**	**140.00**	**3.68**					
	Daily Total		**32.0**	**32.0**	**32.0**	**32.0**	**32.0**	**48.0**	**48.0**	**256.00**	**6.74**	**33.60**	**24.00**	**48.00**	**11.08**	**116.68**

Other roster construct

Title	**Grade**	**Mon**	**Tues**	**Wed**	**Thur**	**Fri**	**Sat**	**Sun**	**Total Hrs**	**Total FTE**
Administration	AO3	4.0		3.5					7.50	0.20
Psychologist	HP4								0.00	0.00
Social Worker	HP4								0.00	0.00
Community Support Team Leader	HP4	7.6	7.6	7.6	7.6	7.6			38.00	1.00
CN	NO7								0.00	0.00
Psychiatrist	MO		2.0		2.0				4.00	0.11
Total		**11.6**	**9.6**	**11.1**	**9.6**	**7.6**	**0.0**	**0.0**	**49.50**	**1.30**

FTE Allocations **8.04**

Level	Productive FTE	Sick Leave (3.5%)	Professional Development Leave	Organisational Education	Mandatory Training (Award Entitlement)	Recreational Leave (Award Entitlement)		
AO3	0.20	0.01					0.20	CHQ
PO3	6.7	0.24					6.97	NGO
Psychologist	0.0	0.00					0.00	CHQ
Social Worker	0.0	0.00					0.00	CHQ
Community Support Te	1.0	0.04					1.04	NGO
NO6 CN	0.0	0.00	0.00		0.00	0.00	5 wk 0.00	
MO - con	0.1	0.00					0.11	CHQ
Total FTE	**8.04**	**0.3**	**0.0**			**0.0**	**8.32**	
Productive FTE					**8.3**	**8.0**		
Funded FTE								
Employable FTE								

Resi Rehab Unit
Budget 2013-17

											Labour inflation				0.0%	2.5%	2.5%			
											Non-labour inflation				3.0%	3.0%	3.0%			
														Aftercare		1st Resi Rehab			Additional Resi Rehabs		1st Resi
Days in Period:	**31**	**31**	**30**	**31**	**30**	**31**	**31**	**28**	**31**	**30**	**31**	**30**	**365**	**Feb-June 2013-14 Total**	**July-Dec 2014-15 Total**	**Jan-June 2014-15 *Total**	**2015-16 Total**	**2016-17 Total**	**2015-16 Total**	**2016-17 Total**	**Jan-June 2014-15 *0.1 Psych**
	July	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**									
Managerial and Clerical	*1,125*	*1,125*	*1,089*	*1,125*	*1,089*	*1,125*	*1,125*	*1,016*	*1,125*	*1,089*	*1,125*	*1,089*				*6,571*	*13,581*	*13,921*	*13,581*	*13,921*	
Medical	*1,875*	*1,875*	*1,815*	*1,875*	*1,815*	*1,875*	*1,875*	*1,694*	*1,875*	*1,815*	*1,875*	*1,815*			*11,131*	*10,949*	*22,632*	*23,198*	*22,632*	*23,198*	*10,949*
Nursing	-	-	-	-	-	-	-	-	-	-	-	-				-	-	-	-	-	
Operational	-	-	-	-	-	-	-	-	-	-	-	-				-	-	-	-	-	
Professional	*48,224*	*48,224*	*46,668*	*48,224*	*46,668*	*48,224*	*48,224*	*43,557*	*48,224*	*46,668*	*48,224*	*46,668*				*281,565*	*581,992*	*596,542*	*581,992*	*596,542*	
Health Practitioners	*8,747*	*8,747*	*8,465*	*8,747*	*8,465*	*8,747*	*8,747*	*7,900*	*8,747*	*8,465*	*8,747*	*8,465*				*51,070*	*105,561*	*108,200*	*105,561*	*108,200*	
Total Base	59,971	59,971	58,037	59,971	58,037	59,971	59,971	54,168	59,971	58,037	59,971	58,037			11,131	350,156	723,768	741,862	723,768	741,862	10,949
Super and work cover (on total base)	10,615	10,615	10,273	10,615	10,273	10,615	10,615	9,588	10,615	10,273	10,615	10,273			*1,970*	*61,978*	*128,107*	*131,310*	*128,107*	*131,310*	1,938
Other allowances	24,674	24,674	23,878	24,674	23,878	24,674	24,674	22,286	24,674	23,878	24,674	23,878			*21,596*	*144,065*	*297,781*	*305,225*	*297,781*	*305,225*	21,244
Total Labour	**95,260**	**95,260**	**92,188**	**95,260**	**92,188**	**95,260**	**95,260**	**86,042**	**95,260**	**92,188**	**95,260**	**92,188**			**34,697**	**556,198**	**1,149,655**	**1,178,397**	**1,149,655**	**1,178,397**	**34,132**
Drugs	-	-	-	-	-	-	-	-	-	-	-	-				-	-	-	-	-	
Clinical Supplies	-	-	-	-	-	-	-	-	-	-	-	-				-	-	-	-	-	
Staff Development	347	347	347	347	347	347	347	347	347	347	347	347				*2,143*	*4,414*	*4,547*	*4,414*	*4,547*	
Vehicle costs	1,494	1,494	1,494	1,494	1,494	1,494	1,494	1,494	1,494	1,494	1,494	1,494				*9,233*	*19,020*	*19,590*	*19,020*	*19,590*	
Fuel costs	300	300	300	300	300	300	300	300	300	300	300	300				*1,852*	*3,816*	*3,930*	*3,816*	*3,930*	
Vehicle maint costs	196	196	196	196	196	196	196	196	196	196	196	196				*1,210*	*2,493*	*2,568*	*2,493*	*2,568*	
Rent	4,136	4,136	4,136	4,136	4,136	4,136	4,136	4,136	4,136	4,136	4,136	4,136				*25,558*	*52,650*	*54,230*	*52,650*	*54,230*	
Utilities	535	535	535	535	535	535	535	535	535	535	535	535				*3,309*	*6,817*	*7,021*	*6,817*	*7,021*	
ICT costs	333	333	333	333	333	333	333	333	333	333	333	333				*2,060*	*4,244*	*4,371*	*4,244*	*4,371*	
Catering	1,752	1,752	1,752	1,752	1,752	1,752	1,752	1,752	1,752	1,752	1,752	1,752				*10,828*	*22,307*	*22,976*	*22,307*	*22,976*	
Linen	-	-	-	-	-	-	-	-	-	-	-	-				-	-	-	-	-	
Domestic Services	904	904	904	904	904	904	904	904	904	904	904	904				*5,584*	*11,504*	*11,849*	*11,504*	*11,849*	
Consumables	907	907	907	907	907	907	907	907	907	907	907	907				*5,603*	*11,542*	*11,888*	*11,542*	*11,888*	
Therapeutic Programs	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000				*12,357*	*25,456*	*26,220*	*25,456*	*26,220*	
Therapeutic Equipment	555	555	555	555	555	555	555	555	555	555	555	555				*3,428*	*7,061*	*7,273*	*7,061*	*7,273*	
R&M	594	594	594	594	594	594	594	594	594	594	594	594				*3,668*	*7,556*	*7,783*	*7,556*	*7,783*	
NGO overhead charges	11,764	11,764	11,384	11,764	11,384	11,764	11,764	10,626	11,764	11,384	11,764	11,384				*70,747*	*146,946*	*151,355*	*146,946*	*151,355*	
IT and FFE establishment							12,000									*12,360*	*12,731*	*13,113*	*12,731*	*13,113*	
Establishment costs														*77,611*					*82,338*		
Total Non-Labour	**25,815**	**25,815**	**25,435**	**25,815**	**25,435**	**25,815**	**37,815**	**24,676**	**25,815**	**25,435**	**25,815**	**25,435**				**169,942**	**338,557**	**348,714**	**420,895**	**348,714**	
TOTAL OPERATING COST	**121,075**	**121,075**	**117,623**	**121,075**	**117,623**	**121,075**	**133,075**	**110,718**	**121,075**	**117,623**	**121,075**	**117,623**		**592,767**	**652,885**	**726,140**	**1,488,212**	**1,527,111**	**1,570,550**	**1,527,111**	

Step Up Step Down Unit - Input Sheet

KPIs	Beds/Consumers	10	
	m2	1600	
	bed utilisation %	100	
Budget Phasing			
Days/year	July	31	
	August	31	
	September	30	
	October	31	
	November	30	
	December	31	
	January	31	
	February	28	
	March	30	
	April	31	
	May	31	
	June	30	
		365	0
On-costs		%	
	Super	12.75	
	Rec Leave loading	1.7	
	Long Service Leave levy	1.75	
	Work cover	1.5	
		17.7	

LABOUR COSTS

	Pay Level	Base salary	FTE	Salaries	All other allowances Option A,PD, MV etc	Penalties	IT Req	FFE Req
Managerial and Clerical								
Administration Officer	AO3	64952	1.04	67,225			1	1
				67,225				
Medical								
Registrar	L13	137517	0.61	84,298				
Psychiatrist	L23	180107	0.52	93,295	62291		1	1
				177,593				
Nursing								
Enrolled Nurse	NG3(4)	54073		-	0			
Registered Nurse	NG5(6)	76896	5.23	402,089	7843.5	74,936	1	1
Clinical Nurse	NG6(2)	80522		-	0			
Clinical Nurse	NG6(3)	82393		-	0			
Nurse Unit Manager	NG7(2)	104388	1.16	121,508	1746		1	1
				523,597				
Operational								
Operational staff	OO2(4)	49676		-				
				-				
Professional								
Community Support Worker	PO3(3)	81428	4.58	372,615		129,717		
				372,615				
Health Practitioners								
MH Therapist	HP3(5)	78672	1.04	81,426			1	1
Psychologist	HP3(5)	78672		-				
Social Worker	HP3(5)	78672		-				
Comm Supp Team Leader	HP4(3)	99504	1.04	102,987			1	1
MH Therapist	HP4(3)	99504	0.52	51,543				
Occupational Therapist	HP4(3)	99504	0.52	51,543				
Psychologist	HP4(3)	99504	1.04	102,987			1	1
Social Worker	HP4(3)	99504	1.04	102,987			1	1
Speech Pathologist	HP4(3)	99504		-				
				493,472				
				1,634,502	**71,881**	**204,654**		
Headcount			18.31				8	8

NON-LABOUR COSTS

Staff Development Training	annual cost per FTE	500		
Vehicle costs	lease cost/month	507		Qfleet Toyota Corolla Sedan
	No of vehicles	1		
Fuel costs	monthly cost/vehicle	300		
Vehicle running costs	monthly cost/vehicle	200		
Rent	annual cost per m2	450		based on commercial rent rate
Property service charge	% of rent	10		Includes gardening, external paint, maintenance, etc
Utilities	annual cost 10c/kw.	43200		270kw/annum/m2
ICT	annual cost per FTE	2500		
Catering	per bed day/consumer	14		
Linen	per bed day/consumer	4.19		
Domestic Services	monthly cost	2000		
Consumables and Staff amenities	monthly cost	408.33		used oncology day ward 12-13 actuals as benchmark 15 patients/day + 11 staff
Therapeutic programs	per consumer per month	100		
Therapeutic equipment	per consumer per month	100		
Drugs	per bed day/consumer	28.3		
Clinical Supplies	per bed day/consumer	17		
Repairs and Maintenance	annual % of fit out	2.5%		

ESTABLISHMENT COSTS (YR 1 ONLY)

ICT	per applicable ee	2600	20800	
FFE	per applicable ee	1400	11200	32000
Fitout	cost per m2	1500		
R&M	annual % of build	2.5%		
Construction	cost per m2	3200		

Step Up Step Down Unit - Roster

Demand	7 days per week & 24 hours per day
	10 beds stand alone
Indicators	LOS 28 day maximum

24 hr Roster Construct

			Mon	Tues	Wed	Thur	Fri	Sat	Sun	Total Hrs	Total FTE
AM											
	Registered Nurse	NO Gr5	8.0	8.0	8.0	8.0	8.0	8.0	8.0	56.00	1.47
	Community Support Workers	PO3	8.0	8.0	8.0	8.0	8.0	8.0	8.0	56.00	1.47
		Total	**16.0**	**16.0**	**16.0**	**16.0**	**16.0**	**16.0**	**16.0**	**112.00**	**2.95**
			Mon	**Tues**	**Wed**	**Thur**	**Fri**	**Sat**	**Sun**	**Total Hrs**	**Total FTE**
PM	Registered Nurse	NO Gr5	6.0	6.0	6.0	6.0	6.0	6.0	6.0	42.00	1.11
	Community Support Workers	PO3	6.0	6.0	6.0	6.0	6.0	6.0	6.0	42.00	1.11
		Total	**12.0**	**12.0**	**12.0**	**12.0**	**12.0**	**12.0**	**12.0**	**84.00**	**2.21**
			Mon	**Tues**	**Wed**	**Thur**	**Fri**	**Sat**	**Sun**	**Total Hrs**	**Total FTE**
Night	Registered Nurse	NO Gr5	10.0	10.0	10.0	10.0	10.0	10.0	10.0	70.00	1.84
	Community Support Workers	PO3	10.0	10.0	10.0	10.0	10.0	10.0	10.0	70.00	1.84
		Total	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**	**140.00**	**3.68**
		Daily Total	**48.0**	**48.0**	**48.0**	**48.0**	**48.0**	**48.0**	**48.0**	**336.00**	**8.84**

Other roster construct

	Title	**Grade**	**Mon**	**Tues**	**Wed**	**Thur**	**Fri**	**Sat**	**Sun**	**Total Hrs**	**Total FTE**	
		OO2								0.00	0.00	-
	Administration	AO3	7.6	7.6	7.6	7.6	7.6			38.00	1.00	1.00
	Psychologist	HP4	7.6	7.6	7.6	7.6	7.6			38.00	1.00	
	Social Worker	HP4	7.6	7.6	7.6	7.6	7.6			38.00	1.00	
	OT	HP4	5.0	5.0	5.0	4.0				19.00	0.50	
	Mental Health Therapist	HP4	5.0	5.0	5.0	4.0				19.00	0.50	
	Community Support Team Leader	HP4	7.6	7.6	7.6	7.6	7.6			38.00	1.00	
	Mental Health Therapist	HP3	7.6	7.6	7.6	7.6	7.6			38.00	1.00	5.00
	CNC	NO7	7.6	7.6	7.6	7.6	7.6			38.00	1.00	1.00
	Psychiatrist	MO	6.0	6.0		7.0				19.00	0.50	
	Registrar	MO	7.5	7.5		7.5				22.50	0.59	1.09
		Total	**69.1**	**69.1**	**55.6**	**68.1**	**45.6**	**0.0**	**0.0**	**307.50**	**8.09**	

FTE Allocations **16.93**

Level	Productive FTE	Sick Leave (3.5%)	Professional Development Leave	Organisational Education	Mandatory Training (Award Entitlement)	Recreational Leave (Award Entitlement)		
OO2	0.0	0.00						0.00
AO3	1.0	0.04						1.04
PO3	4.4	0.15						4.58
Psychologist	1.0	0.04						1.04
Social Worker	1.0	0.04						1.04
OT	0.5	0.02						0.52
Mental Health Therapist	0.5	0.02						0.52
Community Support Tea	1.0	0.04						1.04
HP3	1.0	0.04						1.04
NO7 CNC	1.0	0.04	0.01		0.02	0.10	5 wk	1.16
NO5 RN	4.4	0.15	0.05		0.09	0.51	6wk	5.23
MO - con	0.5	0.02						0.52
MO - reg	0.6	0.02						0.61
Total FTE	**16.93**	**0.6**	**0.1**	**0.00**		**0.6**		**18.31**
Productive FTE					**17.6**	**17.6**		
Funded FTE								
Employable FTE								

Step Up Step Down Unit Budget 2014-17													Labour inflation	0.0%	0.0%	2.5%	2.5%	2.5%	2.5%
													Non-labour inflation	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
																		1	2
														1st SUSDU				1 x SUSDU	2 x SUSDU
Days in Period:	**31**	**31**	**30**	**31**	**30**	**31**	**31**	**28**	**30**	**31**	**31**	**30**		**365**					
	July	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**		**Jan-June 2014-15 Total**	**Full Year 2014-15 Total**	**2015-16 Total**	**2016-17 Total**	**2015-16 Total**	**2016-17 Total**
Managerial and Clerical	*5,710*	*5,710*	*5,525*	*5,710*	*5,525*	*5,710*	*5,710*	*5,157*	*5,525*	*5,710*	*5,710*	*5,525*		*33,336*	*67,225*	*68,906*	*70,629*	*68,906*	*141,257.20*
Medical	*15,083*	*15,083*	*14,597*	*15,083*	*14,597*	*15,083*	*15,083*	*13,624*	*14,597*	*15,083*	*15,083*	*14,597*		*88,067*	*177,593*	*182,033*	*186,584*	*182,033*	*373,168*
Nursing	*44,470*	*44,470*	*43,035*	*44,470*	*43,035*	*44,470*	*44,470*	*40,166*	*43,035*	*44,470*	*44,470*	*43,035*		*259,647*	*523,597*	*536,687*	*550,104*	*536,687*	*1,100,208*
Operational	-	-	-	-	-	-	-	-	-	-	-	-		-	-	-	-	-	-
Professional	*31,647*	*31,647*	*30,626*	*31,647*	*30,626*	*31,647*	*31,647*	*28,584*	*30,626*	*31,647*	*31,647*	*30,626*		*184,776*	*372,615*	*381,930*	*391,478*	*381,930*	*782,956*
Health Practitioners	*41,911.29*	*41,911*	*40,559*	*41,911*	*40,559*	*41,911*	*41,911*	*37,855*	*40,559*	*41,911*	*41,911*	*40,559*		*244,708*	*493,472*	*505,808*	*518,454*	*505,808*	*1,036,907*
Total Base	138,821	138,821	134,343	138,821	134,343	138,821	138,821	125,386	134,343	138,821	138,821	134,343		810,534	1,634,502	1,675,364	1,717,248	1,675,364	3,434,496
Super and work cover (on total base)	24,571	24,571	23,779	24,571	23,779	24,571	24,571	22,193	23,779	24,571	24,571	23,779		*143,464*	*289,307*	*296,539*	*303,953*	*296,539*	*607,906*
Other allowances	23,486	23,486	22,729	23,486	22,729	23,486	23,486	21,214	22,729	23,486	23,486	22,729		*137,131*	*276,534*	*283,448*	*290,534*	*283,448*	*581,068*
Total Labour	**186,878**	**186,878**	**180,850**	**186,878**	**180,850**	**186,878**	**186,878**	**168,793**	**180,850**	**186,878**	**186,878**	**180,850**		**1,091,129**	**2,200,343**	**2,255,351**	**2,311,735**	**2,255,351**	**4,623,470**
Drugs	8,773	8,773	8,490	8,773	8,490	8,773	8,773	7,924	8,490	8,773	8,773	8,490		*52,760*	*106,394*	*109,586*	*112,873*	*109,586*	*225,746*
Clinical Supplies	5,270	5,270	5,100	5,270	5,100	5,270	5,270	4,760	5,100	5,270	5,270	5,100		*31,693*	*63,912*	*65,829*	*67,804*	*65,829*	*135,607*
Staff Development	763	763	763	763	763	763	763	763	763	763	763	763		*4,715*	*9,430*	*9,713*	*10,004*	*9,713*	*20,009*
Vehicle costs	507	507	507	507	507	507	507	507	507	507	507	507		*3,133*	*6,267*	*6,455*	*6,648*	*6,455*	*13,296*
Fuel costs	300	300	300	300	300	300	300	300	300	300	300	300		*1,854*	*3,708*	*3,819*	*3,934*	*3,819*	*7,868*
Vehicle maint costs	200	200	200	200	200	200	200	200	200	200	200	200		*1,236*	*2,472*	*2,546*	*2,623*	*2,546*	*5,245*
Rent	61,151	61,151	59,178	61,151	59,178	61,151	61,151	55,233	59,178	61,151	61,151	59,178		*367,752*	*741,600*	*763,848*	*786,763*	*763,848*	*1,573,527*
Property service charges	6,115	6,115	5,918	6,115	5,918	6,115	6,115	5,523	5,918	6,115	6,115	5,918		*36,775*	*74,160*	*76,385*	*78,676*	*76,385*	*157,353*
Utilities	3,600	3,600	3,600	3,600	3,600	3,600	3,600	3,600	3,600	3,600	3,600	3,600		*22,248*	*44,496*	*45,831*	*47,206*	*45,831*	*94,412*
ICT costs	1,667	1,667	1,667	1,667	1,667	1,667	1,667	1,667	1,667	1,667	1,667	1,667		*10,300*	*20,600*	*21,218*	*21,855*	*21,218*	*43,709*
Catering	4,340	4,340	4,200	4,340	4,200	4,340	4,340	3,920	4,200	4,340	4,340	4,200		*26,100*	*52,633*	*54,212*	*55,838*	*54,212*	*111,677*
Linen	1,299	1,299	1,257	1,299	1,257	1,299	1,299	1,173	1,257	1,299	1,299	1,257		*7,811*	*15,752*	*16,225*	*16,712*	*16,225*	*33,423*
Domestic Services	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000		*12,360*	*24,720*	*25,462*	*26,225*	*25,462*	*52,451*
Consumables	408	408	408	408	408	408	408	408	408	408	408	408		*2,523*	*5,047*	*5,198*	*5,354*	*5,198*	*10,709*
Therapeutic programs	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000		*6,180*	*12,360*	*12,731*	*13,113*	*12,731*	*26,225*
Therapeutic equipment	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000		*6,180*	*12,360*	*12,731*	*13,113*	*12,731*	*26,225*
R&M	5,150	5,150	5,150	5,150	5,150	5,150	5,150	5,150	5,150	5,150	5,150	5,150		*31,827*	*63,654*	*65,564*	*67,531*	*65,564*	*135,061*
ICT & FFE establishment							32,000							*32,960*	*32,960*	*33,949*		*33,949*	*34,967*
Total Non-Labour	**103,543**	**103,543**	**100,738**	**103,543**	**100,738**	**103,543**	**135,543**	**95,128**	**100,738**	**103,543**	**103,543**	**100,738**		**658,409**	**1,292,524**	**1,331,300**	**1,336,272**	**1,331,300**	**2,707,511**
TOTAL OPERATING COST	**290,421**	**290,421**	**281,588**	**290,421**	**281,588**	**290,421**	**322,421**	**263,922**	**281,588**	**290,421**	**290,421**	**281,588**		**1,749,538**	**3,492,867**	**3,586,651**	**3,648,007**	**3,586,651**	**7,330,981**

Statewide Subacute Beds - Input Sheet

KPIs	Beds/Consumers	4						
	Utilisation	80						
	m2	100						
Budget Phasing								
Days/year	July	31						
	August	31						
	September	30						
	October	31						
	November	30						
	December	31						
	January	31						
	February	28						
	March	31						
	April	30						
	May	31						
	June	30						
		365	0					
On-costs		%						
	Super	12.75						
	Rec Leave loading	1.7						
	Long Service Leave Levy	1.75						
	Work cover	1.5						
		17.7						
LABOUR COSTS								
	Pay Level	Base salary	FTE	Salaries	All other allowances	Penalties	IT Req	FFE Req
Managerial and Clerical					Option A,PD, MV etc			
Administration Officer	AO3-4	64952	0.20	13,250			1	1
				13,250				
Medical								
Registrar	L13	137517	0.41	56,519	1,500			
Psychiatrist	L23	180107	0.20	36,742	24,532			
				93,261				
Nursing								
Enrolled Nurse	NG3(4)	54073	1.74	94,087	2,610			
Registered Nurse	NG5(6)	76896	1.74	133,799	2,610	58,684	1	1
Clinical Nurse	NG6(2)	80522		-	-			
Clinical Nurse	NG6(3)	82393	1.71	140,892	2,565		1	1
Nurse Unit Manager	NG7(2)	104388		-	-			
				368,778				
Operational								
Rec Officer	OO2(4)	49676	2.23	110,777		46,880		
				110,777				
Professional								
Community Support Worker	PO3(3)	81428		-				
				-				
Health Practitioners								
MH Therapist	HP3(5)	78672		-				
Psychologist	HP3(5)	78672		-				
Social Worker	HP3(5)	78672		-				
Comm Supp Team Leader	HP4(3)	99504		-				
MH Therapist	HP4(3)	99504		-				
Occupational Therapist	HP4(3)	99504	0.20	20,299				
Psychologist	HP4(3)	99504	0.20	20,299				
Social Worker	HP4(3)	99504	0.20	20,299				
Speech Pathologist	HP4(3)	99504	0.20	20,299				
				81,195				
				667,262	**33,817**	**105,564**		
Headcount			9.06				3	3
NON-LABOUR COSTS								
Staff Development	annual cost per FTE	500						
Vehicle costs	lease cost/month							
	No of vehicles							
Fuel costs	monthly cost/vehicle							
Vehicle running costs	monthly cost/vehicle							
Rent	annual cost per m2							
Property service charge	% of rent							
Utilities	annual cost 10c/kw.							
ICT	annual cost per FTE	2500						
Catering	per bed day/consumer							
Linen	per bed day/consumer							
Domestic Services	monthly cost							
Consumables and Staff amenities	monthly cost							
Therapeutic programs	per consumer per month	100						
Therapeutic equipment	per consumer per month	100						
Drugs	per bed day/consumer	28.3						
Clinical Supplies	per bed day/consumer							
Repairs and Maintenance	monthly cost	2.5%						
ESTABLISHMENT COSTS (YR 1 ONLY)								
ICT	per applicable ee	2600	7800					
FFE	per applicable ee	1400	4200	12000				
Fitout	cost per m2	0						

Statewide Subacute Beds - Roster

Demand	7 days, 24 hours per day, 75% occupancy
	4 beds co-located within adolescent unit
Indicators	LOS up to 120 days

24 hr Roster Construct

			Mon	Tues	Wed	Thur	Fri	Sat	Sun	Total Hrs	Total FTE	
AM	Clinical Nurse	NO Gr6	8.0	8.0	8.0	8.0	8.0	8.0	8.0	56.00	1.47	1.5
	Registered Nurse	NO Gr5								0.00	0.00	
	Rec Officer	OO / HP	2.0	2.0	2.0	2.0	2.0	8.0	8.0	26.00	0.68	
		Total	**10.0**	**10.0**	**10.0**	**10.0**	**10.0**	**16.0**	**16.0**	**82.00**	**2.16**	
			Mon	**Tues**	**Wed**	**Thur**	**Fri**	**Sat**	**Sun**	**Total Hrs**	**Total FTE**	
PM	Registered Nurse	NO Gr5	8.0	8.0	8.0	8.0	8.0	8.0	8.0	56.00	1.47	
	Rec Officer	OO / HP	8.0	8.0	8.0	8.0	8.0	8.0	8.0	56.00	1.47	2.2
		Total	**16.0**	**16.0**	**16.0**	**16.0**	**16.0**	**16.0**	**16.0**	**112.00**	**2.95**	
			Mon	**Tues**	**Wed**	**Thur**	**Fri**	**Sat**	**Sun**	**Total Hrs**	**Total FTE**	
Night	Enrolled Nurse	NO Gr3	8.0	8.0	8.0	8.0	8.0	8.0	8.0	56.00	1.47	2.9
		Total	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**56.00**	**1.47**	
		Daily Total	**34.0**	**34.0**	**34.0**	**34.0**	**34.0**	**40.0**	**40.0**	**250.00**	**6.58**	

Other roster construct

Title	**Grade**	**Mon**	**Tues**	**Wed**	**Thur**	**Fri**	**Sat**	**Sun**	**Total Hrs**	**Total FTE**	
	OO2								0.00	0.00	0.0
Administration	AO3	4.0		3.5					7.50	0.20	0.2
Psychologist	HP4	4.0		3.5					7.50	0.20	
Social Worker	HP4	4.0		3.5					7.50	0.20	
OT	HP4	4.0		3.5					7.50	0.20	
Speech Pathology	HP4	4.0		3.5					7.50	0.20	0.8
CNC	NO7								0.00	0.00	0.0
Psychiatrist	MO	4.0		3.5					7.50	0.20	
Registrar	MO	4.0	3.5	4.0	3.6				15.10	0.40	0.6
	Total	**28.0**	**3.5**	**25.0**	**3.6**	**0.0**	**0.0**	**0.0**	**60.10**	**1.58**	

FTE Allocations **8.16**

Level	Productive FTE	Sick Leave (3.5%)	Professional Development Leave	Organisational Education	Mandatory Training (Award Entitlement)	Recreational Leave (Award Entitlement)		
OO / HP	2.2	0.08						2.23
AO3	0.1974	0.0069						0.20
Psychologist	0.1974	0.01						0.20
Social Worker	0.2	0.01						0.20
OT	0.2	0.01						0.20
Speech Pathology	0.2	0.01						0.20
NO7 CNC	0.0	0.00	0.00		0.00	0.00	5 wk	0.00
NO6 CN	1.5	0.05	0.02		0.03	0.14	5wk	1.71
NO5 RN	1.5	0.05	0.02		0.03	0.17	6wk	1.74
NO3 EN	1.5	0.05	0.02		0.03	0.17		1.74
MO - con	0.2	0.01						0.20
MO - reg	0.4	0.01						0.41
Total FTE	**8.2**	**0.3**	**0.05**	**0.00**		**0.5**		**9.07**
Productive FTE					**8.5**	**8.7**		
Funded FTE								
Employable FTE								

Statewide Subacute Beds
Budget 2014-17

											Labour inflation		0.0%	2.5%	2.5%
											Non-labour inflation		3.0%	3.0%	3.0%
Days in Period:	**31**	**31**	**30**	**31**	**30**	**31**	**31**	**28**	**31**	**30**	**31**	**30**	**365**		
													Nov-June 2014-15	**2015-16**	**2016-17**
	July	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**	**Total**	**Total**	**Total**
Managerial and Clerical	*1,125.36*	*1,125*	*1,089*	*1,125*	*1,089*	*1,125*	*1,125*	*1,016*	*1,125*	*1,089*	*1,125*	*1,089*	*8,785*	*13,581*	*13,921*
Medical	*7,921*	*7,921*	*7,665*	*7,921*	*7,665*	*7,921*	*7,921*	*7,154*	*7,921*	*7,665*	*7,921*	*7,665*	*61,834*	*95,593*	*97,983*
Nursing	*31,321*	*31,321*	*30,311*	*31,321*	*30,311*	*31,321*	*31,321*	*28,290*	*31,321*	*30,311*	*31,321*	*30,311*	*244,505*	*377,998*	*387,447*
Operational	*9,408.50*	*9,408*	*9,105*	*9,408*	*9,105*	*9,408*	*9,408*	*8,498*	*9,408*	*9,105*	*9,408*	*9,105*	*73,447*	*113,547*	*116,386*
Professional	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Health Practitioners	*6,896*	*6,896*	*6,674*	*6,896*	*6,674*	*6,896*	*6,896*	*6,229*	*6,896*	*6,674*	*6,896*	*6,674*	*53,834*	*83,225*	*85,306*
Total Base	56,672	56,672	54,843	56,672	54,843	56,672	56,672	51,187	56,672	54,843	56,672	54,843	442,404	683,944	701,043
Super and work cover (on total base)	10,031	10,031	9,707	10,031	9,707	10,031	10,031	9,060	10,031	9,707	10,031	9,707	*78,306*	*121,058*	*124,085*
Other allowances	11,838	11,838	11,456	11,838	11,456	11,838	11,838	10,692	11,838	11,456	11,838	11,456	*92,411*	*142,865*	*146,437*
													-		
Total Labour	**78,540**	**78,540**	**76,007**	**78,540**	**76,007**	**78,540**	**78,540**	**70,940**	**78,540**	**76,007**	**78,540**	**76,007**	**613,121**	**947,867**	**971,564**
Drugs	2,807	2,807	2,717	2,807	2,717	2,807	2,807	2,536	2,807	2,717	2,807	2,717	*21,916*	*35,067*	*36,119*
Clinical Supplies	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Staff Development	377	377	377	377	377	377	377	377	377	377	377	377	*3,018*	*4,803*	*4,947*
Vehicle costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Fuel costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Vehicle maint costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Rent	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Property service charge	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Utilities	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
ICT costs	625	625	625	625	625	625	625	625	625	625	625	625	*5,000*	*7,957*	*8,195*
Catering	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Linen	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Domestic Services	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Consumables	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Therapeutic Programs	400	400	400	400	400	400	400	400	400	400	400	400	*3,200*	*5,092*	*5,245*
Therapeutic Equipment	400	400	400	400	400	400	400	400	400	400	400	400	*3,200*	*5,092*	*5,245*
R&M	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
IT and FFE establishment							12,000						*12,000*		
Total Non-Labour	**4,610**	**4,610**	**4,519**	**4,610**	**4,519**	**4,610**	**16,610**	**4,338**	**4,610**	**4,519**	**4,610**	**4,519**	**48,334**	**58,012**	**59,752**
TOTAL OPERATING COST	**83,150**	**83,150**	**80,526**	**83,150**	**80,526**	**83,150**	**95,150**	**75,278**	**83,150**	**80,526**	**83,150**	**80,526**	**661,455**	**1,005,880**	**1,031,317**