In the matter of the *Commissions of Inquiry Act 1950*

Commissions of Inquiry Order (No.4) 2015

Barrett Adolescent Centre Commission of Inquiry

AFFIDAVIT

Ingrid Adamson of Children's Health Queensland Hospital and Health Service, Project Manager, solemnly and sincerely affirms and declares:

1. I have been issued with a requirement to attend to give information and answer questions by the Barrett Adolescent Centre Commission of Inquiry dated 16 December 2016. **Exhibit A** to this affidavit is a copy of this document.

2. I attended the offices of the Barrett Adolescent Centre Commission of Inquiry on 17 December 2015 and was interviewed by Commission staff.

3. I have been issued with a requirement to produce a supplementary written statement by the Barrett Adolescent Centre Commission of Inquiry dated 7 January 2015. **Exhibit B** to this affidavit is a copy of this document.

Logan Site Visit

In paragraph 8 of your affidavit affirmed on 24 November 2015 (your earlier statement), you stated that you participated in a site visit to Logan Hospital on 30 August 2013 and provided an email report of the site visit to Dr Peter Steer and Deborah Miller (Exhibit D to your earlier statement).

Deponent A J.P., C.Dec., Solicitor

AFFIDAVIT

On behalf of the State of Queensland

Crown Solicitor
11th Floor, State Law Building
50 Ann Street
BRISBANE QLD 4000
TEL:
Email:

a) Who asked you to participate in this site visit? For what purpose? What was the outcome?

4. Dr Peter Steer asked me to participate in the site visit and it was to look at Logan as a potential site for relocation of the Barrett. Dr Peter Steer and Deborah Miller asked me what my views were in terms of the Logan site being suitable for this purpose. From my perspective, I believed there were issues in terms of timing – the unit was still occupied and not available to transition anyone to.

b) What was the genesis of Logan as an interim bed-based replacement of the BAC?

5. I do not know when or how the Logan site became an interim option for consideration.

Communication

The Commission understands that you do not currently have access to your Group Wise emails, but in paragraph 11 of your earlier statement, you made reference to frequent contact with Dr Leanne Geppert regarding BAC and transition updates.

a) What form did these communications take?

6. These communications took the form of emails and phone calls.

b) Do you recall the nature of the contact?

7. These communications would be updates on progress of activities being undertaken by West Moreton, and any correspondence being received and how we would work together in terms of responding to that correspondence. Most correspondence received from the community, the Director General, or the Minister would involve a

joint response, West Moreton would prepare their response and I would prepare CHQ's responses.

c) Did you make file notes of your conversations?

8. No.

d) Did you have face-to-face meetings?

9. I do not recall any face-to-face meetings outside of the Steering Committee meetings.

There is another reference to contact with Dr Geppert in paragraph 47 of your earlier statement. Is this a reference to the same contact in paragraph 11? What form did these communications take? Do you recall the nature of the contact?

10. The communications referred to in paragraph 47 were more formal updates so were via email with reports attached. These emails and attachments have been enclosed in the exhibits.

Parent Presentation

You stated in paragraph 78 of your earlier statement (in response to question 18(c) of the Notice to Provide a Formal Statement dated 14 October 2015) that parents of BAC patients were invited to make a presentation to the Steering Committee on 4 November 2013. In paragraph 79, you stated "The presentation was never intended to be evaluated by the Steering Committee." There is also an email to [redacted] dated 22 October 2013 on page 1632 of the exhibits to your earlier statement which states, "This cumulative information will then be presented to the Steering Committee for review to inform the

forward direction of the project". How were the presentations considered and incorporated into decision-making in the transition process?

11. I define evaluation as a process that involves pre-defined criteria against which information can be assessed. The Steering Committee did not formally sit down with set criteria to evaluate the parents' presentation. There was no evaluation process in the way that I define evaluation.

12. The parent presentation provided the Steering Committee with the parents' personal experience, and their expectations and ideas regarding service provision. I cannot comment as to how individual Steering Committee members incorporated this information into their views taken on decisions being made.

13. The transition process was the responsibility of West Moreton and I cannot comment on how they incorporated information from the parents' presentation in this process.

Transition

In paragraph 31 of your earlier statement, you stated that by 18 November 2013 there were only 4 patients who remained at the Barrett Adolescent Centre, but the West Moreton Status Report for November 2013 in Exhibit M on page 592 (which you state in paragraph 31 was provided to the Steering Committee) lists 10 inpatients, 3 day patient and 1 outpatient who had not been discharged by 18 November. Explain this discrepancy.

14. The information was provided to me as a member of the Steering Committee and would be documented in the minutes. It would depend on the date that the report was prepared. I believe only West Moreton can explain the discrepancy between the report and the information provided to the Steering Committee.

In paragraph 32 of your earlier statement, you stated that by the end of December 2013 only 3 patients remained, two of whom had transition plans in place. The West Moreton Status Report for December 2013 (Exhibit M, page 5 94) lists 5 inpatients and 2 day patients who were yet to be discharged. Explain this discrepancy.

15. I am not able to explain this discrepancy. I believe this question should be put to West Moreton.

BAC Consumer Meeting

In paragraph 38 of your earlier statement, you stated that you were routinely invited to meetings as part of your role as Project Manager so you could remain abreast of transition arrangement progression, risks and issues.

a) What other meetings (besides the consumer meeting of 18 December 2013) did you attend?

16. I cannot recall attending other specific meetings without referring to my calendar.

b) Please provide or identify any minutes of these meetings.

17. N/A

Tier 3

In paragraph 51 of your earlier statement, you stated, "from my own research and consultation with members of the Steering Committee, I was not able to find any evidence of a tiered system that categorises tiered services in Australia."

a) What research did you undertake?

18. I performed a search online, and I conferred with members of the Steering Committee asking them if they had heard of this tiered system.

b) Are you aware of where this Tiered system came from?

19. I am not aware of where this tiered system came from. This question is best directed to members of the ECRG.

c) Why did Children's Health Queensland refer to tiers in the Business Case?

20. I was involved in producing the Business Case and we decided to refer to tiers for clarity of communication. The community and areas within the Department of Health had attached to the tier terminology. We were trying to demonstrate a connection between the AMHETI model of care developed and the tier structure that was referred to by the ECRG, for ease of understanding.

Save the Barrett

In paragraph 58 of your earlier statement, you stated that you initially signed an online petition and provided your personal email address.

a) When did you do this?

21. The month I started, September 2013.

b) Why did you sign the petition?

22. I signed the petition to receive the emails sent out by them, and to be kept updated on their views.

The Commission understands that parents of BAC patients were invited to make a submission to the Steering Committee on 4 November 2013. In

paragraph 65 of your earlier statement, you stated that you were involved in organising a presentation to BAC patients' families on 11 December 2013 to inform families of new services being established by CHQ.

a) Were families given an opportunity to provide further feedback or debrief?

23. CHQ did not provide any further opportunities for feedback or debrief to the parents after the parents' presentation to the Steering Committee on 4 November 2013.

24. The 11 December 2013 presentation was facilitated by West Moreton. I cannot comment on whether West Moreton extended an invitation to provide further feedback or debrief.

b) What was CHQ's involvement in this?

25. CHQ's involvement in the 11 December 2013 presentation was to prepare and present the proposed future model of care.

In paragraph 66 of your earlier statement, you referred to Exhibit X which at page 909 contains a PowerPoint presentation you prepared which includes a slide entitled "Proposed Subacute Bed-Based Unit (Tier 3)".

a) Was this presentation referring to the subacute beds at the Mater Children's Hospital (now the Lady Cilento Children's Hospital)?

26. This model, when it was presented at the time, was a proposed model. There were no services in place at the time this model was presented. We had not confirmed a location for those beds at that particular date.

b) Are the subacute beds part of the adolescent acute inpatient unit at the Lady Cilento Children's Hospital? Is there any sort of partition?

27. The subacute beds are part of the of the Adolescent Acute inpatient Unit. There is no partition as far as I am aware.

c) Are the clinicians qualified to provide both acute and subacute care?

28. At the time of the delivery of the presentation of the PowerPoint slide, the models of care that sat behind the presentation clearly identified multidisciplinary clinicians.

29. As far as I am aware, the clinicians in the Adolescent Acute Inpatient Unit are qualified to provide both acute and subacute care.

d) What is your understanding of the subacute service, and how this differs from the care provided to acute patients within the unit?

30. I understand that the subacute service involves detailed individual and family assessment, followed by multidisciplinary treatment tailored specifically for the individual consumer and their family. The acute service is a shorter length of stay service focused on crisis management.

31. Consumers are assessed on entry and the therapeutic care they receive is determined by the treating clinician within the unit. As to the specific therapeutic and treatment differences, that is a question for a qualified mental health clinician.

Waitlist

In paragraph 73 of your earlier statement, you stated, "I do recall being part of a telephone conversation where waitlist patients were being discussed, I recall Dr Stephen Stathis, Dr Leanne Geppert and Dr Anne Brennan were also parties to that telephone conversation. I recall a spreadsheet was created which captured the content of this telephone conversation." (Exhibit ZA) Do you recall the date of the conversation?

32. I cannot recall when this conversation occurred.

Post-closure

In paragraph 117 of your earlier, you stated, "I was responsible for the continued management of transition funding arrangements for Barrett Adolescent Centre patients. I am still kept abreast of the progress and updates of some Barrett Adolescent Centre patients who continue to require mental health services today."

a) For what period were you responsible for the continued management of transition funding arrangements for the Barrett Adolescent Centre patients? Is this an ongoing responsibility?

33. My role in managing and monitoring funds used for transition care arrangements commenced in January 2014 (upon receipt of the first request for funds) and concluded at the end of the financial year, 30 June 2014. The Mental Health, Alcohol, and Other Drugs Branch assumed financial responsibility for any transition funding support for ex-BAC consumers from 1 July 2014. Emails regarding these arrangements have been provided attached to my previous affidavit at Exhibit Y.

b) What was your role in the management of transition funding arrangements?

34. CHQ was allocated a pool of money from which we had to establish new and enhanced adolescent services, and support the transition of consumers from BAC, where they needed additional support. I was responsible for ensuring funds were managed within the limits of our allocated funding.

35. My management would include determining what funds were available and then ensuring that the receiving Hospital and Health Service received the available funds to provide support to the clients/families that needed it.

36. Conversations would take place between Dr Leanne Geppert, Dr Stephen Stathis, and Dr Bill Kingswell, together with the receiving Hospital and Health Service with regard to the request for support and the funds required.

c) How were you kept abreast of the progress? Please provide or identify records of this information.

37. I was kept abreast of progress via email. Records of this are provided at Exhibit Y.

Future services

Did you in your capacity as Project Manager, or any of the committees of which you were a member, consider the alignment (or lack of alignment) between adolescent and adult mental health services?

38. I cannot recall if alignment of adolescent and adult services were discussed at any of the committees I attended. I believe this discussion would be captured in the minutes of meetings if it did in fact take place.

In paragraph 119 of your earlier statement, you stated that "a large part of my time was involved in the development of new and enhanced service options as alternatives to the Barrett Adolescent Centre. This involved extensive consultation with clinicians and research."

a) Are all of your notes of consultations in exhibit ZI?

39. Yes, and Exhibit ZC, which contains papers and output from the Service Options Implementation Working Group workshop.

b) Do these notes identify who was consulted?

40. Yes.

The Commission understands that the Y-PARC model was considered for implementation in Queensland at one stage. Explain when and why the Steering Committee progressed the residential rehab service (the Greenslopes YPETRI) as the priority within the AMHETI replacement model, rather than the YPARC (step up/step down) model?

41. CHQ received $5.8 million to establish new services following the closure of the Barrett Adolescent Centre.

42. The Step Up/ Step Down unit is a purpose-built facility. Based on Victorian Y-PARC budget indications, the cost of a single facility was in excess of $5 million, so straight away it was clear we could not afford a Step Up/ Step Down unit let alone establish additional new services.

43. We considered a full suite of adolescent services, which is documented in the AMHETI business case together with costings. This Business Case was presented to the Department of Health, with a request for new recurrent operational funds to establish the full suite of services, including Step Up/Step Down units. We continue to make requests for funding to establish new services.

In paragraph 122 of your earlier statement, you discuss a discussion paper developed by Sophie Morson regarding subacute beds. On what basis was Ms Morson engaged to develop this paper and for what purpose?

44. This question is best directed to Judi Krause. However, I understand the purpose of this paper is to explore the appropriateness of subacute beds as a service option for adolescents with severe and complex mental health problems. Sophie Morson was

asked to document what current evidence exists around subacute services and treatment.

45. I understand that this paper will be provided to the Commission when it is available. It is currently expected to be finalised by the end of January 2016.

Business case

There are two copies of the AMHETI Business Case labelled "Version 4"; one is dated April, the other is dated July. Identify which version is the relevant version.

46. I can confirm Version 4 dated July is the relevant version, and was the version submitted to the Department of Health.

Budget process for AMHETI

Please identify the committee (or other governance entity) responsible for approving the budget for the AMHETI Business Case.

47. The Business Case (outlining recurrent costs and funding required for services) was not approved by a set committee. Rather, I submitted this to CHQ senior executives, Chief Financial Officer, Loretta Seamer and Chief Executive, Dr Peter Steer.

48. Funds for the first phase of AMHETI services had already been allocated by the Department of Health, using the operational funds redirected from the BAC.

49. The approval process to seek budget for new services in the Business Case formed part of a wider planning and budgeting process within the Department of Health.

50. The first meeting to discuss the Business Case with the Department of Health (for new funding) was on 4 March 2014, and the participants who accepted this meeting (as noted on my calendar invite) were:

- Nick Steele, Healthcare Purchasing and System Performance Division, Department of Health
- Colleen Jen, Health Service Strategy & Planning Unit, Department of Health
- Marie Kelly, Director, Mental Health, Alcohol, and Other Drugs Branch
- Stephen Stathis, Medical Director, CYMHS CHQ HHS
- Deborah Miller, A/ED CHQ HHS

51. This was the only meeting I participated in regarding the Business Case.

52. My recollection is that CHQ Chief Financial Officer, Loretta Seamer, and CHQ Senior Director, Performance Management & Analysis, Alan Fletcher, discussed the Business Case at other "Relationship Management Meetings" (which were regular meetings between the Department of Health and CHQ to discuss service funding requirements).

a) Is it a Department of Health or Children's Health Queensland HHS Committee?

53. I do not believe there was a committee. The staff in attendance were employees of the Department of Health and CHQ.

Was there a briefing note that accompanied the Business Case for budget consideration/approval? If so, please provide or identify the relevant document.

54. There was no briefing note to accompany the Business Case.

What feedback was provided by the responsible committee/entity in response to the Business Case? What form did it take (for example, a minute, email)? Please provide or identify the relevant document.

55. I received an email from Colleen Jen, Department of Health, seeking clarification on elements of the Business Case, to which I responded to on 2 April 2014.

56. Colleen advised in a reply email, on 10 April 2014, that "*additional funding for the outer years would need to be held over till the next service agreement round as growth funding from Treasury for 2015-16 onwards has not been allocated to Health at this point*".

57. I have a number of emails that I sent to Loretta Seamer seeking updates on the progress of the Business Case. I rarely if ever got a reply. She would be the best person to speak to in regard to any further written feedback/comments from the Department about the AMHETI Business Case.

58. I have included emails regarding the Business Case at **Exhibit C**.

Cairns Time Out House Initiative

Pages 803 7-8073 of the exhibits to your earlier statement include briefing notes and a service agreement in relation to the provision of additional funds to the Time Out House Initiative (TOHI) in Cairns (described as an "enhancement") and its subsequent conversion to a Youth Residential Rehabilitation Unit.

a) Explain the decision-making process around the enhancement funds for the TOHI and the subsequent conversion of the TOHI to a Residential Rehabilitation Unit?

59. I can only recall what is documented in the minutes of the CYMHS and TOHI meetings.

b) What are the differences between the TOHI and the RRU?

60. The TOHI provided short term crisis and respite accommodation for 18 to 25 year olds. It only received temporary funding year on year.

61. The Youth Residential Rehabilitation Unit provides long term accommodation (up to 1 year) for 16 to 21 year olds seeking support to launch into independent living. This model of service is very different to crisis and respite care. Copies of the models of care have been provided in my exhibits.

Model of Service Delivery

There are two different formats of Models of Service Delivery – the ones in the Business Case and the ones attached to the service agreements. Explain the difference between them.

62. The format of the Models in the Business Case leverages the format of the draft National Mental Health Service Planning Framework (NMHSPF) elements. We took the information provided from the NMHSPF and adapted that information for the 13-18 year age cohort. These models are a high level summary.

63. As services were approved for establishment, further work was undertaken to expand the detail of each model of service into the versions that are attached to the service agreements. These versions are based on the Model of Service template provided by the Mental Health Alcohol and Other Drugs Branch.

Status of AMHETI Steering Committee after 15 December 2014

There are no minutes for the Steering Committee available after 15 December 2014. What happened after this time?

64. There were no further meetings of the Steering Committee after 15 December 2014.

65. We were unsure if the Steering Committee would be required again in 2015. There was an intention to have more meetings in 2015; however, those meetings did not eventuate as they were not needed.

66. A notice was never sent to members to formally disband this Committee.

67. After the services had been established, it was the responsibility of CYMHS business operations, under the direction of the Divisional Director, Judi Krause, to continue overseeing the operation of those services.

Exhibits

Exhibit ZI to your earlier statement includes a document entitled "A Bed-Based Unit: What does it offer that Day Units, Acute Inpatients Units, Residential Services and Extended Outreach Services cannot - Notes of phone call 16/10/13" (page 31 73).

a) Who participated in this phone call?

68. I participated in this phone call. I cannot recall who else participated in this phone call.

b) Who made the notes?

69. I am the author of the notes.

70. ***Exhibit ZI to your earlier statement includes documents entitled "WHO Atlas Report 2005: Summary" (page 5210) and "Canadian Adolescent Mental Health Services - Research" (page 5211). Did you write these notes yourself?***

71. I can confirm I prepared the Canadian Adolescent Mental Health Service - Research Notes. It captures the websites I referred to.

Exhibit ZI to your earlier statement is a bundle of research papers and documentation with regard to enhanced service options.

a) How did you use this research? Do you have any material summarising your research?

72. I would read the research to look for evidence relating to the recommendations from the ECRG or to inform the model care under development.

73. Apart from the actual articles, I do not have any material summarising my research.

b) Did you incorporate it into a discussion paper?

74. I did not summarise my findings into a discussion paper.

c) How were the statistics on page 2566 used to inform planning?

75. The statistics were sourced from the Australian Bureau of Statistics and was used to inform our understanding of the population spread of adolescents aged 13 to 18 years across Queensland. The percentages used in the table were sourced from the Mental Health and Alcohol and Other Drugs Branch, and provided us with an indication of the size of the target population suffering severe and complex mental health issues. We used that information to prioritise where new services should be located throughout Queensland.

There is a bibliography on page 2219 of your earlier statement (Exhibit ZI). What is this document? Why was this document created?

76. I was asked by the Mental Health and Alcohol and Other Drugs Branch if I could provide them with a list of references we had used to date, and that's what this is.

77. The bibliography is a combined list of references referred to in the Business Case and the Subacute Bed Discussion Paper.

At page 5903 of your earlier statement (Exhibit ZJ) there is a document entitled "Advantages/Disadvantages of fast tracking an 8-bed SUSDU in Cairns by 2015". What is the context and purpose of this document?

78. This document is notes of a conversation I had with Dr Stephen Stathis. I cannot recall the purpose of this conversation.

All the facts affirmed in this affidavit are true to my knowledge and belief except as stated otherwise.

Affirmed by Ingrid Adamson on 15 January 2016 at Brisbane in the presence of:)

[redacted]

[redacted]

~~A Justice of the Peace, C~~.Dec., Solicitor

In the matter of the *Commissions of Inquiry Act 1950*

Commissions of Inquiry Order (No.4) 2015

Barrett Adolescent Centre Commission of Inquiry

CERTIFICATE OF EXHIBIT

Exhibit A to C the Affidavit of Ingrid Adamson sworn on 15 January 2016.

[redacted] [redacted]

Deponent ~~A J.P., C.Dec.,~~ Solicitor

In the matter of the *Commissions of Inquiry Act 1950*

Commissions of Inquiry Order (No.4) 2015

Barrett Adolescent Centre Commission of Inquiry

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BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

Commissions of Inquiry Act 1950
Section 5(1)(c)

REQUIREMENT TO ATTEND TO GIVE INFORMATION AND ANSWER QUESTIONS

To: Ms Ingrid Adamson

Of: c/- Crown Solicitor, by email to [redacted]

I, the Honourable MARGARET WILSON QC, Commissioner, appointed pursuant to Commissions of Inquiry Order (No. 4) 2015 to inquire into certain matters pertaining to the Barrett Adolescent Centre ("the Commission") require you to attend to give information to, and answer questions asked by, a person authorised by me.

YOU MUST COMPLY WITH THIS REQUIREMENT BY:

Attending at Level 10, 179 North Quay, Brisbane on **Thursday 17 December 2015 at 10:00 am.**

If you believe that you have a reasonable excuse for not complying with this notice, for the purposes of section 5(2)(b) of the *Commissions of Inquiry Act 1950* you will need to provide evidence to the Commission in that regard by the due date specified above.

DATED this 16th day of December 2015

[redacted]

The Hon Margaret Wilson QC
Commissioner
Barrett Adolescent Centre

BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

Commissions of Inquiry Act 1950
Section 5(1)(d)

REQUIREMENT TO GIVE INFORMATION IN A WRITTEN STATEMENT

To: Ms Ingrid Adamson

Of: c/- Crown Solicitor, by email to [redacted]

I, the Honourable MARGARET WILSON QC, Commissioner, appointed pursuant to Commissions of Inquiry Order (No. 4) 2015 to inquire into certain matters pertaining to the Barrett Adolescent Centre ("the Commission") require you to give a written statement to the Commission pursuant to sections 5(1)(d) of the *Commissions of Inquiry Act 1950* in regard to your knowledge of the matters set out in the Schedule annexed hereto.

YOU MUST COMPLY WITH THIS REQUIREMENT BY:

Giving a written statement prepared either in affidavit form or verified as a statutory declaration under the *Oaths Act 1867* to the Commission before **Friday 15 January 2016**, by delivering it to the Commission at Level 10, 179 North Quay, Brisbane.

A copy of the written statement must also be provided electronically either by: email at mail@barrettinquiry.qld.gov.au (in the subject line please include "Requirement for Written Statement"); or via the Commission's website at www.barrettinquiry.qld.gov.au (confidential information should be provided via the Commission's secure website).

If you believe that you have a reasonable excuse for not complying with this notice, for the purposes of section 5(2)(b) of the *Commissions of Inquiry Act 1950* you will need to provide evidence to the Commission in that regard by the due date specified above.

DATED this 7th day of January 2016

[redacted]

The Hon Margaret Wilson QC
Commissioner
Barrett Adolescent Centre Commission of Inquiry

SCHEDULE

Logan Site Visit

1. In paragraph 8 of your affidavit affirmed on 24 November 2015 (your earlier statement), you stated that you participated in a site visit to Logan Hospital on 30 August 2013 and provided an email report of the site visit to Dr Peter Steer and Deborah Miller (Exhibit D to your earlier statement).

    a. Who asked you to participate in this site visit? For what purpose? What was the outcome?

    b. What was the genesis of Logan as an interim bed-based replacement for the BAC?

Communication

2. The Commission understands that you do not currently have access to your GroupWise emails, but in paragraph 11 of your earlier statement, you made reference to frequent contact with Dr Leanne Geppert regarding BAC and transition updates.

    a. What form did these communications take?

    b. Do you recall the nature of the contact?

    c. Did you make file notes of your conversations?

    d. Did you have any face-to-face meetings?

3. There is another reference to contact with Dr Geppert in paragraph 47 of your earlier statement. Is this a reference to the same contact in paragraph 11? What form did these communications take? Do you recall the nature of the contact?

Parent Presentation

4. You stated in paragraph 78 of your earlier statement (in response to question 18(c) of the Notice to Provide a Formal Statement dated 14 October 2015) that parents of BAC patients were invited to make a presentation to the Steering Committee on 4 November 2013. In paragraph 79, you stated "The presentation was never intended to be evaluated by the Steering Committee." There is also an email to [redacted] dated 22 October 2013 on page 1632 of the exhibits to your earlier statement which states, "This cumulative information will then be presented to the Steering Committee for review to inform the forward direction of the project". How were the presentations considered and incorporated into decision-making in the transition process?

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5. In paragraph 31 of your earlier statement, you stated that by 18 November 2013 there were only 4 patients who remained at the Barrett Adolescent Centre, but the West Moreton Status Report for November 2013 in Exhibit M on page 592 (which you state

in paragraph 31 was provided to the Steering Committee) lists 10 inpatients, 3 day patient and 1 outpatient who had not been discharged by 18 November. Explain this discrepancy.

6. In paragraph 32 of your earlier statement, you stated that by the end of December 2013 only 3 patients remained, two of whom had transition plans in place. The West Moreton Status Report for December 2013 (Exhibit M, page 594) lists 5 inpatients and 2 day patients who were yet to be discharged. Explain this discrepancy.

BAC Consumer Meeting

7. In paragraph 38 of your earlier statement, you stated that you were routinely invited to meetings as part of your role as Project Manager so you could remain abreast of transition arrangement progression, risks and issues.

   a. What other meetings (besides the consumer meeting of 18 December 2013) did you attend?

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Tier 3

8. In paragraph 51 of your earlier statement, you stated, "from my own research and consultation with members of the Steering Committee, I was not able to find any evidence of a tiered system that categorises tiered services in Australia."

   a. What research did you undertake?

   b. Are you aware of where this Tiered system came from?

   c. Why did Children's Health Queensland refer to tiers in the business case?

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9. In paragraph 58 of your earlier statement, you stated that you initially signed an online petition and provided your personal email address.

   a. When did you do this?

   b. Why did you sign the petition?

10. The Commission understands that parents of BAC patients were invited to make a submission to the Steering Committee on 4 November 2013. In paragraph 65 of your earlier statement, you stated that you were involved in organising a presentation to BAC patients' families on 11 December 2013 to inform families of new services being established by CHQ.

    a. Were families given an opportunity to provide further feedback or debrief?

    b. What was CHQ's involvement in this?

11. In paragraph 66 of your earlier statement, you referred to Exhibit X which at page 909 contains a Powerpoint presentation you prepared which includes a slide entitled "Proposed Subacute Bed-Based Unit (Tier 3)".

    a. Was this presentation referring to the subacute beds at the Mater Children's Hospital (now the Lady Cilento Children's Hospital)?

    b. Are the subacute beds part of the adolescent acute inpatient unit at the Lady Cilento Children's Hospital? Is there any sort of partition?

    c. Are the clinicians qualified to provide both acute and subacute care?

    d. What is your understanding of the subacute service, and how this differs from the care provided to acute patients within the unit?

Waitlist

12. In paragraph 73 of your earlier statement, you stated, "I do recall being part of a telephone conversation where waitlist patients were being discussed, I recall Dr Stephen Stathis, Dr Leanne Geppert and Dr Anne Brennan were also parties to that telephone conversation. I recall a spreadsheet was created which captured the content of this telephone conversation." (Exhibit ZA) Do you recall the date of the conversation?

Post-closure

13. In paragraph 117 of your earlier, you stated, "I was responsible for the continued management of transition funding arrangements for Barrett Adolescent Centre patients. I am still kept abreast of the progress and updates of some Barrett Adolescent Centre patients who continue to require mental health services today."

    a. For what period were you responsible for the continued management of transition funding arrangements for the BAC patients? Is this an ongoing responsibility?

    b. What was your role in the management of transition funding arrangements?

    c. How are you kept abreast of the progress? Please provide or identify records of this information.

Future Services

14. Did you in your capacity as Project Manager, or any of the committee of which you were a member, consider the alignment (or lack of alignment) between adolescent and adult mental health services?

15. In paragraph 119 of your earlier statement, you stated that "a large part of my time was involved in the development of new and enhanced service options as alternatives to the Barrett Adolescent Centre. This involved extensive consultation with clinicians and research."

a. Are all your notes of consultations in Exhibit ZI?

b. Do these notes identify who was consulted?

16. The Commission understands that the Y-PARC model was considered for implementation in Queensland at one stage. Explain when and why the Steering Committee progressed the residential rehab service (the Greenslopes YPETRI) as the priority within the AMHETI replacement model, rather than the YPARC (step up/step down) model?

17. In paragraph 122 of your earlier statement, you discuss a discussion paper developed by Sophie Morson regarding subacute beds. On what basis was Ms Morson engaged to develop this paper and for what purpose?

Business Case

18. There are two copies of the AMHETI Business Case labelled "Version 4"; one is dated April, the other is dated July. Identify which version is the relevant version.

Budget process for AMHETI

19. Please identify the committee (or other governance entity) responsible for approving the budget for the AMHETI Business Case.

a. Is it a Department of Health or Children's Health Queensland HHS committee?

20. Was there a briefing note that accompanied the Business Case for budget consideration/approval? If so, please provide or identify the relevant document.

21. What feedback was provided by the responsible committee/entity in response to the Business Case? What form did it take (for example, a minute, email)? Please provide or identify the relevant document.

Cairns Time Out House Initiative

22. Pages 8037-8073 of the exhibits to your earlier statement include briefing notes and a service agreement in relation to the provision of additional funds to the Time Out House Initiative (TOHI) in Cairns (described as an "enhancement") and its subsequent conversion to a Youth Residential Rehabilitation Unit.

a. Explain the decision-making process around the enhancement funds for the TOHI and the subsequent conversion of the TOHI to a Residential Rehabilitation Unit?

b. What are the differences between the TOHI and the RRU?

Model of Service Delivery

23. There are two different formats of Models of Service Delivery — the ones in the Business Case and the ones attached to the service agreements. Explain the difference between them.

Status of AMHETI steering committee after 15 December 2014

24. There are no minutes for the Steering Committee available after 15 December 2014. What happened to this Committee after this time?

Exhibits

25. Exhibit ZI to your earlier statement includes a document entitled "A Bed-Based Unit: What does it offer that Day Units, Acute Inpatients Units, Residential Services and Extended Outreach Services cannot - Notes of phone call 16/10/13" (page 3173).

    a. Who participated in this phone call?

    b. Who made the notes?

26. Exhibit ZI to your earlier statement includes documents entitled "WHO Atlas Report 2005: Summary" (page 5210) and "Canadian Adolescent Mental Health Services – Research" (page 5211). Did you write these notes yourself?

27. Exhibit ZI to your earlier statement is a bundle of research papers and documentation with regard to enhanced service options.

    a. How did you use this research? Do you have any material summarising your research?

    b. Did you incorporate it into a discussion paper?

    c. How were the statistics on page 2566 used to inform planning?

28. There is a bibliography on page 2219 of your earlier statement (Exhibit ZI). What is this document? Why was this document created?

29. At page 5903 of your earlier statement (Exhibit ZJ) there is a document entitled "Advantages/Disadvantages of fast tracking an 8-bed SUSDU in Cairns by 2015". What is the context and purpose of this document?

Robert Boal

From: Ingrid Adamson
Sent: Monday, 31 March 2014 4:46 PM
To: Loretta Seamer; Deborah Miller
Subject: RE: Business Case for Adolescent Mental Health Extended Treatment Model of Care

Importance: High

Hi Loretta,

I have prepared a response which is with Deb for review before sending. At our last meeting with Colleen and Nick, we were advised that there was no new funding for 2014/15 and to remove this altogether from our Business Case. Has this position changed since then, and are there funds we could put in a request for? We would definitely submit for funds if available (it would mean reworking the amended business case).

On a separate note, I mentioned to Peter that as a consequence of service establishment and recruitment delays, we would have some underspend on this project this year and would like to roll it over into 2014/15 to help with non-recurrent service establishment and project resourcing costs. He suggested I speak with you about how to go about this. Is there a template/brief that you require to seek approval for rolling funds into next financial year?

Thanks Loretta,
Ingrid

From: Loretta Seamer
Sent: Monday, 31 March 2014 1:29 PM
To: Deborah Miller; Ingrid Adamson
Subject: FW: Business Case for Adolescent Mental Health Extended Treatment Model of Care

Hi Ingrid,

We raised the request for additional funding for this service at the DoH contract meeting on Friday last week, but were not aware of this feedback to you from Colleen Jen.

Have you had a chance to consider this information and the impact of your business case? Do you want me to proceed with requesting any additional funding for 2014/15?

Can you please provide me some feedback today so I can indicate to Nick if we are progressing this at all?

Thanks

Loretta

From: Colleen Jen
Sent: Sunday, 30 March 2014 7:45 AM
To: Loretta Seamer; Peter Steer
Subject: Fwd: Business Case for Adolescent Mental Health Extended Treatment Model of Care

Hi

As requested see feedback on business case below.

Regards

Colleen Jen

Senior Director
Policy and Planning Branch
System Policy and Performance Division
T:
M:

Begin forwarded message:

From: Colleen Jen <
Date: 17 March 2014 11:07:40 AM AEST
To: Ingrid Adamson <, Nick Steele
<
Cc: Helen Ceron <, Deborah Miller
<, Stephen Stathis <, Judi
Krause <, Marie Kelly <, Ellen
Cumberland <, Bill Kingswell
<
Subject: RE: Business Case for Adolescent Mental Health Extended Treatment Model of Care

Hi

After discussing the business case with Mental Health Branch the following joint comments are for your consideration.

1. Mobile outreach service in each HHS with 2 staff and access to Psychiatrist

The statement that 16-20 adolescents will be treated is unclear whether this refers to whole of QLD or to each HHS. Assume it's each HHS so could be made clearer. Existing staffing need to be considered in costings. It's expected that no additional FTE required to deliver IMYOS Cairns (currently 80% of C&Y 2017 target and 93% of all FTE target) Townsville (has existing adol MH unit and day centre and 95% of FTE target) Rockhampton over state average, PAH over state average, Toowoomba over state average. Additional FTE for IMYOS can be justified (12 in total) Mackay Metro Nth (55% C&Y target, 64% all FTE target) Wide Bay (57% and 59%) Sunshine Coast (46% and 52%) Gold Coast (42% and 49%) West Moreton (43% and 49%).

2. Day programs

Increase from 3 to 6, with two additional services in Brisbane. Not clear on what basis this has been made apart from the population numbers. There may be a very different distribution of adolescents with mental health concerns to that of the general population i.e. the rate of mental health issues may be higher in certain regions and therefore the location of services might need to be different from population locations. Note Deloittes considered a day program in the Preliminary evaluation of Stage 2 MH plan and it came back as low priority. It may be worth prioritising the sites if all 3 are not funded. Is the capital funding identified in the submission? It's noted that the C&Y inpatient units run at 75% or less occupancy so there might be opportunity to redirect some investment.

3. Resi care

Business case proposes a requirement of 140 beds across Queensland, but we are starting with 30 beds. Current Community Care Unit planning guideline is 10 per 100,000 population – this is equivalent to 35 adolescent beds across the state. The proposed 140 beds translates to about 40 beds per 100,000. This is a big gap to close and timing and priorities will be important.

4. Step Up/Step Down

Business case is proposing 30 beds. Would these adolescents have been accessing other services existing CYMH community based services and therefore some redirection of funds?

5. Recurrent funding

The costing state that total required recurrent funding in 16-17 is $12.4M and that this funding would allow treatment of 260 more adolescents each week compared with the Barrett Centre alone. Is there evidence this demand exists? It should be clear in the business case that these costs relate to new services delivering end to end treatment models for youths which is well in excess to what was being offered at Barrett.

6. Bed based service

There appears to be some discrepancy between the Document and Appendix 1 – appendix 1 states a bed based service should be 8-10 beds, while the document states it will be 2 – 4 beds. Support for a bed based service is low. Suggest wait and see the impact of the day programs and IMYOS teams (as discussed at the meeting). Note that the NMHSPF does not support a bed based service and NSW is keen to close their Walker Unit at Concorde.

7. Existing programs

The Business Case doesn't appear to take into account services already provided in other HHSs (other than MS, MS and WM) and/or reorientation of any existing programs. Consideration needs to be given to the expanded head space ear marked for GC and Logan/Beenleigh that will see $5m invested in early psychosis (young people 16-25) services.

8. Deliverables

There should be some linkage of measure of output or activity to be provided for the cost of the service besides just supplying labour costs and capital cost?

9. Section 1.3 Statement of Need

The statement of is very non- specific – describes strategic goals and notes gaps but does not explain the health service need in a true planning context or identify what the gaps are – would be good to know what needs are currently being addressed through existing services (page 9 states that a more detailed understanding of the true need won't be known until later in 2014). The state MH plan was based on the epidemiological study of Qld Centre for MH research and was then translated into the inputs needed to provide the service. 14 FTE/100,000 pop'n to provide ambulatory services and 2.5 beds/100,000 pop'n.

10. Section 1.5 Scope

There is reference to "do not meet the definition of mental health extended treatment and rehabilitation services (such as acute, forensic, and Community CYMHS)" however there is not a definition for "mental health extended treatment and rehabilitation services" – suggest a Glossary. Aligning to the taxonomy of the National MHSPF would be good. Does this service cover rehabilitation service for patients with and Acquired Brain Injury and a Mental Health disorder?

11. Section 4 Issues

Tables 1 and 2 - column 1 labelled Hospital and Health Services refers to locations - Logan/ Bayside/ Beenleigh and Redcliffe/ Caboolture not HHS.

a. the assumption that 10% of all youth population for every HHS has "mental health needs" is not supported by any argument/data except the source statement of "general epidemiology data"
b. There appears to be no link between the demand and how the model of care meets or works towards this demand. There appears to be no information that links growing demand (growing population) and future expansion of services required to meet this demand over the longer term. Is it a one-off solution to meet current need only?

Happy to discuss as required.

Regards

Colleen Jen
Senior Director
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Department of Health | Queensland Government
147-163 Charlotte Street Brisbane QLD 4000
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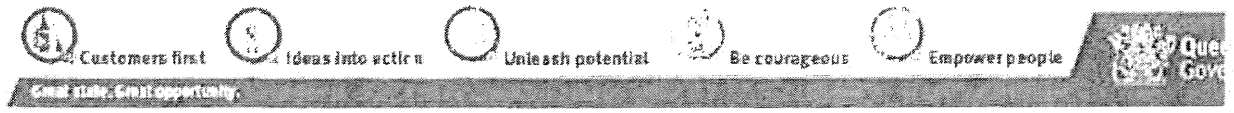

From: Ingrid Adamson
Sent: Tuesday, 4 March 2014 1:56 PM
To: Nick Steele; Colleen Jen
Cc: Helen Ceron; Deborah Miller; Stephen Stathis; Judi Krause; Marie Kelly; Ellen Cumberland
Subject: Business Case for Adolescent Mental Health Extended Treatment Model of Care

Hello Nick/Colleen and thank you again for your time this morning.

As promised, I have attached the information provided to us by the Mater regarding the supply of two subacute inpatient beds until November 2014, at which time the Lady Cilento will open and other arrangements will be made. This information was only received late last week and the business case figures are yet to be adjusted accordingly.

Colleen, if you are able to send through Evelyn's contact details (Medicare Local) that would be greatly appreciated.

In the meantime, please let me know if you have any questions or require any other information.

Warm regards,

Ingrid Adamson
Project Manager
Office of Strategy Management

Children's Health Queensland
Hospital and Health Service
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E: [redacted]
Level 1, Foundation Building
Royal Children's Hospital, Herston Road, Herston, QLD 4029
www.health.qld.gov.au/childrenshealth

From: Erica Lee [redacted]
Sent: Wednesday, 26 February 2014 4:53 PM
To: Stephen Stathis
Cc: Judi Krause; Amanda Tilse; Brett McDermott
Subject: FW: Extended Treatment Beds.doc

Hello Stephen

Please find attached the costing calculation for the Extended Treatment Beds. We now have approval to release this information to you.

Please note that this cost is in addition to the normal cost per bed per patient admitted to the CYMHS Inpatient Services Unit.

With regard to the admission criteria and protocols for use of these beds, I would suggest that you speak with Brett prior to taking this agenda item to the statewide meeting next week. There are a number of considerations that need to be taken into account.

Please contact if you are requiring any further information.

Regards
Erica

Erica Lee
Executive Manager
Mater Child and Youth Mental Health Service

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w: www.mater.org.au www.kidsinmind.org.au

Robert Boal

From: Ingrid Adamson
Sent: Wednesday, 2 April 2014 6:57 PM
To: Loretta Seamer; CHQ_CFO
Cc: Deborah Miller; Judi Krause; Stephen Stathis
Subject: RE: Business Case for Adolescent Mental Health Extended Treatment Model of Care

Importance: High

Hi Loretta,

Further to our corridor conversation last night, it would be of enormous value if we were able to access any new funds that might be available in 2014/15. The table below identifies the additional new services we would fund, and the associated FTE. The number of AMYOS teams can be scaled in numbers to accommodate whatever funds could be secured (e.g. 1 team, 6 teams, or all 12 teams). The more teams we are able to fund, the more we are able to make available to the HHSs. Please let me know if you require any other information.

Service Funding Options	2013/14	2014/15	2015/16	2016/17	FTE
Subacute inpatient unit (4 bed unit)	$0	$665,397	$1,010,123	$1,035,686	9 06
AMYOS Psychiatrists x 2	$0	$719,320	$728,928	$747,183	2 00
AMYOS x 12 Teams (rest of Qld)	$0	$3,418,686	$3,404,141	$3,490,625	24.00
TOTAL	$0	$4,803,403	$5,143,192	$5,273,494	35.06

In the meantime, we have finished collating our response to Colleen's email below and this will be sent through shortly. The above information (and supporting detail) is also contained in the revised business case that will be attached to this response.

Thanks again Loretta,
Ingrid

From: Loretta Seamer
Sent: Monday, 31 March 2014 1:29 PM
To: Deborah Miller; Ingrid Adamson
Subject: FW: Business Case for Adolescent Mental Health Extended Treatment Model of Care

Hi Ingrid,

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Subject: Fwd: Business Case for Adolescent Mental Health Extended Treatment Model of Care

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Senior Director
Policy and Planning Branch
System Policy and Performance Division
T:
M:

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Date: 17 March 2014 11:07:40 AM AEST
To: Ingrid Adamson <>, Nick Steele
<>
Cc: Helen Ceron <>, Deborah Miller
<>, Stephen Stathis <>, Judi
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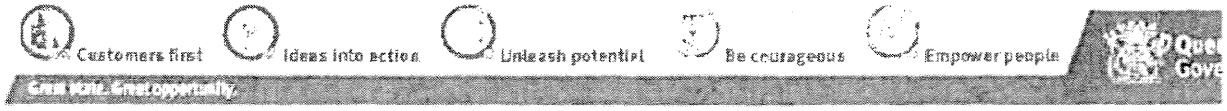

From: Ingrid Adamson
Sent: Tuesday, 4 March 2014 1:56 PM
To: Nick Steele; Colleen Jen
Cc: Helen Ceron; Deborah Miller; Stephen Stathis; Judi Krause; Marie Kelly; Ellen Cumberland
Subject: Business Case for Adolescent Mental Health Extended Treatment Model of Care

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In the meantime, please let me know if you have any questions or require any other information.

Warm regards,

Ingrid Adamson
Project Manager
Office of Strategy Management

Children's Health Queensland
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E: [redacted]
Level 1, Foundation Building
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Erica

Erica Lee
Executive Manager
Mater Child and Youth Mental Health Service

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w: www.mater.org.au www.kidsinmind.org.au

Robert Boal

From: Ingrid Adamson
Sent: Wednesday, 2 April 2014 7:02 PM
To: Colleen Jen
Cc: Helen Ceron; Deborah Miller; Stephen Stathis; Judi Krause; Marie Kelly; Ellen Cumberland; Bill Kingswell; Loretta Seamer
Subject: Response to Queries RE: Business Case for Adolescent Mental Health Extended Treatment Model of Care
Attachments: QLD FTE Report 11012013.pdf; AMHETI Business Case v3.0.pdf

Importance: High

Hello Colleen and thank you for your email.

Firstly, my apologies for not having our response to you sooner. We have responded to each of your queries in red below, and welcome the opportunity to discuss this further, if you have any questions or would like any other information.

Thanks again and warm regards,
Ingrid

Ingrid Adamson
Project Manager
Office of Strategy Management

Children's Health Queensland
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From: Colleen Jen
Sent: Monday, 17 March 2014 11:08 AM
To: Ingrid Adamson; Nick Steele
Cc: Helen Ceron; Deborah Miller; Stephen Stathis; Judi Krause; Marie Kelly; Ellen Cumberland; Bill Kingswell
Subject: RE: Business Case for Adolescent Mental Health Extended Treatment Model of Care

Hi

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1. Mobile outreach service in each HHS with 2 staff and access to Psychiatrist

The statement that 16-20 adolescents will be treated is unclear whether this refers to whole of QLD or to each HHS. Assume it's each HHS so could be made clearer. This figure of 16-20 is per each AMYOS team, of which we are proposing 1 team per HHS – this has now been clarified in the business case attached, pg 9. Existing staffing need to be considered in costings. It's expected that no additional FTE required to deliver AMYOS Cairns (currently 80% of C&Y 2017 target and 93% of all FTE target) Townsville (has existing adol MH unit and day centre and 95% of FTE target) Rockhampton over state average, PAH over state average (includes Mater staff), Toowoomba over state average. Additional FTE for AMYOS can be justified (12 in total) Mackay Metro Nth (55% C&Y target, 64% all FTE target) Wide Bay (57% and 59%) Sunshine Coast (46% and 52%) Gold Coast (42% and 49%) West Moreton (43% and 49%). We have been working with the target FTE figures as identified in the June 2012 MHAODB FTE Report

(attached). We note that the figures you have quoted above are different to those in the attached report – do you have different FTE data we should be working with? We have worked with the Child and Youth Mental Health percentages from this report (excluding acute care or adult MH FTE as these are out of scope). Based on the figures in this report, we have identified that additional staff are required to implement the AMYOS service.

In regard to staff re-allocation, if required, this is not within CHQ's remit to request of other HHSs.

2. Day programs

Increase from 3 to 6, with two additional services in Brisbane. Not clear on what basis this has been made apart from the population numbers. There may be a very different distribution of adolescents with mental health concerns to that of the general population i.e. the rate of mental health issues may be higher in certain regions and therefore the location of services might need to be different from population locations. Note Deloittes considered a day program in the Preliminary evaluation of Stage 2 MH plan and it came back as low priority. We are unaware of a Deloittes report on Adolescent Day Programs – this has not been provided to us on previous requests for information; however, we welcome the opportunity to review the report to better inform this business case. It may be worth prioritising the sites if all 3 are not funded. We have prioritised the sites based on current available funding, noting North Brisbane as critical and the first Day Program to be established. The remaining two Day Programs at Logan and the Gold Coast would be established as and when funding became available. Is the capital funding identified in the submission? Capital Expenditure is outlined on page 19 of the Business Case It's noted that the C&Y inpatient units run at 75% or less occupancy so there might be opportunity to redirect some investment. We do not believe it would be appropriate to redirect funding away from acute inpatient units into adolescent extended treatment. There has been a significant increase in bed occupancy over the past 12 to 24 months and it is anticipated that this trend could continue.

3. Resi care

Business case proposes a requirement of 140 beds across Queensland, but we are starting with 30 beds. Current Community Care Unit planning guideline is 10 per 100,000 population – this is equivalent to 35 adolescent beds across the state. The proposed 140 beds translates to about 40 beds per 100,000. This is a big gap to close and timing and priorities will be important. The information on Resi beds may have been misunderstood. The information provided was merely to highlight that the Victorian Government recognises the value of the Resi and has invested heavily in beds. If Queensland were to adopt a similar approach, we would require up to 140 beds for the population of adolescents in Queensland. However, we are not proposing this but rather, due to funding limitations, that 30 beds be considered in the first instance and until success of the service can be evaluated. The Community Care Unit Planning Guideline is based on an adult population that is not applicable to adolescents, as young people require different models of service with different supervision requirements.

4. Step Up/Step Down

Business case is proposing 30 beds. Would these adolescents have been accessing other services existing CYMH community based services and therefore some redirection of funds? The Step Up/Step Down unit provides a more effective and efficient approach to treatment of young people and assists in the promotion of hospital avoidance. There may be efficiencies achieved through their implementation; however, this would require a robust evaluation and analysis of the potential before redirection of funds could be supported.

5. Recurrent funding

The costing state that total required recurrent funding in 16-17 is $12.4M and that this funding would allow treatment of 260 more adolescents each week compared with the Barrett Centre alone. Is there evidence this demand exists? A request for data regarding demand for services was submitted to MHAODB however no information regarding demand for services has been received. We have been unable to find any other data sources that identify current, future or latent demand for services. It should be clear in the business case that these costs relate to new services delivering end to end treatment models for youths which is well in excess to what was being offered at Barrett. As noted in the Background and Statement of Need (pgs 4 and 5), the Adolescent Mental Health Extended Treatment and Rehabilitation Initiative has been established to explore and develop a more contemporary, enhanced model of care for young people, in light of the Barrett closure. We would appreciate further guidance as to how this should be made more clear in the business case.

6. Bed based service

There appears to be some discrepancy between the Document and Appendix 1 – appendix 1 states a bed based service should be 8-10 beds, while the document states it will be 2 – 4 beds. Discrepancy has been corrected in the version attached. The case is for 2-4 beds. Support for a bed based service is low. Suggest wait and see the impact of the day programs and AMYOS teams (as discussed at the meeting). Agreed – 2 interim beds are being supported from existing operation funds until November 2014. It is hoped that that a better understanding of demand will be known to determine whether the 4 subacute beds proposed at Lady Cilento should progress. Note that the NMHSPF does not support a bed based service We based the development of services on the draft NMHSPF as a key reference document. The subacute bed-based option is based on information provided at item 2.3.2.5 of the draft NMHSPF. and NSW is keen to close their Walker Unit at Concorde.

7. Existing programs

The Business Case doesn't appear to take into account services already provided in other HHSs (other than MS, MS and WM) and/or reorientation of any existing programs. Apart from acute inpatient units and three existing day programs, there are no other existing programs provided by other HHSs. Based on the FTE figures in the attached report, where Child and Youth MH FTE are short of targets, we believe new programs with additional staffing is needed. Consideration needs to be given to the expanded head space ear marked for GC and Logan/Beenleigh that will see $5m invested in early psychosis (young people 16-25) services. The EPIC services proposed for GC and Logan do not care for 13 to 15 year olds, or adolescents without a psychotic illness. Based on CIMHA data, the majority of young people targeted by the new services proposed fall outside the scope of the EPIC services noted. Where appropriate, CYMHS collaborates with headspace to explore synergies in service provision and have successful partnerships across metro Brisbane. Furthermore, the QLD/NT State Manager for headspace is a participating Steering Committee member for this initiative, overseeing the development of the proposed services. All opportunities to collaborate have and continue to be explored.

8. Deliverables

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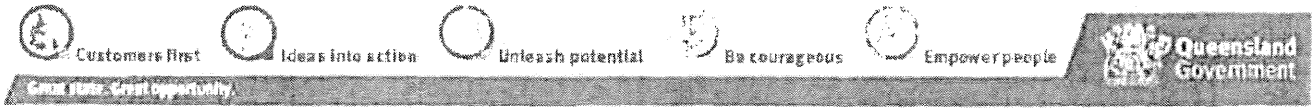
11. Section 4 Issues

Tables 1 and 2 - column 1 labelled Hospital and Health Services refers to locations - Logan/ Bayside/ Beenleigh and Redcliffe/ Caboolture not HHS. This column label has been altered to the more appropriate title of *Geographical Catchment* in the attached business case.

a. the assumption that 10% of all youth population for every HHS has "mental health needs" is not supported by any argument/data except the source statement of "general epidemiology data" In the absence of more concrete data, we have utilised estimates provided by the MHAODB.
b. There appears to be no link between the demand and how the model of care meets or works towards this demand. There appears to be no information that links growing demand (growing population) and future expansion of services required to meet this demand over the longer term. As noted above, in the absence of quantifiable data, we have been unable to link demand with services. However, there is data that indicates young people fall out of care or are lost to follow up due to the current limited child and youth mental health service, which is currently inadequate to meet their needs. Anecdotal information collected from the NGO sector further supports this position. Is it a one-off solution to meet current need only? We believe the proposed model of care is a robust plan to address current and future gaps in service delivery, providing a continuum of care for young people across the state.

Happy to discuss as required.

Regards
Colleen Jen
Senior Director
Policy and Planning Branch | System Policy and Performance Division
Department of Health | Queensland Government
147-163 Charlotte Street Brisbane QLD 4000
[redacted] | www.health.qld.gov.au



From: Ingrid Adamson
Sent: Tuesday, 4 March 2014 1:56 PM
To: Nick Steele; Colleen Jen
Cc: Helen Ceron; Deborah Miller; Stephen Stathis; Judi Krause; Marie Kelly; Ellen Cumberland
Subject: Business Case for Adolescent Mental Health Extended Treatment Model of Care

Hello Nick/Colleen and thank you again for your time this morning.

As promised, I have attached the information provided to us by the Mater regarding the supply of two subacute inpatient beds until November 2014, at which time the Lady Cilento will open and other arrangements will be made. This information was only received late last week and the business case figures are yet to be adjusted accordingly.

Colleen, if you are able to send through Evelyn's contact details (Medicare Local) that would be greatly appreciated.

In the meantime, please let me know if you have any questions or require any other information.

Warm regards,

Ingrid Adamson
Project Manager
Office of Strategy Management

Children's Health Queensland
Hospital and Health Service
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Royal Children's Hospital, Herston Road, Herston, QLD 4029
www.health.qld.gov.au/childrenshealth

Robert Boal

From: Ingrid Adamson
Sent: Thursday, 17 April 2014 6:02 PM
To: Deborah Miller
Subject: RE: Response to Queries RE: Business Case for Adolescent Mental Health Extended Treatment Model of Care

Thanks Deb – appreciated!

From: Deborah Miller
Sent: Thursday, 17 April 2014 6:02 PM
To: Ingrid Adamson
Subject: RE: Response to Queries RE: Business Case for Adolescent Mental Health Extended Treatment Model of Care

Ingrid
I have sent her an urgent email = hopefully we'll hear back – otherwise I will have Jake put a recall in my diary for 28 April

Deb

From: Ingrid Adamson
Sent: Tuesday, 15 April 2014 7:37 PM
To: Deborah Miller
Subject: Re: Response to Queries RE: Business Case for Adolescent Mental Health Extended Treatment Model of Care

It would be great if you could follow up as I haven't heard from her.

Thanks heaps

Sent from my iPhone

On 15 Apr 2014, at 7:04 pm, "Deborah Miller" <[redacted]> wrote:

> Ingrid
> Do you need me to follow this up with Loretta or has she responded.
> Deb
>
> **From:** Ingrid Adamson
> **Sent:** Tuesday, 15 April 2014 10:13 AM
> **To:** Loretta Seamer; CHQ_CFO
> **Cc:** Judi Krause; Stephen Stathis; Deborah Miller
> **Subject:** RE: Response to Queries RE: Business Case for Adolescent Mental Health Extended Treatment Model of Care
>
> Hi Loretta – just following up on my earlier email and wondering if you can make sense of Colleen's latest request?
>
> Thanks heaps
> Ingrid
>
> **From:** Ingrid Adamson
> **Sent:** Thursday, 10 April 2014 10:37 AM

To: Loretta Seamer
Cc: Judi Krause; Stephen Stathis; Deborah Miller
Subject: FW: Response to Queries RE: Business Case for Adolescent Mental Health Extended Treatment Model of Care

Hi Loretta - I am just reading Colleen's email and want to make sure I am clear - appreciate your view.

Colleen makes mention of *putting forward a proposal for 2014/15.* You requested from me an email seeking funding and FTE for 2014/15 to forward onto Nick Steele. Does that email (sent to you on 2nd April) meet this requirement?

If not, does the updated business case, attached to my email to Colleen meet this requirement? It was amended for 2014/15 funding. Appreciate your guidance on what is required by them.

Thanks,
Ingrid

From: Colleen Jen
Sent: Thursday, 10 April 2014 9:18 AM
To: Ingrid Adamson
Cc: Helen Ceron; Deborah Miller; Stephen Stathis; Judi Krause; Marie Kelly; Ellen Cumberland; Bill Kingswell; Loretta Seamer; Liz Drake; Nick Steele
Subject: RE: Response to Queries RE: Business Case for Adolescent Mental Health Extended Treatment Model of Care

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Loretta raised the proposal for additional funding for 2014-15 at the recent Children's Health Queensland service agreement meeting and the action was once the HHS has reviewed the comments that were forwarded the HHS would put forward a proposal for consideration for 2014-15 as part of the service agreement negotiations. Additional funding for the outer years would need to be held over till the next service agreement round as growth funding from Treasury for 2015-16 onwards has not been allocated to Health at this point.

Mental Health Branch and Policy and Planning Branch would be more than happy to work with the HHS as required to progress this.

Regards
Colleen Jen
Senior Director
Policy and Planning Branch | System Policy and Performance Division
Department of Health | Queensland Government
147-163 Charlotte Street Brisbane QLD 4000
[redacted] | www.health.qld.gov.au

From: Ingrid Adamson
Sent: Wednesday, 2 April 2014 7:02 PM
To: Colleen Jen
Cc: Helen Ceron; Deborah Miller; Stephen Stathis; Judi Krause; Marie Kelly; Ellen Cumberland; Bill Kingswell; Loretta Seamer
Subject: Response to Queries RE: Business Case for Adolescent Mental Health Extended Treatment Model of Care
Importance: High

Hello Colleen and thank you for your email.

Firstly, my apologies for not having our response to you sooner. We have responded to each of your queries in red below, and welcome the opportunity to discuss this further, if you have any questions or would like any other information.

Thanks again and warm regards,
Ingrid

Ingrid Adamson
Project Manager
Office of Strategy Management

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From: Colleen Jen
Sent: Monday, 17 March 2014 11:08 AM
To: Ingrid Adamson; Nick Steele
Cc: Helen Ceron; Deborah Miller; Stephen Stathis; Judi Krause; Marie Kelly; Ellen Cumberland; Bill Kingswell
Subject: RE: Business Case for Adolescent Mental Health Extended Treatment Model of Care

Hi

After discussing the business case with Mental Health Branch the following joint comments are for your consideration.

1. Mobile outreach service in each HHS with 2 staff and access to Psychiatrist

The statement that 16-20 adolescents will be treated is unclear whether this refers to whole of QLD or to each HHS. Assume it's each HHS so could be made clearer. This figure of 16-20 is per each AMYOS team, of which we are proposing 1 team per HHS – this has now been clarified in the business case attached, pg 9. Existing staffing need to be considered in costings. It's expected that no additional FTE required to deliver AMYOS Cairns (currently 80% of C&Y 2017 target and 93% of all FTE target) Townsville (has existing adol MH unit and day centre and 95% of FTE target) Rockhampton over state average, PAH over state average (includes Mater staff), Toowoomba over state average. Additional FTE for AMYOS can be justified (12 in total) Mackay Metro Nth (55% C&Y target, 64% all FTE target) Wide Bay (57% and 59%) Sunshine Coast (46% and 52%) Gold Coast (42% and 49%) West Moreton (43% and 49%). We have been working with the target FTE figures as identified in the June 2012 MHAODB FTE Report (attached). We note that the figures you have quoted above are different to those in the attached report – do you have different FTE data we should be working with? We have worked with the Child and Youth Mental Health percentages from this report (excluding acute care or adult MH FTE as these are out of scope). Based on the figures in this report, we have identified that additional staff are required to implement the AMYOS service.

In regard to staff re-allocation, if required, this is not within CHQ's remit to request of other HHSs.

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Business case proposes a requirement of 140 beds across Queensland, but we are starting with 30 beds. Current Community Care Unit planning guideline is 10 per 100,000 population – this is equivalent to 35 adolescent beds across the state. The proposed 140 beds translates to about 40 beds per 100,000. This is a big gap to close and timing and priorities will be important. The information on Resi beds may have been misunderstood. The information provided was merely to highlight that the Victorian Government recognises the value of the Resi and has invested heavily in beds. If Queensland were to adopt a similar approach, we would require up to 140 beds for the population of adolescents in Queensland. However, we are not proposing this but rather, due to funding limitations, that 30 beds be considered in the first instance and until success of the service can be evaluated. The Community Care Unit Planning Guideline is based on an adult population that is not applicable to adolescents, as young people require different models of service with different supervision requirements.

4. Step Up/Step Down

Business case is proposing 30 beds. Would these adolescents have been accessing other services existing CYMH community based services and therefore some redirection of funds? The Step Up/Step Down unit provides a more effective and efficient approach to treatment of young people and assists in the promotion of hospital avoidance. There may be efficiencies achieved through their implementation; however, this would require a robust evaluation and analysis of the potential before redirection of funds could be supported.

5. Recurrent funding

The costing state that total required recurrent funding in 16-17 is $12.4M and that this funding would allow treatment of 260 more adolescents each week compared with the Barrett Centre alone. Is there evidence this demand exists? A request for data regarding demand for services was submitted to MHAODB however no information regarding demand for services has been received. We have been unable to find any other data sources that identify current, future or latent demand for services. It should be clear in the business case that these costs relate to new services delivering end to end treatment models for youths which is well in excess to what was being offered at Barrett. As noted in the Background and Statement of Need (pgs 4 and 5), the Adolescent Mental Health Extended Treatment and Rehabilitation Initiative has been established to explore and develop a more contemporary, enhanced model of care for young people, in light of the Barrett closure. We would appreciate further guidance as to how this should be made more clear in the business case.

6. Bed based service

There appears to be some discrepancy between the Document and Appendix 1 – appendix 1 states a bed based service should be 8-10 beds, while the document states it will be 2 – 4 beds. Discrepancy has been corrected in the version attached. The case is for 2-4 beds. Support for a bed based service is low. Suggest wait and see the impact of the day programs and AMYOS teams (as discussed at the meeting). Agreed – 2 interim beds are being supported from existing operation funds until November 2014. It is hoped that that a better understanding of demand will be known to

determine whether the 4 subacute beds proposed at Lady Cilento should progress. Note that the NMHSPF does not support a bed based service We based the development of services on the draft NMHSPF as a key reference document. The subacute bed-based option is based on information provided at item 2.3.2.5 of the draft NMHSPF. and NSW is keen to close their Walker Unit at Concorde.

7. Existing programs

The Business Case doesn't appear to take into account services already provided in other HHSs (other than MS, MS and WM) and/or reorientation of any existing programs. Apart from acute inpatient units and three existing day programs, there are no other existing programs provided by other HHSs. Based on the FTE figures in the attached report, where Child and Youth MH FTE are short of targets, we believe new programs with additional staffing is needed. Consideration needs to be given to the expanded head space ear marked for GC and Logan/Beenleigh that will see $5m invested in early psychosis (young people 16-25) services. The EPIC services proposed for GC and Logan do not care for 13 to 15 year olds, or adolescents without a psychotic illness. Based on CIMHA data, the majority of young people targeted by the new services proposed fall outside the scope of the EPIC services noted. Where appropriate, CYMHS collaborates with headspace to explore synergies in service provision and have successful partnerships across metro Brisbane. Furthermore, the QLD/NT State Manager for headspace is a participating Steering Committee member for this initiative, overseeing the development of the proposed services. All opportunities to collaborate have and continue to be explored.

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Regards
Colleen Jen
Senior Director
Policy and Planning Branch | System Policy and Performance Division
Department of Health | Queensland Government
147-163 Charlotte Street Brisbane QLD 4000

| www.health.qld.gov.au
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From: Ingrid Adamson
Sent: Tuesday, 4 March 2014 1:56 PM
To: Nick Steele; Colleen Jen
Cc: Helen Ceron; Deborah Miller; Stephen Stathis; Judi Krause; Marie Kelly; Ellen Cumberland
Subject: Business Case for Adolescent Mental Health Extended Treatment Model of Care

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Warm regards,

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Project Manager
Office of Strategy Management

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Hospital and Health Service
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Royal Children's Hospital, Herston Road, Herston, QLD 4029
www.health.qld.gov.au/childrenshealth

Robert Boal

From: Ingrid Adamson
Sent: Thursday, 24 April 2014 10:32 AM
To: Alan Fletcher
Cc: Deborah Miller
Subject: RE: Response to Queries RE: Business Case for Adolescent Mental Health Extended Treatment Model of Care
Attachments: RE: Business Case for Adolescent Mental Health Extended Treatment Model of Care

Hi Alan – in Colleen's email below, she notes that CHQ was going to forward a 2014/15 proposal for consideration. I provided this to Loretta (see attached email) back on the 2nd April with the understanding that Loretta was going to send this onto Nick Steele and Colleen. The fact that Colleen is now asking for this in her email dated 10th April suggests that perhaps the attached email did not make it to them. I was just following Loretta up in regard to this as I am not sure what is required now???

Appreciate any insight you can provide.

Cheers
Ingrid

From: Deborah Miller
Sent: Thursday, 24 April 2014 10:15 AM
To: Alan Fletcher
Cc: Ingrid Adamson
Subject: Fwd: Response to Queries RE: Business Case for Adolescent Mental Health Extended Treatment Model of Care

Alan
Given Loretta is away can you please see email below and advise if Anything further is required . Thanks so much
Deb

Deborah Miller
A/Executive Director
Office Strategy Management
Office of the Chief Executive Children's Health Queensland

Sent from IPhone

Begin forwarded message:

From: Ingrid Adamson <
Date: 24 April 2014 9:59:40 AM AEST
To: Loretta Seamer , CHQ_CFO
<
Cc: Judi Krause <>, Stephen Stathis
, Deborah Miller
Subject: RE: Response to Queries RE: Business Case for Adolescent Mental Health Extended Treatment Model of Care

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Thanks heaps
Ingrid

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Sent: Thursday, 10 April 2014 10:37 AM
To: Loretta Seamer
Cc: Judi Krause; Stephen Stathis; Deborah Miller
Subject: FW: Response to Queries RE: Business Case for Adolescent Mental Health Extended Treatment Model of Care

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Ingrid Adamson
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Business case proposes a requirement of 140 beds across Queensland, but we are starting with 30 beds. Current Community Care Unit planning guideline is 10 per 100,000 population – this is equivalent to 35 adolescent beds across the state. The proposed 140 beds translates to about 40 beds per 100,000. This is a big gap to close and timing and priorities will be important. The information on Resi beds may have been misunderstood. The information provided was merely to highlight that the Victorian Government recognises the value of the Resi and has invested heavily in beds. If Queensland were to adopt a similar approach, we would require up to 140 beds for the population of adolescents in Queensland. However, we are not proposing this but rather, due to funding limitations, that 30 beds be considered in the first instance and until success of the service can be evaluated. The Community Care Unit Planning Guideline is based on an adult population that is not applicable to adolescents, as young people require different models of service with different supervision requirements.

4. Step Up/Step Down

Business case is proposing 30 beds. Would these adolescents have been accessing other services existing CYMH community based services and therefore some redirection of funds? The Step Up/Step Down unit provides a more effective and efficient approach to treatment of young people and assists in the promotion of hospital avoidance. There may be efficiencies achieved through their implementation; however, this would require a robust evaluation and analysis of the potential before redirection of funds could be supported.

5. Recurrent funding

The costing state that total required recurrent funding in 16-17 is $12.4M and that this funding would allow treatment of 260 more adolescents each week compared with the Barrett Centre alone. Is there evidence this demand exists? A request for data regarding demand for services was submitted to MHAODB however no information regarding demand for services has been received. We have been unable to find any other data sources that identify current, future or latent demand for services. It should be clear in the business case that these costs relate to new services delivering end to end treatment models for youths which is well in excess to what was being offered at Barrett. As noted in the Background and Statement of Need (pgs 4 and 5), the Adolescent Mental Health Extended Treatment and Rehabilitation Initiative has been established to explore and

develop a more contemporary, enhanced model of care for young people, in light of the Barrett closure. We would appreciate further guidance as to how this should be made more clear in the business case.

6. Bed based service

There appears to be some discrepancy between the Document and Appendix 1 – appendix 1 states a bed based service should be 8-10 beds, while the document states it will be 2 – 4 beds. Discrepancy has been corrected in the version attached. The case is for 2-4 beds. Support for a bed based service is low. Suggest wait and see the impact of the day programs and AMYOS teams (as discussed at the meeting). Agreed – 2 interim beds are being supported from existing operation funds until November 2014. It is hoped that that a better understanding of demand will be known to determine whether the 4 subacute beds proposed at Lady Cilento should progress. Note that the NMHSPF does not support a bed based service We based the development of services on the draft NMHSPF as a key reference document. The subacute bed-based option is based on information provided at item 2.3.2.5 of the draft NMHSPF. and NSW is keen to close their Walker Unit at Concorde.

7. Existing programs

The Business Case doesn't appear to take into account services already provided in other HHSs (other than MS, MS and WM) and/or reorientation of any existing programs. Apart from acute inpatient units and three existing day programs, there are no other existing programs provided by other HHSs. Based on the FTE figures in the attached report, where Child and Youth MH FTE are short of targets, we believe new programs with additional staffing is needed. Consideration needs to be given to the expanded head space ear marked for GC and Logan/Beenleigh that will see $5m invested in early psychosis (young people 16-25) services. The EPIC services proposed for GC and Logan do not care for 13 to 15 year olds, or adolescents without a psychotic illness. Based on CIMHA data, the majority of young people targeted by the new services proposed fall outside the scope of the EPIC services noted. Where appropriate, CYMHS collaborates with headspace to explore synergies in service provision and have successful partnerships across metro Brisbane. Furthermore, the QLD/NT State Manager for headspace is a participating Steering Committee member for this initiative, overseeing the development of the proposed services. All opportunities to collaborate have and continue to be explored.

8. Deliverables

There should be some linkage of measure of output or activity to be provided for the cost of the service besides just supplying labour costs and capital cost? We have been unable to identify an activity based funding model for child and youth mental health services and understand work on this is still underway. We are also unaware of any activity based funding models specific to the services being proposed. We understand that activity based funding will come into effect from 2016.

9. Section 1.3 Statement of Need

The statement of is very non- specific – describes strategic goals and notes gaps but does not explain the health service need in a true planning context or identify what the gaps are – would be good to know what needs are currently being addressed through existing services (page 9 states that a more detailed understanding of the true need won't be known until later in 2014). As noted above, we have been unable to find any data sources that identifies the current, future or latent demand for services. The state MH plan was based on the epidemiological study of Qld Centre for MH research and was then translated into the inputs needed to provide the service. 14 FTE/100,000 pop'n to provide ambulatory services and 2.5 beds/100,000 pop'n. Based on the figures in the attached FTE report, Child and Youth mental health is still under-resourced.

10. Section 1.5 Scope

There is reference to "do not meet the definition of mental health extended treatment and rehabilitation services (such as acute, forensic, and Community CYMHS)" however there is not a definition for "mental health extended treatment and rehabilitation services" – suggest a Glossary.

Aligning to the taxonomy of the National MHSPF would be good. Does this service cover rehabilitation service for patients with and Acquired Brain Injury and a Mental Health disorder? Acquired brain injury and intellectual disorders are out of scope of the proposed services. These services will treat adolescents with co-morbidities but not ABI or ID in isolation.

A definition, sourced from the Queensland Clinical Services Capability Framework v3.1, has been provided in the updated business case attached. It reads: *Adolescent mental health extended treatment and rehabilitation 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.*

11. Section 4 Issues

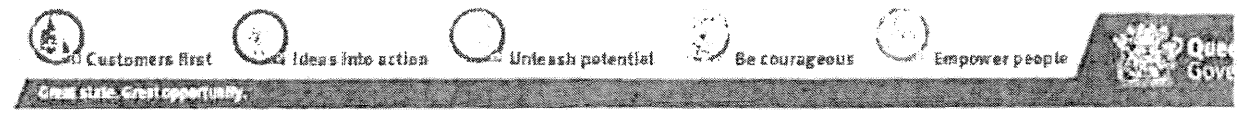
Tables 1 and 2 - column 1 labelled Hospital and Health Services refers to locations - Logan/ Bayside/ Beenleigh and Redcliffe/ Caboolture not HHS. This column label has been altered to the more appropriate title of *Geographical Catchment* in the attached business case.

a. the assumption that 10% of all youth population for every HHS has "mental health needs" is not supported by any argument/data except the source statement of "general epidemiology data" In the absence of more concrete data, we have utilised estimates provided by the MHAODB.
b. There appears to be no link between the demand and how the model of care meets or works towards this demand. There appears to be no information that links growing demand (growing population) and future expansion of services required to meet this demand over the longer term. As noted above, in the absence of quantifiable data, we have been unable to link demand with services. However, there is data that indicates young people fall out of care or are lost to follow up due to the current limited child and youth mental health service, which is currently inadequate to meet their needs. Anecdotal information collected from the NGO sector further supports this position. Is it a one-off solution to meet current need only? We believe the proposed model of care is a robust plan to address current and future gaps in service delivery, providing a continuum of care for young people across the state.

Happy to discuss as required.

Regards

Colleen Jen
Senior Director
Policy and Planning Branch | System Policy and Performance Division
Department of Health | Queensland Government
147-163 Charlotte Street Brisbane QLD 4000
[redacted] | www.health.qld.gov.au



From: Ingrid Adamson
Sent: Tuesday, 4 March 2014 1:56 PM
To: Nick Steele; Colleen Jen
Cc: Helen Ceron; Deborah Miller; Stephen Stathis; Judi Krause; Marie Kelly; Ellen Cumberland
Subject: Business Case for Adolescent Mental Health Extended Treatment Model of Care

Hello Nick/Colleen and thank you again for your time this morning.

As promised, I have attached the information provided to us by the Mater regarding the supply of two subacute inpatient beds until November 2014, at which time the Lady Cilento will open and other arrangements will be made. This information was only received late last week and the business case figures are yet to be adjusted accordingly.

Colleen, if you are able to send through Evelyn's contact details (Medicare Local) that would be greatly appreciated.

In the meantime, please let me know if you have any questions or require any other information.

Warm regards,

Ingrid Adamson
Project Manager
Office of Strategy Management

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Hospital and Health Service
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www.health.qld.gov.au/childrenshealth

Robert Boal

From: Ingrid Adamson
Sent: Wednesday, 2 April 2014 6:57 PM
To: Loretta Seamer; CHQ_CFO
Cc: Deborah Miller; Judi Krause; Stephen Stathis
Subject: RE: Business Case for Adolescent Mental Health Extended Treatment Model of Care

Importance: High

This message has been archived.

Hi Loretta,

Further to our corridor conversation last night, it would be of enormous value if we were able to access any new funds that might be available in 2014/15. The table below identifies the additional new services we would fund, and the associated FTE. The number of AMYOS teams can be scaled in numbers to accommodate whatever funds could be secured (e.g. 1 team, 6 teams, or all 12 teams). The more teams we are able to fund, the more we are able to make available to the HHSs.

Attachments:

image001.png	(1 KB)
image002.png	(1 KB)
image003.png	(1 KB)
image004.png	(18 KB)

Robert Boal

From: Ingrid Adamson
Sent: Tuesday, 26 August 2014 5:15 PM
To: Loretta Seamer; Alan Fletcher
Cc: CHQ_CFO; Peter Steer; Stephen Stathis; Judi Krause
Subject: Relationship Management Meeting - AMHETI Business Case
Attachments: AMHETI Business Case v4.0.doc

Hi Loretta/Alan,

I am not sure if you are aware that we have had another sentinel event recently, involving a third adolescent. This young person left the Barrett mid-way through last year and unfortunately the community and media are connecting their death to the closure of the Barrett. Consequently, the Department has instigated an external Health Service Investigation into transition planning for the young people that left the Barrett. This has also raised adolescent mental health front and centre to the DG and Minister.

After speaking with Peter, we are wondering whether there is enough attention to warrant putting the AMHETI business case back on the table at the next Relationship Management Meeting? I'd be interested in your thoughts on this...

I have attached the latest version of the business case, for your information, and summarise our funding request as follows:

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> If further funding is available, the second tranche of services could be added, which would include another day program (Gold Coast or Logan area), another residential rehabilitation unit, and the first Step Up/Step Down Unit for Queensland, providing even more options for the more severe and complex cases. This would require an additional $6.7m (on top of $5.5m mentioned above – total $12.2m additional funding).
>
> The total additional, recurrent funding required, to support the entire proposed model of care, is $17.2m in 2015/16, increasing to $22.7m ongoing. This is comparative to the $18m Communities currently spends on the Evolve service, for a smaller cohort of consumers. The total spend is summarised in the table below:

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AMYOS x 12 Teams (approx. the rest of Qld)	$3,719,396	$3,712,369	$3,806,559
TOTAL	$5,136,930	$5,452,380	$5,590,515
Second Day Program	$0	$1,528,015	$1,568,101

Second Resi Rehab Unit	$0	$1,570,550	$1,527,111
Step Up/Step Down Unit (SUSDU)	$0	$3,586,651	$3,648,007
TOTAL	**$0**	**$6,685,216**	**$6,743,219**
Third Day Program	$0	$0	$1,568,101
Third Resi Rehab Unit	$0	$1,570,550	$1,527,111
Step Up/Step Down Units 2 & 3	$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

Please let me know if you need any other information.
Regards
Ingrid

Ingrid Adamson
Project Manager, Adolescent Mental Health Extended Treatment Initiative (AMHETI)
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Robert Boal

From: Ingrid Adamson
Sent: Thursday, 2 October 2014 11:23 AM
To: Stephen Stathis
Subject: FW: Relationship Management Meeting - AMHETI Business Case

Follow Up Flag: Follow up
Flag Status: Flagged

Hi Stephen – here are the follow up emails....you might have better luck with Alan and Loretta.

Cheers
Ingrid

> **From:** Ingrid Adamson
> **Sent:** Monday, 22 September 2014 9:14 AM
> **To:** Loretta Seamer; Alan Fletcher
> **Cc:** CHQ_CFO; Peter Steer; Stephen Stathis; Judi Krause
> **Subject:** RE: Relationship Management Meeting - AMHETI Business Case
>
> Good morning Alan,
>
> Just following up to see if what was decided regarding the AMHETI business case?
>
> Cheers
> Ingrid
>
> **From:** Ingrid Adamson
> **Sent:** Tuesday, 2 September 2014 10:11 AM
> **To:** Loretta Seamer; Alan Fletcher
> **Cc:** CHQ_CFO; Peter Steer; Stephen Stathis; Judi Krause
> **Subject:** RE: Relationship Management Meeting - AMHETI Business Case
>
> Hi Alan/Loretta – just following up on my earlier email to see whether you have had a chance to consider whether the AMHETI Business Case should go up to the Department again?
>
> Thanks
> Ingrid
>
> **From:** Ingrid Adamson
> **Sent:** Tuesday, 26 August 2014 5:15 PM
> **To:** Loretta Seamer; Alan Fletcher
> **Cc:** CHQ_CFO; Peter Steer; Stephen Stathis; Judi Krause
> **Subject:** Relationship Management Meeting - AMHETI Business Case
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GRAND TOTAL	**$5,136,930**	**$17,294,797**	**$22,759,927**

Please let me know if you need any other information.
Regards
Ingrid

Ingrid Adamson
Project Manager, Adolescent Mental Health Extended Treatment Initiative (AMHETI)
Child and Youth Mental Health Service I Division of Child and Youth Mental Health
Children's Health Queensland Hospital and Health Service I Queensland Government
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Robert Boal

From: Ingrid Adamson
Sent: Monday, 13 October 2014 5:49 PM
To: Alan Fletcher
Cc: Stephen Stathis
Subject: RE: Relationship Management Meeting - AMHETI Business Case
Attachments: AMHETI Business Case v4.0.doc

Thanks Alan – latest version of the business case attached for you, and summary of funding bid below.

Cheers...Ingrid

From: Alan Fletcher
Sent: Monday, 13 October 2014 5:42 PM
To: Stephen Stathis; Ingrid Adamson
Cc: Loretta Seamer; CHQ_CFO; Peter Steer; Judi Krause; Ross Stanley
Subject: RE: Relationship Management Meeting - AMHETI Business Case

Stephen and Ingrid,

We had the Relationship Management meeting with DoH last Thursday and the AHMETI business case was raised during the meeting to ascertain whether there was support with the proposed program enhancement.

There had been turnover of key staff within HPFB in DoH and therefore weren't yet in apposition to have a definite position.

Could you please forward to me the latest version of the business case so I can forward it to Kerrie Freeman who has replaced Helen Ceron.

Thanks

Alan

Alan Fletcher
Senior Director Performance Management and Analysis
Children's Health Queensland Hospital and Health Service
Royal Children's Hospital

P :
M :

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Robert Boal

From: Stephen Stathis
Sent: Monday, 17 November 2014 4:49 PM
To: Alan Fletcher; Ingrid Adamson
Cc: Loretta Seamer; CHQ_CFO; Peter Steer; Judi Krause; Ross Stanley
Subject: RE: Relationship Management Meeting - AMHETI Business Case

G'day Alan

Following up on this: Not only is this important clinically, but with the recent increased media and political interest in the ex-Barrett clients, I am keen to advocate for the roll out of new Adolescent Extended Treatment and Rehabilitation Services across the state (as per our Business Plan). I am worried about the reputational risk to CHQ if we can't demonstrate that we have pushed this up through the DoH.

From memory, Ingrid sent you the latest version of our Business plan in response to this email.

Thanks

Stephen

From: Alan Fletcher
Sent: Monday, 13 October 2014 5:42 PM
To: Stephen Stathis; Ingrid Adamson
Cc: Loretta Seamer; CHQ_CFO; Peter Steer; Judi Krause; Ross Stanley
Subject: RE: Relationship Management Meeting - AMHETI Business Case

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hanks

Alan

Alan Fletcher
Senior Director Performance Management and Analysis
Children's Health Queensland Hospital and Health Service
Royal Children's Hospital

P :
M :

From: Stephen Stathis
Sent: Monday, 13 October 2014 4:07 PM
To: Ingrid Adamson; Alan Fletcher

Cc: Loretta Seamer; CHQ_CFO; Peter Steer; Judi Krause; Ross Stanley
Subject: RE: Relationship Management Meeting - AMHETI Business Case
Importance: High

Dear Alan

I was going through my old emails and came across this. I haven't seen any reply.

Re Ingrid's email of 26 August ; has this progressed at all? I am mindful it has been almost 2 months.

We need to be advocating for a further role out of additional AMHETI business case funding for the 2015/16 FY

Stephen

Stephen Stathis

Medical Director
Child and Youth Mental Health Service | Division of Child and Youth Mental Health
Children's Health Queensland Hospital and Health Service Queensland Government

"Citilink" Business Centre Building 2, Foyer 4, Level 2, 153 Campbell Street, Bowen Hills QLD 4006 PO Box 1507 Fortitude Valley QLD 4006
t:
e: www.health.qld.gov.au/childrenshealth

From: Ingrid Adamson
Sent: Monday, 22 September 2014 7:53 PM
To: Alan Fletcher
Cc: Loretta Seamer; CHQ_CFO; Peter Steer; Stephen Stathis; Judi Krause; Ross Stanley
Subject: Re: Relationship Management Meeting - AMHETI Business Case

Thanks Alan - the window amendment is a separate matter to the email below but I appreciate the follow up on the TOHI funding as this is now urgent.

I was following up on whether the AMHETI business case has made it to another Relationship Mgt Meeting for consideration?

Cheers
Ingrid

Sent from my iPhone

On 22 Sep 2014, at 6:04 pm, "Alan Fletcher" < > wrote:

> Ingrid,
>
> I have asked Ross and Mary to have the finances actioned as a matter of urgency in order to progress through the amendment window process.
>
> I will let you know of progress in the morning.
>
> Regards
>
> Alan

From: Ingrid Adamson
Sent: Monday, 22 September 2014 9:14 AM
To: Loretta Seamer; Alan Fletcher
Cc: CHQ_CFO; Peter Steer; Stephen Stathis; Judi Krause
Subject: RE: Relationship Management Meeting - AMHETI Business Case

Good morning Alan,

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Cheers
Ingrid

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Cc: CHQ_CFO; Peter Steer; Stephen Stathis; Judi Krause
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Ingrid

From: Ingrid Adamson
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AMYOS Psychiatrists x 2	$756,079	$734,131	$752,639
AMYOS x 12 Teams (approx. the rest of Qld)	$3,719,396	$3,712,369	$3,806,559
TOTAL	**$5,136,930**	**$5,452,380**	**$5,590,515**
Second Day Program	$0	$1,528,015	$1,568,101
Second Resi Rehab Unit	$0	$1,570,550	$1,527,111
Step Up/Step Down Unit (SUSDU)	$0	$3,586,651	$3,648,007
TOTAL	**$0**	**$6,685,216**	**$6,743,219**
Third Day Program	$0	$0	$1,568,101
Third Resi Rehab Unit	$0	$1,570,550	$1,527,111
Step Up/Step Down Units 2 & 3	$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**

Please let me know if you need any other information.
Regards
Ingrid

Ingrid Adamson
Project Manager, Adolescent Mental Health Extended Treatment Initiative (AMHETI)
Child and Youth Mental Health Service I Division of Child and Youth Mental Health
Children's Health Queensland Hospital and Health Service I Queensland Government
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Robert Boal

From: CHQ_CFO
Sent: Wednesday, 17 December 2014 11:35 AM
To: Ingrid Adamson; CHQ_CFO; Peter Steer
Cc: Judi Krause; Stephen Stathis; Loretta Seamer
Subject: RE: AMHETI Business Case Summary for Relationship Management Meeting

Thanks Ingrid,
I will forward today to DoH for our meeting tomorrow.

Regards,

Loretta Seamer

T:
M:

From: Ingrid Adamson
Sent: Tuesday, 16 December 2014 3:13 PM
To: CHQ_CFO; Peter Steer
Cc: Judi Krause; Stephen Stathis
Subject: AMHETI Business Case Summary for Relationship Management Meeting

Hi Loretta/Peter,

Please find the AMHETI Business Case Summary attached in preparation for the Relationship Management Meeting this week. Please let me know if you require anything else at this time.

Regards,
Ingrid

Ingrid Adamson
Project Manager

Child and Youth Mental Health Service (CYMHS)
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