5.2.2 Capital Costs

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

Capital Fit-Out Costs ($2,000/sqm)	2013-14	2014-15	2015-16	2016-17
Day Program (2 units)			$501,275	$516,314
Step Up/Step Down Unit (3 units)			5,092,320*	$ 2,622,545
Total	**$0**	**$0**	**$5,593,595**	**$3,138,859**
Capital Construction Costs ($3,200/sqm)				
Day Program (2 units)			$1,069,387	$1,101,469
Step Up/Step Down Unit (3 units)			$10,863,616*	$5,594,762
Total	**$0**	**$0**	**$11,933,003**	**$6,696,231**

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

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

6 Recommended Option

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

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

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

7 Risk

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

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

8 Stakeholder Engagement

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

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

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

Key stakeholders involved in this initiative are identified below:

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

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

Consultation undertaken:

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

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

In August 2013, the Statewide Adolescent Extended Treatment and Rehabilitation Strategy (SW AETRS) initiative was established. The **SW AETRS Steering Committee** met for the first time on 26th August. The purpose of the SW AETRS Steering Committee is to oversee the implementation of the SW AETRS, and provide a decision-making, guidance, and leadership role with respect to mental health service planning, models of care, workforce planning, financial management and consumer needs associated with future adolescent extended treatment and rehabilitation services. The committee is co-chaired by the Divisional

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

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

Supporting References and Project Documentation:

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

9 Approval of Recommendation and Decision-Making

Recommendation			
To deliver a robust and comprehensive model for adolescent mental health care, it is strongly recommended that the full spectrum of services be funded and implemented.			
Next Steps	**Prepared By**	**Name:**	Ingrid Adamson
		Work Unit/ Site:	Office of Strategy Management / CHQ HHS
		Date:	02/04/14
	Cleared By (Project Sponsor)	**Name:**	Deborah Miller
		Position:	A/Executive Director, Office of Strategy Management
		Signed:	
		Date:	
		Comments:	

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

Appendix 1: ECRG Recommendations

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

Preamble

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

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

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

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

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

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

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

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

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

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

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

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

Recommendations:

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

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

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

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

Recommendation:

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

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

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

Recommendations:

a) Safe, high quality service provision for adolescents requiring extended treatment and rehabilitation requires a Tier 3 service alternative to be available in a timely manner if BAC is closed.
b) Interim service provision for current and 'wait list' consumers of BAC while Tier 3 service options are established must prioritise the needs of each of these individuals and their families/carers. 'Wrap-around care' for each individual will be essential.
c) BAC staff (clinical and educational) must receive individual care and case management if BAC closes, and their specialist skill and knowledge must be recognised and maintained.

4. Duration of treatment

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

Recommendation:

a) 'Up to 12 months' has been identified by the ECRG as a reasonable duration of treatment, but it was noted that this depends on the availability of effective step-down services and a suitable community residence for the young person. It is important to note that like all mental health service provision, there will be a range in the duration of admission.

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

- Comprehensive educational support underpins social recovery and decreases the likelihood of the long term burden of illness. A specialised educational model and workforce is best positioned to engage with and teach this target group.
- Rehabilitation requires intervention to return to a normal developmental trajectory, and successful outcomes are measured in psychosocial functioning, not just absence of psychiatric symptoms.
- Education is an essential part of life for young people. It is vital that young people are able to access effective education services that understand and can accommodate their mental health needs throughout the care episode.

- For young people requiring extended mental health treatment, the mainstream education system is frequently not able to meet their needs. Education is often a core part of the intervention required to achieve a positive prognosis.

Recommendations:

a) Access to on-site schooling (including suitably qualified educators), is considered essential for Tiers 2 (day programs) and 3. It is the position of the ECRG that a Band 7 Specific Purpose School (provided by Department of Education, Training and Employment) is required for a Tier 3 service.
b) As an aside, consideration should also be given to the establishment of a multi-site, statewide education service for children/adolescents in acute units (hub and spoke model).

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

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

Recommendations:

a) It is considered vital that further consultation and planning is conducted on the best service model for adolescent non-government/private residential and therapeutic services in community mental health. A pilot site is essential.
b) Governance should remain with the local CYMHS or treating mental health team.
c) It is essential that residential services are staffed adequately and that they have clear service and consumer outcome targets.

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

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

Recommendations:

a) Local service provision to North Queensland should be addressed immediately by ensuring a full range of CYMHS services are available in Townsville, including a residential community-based service.
b) If a decision is made to close BAC, this should not be finalised before the range of service options in Townsville are opened and available to consumers and their families/carers.

Appendix 2: Proposed Model of Care

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

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

* Age range includes all young people completing high school

** A phased approach to service implementation is proposed.

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

Appendix 3: Detailed Service Elements

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

MODEL of SERVICE for ASSERTIVE MOBILE YOUTH OUTREACH SERVICE

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

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

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

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

The AMYOS will:

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

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

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

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

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

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

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

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

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

MODEL of SERVICE for a MENTAL HEALTH DAY PROGRAM	
including schooling. • Coordinate and support access to a range of integrated services to ensure seamless service provision. Treatment programs will include an extensive range of therapeutic, educational/vocational interventions, and comprehensive activities to assist in the development and recovery of the adolescent. The MHDP will follow structured phases incorporating assessment, establishment of therapeutic alliances, development of realistic therapeutic goals, treatment, and assertive discharge planning to facilitate reintegration back to community-based treatment. **Programs will include:** • Phased treatment programs that are developed in partnership with adolescents and where appropriate, their parents or carers. • Targeted treatment incorporating a range of therapeutic interventions delivered by appropriately trained staff. • Access to schooling within the hospital campus or unit. • Access to Indigenous and transcultural support services. • Flexible and targeted programs that can be delivered in a range of contexts including individual, family, group, school, and community. • Assertive discharge planning to integrate the adolescent back into their community, including appropriate local mental health treatment, education or vocational services, and accommodation.	
Referral /Access	• Referrals to the MHDP are made by services providing specialist child and youth mental health services. • It is anticipated that young people referred to the MHDP will have the capacity to attend on a daily basis. For young people outside the HHS catchment, this may involve temporary re-location with parents/relatives /alternative accommodation options. It will be the responsibility of the family to fund any alternative accommodation arrangements. • All referrals are received through a designated intake process. There will be a single point of entry for each day program. This single point of referral ensures consistent collection of adequate referral data and immediate feedback on appropriateness. Referrals will be triaged and prioritised according to documented clinical need and risk assessment. • Priorities for admission into the MHDP will be determined on the basis of levels of acuity, the risk of deterioration, the current mix of adolescents in the program, the potential impact on the adolescent and others, length of time on the waiting list, and age at time of referral. • Responsibility for the clinical care of the adolescent remains with the referring HHS until the adolescent is admitted to the MHDP. • Referral agencies will be supported to remain actively involved during MHDP service provision and continue their role as a major service provider following discharge (unless another appropriate referral is made). • Suitability for entry to the MHDP will be undertaken by a Multidisciplinary Intake Panel (MIP) that will consist of: a Consultant Psychiatrist and Registrar; Designated Intake Officer; Team Leader/Coordinator/NUM; Allied Health Representative; and Education representative.

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

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

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

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

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

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

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

MODEL of SERVICE for RESIDENTIAL REHABILITATION

What does the service do?

The key functions:

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

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

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

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

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

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

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

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

MODEL of SERVICE for RESIDENTIAL REHABILITATION	
	• It is envisaged that the residence will be operated and staffed by the NGO sector, utilising mental health trained staff, including youth and support workers. • Administrative support is essential for the efficient operation of the RRU service and would be the responsibility of the NGO. • All appointed CCYMHS Case Managers are (or are working towards becoming) authorised mental health practitioners. • Caseload sizes need to consider a range of factors, including complexity of need, current staff resources within the team, and the available skill mix of the team. Under normal circumstances, case management will not be provided by students or staff appointed less than 0.5 FTE. • All staff will be provided with continuing education and professional development programs, clinical supervision, mentoring, and other appropriate staff support mechanisms. This will be the shared responsibility of the NGO service administrating the RRU and the CCYMHS.
Geographic Location	Case Managers are based with the local CCYMHS and residential staff are based at the RRU.
Funding	Funding for Case Managers will be absorbed by their substantive CCYMHS. In addition to Case Managers, it is recommended: • Two 0.5 clinicians per RRU – HP4 and /or NG7 • Consultant Psychiatrist support (approximately 0.1 FTE) • Community Support Workers: 7.0 FTE • Community Support Team Leader: 1.0 FTE • Administration Officer: 0.2 FTE This Model of Service is for young people aged 16 to 21 living in a RRU. Under this model, CCYMHS may need to negotiate with local adult mental health services and Mental Health and Other Drugs Branch (MHAODB) to fund ongoing case management for young people aged 18 years or older.
Governance	The RRU will operate under the governance of the local Hospital and Health Service, where CCYMHS is located.
Related Services / Other Providers	The RRU services will operate in a complex, multi-system environment. Services are integrated and co-ordinated with partnerships and linkages with other agencies and specialist mental health services, to ensure continuity of care across the service system and through the young person's developmental transitions. Mechanisms for joint planning, developing, and co-ordinating services are developed and maintained. RRU mental health services will develop linkages with services, including but not limited to: • Strong operational and strategic links to the CYMHS network, including community child and youth mental health services; specialist child and youth mental health services (e.g. forensic services and evolve therapeutic

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

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

MODEL of SERVICE for a STEP UP / STEP DOWN UNIT	
	Other diagnostic profiles would include adolescents presenting with social avoidance or disorganised behaviour characterised by impaired impulse control, emerging personality vulnerabilities, risk of self-harm, or difficulties managing activities of daily living. Some may experience chronic family dysfunction, which serves to exacerbate the severity and persistence of the disorder and associated disabilities.
What does the service do? **The key functions:** • Services are located in the community and delivered in a community residential environment. • Services are delivered through partnerships between, and in collaboration with, clinical services and the community support sector. • There is a strong focus on early and active engagement of family/friend/support persons or carers in an adolescent friendly environment. • Services provide individually tailored evidence-informed treatment interventions to alleviate or treat distressing symptoms and promote recovery. • Services will operate as a component of an integrated, cluster-wide child and youth mental health system. Treatment programs will include a range of therapeutic, educational/vocational interventions, and life-skill activities to assist in the development and recovery of the adolescent. The program will follow structured phases incorporating assessment, establishment of therapeutic alliances, development of realistic therapeutic goals, trauma and evidence-informed treatment, and assertive discharge planning to facilitate reintegration back to community-based treatment programs. **Programs will include:** • Phased treatment programs that are developed in partnership with adolescents and, where appropriate, their parents or carers. • Targeted treatment incorporating a range of therapeutic interventions delivered by appropriately trained staff. • Flexible and targeted programs that can be delivered in a range of contexts including individual, family and group therapy. • 24-hour inpatient care for adolescents in a safe, structured, highly supervised, and supportive environment. • Access to on-site or out-reach schooling to support educational and vocational goals. • Access to Indigenous and transcultural support services as required. • Assertive discharge planning to integrate the adolescent back into their community of choice, including appropriate local mental health treatment, education or vocational services, and accommodation.	
Referral /Access	• *Step Up*: Queensland CYMHS services such as community CYMHS (CCYMHS) and day programs will function as the referral agencies. • *Step Down:* Acute Adolescent Inpatient Units • All referrals will be processed through a designated intake officer. This single point of referral ensures consistent collection of adequate referral data and immediate feedback on appropriateness. It also expedites a pre-

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

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

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

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

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

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

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

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

What does the service do?
The key functions:

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

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

MODEL of SERVICE for the BED-BASED UNIT	
Programs will include: • Phased treatment programs that are developed in partnership with adolescents and, where appropriate, their parents or carers. • A comprehensive family assessment completed within the first 4 weeks of admission. • Targeted treatment incorporating a range of therapeutic interventions delivered by appropriately trained staff. • Access to schooling within the hospital campus. • Access to Indigenous and transcultural support services. • 24-hour inpatient care for adolescents in a safe, structured, highly supervised, and supportive environment. • Flexible and targeted programs that can be delivered in a range of contexts including individual, family, group, school, and community. • Assertive discharge planning to integrate the adolescent back into their community of choice, including appropriate local mental health treatment, education or vocational services, and accommodation.	
Referral /Access	• Queensland CYMHS services will act as the referral agency. • All referrals will be processed through a designated intake officer. This single point of referral ensures consistent collection of adequate referral data and immediate feedback on appropriateness. It also expedites a pre-assessment interview (see below) and liaison with the referrer if there is a wait time until the adolescent is admitted. • As a statewide subacute service, referrals will be assessed for suitability for a planned admission via a formal Statewide Admission Panel. The Panel will be chaired by the Clinical Director of the BBU, and include a CHQ Complex Care Co-ordinator, representatives from Mental Health, Education, Housing and Child Safety. Other representatives may be invited onto the Panel as required. This transdisciplinary approach will allow for assertive pre-discharge planning across multiple service providers and promote whole of government partnerships across the sector. • On acceptance, the adolescent will be assigned a Case Manager, who will be responsible for organising admission and ongoing liaison with the referring HHS. • Responsibility for the clinical care of the adolescent remains with the referring HHS until the adolescent is admitted to the BBU. It is anticipated that adolescents will also remain actively engaged with local mental health and other support services prior to, and during the course of, their admission into the BBU. • Priorities for admission will be determined on the basis of levels of acuity, the risk of deterioration, the current mix of admitted adolescents, the potential impact on the adolescent and others, length of time on the waiting list, and age at time of referral. • A pre-admission assessment of the adolescent and family (if appropriate) will be incorporated into the referral process. This may be done in person or via videoconference. The pre-admission assessment enables the adolescent and parents/carers to meet staff and negotiate their

MODEL of SERVICE for the BED-BASED UNIT	
	expectations regarding treatment and discharge planning. It also allows further determination of the potential for therapeutic benefit from the admission, the impact of being with other adolescents, and some assessment of acuity and risk.
Assessment	**Mental Health Assessment** • The Case Manager will obtain a detailed assessment of the nature of mental illness, their behavioural manifestations, impact on function and development, and the course of the mental illness. This assessment will begin with the referral and continues throughout the admission. **Family/Carer Assessment** • A Family Assessment is considered essential. The Case Manager will obtain a detailed history of family structure and dynamics, or a history of care if the adolescent is in care. This process will begin with the referral and continues throughout the admission. • It is expected that the family will be available to complete a comprehensive family assessment and that parents/carers will be involved in the mental health care of the adolescent as much as possible. A significant effort will be made to support the involvement of parents/ carers. As part of this comprehensive assessment, families will be expected to travel to Brisbane for up to a week. The cost of transport, accommodation, meals, and incidentals will be covered by the referring HHS. • If parent/carer mental health needs are identified, the Case Manager will attempt to meet these needs and, if necessary, refer to an adult mental health service or other appropriate supports. **Developmental/Educational** • School-based interventions, to promote learning, educational or vocational goals, and life skills, are a key feature of the assessment process and treatment plan. Access to on-site schooling will be available to all inpatients. • The Case Manager will obtain a comprehensive understanding of any developmental, cognitive, speech and language, or learning disorders and their impact on the adolescent's mental health and schooling. This process begins with available information on referral and during admission. **Physical Health** • Routine physical examination will occur on admission and be monitored throughout admission. • Appropriate investigations will be completed as necessary. • The BBU will have access to local tertiary paediatric consultation services if required. **Risk Assessment** • A key function of the Statewide Admission Panel will be to assess the risk of harm to self and others prior to admission. • Risk assessments will be conducted on admission. Ongoing risk assessments will occur at a frequency as recommended by the treating

MODEL of SERVICE for the BED-BASED UNIT	
	team and updated at case review. • Risk assessments will be conducted in accordance with the statewide standardised clinical documentation. **Alcohol and other Drugs** • Assessments of alcohol and other drug use will be conducted during the referral process, on admission, and routinely throughout treatment. • There will be capacity for adolescents with substance dependence issues to detoxify on admission although this is not the primary function of admission. **Child Safety** • Child safety concerns will be addressed in accordance with legislative mandatory reporting requirements.
Recovery Planning and Clinical Interventions: *** Service Inclusions**	All adolescents will have a designated consultant psychiatrist. A Recovery Plan will be developed in consultation with the adolescent and their family/carers on admission. Adolescents will have access to a range of least restrictive, therapeutic interventions determined by evidence-informed practice, and developmentally appropriate programs to optimise their rehabilitation and recovery. The adolescent's progress against their Recovery Plan is regularly reviewed through collaboration between the treating team, the adolescent, their family/carer, the referrer/s, and other relevant agencies. **Clinical Interventions will include:** Behavioural and psychotherapeutic: • Individual and group-based interventions will be developed according to the adolescent's treatment needs. This will include a range of therapeutic and supportive verbal and non-verbal modalities and frameworks. Family Interventions: • Supportive family interventions will be integrated into the overall therapeutic approaches to the adolescent, where possible. This will include psycho-education for the parents and carers. Where possible, family therapy will also be integrated into the overall therapeutic approaches to the adolescent during admission and as part of their discharge plan. This may include videoconference family therapy support to local mental health services. Tasks to Facilitate Adolescent Development and Schooling: • The BBU will offer a range of interventions to promote appropriate development in a safe and validating environment. • School-based interventions to promote learning, educational or vocational goals, and life skills. • Individual and group-based interventions to promote aspects of adolescent development, which may include local adventure-based and other recreational activities.

MODEL of SERVICE for the BED-BASED UNIT	
	Pharmacological: • Administration will occur under the direction of a consultant psychiatrist. • Regular administration and supervision of psychotropic medications will include monitoring for efficacy and adverse effects of psychotropic medications. • Education will be given to the adolescent and parent(s)/carer about medication and potential adverse effects.
Clinical Intervention: *** Service Exclusions**	• Secure forensic beds are not offered as part this service. • It is also not anticipated that young people with a primary diagnosis of an eating disorder will be accepted into the BBU.
Care Co-Manager / Continuity	• The Case Manager will monitor the adolescent's level of risk, mental state, and function in developmental tasks throughout admission. • The Case Manager will act as the primary liaison person for the parent(s)/carer and external agencies on admission and during the discharge process. • Depending on their skill set, the Case Manager will provide therapeutic input over the course of admission.
Discharge/Transition Planning	• Discharge planning should begin at time of admission, with key stakeholders being actively involved. Discharge planning will address potential significant obstacles, such as accommodation, engagement with other child and youth mental health services, and transition to adult mental health services. • Discharge planning will involve multifactorial components that attend to therapeutic needs, developmental tasks, and reintegration into the family if appropriate. • The school linked to the BBU will have primary responsibility for school reintegration, and /or vocational options, and the support required during this process.
Frequency of activity	• Access to the full multidisciplinary team will be provided weekdays during business hours. • Nursing staff will be rostered to cover shifts 24 hours, 7 days a week. • An on-call consultant child and adolescent psychiatrist, with Registrar support, will be available 24 hours, 7 days per week.
Average Length of Stay	90 days with an expected maximum stay of less than 180 days.
Hours of Operation	24 x 7
Unit Size / Facility Features	Gazetted. 2 to 4 beds. Seclusion room.
Staffing/Workforce	• The staffing profile will incorporate the child and adolescent expertise and skills of psychiatry (consultant psychiatrist and psychiatry registrar),

MODEL of SERVICE for the BED-BASED UNIT	
	mental health nursing, psychology, social work, occupational therapy, speech pathology, and other specialist CYMHS staff. The registrar position will be accredited for basic or advanced training by the Royal Australian and New Zealand College of Psychiatrists. • While there is a typical staff establishment, this may be altered according to levels of acuity and the need for specific therapeutic skills. • Administrative support is essential for the efficient operation of the BBU. • All permanently appointed medical, allied health, and senior nursing staff are (or are working towards becoming) authorised mental health practitioners. • Caseload sizes need to consider a range of factors, including complexity of need, current staff resources within the team, and the available skill mix of the team. Under normal circumstances, case management will not be provided by students or staff appointed less than 0.5 FTE. • The effectiveness of the BBU is dependent upon an adequate number of appropriately trained clinical and non-clinical staff. The complexity of the mental health needs of children and adolescents suggests the need to provide staff with continuing education and professional development programs, clinical supervision, mentoring, and other appropriate staff support mechanisms. The BBU will undertake recruitment and retention strategies, such as providing clinical placements for students, encouraging rotation of staff from other areas of the integrated mental health service through the unit, and supporting education and research opportunities.
Geographic Location	The BBU will be located on a hospital campus in Children's Health Queensland catchment (Brisbane).
Funding	Recommended Clinical Staff per 4 bed unit: • Psychiatrist: 0.2 FTE • Registrar: 0.4 FTE • Total Nursing: 5.1 FTE • Psychologist: 0.2 FTE • Social Work: 0.2 FTE • Occupational Therapist: 0.2 FTE • Speech Therapist: 0.2 FTE • Recreational Officer: 2.2 FTE • Administration Officer: 0.2 FTE
Governance	• The BBU will operate under the governance of Children's Health Queensland Hospital and Health Service (CHQ HHS), within a statewide integrated mental health service. • Operational governance will occur through the BBU Clinical Director reporting directly to the Divisional Director, CYMHS CHQ HHS. • Clinical governance will occur through the BBU Clinical Director reporting directly to the Divisional Medical Director, CHQ HHS. • Interim line management arrangements may be required.

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

MODEL of SERVICE for the BED-BASED UNIT	
	Educational resources are essential to adolescent extended treatment and rehabilitation services. Access to on-campus schooling (including suitably qualified educators) will be offered as an integral part of the BBU. All educational services will need to be evaluated and provided by the Department of Education, Training and Employment (DETE). Consumers and carers will contribute to continued practice improvement through the following mechanisms: • Participation in collaborative treatment planning • Feedback tools (e.g. surveys, suggestion boxes) • Inform workforce development Consumer and carer involvement will reflect the National Mental Health Standards and the Equip National Safety Standards.

Appendix 4: Detailed Costing Models

Statewide Panel Coordinator - Input Sheet

KPIs	Beds/Consumers	0						
	Utilisation %	100						
	m2	4						
Budget Phasing								
Days/year	July	23						
	August	20						
	September	22						
	October	22						
	November	19						
	December	21						
	January	20						
	February	20						
	March	22						
	April	19						
	May	21						
	June	21						
		250						
On-costs		%						
	Super	12.75						
	Rec Leave loading	1.7						
	Work cover	1.5						
		15.95						
LABOUR COSTS								
	Pay Level	Base salary	FTE	Salaries	All other allowances Option A,PD, MV etc		IT Req	FFE Req
Managerial and Clerical								
Administration Officer	AO3	60767	1.00	60,767			1	1
				60,767				
Medical								
Registrar	L13	137517		-				
Psychiatrist	L23	180107		-		0		
				-				
Nursing								
Enrolled Nurse	NG3(4)	54073		-		0		
Registered Nurse	NG5(6)	74474		-		0		
Clinical Nurse	NG6(2)	80522		-		0		
Clinical Nurse	NG6(3)	82393		-		0		
Nurse Unit Manager	NG7(2)	101099		-		0		
				-				
Operational								
Domestic & other staff	OO2(4)	48583		-				
				-				
Professional								
Community Support Worker	PO3(3)	80942		-				
				-				
Health Practitioners								
MH Therapist	HP3(5)	78203		-				
Psychologist	HP3(5)	78203		-				
Social Worker	HP3(5)	78203		-				
Comm Supp Team Leader	HP4(3)	98910		-				
MH Therapist	HP4(3)	98910		-				
Occupational Therapist	HP4(3)	98910		-				
Psychologist	HP4(3)	98910		-				
Social Worker	HP4(3)	98910		-				
Speech Pathologist	HP4(3)	98910		-				
				-				
				60,767		-		
Headcount			1				1	1
NON-LABOUR COSTS								
Staff Development	annual cost per FTE	500						
Vehicle costs	lease cost/month/vehicles							
	No of vehicles							
Fuel costs	monthly cost/vehicle							
Vehicle running costs	monthly cost/vehicle							
Rent	annual cost per m2		based on commercial rent rate					
Property service charge	% of rent		Includes gardening, sewage, external paint, maintenance of guttering, etc.					
Utilities	annual cost 10c/kw.		270kw/annum/m2					
ICT	annual cost per FTE	2500						
Catering	per bed day/consumer							
Linen	per bed day/consumer							
Domestic Services	monthly cost							
Consumables and Staff amenitie	monthly cost							
Therapeutic programs	per annum							
Therapeutic equipment	per annum							
Drugs	per bed day/consumer							
Clinical Supplies	per bed day/consumer							
Repairs and Maintenance	monthly cost							
ESTABLISHMENT COSTS (YR 1 ONLY)								
ICT	per applicable ee	2600	2600					
FFE	per applicable ee	1400	1400	4000				
Fitout	cost per m2							
Construction	cost per m2							

Statewide Panel Coordinator
Budget 2013-17

Labour inflation	2.5%	2.5%	2.5%
Non-labour inflation	3.0%	3.0%	3.0%

Days in Period:	23	20	22	22	19	21	20	20	22	19	21	21	250		
	July	August	September	October	November	December	January	February	March	April	May	June	2014-15 Total	2015-16 Total	2016-17 Total
Managerial and Clerical	5,591	4,861	5,347	5,347	4,618	5,104	4,861	4,861	5,347	4,618	5,104	5,104	62,286	63,843	65,439
Medical	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Nursing	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Operational	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Professional	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Health Practitioners	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Base	5,591	4,861	5,347	5,347	4,618	5,104	4,861	4,861	5,347	4,618	5,104	5,104	62,286	63,843	65,439
Super and work cover (on total base)	892	775	853	853	737	814	775	775	853	737	814	814	9,935	10,183	10,438
Other allowances	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Labour	**6,482**	**5,637**	**6,200**	**6,200**	**5,355**	**5,919**	**5,637**	**5,637**	**6,200**	**5,355**	**5,919**	**5,919**	**72,221**	**74,026**	**75,877**
Drugs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Clinical Supplies	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Staff Development	42	42	42	42	42	42	42	42	42	42	42	42	515	530	546
Vehicle costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Fuel costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Vehicle maint costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Rent	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Property Service charges	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Utilities	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
ICT costs	208	208	208	208	208	208	208	208	208	208	208	208	2,575	2,652	2,732
Catering	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Linen	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Domestic Services	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Consumables	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Therapeutic Programs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Therapeutic Equipment	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
R&M	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
ICT & FFE establishment cost	4,000														
Total Non-Labour	**4,250**	**250**	**250**	**250**	**250**	**250**	**250**	**250**	**250**	**250**	**250**	**250**	**3,090**	**3,183**	**3,278**
TOTAL OPERATING COST	**10,732**	**5,887**	**6,450**	**6,450**	**5,605**	**6,169**	**5,887**	**5,887**	**6,450**	**5,605**	**6,169**	**6,169**	**75,311**	**77,209**	**79,155**

AMYOS Team - Input Sheet

KPIs	Beds/Consumers	8	16 to 20 consumers in caseload per team
	Utilisation %	100	
	m2	8	
Budget Phasing			
Days/year	July	23	
	August	20	
	September	22	
	October	22	
	November	19	
	December	21	
	January	20	
	February	20	
	March	22	
	April	19	
	May	21	
	June	21	
		250	
On-costs		%	
	Super	12.75	
	Rec Leave loading	1.7	
	Work cover	1.5	
		15.95	

LABOUR COSTS

	Pay Level	Base salar	FTE	Salaries	All other allowances Option A,PD, MV etc	Public Holiday/ Weekend rates	IT Req	FFE Req	
Managerial and Clerical									
Administration Officer	AO3	60767		-					
				-					
Medical									
Registrar	L13	137517		-					
Psychiatrist	L23	180107		-	0				
				-					
Nursing									
Enrolled Nurse	NG3(4)	54073		-	0				
Registered Nurse	NG5(6)	74474		-	0				
Clinical Nurse	NG6(2)	80522		-	0				
Clinical Nurse	NG6(3)	82393		-	0				
Nurse Unit Manager	NG7(2)	101099		-	0				
				-					
Operational									
Operational staff	OO2(4)	48583		-					
				-					
Professional									
Community Support Worker	PO3(3)	80942		-					
				-					
Health Practitioners (Teams)									hrly rate
Psychologist	HP4(3)	98910	2.00	197,820		18,741	2	2	100.11 will work bh
				197,820					
Health Practitioners									
MH Therapist	HP3(5)	78203		-					
Psychologist	HP3(5)	78203		-					
Social Worker	HP3(5)	78203		-					
Comm Supp Team Leader	HP4(3)	98910		-					
MH Therapist	HP4(3)	98910		-					
Occupational Therapist	HP4(3)	98910		-					
Psychologist	HP4(3)	98910		-					
Social Worker	HP4(3)	98910		-					
Speech Pathologist	HP4(3)	98910		-					
				-					
				197,820	-	18,741			
Headcount			2				2	2	

NON-LABOUR COSTS

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

ESTABLISHMENT COSTS (YR 1 ONLY)

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

AMYOS Team Summary
Budget 2013-17

Labour	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	
Non-Labour	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	

	Teams 2013-14 (from 3 up to 7) Total	Teams 2014-15 (7) Total	Teams 2015-16 (7) Total	Teams 2016-17 (7) Total	Teams 2014-15 (12) Total	Teams 2015-16 (12) Total	Teams 2016-17 (12) Total
Managerial and Clerical	-	-	-	-	-	-	-
Medical	-	-	-	-	-	-	-
Nursing	-	-	-	-	-	-	-
Operational	-	-	-	-	-	-	-
Professional	-	-	-	-	-	-	-
Teams	211,272	1,419,359	1,454,842	1,491,214	2,433,186	2,494,016	2,556,366
Health Practitioners	-	-	-	-	-	-	-
Total Base	211,272	1,419,359	1,454,842	1,491,214	2,433,186	2,494,016	2,556,366
Super and work cover (on total base)	33,698	226,388	232,047	237,849	388,093	397,795	407,740
Other allowances	20,015	134,466	137,827	141,273	230,512	236,275	242,182
Total Labour	**264,985**	**1,780,212**	**1,824,717**	**1,870,335**	**3,051,792**	**3,128,086**	**3,206,288**
Drugs	-	-	-	-	-	-	-
Clinical Supplies	-	-	-	-	-	-	-
Staff Development	4,333	28,840	29,705	30,596	49,440	50,923	52,451
Vehicle costs	6,591	43,866	45,182	46,537	75,198	77,454	79,778
Fuel costs	3,900	25,956	26,735	27,537	44,496	45,831	47,206
Vehicle maint costs	3,250	21,630	22,279	22,947	37,080	38,192	39,338
Rent	-	-	-	-	-	-	-
Property servicing	-	-	-	-	-	-	-
Utilities	-	-	-	-	-	-	-
ICT costs	5,417	36,050	37,132	38,245	61,800	63,654	65,564
Catering	-	-	-	-	-	-	-
Linen	-	-	-	-	-	-	-
Domestic Services	-	-	-	-	-	-	-
Consumables	-	-	-	-	-	-	-
Therapeutic Programs	-	-	-	-	-	-	-
Therapeutic Equipment	-	-	-	-	-	-	-
R&M	-	-	-	-	-	-	-
ICT & FFE establishment cost	24,000	33,680			98,880		
Total Non-Labour	**47,491**	**190,022**	**161,032**	**165,863**	**366,894**	**276,055**	**284,336**
TOTAL OPERATING COST	**312,476**	**1,970,233**	**1,985,749**	**2,036,198**	**3,418,686**	**3,404,141**	**3,490,625**

Queensland Government

AMYOS
Budget 2013-14

FTE Teams	-	-	-	-	-	-	-	-	-	3	3	7	
Days in Period:	23	20	22	22	19	21	20	20	22	19	21	21	250
	July	August	September	October	November	December	January	February	March	April	May	June	Total
Managerial and Clerical	-	-	-	-	-	-	-	-	-	-	-	-	-
Medical	-	-	-	-	-	-	-	-	-	-	-	-	-
Nursing	-	-	-	-	-	-	-	-	-	-	-	-	-
Operational	-	-	-	-	-	-	-	-	-	-	-	-	-
Professional	-	-	-	-	-	-	-	-	-	-	-	-	-
Teams	-	-	-	-	-	-	-	-	-	*45,103*	*49,851*	*116,318*	*211,272*
Health Practitioners	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Base	-	-	-	-	-	-	-	-	-	45,103	49,851	116,318	211,272
Super and work cover (on total base)	-	-	-	-	-	-	-	-	-	7,194	7,951	18,553	33,698
Other allowances	-	-	-	-	-	-	-	-	-	4,273	4,723	11,020	**20,015**
Total Labour	-	-	-	-	-	-	-	-	-	**56,570**	**62,525**	**145,891**	**264,985**
Drugs	-	-	-	-	-	-	-	-	-	-	-	-	-
Clinical Supplies	-	-	-	-	-	-	-	-	-	-	-	-	-
Staff Development	-	-	-	-	-	-	-	-	-	1,000	1,000	2,333	**4,333**
Vehicle costs	-	-	-	-	-	-	-	-	-	1,521	1,521	3,549	**6,591**
Fuel costs	-	-	-	-	-	-	-	-	-	900	900	2,100	**3,900**
Vehicle maint costs	-	-	-	-	-	-	-	-	-	750	750	1,750	**3,250**
Rent	-	-	-	-	-	-	-	-	-	-	-	-	-
Property service charge	-	-	-	-	-	-	-	-	-	-	-	-	-
Utilities	-	-	-	-	-	-	-	-	-	-	-	-	-
ICT costs	-	-	-	-	-	-	-	-	-	1,250	1,250	2,917	**5,417**
Catering	-	-	-	-	-	-	-	-	-	-	-	-	-
Linen	-	-	-	-	-	-	-	-	-	-	-	-	-
Domestic Services	-	-	-	-	-	-	-	-	-	-	-	-	-
Consumables	-	-	-	-	-	-	-	-	-	-	-	-	-
Therapeutic Programs	-	-	-	-	-	-	-	-	-	-	-	-	-
Therapeutic Equipment	-	-	-	-	-	-	-	-	-	-	-	-	-
R&M	-	-	-	-	-	-	-	-	-	-	-	-	-
ICT & FFE establishment cost									-	24,000			**24,000**
Total Non-Labour	-	-	-	-	-	-	-	-	-	**29,421**	**5,421**	**12,649**	**47,491**
TOTAL OPERATING COST	-	-	-	-	-	-	-	-	-	**85,991**	**67,946**	**158,540**	**312,476**

AMYOS
Budget 2013-14

	FTE Teams												
	7	7	7	7	7	7	7	7	7	7	7	7	
Days in Period:	23	20	22	22	19	21	20	20	22	19	21	21	250
	July	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**	**Total**
Managerial and Clerical	-	-	-	-	-	-	-	-	-	-	-	-	-
Medical	-	-	-	-	-	-	-	-	-	-	-	-	-
Nursing	-	-	-	-	-	-	-	-	-	-	-	-	-
Operational	-	-	-	-	-	-	-	-	-	-	-	-	-
Professional	-	-	-	-	-	-	-	-	-	-	-	-	-
Teams	*127,396*	*110,779*	*121,857*	*121,857*	*105,240*	*116,318*	*110,779*	*110,779*	*121,857*	*105,240*	*116,318*	*116,318*	*1,384,740*
Health Practitioners	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Base	127,396	110,779	121,857	121,857	105,240	116,318	110,779	110,779	121,857	105,240	116,318	116,318	1,384,740
Super and work cover (on total base)	20,320	17,669	19,436	19,436	16,786	18,553	17,669	17,669	19,436	16,786	18,553	18,553	220,866
Other allowances	12,069	10,495	11,544	11,544	9,970	11,020	10,495	10,495	11,544	9,970	11,020	11,020	**131,186**
Total Labour	**159,785**	**138,943**	**152,838**	**152,838**	**131,996**	**145,891**	**138,943**	**138,943**	**152,838**	**131,996**	**145,891**	**145,891**	**1,736,792**
Drugs	-	-	-	-	-	-	-	-	-	-	-	-	-
Clinical Supplies	-	-	-	-	-	-	-	-	-	-	-	-	-
Staff Development	2,333	2,333	2,333	2,333	2,333	2,333	2,333	2,333	2,333	2,333	2,333	2,333	**28,000**
Vehicle costs	3,549	3,549	3,549	3,549	3,549	3,549	3,549	3,549	3,549	3,549	3,549	3,549	**42,588**
Fuel costs	2,100	2,100	2,100	2,100	2,100	2,100	2,100	2,100	2,100	2,100	2,100	2,100	**25,200**
Vehicle maint costs	1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,750	**21,000**
Rent	-	-	-	-	-	-	-	-	-	-	-	-	-
Property service charge	-	-	-	-	-	-	-	-	-	-	-	-	-
Utilities	-	-	-	-	-	-	-	-	-	-	-	-	-
ICT costs	2,917	2,917	2,917	2,917	2,917	2,917	2,917	2,917	2,917	2,917	2,917	2,917	**35,000**
Catering	-	-	-	-	-	-	-	-	-	-	-	-	-
Linen	-	-	-	-	-	-	-	-	-	-	-	-	-
Domestic Services	-	-	-	-	-	-	-	-	-	-	-	-	-
Consumables	-	-	-	-	-	-	-	-	-	-	-	-	-
Therapeutic Programs	-	-	-	-	-	-	-	-	-	-	-	-	-
Therapeutic Equipment	-	-	-	-	-	-	-	-	-	-	-	-	-
R&M	-	-	-	-	-	-	-	-	-	-	-	-	-
ICT & FFE establishment cost	56,000												**56,000**
Total Non-Labour	**68,649**	**12,649**	**12,649**	**12,649**	**12,649**	**12,649**	**12,649**	**12,649**	**12,649**	**12,649**	**12,649**	**12,649**	**207,788**
TOTAL OPERATING COST	**228,434**	**151,592**	**165,487**	**165,487**	**144,645**	**158,540**	**151,592**	**151,592**	**165,487**	**144,645**	**158,540**	**158,540**	**1,944,580**

AMYOS
Budget 2013-14

	FTE Teams												
	12	12	12	12	12	12	12	12	12	12	12	12	
Days in Period:	23	20	22	22	19	21	20	20	22	19	21	21	250
	July	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**	**Total**
Managerial and Clerical	-	-	-	-	-	-	-	-	-	-	-	-	-
Medical	-	-	-	-	-	-	-	-	-	-	-	-	-
Nursing	-	-	-	-	-	-	-	-	-	-	-	-	-
Operational	-	-	-	-	-	-	-	-	-	-	-	-	-
Professional	-	-	-	-	-	-	-	-	-	-	-	-	-
Teams	*218,393*	*189,907*	*208,898*	*208,898*	*180,412*	*199,403*	*189,907*	*189,907*	*208,898*	*180,412*	*199,403*	*199,403*	*2,373,840*
Health Practitioners	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Base	218,393	189,907	208,898	208,898	180,412	199,403	189,907	189,907	208,898	180,412	199,403	199,403	2,373,840
Super and work cover (on total base)	34,834	30,290	33,319	33,319	28,776	31,805	30,290	30,290	33,319	28,776	31,805	31,805	378,627
Other allowances	20,690	17,991	19,790	19,790	17,092	18,891	17,991	17,991	19,790	17,092	18,891	18,891	**224,890**
Total Labour	**273,917**	**238,189**	**262,007**	**262,007**	**226,279**	**250,098**	**238,189**	**238,189**	**262,007**	**226,279**	**250,098**	**250,098**	**2,977,358**
Drugs	-	-	-	-	-	-	-	-	-	-	-	-	-
Clinical Supplies	-	-	-	-	-	-	-	-	-	-	-	-	-
Staff Development	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	**48,000**
Vehicle costs	6,084	6,084	6,084	6,084	6,084	6,084	6,084	6,084	6,084	6,084	6,084	6,084	**73,008**
Fuel costs	3,600	3,600	3,600	3,600	3,600	3,600	3,600	3,600	3,600	3,600	3,600	3,600	**43,200**
Vehicle maint costs	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	**36,000**
Rent	-	-	-	-	-	-	-	-	-	-	-	-	-
Property service charge	-	-	-	-	-	-	-	-	-	-	-	-	-
Utilities	-	-	-	-	-	-	-	-	-	-	-	-	-
ICT costs	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	**60,000**
Catering	-	-	-	-	-	-	-	-	-	-	-	-	-
Linen	-	-	-	-	-	-	-	-	-	-	-	-	-
Domestic Services	-	-	-	-	-	-	-	-	-	-	-	-	-
Consumables	-	-	-	-	-	-	-	-	-	-	-	-	-
Therapeutic Programs	-	-	-	-	-	-	-	-	-	-	-	-	-
Therapeutic Equipment	-	-	-	-	-	-	-	-	-	-	-	-	-
R&M	-	-	-	-	-	-	-	-	-	-	-	-	-
ICT & FFE establishment cost	96,000												**96,000**
Total Non-Labour	**117,684**	**21,684**	**21,684**	**21,684**	**21,684**	**21,684**	**21,684**	**21,684**	**21,684**	**21,684**	**21,684**	**21,684**	**356,208**
TOTAL OPERATING COST	**391,601**	**259,873**	**283,691**	**283,691**	**247,963**	**271,782**	**259,873**	**259,873**	**283,691**	**247,963**	**271,782**	**271,782**	**3,333,566**

Queensland Government

AMYOS Psychiatrists (2.0+Admin) - Input Sheet

KPIs	Beds/Consumers	0					
	Utilisation %	100					
	m2	16					
Budget Phasing							
Days/year	July	23					
	August	20					
	September	22					
	October	22					
	November	19					
	December	21					
	January	20					
	February	20					
	March	22					
	April	19					
	May	21					
	June	21					
		250					
On-costs		%					
	Super	12.75					
	Rec Leave loading	1.7					
	Work cover	1.5					
		15.95					

LABOUR COSTS

	Pay Level	Base salary	FTE	Salaries	All other allowances Option A,PD, MV etc	IT Req	FFE Req
Managerial and Clerical							
Administration Officer	AO3	60767	1.00	60,767		1	1
				60,767			
Medical							
Registrar	L13	137517		-			
Psychiatrist	L23	180107	2.00	360,214	270107	2	2
				360,214			
Nursing							
Enrolled Nurse	NG3(4)	54073		-	0		
Registered Nurse	NG5(6)	74474		-	0		
Clinical Nurse	NG6(2)	80522		-	0		
Clinical Nurse	NG6(3)	82393		-	0		
Nurse Unit Manager	NG7(2)	101099		-	0		
				-			
Operational							
Domestic & other staff	OO2(4)	48583		-			
				-			
Professional							
Community Support Worker	PO3(3)	80942		-			
				-			
Health Practitioners							
MH Therapist	HP3(5)	78203		-			
Psychologist	HP3(5)	78203		-			
Social Worker	HP3(5)	78203		-			
Comm Supp Team Leader	HP4(3)	98910		-			
MH Therapist	HP4(3)	98910		-			
Occupational Therapist	HP4(3)	98910		-			
Psychologist	HP4(3)	98910	0.50	49,455		1	1
Social Worker	HP4(3)	98910		-			
Speech Pathologist	HP4(3)	98910		-			
				49,455			
				470,436	**270,107**		
Headcount			3.5			4	4

NON-LABOUR COSTS

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

ESTABLISHMENT COSTS (YR 1 ONLY)

ICT	per applicable ee	2600	10400	
FFE	per applicable ee	1400	5600	16000
Fitout	cost per m2			
Construction	cost per m2			

AMYOS Psychiatrists (2+Admin)
Budget 2013-17

Labour inflation	2.5%	2.5%	2.5%
Non-labour inflation	3.0%	3.0%	3.0%

Days in Period:	23	20	22	22	19	21	20	20	22	19	21	21	Apr-June	250		
	July	August	September	October	November	December	January	February	March	April	May	June	2013-14 Total	2014-15 Total	2015-16 Total	2016-17 Total
Managerial and Clerical	*5,590.56*	*4,861*	*5,347*	*5,347*	*4,618*	*5,104*	*4,861*	*4,861*	*5,347*	*4,618*	*5,104*	*5,104*	*14,827*	*62,286*	*63,843*	*65,439*
Medical	*33,140*	*28,817*	*31,699*	*31,699*	*27,376*	*30,258*	*28,817*	*28,817*	*31,699*	*27,376*	*30,258*	*30,258*	*87,892*	*369,219*	*378,450*	*387,911*
Nursing	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Operational	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Professional	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Health Practitioners	*4,550*	*3,956*	*4,352*	*4,352*	*3,759*	*4,154*	*3,956*	*3,956*	*4,352*	*3,759*	*4,154*	*4,154*	*12,067*	*50,691*	*51,959*	*53,258*
Total Base	43,280	37,635	41,398	41,398	35,753	39,517	37,635	37,635	41,398	35,753	39,517	39,517	114,786	482,197	494,252	506,608
Super and work cover (on total base)	6,903	6,003	6,603	6,603	5,703	6,303	6,003	6,003	6,603	5,703	6,303	6,303	18,308	76,910	78,833	80,804
Other allowances	24,850	21,609	23,769	23,769	20,528	22,689	21,609	21,609	23,769	20,528	22,689	22,689	65,906	276,860	283,781	290,876
Total Labour	**75,033**	**65,246**	**71,771**	**71,771**	**61,984**	**68,509**	**65,246**	**65,246**	**71,771**	**61,984**	**68,509**	**68,509**	**199,001**	**835,967**	**856,866**	**878,288**
Drugs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Clinical Supplies	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Staff Development	146	146	146	146	146	146	146	146	146	146	146	146	438	1,803	1,857	1,912
Vehicle costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Fuel costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Vehicle maint costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Rent	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Property Service charges	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Utilities	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
ICT costs	833	833	833	833	833	833	833	833	833	833	833	833	2,500	10,300	10,609	10,927
Catering	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Linen	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Domestic Services	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Consumables	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Therapeutic Programs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Therapeutic Equipment	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
R&M	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
ICT & FFE establishment cost											16,000		16,000			
Total Non-Labour	**979**	**979**	**979**	**979**	**979**	**979**	**979**	**979**	**979**	**979**	**16,979**	**979**	**18,938**	**12,103**	**12,466**	**12,840**
TOTAL OPERATING COST	**76,012**	**66,225**	**72,750**	**72,750**	**62,963**	**69,488**	**66,225**	**66,225**	**72,750**	**62,963**	**85,488**	**69,488**	**217,938**	**848,069**	**869,332**	**891,127**

AMYOS Psychiatrists (2.0) - Input Sheet

KPIs	Beds/Consumers	0						
	Utilisation %	100						
	m2	8						
Budget Phasing								
Days/year	July	23						
	August	20						
	September	22						
	October	22						
	November	19						
	December	21						
	January	20						
	February	20						
	March	22						
	April	19						
	May	21						
	June	21						
		250						
On-costs		%						
	Super	12.75						
	Rec Leave loading	1.7						
	Work cover	1.5						
		15.95						
LABOUR COSTS								
	Pay Level	Base salary	FTE	Salaries	All other allowances Option A,PD, MV etc		IT Req	FFE Req
Managerial and Clerical								
Administration Officer	AO3	60767		-				
				-				
Medical								
Registrar	L13	137517		-				
Psychiatrist	L23	180107	2.00	360,214	270,107		2	2
				360,214				
Nursing								
Enrolled Nurse	NG3(4)	54073		-	0			
Registered Nurse	NG5(6)	74474		-	0			
Clinical Nurse	NG6(2)	80522		-	0			
Clinical Nurse	NG6(3)	82393		-	0			
Nurse Unit Manager	NG7(2)	101099		-	0			
				-				
Operational								
Domestic & other staff	OO2(4)	48583		-				
				-				
Professional								
Community Support Worker	PO3(3)	80942		-				
				-				
Health Practitioners								
MH Therapist	HP3(5)	78203		-				
Psychologist	HP3(5)	78203		-				
Social Worker	HP3(5)	78203		-				
Comm Supp Team Leader	HP4(3)	98910		-				
MH Therapist	HP4(3)	98910		-				
Occupational Therapist	HP4(3)	98910		-				
Psychologist	HP4(3)	98910		-				
Social Worker	HP4(3)	98910		-				
Speech Pathologist	HP4(3)	98910		-				
				-				
				360,214	**270,107**			
Headcount			2				2	2
NON-LABOUR COSTS								
Staff Development	annual cost per FTE	500						
Vehicle costs	lease cost/month/vehicles							
	No of vehicles							
Fuel costs	monthly cost/vehicle							
Vehicle running costs	monthly cost/vehicle							
Rent	annual cost per m2	based on commercial rent rate						
Property service charge	% of rent	Includes gardening, sewage, external paint, maintenance, etc.						
Utilities	annual cost 10c/kw.	270kw/annum/m2						
ICT	annual cost per FTE	2500						
Catering	per bed day/consumer							
Linen	per bed day/consumer							
Domestic Services	monthly cost							
Consumables and Staff amenitie	monthly cost							
Therapeutic programs	annual cost							
Therapeutic equipment	annual cost							
Drugs	per bed day/consumer							
Clinical Supplies	per bed day/consumer							
Repairs and Maintenance	monthly cost							
ESTABLISHMENT COSTS (YR 1 ONLY)								
ICT	per applicable ee	2600	5200					
FFE	per applicable ee	1400	2800	6000				
Fitout	cost per m2							
Construction	cost per m2							

AMYOS Psychiatrists (2)
Budget 2013-17

Labour inflation	2.5%	2.5%	2.5%
Non-labour inflation	3.0%	3.0%	3.0%

Days in Period:	23	20	22	22	19	21	20	20	22	19	21	21		250		
	July	August	September	October	November	December	January	February	March	April	May	June	2013-14 Total	2014-15 Total	2015-16 Total	2016-17 Total
Managerial and Clerical	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Medical	*33,140*	*28,817*	*31,699*	*31,699*	*27,376*	*30,258*	*28,817*	*28,817*	*31,699*	*27,376*	*30,258*	*30,258*	*360,214*	*369,219*	*378,450*	*387,911*
Nursing	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Operational	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Professional	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Health Practitioners	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Base	33,140	28,817	31,699	31,699	27,376	30,258	28,817	28,817	31,699	27,376	30,258	30,258	360,214	369,219	378,450	387,911
Super and work cover (on total base)	5,286	4,596	5,056	5,056	4,367	4,826	4,596	4,596	5,056	4,367	4,826	4,826	*57,454*	*58,890*	60,363	61,872
Other allowances	24,850	21,609	23,769	23,769	20,528	22,689	21,609	21,609	23,769	20,528	22,689	22,689	*270,107*	*276,860*	283,781	290,876
Total Labour	**63,275**	**55,022**	**60,524**	**60,524**	**52,271**	**57,773**	**55,022**	**55,022**	**60,524**	**52,271**	**57,773**	**57,773**	**687,775**	**704,970**	**722,594**	**740,659**
Drugs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Clinical Supplies	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Staff Development	83	83	83	83	83	83	83	83	83	83	83	83	*1,000*	*1,025*	1,056	1,087
Vehicle costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Fuel costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Vehicle maint costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Rent	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Property Service charges	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Utilities	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
ICT costs	417	417	417	417	417	417	417	417	417	417	417	417	*5,000*	*5,125*	5,279	5,437
Catering	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Linen	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Domestic Services	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Consumables	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Therapeutic Programs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Therapeutic Equipment	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
R&M	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
ICT & FFE establishment cost										8,000				*8,200*		
Total Non-Labour	**500**	**500**	**500**	**500**	**500**	**500**	**500**	**500**	**500**	**8,500**	**500**	**500**	**6,000**	**14,350**	**6,335**	**6,525**
TOTAL OPERATING COST	**63,775**	**55,522**	**61,024**	**61,024**	**52,771**	**58,273**	**55,522**	**55,522**	**61,024**	**60,771**	**58,273**	**58,273**	**693,775**	**719,320**	**728,928**	**747,183**

Day Program - Input Sheet

KPIs	Beds/Consumers	15						
	m2	315	based on Salvation army space available					
	Utilisation %	100						
Budget Phasing								
Days/year	July	23						
	August	20						
	September	22						
	October	22						
	November	19						
	December	21						
	January	20						
	February	20						
	March	22						
	April	19						
	May	21						
	June	21						
		250						
On-costs		%						
	Super	12.75						
	Rec Leave loading	1.7						
	Work cover	1.5						
		15.95						

LABOUR COSTS								
	Pay Level	Base salary	FTE	Salaries	All other allowances Option A,PD, MV etc	IT Req	FFE Req	
Managerial and Clerical								
Administration Officer	AO3	60767	1.04	62,894		1	1	
				62,894				
Medical								
Registrar	L13	137517	0.52	71,234				
Psychiatrist	L23	180107	0.52	93,295	69958	1	1	
				164,529				
Nursing								
Enrolled Nurse	NG3(4)	54073		-	0			
Registered Nurse	NG5(6)	74474		-	0			
Clinical Nurse	NG6(2)	80522		-	0			
Clinical Nurse	NG6(3)	82393		-	0			
Clinical Nurse Consultant	NG7(2)	101099	1.16	117,679	1746	1	1	
				117,679				
Operational								
Operational staff	OO3(3)	50858	1.04	52,638		1	1	
				52,638				
Professional								
Community Support Worker	PO3(3)	80942		-				
				-				
Health Practitioners								
MH Therapist	HP3(5)	78203	1.04	80,940		1	1	
Psychologist	HP3(5)	78203		-				
Social Worker	HP3(5)	78203		-				
Comm Supp Team Leader	HP4(3)	98910		-				
MH Therapist	HP4(3)	98910		-				
Occupational Therapist	HP4(3)	98910	1.04	102,372		1	1	
Psychologist	HP4(3)	98910	1.04	102,372				
Social Worker	HP4(3)	98910	1.04	102,372		1	1	
Psychologist	HP5(3)	111459	1.04	115,360		1	1	
				503,416				
				901,156	**71,704**			
Headcount			9.45			8	8	

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

ESTABLISHMENT COSTS (YR 1 ONLY)				
ICT	per applicable ee	2600	20800	
FFE	per applicable ee	1400	11200	32000
Fitout	cost per m2	1500		
R&M	annual % of build	2.5%		
Construction	cost per m2	3200		

Day Program - Roster

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

24 hr Roster Construct

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

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

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

Other $ ster construct

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

FTE Allocations

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

Day Program
Budget 2013-17

Labour inflation	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
Non-labour inflation	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%

													1st Day Program				Additional Day Programs		
Days in Period:	23	20	22	22	19	21	20	20	22	19	21	21	May-Jun 2013-14 Total	2014-15 Total	2015-16 Total	2016-17 Total	2014-15 Total	2015-16 Total	2016-17 Total
	July	August	September	October	November	December	January	February	March	April	May	June							
Managerial and Clerical	5,786	5,032	5,535	5,535	4,780	5,283	5,032	5,032	5,535	4,780	5,283	5,283	10,566	64,466	66,078	67,730	64,466	66,078	67,730
Medical	15,137	13,162	14,479	14,479	12,504	13,820	13,162	13,162	14,479	12,504	13,820	13,820	27,641	168,642	172,859	177,180	168,642	172,859	177,180
Nursing	10,826	9,414	10,356	10,356	8,944	9,885	9,414	9,414	10,356	8,944	9,885	9,885	19,770	120,621	123,637	126,728	120,621	123,637	126,728
Operational	4,843	4,211	4,632	4,632	4,000	4,422	4,211	4,211	4,632	4,000	4,422	4,422	8,843	53,954	55,303	56,685	53,954	55,303	56,685
Professional	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Health Practitioners	46,314	40,273	44,301	44,301	38,260	42,287	40,273	40,273	44,301	38,260	42,287	42,287	84,574	516,001	528,901	542,124	516,001	528,901	542,124
Total Base	82,906	72,092	79,302	79,302	68,488	75,697	72,092	72,092	79,302	68,488	75,697	75,697	151,394	923,685	946,777	970,447	923,685	946,777	970,447
Super and work cover (on total base)	13,224	11,499	12,649	12,649	10,924	12,074	11,499	11,499	12,649	10,924	12,074	12,074	24,147	147,328	151,011	154,786	147,328	151,011	154,786
Other allowances	6,597	5,736	6,310	6,310	5,449	6,023	5,736	5,736	6,310	5,449	6,023	6,023	12,046	73,496	75,334	77,217	73,496	75,334	77,217
Total Labour	**102,727**	**89,328**	**98,260**	**98,260**	**84,861**	**93,794**	**89,328**	**89,328**	**98,260**	**84,861**	**93,794**	**93,794**	**187,588**	**1,144,509**	**1,173,122**	**1,202,450**	**1,144,509**	**1,173,122**	**1,202,450**
Drugs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Clinical Supplies	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Staff Development	394	394	394	394	394	394	394	394	394	394	394	394	787	4,864	5,010	5,160	4,864	5,010	5,160
Vehicle costs	1,494	1,494	1,494	1,494	1,494	1,494	1,494	1,494	1,494	1,494	1,494	1,494	2,988	18,466	19,020	19,590	18,466	19,020	19,590
Fuel costs	300	300	300	300	300	300	300	300	300	300	300	300	600	3,708	3,819	3,934	3,708	3,819	3,934
Vehicle maint costs	200	200	200	200	200	200	200	200	200	200	200	200	400	2,472	2,546	2,623	2,472	2,546	2,623
Rent	8,694	7,560	8,316	8,316	7,182	7,938	7,560	7,560	8,316	7,182	7,938	7,938	15,876	97,335	100,255	103,263	97,335	100,255	103,263
Property service charges	869	756	832	832	718	794	756	756	832	718	794	794	1,588	9,734	10,026	10,326	9,734	10,026	10,326
Utilities	225	225	225	225	225	225	225	225	225	225	225	225	450	2,781	2,864	2,950	2,781	2,864	2,950
ICT costs	1,667	1,667	1,667	1,667	1,667	1,667	1,667	1,667	1,667	1,667	1,667	1,667	3,333	20,600	21,218	21,855	20,600	21,218	21,855
Catering	4,830	4,200	4,620	4,620	3,990	4,410	4,200	4,200	4,620	3,990	4,410	4,410	8,820	54,075	55,697	57,368	54,075	55,697	57,368
Linen	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Domestic Services	900	900	900	900	900	900	900	900	900	900	900	900	1,800	11,124	11,458	11,801	11,124	11,458	11,801
Consumables	353	353	353	353	353	353	353	353	353	353	353	353	705	4,358	4,489	4,623	4,358	4,489	4,623
Therapeutic Programs	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	3,000	18,540	19,096	19,669	18,540	19,096	19,669
Therapeutic Equipment	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	3,000	18,540	19,096	19,669	18,540	19,096	19,669
R&M	984	984	984	984	984	984	984	984	984	984	984	984	1,969	12,167	12,532	12,908	12,167	12,532	12,908
IT and FFE establishment											32,000		32,000				32,960	33,949	34,967
Total Non-Labour	**23,910**	**22,032**	**23,284**	**23,284**	**21,406**	**22,658**	**22,032**	**22,032**	**23,284**	**21,406**	**54,658**	**22,658**	**77,316**	**278,763**	**287,126**	**295,740**	**311,723**	**321,075**	**330,707**
TOTAL OPERATING COST	126,636	111,360	121,544	121,544	106,268	116,452	111,360	111,360	121,544	106,268	148,452	116,452	264,904	1,423,272	1,460,248	1,498,190	1,456,232	1,494,197	1,533,157

98

Resi Rehab Unit - Input Sheet

KPIs	Beds/Consumers	6							
	Utilisation	100							
	m2	490							
Budget Phasing									
Days/year	July	31							
	August	31							
	September	30							
	October	31							
	November	30							
	December	31							
	January	31							
	February	28							
	March	31							
	April	30							
	May	31							
	June	30							
		365	0						
On-costs		%							
	Super	12.75							
	Rec Leave loading	1.7							
	Work cover	1.5							
		15.95							
LABOUR COSTS									
	Pay Level	Base salary	FTE	Salaries	All other allowances Option A,PD, MV etc	Penalty payments	IT Req	FFE Req	
Managerial and Clerical									
Administration Officer	AO3	60767	0.20	12,396			1	1	
				12,396					
Medical									
Registrar	L13	137517		-					
Psychiatrist	L23	180107	0.11	19,632	14721				
				19,632					
Nursing									
Enrolled Nurse	NG3(4)	54073		-	0				
Registered Nurse	NG5(6)	74474		-	0				
Clinical Nurse	NG6(2)	80522		-	0				
Clinical Nurse	NG6(3)	82393		-	0				
Nurse Unit Manager	NG7(2)	101099		-	0				
				-					
Operational									
Operational staff	OO2(4)	48583		-					
				-					
Professional									Hrly rate
Community Support Worker	PO3(3)	80942	6.97	564,409		248,528	1	1	40.96
				564,409					
Health Practitioners									
MH Therapist	HP3(5)	78203		-					
Psychologist	HP3(5)	78203		-					
Social Worker	HP3(5)	78203		-					
Comm Supp Team Leader	HP4(3)	98910	1.04	102,372			1	1	
MH Therapist	HP4(3)	98910		-					
Occupational Therapist	HP4(3)	98910		-					
Psychologist	HP4(3)	98910	0.52	51,235			1	1	
Social Worker	HP4(3)	98910	0.52	51,235					
Speech Pathologist	HP4(3)	98910		-					
				204,843					
				801,279	14,721	248,528			
Headcount			9.36				4	4	
NON-LABOUR COSTS									
Staff Development	annual cost per FTE	500							
Vehicle costs	lease cost/month	747	This is for 14-seater and Corolla Sedan (QFLeet lease costs)						
	No of vehicles	2							
Fuel costs	monthly cost/vehicle	150	NGO estimate for 11 mths						
Vehicle running costs	monthly cost/vehicle	98	NGO estimate for 11 mths						
Rent	monthly cost	4,136	NGO estimate for 12 mths - lease signed for 12 mths						
Utilities	monthly cost	535	NGO estimate for 11 mths						
ICT	monthly lease	333	within NGO Ohds charge						
Catering	Monthly cost	1752	NGO estimate for 11 mths						
Linen	per bed day/consumer		within NGO Client Support Services						
Cleaning	monthly cost	904	NGO estimate for 11 mths						
Consumables and Staff amenities	monthly cost	907	NGO estimate for 11 mths						
Therapeutic programs	annual costs	23995	NGO annual estimate						
Therapeutic equipment	annual costs	6656	NGO estimate for 11 mths						
Drugs	per bed day/consumer								
Clinical Supplies	per bed day/consumer								
Building maintenance	monthly cost	594	NGO estimate for 11 mths						
NGO Overheads	annual costs	138511	NGO estimate for 11 mths						
ESTABLISHMENT COSTS (YR 1 ONLY)									
ICT	per applicable ee	2600	10400						
FFE	per applicable ee	1400	5600	16000					

Resi Rehab Unit - Roster

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

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

Other roster construct

Title	**Grade**	**Mon**	**Tues**	**Wed**	**Thur**	**Fri**	**Sat**	**Sun**	**Total Hrs**	**Total FTE**
Administration	AO3	4.0		3.5					7.50	0.20
Psychologist	HP4	7.0	0.0	7.0	0.0	5.0			19.00	0.50
Social Worker	HP4	0.0	7.0	0.0	7.0	5.0			19.00	0.50
Community Support Team Leader	HP4	7.6	7.6	7.6	7.6	7.6			38.00	1.00
CN	NO7								0.00	0.00
Psychiatrist	MO		2.0		2.0				4.00	0.11
	Total	**18.6**	**16.6**	**18.1**	**16.6**	**17.6**	**0.0**	**0.0**	**87.50**	**2.30**

FTE Allocations **9.04**

Level	Productive FTE	Sick Leave (3.5%)	Professional Development Leave	Organisational Education	Mandatory Training (Award Entitlement)	Recreational Leave (Award Entitlement)		
AO3	0.20	0.01						0.20 CHQ
PO3	6.7	0.24						6.97 NGO
Psychologist	0.5	0.02						0.52 CHQ
Social Worker	0.5	0.02						0.52 CHQ
Community Support Te	1.0	0.04						1.04 NGO
NO6 CN	0.0	0.00	0.00		0.00	0.00	5 wk	0.00
MO - con	0.1	0.00						0.11 CHQ
Total FTE	**9.04**	**0.3**	**0.0**			**0.0**		**9.36**
Productive FTE					**9.4**	**9.0**		
Funded FTE								
Employable FTE								

Resi Rehab Unit
Budget 2013-17

Labour inflation	2.5%	2.5%	2.5%
Non-labour inflation	3.0%	3.0%	3.0%

Days in Period:	31	31	30	31	30	31	31	28	31	30	31	30	Aftercare		1st Resi Rehab			Additional Resi Rehabs	
												365	Feb-June	July-Dec	Jan-June				
	July	August	September	October	November	December	January	February	March	April	May	June	2013-14 Total	2014-15 Total	2014-15 Total	2015-16 Total	2016-17 Total	2015-16 Total	2016-17 Total
Managerial and Clerical	*1,053*	*1,053*	*1,019*	*1,053*	*1,019*	*1,053*	*1,053*	*951*	*1,053*	*1,019*	*1,053*	*1,019*			*6,301*	*13,024*	*13,350*	*13,024*	*13,350*
Medical	*1,667*	*1,667*	*1,614*	*1,667*	*1,614*	*1,667*	*1,667*	*1,506*	*1,667*	*1,614*	*1,667*	*1,614*			*9,979*	*20,626*	*21,141*	*20,626*	*21,141*
Nursing	-	-	-	-	-	-	-	-	-	-	-	-			-	-	-	-	-
Operational	-	-	-	-	-	-	-	-	-	-	-	-			-	-	-	-	-
Professional	*47,936*	*47,936*	*46,390*	*47,936*	*46,390*	*47,936*	*47,936*	*43,297*	*47,936*	*46,390*	*47,936*	*46,390*			*286,882*	*592,982*	*607,806*	*592,982*	*607,806*
Health Practitioners	*17,398*	*17,398*	*16,836*	*17,398*	*16,836*	*17,398*	*17,398*	*15,714*	*17,398*	*16,836*	*17,398*	*16,836*			*104,119*	*215,213*	*220,593*	*215,213*	*220,593*
Total Base	68,054	68,054	65,859	68,054	65,859	68,054	68,054	61,468	68,054	65,859	68,054	65,859			407,280	841,844	862,890	841,844	862,890
Super and work cover (on total base)	10,855	10,855	10,504	10,855	10,504	10,855	10,855	9,804	10,855	10,504	10,855	10,504			*64,961*	*134,274*	*137,631*	*134,274*	*137,631*
Other allowances	22,358	22,358	21,637	22,358	21,637	22,358	22,358	20,194	22,358	21,637	22,358	21,637			*133,806*	*276,576*	*283,490*	*276,576*	*283,490*
Total Labour	**101,267**	**101,267**	**98,000**	**101,267**	**98,000**	**101,267**	**101,267**	**91,467**	**101,267**	**98,000**	**101,267**	**98,000**	**45,608**		**606,048**	**1,252,694**	**1,284,011**	**1,252,694**	**1,284,011**
Drugs	-	-	-	-	-	-	-	-	-	-	-	-			-	-	-	-	-
Clinical Supplies	-	-	-	-	-	-	-	-	-	-	-	-			-	-	-	-	-
Staff Development	390	390	390	390	390	390	390	390	390	390	390	390			*2,409*	*4,963*	*5,112*	*4,963*	*5,112*
Vehicle costs	1,494	1,494	1,494	1,494	1,494	1,494	1,494	1,494	1,494	1,494	1,494	1,494			*9,233*	*19,020*	*19,590*	*19,020*	*19,590*
Fuel costs	300	300	300	300	300	300	300	300	300	300	300	300			*1,852*	*3,816*	*3,930*	*3,816*	*3,930*
Vehicle maint costs	196	196	196	196	196	196	196	196	196	196	196	196			*1,210*	*2,493*	*2,568*	*2,493*	*2,568*
Rent	4,136	4,136	4,136	4,136	4,136	4,136	4,136	4,136	4,136	4,136	4,136	4,136			*25,558*	*52,650*	*54,230*	*52,650*	*54,230*
Utilities	535	535	535	535	535	535	535	535	535	535	535	535			*3,309*	*6,817*	*7,021*	*6,817*	*7,021*
ICT costs	333	333	333	333	333	333	333	333	333	333	333	333			*2,060*	*4,244*	*4,371*	*4,244*	*4,371*
Catering	1,752	1,752	1,752	1,752	1,752	1,752	1,752	1,752	1,752	1,752	1,752	1,752			*10,828*	*22,307*	*22,976*	*22,307*	*22,976*
Linen	-	-	-	-	-	-	-	-	-	-	-	-			-	-	-	-	-
Domestic Services	904	904	904	904	904	904	904	904	904	904	904	904			*5,584*	*11,504*	*11,849*	*11,504*	*11,849*
Consumables	907	907	907	907	907	907	907	907	907	907	907	907			*5,603*	*11,542*	*11,888*	*11,542*	*11,888*
Therapeutic Programs	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000			*12,357*	*25,456*	*26,220*	*25,456*	*26,220*
Therapeutic Equipment	555	555	555	555	555	555	555	555	555	555	555	555			*3,428*	*7,061*	*7,273*	*7,061*	*7,273*
R&M	594	594	594	594	594	594	594	594	594	594	594	594			*3,668*	*7,556*	*7,783*	*7,556*	*7,783*
NGO overhead charges	11,764	11,764	11,384	11,764	11,384	11,764	11,764	10,626	11,764	11,384	11,764	11,384			*70,747*	*146,946*	*151,355*	*146,946*	*151,355*
IT and FFE establishment							16,000								*16,480*	*16,974*	*17,484*	*16,974*	*17,484*
Establishment costs													*77,611*		*78,280*			*80,628*	
Total Non-Labour	**25,858**	**25,858**	**25,479**	**25,858**	**25,479**	**25,858**	**41,858**	**24,720**	**25,858**	**25,479**	**25,858**	**25,479**			**252,608**	**343,350**	**353,650**	**423,978**	**353,650**
TOTAL OPERATING COST	**127,125**	**127,125**	**123,478**	**127,125**	**123,478**	**127,125**	**143,125**	**116,186**	**127,125**	**123,478**	**127,125**	**123,478**	**638,375**	**618,188**	**858,656**	**1,596,044**	**1,637,662**	**1,676,672**	**1,637,662**

Queensland Government

Step Up Step Down Unit - Input Sheet

KPIs	Beds/Consumers	10								
	m2	1600								
	bed utilisation %	100								
Budget Phasing										
Days/year	July	31								
	August	31								
	September	30								
	October	31								
	November	30								
	December	31								
	January	31								
	February	28								
	March	30								
	April	31								
	May	31								
	June	30								
		365	0							
On-costs		%								
	Super	12.75								
	Rec Leave loading	1.7								
	Work cover	1.5								
		15.95								
LABOUR COSTS										
	Pay Level	Base salary	FTE	Salaries	All other allowances Option A,PD, MV etc	Penalties		IT Req	FFE Req	
Managerial and Clerical										
Administration Officer	AO3	60767	1.04	62,894				1	1	
				62,894						
Medical										
Registrar	L13	137517	0.61	84,298						
Psychiatrist	L23	180107	0.52	93,295	69958			1	1	
				177,593						
Nursing										
Enrolled Nurse	NG3(4)	54073		-	0					Hrly rate
Registered Nurse	NG5(6)	74474	5.23	389,425	7843.5	73,004		1	1	37.69
Clinical Nurse	NG6(2)	80522		-	0					
Clinical Nurse	NG6(3)	82393		-	0					
Nurse Unit Manager	NG7(2)	101099	1.16	117,679	1746			1	1	
				507,104						
Operational										
Operational staff	OO2(4)	48583		-						
				-						
Professional										Hrly rate
Community Support Worker	PO3(3)	80942	4.58	370,391		130,163				40.96
				370,391						
Health Practitioners										
MH Therapist	HP3(5)	78203	1.04	80,940				1	1	
Psychologist	HP3(5)	78203		-						
Social Worker	HP3(5)	78203		-						
Comm Supp Team Leader	HP4(3)	98910	1.04	102,372				1	1	
MH Therapist	HP4(3)	98910	0.52	51,235						
Occupational Therapist	HP4(3)	98910	0.52	51,235						
Psychologist	HP4(3)	98910	1.04	102,372				1	1	
Social Worker	HP4(3)	98910	1.04	102,372				1	1	
Speech Pathologist	HP4(3)	98910		-						
				490,526						
				1,608,508	79,547	203,167				
Headcount			16.31					8	8	
NON-LABOUR COSTS										
Staff Development Training	annual cost per FTE	500								
Vehicle costs	lease cost/month	507		Qfleet Toyota Corolla Sedan						
	No of vehicles	1								
Fuel costs	monthly cost/vehicle	300								
Vehicle running costs	monthly cost/vehicle	200								
Rent	annual cost per m2	450		based on commercial rent rate						
Property service charge	% of rent	10		includes gardening, sewage, external paint, maintenance, etc						
Utilities	annual cost 10c/kw.	43200		270kw/annum/m2						
ICT	annual cost per FTE	2500								
Catering	per bed day/consumer	14								
Linen	per bed day/consumer	4.19								
Domestic Services	monthly cost	2000								
Consumables and Staff amenities	monthly cost	408.33		used oncology day ward 12-13 actuals as benchmark 15 patients/day + 11 staff						
Therapeutic programs	per consumer per month	100								
Therapeutic equipment	per consumer per month	100								
Drugs	per bed day/consumer	28.3								
Clinical Supplies	per bed day/consumer	17								
Repairs and Maintenance	annual % of fit out	2.5%								
ESTABLISHMENT COSTS (YR 1 ONLY)										
ICT	per applicable ee	2600	20800							
FFE	per applicable ee	1400	11200	32000						
Fitout	cost per m2	1500								
R&M	annual % of build	2.5%								
Construction	cost per m2	3200								

Step Up Step Down Unit - Roster

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

24 hr Roster Construct

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

Other roster construct

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

FTE Allocations **16.93**

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

Step Up Step Down Unit
Budget 2014-17

Labour inflation	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
Non-labour inflation	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%

													1		1	2
													1st SUSDU			1 x SUSDU	2 x SUSDU
Days in Period:	31	31	30	31	30	31	31	28	30	31	31	30	365				
	July	August	September	October	November	December	January	February	March	April	May	June	Jan-June 2014-15 Total	Full Year 2014-15 Total	2015-16 Total	2016-17 Total	2015-16 Total	2016-17 Total
Managerial and Clerical	5,342	5,342	5,169	5,342	5,169	5,342	5,342	4,825	5,169	5,342	5,342	5,169	31,968	64,466	66,078	67,730	66,078	135,459.58
Medical	15,083	15,083	14,597	15,083	14,597	15,083	15,083	13,624	14,597	15,083	15,083	14,597	90,269	182,033	186,584	191,249	186,584	382,497
Nursing	43,069	43,069	41,680	43,069	41,680	43,069	43,069	38,901	41,680	43,069	43,069	41,680	257,755	519,781	532,776	546,095	532,776	1,092,191
Operational	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Professional	31,458	31,458	30,443	31,458	30,443	31,458	31,458	28,414	30,443	31,458	31,458	30,443	188,265	379,650	389,142	398,870	389,142	797,740
Health Practitioners	41,661.15	41,661	40,317	41,661	40,317	41,661	41,661	37,629	40,317	41,661	41,661	40,317	249,329	502,790	515,359	528,243	515,359	1,056,487
Total Base	136,613	136,613	132,206	136,613	132,206	136,613	136,613	123,392	132,206	136,613	136,613	132,206	817,585	1,648,721	1,689,939	1,732,187	1,689,939	3,464,374
Super and work cover (on total base)	21,790	21,790	21,087	21,790	21,087	21,790	21,790	19,681	21,087	21,790	21,790	21,087	130,405	262,971	269,545	276,284	269,545	552,568
Other allowances	24,011	24,011	23,237	24,011	23,237	24,011	24,011	21,688	23,237	24,011	24,011	23,237	143,700	289,782	297,026	304,452	297,026	608,904
Total Labour	**182,414**	**182,414**	**176,530**	**182,414**	**176,530**	**182,414**	**182,414**	**164,761**	**176,530**	**182,414**	**182,414**	**176,530**	**1,091,690**	**2,201,473**	**2,256,510**	**2,312,923**	**2,256,510**	**4,625,846**
Drugs	8,773	8,773	8,490	8,773	8,490	8,773	8,773	7,924	8,490	8,773	8,773	8,490	52,760	106,394	109,586	112,873	109,586	225,746
Clinical Supplies	5,270	5,270	5,100	5,270	5,100	5,270	5,270	4,760	5,100	5,270	5,270	5,100	31,693	63,912	65,829	67,804	65,829	135,607
Staff Development	763	763	763	763	763	763	763	763	763	763	763	763	4,715	9,430	9,713	10,004	9,713	20,009
Vehicle costs	507	507	507	507	507	507	507	507	507	507	507	507	3,133	6,267	6,455	6,648	6,455	13,296
Fuel costs	300	300	300	300	300	300	300	300	300	300	300	300	1,854	3,708	3,819	3,934	3,819	7,868
Vehicle maint costs	200	200	200	200	200	200	200	200	200	200	200	200	1,236	2,472	2,546	2,623	2,546	5,245
Rent	61,151	61,151	59,178	61,151	59,178	61,151	61,151	55,233	59,178	61,151	61,151	59,178	367,752	741,600	763,848	786,763	763,848	1,573,527
Property service charges	6,115	6,115	5,918	6,115	5,918	6,115	6,115	5,523	5,918	6,115	6,115	5,918	36,775	74,160	76,385	78,676	76,385	157,353
Utilities	3,600	3,600	3,600	3,600	3,600	3,600	3,600	3,600	3,600	3,600	3,600	3,600	22,248	44,496	45,831	47,206	45,831	94,412
ICT costs	1,667	1,667	1,667	1,667	1,667	1,667	1,667	1,667	1,667	1,667	1,667	1,667	10,300	20,600	21,218	21,855	21,218	43,709
Catering	4,340	4,340	4,200	4,340	4,200	4,340	4,340	3,920	4,200	4,340	4,340	4,200	26,100	52,633	54,212	55,838	54,212	111,677
Linen	1,299	1,299	1,257	1,299	1,257	1,299	1,299	1,173	1,257	1,299	1,299	1,257	7,811	15,752	16,225	16,712	16,225	33,423
Domestic Services	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	12,360	24,720	25,462	26,225	25,462	52,451
Consumables	408	408	408	408	408	408	408	408	408	408	408	408	2,523	5,047	5,198	5,354	5,198	10,709
Therapeutic programs	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	6,180	12,360	12,731	13,113	12,731	26,225
Therapeutic equipment	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	6,180	12,360	12,731	13,113	12,731	26,225
R&M	5,150	5,150	5,150	5,150	5,150	5,150	5,150	5,150	5,150	5,150	5,150	5,150	31,827	63,654	65,564	67,531	65,564	135,061
ICT & FFE establishment							32,000						32,960	32,960	33,949		33,949	34,967
Total Non-Labour	**103,543**	**103,543**	**100,738**	**103,543**	**100,738**	**103,543**	**135,543**	**95,128**	**100,738**	**103,543**	**103,543**	**100,738**	**658,409**	**1,292,524**	**1,331,300**	**1,336,272**	**1,331,300**	**2,707,511**
TOTAL OPERATING COST	**285,957**	**285,957**	**277,268**	**285,957**	**277,268**	**285,957**	**317,957**	**259,889**	**277,268**	**285,957**	**285,957**	**277,268**	**1,750,098**	**3,493,998**	**3,587,810**	**3,649,195**	**3,587,810**	**7,333,357**

Queensland Government

Sub Acute Bed-Based Unit - Input Sheet

KPIs	Beds/Consumers	4							
	Utilisation	80							
	m2	100							
Budget Phasing									
Days/year	July	31							
	August	31							
	September	30							
	October	31							
	November	30							
	December	31							
	January	31							
	February	28							
	March	31							
	April	30							
	May	31							
	June	30							
		365	0						
On-costs		%							
	Super	12.75							
	Rec Leave loading	1.7							
	Work cover	1.5							
		15.95							
LABOUR COSTS									
	Pay Level	Base salary	FTE	Salaries	All other allowances Option A,PD, MV etc	Penalties	IT Req	FFE Req	
Managerial and Clerical									
Administration Officer	AO3	60767	0.20	12,396			1	1	
				12,396					
Medical									
Registrar	L13	137517	0.41	56,519					
Psychiatrist	L23	180107	0.20	36,742	27551				
				93,261					
Nursing									
Enrolled Nurse	NG3(4)	54073	1.74	94,087	2610				Hrly rate
Registered Nurse	NG5(6)	74474	1.74	129,585	2610	56,835	1	1	37.69
Clinical Nurse	NG6(2)	80522		-	0				
Clinical Nurse	NG6(3)	82393	1.71	140,892	2565		1	1	
Nurse Unit Manager	NG7(2)	101099		-	0				
				364,564					
Operational									Hrly rate
Rec Officer	OO2(4)	48583	2.23	108,340		45,849			24.59
				108,340					
Professional									
Community Support Worker	PO3(3)	80942		-					
				-					
Health Practitioners									
MH Therapist	HP3(5)	78203		-					
Psychologist	HP3(5)	78203		-					
Social Worker	HP3(5)	78203		-					
Comm Supp Team Leader	HP4(3)	98910		-					
MH Therapist	HP4(3)	98910		-					
Occupational Therapist	HP4(3)	98910	0.20	20,178					
Psychologist	HP4(3)	98910	0.20	20,178					
Social Worker	HP4(3)	98910	0.20	20,178					
Speech Pathologist	HP4(3)	98910	0.20	20,178					
				80,711					
				659,272	35,336	102,684			
Headcount			9.06				4	3	
NON-LABOUR COSTS									
Staff Development	annual cost per FTE	500							
Vehicle costs	lease cost/month								
	No of vehicles								
Fuel costs	monthly cost/vehicle								
Vehicle running costs	monthly cost/vehicle								
Rent	annual cost per m2								
Property service charge	% of rent								
Utilities	annual cost 10c/kw.								
ICT	annual cost per FTE	2500							
Catering	per bed day/consumer								
Linen	per bed day/consumer								
Domestic Services	monthly cost								
Consumables and Staff amenities	monthly cost								
Therapeutic programs	per consumer per month	100							
Therapeutic equipment	per consumer per month	100							
Drugs	per bed day/consumer	28.3							
Clinical Supplies	per bed day/consumer								
Repairs and Maintenance	monthly cost	2.5%							
ESTABLISHMENT COSTS (YR 1 ONLY)									
ICT	per applicable ee	2600	7800						
FFE	per applicable ee	1400	4200	12000					
Fitout	cost per m2	0							

Sub Acute Bed-Based Unit - Roster

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

24 hr Roster Construct

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

Other roster construct

	Title	**Grade**	**Mon**	**Tues**	**Wed**	**Thur**	**Fri**	**Sat**	**Sun**	**Total Hrs**	**Total FTE**	
		OO2								0.00	0.00	0.0
	Administration	AO3	4.0		3.5					7.50	0.20	0.2
	Psychologist	HP4	4.0		3.5					7.50	0.20	
	Social Worker	HP4	4.0		3.5					7.50	0.20	
	OT	HP4	4.0		3.5					7.50	0.20	
	Speech Pathology	HP4	4.0		3.5					7.50	0.20	0.8
	CNC	NO7								0.00	0.00	0.0
	Psychiatrist	MO	4.0		3.5					7.50	0.20	
	Registrar	MO	4.0	3.5	4.0	3.6				15.10	0.40	0.6
		Total	**28.0**	**3.5**	**25.0**	**3.6**	**0.0**	**0.0**	**0.0**	**60.10**	**1.58**	
											8.16	

FTE Allocations

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

Sub Acute Bed-Based Unit
Budget 2014-17

Labour inflation	2.5%	2.5%	2.5%
Non-labour inflation	3.0%	3.0%	3.0%

Days in Period:	31	31	30	31	30	31	31	28	31	30	31	30	365		
	July	August	September	October	November	December	January	February	March	April	May	June	Nov-June 2014-15 Total	2015-16 Total	2016-17 Total
Managerial and Clerical	*1,053*	*1,053*	*1,019*	*1,053*	*1,019*	*1,053*	*1,053*	*951*	*1,053*	*1,019*	*1,053*	*1,019*	*8,425*	*13,024*	*13,350*
Medical	*7,921*	*7,921*	*7,665*	*7,921*	*7,665*	*7,921*	*7,921*	*7,154*	*7,921*	*7,665*	*7,921*	*7,665*	*63,379*	*97,983*	*100,432*
Nursing	*30,963*	*30,963*	*29,964*	*30,963*	*29,964*	*30,963*	*30,963*	*27,967*	*30,963*	*29,964*	*30,963*	*29,964*	*247,754*	*383,020*	*392,595*
Operational	*9,201.49*	*9,201*	*8,905*	*9,201*	*8,905*	*9,201*	*9,201*	*8,311*	*9,201*	*8,905*	*9,201*	*8,905*	*73,627*	*113,825*	*116,670*
Professional	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Health Practitioners	*6,855*	*6,855*	*6,634*	*6,855*	*6,634*	*6,855*	*6,855*	*6,191*	*6,855*	*6,634*	*6,855*	*6,634*	*54,850*	*84,797*	*86,916*
Total Base	55,993	55,993	54,187	55,993	54,187	55,993	55,993	50,574	55,993	54,187	55,993	54,187	448,034	692,648	709,964
Super and work cover (on total base)	8,931	8,931	8,643	8,931	8,643	8,931	8,931	8,067	8,931	8,643	8,931	8,643	*71,461*	*110,477*	*113,239*
Other allowances	11,722	11,722	11,344	11,722	11,344	11,722	11,722	10,588	11,722	11,344	11,722	11,344	*93,797*	*145,008*	*148,633*
													-		
Total Labour	**76,646**	**76,646**	**74,174**	**76,646**	**74,174**	**76,646**	**76,646**	**69,229**	**76,646**	**74,174**	**76,646**	**74,174**	**613,293**	**948,133**	**971,836**
Drugs	2,807	2,807	2,717	2,807	2,717	2,807	2,807	2,536	2,807	2,717	2,807	2,717	*22,463*	*35,067*	*36,119*
Clinical Supplies	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Staff Development	377	377	377	377	377	377	377	377	377	377	377	377	*3,094*	*4,803*	*4,947*
Vehicle costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Fuel costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Vehicle maint costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Rent	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Property service charge	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Utilities	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
ICT costs	625	625	625	625	625	625	625	625	625	625	625	625	*5,125*	*7,957*	*8,195*
Catering	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Linen	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Domestic Services	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Consumables	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Therapeutic Programs	400	400	400	400	400	400	400	400	400	400	400	400	*3,280*	*5,092*	*5,245*
Therapeutic Equipment	400	400	400	400	400	400	400	400	400	400	400	400	*3,280*	*5,092*	*5,245*
R&M	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
IT and FFE establishment							12,000						*12,300*		
Total Non-Labour	**4,610**	**4,610**	**4,519**	**4,610**	**4,519**	**4,610**	**16,610**	**4,338**	**4,610**	**4,519**	**4,610**	**4,519**	**49,542**	**58,012**	**59,752**
TOTAL OPERATING COST	**81,256**	**81,256**	**78,693**	**81,256**	**78,693**	**81,256**	**93,256**	**73,567**	**81,256**	**78,693**	**81,256**	**78,693**	**662,835**	**1,006,145**	**1,031,589**