ACT Government | ACT Health

Our reference: **ACTHDFOI21-22.36**

[redacted]

Dear [redacted]

DECISION ON YOUR ACCESS APPLICATION

I refer to your application under section 30 of the *Freedom of Information Act 2016* (FOI Act), received by ACT Health Directorate (ACTHD) on Wednesday 15 December 2021.

This application requested access to:

> *'Meeting minutes pertaining to the Eating Disorder Early Intervention Steering Committee and Reference Group'.*

I am an Information Officer appointed by the Director-General of ACT Health Directorate (ACTHD) under section 18 of the FOI Act to deal with access applications made under Part 5 of the Act. ACTHD was required to provide a decision on your access application by **Tuesday 8 February 2022**.

I have identified eight documents holding the information within scope of your access application. These are outlined in the schedule of documents included at Attachment A to this decision letter.

Decisions

I have decided to:

- grant full access to one document: and
- grant part access to seven documents.

My access decisions are detailed further in the following statement of reasons and the documents released to you are provided as Attachment B to this letter.

In reaching my access decision, I have taken the following into account:

- The FOI Act;
- The contents of the documents that fall within the scope of your request;
- The views of relevant third parties; and
- The *Human Rights Act 2004*.

Full Access

I have decided to grant full access to one document at reference 8.

Partial Access

I have decided to grant partial access to seven documents. Partial redactions have been made to the documents where it contains information that I consider, on balance, to be contrary to the public interest to disclose under the test set out in section 17 of the Act. The information contained in these folios is partially comprised of a community representative's personal information and information obtained through confidential discussions including information that relates to other jurisdictions and business affairs of other agencies/ third parties. The disclosure of this information could reasonably be expected to prejudice intergovernmental relations.

Public Interest Factors Favouring Disclosure
The following factors were considered relevant in favour of the disclosure of the documents:

- Schedule 2, 2.1(a)(i) promote open discussion of public affairs and enhance the government's accountability;
- Schedule 2, 2.1(a)(ii) contribute to positive and informed debate on important issues or matters of public interest;
- Schedule 2, 2.1(a)(iv) ensure effective oversight of expenditure of public funds; and
- Schedule 2, 2.1(a)(viii) reveal the reason for a government decision and any background or contextual information that informed the decision.

Public Interest Factors Favouring Non-Disclosure
The following factors were considered relevant in favour of the non-disclosure of the documents:

- Schedule 2, Schedule 2.2 (a)(ii) prejudice the protection of an individual's right to privacy or any other right under the *Human Rights Act 2004*;
- Schedule 2, Schedule 2.2 (a)(x) prejudice intergovernmental relations;
- Schedule 2, Schedule 2.2 (a)(xi) prejudice trade secrets, business affairs or research of an agency or person; and
- Schedule 2, Schedule 2.2 (a)(xii) prejudice an agency's ability to obtain confidential information.

Following the consideration of the above factors I have decided, regarding personal information and confidential business affairs information of agencies external to ACT Government, the factors favouring non-disclosure outweighed the factors favouring disclosure. Therefore, and I have determined the information identified is contrary to the public interest and I have decided not to disclose this information.

Corrections
I would like to take this opportunity to make a correction to the record of the Minutes of the Eating Disorders Project Steering Committee dated 31 March 2021. The record incorrectly states that the Residential Treatment Facility will be run by a non-government organisation. No decision has been made regarding the organisation responsible for delivering the Facility. I would also like to confirm that union consultation will be undertaken on this matter before any decision is made.

Charges
Processing charges are not applicable to this request.

Disclosure Log
Under section 28 of the FOI Act, ACTHD maintains an online record of access applications called a disclosure log. The scope of your access application, my decision and documents released to you will be published in the disclosure log not less than three days but not more than 10 days after the date of this decision. Your personal contact details will not be published.

https://www.health.act.gov.au/about-our-health-system/freedom-information/disclosure-log.

Ombudsman review
My decision on your access request is a reviewable decision as identified in Schedule 3 of the FOI Act. You have the right to seek Ombudsman review of this outcome under section 73 of the Act within 20 working days from the day that my decision is published in ACT Health's disclosure log, or a longer period allowed by the Ombudsman.

If you wish to request a review of my decision you may write to the Ombudsman at:

The ACT Ombudsman
GPO Box 442
CANBERRA ACT 2601
Via email: ACTFOI@ombudsman.gov.au
Website: ombudsman.act.gov.au

ACT Civil and Administrative Tribunal (ACAT) review
Under section 84 of the Act, if a decision is made under section 82(1) on an Ombudsman review, you may apply to the ACAT for review of the Ombudsman decision. Further information may be obtained from the ACAT at:

ACT Civil and Administrative Tribunal
Level 4, 1 Moore St
GPO Box 370
Canberra City ACT 2601
Telephone: (02) 6207 1740
http://www.acat.act.gov.au/

Further assistance
Should you have any queries in relation to your request, please do not hesitate to contact the FOI Coordinator on (02) 5124 9831 or email HealthFOI@act.gov.au.

Yours sincerely

EMoore.

Dr Elizabeth Moore
Coordinator-General, Mental Health and Wellbeing
ACT Health Directorate

7 February 2022

ACT Government | ACT Health

FREEDOM OF INFORMATION SCHEDULE OF DOCUMENTS

Please be aware that under the *Freedom of Information Act 2016*, some of the information provided to you will be released to the public through the ACT Government's Open Access Scheme. The Open Access release status column of the table below indicates what documents are intended for release online through open access.
Personal information or business affairs information will not be made available under this policy. If you think the content of your request would contain such information, please inform the contact officer immediately.
Information about what is published on open access is available online at: http://www.health.act.gov.au/public-information/consumers/freedom-information

APPLICANT NAME	WHAT ARE THE PARAMETERS OF THE REQUEST	FILE NUMBER
[redacted]	Meeting minutes pertaining to the Eating Disorder Early Intervention Steering Committee and Reference Group.	ACTHDFOI21-22.36

Ref Number	Page Number	Description	Date	Status Decision	Factor	Open Access release status
1.	1 – 6	Eating Disorders Project Steering Committee	31/03/2021	Partial Release	Schedule 2.2(a)(x) Intergovernmental affairs Schedule 2.2(a)(xi) Business affairs Schedule 2.2(a)(xii) Confidential information	YES
2.	7 – 12	Eating Disorders Project Steering Committee	07/05/2021	Partial Release	Schedule 2.2(a)(x) Intergovernmental affairs	YES
3.	13 – 17	Eating Disorders Project Reference Group	26/05/2021	Partial Release	Schedule 2.2(a)(ii) Privacy Schedule 2.2(a) Business affairs	YES
4.	18 – 21	Eating Disorders Project Reference Group	16/06/2021	Partial Release	Schedule 2.2(a)(ii) Privacy	YES
5.	22 – 25	Eating Disorders Project Reference Group	18/08/2021	Partial Release	Schedule 2.2(a)(ii) Privacy & Schedule 2.2(a)(xi) Business affairs	YES

6.	26 – 30	Eating Disorders Project Steering Committee	07/10/2021	Partial Release	Schedule 2.2(a)(xi) Business affairs Schedule 2.2(a)(x) Intergovernmental relations Schedule 2.2(a)(xii) Confidential information	YES
7.	31 – 34	Eating Disorders Project Steering Committee	04/11/2021	Partial Release	Schedule 2.2(a)(xi) Business affairs	YES
8.	35 – 39	Eating Disorders Project Steering Committee	09/12/2021	Full Release		YES
Total Number of Documents						
8.						

MINUTES
Eating Disorders Project Steering Committee

ACT Government | ACT Health

11.00am-12.00pm
Wednesday 31st March 2021
Webex

1 Welcome and apologies

Title/Department	Name	Attendance	Apologies
Executive Group Manager, Policy Partnerships and Programs	Michael Culhane	√	
Executive Group Manager, Strategic Infrastructure	Liz Lopa	√	
Snr Director, Business Analyst, Strategic Infrastructure	Daniel Landon	√	
A/g Executive Branch Manager, Mental Health Policy Unit	Jon Ord	√	
A/g ACT Chief Psychiatrist	Dr Dinesh Ayra		√
Operational Director, CAMHS	Cathy Furner (proxy for Karen Grace)	√	
Calvary Public Hospital Bruce Representative	Narelle Comer	√	
Clinical Director, Division of Medicine, CHS Director, General Medicine Unit Canberra Hospital	Ashwin Swaminathan		√
GP Policy Advisor, Academic Unit of General Practice	Dr Melinda Choy		√
Clinical Director, CAMHS	Dr Denise Riordan		√
Clinical Hub Manager, Eating Disorders Program	Kalvinder Bains		√
Project Manager, Program Support Unit	Jessica Miko	√	
Secretariat	PSU	√	

2 Minutes and actions arising from previous meeting

#	Action	Lead	Status
1	LL will follow up with Erin Brady EPSDD on the process to secure the block and will report back to the Steering Committee out of session.	LL/DL	Complete. The Coombs block has been endorsed out of session.
2	MC to ask Maria Travers to explore how ACT could recoup Commonwealth funding for interstate clients.	MC	31.03 – This work is underway with one avenue explored already and another yet to be explored. This action will be brought to Steering Committee members for discussion later. This action remains open.
3	Schedule 2.2(a)(xi) Business affairs [redacted]		

			CF -Does the agreement with Commonwealth stipulate requirement for ACT to take NSW patients? EDP don't see clients from NSW. MC – The residential facility is a public health service, and admissions will be based on clinical need. However, if we can't claim out-of-state clients under the National Health Reform Agreement (NHRA) - noting the significant NSW numbers given above – why would the ACT accept out-of-state clients, unless it is cheaper in the long-term for the ACT to have the out-of-state client attend the residential and not a more costly service (such as inpatient services). As related to Action #2, we are currently looking at other avenues to reclaim money. CF – As the residential facility is being run by an NGO, is the ACT required to take NSW/out-of-state clients? MC - No. The question is what happens to NSW patients if not accepted in ACT residential facility, for if they are later admitted to ACT hospitals, this imposes a higher cost to ACT. JO – If the ACT accept Commonwealth funds for the residential facility and therefore accepts clients from other states, this could present access issues for ACT residents. NC – Alternate facility for NSW? JO – Each state has been given funding for a residential ED facility, [redacted] MC – Need to ensure adequate access for ACT patients to ACT facility. Financial analysis is required. The EOIs give us the extend of referrals/demand we can expect in the ACT. This action is closed. **ACTION:** JM to liaise with NSW counterparts on their residential facility progress (inclusive of catchment discussions, bed numbers and location).
4	JM to update the MoC based upon today's discussion and recirculate for out of session endorsement by the Steering Committee members.	JM	Complete. The MoC has been endorsed out of session.

Items for discussion and endorsement

3.1 Project Overview Report – presented by JM

- High-level MoC for the Residential Facility has been completed and was endorsed 19 March 2021 out of session.
- The Early Intervention Service MoC (which will be incorporated into the Territory Wide MoC) is the next piece of work.
- Project team is currently working with other mental health services and how this project work interacts with them.
- Clinical processes and training is scheduled for April, this may be pushed back, dependent on project progress.
- The final Clinical Hub recruitment is underway for Clinical Coordinator and consultant positions.
- The project team is currently working on drafting the clinical hub governance.
- Development of the Eating Disorders Day Program is in progress under CHS.

3.2 Strategic Infrastructure Update – Presented by LL

- Given the out of session endorsement of the Coombs site and MoC, the next steps are due diligence of the site, and engaging Geotech and the Suburban Land Authority (SLA). DL will work with JM and Major Projects Canberra (MPC) to progress this work.
- A consultant will be hired to do due diligence, which is normally done through MPC.
- LL advised she has been in contact with MPC and is now waiting for a project manager resource.
- MPC charge a 4 percent fee of the project budget.
- Discussions with the SLA on community consultation will need to occur. This could result in a local letterbox drop in the local area.
- Other infrastructure considerations include whether other outpatient service/s should be co-located with the residential facility on the Coombs block.

Discussion:
JO – Is block big enough to have outpatients co-located?
LL - Site is big enough to co-locate services. Issue is if we don't ask for enough of the block in the first instance.
JM – In addition to the Early Intervention Service, consider if extra office space is required for other services such as the Clinical Hub, Eating Disorder Program or CHS Day Program.
MC – Unless there is a clinical reason not to co-locate services, particularly if the same skill sets applied to the day and residential programs, it would be more efficient to co-locate the other services if possible.
LL – Yes, needs to be based on a clinical decision.
MC – Require a paper outlining the pro and cons for the co-location of services.

ACTION: JM to develop a paper on the benefits and risks of co-locating other eating disorder services with the residential facility, for Steering Committee consideration.

3.3 For Discussion: ACT Early Intervention Service Options Paper

The options paper details two key decisions in relation to the ACT Early Intervention Service:

Decision 1: Service Provider for ACT EIS

1. Non-Government Organisation as the service provider
2. CHS as the service provider – Further Senior engagement will be required.

Decision 2: MoC Consideration

1. FREED MoC
2. Alternative MoC

Decision 2: MoC Consideration

FREED MoC – Background

- This is an adaptable, evidence based MoC for Early Intervention of Eating Disorders.
- FREED was developed in London and has been implemented throughout the UK.
- FREED has been adopted in Australia, with two separate NGOs running FREED in South Australia.
- The project team and DR met with the UK FREED team early this year and discussed the possibility of adapting FREED to the ACT health care context.
- All resources would be provided to the ACT to implement FREED, on the proviso that the ACT enters into an operational agreement with FREED. This agreement includes a data sharing component.
- In South Australia, the NGOs have adopted the FREED age range (16- to 25-year-olds) but are flexible on accepting older clients if appropriate. Initially, they accepted clients who had a duration longer than 3 years, but have adjusted this due to demand increases.
- The premise of FREED is that clients are provided treatment that suits their individual needs. For example, EDP only offers FBT for under 18s, whilst the FREED model would offer the client CBT if more appropriate.
- FREED has made all of their resources and tools available online. This model is essentially a ready-made package for a service provider to implement.

<u>Discussion:</u>

JO – Is this similar to a franchise model, where we would effectively commission an NGO to use FREED?

JM – Yes, however it should be noted that the FREED model was designed to be implemented into an existing public health system/eating disorder service with the only cost being an ongoing FTE.

JO – Require further research on how FREED is working in Australian health care system and adaptions that been made.

CF – Previous experience with implementation of UK models into Australian context with CAMHS adopting the CAPA model of referrals. This has worked very well for CAMHS.

JM – The two South Australian NGOs also found it has worked well for them. The only issue they reported was minimal client referrals at the start due to lack of promotion with other local service providers.

MC – Supportive of the FREED MoC based on the availability of support and its evidence based. Difficult to see that ACT can come up with a better, more cost-effective model.

JO – NGO sector in relation to mental health and eating disorders is not very mature, noting this is a new service.

ACTION: JM and the project team to further explore the application of the FREED model in Australia by liaising with South Australian NGOs to understand their early intervention models of care.

Decision 1 – Service Provider for ACT EIS

Discussion:

LL – Timing of this decision and whether this is put in place before design and construction process. e.g if CHS is the service provider can involve in the process. If outside provider they usually wouldn't be involved due to tender process being in progress. If this decision is made early and service provider engaged you could involve them in the process and value add to the design.
CF – If run by an NGO for the residential program, what would the connection be between services? A few decisions to be made, is it better to have the same provider running both the residential and the early intervention?
MC – Are there other jurisdictions rolling out services at same time?
JM – EIS is largely a part of BAU in the other states. In the ACT we are labelling as a dedicated service. EIS is about the timing of when the therapy starts. Currently EDP have long waitlist and are unable to offer early intervention.
MC – Could be service delivery efficiency and clinical effectiveness, better referral pathways if all one provider.
JM – Services won't be coming online in the same year for EIS and Residential Facility in the ACT. EIS expected to be operational by 1 July 2022, with the residential unknown.
JO – Due to market maturity and budget of $220K we are unlikely to attract providers that are new to the market in ACT. If they run both services could be more attractive, but no guarantee.
JM – South Australia has 2 different NGOs running early intervention as a new service offering for the state. Expect out of state tender responses for ACT EIS. For Residential Facility tender the Butterfly Foundation is the only NGO currently operating a similar facility currently. If go with FREED model for the EIS, can hand the resources and model over to service provider to run.
MC – 2 tender processes required, with first one for EIS. FREED model with condition that successful tender to work in consultation with other ACT eating disorder service providers.
JM – Clinical Hub will be integration point so all services working together to step up/step down as per holistic MoC.
CF – Option for CHS to run the EIS in the interim until the residential facility is operational, then CHS transfer the EIS over to one NGO to run EIS in conjunction with the residential?
JM – [redacted]. ACT will probably require 1 FTE for EIS. In terms of CHS as service provider, need to consider capacity of EDP noting current issues with staff sharing and recruitment as the EIS would likely be absorbed into EDP operations. Noting EDP's waitlist, it is unlikely EIS would be run effectively (ie in recommended timeframes) in the current EDP environment.
JO – Staff profile for the EIS?
JM – Both South Australian NGOs had psychologists employed.
JO – Private facility in Deakin will be open around same timeframe and we will be competing for resources and staff.
MC - Further discussions are required on the options paper including the issue raised by LL at the next meeting. We will also have the outcomes of the funding from Maria, and the FREED meeting with South Australia.
ACTION: JM to expand upon ACT Early Intervention Service Options paper and share/discuss further at next meeting.

4 Other business

No other business.

Next meeting: 6 May 2021

#	Action	Lead	Status
1	MC to ask Maria Travers to explore how ACT could recoup Commonwealth funding for interstate clients.	MC	31.03 – This work is underway with one avenue explored already and another yet to be explored. This action will be brought to Steering Committee members for discussion later. This action remains open.
2	JM to liaise with NSW counterparts on their residential facility progress (inclusive of catchment discussions, bed numbers and location).	JM	
3	JM to develop a paper on the benefits and risks of co-locating other eating disorder services with the residential facility, for Steering Committee consideration.	JM	
4	JM and the project team to further explore the application of the FREED model in Australia by liaising with South Australian NGOs to understand their early intervention models of care	JM	
5	JM to expand upon ACT Early Intervention Service Options paper and share/discuss further at next meeting.	JM	

Minutes
Eating Disorders Project Steering Committee

ACT Government | ACT Health

1.00pm-2.00pm
Friday 7th May 2021
Webex

1 Welcome and apologies

Title/Department	Name	Attendance	Apologies
Executive Group Manager, Policy Partnerships and Programs	Michael Culhane	√	
Executive Group Manager, Strategic Infrastructure	Liz Lopa		√
Senior Manager, Strategic Infrastructure	Dan Landon	√	
A/g Senior Manager, Mental Health Policy Unit	Yasmin Barrington-Knight	√	
A/g Executive Branch Manager, Mental Health Policy Unit	Cheryl Garrett	√	
A/g ACT Chief Psychiatrist	Dr Dinesh Ayra	√	
Operational Director, CAMHS	Cathy Furner (proxy for Karen Grace)	√	
Calvary Public Hospital Bruce Representative	Kelly Howard	√	
Calvary Public Hospital Bruce Representative	Janeen Johnson	√	
Calvary Public Hospital Bruce Representative	Narelle Comer		√
Clinical Director, Division of Medicine, CHS Director, General Medicine Unit Canberra Hospital	Dr Ashwin Swaminathan		√
GP Policy Advisor, Academic Unit of General Practice	Dr Melinda Choy		√
Clinical Director, CAMHS	Dr Denise Riordan		√
Clinical Hub Manager, Eating Disorders Program	Kalvinder Bains	√	
Project Manager, Program Support Unit	Jessica Miko	√	
Secretariat	PSU	√	

2 Minutes and actions arising from previous meeting

#	Action	Lead	Status
1	MC to ask Maria Travers to explore how ACT could recoup Commonwealth funding for interstate clients.	MC	31.03 – This work is underway with one avenue explored already and another yet to be explored. This action will be brought to Steering Committee members for discussion later. This action remains open.
2	JM to liaise with NSW counterparts on their residential facility progress (inclusive of catchment discussions, bed numbers and location).	JM	07/05/21 - Meeting scheduled for next week. JM will report the outcome at the next Steering Committee meeting.
3	JM to develop a paper on the benefits and risks of co-locating other eating disorder services with	JM	Please see **Item 3.4**. This action item is closed.

	the residential facility, for Steering Committee consideration.		
4	JM and the project team to further explore the application of the FREED model in Australia by liaising with South Australian NGOs to understand their early intervention models of care.	JM	Project team met with Tracey Wade on 22/4/21. Details from this have been added to the Options Paper. This action item is closed.
5	JM to expand upon ACT Early Intervention Service Options paper and share/discuss further at next meeting.	JM	Further detail and attachments have been added to this Options Paper for Steering Committee consideration. Please see **Item 3.3.** This action is closed.

3 Items for discussion and endorsement

3.1 Project Overview Report

- Two delays to the project schedule:
  - Early Intervention Service (EIS) Model of Care (MoC) – This is awaiting decision from the Steering Committee via the options paper. Once a decision is made this will no longer be delayed.
  - EIS – Decision to be made on if this is CHS or NGO run service. Once this decision is made this piece of work will be on track.

3.2 Infrastructure Update

- Major Projects Canberra will do the detailed design and commissioning of the builders for the residential facility.
- Residential facility build is reasonably straight forward, with the next step to get the concept designs drafted to get a cost planner on board. Infrastructure need to understand if the Steering Committee wants to co-locate other services on the site as soon as possible as this can inform the design of the residential facility.
- JM requested Item 3.4 be discussed next given current conversation.

3.4 For discussion: Co-location of Eating Disorder Services

- CF – Agreed that we could have some office space for Clinical Hub.
- JM met with Cathy Furner, Dan Landon and EDP staff to discuss the pros and cons of co-location and has put together a paper based on these discussions.
- JM also met with the Commonwealth to discuss potentially re-allocating a portion of the $13.5M to build infrastructure for other eating disorder services on the Coombs block. The Commonwealth have advised that the ACT would need to seek approval from Greg

Hunt via a brief for this. Schedule 2.2(a)(x) Intergovernmental affairs [redacted]

- The brief would need to include the following information:
  - demonstrate that there is a surplus of funds,
  - demonstrate there would be no impact on the Residential Facility, and
  - caveat that the ACT would not seek further Commonwealth funding for the co-located services.
- Potential ACT eating disorder services that could be co-located include the Clinical Hub, EDP (as it has outgrown its current office space), EIS and the Day Program.
- KB – Preference is to co-locate the Clinical Hub and EDP as the priorities, with the EIS to be operated out of NGO office space (if applicable). For those accessing the EIS, if an existing service (such as Head Space) operate the EIS, it can be less stigmatizing for clients to go to Head Space than Coombs.
- CF – Preference to co-locate services identified as a priority such as the Clinical Hub. Co-location is also cost effective as you can utilise staff across different services, less travel to other locations etc.
- CF – As committed to in the business case, the EPHSED project includes the activity of scoping out an outpatient day program. This is separate to the CHS Day Program, which is currently being considered as a CHS business case and is being set up for eating disorder patients as a 'step-down' from hospital or a 'step-up' from EDP. This service will most likely remain at the Canberra Hospital and will not require co-location at Coombs.
- MC asked what the difference is between the CHS Day Program and the EDP.
- KB – The CHS Day Program will offer meal support and some group therapy three days a week. In contrast, EDP clients receive individual evidence-based therapy (Family Based Therapy or Cognitive Behavioral Therapy) over a longer period of time.
- KB - Clinical Hub needs to be prioritised for co-location as it currently has no office space.
- JJ – Agree, site plan is required that accommodates other services. Will another business case be required to support this?
- DL – If co-location is agreed, the next steps are concept design and costing so we have an idea of how much the residential facility will cost and what's left over in the $13.5M. Then we can work out what we can spend on the other facilities.
- DA – If Clinical Hub and EDP are co-located, do we have budget to be able to operate the services?
- CF – The Clinical Hub and EDP are already operational now with a recurrent budget, and therefore not an issue in terms of operational budget.
- MC –As already operational, should be able to predict the size of the facilities required based on the current space for the services.
- DL – This will form part of the concept design.
- DA – What happens after 3 years of funding from the Commonwealth is complete in terms of residential facility operations?

- JM – The ACT will need to put in budget bid to seek funding for the operational costs/recurrent funding going forward, however this has always been known.

DECISION: The Steering Committee members agree that there needs to be co-location of services, but they need to be prioritised. The Clinical Hub is the first priority.

ACTION: DL to get costings for the Residential Facility and co-location of services.

3.3. For further discussion & decision: ACT Early Intervention Service Options Paper

- The project team met with Tracey Wade in SA where FREED has been implemented to discuss how they have adapted the model to the Australian healthcare setting. Tracey advised that SA have not experienced any issues, and that FREED is the only evidence-based model for early intervention for eating disorders.
- The alternative to FREED is going out to market and asking tenderers to submit their recommended MoC.
- KB – As FREED is an evidence-based model with successful implementation in both the UK and Australia, this should be the preferred model of care for the ACT.
- CF – Agree with using FREED for the ACT EIS. Utilizing a model that is already established is easier for implementation.
- DA – What costs are involved with FREED?
- MC – No costs to sign up to the FREED Network. As stipulated in the Operational Agreement (Attachment 2), we would need to agree to share data with UK researchers. Implementing the model requires a part time resource if done in the public system.
- JM – The FREED model was originally designed to for the EIS to be adopted into existing eating disorder service. However, FREED can also be run through an NGO, with the only cost incurred via the contractual arrangements. The ACT currently has $220K recurrent annual funding to run this service via an NGO.
- KH – Unsure that NGOs have expertise required to implement this model.
- JM – Benefit of FREED is all resources are provided by the UK and the FREED Network. We would also get support from FREED researchers if signed up to the FREED network, regardless of whether this is NGO or publicly run. If chosen to implement the EIS in the existing ACT public system, the main concern is that EDP don't have the capacity to meet the FREED timeframes as their current wait list is extensive. FREED requires contact within 48 hours of a referral being made.
- CF – Agreed that concern is that if EIS is run in existing Eating Disorders service like EDP, the model may get lost due to emphasis on the backlog of long and enduring clients the service currently sees. Acute and emergency appointments would also take priority.

- MC – If move into existing service, early intervention clients may be de-prioritised and therefore the service would not operate as it should.
- KH – Note that there are many different eating disorders services coming online in the ACT soon which will all need to be coordinated.
- CF – It is intended that the Eating Disorders Clinical Hub will be the single referral point for all eating disorder clients. The Hub will be responsible for triaging and referring clients as appropriate to services (such as the EIS or Residential Facility).
- KH – We could go out to market for an alternative model as part of the procurement process for the NGO service provider.
- MC – Preferable to go with evidence-based approach for the EIS as this provides cost efficiencies and other benefits as outlined in the discussion paper. If we go out to market, there is a risk could get an alternative model which is not as good.
- MC – Possible factor in deciding between NGO and CHS service provision is how much money if any we can claim under the NHRA for this service. This will be explored further at the next Steering Committee meeting.
- DA – FREED model makes sense. Service provider - Clinician FREED model vs NGO FREED model?
- KB – UK implemented FREED in public health system and NGOs. FREED focuses on the first 3 years, EIS for 16 to 25 years of age. Contact with client within 48 hours, assessment in 2 weeks, treatment starts withing 4 weeks. Positive feedback received for FREED. It's proven to decrease the duration of illness.
- KH – What positions/expertise are required for FREED?
- KB – Psychologists.
- KH – Why not employ 2 staff at EDP rather than engaging an NGO?
- KB – EDP is a crisis intervention for chronic illness and does not have the current capacity to offer early intervention in a timely manner.
- CF – This is an opportunity to expand Eating Disorders services in the ACT that are not just Government run. As the ACT already has $220K budgeted we are likely to receive more value if run via an NGO.

DECISION: The ACT will utilize the FREED as the model of care for the ACT EIS.

DECISION: The disposition is for an NGO to run the ACT EIS. This will be confirmed once financial discussion is had at the next Steering Committee meeting.

3.5 For noting: Health Unit Planning Brief (Residential Facility)

- Any comments on the Health Unit Planning Brief please send to JM out of session.

4. **Other Business**
   - Welcome to Cheryl Garret who is acting in Jon Ord's position temporarily as the Executive Branch Manager of the Mental Health Policy Unit.
   - Commonwealth Report - JM will send the Commonwealth Report to the Steering Committee members for endorsement out of session next week.

Next meeting: TBA June 2021

Action Table

#	Action	Lead	Status
1	MC to ask Maria Travers to explore how ACT could recoup Commonwealth funding for interstate clients.	MC	31.03 – This work is underway with one avenue explored already and another yet to be explored. This action will be brought to Steering Committee members for discussion later. 7/5/21 This action remains open. To be discussed at next meeting.
2	JM to liaise with NSW counterparts on their residential facility progress (inclusive of catchment discussions, bed numbers and location).	JM	07/05/21 - Meeting scheduled for next week. JM will report the outcome at the next Steering Committee meeting.
3	DL to get costings for the Residential Facility to inform the co-location of services.	DL	

Decision Table

#	Decision
1	The Steering Committee members agree that there needs to be co-location of services, but they need to be prioritised, with the Clinical Hub the first priority.
2	The ACT will utilize the FREED as the model of care for the ACT EIS.
3	The disposition is for an NGO to run the ACT EIS. This will be confirmed once financial discussion is had at the next Steering Committee meeting.

MINUTES

Eating Disorders Project Reference Group

ACT Government | ACT Health

Time: 12.00pm to 1:00pm
Date: 26th May 2021
Via MS Teams

1 Welcome and apologies

Title/Department	Name	Attendance	Apologies
A/g EBM, Mental Health Policy Unit, ACTHD	Cheryl Garrett	√	
Clinical Dietician, CHS	Claire Speer		√
Staff Specialist, Paediatrics, CHS	Dr Pearl Chan		√
Dietitian, WYC, CHS	Tiffany Peddle	√	
Manager, Eating Disorders Program, CHS	Zoie Fortington	√	
Clinical Hub Manager, MHJHADS	Kalvinder Bains	√	
Psychiatrist, CPHB	Dr Priyani Ratnayake		√
Manager Public Mental Health Services, CPHB	Kelly Howard		√
Health Services Planning, ACTHD	Serena Eynon	√	
The Capital Health Network Representative	Kath Carleton		√
EO, ACT Mental Health Consumer Network Representative	Dalane Drexler		√
Eating Disorders Families Australia Representative	David Quilty	√	
Assoc. Prof. & Clinical Psychologist, Research School of Psychology ANU	Dr Elizabeth Rieger		√
Head of ANU Counselling Service	Andrew Staniforth		√
Health Care Consumers Association (HCCA) Representative	Kate Gorman	√	
Women's Centre for Health Matters	Julia Tran	√	
Community representative	[redacted] Schedule 2.2(a)(ii) Privacy	√	
Project Manager, Program Support Unit	Jessica Miko	√	
Secretariat	PSU	√	
Guest Member	**Name**	**Attendance**	**Apologies**
Procurement Officer, Procurement ACT	Laura Rayner-Smith	√	

Welcome to Cheryl Garrett, A/g EBM, Mental Health Policy Unit, ACTHD. Cheryl is taking over as the chair of the Reference Group from Jon Ord.

Also welcome to [redacted] Schedule 2.2(a)(ii) Privacy who is a community representative with lived experience of an Eating Disorder, and Laura Rayner-Smith from Procurement ACT.

2 Previous Actions

#	Action	Responsibility	Due Date	Status
1	Reference Group members to provide feedback on the HPU brief v0.3 to JM in the next ten days (by COB 12 Mar).	All	12/3/21	This has been completed and action is closed.
2	JM to request floorplans of TAS Facility, if available.	JM	26/5/21	These have not yet been completed. 26.05.21 – JM will touch base with TAS.

3 Items for discussion

3.1 Update on EPHSED Project Progress

- The Eating Disorder Residential Facility Model of Care was endorsed by the Steering Committee on 19th March 2021. Thank you to Reference Group members for their contributions to this document.
- The preferred Residential Facility block of land has been endorsed by the Steering Committee. The process to secure the block of land is quite time-intensive, with the next steps being geotech works and architect designs which will be informed by the Health Planning Unit Brief.
- As the block of land is large the project team is investigating if other services can be co-located onsite. Other possible services include the Clinical Hub, and Early Intervention Service, Eating Disorders Program. Once the block of land is secured this will come to the Reference group for discussion.
- The Clinical Hub is in the last stage of recruitment before being operational. The Project Team is currently working on the Governance and operation documents which will be discussed in future Reference Group meetings.
- Early Intervention Service (EIS) - Procurement process for an NGO to run the service is in progress. Funding for the service begins on the 1st July 2022. Procurement protocols will be explained in the next agenda item.

- Deed of confidentiality forms have been distributed to all Reference group members for completion as we move into discussions on the Early Intervention Service.

DQ – Is there a timeline for when the Residential Facility will be operational?
JM – Due to the amount of work that needs to be done before the site is confirmed, unable to forecast an opening date at this stage.

3.2 Upholding of Procurement Protocols

3.2.1 Guest Speaker Laura Rayner-Smith

- A power- point presentation on the overview of the procurement process and probity obligations was given.
- We are in Phase 3 for the EIS Procurement, the next step is Request For Tender (RFT) drafting to go out to market.
- The Tender will be open for 30 days. Once closed, the evaluation period begins. The Tender Evaluation Period can vary depending on the responses received.
- 6 months is generally required for a procurement process to be completed. This can vary depending on the complexity of the project, questions and clarification sought by the Tenderer and contract negotiations. It is important to have a detailed Statement of Requirements (SoR) to avoid this.
- Any questions regarding the procurement process or probity, please send onto the Project Team.

3.3 FREED Model of Care – Consideration for ACT Early Intervention Service

3.3.1 FREED Implementation Guide
3.3.2 FREED Operational Agreement (for information only)
3.3.3 ACT Statement of Requirements

- FREED is a UK model, and is an evidence-based model of care for Early Intervention of Eating Disorders. FREED criteria is the age range of 16 to 25 years old, with a strict timeframe for contact to be made with the client within 48 hours, 2 weeks for assessment 4 weeks until commencement of treatment.

- FREED is a flexible model that can be tailored to individual needs.
- FREED was originally designed to be implemented into an existing public health eating disorder system/service. This approach would be altered in the ACT as it is intended that the ACT will be employing an NGO to deliver the ACT EIS. The reason for this is that there is no capacity within the current eating disorder services in the ACT to enable implementation of FREED and meet the timeframes of engagement, assessment and treatment with clients.
- Other benefits are the ability to cross-skill staff and have a partnership approach, with the potential for staff sharing across services.
- Set amount of funding of $220,000 per year is provided to implement the EIS from 1 July 2022.
- South Australia has two NGOs currently running versions of FREED for early intervention. [redacted]

Discussion:

SE - Is there any evidence on outcomes from data re changes South Australia made?

JM - No, changes initially meant they could capture more people, now adapted back as long waitlist. South Australia have used the 3 years seeking treatment not onset of condition. Age range open for debate i.e. below 16yrs, do we have an age cap? FREED model is liked by clinicians in South Australia and has good outcomes for patients.

KB – FREED is the only evidence based model available for early intervention and is well researched and evaluated. Clinical supervision of the NGO could come from the Clinical Hub.

JM - As we are now in the process of procurement for the EIS service provider, and it has been decided that FREED is the MoC that will be used, we now require guidance from Reference Group members to inform the SoR to move forward.

JD: On the topic of 3-year onset from symptoms versus diagnosis – believe this is a good change as onset from symptoms is hard to measure. On the topic of age range –people developing ED later in life and would be good for EI service to be able to support them.

CG and KB agreed with JD.

JM - Discussions with Pacific Health indicate there is a demand for older cohort, 40- 60 year old's particularly with binge eating issues.

ZF – Admission criteria, besides the early onset may help to determine the age range requirements.

JD – Relapse with this model – only one stage what about recovery for 10 years and this is a new case?

JM - Clinical Hub assess client's suitability for service, relapse would be back to Hub and re-allocation for appropriate service.
The Project Team is in the process of drafting the Governance and structure for EDP and Clinical Hub. How these fits into service model is a work in progress.

KG - support is required for lower age range as by 16 years an eating disorder can be entrenched. There is a service gap for younger children. Could consider a different approach with the younger cohort.

JM – SA had concerns around the treatment model as FBT, too difficult to implement into their model so they went with 16 as the minimum age.
ACTION: JM to talk to EDP clinicians to discuss options for younger cohort.

JD - Agree, 16 years is the minimum age for Northside, Geelong. For early intervention, the hope would be that this program could catch people before this – even if different approach for younger cohort.

ACTION: JM to draft the SoR and populate with FREED MoC and have it reviewed by procurement before distribution and discussion at the next Reference Group Meeting.

JM – Draft SoR for discussion to be progressed in next few Reference Group meetings then to the Steering Committee for endorsement before Procurement.

4 Other business
Nil

Next meeting: 16 June 2021

Minutes

Eating Disorders Project Reference Group

ACT Government | ACT Health

Time: 12.00pm to 1:00pm
Date: Wednesday 16th June 2021
Via MS Teams

1 Welcome and apologies

Title/Department	Name	Attendance	Apologies
A/g EBM, Mental Health Policy Unit, ACTHD	Cheryl Garrett	√	
Clinical Dietician, CHS	Claire Speer		√
Staff Specialist, Paediatrics, CHS	Dr Pearl Chan		√
Dietitian, WYC, CHS	Tiffany Peddle		√
Manager, Eating Disorders Program, CHS	Zoie Fortington	√	
Clinical Hub Manager, MHJHADS	Kalvinder Bains	√	
Psychiatrist, CPHB	Dr Priyani Ratnayake		√
Manager Public Mental Health Services, CPHB	Kelly Howard		√
Health Services Planning, ACTHD	Serena Eynon	√	
The Capital Health Network Representative	Kath Carleton		√
EO, ACT Mental Health Consumer Network Representative	Dalane Drexler		√
Eating Disorders Families Australia Representative	David Quilty	√	
Assoc. Prof. & Clinical Psychologist, Research School of Psychology ANU	Dr Elizabeth Rieger	√	
Head of ANU Counselling Service	Andrew Staniforth		√
Health Care Consumers Association (HCCA) Representative	Kate Gorman		√
Women's Centre for Health Matters	Julia Tran	√	
Community representative	[redacted] Schedule 2.2(a)(ii) Privacy	√	
Project Manager, Program Support Unit	Jessica Miko	√	
Secretariat	PSU	√	

2 Previous Actions

#	Action	Responsibility	Status
1	JM to request floorplans of TAS Facility, if available.	JM	These have not yet been completed by Tasmania.
2	JM to talk to EDP clinicians to discuss options for younger cohort.	JM	This action is completed. The project team met with EDP, with the agreement that EIS should be 16 years and above, but can take younger clients on a case by case basis if FBT is not appropriate. This detail is to be added to TW MoC.
3	JM to draft the SoR and populate with FREED MoC for distribution and discussion at the next Reference Group Meeting.	JM	This action is complete – please see **Item 3.2.**

3 Items for discussion

3.1 Update on EPHSED Project Progress

- Major Projects Canberra (MPC) has been engaged to progress infrastructure. The Project Team is in the process of acquiring the block of land for the Residential Facility and organising upcoming community consultations.
- Early Intervention Service (EIS) Procurement is on track. The Statement of Requirements (SoR) drafting is in progress, as discussed in these Reference Group meetings.
- The Clinical Hub has 1 position left to recruit to before being fully staffed. Set up of the governance structure and admission pathways is the next piece of work.

3.2 Draft Statement of Requirements: ACT Early Intervention Service

- The SoR will be used to go out to market to acquire a service provider for the EIS. The FREED Model has been added to the draft SoR for member's consideration.

3.2.1 Discussion Points

Heading	Discussion Point/s	RG Recommendation
The FREED Service Model	Consideration for telehealth/virtual service offerings?	DQ -Telehealth option is essential. KB - Group work and psycho education service could be offered. ER - Agree. New norm offering greater flexibility. JD – Agree telehealth as an option but don't rely on it as eating disorders can be hidden. Optional offering for the service but not the core modality.
FREED Champion	Stipulation of a FREED Champion and what this role entails.	KB - Pull out core components (tasks/responsibilities) ensure are covered and NGO meets the requirements, doesn't need to be FREED champion. ZF - Suggest 'FREED Coordinator' – consider revising use of language. ER - Could seek consumer feedback on the name. Curious why choose this name. JM - Not tied to terminology, think it was used to differentiate role from other public eating disorder service roles.

		JD - Like 'FREED Coordinator'. Champion denotes someone who is not a professional. JM - Will revise role/name ensuring it has still has the core components/responsibilities of FREED Champion.
FREED Mini-Team	Use/labelling of a FREED Mini-Team.	JM - likely no more than 2 FTE due to the budget. Is mini team useful given the small staffing number? ZF – Suggest remove mini team. CG - Not much use in terminology when a small team. JD - Peer support role, voluntary champion to assist.
FREED Mini-Team	Role of the FREED team to conduct promotional activities – or is this the responsibility of the Clinical Hub?	JD - Agree.
Outcomes	What are our expected outcomes from implementing FREED?	JD - Data on requirements of patients who required longer support through the Clinical Hub/ stats on how long people have suffered for.
Performance Requirements	What are the operational hours?	JM - Propose Mon to Fri 9 to 5. FREED model requires contact within 48 hours. ZF - Non crisis service. 9-5 makes sense. JD - This could limit those able to seek help if only business hours. KB - Contact Access Mental Health receive calls on weekends and afterhours.
Performance Requirements	Any other service stipulations that are crucial to the ACT EISed?	KB - Could NGO provide parenting groups at EIS? JM - Could incorporate into the Optional Requirements of the SoR. DQ - EDFA runs monthly ACT parents/carers peer support group and monthly education sessions over ZOOM, could look at integrating with the EIS FREED service in terms of peer support and providing information about the EIS/FREED. Have federal Government funding to do peer support. Ensure families are involved in early intervention so families can be effective before eating disorder entrenched.

JM will put feedback from the Reference Group into SoR then meet with Procurement ACT in preparation for going out to tender.

3.3 ACT Stepped Model of Care for Eating Disorders – presentation

- The Stepped MoC for Eating Disorders directly correlates to Territory Wide MoC and gives an overview of how all the services integrate and the step-up step-down capabilities within the model.

Stepped Care Options: Residential Centre

- Residential Centre – The phased treatment approach to discharge will include family/carer workshops, online meal support and potentially a day program.

Stepped Care options: Eating Disorders Program

- GP will be part of the treating team and kept up to date on client progress and engage with the Clinical Hub.

Stepped Care Options: GP/Primary Care

- Need to ensure the process is simple and easy for GPs, and will promote the Clinical Hub as the central referral point.
- Medically unstable clients should to Emergency if directed by their GP, with notification to the Clinical Hub who can assist from there.
- Plan to integrate the EDs with the Clinical Hub? JM to progress this at a later project stage.

Eating Disorders Clinical Hub Referral Pathway

- This is based on the CAPA model and is currently being revised. Feedback will be sought from clinicians and the Reference Group.
- Clinical Hub is available to clients across the lifespan.

ACTION: JM to circulate presentation slides to all members.

4 Other business

No other business.

Next meeting: 21 July 2021

Minutes

Eating Disorders Project Reference Group

Time: 12.00pm to 1:00pm

Date: Wednesday 18th August 2021

Via MS Teams

1 Welcome and apologies

Title/Department	Name	Attendance	Apologies
A/g EBM, Mental Health Policy Unit, ACTHD	Cheryl Garrett	√	
Clinical Dietician, CHS	Claire Speer		√
Staff Specialist, Paediatrics, CHS	Dr Pearl Chan		√
Dietitian, WYC, CHS	Tiffany Peddle	√	
Manager, Eating Disorders Program, CHS	Zoie Fortington	√	
Clinical Hub Manager, MHJHADS	Kalvinder Bains	√	
Psychiatrist, CPHB	Dr Priyani Ratnayake		√
Manager Public Mental Health Services, CPHB	Kelly Howard		√
Health Services Planning, ACTHD	Serena Eynon		√
Capital Health Network Representative	Stephanie Lentern	√	
EO, ACT Mental Health Consumer Network Representative	Dalane Drexler		√
Eating Disorders Families Australia Representative	David Quilty		√
Assoc. Prof. & Clinical Psychologist, Research School of Psychology ANU	Dr Elizabeth Rieger	√	
Head of ANU Counselling Service	Andrew Staniforth		√
Health Care Consumers Association (HCCA) Representative	Kate Gorman		√
Women's Centre for Health Matters	Julia Tran		√
Community representative	Schedule 2.2(a)(ii) Privacy [redacted]	√	
Project Manager, Program Support Unit	Jessica Miko	√	
Secretariat	PSU	√	

2 Previous Actions

#	Action	Responsibility	Status
1	Schedule 2.2(a)(xi) Business affairs [redacted]		

2	JM to circulate presentation slides to all members.	JM	This has been completed, with slides sent out with last meeting minutes to members. This action is closed.

3 Items for discussion

3.1 Update on EPHSED Project Progress – JM provided update:

- Residential Facility – The first installment of funding provided on the 1st July 2021. The Procurement process for Geotech work and site investigations is currently in progress. Next steps will be architect for preliminary designs.
- Early Intervention Service (EISed) – Funding to be provided 1st July 2022. Procurement for an NGO to run the EISed is in progress and will go out to tender soon. From the 1st July 2022 the NGO will have 3 months to plan the service in consultation with ACTHD and UK FREED researchers, with the aim of the service being operational by the 1st Oct 2022.
- TW MoC is being developed service by service. The Residential Facility MoC has been endorsed. The next MoC is the Clinical Hub, then the Eating Disorders Program and Inpatient and GP integration to all form one Territory Wide MoC.

3.2 For Discussion: ACT Clinical Hub Model of Care

3.2.1 Discussion Points

Heading	Discussion Point/s	RG Recommendation
Description of Service	Catchment area – Does the Clinical Hub accept referrals/provide stepped care to those outside the ACT?	JM - Workshops were held with CHS Senior Managers. Mapped out the staffing for proposed admission process. The Clinical Hub is a pathway into Eating Disorders Services for the Territory and surrounds. Clinical Hub is almost fully recruited, with one position outstanding. Hub will be stood up once MoC is cleared/approved. ER – Fabulous job on MoC, had no additional points to add. JM – Currently discussing the catchment areas at the Steering Committee, and how we connect the

		surrounding areas. Currently inpatient services in the ACT take all patients, but Eating Disorders Program (EDP) only take ACT residents. Noting endorsed Residential MoC includes Canberra and surrounds. ER – With services stretched at the moment does this raise any alarms? ZF – Presently EDP is only funded for ACT. Concerns are how we step down to local NSW services, the boundaries and how we manage and monitor this. KB – Concerns only 3.5 FTE clinicians at EDP and a long waiting list, if we service surrounding areas, we will be unable to provide timely access to treatment. Mental Health services like HARRT would not be able to go outside of the ACT to provide support either. Bigger complications with crisis support out of hours. CG – To continue to look at this. The Steering Committee will be looking at these issues more broadly (considering funding arrangements). KB – Would need to increase the FTE if servicing the surrounding areas. ER - Boarder services will also need to broaden their reach. JM - Decisions would need to be across the board for all ACT eating disorder services. KB - Idea is to link into the service coordinators at Clinical Hub, but just haven't got the resources. JM - A consideration might be to start with ACT only, then review in a few years' time – have a staggered approach to broadening the catchment area.
Eating Disorder Research	Discussion on content to be included in this section	JM - How much do we stipulate how the Clinical Hub participates in research? KB – Difficult as depends on the grants we receive. Tracy Wade (SA) has approached EDP for participation in national Eating Disorder research, depends if the funding application is successful. CG – Should note that it will be dependent on grants and resources in the MoC. ER – Add a statement about how the Clinical Hub recognizes the value of research integrated. KB – Research Officer FTE could be included for future consideration. ER – Consideration note to be added on mutual support – the researchers would be supporting the Clinical Hub. Bi-

		directional support could include data from Hub to researchers and workshops form researchers to staff. KB – Student run clinics have been initiated with CHS, 5 students are providing CBT-10 sessions and developing capacity for initial presentations and supporting EDP and getting people off the wait list and supported staff burnout. The Service Coordinators have initiated this innovative program and done a fantastic job. It has already reduced the EDP waitlist by 60%. Help from ZF and EDP staff is greatly appreciated. ER is involved in the student clinic in terms of training. Have pooled resources together.
Discharge Process	Discussion on content to be included in this section	JM – When stepping people down, what we expect from the Clinical Hub, how much involvement the Clinical Hub has with individuals? ER – Due to resources, should the individual go back to the GP for follow up support? KB – Hub won't have resources for follow-up. ZF – EDP refers onto other services after discharge or onto the GP. Try to follow up with discharge pathways as part of the treatment, return to private support or GP as point of care or things have resolved.

Next steps

- JM to update the Clinical Hub MoC as per this meeting discussions. The updated Clinical Hub MoC will be circulated to the Reference Group for discussion at the next Reference Group Meeting to ensure that the MoC goes through 2 Reference Group meetings.
- Next piece of work is the MoC for EDP MoC.
- Any further comments please contact JM to add.

4 Other business

No other business.

CG - stay safe and encourage everyone to practice self-care and reach out to others
Meeting closed 12:37

Next meeting: 15 September 2021

Minutes

Eating Disorders Project Steering Committee

ACT Government | ACT Health

4.00pm – 5.00pm
Thursday 7th October 2021
MS Teams

1 Welcome and apologies

Title/Department	Name	Attendance	Apologies
Executive Group Manager, Policy Partnerships and Programs	Michael Culhane	x	
Executive Group Manager, Strategic Infrastructure	Liz Lopa (Dan Lopa as proxy)	x	
A/g EBM, Mental Health Policy Unit	Cheryl Garrett	x	
A/g ACT Chief Psychiatrist	Dr Dinesh Ayra		x
Clinical Director, CAMHS	Dr Denise Riordan		x
Clinical Director, Division of Medicine, CHS Director, General Medicine Unit Canberra Hospital	Dr Ashwin Swaminathan		x
A/g Operational Director, CAMHS	Kalvinder Bains	x	
A/g Clinical Hub Manager, Eating Disorders Program	Kirsten Stafford	x	
Calvary Public Hospital Bruce Representative	Narelle Comer (Janeen Johnston as proxy)	x	
GP Policy Advisor, ACT Health	Melanie Dorrington	x	
Project Manager, Program Support Unit	Jessica Miko	x	
Secretariat	PSU	x	

2 Minutes and actions arising from previous meeting

#	Action	Lead	Update	Status
1	Schedule 2.2(a)(xi) Business affairs [redacted]			

2	Schedule 2.2(a)(xi) Business affairs [redacted]			
3	JM will follow-up on bed numbers for NSW facility and report back to next meeting.	JM	Schedule 2.2(a)(x) Intergovernmental affairs [redacted] This action is closed.	Closed
4	MPC to keep DL updated to advise JM as things progress and provide regular updates at monthly Steering Committee meetings.	DL	DL to provide an update at the next meeting, as per standing **Agenda Item 3.2**.	Closed
5	Question for the Cross-Border team: if not funded under NHRA, what stops ACT limiting access on geography or place of residence?	CG/JM	JM met with SNSW Eating Disorder Coordinator. Limited care options for SNSW, with dedicated eating disorder services only available in ACT. Please see **Agenda Item 3.4** for further discussion.	Closed
6	JM to share stepped care presentation slides with minutes.	JM	This has been completed. This action is closed.	Closed

3 Items for discussion and endorsement

3.1 Project Overview Report – by exception

- Clinical Hub MoC for endorsement today. To develop EIS and EDP MoC soon, with endorsement expected for these components sometime next year.

- Current focus is clinical hub operations now they are fully staffed to ensure they can be open as central referral point by end Dec 2021.
- Other focus is EIS procurement with paperwork for endorsement at next SC meeting in Nov.
- Residential block and proof of concept both in red as advised by DL/MPC.

3.2 Infrastructure Update

DL reported MPC will be issuing tender on ACTHD behalf for concept design. MPC work has been delayed due to COVID activities, which has delayed the tender. MPC will be running the process from here – issues tender and responds to potential tenderer queries. ACTHD invited to comment on our behalf. JM and DL will be on the Evaluation Panel so will be able to provide input re who successful tenderer should be (noting DL has infrastructure background and JM has project background). MPC have advised Concept design process likely to finish in May 2022 (originally scheduled for completion by Dec 2021). SID have impressed on MPC the need to keep it moving with SID turning things around ASAP. Concept Design will be a broad outline - rough floor plans and high level, similar to a glossy real estate brochure. Concept Designer will liaise with SC who will also have input with the process.

MD: Will the Concept Design process have diverse input e.g. end users to ensure it feels like a home?

DL: There will be ongoing input throughout the process with possible weekly meetings with designers for JM and DL to ensure design meets intent and informed by MoC.

Next step will be architect for detailed design work for development application. The ultimate design from the architect will also have many iterations with the possibility for more consultation.

DL to provide regular update at these meeting as a Standing Agenda Item.

3.3 For discussion & endorsement: DRAFT ACT Clinical Hub Model of Care

JM: Each Eating Disorder service will have individual MoC and will be amalgamated to inform overarching TW MoC, which details the stepped model and integration points. This is the 2nd MoC component for SC endorsement, as the Residential Centre MoC endorsed in Mar 2021.

Note: Hub will be ACT residents only as per Eating Disorders Program, with the understanding this will be reviewed once discussions progress regarding the eligibility of the Residential Centre for NHRA funding.

KB: Well done, whole of government approach to consultation – great job.

JJ: Minor edit for page 15 change “private” to “public” for CPHB.

MD: Given shortage of services as outlined, if patient refers themselves, is GP being asked whether they want to be involved? Ideally, they will but dependent on their load as it is time consuming to give patients regular ongoing support when not linked in e.g. weekly bloods takes up a lot of time. Also, if the GP then charges for each consultation, the patient may be in a worse situation financially. In short, is the GP being contacted prior to acceptance of referral?

JM: If self-referred to the Hub and GP is already engaged, will include medical monitoring, and stepped down care. However, the Hub does not want a barrier if the person doesn't have a GP but will need to have someone who can support their medical monitoring.

KB: Agree. Need to continue with GP for step down.

MD: If going on waitlist, what supports will be going out while waiting i.e. held by Hub not just outsourced back to primary care?

KB: EDP/Hub will maintain regular contact while on waitlist.

MD: If a patient is being discharged from emergency but patient at risk of refeeding syndrome – not sufficient if the only support was just GP involvement.

JM: Plan is to expedite clients as much as possible through the Hub i.e. shortening pathways into services. Also, possibility of support whilst on the waitlist – JM to talk about this further in 'Other Business'.

KB: Also, with the Hub there will be a transitional coordinator to in-reach into hospital to support the person during their hospital stay to provide short term support.

MC: If no further comments/edits Clinical Hub MoC agreed for endorsement out of session.

ACTION: JM to make final edits from this discussion and members to endorse out of session.

3.4 NHRA In-Scope Resource Guide

JM: Spoke with Maria Travers from Policy regarding NHRA and the funding claim process. If services are in scope for NHRA could broaden catchment for Residential Centre to surrounding NSW regions. Determination of whether Residential Centre is in or out of scope also has implications for other ACT eating disorder services.

CG: Commonwealth conversations to see if other States and Territories also starting eating disorder services are claiming NHRA funding. Will also progress bilateral conversations with IHPA to see if they can help provide advice with this assessment.

MC: Noted Tas has is intending to claim NHRA, seems it could be an option also for the ACT Need to have discussions with Commonwealth and IHPA. Decision will be for Government, but funding and catchment decisions are linked. If funded under NHRA – Commonwealth fund 45% of activity.

MC: ACT doesn't have operational funding agreed by Gov at this stage. Issue of operational funding to be considered when we know when it will open and staffing etc.

ACTION: Update on Commonwealth funding and IHPA discussions to be provided at next meeting.

4 Other business

KB: Schedule 2.2(a)(x) Intergovernmental affairs Schedule 2.2(a)(xii) Confidential information [redacted]

MC: Supportive of this.

Members agreed – endorsement of the Clinical Hub participating in the research initiative being led by Tracey Wade.

Meeting closed 4:46

Next meeting: 4 November 2021

MINUTES
Eating Disorders Project Steering Committee

ACT Government | ACT Health

4.30pm – 5.00pm
Thursday 4th November 2021
MS Teams

1 Welcome and apologies

Title/Department	Name	Attendance	Apologies
Executive Group Manager, Policy Partnerships and Programs	Michael Culhane	x	
Executive Group Manager, Strategic Infrastructure	Liz Lopa (Dan Landon as proxy)	x	
A/g EBM, Mental Health Policy Unit	Cheryl Garrett		x
A/g ACT Chief Psychiatrist	Dr Dinesh Ayra		x
Clinical Director, CAMHS	Dr Denise Riordan		x
Clinical Director, Division of Medicine, CHS Director, General Medicine Unit Canberra Hospital	Dr Ashwin Swaminathan		x
A/g Operational Director, CAMHS	Kalvinder Bains	x	
A/g Manager, Eating Disorders Clinical Hub	Kirsten Stafford	x	
Calvary Public Hospital Bruce Representative	Narelle Comer		x
GP Policy Advisor, ACT Health	Melanie Dorrington	x	
Project Manager, Program Support Unit	Jessica Miko	x	
Secretariat	PSU	x	

2 Minutes and actions arising from previous meeting

#	Action	Lead	Update	Status
1	Schedule 2.2(a)(xi) Business affairs [redacted]			
2	JM to make final edits from this discussion and members to endorse out of session the Clinical Hub Model of Care.	JM	This was completed, with the Clinical Hub MoC endorsed out of session on 15 October 2021.	Closed
3	Update on Commonwealth funding and IHPA discussions to be provided at next meeting.	MC	From recent Ministers meeting, MC and LL have decided to expedite this work to seek to engage consultant to provide advice on where and how much we could claim on NHRA and what structural arrangements are needed to weigh up pros and cons. The Minister wants to consider the tradeoffs if	Ongoing

			we go down NHRA path, dependent on value of Commonwealth contribution versus requirements for ACT. This will be the fast way to get answer with high certainty, which may possibly cost $25K.	

Previous minutes passed.

3 Items for discussion and endorsement

3.1 Project Overview Report

Update from JM – by exception:
Hub MoC endorsed out of session. Progressing with EISED procurement and hoping to go to tender in 2 weeks' time. Milestones for Residential amended with advice from MPC and LL.

3.2 Strategic Infrastructure Division: Update

Update from DL:
Tender from MPC for initial design will be released on the Tenders ACT website on 11 Nov 2021 for initial concepts design. The tender will be open for 3 weeks with view for successful tenderer confirmed by end Jan 2022. Hope to have designs completed by May 2022 moving to more detailed design and construction. MPC, LL and DL have advised best case scenario for completion of build is Oct 2023, previously was end of 2023. LL and DL are exploring ways to move things forward e.g. shortening the next stage of procurement**.** Tender documents will name Coombs as the preferred site. Minister will be doing a press release to coincide with tender released. Design consultation process will also include key stakeholders e.g. clinicians, patients.

MC:
Timeframe was early 2024 for construction complete – Min Davidson requested it to come forward so ambitious timeframe for late 2023. Spoke with Min re Hub, EIS and Residential Treatment Centre. Min has key interest in ED services being delivered on time. If slippage occurs, there will be questions from Mins Office. Eating disorders to be discussed at Minister weekly catchups for some time as she is very keen and interested in this work.

DL:
Noting significant issues with completion by end 2023 e.g. supplies, trades, and weather which could push timeframes out.

3.2.1 Communication Strategy

JM update:
To align with infrastructure and Coombs tender announcement on 11 Nov 2021, Minister to also make an announcement on 11 Nov with Commonwealth input and SLA support. SLA to then do targeted forums with community following this.

3.3 Early Intervention Service for Eating Disorders: Update

JM update:
$220k from 1 July 2022 to be provided to NGO. Open tender for this released the week of 15 Nov opened for 1 month then closed. Contract to be negotiated by 1 July then operational by 1 Oct 2022 to provide time for operational setup e.g. align with FREED and ACT healthcare context.

3.4 Clinical Hub: Update

JM update:
To be fully operational as central referral point on track for Christmas start date. Fortnightly meetings alternating between Hub leadership team and EDP to discuss intake, triage and referral process. This will be complied into operational document for Hub. Work on website commenced for Jan 2022 go live date.

KB:
HP2 recruitment was unsuccessful twice – moved to RN2 but successful applicant turned down the position. This means CHS will need to re advertise. This role was the Intake person for the Hub.

MC:
Is it the same level of clinicians being sought for both the EISED and Residential – do we need to speak with universities with regards to staffing issues/workforce?

KB:
STRIDE clinic providing shorter intervention of CBT is delivered by university students. To channel these students into CHS, they must start as HP1 then after 12 months move to HP2. CHS will need to create HP1 roles for people to move through various steps of career progression. May need to consider this for NGO for both EISED and Residential e.g. workforce strategy.

MD:
Is this Canberra or is it nationwide shortage?

KB:
National shortage of ED and MH clinicians – probably international as well.

MC:
Maybe need to speak with skills areas?

DL:
Skills areas in CMTEDD economic directory. Dan can ask for a contact name re person to speak to re broader issue for skills.

MC:
May not help with Hub but if we can speak with skills pipeline how can they help longer term might be useful.

ACTION: DL to speak with skills contact from CMTEDD to discuss workforce strategy and skills shortage in the eating disorder clinician space.

4 Other business

MC:
ACT Health Directorate organizational changes, with MH Policy Branch to move out from MC's Division and under Coordinator General. CG, A/g EBM will move to work under Dr Elizabeth Moore, who will be the new project sponsor. CG will remain chair of Reference Group and provide continuity for the project. Thanks, Steering Committee has worked well and wish the project luck with the next stages of work.
KB:
Thanks Michael – you will be missed.

Meeting closed at 5:02pm

Next meeting: 2 December 2021

MINUTES

Eating Disorders Project Steering Committee

ACT Government | ACT Health

4.00pm – 5.00pm
Thursday 9th December 2021
MS Teams

1 Welcome and apologies

Title/Department	Name	Attendance	Apologies
A/g EBM, Mental Health Policy Unit	Cheryl Garrett	√	
Executive Group Manager, Strategic Infrastructure	Liz Lopa		√
A/g ACT Chief Psychiatrist	Dr Dinesh Ayra	√	
Clinical Director, CAMHS	Dr Denise Riordan		√
Clinical Director, Division of Medicine, CHS Director, General Medicine Unit Canberra Hospital	Dr Ashwin Swaminathan		√
Operational Director, CAMHS	Kalvinder Bains	√	
A/g Manager, Eating Disorders Clinical Hub	Kirsten Stafford	√	
Calvary Public Hospital Bruce Representative	Narelle Comer		√
GP Policy Advisor, ACT Health	Melanie Dorrington	√	
Senior Manager, SID	Dan Landon	√	
Senior Manager, SID	Caitlin Bladin	√	
Project Manager, Program Support Unit	Jessica Miko	√	
Secretariat	PSU	√	
Title/Department	**Guest Member**	**Attendance**	**Apologies**
Co-ordinator General, Office of Mental Health & Wellbeing	Dr Elizabeth Moore		√

2 Minutes and actions arising from previous meeting

#	Action	Lead	Update	Status
1	Update on Commonwealth funding and IHPA discussions to be provided at next meeting.	MC	This will now be informed via a procurement process for a consultant to undertake this work.	09.12.21 – The project will be seeking external advice to inform Residential Treatment Centre decisions and navigate potential Commonwealth contributions from IHPA. JM is looking at the panel of providers currently and drafting the SoR to inform this in coming year.

3 Items for discussion and endorsement

3.1 Project leadership change updates & Welcome to new members

- Acknowledgement of County.
- Updates to the Mental Health branch - The MH policy team now sits under Dr Elizabeth Moore. Michael Culhane has stepped out of the leadership position for

this project. Dr Elizabeth Moore is now the Project Owner, and Cheryl Garrett is the Project Sponsor.

- Caitlin Bladin is taking over the project from Dan Landon for SID.
- The Steering Committee members thanked Dan and acknowledged all the work Jessica Miko has done to date.

3.2 Project Overview Report

- Territory-wide Model of Care:
    - The Clinical Hub MoC was endorsed in the October meeting – Completed.
    - Work continues on the on EDP MoC which is the next focus followed by the EISED MoC.
- JM is working with the Clinical Hub staff on the operations manual ahead of the service launch in January. A number of meetings have been held and now completed. Currently combining into a completed Clinical Hub manual.
- EISED – Tender was released on 19th November, and closes on 20th December.
- Residential Treatment Centre – Early concept design tender released 17th November and closes on 17th December. The tender evaluation is scheduled to occur on 20th December.

3.3 Strategic Infrastructure Division: Update

- 16 consultants signed the deed of confidentiality to access the tender and 9 attended the information session.

- Session booked with Major Projects Canberra to complete the tender evaluation on December 20th. Expect there to be a push to get this signed off by Christmas.
- A few weeks will be required to formally commission the successful consultant with the aim of late January to early February having the design, plans etc with the final concept design delivered by May – June.
- Once the consultant is engaged will report on this to the Steering Committee at the next meeting.
- Media release about the Coombs site went out on November 17th. The Community are now aware this site is preferred for the Residential Treatment Centre. We are not anticipating any issues with being formally granted the land.

3.4 Early Intervention Service for Eating Disorders: Update

- Tender was released on the 19th November and closes on the 20th December.
- Have received a few questions from potential tenders which is promising.
- The tender has gained interest from the CPSU who have raised concerns over outsourcing, privatization and probity processes, and have requested a pause to the tender. CPSU have spoken to multiple Ministers on this. ACTHD does not support a tender pause and is continuing to proceed with the tender process.
- At this stage ACTHD is still on track for the EISED to engage an NGO by the 1st July and commence operations by the 1st October.

3.5 Clinical Hub: Update

- The Clinical Hub will be launched as the central referral point and fully operational in late January. The proposed date was the 31st, however the Minister is on leave so now looking at the 24th January for the launch. Currently with Comms teams from CHS and ACTHD on this.
- Operations manual is expected to be completed by the launch date.
- The Clinical Hub won't be fully staffed prior to the launch.
  - GP is starting on the 11th January, Dr Helena Morris.
  - Recruitment underway for the Clinical Hub Manager.
  - Temporary RN2 starts next week for 3 months while the Hub undertakes a permanent recruitment round for this role.
  - The Hub is waiting on the position number for the in reach clinician, which is funded through the community support package. Going to have 1 x HP3 to in-reach into the wards for about 4 weeks. Will also recruit a H01 at 0.8 FTE.
- Kalvinder Bains has been successfully awarded the Operations Manager, CAMHS, CHS.

4 Other business

New meeting series for 2022 will be sent out shortly.

- Mel Choy may return next year as Melanie Dorrington is currently backfilling for Maternity leave. The EOI closed for the position last week. If this meeting continues on a Thursday it will be Mel Choy attending this meeting in the New Year.

- **ACTION:** JM will send out a new meeting series for the new year for the next 6 months for the same time slot to start at the end of January.

Next meeting: TBC