Discussion Paper No. 4D: CHQ HHS Statewide Adolescent Mental Health Extended Treatment Initiative (AMHETI) — Draft Summary of Service Elements & Models of Service (Age Range needs to be clearly identified)

Service Element	Assertive Mobile Youth Outreach Service (AMYOS) (new)	Mental Health Day Program (MHDP) (expanded)	Youth Residential Rehabilitation Unit (Youth Resi) (new)	Step-Up / Step-Down Unit (SUSDU) (proposed)	Statewide Subacute Beds (SSB) (QH classifies as new, but amended is more accurate)	Adolescent Acute Inpatient Units[1] (existing) (Not an extended treatment and rehabilitation service element)
ECRG Tier[2]	• Tier 2a[3]	• Tier 2a confirmed	• Tier 2b confirmed	• Tier 2b Confirmed as 2b	• Tier 3[4]	• Tier: 3
Clinical Services Capability Framework (CSCF) Level and Category[5]	• *Level*: (6 • *Service sub-section:* Ambulatory services	• *Level*: 5 confirmed • *Service sub-section:* Ambulatory services	• *Level*: Nil • • *Clinical services are provided by Community CYMHS or other mental health services – a Youth Resi does not provide clinical services and therefore is not categorised according to the CSCF.*	• *Level*: • *Service sub-section*: Non-Acute Inpatient Service — subject to QH service mapping[6] • Highest level for non-acute is Level 5; however, CHQ advised MHAODB that a Level 6 classification is required to accurately reflect the level of this service.	• *Level*: 6 • *Service sub-section*: (IDENTIFY)Acute Inpatient	• *Level*: 6 at LCCH • *Service sub-section*: (IDENTIFY) Acute Inpatient • Need to confirm whether level 5 or 6 for other inpatient units at RBWH, Robina, Logan, Toowoomba, Townsville
National Mental Health Service Planning Framework (NMHSPF) service[7]	• *Stream*: Primary and specialised clinical ambulatory • *Category*: Intensive community treatment service • *Element*: 2.1.5.1 Intensive community treatment team — child and adolescent	• *Stream:* Primary and specialised clinical ambulatory • *Category*: Day program • *Element*: 2.1.6.1 Day program team — child and adolescent	• **Combination of Elements –** Individual Support and Rehabilitation Services + a non-acute residential in the community (the NMHSPF does not allow for adolescent/youth services under the non-acute service element) •	• *Stream*: Specialised bed-based • *Category*: Sub-acute (Residential and hospital or nursing home based) • *Element*: 2.3.2.1 Step Up/Step Down — Youth (Residential)	• • 2.3.2.5 Sub-acute intensive care service (hospital) •	• • *Category*: Acute inpatient (hospital) • *Element*: 2.3.1.2 Acute — Child and youth
Gazetted Mental Health facility	• Not gazetted. Confirmed	• Gazetted • Some clients may be subject to community treatment orders of forensic orders.	• Not gazetted • Young people on a community treatment order may be voluntarily admitted • Young people on a forensic order may be voluntarily admitted if assessed as safe for other residents.[8]	• Not gazetted • Young people on a community treatment order may be voluntarily admitted.[9]	• Gazetted • Seclusion room.	• Gazetted • Seclusion room.
Features	– "Assertive" treatment (CLARIFY) Clinicians actively (i.e. assertively) reach out to engage young people within the community rather than the young person having to come into a clinic. • Intensive mobile interventions • Multidisciplinary teams • Emphasis on: – Recovery – Rehabilitation – Community integration • Joint care planning and case management with other government and non-government services.[10] • Community or residential based settings.[11] • Do the AMYOS teams also provide crisis intervention? (CLARIFY) AMYOS teams will provide advice, support and appropriate treatment for open clients who present in crisis.	• Flexible intensive treatment • Rehabilitation-oriented • Multidisciplinary teams • Emphasis on: – working with families, carers, peers and community support people – integration with education or vocation programs • Time-limited • Interventions delivered in the least restrictive environment.[12]	• Extended rehabilitation service • Not a clinical service – the extended treatment component is provided separately by Child and Youth Mental Health (CYMHS) case managers (or sometimes AMYOS case managers)[13] • Subacute residential (bed-based) facility • Emphasis on: – building daily living skills to support transition to independent living – education or employment • Suitable for low-moderate acuity, but with complex psychosocial needs. • Provider agnostic (meaning the service can be delivered by an NGO or Queensland Health) • Planned admissions.	• Intensive therapeutic support for up to 3 months (CONFIRM max. LOS) Support is 1 month + 1 month + 1 month if clinically indicated. • Subacute residential (bed-based) facility • Delivered by Hospital and Health Service (HHS) in partnership with NGOs — mix of Queensland Health and NGO staff • Initially designed to accept referrals from across a clinical cluster. The planned SUSDU for Cairns HHS has deviated from this model.[14] (CONFIRM) What is stated is that there is "some potential" to accept patients from adjoining HHSs, i.e. Cape and Torres. • Clinically staffed by Queensland Health 7am–11pm; overnight by NGO mental health workers. () The SUSDU provides a 24 hour service,	• Four "swing" beds located in the Lady Cilento Children's Hospital (LCCH) adolescent acute inpatient unit for use by subacute patients as needed. They are "swing" beds because they can alternate between different types of care. • Statewide service — referrals managed by State-wide sub-acute bed referral panel (chaired by CHQ) • Allows for involuntary detention • Access to LCCH onsite schooling and day program. • May include both planned and unplanned admissions? (CONFIRM) All admissions are triaged through the Statewide Subacute Bed Referral Panel; consequently, it would be very rare to have an unplanned admission.	• Short to medium term 24 hour inpatient assessment and treatment services i.e. short-term targeted treatment programs[15] • Focus on providing a safe, containing and low stimulus environment in which to rapidly stabilise an adolescent's symptoms and reduce their level of acuity before discharge to continued community-based treatment. An acute admission may also be needed for diagnostic clarification and review of psychopharmacology.[16] • Focus on "immediate acute symptom reduction, providing safety and containment, diagnostic clarification and review of psychopharmacology if appropriate".[17] • Generally unplanned "crisis" admissions, but may include planned

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Service Element	Assertive Mobile Youth Outreach Service (AMYOS) (new)	Mental Health Day Program (MHDP) (expanded)	Youth Residential Rehabilitation Unit (Youth Resi) (new)	Step-Up / Step-Down Unit (SUSDU) (proposed)	Statewide Subacute Beds (SSB) (QH classifies as new, but amended is more accurate)	Adolescent Acute Inpatient Units[1] (existing) (Not an extended treatment and rehabilitation service element)
				which requires community care staff to be continuous shift workers. Nurses on the unit will be present between the hours of 8:00 am and 10:00 pm. The model of nursing care will be a combination of case management and patient allocation. The skill mix and patient complexity is taken into consideration when allocating nursing staff. The patient will be informed of their focal nurse for each shift.		admissions (including regular planned admissions).
Age range	• 13 and up to 18 years (flexible)[18]	• 13 and up to 18 years (flexible)[19]	• 16–21 years • Exception: a 15 year old was admitted, but did not complete program.[20]	• 16–21 years (CONFIRM) • CHQ developed a model for 13-18yo; Cairns HHS has subsequently locally adapted the model for 16-21yo	• 13 and up to 18 years (flexible)	• 13 and up to 18 years (flexible) – most units • 0–17 years (Gold Coast unit), but most patients are adolescents (CONFIRM) Confirmed • LCCH has separate child unit
Service aims	• Provide ongoing: – Recovery-oriented assessment – Assertive treatment (CLARIFY) and care Clinicians actively (i.e. assertively) reach out to engage young people within the community rather than the young person having to come into a clinic. – Management of crisis situations. • Done by: – Intensive, developmentally-appropriate mobile interventions delivered in the community or residential setting. • For young people with: – Complex mental health needs – High risk and difficult to engage. • In order to: – Reduce the need for inpatient bed-based care.[21,22]	• Provide ongoing: – Diagnostic assessment and treatment – Recovery and discharge planning – Rehabilitation options to maximise recovery. • Done by: – Targeted treatment interventions delivered in the least restrictive environment – Supporting young person in achieving their recovery goals. • For young people with: – Complex health needs. • In order to: – Reduce the severity of mental health symptoms – Provide an alternative to acute hospital admission – Promote effective participation in schooling, social functioning.[23]	• Provide ongoing: – Support to young people • Done by: – Enhancing their social and daily living skills – Decreasing self-harming behaviour – Improving their capacity to manage and be responsible for self-care • For young people who: – Are aged between 16 and 21 years of age. – Present with severe or complex mental health problems. – Continue to receive mental health care provided by an external source to the Youth Resi. – Are a willing/voluntary participant. – Are likely to benefit from an extended treatment and rehabilitation model of care in a residential facility within the community. • In order to: – Develop and maintain links with the community, family, social networks, education and vocational opportunities. – Improve young people's ability to live independently in the community.[24]	• Step up (prevent unnecessary inpatient admissions): – "prevent further deterioration of a person's mental state and associated disability…to reduce the likelihood of an acute inpatient admission" – early intervention alternative for those at increased risk of further deterioration or relapse. • Step down (early discharge option): – no longer needing acute-level intervention, but need further stabilisation and recovery before returning to the community – strengthen and consolidate gains made as acute inpatient – minimise trauma and disruption of acute episode for consumers and carers. • Respite: (CONFIRM role as respite) – "lessen the possible difficulties and stresses experienced by families and carers in supporting consumers who are acutely unwell and receiving community treatment."[25] The young person is acutely unwell and it is not safe for them to remain at home. This model allows the young person to "step up" to this unit. It does not constitute "respite". –	• Enable 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. • Organise ongoing care in these complex and chronic clinical presentations, requiring extensive collaboration and coordination that is beyond the scope and time available to acute inpatient units.	• Provide: – Multidisciplinary and intensive specialist assessment, particularly where there are difficulties with diagnosis – Review and adjustment of psychopharmacological treatments in a safe environment under clinical observation • Done by: – HOW Multi-disciplinary team under the clinical guidance of a child and adolescent psychiatrist • For young people who are: – Experiencing severe or acute episodes of mental illness • In order to: – Reduce emotional distress (acuity) and stabilise symptoms before discharged to community-based treatment – Promote functional and/or independent living within the community.[26]

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Primary referral / Referral pathway	• Child and Youth Mental Health Services (CYMHS) • Via a designated referral process.[27,28]	• Child and Youth Mental Health Services (CYMHS) • Via a designated referral process.[29]	• Child and Youth Mental Health Services (CYMHS) or Adult Mental Health Services • Via a multidisciplinary panel (includes CYMHS and NGO service provider).	• *Step up*: from Community Child and Youth Mental Health Services (CCYMHS), enrolment in day program, other less-restrictive CYMHS services, admission to nearest hospital for rural and remote locations[30] • *Step down*: from acute inpatient unit[31] • Via a designated referral process – Hospital and Health Service (HHS)-chaired assessment panel including representatives from the SUSDU and other local CYMHS services, and at least one CYMHS consultant psychiatry representative.[32]	• Statewide Admission Panel	• Community CYMHS • Department of Emergency Medicine • Hospital inpatient services • Private psychiatrists • Other specialist services • Via a designated intake process.
Client profile	• Difficult to engage[33] or have previously not engaged with mental health services (e.g. mainstream clinic-based CCYMHS)[34,35] OR • Exhibit high risk behaviour or risk of deterioration[36] • Increased risk of suicide and other adverse or life-threatening events (as a consequence of no previous engagement).[37]	• Require additional support due to difficulties engaging in mainstream services, including schooling • Severe and complex mental health issues • In a living environment supportive enough to ensure safety and facilitate attendance on a daily basis.[38]	• Must be a client of a local/cluster Child and Youth Mental Health Services (CYMHS) or Adult Mental Health Service. • Severe and complex mental health issues.[39]	• Require higher intensity of treatment and care to reduce symptoms and/or distress that cannot be adequately provided for in the community. • Meets criteria for admission to a mental health service inpatient unit, but level of risk can be safely supported in a less restrictive environment than an acute inpatient unit.	• Severe or complex symptoms of mental illness and associated with significant disturbance in behaviour precluding treatment in a less restrictive environment safely. • Improvement in mental health not expected to occur within short term; measured in weeks/months. • Requires therapeutic milieu not provided by an acute inpatient unit.	• Young people experiencing "severe episodes of mental illness, who cannot be adequately treated in a less restrictive environment."[40] • Young people with "acute episodes of mental illness" with the "episodes characterised by a recent onset of severe clinical symptoms that have the potential to result in prolonged functional impairment or emotional distress, or risk to self and/or others.[41]
Primary diagnostic profile	• Young people with: – Psychosis – Mood disorder – Anxiety disorder – Complex trauma – Deficits in psychosocial functioning – Marked social avoidance – Severely disorganised behaviour characterised by impaired impulse control – Substance misuse – Emerging personality vulnerabilities – Complex disruptive behavioural disorders – Difficulties managing activities of daily living – Chronic family dysfunction.[42]	• Young people with: – Early psychosis – Extreme anxiety – Chronic depression – Eating disorders – Post-Traumatic – Stress Disorder (PTSD) – Comorbid developmental disorders linked to school refusal and social exclusion.[43]	• Young people with: – Psychotic illness – Severe mood disorder, or – Complex trauma with severe deficits in psychosocial functioning.	• Young people with: – Psychotic illness – Severe mood disorder – Complex trauma with severe deficits in psychosocial functioning[44] – Depression – Anxiety – Adjustment attachment – Eating disorders – Developmental disorders.[45]	• Young people with: – Schizophrenia or other psychotic illness – Severe mood disorder, or – Complex trauma with severe deficits in psychosocial functioning.	• Young people with: – Severe behavioural, emotional or stress-related illnesses – Depression/mood illnesses – Psychotic illnesses – Eating disorders – Autistic spectrum illnesses – Post-Traumatic Stress Disorder (PTSD) – Disruptive illnesses. – Comorbid developmental problems such as cognitive, learning and language difficulties. – Chronic family dysfunction.[46]
Service exclusions	• Do not present with severe and complex mental health problems.[47]	• Substance-dependent • Assessed as being at an unacceptably high risk to self or others.	• • Require admission to an acute inpatient mental health unit. • Are considered to be at high risk of suicide. • Are actively engaging in threatening, aggressive, destructive, or antisocial behaviours.	• Secure forensic patients. • Level of acuity or risk too high to be safely managed.	• Young people who can be treated in a less restrictive environment. • "It is not anticipated that young people with a primary diagnosis of an eating disorder will be accepted into the SSB."[48] At the current drafting of the model (it is a work in progress), this is still the case.	• Secure forensic beds not offered.[49]

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			• Primarily need support with substance misuse issues. The Youth Resi does not have the capacity to manage withdrawal/detoxification or to support young people who continue to actively use substances of dependence. • Their primary problem to be addressed is accommodation. •			
Hours of operation	• Operate during business hours • Flexible with capacity for extended hours.	• Operate during business hours (Monday to Friday) • Flexibility to accommodate extracurricular and recreational activities.	• Residential: 24/7 including 2 staff overnight (one awake shift and one sleep-over shift). • Extended treatment (CYMHS)÷ Generally business hours, with capacity for extended hours to meet particular needs.	• 24/7 including 2 Queensland Health nursing staff for two of the three daily shifts (up to 10pm), with NGO staffing the overnight shift. CLARIFY minimum requirements for NGO to staff overnight shift. Model still being finalised.	• 24/7	• 24/7
Length of stay and frequency of activity	• Determined on a case by case basis.	• 120 days average stay (one school term), with maximum stay 180 days (two school terms) • 5 supervised hours per day (up to 25 hours per week); this includes 2 hours individual therapy and 3 hours group therapy (per day).	• Up to 365 days • Up to 3 months ongoing outreach service post exit (flexible) • Weekly group activities.	• Generally up to 28 days Support is 1 month + 1 month + 1 month if clinically indicated.	• 120 days; maximum of 180 days.	• 14 days.[50] • Most recent public data indicates an average LOS of 11.5 days.[51]
Unit size	• 16–20 adolescents per team at any one time.	• 10–15 adolescents per day, per program.	• Nominally up to 5beds. • Greenslopes and Cairns units each have 5 beds. • The two Townsville units will have 4 beds each.	• Up to 10 beds per SUSDU • Initial unit in Cairns to have X beds (CLARIFY). Seek input from Cairns HHS	• 4 “swing” beds.	• Varies – see “Locations”.
Key service functions	• Collaborative, system-based care • Treat mental illness, reduce emotional distress and promote function within the community • Mental health interventions and ongoing assessment • Risk assessment, crisis/safety planning and management, and rehabilitation and support to recover from mental illness • Co-ordinate and establish collaborative links with other community service providers • Facilitate and support the safe transition to more functional or independent living.”[52] (CONFIRM with Final version of Model of Service)	• Multidisciplinary and collaborative consultation • Diagnostic assessment • Treatment • Evidence-informed interventions (including recovery and discharge planning • Therapeutic, educational/vocational interventions and comprehensive activities (CONFIRM with Final version of Model of Service and Service Agreement)	• Mental health clinician in-reach. • Case management by the relevant CYMHS (health practitioner or nursing officer) or AMYOS case manager.[53] • Residential staff facilitate Life Skills Programs five days per week, including recovery support.	• All adolescents to have a designated consultant psychiatrist. • Access to multidisciplinary team during business hours on weekdays. Clinical care is primarily provided at the Unit (in-reach). • Acute mental health or medical assessment requires transport to most appropriate hospital.	•	(CONFIRM with Final version of Model of Service and Service Agreement)
Interventions	• Behavioural and psychotherapeutic (individual and group based) • Family interventions (psychoeducation and family therapy) • Pharmacological (administration, supervision and education).	• Behavioural and psychotherapeutic (individual and group based) • Family interventions (psychoeducation and family therapy) • Pharmacological (administration, supervision and education).	• Clinical interventions are managed by CYMHS or Adult Mental Health Service case workers. • Residential interventions target psychosocial rehabilitation through: – daily living skills – engagement in education and/or employment	• Behavioural and psychotherapeutic (individual and group based) • Family interventions (short-term intervention and psychoeducation, and referral to follow-up therapy)[54,55] • Pharmacological (administration, supervision and education)	• 3–6 month individualised treatment program. • IDENTIFY range of interventions and how these would differ to an acute admission. Model of Service still under development.	

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			– family interventions, including family therapy where appropriate – pharmacological supervision and education – distress management when needed – re-engagement with community of origin.	• Multidisciplinary case review, including a consultant psychiatrist or appropriate medical delegate, at least weekly[56] • Psychosocial rehabilitation including personal care, daily living skills, parenting (if relevant), community access, and social skills.[57]		
Educational and vocational options	• Support local schooling • Facilitate transition to other appropriate services[58]	• Access to on-campus schooling; or "in-reach" schooling (provided by Dept of Education Outreach Support Officers); Distance Education and/or support local schooling • School linked to the MHDP has primary responsibility for school reintegration and/or vocational options.	• Residential staff support residents to engage or re-engage with schooling, other educational options and/or employment within 4 weeks of entry (although there needs to be flexibility for individual circumstances).	• "In-reach" educational support, e.g. tutoring by Department of Education and Training (DET) Outreach Support Officers providing on-site support, or distance education.[59] • Structured group and educational timetable, "predominantly activity based, targeting areas of psychological and developmental need"[60]	• On-site and/or Distance Education	
Staffing profile and case load (including recommended and actual profile) • *This section still needs a lot of work. The AMHETI business case outlines recommended staffing based on the National Mental Health Services Planning Framework.* • *We are still investigating actual staffing.* • *In some cases (e.g. AMYOS) the specific allocation of particular staffing disciplines is at the discretion of the relevant HHS.*	• Typical caseload: – No more than 10 clients per case manager at any one time (CONFIRM if n=8).[61] Confirmed – 2 staff (minimum) per team. • Recommended funding per team (Business Case): – 2 x 1.0 FTE clinicians (NG7 or HP4) – 1 x 0.2 FTE Psychiatrist (4.0 x FTE to cover all AMYOS teams) – 0.5 x 1.0 FTE psychologist – 1 x 1.0 FTE administration officer • Actual funding per team (Service Agreement): – 2 x 1.0 FTE Clinical Nurse and/or Health Practitioner (ideally mental health nursing, psychology, social work or other specialist CYMHS multi-disciplinary staff) – 1 x 0.2 FTE Child and Adolescent Psychiatrist • In practice: – **CHQ**: • Admin Officer (1.0 FTE) • 4 x 1.0 FTE Clinicians (NG7/HP4) • Psychiatrist (1.0 FTE) • Team Leader (1.0 FTE) Per team in each **HHS**: • 2 x 1.0 FTE Clinicians (NG7/ HP4) • Psychiatrist (0.2 FTE) It was acknowledged that in some HHSs, they would have a limited	• Typical caseload: – 15 clients per team – 1 clinician per 5 clients in group work • Recommended funding per team (Business Case): – Psychiatrist (0.5 FTE) – Registrar (0.5 FTE) – Nursing (1.0 FTE) – Psychologist (2.0 FTE) – Social Worker (1.0 FTE) – Occupational Therapist (1.0 FTE) – Other CYMHS therapists (speech pathology, music, art etc.) (1.0 FTE) – Administration Officer (1.0 FTE) – Operational Officer (1.0 FTE) • Actual funding per team (Service Agreement) – No Service Agreement for this service • In practice: – Psychiatrist (0.5 FTE) – Registrar (0.5 FTE) – Nursing (1.0 FTE) – Team Leader (1.0 FTE) – Psychologist (1.0 FTE) – Social Worker (1.0 FTE) – Occupational Therapist (1.0 FTE) – Other CYMHS therapists (speech pathology, music, art) (0.9 FTE) – Administration Officer (1.0 FTE)	• Flexible staffing arrangements. • Staffed 24/7 at a ratio of 2 staff for 5 residents across all shifts. • Qld Health does not mandate minimum qualifications and experience for staff. This is at the discretion of the NGO. • The only Queensland Health requirement is for two staff per shift. • Aftercare staffing per residential (Greenslopes and Cairns): – 1 x Team Leader who must be tertiary qualified in psychology, allied health or nursing and an experienced youth mental health worker (currently social worker and community engagement officer) – 2 x senior support workers who must be tertiary qualified allied health professionals (currently social workers, psychologists, nurses and special education teacher) – Adolescent support workers who must be at least vocationally qualified in mental health and youth support work (currently most ASWs are tertiary qualified in social work, special education, psychology, teaching or nursing). • Funding for case managers to be absorbed by local CYMHS.	• Proportion of disciplines at each SUSDU to be determined by local HHS • Every SUSDU to have: – a designated team leader – a consultant psychiatrist • Clinical staff (preferably led by a nurse) may include doctors, nurses, allied health staff, and music and art therapists. • Non-clinical staff may include ATSI mental health workers, community care staff and Department of Education Training (DET) staff. • All support staff must have completed, or be currently be enrolled in, a certificate 4 in mental health, as a minimum qualification. • All staff to have attended non-violent crisis intervention training. • Recommended per 10-bed unit (Business Case): – 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 pathology, music, art etc.) (1.5 FTE) – Community Support Worker (4.6 FTE) – Community Support Team Leader (1.0 FTE)	• 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	• Nursing staff rostered to cover shifts 24 hours, 7 days a week. • On call child and adolescent psychiatrist (with Registrar support) available 24 hours, 7 days a week. • Recommended staffing profile per 12 bed unit: – Psychiatrist 1.0 FTE (0.08 FTE/bed) – Registrar 1.65 FTE (0.14 FTE/bed) – Junior Medical Officer 0.5 FTE (0.04 FTE/bed) – Total Nursing 23.0 FTE (1.9 FTE/bed) – Psychologist 1.0 FTE (0.08 FTE/bed) – Social Worker 1.0 FTE (0.08 FTE/bed) – Other CYMHS therapists 1.0 FTE (0.08 FTE/bed) – Other specialist CYMHS staff 1.0 FTE (0.08 FTE/bed).[62] –

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	applicant pool and consequently have been given flexibility on the disciplines appointed to these roles, provided they meet the mandatory criteria in the role descriptions developed.			– Administration Officer (1.0 FTE).		
Service provider	• Queensland Health	• Queensland Health	• NGO • "Provider agnostic" (meaning the service can be delivered by an NGO or Queensland Health)	• Technically provider agnostic (meaning the service can be delivered by an NGO or Queensland Health) • In practice, a mixed model: Clinically staffed by Queensland Health, in partnership with an NGO providing support staff.	• Queensland Health — Children's Health Queensland.	• Queensland Health — relevant Hospital and Health Service.
Governance	• Children's Health Queensland (CHQ) • Local Hospital and Health Service (HHS), where the Community CYMHS is located: – Provides oversight of some AMYOS via eCYMHS. Statewide governance provided by CHQ (holds funds and develops clinicians in AMYOS network)	• Children's Health Queensland (CHQ) • Local Hospital and Health Service (HHS) where the MHDP is located.	• Children's Health Queensland (CHQ) • Local Hospital and Health Service (HHS) where the Community CYMHS is located: – Provides clinical governance for each consumer. • Statewide governance panel (CHQ, HHS and NGOs): – Provides strategic and operational governance – CHQ holds operational funds.	• Local Hospital and Health Service (HHS) • Teams to operate under direction of Local HHS Clinical Director, Clinical Staff Team Leader (preferably a nurse) and SUSDU Support Staff Team Leader. • Oversight by Children's Health Queensland (CHQ) HHS as intended to be a service that crosses HHS boundaries.	• TBC	• Local Hospital and Health Service (HHS)
Location — General	• Mobile teams working from local CYMHS – delivery at residences and/or in community settings • Regional and Rural AMYOS may be supported by eCYMHS.	• Hospital campus or in a gazetted community mental health facility that has access to educational services onsite or with capacity for Dept of Education in-reach.	• Community-based. • Case managers based in local CYMHS (or local AMYOS)[63] • Residential staff based at Youth Resi.	• Residential area close to an acute adolescent inpatient unit. •		• Hospital campus
Locations pre-AMHETI (and Barrett Adolescent Centre closure)	• Nil	• Mater • Toowoomba • Townsville • BAC (CONFIRM: not included in Queensland Health version of AMHETI service mapping.[64] Confirmed	Nil	Nil	• Nil (CONFIRM: according to QH)[65] • BAC (15 beds; 13-18 years)	• Mater (12 beds; 0–17 years) • Royal Brisbane and Women's Hospital (RBWH) 12 beds (14–17 years) • Logan (10 beds; 13–17 years) • Gold Coast (8 beds; 0–17 years) • Toowoomba (8 beds; 13–17 years) • Child and Family Therapy Unit (CFTU) of Children's Health Queensland (10 beds; 0–13 years). • Total = 50 beds available to adolescents (excludes CFTU) Confirmed
Locations proposed in AMHETI business case and Discussion paper	• North Brisbane (x 2) • South Brisbane (x 2) • Gold Coast • Logan • West Moreton • Toowoomba • Redcliffe/Caboolture • Sunshine Coast • Wide Bay • Mackay • Townsville	• Mater • Toowoomba • Townsville • North Brisbane (critical) • South Brisbane (Logan) • Gold Coast.	Cluster-based: • North — Cairns x 1 (until SUSDU operational) and Townsville x 2. These locations were not identified in the AMHETI Business Case – intended on 1 Youth Resi in Townsville • Central — north Brisbane (in or around Caboolture[67]) • Southern — south Brisbane (Greenslopes)	Cluster-based. One SUSDU proposed for each of the three mental health clinical clusters (exact locations were not identified in the AMHETI Business Case): • North — • Central — • Southern —	• One statewide SSB "unit" within CHQ HHS catchment (Brisbane). • Qld Health subacute beds discussion paper canvassing whether this model should be included at all.	• AMHETI out of scope, but Cairns (2 mental health beds proposed, in new adolescent unit TO CONFIRM)

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Service Element	Assertive Mobile Youth Outreach Service (AMYOS) (new)	Mental Health Day Program (MHDP) (expanded)	Youth Residential Rehabilitation Unit (Youth Resi) (new)	Step-Up / Step-Down Unit (SUSDU) (proposed)	Statewide Subacute Beds (SSB) (QH classifies as new, but amended is more accurate)	Adolescent Acute Inpatient Units[1] (existing) (Not an extended treatment and rehabilitation service element)
	• Central Queensland (Rockhampton) • • 0.5 teams in South West, Central West, North West, and Cape York					
Current locations (as at February 2016)	*Since July 2014* • North Brisbane • South Brisbane • Redcliffe/Caboolture *Since December 2014* • Toowoomba • Townsville *Since May 2015* • Logan *Since October 2015* • Rockhampton • Cairns (1 clinician yet to be recruited) *Since November 2015* • Gold Coast[68] •	• Brisbane South (LCCH) • Brisbane North (since January 2015) — currently at old Royal Children's Hospital site – to relocate to Chermside by mid-2016[69] • Toowoomba • Townsville.	• Brisbane (Greenslopes) – 5 beds • Cairns — 5 beds (converted from Time Out House Initiative service) • Townsville x 2 — 4 beds each from early 2016.	• Nil • Planning underway to establish the first SUSDU in Cairns by end of 2016–17.[70] CONFIRM DATE	• 4 x "swing" beds within the adolescent acute inpatient unit at the Lady Cilento Children's Hospital. • CLARIFY how: a) subacute patients are managed differently within the acute unit and b) the therapeutic milieu is different when there may be only one or two subacute patients).	• Lady Cilento Children's Hospital (9 beds for 0–13 years Confirmed; 11 beds for 14–17 years — includes 4 swing beds for subacute use) • Royal Brisbane and Women's Hospital Adolescent Mental Health Inpatient Unit (12 beds; 14–17 years) • Logan (10 beds; 13–17 years) • Gold Coast (Robina) (8 beds; 0–17 years). (Exploring an acute unit for 18–25 year olds) • Toowoomba (8 beds; 13–17 years) • Townsville (8 beds; 12–17 years) (opened 20 Jan 2014). • Total = 57 beds available to adolescents (excludes LCCH CMHU) Confirmed
Service informed by (as described by Queensland Health)	• Victorian Intensive Mobile Youth Outreach Services (IMYOS) • Queensland (Adult) Mobile Intensive Team • Wraparound system of care.	• Queensland's existing day programs (endorsed statewide model of service) • Queensland Adolescent Drug and Alcohol Withdrawal Service (ADAWS).[71]	• Time Out House Initiative (TOHI), Cairns • Therapeutic Residentials (Child Safety) • Victorian Youth Residential Models (Nous Group Report).	• Victorian Youth Prevention and Recovery Care Service (Y-PARC) model (particularly Frankston and Dandenong services).	• New South Wales Walker Unit, Concorde Hospital • Note that the Walker Unit is not the same model.[72]	
Evidence base (as described by Queensland Health)[73]	• Evaluation of the Victorian IMYOS mode suggested: – Decreased risk of harm to self and others – Increased number and length of inpatient admissions – Increased client engagement and sustained.	• (IDENTIFY)	• **NB:** Y-PARC is a different model of service to the Youth Residential. This service is modelled on the Victorian Youth Residential Service.	• Victorian Y-PARC model, particularly Frankston and Dandenong services.	• To be informed by the CHQ HHS discussion paper on the sub-acute bed model	
Key Performance Indicators (as per Service Agreement)	• "Monthly activity reporting including, providing of services (face to face, telephone, etc.), and third party provision of service • Rate of preadmission community contact • End of episode discharge summary recorded within 48 hours • Rate of 1-7 day post discharge community contact • Twenty eight day mental health readmission rate • Number of unplanned hospital/DEM [Department of Emergency Medicine] presentations • Number of unplanned discharges from CYMHS service."[74]	• The Day Program is not under a service agreement – this unit is a part of local HHS operations.	• Max length of stay is 365 days. • 100% of residents: – Have individualised transition-in plans and activity schedule – Remain engaged with mental health treatment. – "Learning or earning" within 4 weeks of entry. – Engaged in prosocial peer group outside of service provider at time of exit. • Life skills program is undertaken by residential staff each at the Premises 5 days per week. • Three monthly outcome measures for each resident.	• (IDENTIFY)	• (IDENTIFY)	• (IDENTIFY)

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Service Element	Assertive Mobile Youth Outreach Service (AMYOS) (new)	Mental Health Day Program (MHDP) (expanded)	Youth Residential Rehabilitation Unit (Youth Resi) (new)	Step-Up / Step-Down Unit (SUSDU) (proposed)	Statewide Subacute Beds (SSB) (QH classifies as new, but amended is more accurate)	Adolescent Acute Inpatient Units[1] (existing) (Not an extended treatment and rehabilitation service element)
			• Staff meet all accreditation standards and requirements that relate to delivery of services			
Additional areas to clarify (other than highlighted text throughout table)	• INSERT • INSERT	• INSERT • INSERT	• INSERT • INSERT	• INSERT • INSERT	• Very low usage to date (six referrals but only two admissions). CLARIFY reasons. One consumer declined the service and another was more clinically suitable for AMYOS. The two most recent referrals have been assessed; their primary diagnosis was one of an eating disorder and therefore not recommended for subacute admission by the Statewide Referral Panel (Feb 2016). • LCCH day program used by one patient of the two patients as part of treatment.	• INSERT • INSERT
Underpinned by Community CYMHS (Tier 1) — out of scope for AMHETI						

[1] Acute inpatient units fall outside the definition of mental health extended treatment and rehabilitation services. They have been included in this summary table because they are a crucial element of the continuum of mental health services for adolescents.
[2] Relevant Tier according to the Queensland Health Expert Clinical Reference Group (ECRG). The ECRG proposed four tiers of service provision — Tiers 1, 2a, 2b and 3. No witness has yet been able to identify the classification system on the ECRG based its recommendations.
[3] Presentation by Dr Stephen Stathis to the MHAODB Leadership Forum on 29 April 2014, [WMS.0011.0001.02810]
[4] Presentation by Dr Stephen Stathis to the MHAODB Leadership Forum on 29 April 2014, [WMS.0011.0001.02810]
[5] Relevant CSCF level according to the Queensland Health Clinical Services Capability Framework version 3.1. Exhibit ZI of Affidavit of Ingrid Adamson, 24 November 2015. [IAD.900.001.0001], pages 3041–3170. CSCF level refers to the minimum capability requirements for a particular service by capability level. A description of the CSCF is available on the Queensland Health website: <https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/service-delivery/cscf/default.asp>.
[6] Page 81 of draft model of service (October 2015), Adolescent Step Up Step Down Unit, Exhibit D of Affidavit of Stephen Stathis, 15 January 2016. [DSS.001.002.001]. A note at page 81 of the draft MOSD indicates that the CSCF level will be "reviewed and clarified following service mapping".
[7] Exhibit ZI, Affidavit of Ingrid Adamson, 24 November 2015. [IAD.900.001.0001]. In particular, extracts from the *Draft National Mental Health Services Planning Framework* (NMHSPF), pages 4301–4332. The NMHSPF aims to provide a tool "that can be adapted for use within each Australian jurisdiction that will provide transparency and consistency across all jurisdictions for estimating the need and demand for mental health services — across the continuum of care from prevention and early intervention to the most intensive treatment" (p 10, Version 1.03, January 2012 of the NMHSPF project charter). See also Affidavit of Judith Krause, 19 January 2016, pages 16–17, para 12. [JKR.900.002.0001].
[8] Preliminary interview with Myfanwy Pitcher, 27 January 2016 [statement forthcoming].
[9] Exhibit D ('Step Up Step Down Draft Model of Service'), Supplementary Statement of Stephen Stathis, 15 January 2016, p 80, [DSS.001.002.001].
[10] Services may include other Queensland Health Services (such as Alcohol, Tobacco and Other Drug Services (ATODS), Child and Youth Forensic Outreach Service (CYFOS); other Commonwealth and state government services (such as, Medicare Locals, police, education, child safety, housing, youth justice); and non-government service providers (such as General Practitioners, Headspace).
[11] Children's Health Queensland Hospital and Health Service, July 2014, *Business Case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation Model of Care* (Appendix 3, p 39). [QHD.002.003.1447].
[12] Children's Health Queensland Hospital and Health Service, July 2014, *Business Case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation Model of Care* (Appendix 3, p 39). [QHD.002.003.1447].
[13] Preliminary interview with Myfanwy Pitcher, 27 January 2016 [statement forthcoming].
[14] Affidavit of Judith Krause, 4 February 2016, p 29, para Q.63(c), [JKR.900.003.0001] — *"Modifications were made to suit Cairns Hospital and Health Service and at the direction of MHAODB. For example the age range was modified to be from 16 - 21 and the defined catchment area was not extended to the Northern Cluster but confined more to the Cairns Hospital and Health Service area with some potential to admit from adjoining regions."*
[15] Exhibit ZJ, Affidavit of Ingrid Adamson, 24 November 2015. [IAD.900.001.0001]. In particular, *Model of Service for an Acute Adolescent Inpatient Unit* (draft) (p 5912).
[16] Cotgrove, A 2014, 'Inpatient services', in McDougall T and Cotgrove A (eds), *Specialist mental healthcare for children and adolescents: hospital, intensive community and home based services*, Routledge, London, pp 34–53; Royal College of Psychiatrists (RCP) 2013, *Building and sustaining specialist CAMHS to improve outcomes for young children: update guidance on workforce, capacity and functions of CAMHS in the UK*, College Report CR182, RCP, London; Statement of Judith Krause, 19 January 2016, p 22, para 16(d)(i). [JKR.900.002.0001].
[17] Affidavit of Judith Krause, 19 January 2016, p 22, para 16(d)(i). [JKR.900.002.0001].
[18] Exhibit ZJ, Affidavit of Ingrid Adamson, 24 November 2015. [IAD.900.001.0001]. In particular, *Assertive Mobile Youth Outreach Service Model of Service* (as repeated at pages 6180, 6365, 6550, 6707, 6867, 7081 and 7173).
[19] Exhibit ZJ, Affidavit of Ingrid Adamson, 24 November 2015. [IAD.900.001.0001]. In particular, *Model of Service for a Mental Health Day Program* (draft) (p 7217).

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[20] Preliminary interview with Myfanwy Pitcher, 27 January 2016 [statement forthcoming].
[21] Exhibit ZJ, Affidavit of Ingrid Adamson, 24 November 2015. [IAD.900.001.0001]. In particular, *Service Agreement Part B – Agreement Schedules, 1. Background 1.2* for: Gold Coast Hospital and Health Service (p 6309); Metro North Hospital and Health Service (p 6467); Metro South Hospital and Health Service (p 6650); Darling Downs Hospital and Health Service (p 6812); Townsville Hospital and Health Service (p 6972); Cairns Hinterland and Hospital and Health Service (p 7113); Central Queensland Hospital and Health Service (p 7205).
[22] Exhibit ZJ, Statement of Ingrid Adamson, 24 November 2015. [IAD.900.001.0001]. In particular, *Service Agreement Part B – Agreement Schedules, 1. Background 1.3* for: Gold Coast Hospital and Health Service (p 6309); Metro North Hospital and Health Service (p 6467); Metro South Hospital and Health Service (p 6650); Darling Downs Hospital and Health Service (p 6812); Townsville Hospital and Health Service (p 6972); Cairns Hinterland and Hospital and Health Service (p 7113); Central Queensland Hospital and Health Service (p 7205).
[23] Exhibit ZJ, Affidavit of Ingrid Adamson, 24 November 2015. [IAD.900.001.0001]. In particular, *Model of Service for a Mental Health Day Program* (draft) (p 7217).
[24] Children's Health Queensland Hospital and Health Service, July 2014, *Business Case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation Model of Care* (Appendix 3, p 47). [QHD.002.003.1447].
[25] Pages 80 and 83 of draft model of service (October 2015), Adolescent Step Up Step Down Unit, Exhibit D of Affidavit of Stephen Stathis, 15 January 2016, [DSS.001.002.001].
[26] Exhibit ZJ, Affidavit of Ingrid Adamson, 24 November 2015. [IAD.900.001.0001]. In particular, *Model of Service for an Acute Adolescent Inpatient Unit* (draft) (p 5912).
[27] Exhibit ZJ, Affidavit of Ingrid Adamson, 24 November 2015. [IAD.900.001.0001]. In particular, *Assertive Mobile Youth Outreach Service Model of Service* (as repeated at pages 6180, 6365, 6550, 6707, 6867, 7081 and 7173).
[28] Exhibit ZJ, Affidavit of Ingrid Adamson, 24 November 2015. [IAD.900.001.0001]. In particular, *Assertive Mobile Youth Outreach Service Model of Service* (as repeated at pages 6180, 6365, 6550, 6707, 6867, 7081 and 7173).
[29] Exhibit ZJ, Affidavit of Ingrid Adamson, 24 November 2015. [IAD.900.001.0001]. In particular, *Model of Service for a Mental Health Day Program* (draft) (p 7217).
[30] Exhibit D ('Step Up Step Down Draft Model of Service'), Affidavit of Stephen Stathis, 15 January 2016. [DSS.001.002.001].
[31] Section 4.2.6 of Exhibit D ('Step Up Step Down Draft Model of Service'), Affidavit of Stephen Stathis, 15 January 2016, [DSS.001.002.001].
[32] Section 4.2.1 of Exhibit D ('Step Up Step Down Draft Model of Service'), Affidavit of Stephen Stathis, 15 January 2016. [DSS.001.002.001].
[33] Appendix 3: Detailed Service Elements – Model of Service for Assertive Mobile Youth Outreach Service (draft) (IAS.900.001.8354; IAS.900.001.8451; IAS.900.001.5995).
[34] Exhibit ZJ, Affidavit of Ingrid Adamson, 24 November 2015. [IAD.900.001.0001]. In particular, *Service Agreement Part B – Agreement Schedules, 1. Background 1.4* for: Gold Coast Hospital and Health Service (p 6309); Metro North Hospital and Health Service (p 6467); Metro South Hospital and Health Service (p 6650); Darling Downs Hospital and Health Service (p 6812); Townsville Hospital and Health Service (p 6972); Cairns Hinterland and Hospital and Health Service (p 7113); Central Queensland Hospital and Health Service (p 7205).
[35] Draft Assertive Mobile Youth Outreach Service (AMYOS) Model of Service (MSS.003.004.3656) and Appendix 3: Detailed Service Elements – Model of Service for Assertive Mobile Youth Outreach Service (draft) (IAS.900.001.8354; IAS.900.001.8451; IAS.900.001.5995).
[36] Appendix 3: Detailed Service Elements – Model of Service for Assertive Mobile Youth Outreach Service (draft) (IAS.900.001.8354; IAS.900.001.8451; IAS.900.001.5995).
[37] Exhibit ZJ, Statement of Ingrid Adamson, 24 November 2015. [IAD.900.001.0001]. In particular, *Service Agreement Part B – Agreement Schedules, 1. Background 1.4* for: Gold Coast Hospital and Health Service (p 6309); Metro North Hospital and Health Service (p 6467); Metro South Hospital and Health Service (p 6650); Darling Downs Hospital and Health Service (p 6812); Townsville Hospital and Health Service (p 6972); Cairns Hinterland and Hospital and Health Service (p 7113); Central Queensland Hospital and Health Service (p 7205).
[38] Draft Mental Health Day Program (MHDP) Model of Service (IAD.900.001.1545).
[39] Preliminary interview with Myfanwy Pitcher, 27 January 2016 [statement forthcoming].
[40] Exhibit ZJ, Affidavit of Ingrid Adamson, 24 November 2015. [IAD.900.001.0001]. In particular, *Model of Service for an Acute Adolescent Inpatient Unit* (draft) (p 5912).
[41] Exhibit ZJ, Affidavit of Ingrid Adamson, 24 November 2015. [IAD.900.001.0001]. In particular, *Model of Service for an Acute Adolescent Inpatient Unit* (draft) (p 5913).
[42] Draft Assertive Mobile Youth Outreach Service (AMYOS) Model of Service (MSS.003.004.3656) and Appendix 3: Detailed Service Elements – Model of Service for Assertive Mobile Youth Outreach Service (draft) (IAS.900.001.8354; IAS.900.001.8451; IAS.900.001.5995).
[43] Draft Mental Health Day Program (MHDP) Model of Service (IAD.900.001.1545).
[44] Children's Health Queensland Hospital and Health Service, July 2014, *Business Case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation Model of Care.* [QHD.002.003.1447].
[45] Page 6 of Exhibit D ('Step Up Step Down Draft Model of Service'), Affidavit of Stephen Stathis, 15 January 2016, [DSS.001.002.001].
[46] Exhibit ZJ, Statement of Ingrid Adamson, 24 November 2015. [IAD.900.001.0001]. In particular, *Model of Service for an Acute Adolescent Inpatient Unit* (draft) (p 5912).
[47] Appendix 3: Detailed Service Elements – Model of Service for Assertive Mobile Youth Outreach Service (draft) [IAS.900.001.8354; IAS.900.001.8451; IAS.900.001.5995].
[48] Exhibit ZJ, Affidavit of Ingrid Adamson, 24 November 2015. [IAD.900.001.0001]. In particular, *Model of Service for Statewide Subacute Beds* (draft) (p 8488).
[49] Exhibit ZJ, Affidavit of Ingrid Adamson, 24 November 2015. [IAD.900.001.0001]. In particular, *Model of Service for an Acute Adolescent Inpatient Unit* (draft) (p 5915).
[50] Exhibit ZJ, Affidavit of Ingrid Adamson, 24 November 2015. [IAD.900.001.0001]. In particular, *Model of Service for an Acute Adolescent Inpatient Unit* (draft) (p 5915).
[51] Productivity Commission 2015, *Report on Government services*, Volume E (Health), Chapter 12A (Mental health management), Table 12A.60 Average length of stay, public hospitals acute units, by target population (no. of days).
[52] Assertive Mobile Youth Outreach Service (AMYOS) Model of Service (IAS.900.001.6180; IAS.900.001.6365; IAS.900.001.66550; IAS.900.001.6707; IAS.900.001.6867; IAS.900.001.7081; IAS.900.001.7173).
[53] Preliminary interview with Myfanwy Pitcher, 27 January 2016 [statement forthcoming].
[54] Ms Krause's evidence is that, compared with the Victorian Y-PARC model, the SUSDU model has "an increased focus on family visiting spaces and an increased therapeutic focus on family therapy interventions". Statement of Judi Krause, 19 January 2016, p 31, para 24(b).
[55] Section 4.9.2 of draft model of service (October 2015), Adolescent Step Up Step Down Unit, Exhibit D of Affidavit of Stephen Stathis, 15 January 2016. [DSS.001.002.001].
[56] Section 4.4.1 of draft model of service (October 2015), Adolescent Step Up Step Down Unit, Exhibit D of Affidavit of Stephen Stathis, 15 January 2016. [DSS.001.002.001].
[57] Section 4.10 of draft model of service (October 2015), Adolescent Step Up Step Down Unit, Exhibit D of Affidavit of Stephen Stathis, 15 January 2016. [DSS.001.002.001].
[58] Draft Assertive Mobile Youth Outreach Service (AMYOS) Model of Service (MSS.003.004.3656).
[59] Section 4.7.4 of draft model of service (October 2015), Adolescent Step Up Step Down Unit, Exhibit D of Affidavit of Stephen Stathis, 15 January 2016. [DSS.001.002.001].
[60] Section 4.9.2 of draft model of service (October 2015), Adolescent Step Up Step Down Unit, Exhibit D of Affidavit of Stephen Stathis, 15 January 2016. [DSS.001.002.001].
[61] Conference with Judi Krause, 29 January 2016.
[62] Exhibit ZJ, Affidavit of Ingrid Adamson, 24 November 2015. [IAD.900.001.0001]. In particular, *Model of Service for an Acute Adolescent Inpatient Unit* (draft) (p 5915).
[63] Preliminary interview with Myfanwy Pitcher, 27 January 2016 [statement forthcoming].
[64] Exhibit ZJ, Affidavit of Ingrid Adamson, 24 November 2015. [IAD.900.001.0001]. In particular, *AMHETI service mapping: current and proposed services* (p 5879).
[65] Exhibit ZJ, Affidavit of Ingrid Adamson, 24 November 2015. [IAD.900.001.0001]. In particular, *AMHETI service mapping: current and proposed services* (p 5879).
[66] In May 2015 the Government announced another two AMYOS teams will be established in Cairns and Central Queensland as part of the Keriba Omasker Healing Response [AHMETI update — June 2015, QHD.006.002.8942]
[67] Draft Queensland Health briefing note from Mental Health, Alcohol and Other Drugs Branch to Director-General on "Funding for additional services under the Adolescent Mental Health Extended Treatment Initiative", September 2015 [QHD.006.003.3547].
[68] Statement of Judith Krause, 19 January 2016, p 15. [JKR.900.002.0001].
[69] Statement of Judith Krause, 19 January 2016, p 15. [JKR.900.002.0001].
[70] Queensland Health, September 2015. *Discussion paper: Rebuilding intensive mental healthcare for young people*. [QHD.004.009.7704]. Discussion paper notes that once the purpose-built step-up/step-down unit is operational in Cairns from 2017–18, operational funding for the Cairns Youth Residential Unit will be reallocated to contribute to the recurrent operational funding for the SUSDU (p 10).
[71] Children's Health Queensland Hospital and Health Service, July 2014, *Business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation Model of Care*. [QHD.002.003.1447].

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[72] Statement of Professor Philip Hazell, 5 November 2015.
[73] Children's Health Queensland Hospital and Health Service, July 2014, *Business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation Model of Care,* Appendix 2: Proposed model of care, p. 29 [QHD.002.003.1447].
[74] Exhibit ZJ, Statement of Ingrid Adamson, 24 November 2015. [IAD.900.001.0001]. In particular, *Service Agreement Part B – Agreement Schedules, Schedule A, No. 13 Provision of the Services – Key Performance Indicators (PIs) or performance standards* for: Gold Coast Hospital and Health Service (p 6309); Metro North Hospital and Health Service (p 6467); Metro South Hospital and Health Service (p 6650); Darling Downs Hospital and Health Service (p 6812); Townsville Hospital and Health Service (p 6972); Cairns Hinterland and Hospital and Health Service (p 7113); Central Queensland Hospital and Health Service (p 7205).

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