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EXHIBIT 1523

From: Michelle Fryer
Sent: 24 Apr 2013 16:09:54 +1000
To: Kevin Rodgers;Amelia Callaghan;Leanne Geppert;Vaoita Turituri;James Scott;Josie Sorban;Emma Hart;David Hartman;Trevor Sadler;Amanda Tilse;Philip Hazell;
Cc: Emma Foreman
Subject: preamble.
Attachments: v3_Preamble_23.04.13 MF.doc

Dear Leanne and all,

Given the discussion this morning I've added some thoughts to the preamble document. Still rather rough I'm afraid, but I thought I'd send this round anyway as may be helpful.

Regards
Michelle

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 per day, seven days per 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 a new unit is due to open in Townsville in May/June 2013. A statewide specialist multidisciplinary assessment and integrated treatment and rehabilitation program is currently delivered by The Barrett Adolescent Centre (BAC) located at The Park Centre for Mental Health (TPCMH) for adolescents between 13 and 17 years of age with severe, persistent mental illness.

The current policy context and direction for mental health services is 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 is that young people are treated in the least restrictive environment possible, which recognises the need for safety and cultural sensitivity, and the minimum possible disruption to their family, educational, social and community networks

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 on the site at TPCMH. Further to this, the current BAC building has been identified as needing substantial refurbishment. This situation necessitates careful consideration of alternative options for the provision of mental health services to adolescents (and their families) requiring extended treatment and rehabilitation in Queensland.

Accordingly, contemporary evidence-based models of care including additional day programs and alternatives provided by community-based mental health services have been considered by an Expert Clinical Reference Group (ECRG). The ECRG have relied on evidence and data from the field, national and international benchmark service provision, clinical expertise and experience, and consumer and carer feedback to develop a service model elements document for Adolescent Extended

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Treatment and Rehabilitation Services in Queensland. It is essential to note that the final service model elements document produced was cognisant of constraints associated with funding and other resources. For example, there is no capital funding available to relocate the BAC to another site. It is also important to note that this service model elements document *is not a model of service*. A funding and implementation plan will be required.

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 expert group would like to acknowledge and highlight the importance of the input of the consumer and carer representatives. They highlighted the essential role that BAC played in recovery and rehabilitation, the skill and expertise that was provided. There was validation of the skills and expertise of community care and acute units; whilst acknowledging these services, and other community agencies such as mainstream education, were not able to meet the needs of the young person. The care and rehabilitation these young people received from BAC is considered life-saving.

The service model elements document has been proposed by the ECRG as a way forward for adolescent extended treatment and rehabilitation services in Queensland. The contents of the document were endorsed by a process of majority vote within the ECRG, with an overall goal for unanimous support. There are some key messages from the ECRG that need to underpin the reading of the document:

1. Tier 3 essential
2. Interim while Tier 3 being established is associated with risk
3. Duration of treatment
4. Education resource essential – on site school
5. Broader consultation essential next step
6. Residential Service – important for governance to be with CYMHS, capacity and capability requires further consideration
7. Equitable access to AETRS for all adolescents and families is high priority – need to enhance service provision in North Qld (and regional areas)
8. Formal planning processes need to guide all service growth – acknowledge National Mental Health Service Planning Framework

MF Comments:
5./8.: *IMO this should come first.* This is a concept document, a lot of work will be required to move from this to a model of service and implementation plan. Formal planning including further consultation with stakeholder groups will be required. Also note, in this concept proposal tier 2 maps to CSCF 5 and tier 3 to CSCF 6; which is one component that will guide further planning.

1./2.: Absence of tier 3 will result in a small but significant proportion of young people who require highly intensive specialist residential care for their mental health needs not being able to access an appropriate service. This group are characterised by severity of illness, very limited or absent community supports and engagement and significant risk to self and/or others.

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Managing such young people in acute in-patient units does not meet their clinical, therapeutic and especially their rehabilitation needs and is associated with risks for them of institutionalisation if they have extended admissions. Managing them in the community is associated with the difficulty of managing their risks to self and others and also their risk of disengaging from therapeutic services. In addition, there is consensus from clinical experience that prolonged admissions of such young people can have an adverse impact on other young people having admissions through the acute units.

Dissipation and loss of skills and expertise of staff, especially if tier 3 not replaced in timely manner. This includes both the clinical staff and the education staff at BAC.

Transitioning current BAC patients to ??

3. Duration of treatment – 12 months has been given as a guide, but depends on the presence of effective step-down services and a suitable community residence for the young person. It is important to note that the range of admission duration will be very broad, with some young people requiring 2 years of intervention. As feedback from a consumer identifies, establishing trust and therapeutic alliance, which is essential to a positive prognosis, can take months. As with all clinical care, duration of care is determined by clinical indicators and consultation with the young person and their guardian.

4. Education Services: Rehabilitation requires intervention to return to normal developmental trajectory, and successful outcomes are measured in psychosocial functioning not just absence of psychiatric symptoms. Education is an essential part of the life of young people. It is vital that young people are able to access effective education services that understand and can accommodate for their mental health needs throughout the continuum of care. For in-patient units, both acute and rehabilitation, on-site access to schooling including suitable qualified educators, is considered essential. For young people requiring extended treatment, normal education systems are not able to meet their needs and education is often a core part of the intervention required to achieve a positive prognosis.

? band 7 school

? multi-site, statewide education service for children in adolescent units

6. Experience of some of the group with residential services provided for children in state care, identified some difficulties that are commonly found:

- Relatively low skilled, low paid, albeit often highly motivated, workers
- High staff turn-over
- Very limited access for staff for support (such as supervision) and professional development.
- Poor engagement in collaborative practice; disengagement from specialist services such as CYMHS, sometimes when concerns are raised.

It is considered vital that QH?/CYMHS? (need further consultation and planning on how this is best achieved, e.g. state-wide vs district) maintain effective governance over the proposed units so that they are appropriately staffed and supported to be able to meet the needs of the young people in their care.

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