Oaths Act 1867

Statutory Declaration

QUEENSLAND
TO WIT

I, **DR ANNE BRENNAN** of Toowong, in the State of Queensland, do solemnly and sincerely declare that:

In response to further queries raised in the Notice to Give Information in a Written Statement dated 24 December 2015:

Services to replace the Barrett Adolescent Centre (BAC)

Question 1 - Explain whether, and to what extent, you were appointed to be one of two psychiatrists supporting the Assertive Mobile Youth Outreach Service.

1. Although nominally employed to work in AMYOS I was in fact employed in another position. After finishing with the transition program for Barrett I worked with WMHHS at Ipswich doing CYMHS work until 7 or 9 March 2014. I then worked for the Mater Children's Hospital as a consultant psychiatrist doing inpatient work from 20 March 2014 until 20 June 2014. I had been approached by Dr Stephen Stathis to work for CHQHHS when the Lady Cilento Hospital opened. However in order to do this I needed to have been working for either the RCH or Mater Children's Hospital for a particular period of time, which I had not been. A part time position became available through the newly developed AMYOS. My understanding was that I would be nominally employed to work under AMYOS as of 5 August 2013, but on commencement of work I would receive a movement advice which result in me working for CHQHHS in Consultation Liaison and eCYMHS, that is in fact what happened. I then worked 0.3 FTE in consultation liaison and 0.3 FTE in eCYMHS for far north Queensland, I took leave in October 2014 when the Kotze inquiry concluded

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and eventually resigned from the position in February 2015.

Question 2 - Explain whether, and to what extent, you were involved in the development of the model of care that is being developed for the cohort of patients who would formerly have been patients of the BAC.

2. I have had no formal involvement in the development of the model of care that has or is being developed for the cohort of patients who would formerly have been patients of Barrett. Where senior colleagues involved in the development of the model have sought my opinion I have been happy to provide comments. These discussions have occurred in meetings of the Queensland Faculty of Child and Adolescent Psychiatry and in monthly Peer Review Meetings which are part of the Continuing Professional development program of the RANZCP.

Early experience of the BAC

Question 3 - The Commission understands you were a psychiatric registrar at the BAC in 1993/ 1994. Explain how your recollection of the BAC from that time was different to that which you encountered in late 2013, particularly with regard to the:

a. practice of staff and maintenance of appropriate boundaries;
b. length of admissions (inpatient and outpatient);
c. incidence of self-harm;
d. clinical governance;
e. resources; and
f. staff profile (nursing, allied health, and education).

3. Based on my recollection of Barrett from 1993/1994, the service I encountered for the transition program differed from what I had experienced in the following ways:

a) Practice of staff and maintenance of appropriate boundaries – my impression in 2013 was that there were some instances where appropriate boundaries had not been maintained. As of the first day at BAC in September 2013 I observed the concern of the patients about the welfare of the health and education staff. Though understandable that they would be sad to farewell many familiar staff who had cared for them, the depth of their knowledge of staff's future employment prospects and

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the fact that they were exposed to the distress this and other facets of closure were causing staff, seemed inappropriate for young people with their own significant anxieties, particularly at a time when they needed a sense of optimism rather than to be empathising with the pain of their carers. In addition I learnt that one of the ex-patients had spent time living at the house of the principal, Kevin Rogers and was post discharge employed at BAC. There was also an investigation into a concern about some allied health practitioners providing treatment to BAC patients privately while employed by WMHHS or planning to provide private therapy following closure of BAC. I also felt that in some instances staff had not kept up with more modern ways of doing things. Nursing staff told me that they had not been given opportunities for professional development and that this negatively impacted their chances of securing the positions they had hoped to obtain subsequent to closure. Others reported that they would be unemployable after such long employment periods at BAC as they felt unskilled to work in other settings. A noticeable difference between 1994 and 2013 was the breakdown of the relationship between health and education staff. (see 23 b).

b) Lengths of admissions appeared to me to be longer than what I recalled in 1993/1994. My impression was that in 1993/1994 the admissions were generally of the order of a few months at most where in 2013 there were a number of patients with lengths of stay of more than 12 months; the average length of stay of the

c) The incidence of non- accidental self injury appeared to me to be similar. That is that in 1993/1994 there were a significant number of patients with a history of self harm or attempts at self harm, and this was similar in 2013;

d) Clinical governance – this was similar to 1993/1994.

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e) Resources – the resources available appeared to not have changed. It concerned me that we had to look up a White Pages or Yellow pages to find contact details for local services. I would have expected a folder or data base to be kept in which such details were easily available. Kevin Rogers, the principal, had a 2010 list of Brisbane South resources. This was useful but it had not been updated and did not include accommodation providers. The buildings were the same but had deteriorated and were in need of a fair amount of upkeep. For example, several windows in the school wing, including the offices for Allied Health, did not lock;

f) The staff profile – this was quite similar to what I had experienced in 1993/1994. A number of the staff in the nursing and education areas were the same. There were lots of new faces as well particularly in allied health areas but the focus on protecting and supporting the patients was the same. It was noteworthy that remaining staff and patients reported recent loss of staff (prior to my commencement) with failure to refill those positions.;

Question 4 - Explain whether the BAC had, in your view, kept pace with changes in the mainstream of child and youth mental health practices, procedures, and knowledge. To the extent it had not, please give reasons why not.

4. As noted above I felt that to some extent the centre had not kept change with changes in the mainstream of child and youth mental health practices. There were some areas where BAC performed well such as the use of a sensory room for de-escalating intense emotional states and distress. The school brought in innovative opportunities such as drumming workshops. I did not observe intensive family work or family therapy, and liaison with communities of origin seemed lacking. My understanding was that these caring and well-intentioned individuals had not accessed ongoing professional development opportunities.

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Referrals to the BAC

Question 5 - State whether, at various times during your career, you have referred patients to the BAC. Provide details as to:

a. the number and types of patients you referred to the BAC (and when);
b. the reason(s) you determined it was appropriate to refer those patients to the BAC (as opposed to some other service);
c. the service(s) to which you would expect to now refer patients whom you would previously have referred to the BAC (alternative service); and
d. the adequacy or otherwise of such alternative services, as compared to those provided by the BAC.

5.

a)

b)

c) I would now look at services such as a day program with or without a community care residential model with ability for 24 hour observation by trained nurses or, when available, a step up/step down model;

d) It is extremely difficult to compare different models as there are factors

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relating to the particular patient and family, the theoretical model of care, the fidelity of practice to that model and the adequate resourcing of the service. In my experience the important aspects of treating adolescents with mental health conditions include:

(i) A clinician competent at complex case formulation;

(ii) Having staff with skills to understand and relate to patients and used to dealing with adolescents;

(iii) Connections to community, education and opportunities for socialisation;

(iv) The ability to provide 24 hour observation when the patient is acutely unwell;

(v) Connection to local services and the incorporation of each mental health service within a continuum of services for this age group and with established interface with referring services and adult services.

e) Many of the Barrett patients are able to be treated with the services currently available such as CYMHS, AMYOS, day programs and treatment in acute beds in local hospitals. However there are some who require a medium term residential facility which provides not only nursing observation and attention to reduction or prevention of self harm but also education and vocational training and socialisation. There are no such services currently..

Appointment & early arrangements at BAC

Question 6 - Were you told, upon or before accepting the position of A/Clinical Director of the BAC that the role would require you to devise and implement transition plans for all admitted patients at the BAC? If not, please explain your understanding of the role at that time.

6. I was not told before or upon accepting the role as acting clinical director that this would require me to devise and implement transition plans for all admitted

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patients at the BAC. I was advised that a replacement for Dr Sadler was urgently required and that the Centre was closing. I assumed that a transition process was already in place and my role would be to look after the patients until they had moved to new services. It became apparent very early into the role that there were no transition plans in place and that I would need to develop those.

Question 7 - Were you informed, at the time you accepted the position or at a later time, that others had been approached and rejected the role? If so, provide details.

7. I was not informed at the time but learned later that Dr Hoehn and Dr Ian Williams had been approached to take the role.

***Question 8* - To your best recollection, what was the effect of any conversations you had with the following people before commencing the role of A/Clinical Director of the BAC:**

a. Dr Stephen Stathis;
b. Dr John Wakefield;
c. Dr Mark Matussi;
d. Ms Sharon Kelly;
e. Dr Trevor Sadler;
f. Dr Elisabeth Hoehn; and
g. Dr Darren Nellie.

8. I cannot recall each conversation or with whom it was had. I did not have any conversations with Dr Stathis prior to commencing in this role as he was overseas. I recall that Dr Steer called me to ask me to take the role to replace Dr Sadler, [redacted] He indicated Dr Hoehn would assist me. Dr Hoehn confirmed she would assist me and arranged to drive in with me the next day. Dr Nellie confirmed that I would report to him in the acting position for Dr Stedman. Dr Sadler informed me he was being stood down [redacted] He advised he was glad I had been asked to do the role and that he had concerns that Dr Hoehn had initially been approached given her primary clinical experience was with patients under the age of 5. I believe

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Dr Wakefield, Dr Mattussi and Ms Kelly provided information about practical matters such as hours, pay, accreditation etc.

***Question 9* - In relation to Dr Sadler:**

a. were you promised a formal hand-over from Dr Sadler;

b. if 'yes', who promised it, and:

i. was it promised orally, in writing, or partly written and partly oral;

ii. to the extent the promise was oral, state the effect of what was said; and

iii. to the extent the promise was in writing, please provide a copy of any document containing the promise;

c. if 'yes', in what form was the hand-over to take place;

d. what if any impediments prevented a hand-over occurring;

e. if a hand-over did not occur, what if any disadvantage to you ensued;

f. was that disadvantage explained to any person at WM HHS;

g. outline the circumstances of any incidental contact you had with Dr Sadler during the transition period?

9. In relation to receiving a formal handover from Dr Sadler:

a) Yes .

b) In a phone call prior to my commencement Dr Sadler said he would provide a written summary of each patient to Dr Darren Neillie. Dr Neillie said in a meeting in Sharon Kelly's office that Dr Sadler would give him a written hand over.

c) This advice was given by Dr Darren Neillie and was given orally;

d) The effect of what was advised was that Dr Sadler would provide a written summary for each patient;

e) The major impediment to a handover was that staff received a written direction to not contact Dr Sadler;

f) The disadvantage from not receiving a handover from Dr Sadler was lessened by the fact that the nursing staff provided detailed summaries of the patients. However it would have helped in my understanding the clinical background of each patient to have a summary from Dr Sadler. As a result I had to spend more time getting to understand the patients in

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order to develop the transition plans;

g) After waiting two weeks for a hand over from Dr Sadler I raised the lack of handover with Dr Neillie .

h) I had a telephone call from Dr Sadler before I started in the job. He informed he had been advised I would be taking over and he was pleased it was me. He had been concerned that Dr Hoehn had been asked to assume the role, because her experience was with patients under the age of 5 years. He also said that he believed the I saw Dr Sadler at a conference in Melbourne in November. Later in mid December 2013 Dr Sadler rang when it was apparent he wasn't returning to Barrett before it closed, to ask if he could retrieve personal items such as his books and papers. At that time he mentioned concerns about a couple of patients in particular and . We also discussed .

Question 10 - In relation to Dr Hoehn:

a. who suggested to you that she would assist;

b. what assistance from Dr Hoehn was promised or outlined upon or before commencing in the role as A/Clinical Director;

c. if 'yes', who made the promise or outlined the assistance, and was it:

i. oral, in writing, or partly written and partly oral;

ii. to the extent the promise was oral, state the effect of what was said; and

iii. to the extent the promise or outline was in writing, please provide a copy of any document containing the promise or outline; and

d. what assistance did Dr Hoehn provide?

10. In relation to the assistance provided by Dr Hoehn:

a) The advice that she would assist me was provided by Dr Steer and then Dr Hoehn called me and arranged to drive with me to the BAC the following day when I started work;

b) The exact nature of the assistance was not specified. I had the impression that Dr Hoehn was providing a link to CHQHHS and guidance in the aspects of the role relating to communications to and links with

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CHQHHS as she was a senior clinician with CHQHHS and understood the background to the decision to close, the decision to stand down Dr Sadler and the interaction in the process between WMHHS and CHQHHS;

c) My understanding of the role Dr Hoehn would play arose from my discussion with Dr Steer and my discussion with Dr Hoehn. The advice I received as to her role was all oral;

d) The assistance Dr Hoehn provided was in accordance with what is set out in paragraph (b) above. She gave me a handwritten chart setting out the governance structure – attached marked AB-1. She was a connection to CHQHHS although I also spoke to Dr Stathis directly if needed. She was a sounding board in relation to how I thought we should approach the transition and develop transition plans. In some circumstances where I met impediments in securing services I felt patients required, she assisted where she could to persuade relevant persons to resolve issues. Dr Hoehn at times acted independently such as when she organised a meeting with Michelle Bond at Spring Hill to review the education plans for the Barrett patients. In the first week Dr Hoehn came to Barrett from Wednesday to Friday. After that she came out every Wednesday morning and was otherwise available by telephone and email.

Question 11 - Explain the circumstances that led to the psychiatric registrar Dr Tom Pettit leaving the BAC during the transition period.

11. Dr Pettet found the combination of the standing down of Dr Sadler, , the decision to close the BAC and the transition process very distressing. Having regard to those matters and to the training requirements of the RANZCP for him to progress his training, which required that he see new admissions (which was not occurring with no turnover of patients), and the age range of the BAC patients being different from the College requirements, it was decided to find a more suitable training position for him. This was done by Dr Hoehn. She also liaised with Dr Neillie to support Dr Pettit while he worked at Barrett.

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Question 12 - Explain any conversation or other interaction you had with Dr Bill Kingswell at around the time you commenced in the role of A/Clinical Director.

12. I had a brief discussion with Dr Kingswell in the company of Dr Hoehn outside the ward on arrival at Barrett to commence in the role of A/Clinical Director.

Governance

Question 13 - The Commission understands that:

a. the transition planning and implementation was an iterative and fluid process led by you, that occurred daily and on an ad-hoc basis between August 2013 and January 2014; and

b. a formal meeting took place on Wednesday mornings, generally attended by Dr Hoehn and members of the Clinical Care Transition Panel.

Outline any other regular meetings that took place, either on a scheduled or ad hoc basis.

13. In response to question 13 I say:

a) I agree that the transition planning and implementation was a fluid and iterative process led by me which occurred daily and on an ad-hoc basis between August 2013 and January 2014;

b) Formal transition planning meetings did take place on Wednesday mornings generally attended by Dr Hoehn and members of the WMHHS executive and myself. Other meetings which took place included twice weekly transition care panel meetings, weekly case conference to review all patients, morning ward meetings with health and education staff and patients, and consumer meetings with patient advocate. Allied health had a weekly meeting on Tuesday mornings that I was not involved in. There was a large meeting to which many stakeholders were invited at the commencement of transition planning and this was followed by meetings with individual stakeholders such as government departments and NGOs. There were family meetings. There were at least two meetings of all ward staff when critical decisions re transition arrangements required discussion and/or consensus. There were regular nurses meetings which I did not attend. My recollection is that there were one or two business

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meetings during my four months at Barrett but I cannot recall any details of these.

Question 14 - Explain what reports you made to West Moreton HHS, Children's Health Queensland, or any other arm of Queensland Health about the progress of transition plans?

14. I reported informally to Dr Hoehn. When any matter of a serious nature arose such as an assault on a patient I reported to the WMHHS director which initially was Dr Darren Neillie standing in for Dr Terry Stedman, and then on his return from leave, Dr Stedman. I also reported to Leanne Geppert and Sharon Kelly and from time to time reported to Dr Stathis. In terms of written reports Laura Johnstone, project officer for the transition prepared a monthly report, which I reviewed. This was then sent to the SWAETR (Statewide Adolescent Extended Treatment and Rehabilitation) steering committee. She also documented the proceedings and outcomes of the Transitional Care panel meetings. Following closure I wrote a brief de-identified synopsis of each patient, which was sent to the executive. Five weeks after closure I repeated that exercise and highlighted emerging issues for some of the ex Barrett patients.

Question 15 - Explain what if any assistance or response you received from any arm of Queensland Health (or other government department) to which you made reports about the progress of transition plans, particularly regarding:

a. generation of available and appropriate options based upon your clinical advice as to the needs of specific patients;

b. advice, support, or resources about appropriately skilled and trained staff to assist in the transition process and/or clinical care for patients who had yet to move to alternative services; and

c. intervention to secure funding or placements in services deemed by you as a patient's clinician to be clinically and therapeutically appropriate as part of the transition.

15. In response to this question I say:

a) This is a very broad question and I do not have access to the material required to answer it in detail. What I can say from memory is that the

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following services attempted to generate appropriate options when approached –

Metro South
Dr David Crompton was particularly proactive in asking the meeting of HHS staff with BAC staff to come up with options and "not to leave the meeting until there was a plan in place".

Metro South HHS was flexible in engaging Transitional Housing and NGOs to provide additional support.

Within that HHS, Logan adolescent unit staff were welcoming and very flexible about generating workable solutions for BAC patients.

PAMHS staff were similarly supportive. I was impressed by the immediacy with which they engaged in the take over of clinical care following referral of BAC patients and their willingness to visit Mater Children's Hospital and BAC to facilitate ease of transition of those young people.

who had had a long involvement with family prior to admission to BAC.

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These were Q Health and NGO services.

The psychiatrist and NUM demonstrated nuanced competent clinical acumen in how they approached the provision of care and resolved many issues within a short period of time from when the young person left BAC.

WMHHS attempted to generate

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b) This is partly covered in my answer to 15(a). I do not recall anyone in particular who specifically advised in relation to appropriately skilled and trained staff. It went without saying that transition plans were not finalised without an understanding that the various providers were skilled and trained.

Dr Elisabeth Hoehn from CHQHHS provided informed advice on a consistent basis throughout the development of transition plans. Her commitment to this task far exceeded that which would have been expected by someone providing just linkage to and oversight by CHQHHS.

Dr Madonna Gasman sent useful transition literature and gave sensible verbal advice about transition processes.

c) Requests for additional funding and interventions to secure placements were escalated to Dr Leanne Geppert and the WMHHS executive when the Transitional Care Panel were unable to procure appropriate placements and funding. This involved several government departments but details would best be provided by those directly involved.

I understood that the executive of WMHHS worked to secure funding to other HHSs in order that they could provide extra services or fund external service providers to do so, in order that BAC patients could be

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transitioned safely to services that would otherwise have been inadequate to meet their individual clinical needs.

Question 16 - Further to question 15, outline any instances where such assistance was requested, but was not forthcoming.

16. In response to question 16 I refer to my previous statement and in particular to paragraph 103 of the statement. In addition to the matters raised there I can say that initially they agreed to increase their availability and involvement to optimise the likelihood of a smooth transition with a positive outcome.

Question 17 - Outline what administrative assistance you received as part of the transition planning and implementation, the adequacy of such assistance, and whether any shortcomings affected transition planning or implementation.

17. I was provided with an administrative officer who I understood had a good knowledge of government services and departments relevant to adolescents. Unfortunately her knowledge was not as extensive as indicated and so her ability to assist in identifying necessary services was limited. In addition it was her role to maintain a summary of the plans and any changes that were made, but this was not maintained sufficiently. Following closure there was inadequate administrative assistance. The task of completing a large number of discharge summaries was hampered by inability to access a Dictaphone or to have Winscribe software installed on my computer. After a few days of working alone in BAC as people came and went clearing out offices, I moved to an

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administration building where I shared an office with two Administration Officers who were of assistance.

Question 18 - Identify and provide a copy of any literature on transition planning made available to you. If any literature was provided, outline whether and to what extent it assisted in transition planning and/or implementation.

18. No transition literature was provided to me by the WMHHS or CHQHHS. I searched for literature and asked colleagues. I cannot recall who recommended that I contact Madonna Gassman as a useful resource person, however I did. She sent 4 articles relevant to transition planning. Copies of the articles are attached marked **AB -2**. I forwarded these to the Transitional care panel.

Question 19 - In relation to the clinical governance at the BAC before the transition period:

a. To what extent is it correct that before you commenced as A/Clinical Director, the BAC did not have any body of knowledge, database, or list of appropriate services to which patients might transition?

b. Is it correct that the time of year (i.e. leading in to the end of the working year) increased the difficulty of finding appropriate services for patients, and if so why?

c. Explain any view you formed about:

i. insufficient developmental skills imparted to patients; and/or

ii. the adequacy of educational or vocational support provided to patients at the BAC.

d. To what extent, if any, did you consider that record keeping was inadequate or inappropriate?

e. Explain whether in your view, a patient at the BAC should have been receiving individual therapy (in combination with milieu therapy) and any views you formed about the adequacy of individual therapy for patients?

f. Did the co-ordination (or lack thereof) between the BAC and external treating psychologists or other allied health professionals:

i. affect patient care; or

ii. affect the development and/or implementation of transition plans; and

iii. if so, how?

19. In response to question 19 I say:

a) When I commenced as A/Clinical Director I learned that the BAC did not have a database or list of services to which patients might transition.

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Kevin Rodgers, the principal of the BAC school, had a list of services for Brisbane South, but it was a 2010 list so was not current and did not include supported accommodation services. This meant more time had to be spent identifying services;

b) Certainly the transition planning process, as it advanced towards the end of the year, was more difficult as one receiving service had difficulty rostering extra staff due to holiday leaves, and patients were wanting (most appropriately) to have leave with their families. [redacted] in a positive way which exceeded the expectations at the time of patient, family, BAC staff and staff of the receiving service;

c) My views about insufficient developmental skills imparted to patients and the adequacy of vocational or educational support – any comments I make in this regard should be seen as personal views made in the context that I have never before this position had a role as clinical director of a service such as the BAC. Therefore I do not claim to be an expert on what developmental or other occupational or educational training ought to be provided to the cohort of patients treated at the BAC. In that context I can say I was surprised that the training and education being provided to some of the patients was limited. [redacted] This seemed inadequate preparation for learning to live independently and enter the workforce. [redacted]

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[redacted]

d) The clinical documentation was an area of difficulty for a number of reasons. Firstly there had been a transition to the statewide mental health record keeping system CIMHA. This system was not one that staff used consistently. I had no training in the use of CIMHA so found it difficult to record relevant information for patients. Record keeping of dates of transfer from inpatient to day-patient or outpatient status and discharge dates did not seem accurate when I started at BAC.

e) My view on whether patients should have been receiving individual therapy as well as milieu therapy – I consider that it is important in treating patients to ensure they have regular psychiatric reviews, appropriate psychological support, which can include group sessions, together with input by a case manager, properly trained nurses and allied health practitioners, and also general practitioner reviews to ensure the patient's general health was being monitored. I was concerned that for some patients the amount of therapy received at the BAC was limited. [redacted] It is quite possible that the provision of individual therapy and family therapy had waned as the unit was facing closure and all had been aware of that situation for many months.

f) It was my view that a lack of co-ordination with external treating

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practitioners posed a risk to patient wellbeing. However I am not aware of any situation where a lack of co-ordination actually led to problems for patients.

Question 20 - The Commission understands that in or about December 2013, you formed the view that the agency nursing staff at the BAC were not adequately trained to properly care for remaining inpatients. Please state:

a. whether and to what extent that is correct;
b. how did you address the situation;
c. if you sought assistance or redress to the situation, from whom did you seek it;
d. what response you received; and
e. how the situation was resolved (if at all).

20. The impact of having agency nursing staff:

a) It is correct that I was concerned about the ability of agency staff to look after the patients remaining in the BAC. This concern was formed definitely by December 2013, but possibly earlier although I currently do not have documents and my recollection is not sufficient to allow me to say definitely that the concern was formed before December. . Even where the agency staff had the they often did not have specific adolescent mental health experience and I felt that this was a matter of concern; The lack of skilled agency or casual staff also left the remaining staff with added responsibility;

b) I addressed the situation by contacting William Brennan, a Director of Nursing at The Park of which the BAC was a part, to advise of specific nursing issues on at least 3 occasions. He always responded and guaranteed adequate support for nursing staff, adequate nursing numbers

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and that BAC staff would not be rostered elsewhere. I also raised these concerns in a Wednesday morning meeting with the executive and the Directors of Nursing William Brennan and Padraic McGrath who both worked at The Park. I discussed the situation with Leanne Geppert. I met regularly with Alex Bryce NUM. When patient safety seemed at risk because of the particular skill mix or low staffing numbers, I raised the issue with Dr Hoehn;

c) As noted above the persons I sought assistance from were William Brennan, Leanne Geppert, the other members of the WMHHS executive, Padraic McGrath, Alex Bryce and Dr Hoehn;

d) The response was that William Brennan always responded and guaranteed adequate support for nursing staff, adequate nursing numbers and that BAC staff would not be rostered elsewhere. In addition a teleconference was arranged on 13 December 2013 involving the WMHHS executive, Dr Stathis, Peter Steer and Dr Bill Kingswell to discuss the situation of the remaining BAC patients;

e) The situation was resolved by a decision to continue to keep the BAC open with the option of transferring any patients at acute risk to an inpatient mental health unit in a relevant hospital and to continue to find appropriate transition services for the remaining patients. There was a commitment from the executive to fully staff BAC till closure with a contingency plan for if the closure date was some weeks later than when it was expected to close at the end of January. Such planning was essential as there was a high rate of staff leaving to commence other employment. The promise to have adequate numbers of nurses was reassuring enough for me to decide not to close the Centre before Christmas but I was not fully reassured that the skill level could or would be able to be improved. I felt that overall the solution was sufficient to keep the BAC open to allow the transition process for the remaining patients to be completed.

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BAC staff

Question 21 - State, in your view, whether staff at the BAC were adequately supported during the transition period, particularly regarding:

a. loss of employment;
b. perceived damage to reputation by association with the BAC;
c. working conditions; and
d. concern for patients.

21. In my view the support to staff of the BAC during the transition process appeared to not be as good as it could have been. In particular:

a) In terms of employment, staff voiced uncertainty about what the closure would mean for their employment. Some sought to obtain new positions and left the BAC before it closed. Many expected redundancy packages and were anxious as there was a delay in hearing about the provision of these. I do not know exactly what advice was given to staff about employment once the BAC closed but the sense I received is that there was uncertainty and a sense of risk of losing income for some;

b) In terms of perceived damage to reputation by association with the BAC, the standing down of Dr Sadler [redacted] resulted in some staff feeling that any-one associated with the BAC was under a cloud and it would impact adversely on their standing in their respective health communities and consequently on career progression, employment and promotion. Again my feeling was that this was not fully understood and therefore addressed sufficiently by the executive;

c) In terms of working conditions, I know that the executive did go to some lengths to provide information to staff where possible. However the impact on staff morale of the closure of the BAC, the associated standing down of Dr Sadler as well as the [redacted] did not appear to be fully appreciated and therefore more steps could have been taken to address morale and the loss of staff as a number left before the BAC closed. A significant portion of my time was spent just listening to staff and encouraging them;

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d) In terms of concern for patients many of the nursing and allied health staff had worked at the BAC for a long time and knew the patients very well. This was a strength of the facility. They were naturally concerned that a move to other and quite different models of care would impact adversely on the patients. Again it seemed to me that the level of concern was not fully appreciated and therefore responded to by the executive.

Question 22 - Outline how, in your view, support to staff might have been improved?

22. I am not a human resources expert. I felt some further steps could have been taken to increase the support for staff such as:

a) [redacted] Nursing staff should not have been rostered to other areas of the The Park while BAC still needed them.

Question 23 - Outline any:
a. opposition you faced in the performance of your duties by staff of the BAC arising out of the closure of the BAC;
b. fracturing of working relationships between staff at the BAC; and
c. whether any of the matters in (a) or (b) above affected the identification and implementation of transition plans, and if so, how?

23. In relation to question 23 I say:

a) I did not face any overt opposition from staff. However there were a number of staff who were very unhappy with the decision to close and made their views clear. I did feel that the efforts to transition the patients safely were somewhat undermined by staff providing false information about when the BAC was to close – one staff member circulated a rumour that the closure would occur before Christmas which caused great concern for patients and staff. A member of the educational staff was asked not to attend the Transitional care panel meetings because she created division and inappropriately disclosed information. The executive

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asked that she not attend further meetings. In addition some staff did not actively engage with the transition process and were more of a hindrance than help at times. A notable difference in 2013 compared with 1994 was the fractured relationship between health and education staff. Though Dr Sadler and Kevin Rodgers appeared to still have a close relationship and the registrar had good rapport with the teachers, there was a level of anger and antipathy evident. In a meeting between Mr Peter Blatch, Sharon Kelly, myself and Debbie Rankin, when she took over as principal in October 2013, Ms Rankin said the relationship between health and education was irreparably damaged. I had not understood at the time, but appreciate better now, that there was tension arising from how the decision to close was made and communicated to staff of different government departments in the months prior to September 2013. I cannot recall any direct impact on implementation of transition plans but this hostility was sensed by the patients and it may have been an added stress for them at a time when they needed a sense of confidence, hope and trust.

Question 24 - Outline any divisions within the BAC associated with the closure of the BAC, and the effect of any such divisions on the planning and implementation of transition plans and/or clinical care for patients?

24. The BAC had a clinical director or when I was there, an acting clinical director, a registrar, nursing staff with immense experience, allied health staff and education staff for the school. The almost unanimous view of the education staff was that closing the school was wrong and they actively supported the Save the Barrett Campaign. The allied health staff were split on the issue of whether the BAC should close. The nursing staff also were split on the decision to close but generally they worked together with the transition planning group to find the best possible alternative services for each patient. While I cannot be certain of it, I was concerned then and am now that the inability of some staff to accept the closure decision and their active and vocal opposition to it made the transition for some patients more difficult as they were influenced

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by such views.

Development of transition plans

Question 25 - In relation to the BAC school:

a. outline any tasks that you suggested to staff of the BAC school as appropriate as part of the transition plan, and whether such tasks were completed;

b. discuss the attitude of the BAC school staff to the closure and whether it affected the development and implementation of transition plans and/or clinical care of patients at the BAC during the transition period.

25. In relation to this question I say:

a) I requested that all patients have resumes prepared by the school however they were not provided. They did however develop an personal education plan for each student and uploaded these to the Oneschool website.

b) The attitude of most of the education staff was that they considered the decision to close the school was wrong and felt that no other school or facility would be able to understand and support the patients the way that they did. Unfortunately this view became known to the patients and impacted the attitude of some to the transition.

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[redacted]

26. In response to this question I say:

a) [redacted]

b) There were some early meetings in which options were suggested as being feasible but later were not actioned for a number of reasons. I considered it absolutely necessary to involve the patients in the development of the transition plans at appropriate times as they would be much more likely to be comfortable with the new arrangements if they were involved. [redacted]

c) [redacted]

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d) It is correct that I spoke personally to who indicated that they would be willing to provide patient 's mental health care as met the relevant eligibility criteria;

e)

27.

Implementation of plans

Question 28 -

28. In response to question 28 I say:

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a)

b)

c)

d) It is very difficult for me to comment on what the impact of the matters noted in paragraphs (a) to (c) was on the effectiveness of the transition plan for patient

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29. In relation to the for patient I say:

a) I came to the view that the I would consider appropriate on reviewing the patient chart at the BAC;

b)

c) I believe that the was commenced by Dr Sadler and either he or the registrar at the time would have as required;

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d)

e)

f)

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[redacted]

Question 30 - [redacted]

a. [redacted]

b.

30. [redacted]

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Follow-up after closure

Question 31 - Outline what if any follow-up you performed after the BAC closed and all patients had transitioned to new services. What if any funding existed for such work? Explain why you thought it was necessary to do so?

31. The closure date for the BAC was the end of January 2014. However the transition process had been occurring over a period of 5 months. So at the end of January I considered it important to just check on each of the patients and see how each was going before the BAC formally closed. So I made contact and compiled a list of the patients and how they were coping in the transition. Before leaving WMHHS in March 2014 I repeated this process. Leanne Geppert asked that I send a copy to the executive so I highlighted emerging issues of concern. There was no funding for this work but I had approval to use my time with WMHHS to do this.

Kotze & Skippen Inquiry

Question 32 - Look at the report prepared by Ms Kotze and Ms Skippen in relation to transitional
arrangements for six BAC patients. In relation to it:
a. comment upon the scope of the investigation;

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b. whether in light of the scope of the investigation, you agree with its conclusions;

c. whether, in your view, the reasons stated in the report formed proper bases for the conclusions; and

d. what (if any) other topics, or issues, ought to have been examined?

32. In relation to the review done by Professor Kotze and Ms Skippen I say:

a) The scope of the investigation was extremely narrow. I felt this was unlikely to satisfy the concerns of family and those who believed the BAC should not have closed. It was also unlikely to lead to any improvements in mental health services for adolescent patients in Queensland. If the sole purpose of the review was to determine whether any of the transition arrangements for former BAC patients needed to be reconsidered and changed then the scope was probably satisfactory for that purpose;

b) I have only seen that part of the report which was released publicly. In relation to those findings my views are:

(i) I agree that the atmosphere in which the transition occurred was stressful and difficult and resulted in escalation of distress in adolescents and staff. I also agree that although this made the transition process more difficult it did not detrimentally affect the transition planning. However it is possible the "contagion effect' mentioned did affect the way patients felt about new services;

(ii) I agree there was a sense of time pressure and that there were mixed messages involved in the timing – that on the one hand there were clear indications that the BAC would remain open as long as was necessary to ensure the best result for patients while on the other hand there were statements that the BAC needed to close as soon as possible;

(iii) I agree that the transition planning task was enormous and not helped by an absence of resources on available services. I agree that the team was dedicated to the tasks and assisted by care co-

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ordinators;

(iv) I agree that the focus of the transition plans was on individualised and comprehensive needs assessments, iterative planning and collaboration with consumers and families and carers;

(v) [redacted] I agree that as many of the patients had been at the BAC for a long time, a process requiring rapid transition was very challenging;

(vi) I agree that we did emphasise the need for good clinical care and ensured that we addressed physical health needs;

(vii) I agree that we did try to communicate as well as possible to the patients and their families/carers but that there were occasions when communication problems were experienced. I felt I had established a good rapport with the patients in the limited time available and also with many of the families although we were not able to satisfy the expectations of all families in terms of communications;

(viii) I would like to think that the finding that the transition plans were thorough and comprehensive is correct but am not the right person to make a definitive statement on this finding;

(ix) There was some "arm twisting" that needed to occur to obtain funding or acceptance of a patient by a relevant service. I agree that we eventually found what appeared to be satisfactory solutions for all patients;

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(x) I agree that the challenges identified by Prof Kotze and Ms Skippen existed and particularly the transition for adolescents who were at the time of transfer adults or almost adults was particularly challenging;

(xi) I am unable to comment on drop out from care. When I checked on patients in January and March 2014 I was not aware of any significant drop outs.

(xii) I agree that we did try to taper care and involve the receiving service and the BAC staff together to smooth the transition process. The time pressures involved and delays in funding for some patients meant the amount of tapering was not always ideal;

(xiii) Brokerage funding was eventually secured for every patient but I felt it was not done ideally;

(xiv) In relation to the adequacy and appropriateness of the transition plans I believed we had explored all reasonable options for each patient and that the plans were adequate and appropriate for each patient, having regard to the services available, although that is ultimately a matter for the Commission to decide;

(xv) In terms of governance I believe more support and guidance could have been provided.

Transition from child and youth to adult mental health services

Question 33 - What are the mental illnesses and/or behavioural disorders upon which child and adolescent mental health services principally focus, and why?

33. Child and adolescent mental health services in Queensland have been restructured over the past two years. I left the sector more than twelve months ago so am unable to comment on their principal focus. Their website states that they treat severe and/or complex disorders including depression, anxiety, suicidal or self-harming behaviour, eating disorders, psychosis, trauma, and

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significant interpersonal and relationship difficulties.

Question 34 - What are the mental illnesses and/or behavioural disorders upon which adult mental health services principally focus, and why?

34. I have not worked in an adult mental health unit for many years so feel this is not an appropriate question for me to answer.

Question 35 - In light of those differences, can you comment upon the extent of alignment between child and adolescent mental health services on the one hand, and adult mental health services on the other.

35. There are no specific disorders/behaviours treated only by child and adolescent mental health services or only by adult mental health services. Approximately half of all adult disorders are evident by age 14 years and three quarters by 25 years. There is a much higher incidence of psychoses in the adult population.

Transition is not the same as transfer.

Transition needs to be tailored to the young person's needs, be gradual, involve good communication and if possible parallel streams of care. Transition in mental health care at this stage of life, when there is the peak incidence of emerging mental disorders and the highest rate of discontinuity of care in early onset disorders, needs to take into account the myriad of extraneous forces involved, including transition from school to higher education and/ or employment, transition from a child role within the family unit, and the development of relationships with other autonomous young adults. It is particularly challenging for those already in the care of the state or who are unable to reside with their families. This group is at higher risk of self harm, suicide, homelessness, incarceration, unemployment and ongoing mental health and physical health disorders. The particular mental health label given is necessary but not sufficient to inform this process.

In recent years it has been shown that there is very high rate of continuity of childhood psychopathology into adult years as well as the development of

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comorbidities. Child and adolescent mental health has developed from an understanding of the individual in context of relationships with family and community whereas Adult mental health has focused more on individual psychopathology, biology and diagnosis informed interventions. That is an oversimplification but this question seeks to understand the different paradigms and why there are barriers to transition.

Patients with psychoses such as schizophrenia may transition more readily than neurodevelopmental disorders. Personality Disorders may fluctuate in presentation as they may not be fully developed. Fluctuations in behaviour at time of transition may mean that a young person at a particular point in time (referral or assessment or intake) may not meet eligibility criteria.

Adult mental health services and Child and adolescent mental health services are structured differently. There are issues re consent and confidentiality and responsibility for clinical care and there are differing priorities regarding funding and allocation of resources which are scarce across all ages, services and disorders.

Question 36 - Was the extent of any alignment between child and adolescent mental health services and adult mental health services a factor which influenced transition plans devised and implemented for those BAC patients aged about 18 years or older at the time of the closure of the BAC?

36. Yes – in preparing transition plans we were aware that some of the patients were technically adults or going to become adults during the transition or shortly after the BAC closed. A number of patients expressed very clear and strong views that they would do very poorly in an adult acute unit. As such this impacted what services we sought to transition these patients to. Their lengthy admissions further delayed their development of independent living skills, development of identity and capacity for autonomy. So they were ill equipped to bridge the gap between child and adult services. The transition plans took this into account. Extra supports were put in place

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Question 37 - In your clinical opinion, is it common for patients in the age bracket of 18 - 25 years to experience problems in their transition from adolescent to adult mental health services?

37. Yes for the reasons noted above. There is a high rate of discontinuity of care in both mental and physical health in this age group.

Question 38 - In your clinical opinion, is there a need for different or additional mental health services directed to the 18 to 25 year age group, or a similar age group, and if so, explain generally what services are needed?

38. Yes – My opinion is not an expert opinion as I have not devoted adequate time over the past year to researching this area or visited Queensland services, and I have not had the opportunity to visit interstate and overseas services. However it is my opinion that a service designed for 16 -25 years (or similar age range) is needed. This public young adult service should interface with child services and adult services and with private services.

    It needs tiered levels of care with ease of transition between levels of service as well as with referring child services and accepting adult services.

    A stand alone therapeutic residential service is sub-optimal if not closely linked with acute inpatient services, day programs and outpatient services (whether they require the young person to self present or whether they travel to the young person).

    All services should be assertive in outreach and with a strong focus on both prevention and rehabilitation. They need to be integrated with education and vocational and employment services at all levels of mental health service provision.

    Services need to have a strong evidence base or at least have strong evaluation processes so that positive outcomes are assured.

    My experience to date is that our child and adolescent mental health services

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have not adequately addressed the needs of the indigenous population, and the ethnically diverse. There also needs to be improved interface with services for the disabled, intellectually impaired and those with chronic physical illnesses such as is being attempted at Mater Young Adult Health Centre Brisbane in ambulatory care of 15 -25 year olds.

There remains the dilemma of accommodation for young people who are not in the care of the state who need to access mental health care distant to their home, and for those who are over 18 years of age who do not have adequate skills for independent living and who require mental health support.

Other

Question 39 - Outline what clinical experience you have in transitioning child and adolescent patients between inpatient services and other services. Outline whether you are aware of any example in which an entire body of adolescent patients have been transitioned in connection with the closure of a facility?

39. The BAC was my only experience in transitioning an entire cohort of patients into non-inpatient services.

Question 40 - Explain any other information or knowledge (and the source of that knowledge) that you have relevant to the Commission's Terms of Reference.

40. I am concerned that the disclosure of patient details, in this statement and some of the other statements tendered to the Commission of Inquiry, to a wide range of individuals represented at this Inquiry breaches the confidentiality of some patients who may not have consented to such disclosure and may be surprised and possibly distressed by these disclosures.

Question 41 - Identify and exhibit all documents in your custody or control that are referred to in your witness statement.

41. The attachments to this statement are:

    a) **AB-1** – handwritten chart of governance

    b) **AB-2 -** Articles on transition planning and processes

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Additional question 1 – To the best of Dr Brennan's recollection, please provide details of any discussions between her and Ms Holly Ahern, (Lawyer, WMHHS) in relation to identifying patients of BAC whose transitions were considered the most complex. In particular:

a) On or about what date did these discussions occur;

b) How and why did Ms Ahern ask you to identify patients who had complex transitions;

c) Do you recall which patients you identified as having the most complex transitions;

d) If so, explain the basis on which you considered their transitions to be the most complex; and

e) If you were now asked to identify the most complex transitions, who would you select and why ?

42. In answer to additional question 1 I say:

a) Discussions with Ms Ahern primarily occurred when I voluntarily attended the WMHHS premises on 20 and 21 August 2014 to assist her locate documents and fill in a pro forma document used to identify the services involved with each patient. I also had a telephone discussion with Ms Ahern on 22 August as a result of which I sent her a list of dates on which I had telephoned parents;

b) I do not recall Ms Ahern asking me to identify patients who had complex transitions. It is possible that during the location of documents and discussions over 20 to 22 August 2014 that I made comments about the complexity of the transitions of different patients which Ms Ahern used to compile a list of complex transitions;

c) I do not recall which patients I identified as having the most complex

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transitions. Indeed as noted above I do not recall a discussion about which patients had the most complex transitions. If I did comment about the complexity of transitions I

d) The basis for the identification of the patients as having complex transitions is that they Other measures of complexity might be the level of risk for the patients or the difficulty in sourcing appropriate services but I do not recall a discussion trying to apply such measures and don't see this as a useful concept clinically;

e) If I were now asked to identify the patients who had the most complex transitions I would choose the patients as noted in paragraph 42(c) above, and probably add in because , making transition planning for somewhat difficult, and possibly was more difficult than with most other patients;

Additional question 2 - The Commission understands that you convened Clinical Oversight meetings to consider transition plans in relation to four of the more complex patients. Did your involvement in this Clinical Oversight inform your view as to the more complex transition cases, and (to the extent you recall speaking to Ms Ahern about the matter) did it inform your advice to her?

43. In answer to additional question 2 I say that I did not convene any Clinical Oversight meetings. I did approach WMHHS and Dr Hoehn in mid December and suggest we have a meeting. These approaches resulted in two meetings.

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One was on Friday, 13 December 2013, with Dr Steer, Dr Stathis, Dr Hoehn and members of the WMHHS executive and myself. The other was a meeting with Dr Steer, Dr Stathis, Ingrid Adamson from CHQ HHS, Linda Harvey, Dr Geppert and myself and took place on Wednesday, 18 December 2013. The meetings were to discuss my concerns about difficulties in transitioning the , and my particular concerns re and escalating risk due to inadequate numbers of experienced nursing staff. At the meeting on 13 December a proposal was made to move . I thought about this over the weekend and felt this was not appropriate.

And I make this solemn declaration conscientiously believing the same to be true, and by virtue of the provisions of the Oaths Act 1867.

Taken and Declared before me, at Brisbane)
this 27th day of January 2016)
)

.....
Justice of the Peace/C.Dec / Solicitor

ATTACHMENT LISTING

Bound and marked 'AB-1' to AB-2' are the attachments to the Statutory Declaration of **DR ANNE BRENNAN** declared 27 January 2016.

Attachment	Document	Date	Page
AB-1	Hand written chart setting out governance structure	Undated	1
AB-2	Articles on transition planning and processes	Various	2 – 35

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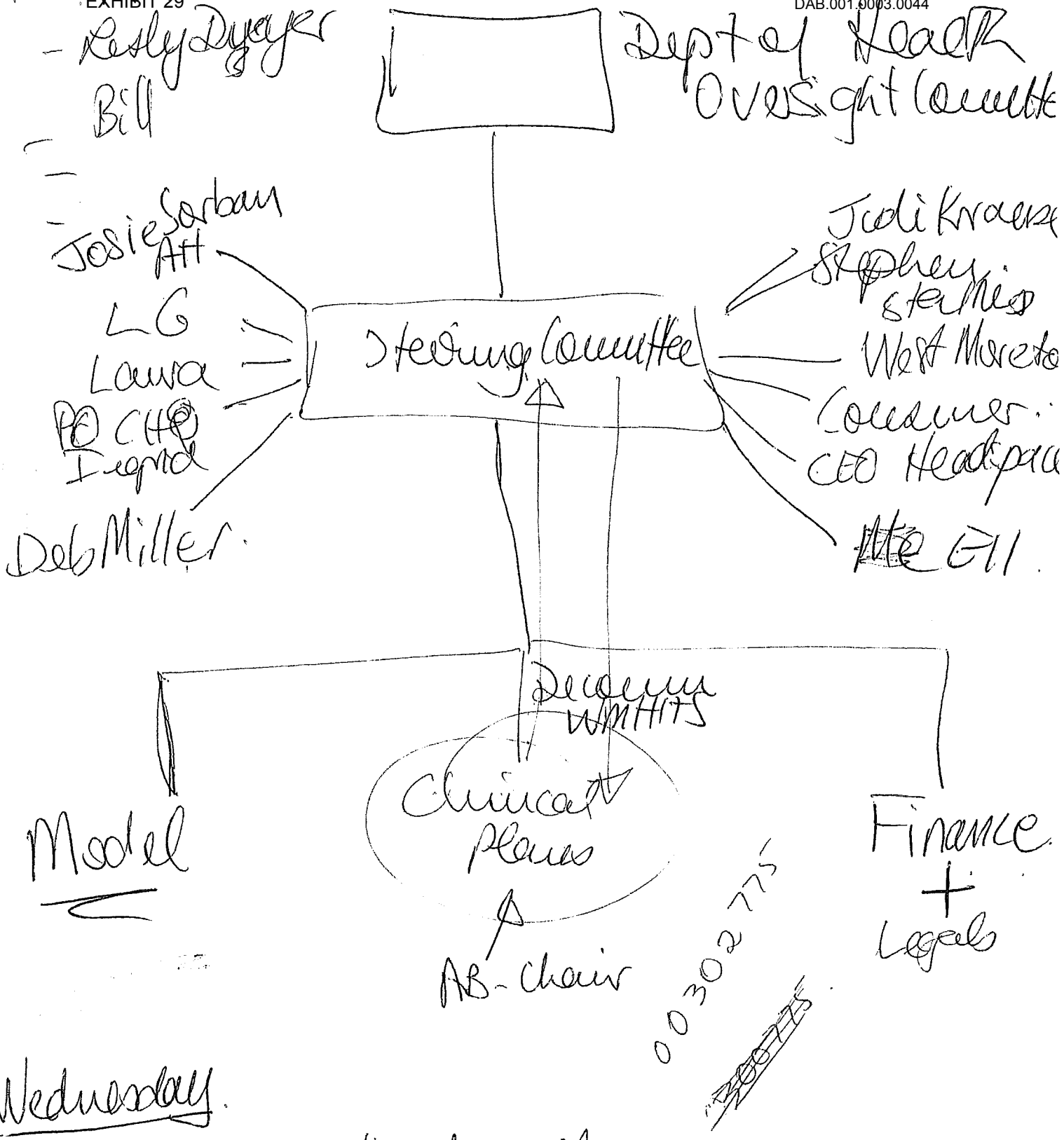


Wednesday

- 9:10 Am patient meeting
- 9:30 See Town
- 10 – 11:30 update.
- 11:30 – 12:30 Dx MX

1–3 pm Planning Panels

Queensland Youth Strategy *connecting young Queenslanders*

Queensland Youth Strategy

connecting young Queenslanders

2013

Great state. Great opportunity.

Queensland Government

For more information on the Queensland Youth Strategy, visit the youth website www.qld.gov.au/youth follow us on twitter @qldyouth, email youth@communities.qld.gov.au or call us on 13 QGOV (7468).

Foreword

The Queensland Government is committed to providing young Queenslanders with the connections and support they need to reach their potential, to be capable and resilient, to take responsibility for their actions, to look after themselves and those around them, and to enjoy happy, healthy and productive lives.

That's what the Queensland Youth Strategy is all about. This plan sets out the Queensland Government's commitment to delivering the right services, in the right locations at the right time.

We want to make sure we use emerging technologies to hear what young people have to say and give them and their families easy access to the information they need.

We will continue to work with communities and the non-government sector to shape the future of services for our young people. By working together we can get the best results possible for Queensland's youth.

We are excited to launch the Queensland Youth Strategy and look forward to it helping to deliver great opportunities for young people in this great state

Hon Campbell Newman MP
Premier

Hon Tracy Davis MP
Minister for Communities,
Child Safety and Disability Services

Introduction

Every area of a young person's life is connected — their health and wellbeing is linked to how they achieve at school just as their education is linked to their future success at work and as active and contributing members of society.

The Queensland Youth Strategy aims to provide connections for young people and to guide the development and coordination of activities and services for young people aged 12–21 years.

The Queensland Youth Strategy is for all young Queenslanders — from every family, from every region of the state, and from every background.

The Queensland Government's vision for Young People

Our vision is for Queensland's young people to be:

- connected, taking hold of opportunities, and fulfilling their individual potential
- confident, resilient, responsible and safe
- good citizens who participate in their communities.

We need the support of all Queenslanders to make this vision a reality for our young people.

This strategy enables the framework for the Queensland Government's direction on engaging, supporting and working with young people, their families, with our communities, local governments and the youth sector as we know that we can be most effective when we work together.

To achieve our vision, the strategy focuses on six action areas for connecting young people to:

- family, friends and social networks
- education, training and employment
- health and wellbeing
- volunteering and participation
- supports and services
- arts and culture

Guiding principles

The strategy is guided by a set of principles that recognises:

- better connections are made when young people are valued and seen as being individual and unique. A 'one size fits all' approach cannot cater to the diversity of young people's experiences. Programs and services must meet the different life experiences, circumstances and needs of young people
- all young people have strengths and abilities that, when nurtured and affirmed, help them achieve throughout their lives, and be resilient when there are setbacks
- young people are best supported when the family as a whole is strengthened
- young people most often connect with information, each other, and the world around them through the digital world

The key approaches this strategy takes to make connections include:

- engaging with young people through contemporary digital technologies
- providing practical resources and services to support a diverse range of young people, particularly those who need additional support and guidance to address challenges
- strengthening early intervention responses for young people before challenges become problems
- encouraging young people's participation in their communities
- building strong partnerships with the non-government sector and local and state government agencies to foster better collaborations.

We know the digital world is important for young Queenslanders, that's why information about services and programs and links to digital tools and apps for young people will become available through a dedicated online youth hub — keeping them connected.

A snapshot — young people in Queensland

Queensland young people are learning, creating, working, caring, contributing and living life in diverse ways throughout our great state.

The latest census data shows more than 587,500 young people aged 12 to 21 live in Queensland and of these:

- 33 per cent live outside Queensland's major cities
- 2.1 per cent have a disability
- 13.5 per cent were born overseas
- 5.75 per cent are Aboriginal or Torres Strait Islander
- 9.1 per cent speak a language other than English at home[1]

A recent survey found that 84.4 per cent of 15 to 19 year old Queenslanders lived at home. As a group, they most valued friends, family, school, and physical and mental health. They were concerned about coping with stress, school/study and body image. The internet was their primary source of information, even ahead of parents and friends.[2]

We also know that:

- tertiary attendance rose 25 per cent in the five years to 2011: the majority of the 98,121 students were full-time
- studying increased from 43.7 per cent in 2006 to 46.5 per cent in 2011
- almost all used the internet — most to access social networking sites
- 16.2 per cent did voluntary work, making up 14.8 per cent of all Queensland volunteers[3]

1 All statistics are approximate.
2 Mission Australia's Youth Survey 2011 (7,222 young people surveyed)
3 In the twelve months prior to the 2011 Census

Investing in Queensland's young people

The State Government invests in wide-ranging services that assist young Queenslanders through education and training, employment, youth justice, health, transport, community safety, housing, community services, child safety, disability services, arts, sport and recreation, and the environment. We want to invest in services that deliver results for our young people.

While most young people grow up in happy, healthy families, some young people are doing it tougher than others. Exposure to risk factors like family conflict and parental stress, abuse or neglect, poverty, housing stress, unemployment, disengagement from school, teen pregnancy and drug and alcohol misuse increases their vulnerability and can dim their hopes.

The Queensland Government's investment direction is on people, programs and systems: offering the right services in the right location to the young people who need our help.

The *Better Services for Queenslanders* plan[4], the state's response to the Queensland Commission of Audit, is a key driver to change the way we invest in services.

For young people, this means services that:

- make a positive difference in their lives, encourage smart choices, and enable connections and actions to make the most of opportunities
- respond to their needs and aspirations — and are readily accessible, particularly for those at risk
- focus on building their skills and knowledge
- provide help earlier, before a problem gets too big and support responsibility, resilience and self-reliance

One of the ways in which we will ensure the right services are delivered in the right location to the right young people is through the Queensland Government investing its youth program funding in ways that will:

- achieve better value for money
- rebalance investment toward prevention and early intervention
- enable greater consumer choice
- make a difference to consumers
- reduce red tape
- partner with and leverage the investment, innovation and enterprise of the community and corporate sectors

4 www.treasury.qld.gov.au/coa-response/better-services.shtml

Areas of connection

The Queensland Youth Strategy will deliver six areas of connection to benefit young Queenslanders.

Areas of connection		Government action areas	Benefits for young people
1	Families, friends and social networks	Information for young people Information for families and parents Youth support	Safe, caring family environment Parents supported to develop skills in parenting young people Better access to information and support networks
2	Education, training and employment	Schools and learning environment Training services Employment services	Effective learning environments Educational attainment and achievement Work skills that are in demand Job opportunities
3	Health and wellbeing	Sport and recreation activities Hospitals and health services Mental health services Youth justice responses	Improved physical health and wellbeing Good mental health Safer communities
4	Volunteering and participation	Youth leadership programs Youth volunteering	Active in community and civic life Develop decision-making and leadership skills Increased engagement
5	Supports and services	Information for young people about youth services Youth support Support for young people at risk of homelessness	Access contemporary supports and services Help to achieve personal goals Safe, stable accommodation (for those unable to live at home)
6	Arts and culture	Art and cultural activities Online workshops and programs Awards and festivals	Participate in creative arts and culture Celebrate and be recognised for creative contributions Develop skills to join in and enjoy arts and culture

1 Connecting to families, friends and social networks

What is the Government's approach to connecting young people with family, friends and social networks?

The Queensland Government recognises that family and friends are the most important influence in a young person's life. Families influence a young person's self-esteem, wellbeing and safety which in turn affect school performance and later, participation as active citizens in our society.

For some young people the transition from adolescence to adulthood is challenging. Families will be able to easily access information and advice, including apps to prepare young people for this transition, wherever they live.

The Queensland Government will provide early intervention and support for those families who need it. Where young people are at risk of harm in their family, funded services will work with them and their family to keep them safe.

Areas of connection

How will we know we're connecting young people to family, friends and social networks?

- Young people and families will be able to more readily find the information they need to support them.
- Fewer young people will experience homelessness.
- More parents needing information or assistance with parenting will get the help they need.

Further information on the actions Government is taking to connect young people with family, friends and social networks can be found at "Connection 1" in the Appendix.

2 Connecting to education, training and employment

What is the Government's approach to connecting young people with education, training and employment?

A young person's participation and achievement at school, training or university impacts on their long-term economic and social wellbeing.

We want young people to be better informed about their study and job opportunities. The longer young people can be engaged with school and learning, the better start they have in entering the workforce and building a secure future.

The Queensland Government is committed to providing young people with vocational information, training opportunities and pathways to jobs.

How will we know we're connecting young people to education, training and employment?

- More young people will attain Year 12 or equivalent.
- More young people will participate in training or further study.
- More young people will be working.

Further information on the actions Government is taking to connect young people to education, training and employment can be found at "Connection 2" in the Appendix.

3 Connecting to health and wellbeing

What is the Government's approach to connecting young people with health and wellbeing?

Fitness, healthy eating and body image are critical for young people's good health, now and in later life. Young Queenslanders also need access to supports and services that promote positive mental health.

Young people should be able to participate in both their local communities and in the digital world, knowing they are safe from anti-social behaviour, abuse and violence.

Equally, the Queensland Government believes young people must be held accountable for their actions when they have committed a crime and they should receive assistance to help make positive changes in their lives.

How will we know we're connecting young people to health and wellbeing?

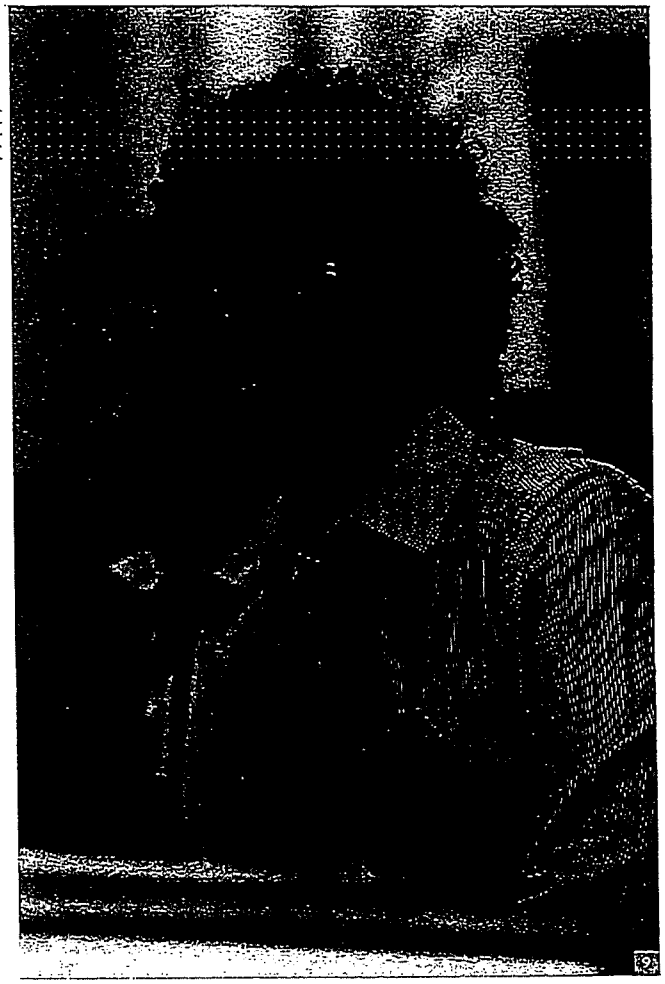
- More young people will be active.
- More young people will report improved physical health.
- More young people will report better mental health.
- More young people will feel safe.
- More young people will act responsibly and lawfully.

Further information on the actions government is taking to improve the health and wellbeing of young people in Queensland can be found at "Connection 3" in the Appendix.

4 Connecting to volunteering and participation

What is the Government's approach to connecting young people to volunteering and participation?

Getting young people involved is good for them and good for Queensland. By participating in volunteering, sport and other community activities young people develop their character and resilience, as well as decision-making and leadership skills and make an important contribution to their community.



Areas of connection

Volunteering gives young people the opportunity to have fun and acquire new skills. It can also be an important path to employment.

The State Government believes young Queenslanders are responsible for making the most of the opportunities in their community, respecting others and voicing their opinions constructively on issues that matter to them. We need to provide access to contemporary digital channels to help this happen effectively.

How will we know we're connecting young people to participation and volunteering?

- More young people will volunteer in their communities.
- More young people will take on leadership roles.
- More young people will have their voices heard.

Further information on the actions Government is taking to connect young people to volunteering and participation can be found at "Connection 4" in the Appendix.

5 Connecting to supports and services

What is the Government's approach to connecting young people to supports and services?

Some young people need extra help. We will provide them with access to high quality, effective support services that meet their individual needs. For example, those young Queenslanders who cannot live at home will be assisted to access safe, stable accommodation. Youth services will work with young people in ways that make a difference — by assisting them to achieve their personal goals and stay connected with their family and community, as well as with education, training and employment

We will make sure young people have information about youth services in ways that will work for them.

How will we know we're connecting young people to supports and services?

- More young people will access the right services at the right time.
- More young people will have their say on issues that affect them.
- Youth services will be more transparent and accountable: there will be less red tape.

Further information on the actions Government is taking to connect young people to supports and services can be found at "Connection 5" in the Appendix.

6 Connecting to arts and culture

What is the Government's approach to connecting young people to arts and culture?

Young people's participation in arts, culture and creative expression has a range of benefits for them and their communities.

The transmission of culture across generations is vital for all young people, including young Aboriginal and Torres Strait Islander people and young people from culturally diverse backgrounds. Participating in cultural activities inspires pride in heritage and identity. These factors contribute to the development of resilient, healthy and socially connected young people.

Engagement in the arts provides positive opportunities for young people to creatively express themselves and their culture. We want to ensure that young people's contributions to the arts in Queensland are recognised and supported.

How will we know that we're connecting young people to arts and culture?

- Young people will join in cultural events and activities.
- More young Queenslanders will be recognised for their creative achievements.

Further information on the actions Government is taking to connect young people to arts and culture can be found at "Connection 6" in the Appendix.

Appendix: Action Plan 2013–2014

Introduction

The Queensland Youth Strategy aims to guide the development, support and connectedness of young people in Queensland so that they can help shape their own economic and social futures, and those of their communities and the world around them. The Strategy is for young Queenslanders from every family, from every region of the State and from every background.

This Action Plan, which will be updated annually, outlines in practical terms what the Government will do to achieve the objectives of the Strategy and connect young people to:

- family, friends and social networks
- education, training and employment
- health and wellbeing
- volunteering and participation
- supports and services
- arts and culture.

1. Connecting to families, friends and social networks

The Queensland Government recognises that family is the most important influence in a young person's life. Families influence a young person's sense of self-esteem, wellbeing and safety which in turn affect school performance and later participation as active citizens in our society.

What will Government do to connect young people to family, friends and social networks in Queensland?

Actions	Agency
A wide range of non-government support services including neighbourhood centres will be funded to assist young people or families address issues that impact on their personal, social or emotional wellbeing and safety.	Department of Communities, Child Safety and Disability Services
Kids Helpline will continue to be funded to provide a free 24-hour counselling service for kids and young people aged 5–25 years.	
The Regional Children's Telephone Counselling initiative will continue to provide 24/7 telephone counselling support for children and young people up to 18 years from regional areas across Queensland on issues including peer pressure, sexual health, social isolation, suicide, bullying, safety and abuse.	
Parentline will continue to provide phone counselling and support services for Queensland parents and primary caregivers to nurture positive, caring relationships between parents, children and teenagers.	
A range of targeted services for young people who experience complex challenges and/or who are vulnerable and at risk will be provided.	
Up to 240 young people with a high needs disability, aged 16 to 25, and their carers, will get extra respite hours through an investment of $22 million over four years.	
Post-school funding will continue to assist school leavers with disabilities plan for the future.	
A two-year, $4 million intensive family intervention program will be trialled, giving about 300 families practical support, advice helplines and information.	
A $3.2 million package of initiatives, increasing to $3.7 million in 2014–15, will strengthen the network of supports and services designed to provide more coordinated care for children and their families across Queensland.	
Parent Connect will provide assistance to parents, including young parents, of newborns with a disability.	

1. Connecting to families, friends and social networks (continued)

Actions	Agency
Community organisations will provide accommodation and support services for families and individuals experiencing homelessness or at risk of homelessness.	Department of Communities, Child Safety and Disability Services and Department of Housing and Public Works
$28.9M over four years has been committed to enhancing Maternal and Child Health Services to provide additional access to home visits and community clinics in the first 12 months following birth.	Department of Health
A Health Visiting Program for families, including young parents, with children up to three years of age, will continue under the Helping Out Families program, through the Gold Coast Hospital and Health Service and Children's Health Queensland.	
Child and Youth Community Health Services including general child health consultations, parenting services including young parents programs, Triple P Positive Parenting education, allied health and nutrition and diversity programs, will continue for children and their families at community locations.	
Information about services and programs and links to digital tools and apps for young people, their family and friends will be available through www.qld.gov.au/youth.	All agencies, informed by the Office for Youth, Department of Communities, Child Safety and Disability Services

2. Connecting to education, training and employment

A young person's participation and achievement at school, training or university links to their long-term economic and social wellbeing. We want young people to be better informed about their study and job opportunities.

What will Government do to connect young people to education, training and employment?

Actions	Agency
Queensland students will benefit from enhanced learning opportunities through investment of $328.2 million in state schools over four years and an additional $293.8 million in recurrent funding and $81.3 million towards non-state schools to move Year 7 to secondary school from 2015.	Department of Education, Training and Employment
Young adolescents transitioning from primary to secondary school will get more support for their academic, social and emotional needs.	
Remaining learning areas of Prep to 10 Australian Curriculum will be implemented.	
The Queensland Government will work with universities to widen participation of low socio-economic and Indigenous people in tertiary study.	
The *Solid partners Solid futures plan 2013–16* will ensure Aboriginal and Torres Strait Islander Queenslanders are supported and engaged in learning from early childhood education and care, through to schooling, training, tertiary education and employment.	
The Great Skills Real Opportunities five year plan to revitalise Queensland's VET sector, will support young Queenslanders to access and complete the skills training they need to get a job.	
The VET in Schools initiative will deliver better alignment to employment pathways for young people in their senior phase of learning.	
Local government traineeships will be offered in flood-affected communities, creating new employment opportunities for 15 to 24 year olds. Local government authorities will receive wage subsidies for 120 new traineeships.	
The Youth Support Coordinator initiative through funding of $9.6 million annually, will support at-risk young people to stay at school, re-engage in education or training or transition to employment.	
500 scholarships of up to $20,000 will be made available to women leaving school, returning to study or changing careers in specified male-dominated fields of study experiencing skills shortages.	

2. Connecting to education, training and employment (continued)

Action	Agency
The Gateway to Industry Schools Program will continue to help young people transition from school to work while completing school and gaining formal qualifications.	Department of Education, Training and Employment
The Queensland Minerals and Energy Academy, assisting young people to prepare for careers in the resources sector, will be supported.	
Funding of $1 million over four years will provide school chaplaincy services to support young people.	
Funding of up to $86 million will provide 10,000 additional apprenticeships over six years to meet Queensland's anticipated skills shortage.	
The QSchools smartphone app will provide a convenient way for people to receive up-to-the minute information from and about schools. This app will be particularly useful to parents who have students in different schools, as the app manages updates from multiple schools in a single view.	
Queensland will continue to support the Take the Stand app, developed by all Australian education authorities, to create safe and supportive school environments that are free from bullying, harassment and violence.	
The Certificate 3 Guarantee will give Queenslanders access to a government subsidised training place up to and including their first certificate III level qualification in priority training areas and will give every year 12 graduate access to fee-free priority training courses within one year of leaving school.	
The Community Learning Program, with $47 million over five years, will provide additional support for Queenslanders with diverse needs, including young people, to gain a qualification.	
Funding of $3 million will improve training pathways for young people into agricultural sciences and economics.	Department of Agriculture, Fisheries and Forestry
The Agribusiness Gateway Schools program, available in 22 secondary schools, will continue to successfully transition participants from school into further education, training, and/or employment in the agribusiness sector.	
The National Regional Initiative—Western Downs, empowering local businesses and community leaders to take charge of their local skills agenda, will be delivered.	

2. Connecting to education, training and employment (continued)

Action	Agency
Funded programs will enable local businesses to tap into contemporary skills and workforce development strategies that will lift the productive capacity of their businesses and, in turn, the region.	Department of Agriculture, Fisheries and Forestry and AgriFood Skills Australia
The School to Industry Partnership Program, developing and strengthening partnerships between rural industry and schools, including engagement of producers through the AgForce Rural Champion Volunteer Program, will continue.	
The web-based learning management system Rural Skills Online will continue in Queensland schools.	Department of Agriculture, Fisheries and Forestry, and Rural Skills Queensland
National Science Week will be supported, acknowledging and celebrating scientific achievements and encouraging interest in science, particularly among school students.	Department of Science, Information Technology, Innovation and the Arts
A catalogue of science, technology, engineering and maths (STEM) education programs and activities operating across Queensland will be collated and maintained.	
GroupX will deliver its i Choose Technology activities, which are dedicated to promoting ICT tertiary studies and careers, primarily through high school visits and career expos.	
Queensland Museum's statewide network will provide programs for young people including curriculum-based education activities, workshops and school-based apprenticeships, encouraging participation and attendance.	
Queensland Museum will provide young people in schools access to object-based learning using museum collections through a statewide loan service of kits aligned to national curriculum.	
Science students will be mentored through internships at the Museum of Tropical Queensland in Townsville.	
State Library of Queensland will provide onsite and online public programs and learning opportunities for young people, including student research support, online literature festivals and literacy workshops and programs.	
Students in tourism will be part of a workshop informing the industry's 20 year development plan and will be represented at the annual DestinationQ tourism forum.	Department of Tourism, Major Events, Small Business and the Commonwealth Games

3. Connecting to health and wellbeing

Fitness, healthy eating, mental wellbeing and healthy body image are critical for young people's good health, now and in later life. Young people should be safe in their communities. They should be able to participate in both their physical communities and in the digital world, knowing they are safe from anti-social behaviour, abuse and violence.

What will Government do to improve the health and wellbeing of young people in Queensland?

Actions	Agency
The $47.8 million Get in the Game initiative will support sport and recreation at the grassroots level, encouraging greater participation of children and young people through: ▪ *Get Started* program, which involves giving eligible young people aged 5 to 17 the opportunity to join a sport and recreation club by providing up to $150 for membership/participation fees. ▪ *Get Going* program, which encourages more young people to join clubs by giving clubs one-off grants up to $10,000 for equipment, training and activities. ▪ *Get Playing* program, which provides up to $100,000 in funding to assist local sport and recreation organisations with facility development.	Department of National Parks, Recreation, Sport and Racing
The Young Athlete Assistance Program will continue to assist athletes under the age of 18 with travel and accommodation costs to attend championship events.	
The Play by the Rules initiative, which aims to make sport inclusive, safe and fair for all involved, will be promoted.	
One-off commitment funding for sport and recreation organisations for facility development, to increase participation opportunities for young people and other groups.	
Healthy eating programs will be promoted under the National Partnership Agreement on Preventative Health through clubs with junior members across Queensland.	
A framework for improved coordination of current and future initiatives will advance youth participation in sport and recreation, including a strategy for closer ties with schools.	
The Indigenous Community Sport and Recreation Program and the Deadly Sports Program will continue.	
Counselling services for child victims of abuse will receive a $1 million boost over four years. Non-government counsellors will deliver additional services for victims of child abuse and sexual assault.	Department of Communities, Child Safety and Disability Services

Actions	Agency
The Safer Schoolies Initiative will continue to respond to the large number of school leavers who attend key Schoolies locations in Queensland, working in partnership with community organisations and councils to improve schoolies' safety and reduce the potential impact on communities.	Department of Communities, Child Safety and Disability Services
A multimedia presentation package for use in schools will be part of an annual Safer Schoolies communication strategy to encourage school leavers to adopt safe behaviours during their end-of-school holidays.	
Extension of the *drinksafe* precinct trials, to keep young people safe when they are having fun and celebrating with friends, will be evaluated.	Department of Justice and Attorney-General
Boot camps, incorporating structured activities and support designed to deter youths from reoffending, will receive $5.5 million and be trialled over two years.	
A blueprint for the future of youth justice, seeking to reduce youth offending and build safer communities, will be developed. This will include the expansion of the boot camp program, review of the *Youth Justice Act 1992*, development of more effective sentencing options, better managing demand for youth justice services, addressing the causes of crime and improving youth detention services.	
School education programs will receive $1 million over four years to teach young people how to protect themselves and their friends and to report suspected abuse and sexual assault.	Department of Education, Training and Employment
Key community stakeholders, including youth groups and services, will be consulted as part of the review of alcohol management plans in discrete Indigenous communities.	Department of Aboriginal and Torres Strait Islander and Multicultural Affairs
Officers-in-charge, school-based police officers and Adopt-a-Cop will continue work with schools, P&Cs and local communities to stimulate school and community-based policing.	Queensland Police Service
Queensland's 54 Police Citizens Youth Clubs (PCYCs) will work statewide to deliver a range of crime-prevention and youth development initiatives including the PCYC Emergency Services Cadets Program.	PCYC in partnership with Queensland Police Service
The Sun Effects Booth app will continue to be available for free through the iTunes store. The app involves a quiz about behaviours in the sun, uploading a photo of the face and a tailored simulated image of how the face might look in the future. The app also provides information about the five recommended sun protection methods and allows the user to check the daily UV Index for their location.	Department of Health

3. Connecting to health and wellbeing (continued)

Actions	Agency
School-based youth health nurses in state secondary schools will continue to provide services including individual health consultations, group health education and whole-of-school health promotion.	Department of Health
Indigenous youth health workers' knowledge and skills will be developed under the National Partnership Agreement on Indigenous Early Childhood Development.	
Access for young Aboriginal and Torres Strait Islander people to sexual and reproductive health services will be increased under the National Partnership Agreement on Indigenous Early Childhood Development.	
A mental health transition service for 8 to 18 year olds with early onset mental illness and complex care needs from Child and Youth Mental Health Services to clinical, community and cultural support services in their communities will continue to be implemented under Making Tracks.	
The Regional Network of Indigenous Alcohol, Tobacco and other Drugs (ATODS) Youth Program will continue to provide a focused treatment model for Aboriginal and Torres Strait Islander young people with substance misuse problems in key locations under Making Tracks.	
A program to improve access to primary health care for young Aboriginal and Torres Strait Islander people at the Brisbane Youth Detention Centre will be implemented under Making Tracks.	
Mental health and substance use transition services will be delivered to Aboriginal and Torres Strait Islander clients leaving the Brisbane Youth Detention Centre.	
The newly established Queensland Mental Health Commission will include young people as a priority group.	
Information, safety tips and updates about the weather and natural disasters will be provided to young people through a range of online tools including Facebook, Twitter, YouTube, Pinterest, blogs and Vine.	Department of Community Safety
The Youthful Prisoner Program, for 18 to 20 year old offenders at the Woodford Correctional Centre, will continue.	
A case management model targeted at young offenders between 17 and 21 years of age will be developed.	

4. Connecting to volunteering and participation

Young Queenslanders need to find their place in society so they can engage with — and participate in — civic life, volunteering, sport and community activities. Through volunteering and participation, young people develop their character and resilience, as well as decision-making and leadership skills.

What will Government do to connect young people to volunteering and participation?

Action	Agency
The Queensland Plan school program will encourage principals and teachers to foster discussion between students and the wider community about their hopes for the future.	Department of Education, Training and Employment and Department of Environment and Heritage Protection
Over three years, 50 young Queensland delegates will be sponsored to attend ANZAC Day ceremonies at Gallipoli and across the Western Front in Europe, encouraging their interest in our nation's history.	Department of Education, Training and Employment
More young Queenslanders will be encouraged to participate in the Duke of Edinburgh Award, presenting a range of positive youth development activities, leadership and community engagement.	
New and emerging online and multimedia communication technology and tools will be used to encourage young people to get involved.	All agencies, informed by the Office for Youth, Department of Communities, Child Safety and Disability Services
The annual Youth Parliament will build young community representatives' skills to influence public decision-making.	Department of Communities, Child Safety and Disability Services in partnership with Queensland Parliament
The Indigenous Youth Leadership program and Eric Deeral Indigenous Youth Parliament will develop skills and encourage a stronger voice among young Aboriginal and Torres Strait Islander Queenslanders.	
The Office for Youth will work collaboratively with young people and community organisations to develop appropriate services, programs and resources.	Department of Communities, Child Safety and Disability Services

4. Connecting to volunteering and participation (continued)

Actions	Agency
The Queensland Indigenous Land and Sea Junior Ranger Program will promote connections to community through the ability to work "on country".	Department of Environment and Heritage Protection
The Queensland Wetlands Program will offer curriculum-based learning opportunities, encouraging students to connect with their natural environment.	
Volunteering opportunities for young people will be promoted through the Queensland State Emergency Service	Department of Community Safety
Volunteering opportunities for young people will be promoted through the Queensland Rural Fire Service	
Young Queenslanders will be encouraged to volunteer to support their local community sport and recreation clubs through participation in the Challenge, Achievement and Pathways (CAPS) leadership program	Department of National Parks, Recreation, Sport and Racing

5. Connecting to supports and services

Young people who need extra help require access to high quality, effective support services that meet their individual needs, at a time and place right for them. We will ensure young people are front and centre of youth supports and services. This means ensuring that key information and support is available in a way that is meaningful to them.

What will Government do to connect young people to supports and services?

Actions	Agency
Practical guidelines, tools and resources will be developed to support youth programs and organisations that work with young people.	Department of Communities, Child Safety and Disability Services
The Office for Youth will coordinate expert advice on young people and implications for policy and service delivery.	
Social media, as well as more traditional forms of community engagement, will be used to get young people's opinions on issues that affect them.	
The Your Life Your Choice framework will give young people with a disability and their families, greater choice and control over the services they receive. This is will help get Queensland ready for DisabilityCare Australia, the national disability insurance scheme.	
Supported accommodation for young people at risk of disengaging from training and/or education due to homelessness, such as Youth Foyers, will be explored as part of the realignment of specialist homelessness services	Department of Communities, Child Safety and Disability Services and Department of Housing and Public Works
The online Road Rules practice test will continue to help prepare learner drivers for the road rules examination for a car, motorbike or heavy vehicle.	Department of Transport and Main Roads
Place-based initiatives targeting young Aboriginal and Torres Strait Islander people will help improve access to education, employment, health and housing opportunities.	Department of Aboriginal and Torres Strait Islander and Multicultural Affairs
Young people and their families will continue to get housing assistance through Rent Connect, Bond Loans and rental grants.	Department of Housing and Public Works
A homelessness strategy, including actions to reduce the number of young homeless people, will be released.	
Young people transitioning from state care will be prioritised for social housing assistance.	

6. Connecting to arts and culture

Young people contribute to all facets of creativity and culture. Cultural and creative participation has a range of social benefits for young people including improved problem solving and creative thinking, increased self-esteem and confidence, and the development of social and emotional skills. We want to ensure that young people's contributions to culture and the arts in Queensland are recognised while supporting their continued involvement in creative activities.

What will Government do to connect young people to creativity and culture?

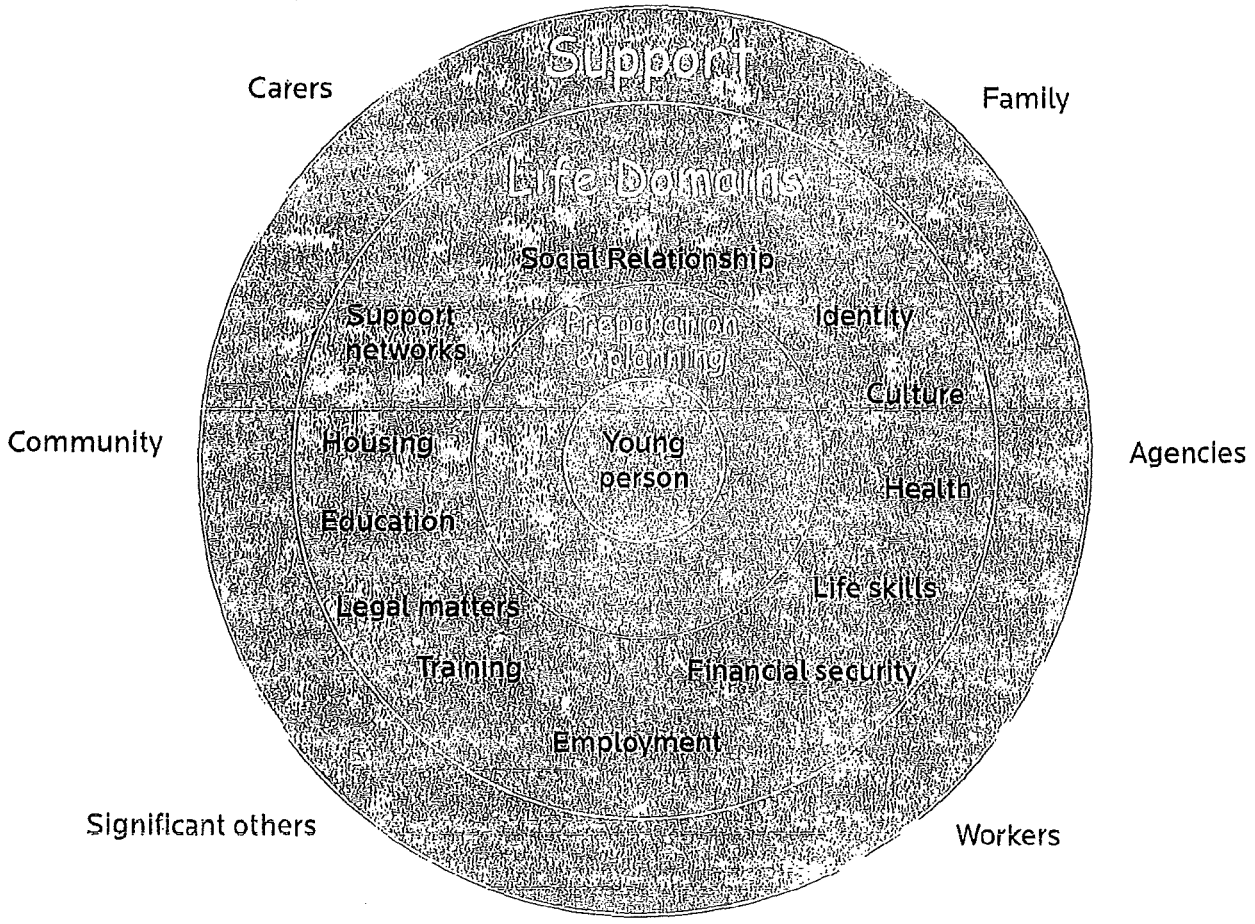
Actions	Agency
National Youth Week events and activities will promote and celebrate young people's achievements.	Department of Communities, Child Safety and Disability Services
Funding programs and other initiatives will actively encourage young people's involvement in Queensland's cultural life — as artists, participants and audiences.	Department of Science, Information Technology, Innovation and the Arts
Artist-facilitated workshops and programs related to exhibitions and collections at the Queensland Art Gallery/Gallery of Modern Art will target 13 to 17 year olds.	
Screen Queensland will deliver film programs for young people through the Cine Sparks International Film Festival and family films at the Brisbane International Film Festival.	
Screen Queensland will recognise and encourage emerging filmmakers including secondary and tertiary students and independent filmmakers through the Queensland New Filmmakers Awards.	
Queensland Museum will collaborate with youth organisations and groups to expand young people's access to the museum spaces and collections.	
The biennial Queensland Music Festival will help grow young people's engagement with music as audiences and participants.	
The Queensland Theatre Company's range of programs — including Theatre Residency Weeks, QTC Youth Ensemble, Young Playwrights' Program, Artists in Residence in Schools and the Wesfarmers Resources Regional Acting Studio — will encourage young people's engagement with theatre as audiences and participants.	

Actions	Agency
The State Library of Queensland, through The Edge, will provide opportunities for young people to explore creativity across the arts, technology, science and enterprise (e.g. introductory digital workshops).	Department of Science, Information Technology, Innovation and the Arts
The Aboriginal Centre for the Performing Arts will provide high quality, nationally accredited training in dance, music and theatre for Aboriginal and Torres Strait Islander young people, from Certificate III to Advanced Diploma in Performing Arts.	
The Artist-in-Residence initiative invests in high quality arts education projects that encourage creative practice between students, educators, artists and arts and cultural organisations.	
Young Queenslanders will be provided with social, cultural and intellectual benefits through agreements with international counterparts, preparing them for their place in the global community.	Department of Education, Training and Employment

Department of Families, Housing, Community Services and Indigenous Affairs
together with the National Framework Implementation Working Group

Transitioning from out-of-home care to Independence: A Nationally Consistent Approach to Planning

A Priority Action in the National Framework for Protecting Australia's Children



OCTOBER 2011

Transitioning from out-of-home care to Independence: A Nationally Consistent Approach to Planning

Introduction

One of the biggest challenges for all young people is to develop the skills and means to achieve and maintain independent living. For young people leaving out-of-home care, emotional support and practical assistance throughout the transition process are essential to help them develop the necessary skills for reaching their full potential. Young people, carers, families and significant others, service providers, communities and governments all have a role to play.

A nationally consistent approach to planning, supporting an effective transition from out-of-home care to independence, is a specific action to support the implementation of the National Framework for Protecting Australia's Children 2009-2020. The National Framework, endorsed by the Council of Australian Governments (COAG) in April 2009, provides an agenda for developing consistent, shared and long-term goals and responsibilities across governments and engages the non-government sector and the broader community at a national level.

Transitioning to independence is a key priority under the National Framework. The Australian Government, state and territory governments and non-government organisations, through the Coalition of Organisations Committed to the Safety and Well-being of Australia's Children, have worked together to deliver a nationally consistent approach to planning informed by evidence supporting 'best practice'.

This approach is an important step towards ensuring that young people who are transitioning from out-of-home care to independence are provided with consistent planning, no matter where they live.

How many young people leave out-of-home care in Australia each year?

In 2009-10, the AIHW reported that 2,695 young people aged 15–17 years were discharged from out-of-home care in Australia[1].

At 30 June 2010, there were 35,895 children and young people in out-of-home care in Australia. 46.1% of children and young people in out-of-home care in Australia were in foster care, 45.5% were in relative or kinship care and 2.1% were in other home based care. 5.1% were in residential care. A very small proportion was living independently.

Aboriginal and Torres Strait Islander children are over-represented in all of these areas of the child protection system with the number of indigenous children on care and protection orders nine times the rate of non indigenous children.

Contextual Framework

As a signatory to the United Nations Convention on the Rights of the Child[2], Australia has a responsibility to protect children and young people, provide the services necessary for them to develop and achieve positive outcomes and enable them to participate in the wider community. The National Framework for Protecting Australia's Children is underpinned by a number of principles that align with Australia's obligations as a signatory to the UN Convention:

- All children have a right to grow up in an environment free from neglect and abuse. Their best interests are paramount in all decisions affecting them.
- Children and their families have a right to participate in decisions affecting them.
- Improving the safety and wellbeing of children is a national priority.
- The safety and wellbeing of children is primarily the responsibility of their families, who should be supported by their communities and governments.
- Australian society values, supports and works in partnership with parents, families and others in fulfilling their caring responsibilities for children.
- Children's rights are upheld by systems and institutions.
- Policies and interventions are evidence based.

Increasing support for young people transitioning from care to better establish their independence is a priority in the first three year action plan of the National Framework, 2009-2012. Community and Disability Services Ministers supported the development of a nationally consistent approach to planning as a key action under this priority.

A nationally consistent approach to planning has been developed to align with the National Standards for out-of-home care. While each of the Standards is relevant to the care provided to the child or young person while in care and therefore have relevance to those preparing to leave care, there are a number of standards that have relevance to a nationally consistent approach to planning. In particular, Standard 13 requires each young person to have a transition from care plan commencing at the age of 15 years that includes details of support to access relevant services and is reviewed regularly. A transition from care plan is to cover required supports, based on individual needs, in areas such as:

- housing
- education and training
- employment
- financial security
- social relationships and support networks
- health – physical, emotional (including self esteem and identity), mental and sexual
- life (and after care) skills

1 Child Protection Australia 2009-10, Australian Institute of Health and Welfare (2011), Child Welfare Series No 51

2 The United Nations Convention on the Rights of the Child establishes a specific international regime for the protection and promotion of the rights of children and young people. It is the most widely ratified international human rights instrument. Australia signed the Convention on 22 August 1990 and ratified it on 17 December 1990.
As a signatory to the United Nations Convention on the Rights of the Child, Australia has a responsibility to protect children, provide the services necessary for them to develop and achieve positive outcomes, and enable them to participate in the wider community.

Consistent with the evidence supporting the National Standards for out-of-home care, the nationally consistent approach to planning recognises that better outcomes occur for those young people who are healthy, safe and secure, have strong cultural, spiritual and community ties, have a positive sense of identity, participate in learning and achieving, and have positive family and other relationships.

This approach realises the commitment from all parties to work together better in areas of shared responsibility. While children and young people in care remain the responsibility of state and territory governments, a nationally consistent approach to planning provides a framework to better link the many supports and services all governments and non-government organisations provide, coordinate planning and implementation, share information and innovation more effectively and support new efforts that build on and link with existing initiatives.

The contextual framework of a nationally consistent approach is summarised in Figure 1.

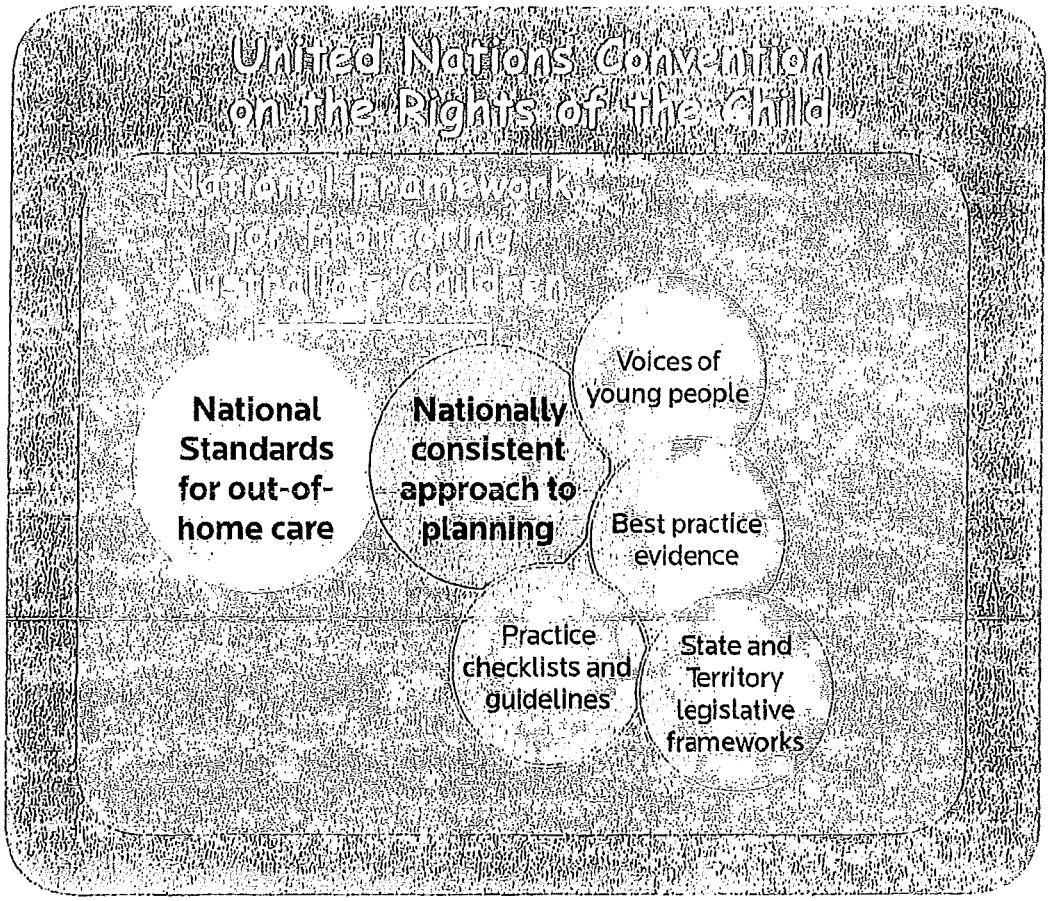


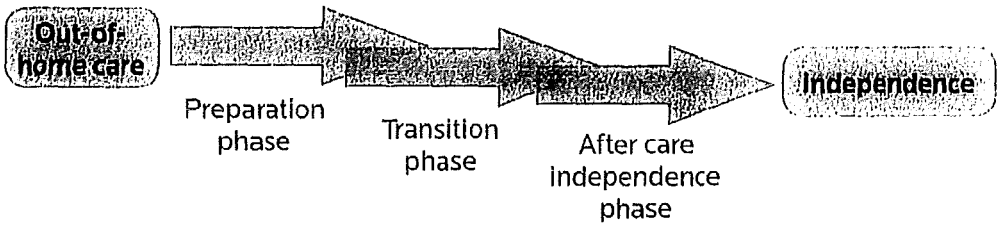
Figure 1 – contextual framework: *Transitioning from out-of-home care to Independence: A Nationally Consistent Approach to Planning*

The transition from out-of-home care to independence

Evidence shows that optimal outcomes for young people transitioning from out-of-home care to independence are more likely to be achieved when the process is a gradual and well supported one, based on strong preparation and planning, with access to tailored support to consolidate living skills and promote independence, and support after leaving care to foster resilience and stability. Maunders, Liddell, Liddell and Green (1999)[3] In a report to the National Youth Affairs Research Scheme (NYARS) recommended that: 'effective models of support must take account of the need to provide a continuum of care for children so that they can make a graduated transition from care to increasing independence as they mature and grow.' The CREATE Foundation report 'What's the Answer?' (2010) [4] supports a gradual transition from care and recommends considerations to be made in each phase.

In this context, the transition from out-of-home care to independence may be represented as a process involving three overlapping phases (Maunders et al (1999)) occurring along a continuum, commencing no later than age 15 years and continuing up to age 25 where the young person needs and/or desires ongoing assistance. This depiction recognises that some young people will require planning to start earlier so as to address specific needs. The process is flexible and recognises the role all parts of the system have to play in supporting the young person; an emerging adult on the path to independence. The concept of phases guides the focus of this support.

Transition from out-of-home care to independence



Transitioning from care to independence and the concept of best practice

According to Mendes (2011) [5], best practice planning aims to promote effective transitions for young people that lead to positive community engagement in areas such as housing, education and employment, health and social and family relationships and networks.

It is an ongoing and dynamic process based on the levels of maturity and skill development of young people, rather than simply their age. It is supported by flexible plans, monitoring of progress, and regular review to update planning in response to individual needs and changing circumstances.

It recognises the role relevant parties have to play in supporting the young person to transition from out-of-home care to independence – the young person; carers; workers; family of origin and significant others in the local community network; non-government organisations; state and territory governments; and the Commonwealth Government through universal and targeted services and income support.

Across Australia, there are many examples of practice that align with this nationally consistent approach to planning for young people transitioning from out-of-home care to independence and that demonstrate elements of good practice aimed at achieving improved outcomes for young people with a care experience. This approach provides an opportunity to share elements of good practice nationally.

3 David Maunders, Max Liddell, Margaret Liddell and Sue Green (1999) *Young People Leaving Care and Protection: A report to the National Youth Affairs Research Scheme*, Australian Clearinghouse for Youth Studies, Hobart, Tas

4 CREATE Foundation (2010) *What's the Answer?*

5 Philip Mendes, Guy Johnson and Badal Moslehuddin *Young People leaving state out-of-home care: a research-based study of Australian policy and practice*. Australian Scholarly Publishing, Melbourne, In Press, late 2011.

Why develop a nationally consistent approach to planning?

Each state and territory government has its own legislative and policy framework to support young people transitioning from out-of-home care to independence. All jurisdictions are investing to improve the effectiveness of the transition for these young people and provide opportunities for them to reach their potential. While there are common elements in the approaches to transition planning, there are also differences.

Increased consistency across jurisdictions will deliver equity in the planning process for young people, regardless of their location. The nationally consistent approach to planning guides practice through a focus on those elements that are essential during the transition process, ensuring they are considered for each young person and addressed where appropriate. Tailoring transition planning to meet the needs of the individual continues to be essential.

A nationally consistent approach to planning provides a framework to drive improvements in the effectiveness of the transition to independence for young people in out-of-home care, wherever they live in Australia. Through improved consistency across jurisdictions and information sharing about what works for these young people, the approach aims to maximise the potential for their social and economic participation into the future.

Including the voices of young people with a care experience

Young people with a care experience see the transition process as central to the quality of the overall out-of-home care experience. They also view their participation in the planning processes as critical to the effectiveness of their transition from care planning. In recent consultations at both the Commonwealth and state and territory levels, young people have emphasised the importance of adequate preparation and planning for transition to empower them to make informed decisions and facilitate access to appropriate supports, including post-care supports. In the CREATE Foundation report *What's the Answer?* young people with a care experience have expressed their views about what works, what can be done better and what should change. Their contribution has provided valuable input into the development of this approach to planning.

Aboriginal and Torres Strait Islander young people

Aboriginal and Torres Strait Islander children are over-represented in all areas of the child protection system. Achieving better outcomes for these young people transitioning from care to independence requires a specific focus including careful consideration in establishing support systems. Family, community and cultural connections are vital for the social, emotional and spiritual wellbeing and development of Aboriginal and Torres Strait Islander young people.

The cultural sensitivity of child protection workers during what can be an intense, emotional and difficult process is important in ensuring a smooth transition for Aboriginal and Torres Strait Islander young people. There is a range of publications available that discuss cultural care for Aboriginal and Torres Strait Islander children. There are also examples of specialised services and supports available for those working with Aboriginal and Torres Strait Islander young people. Elements of good practice underpinning these services and supports that promote positive experiences for the individual young person, are reflected in this approach.

What does the nationally consistent approach to planning cover?

A nationally consistent approach to planning covers the core elements to be considered for each young person making the transition from out-of-home care to independence.

The core elements include:

- participants
- planning and support processes
- life domains

The life domains include those listed in the National Standards as relevant to a transition from care plan, outlined previously. Consultations with young people, service providers, carers, researchers and governments identified culture, legal matters and dental health as additional areas to be included in the nationally consistent approach.

The life domains included in the approach are:

- housing/accommodation
- health – physical, emotional (including self esteem), mental, sexual and dental
- education and training, employment or other suitable activity
- financial security
- social relationships and support networks
- life (and after care) skills
- identity and culture
- legal matters

This approach depicts the core elements of transition planning to be considered throughout the entire planning process. It also identifies the additional focus to be taken around these core elements, where relevant, in each phase.

It draws from the evidence supporting a 'best practice' approach to planning as outlined in the literature and referenced in the paper *Transitioning from out of home care to independence*. It also recognises and builds upon the significant work occurring across jurisdictions to improve the effectiveness of the transition from out-of-home care to independence for young people.

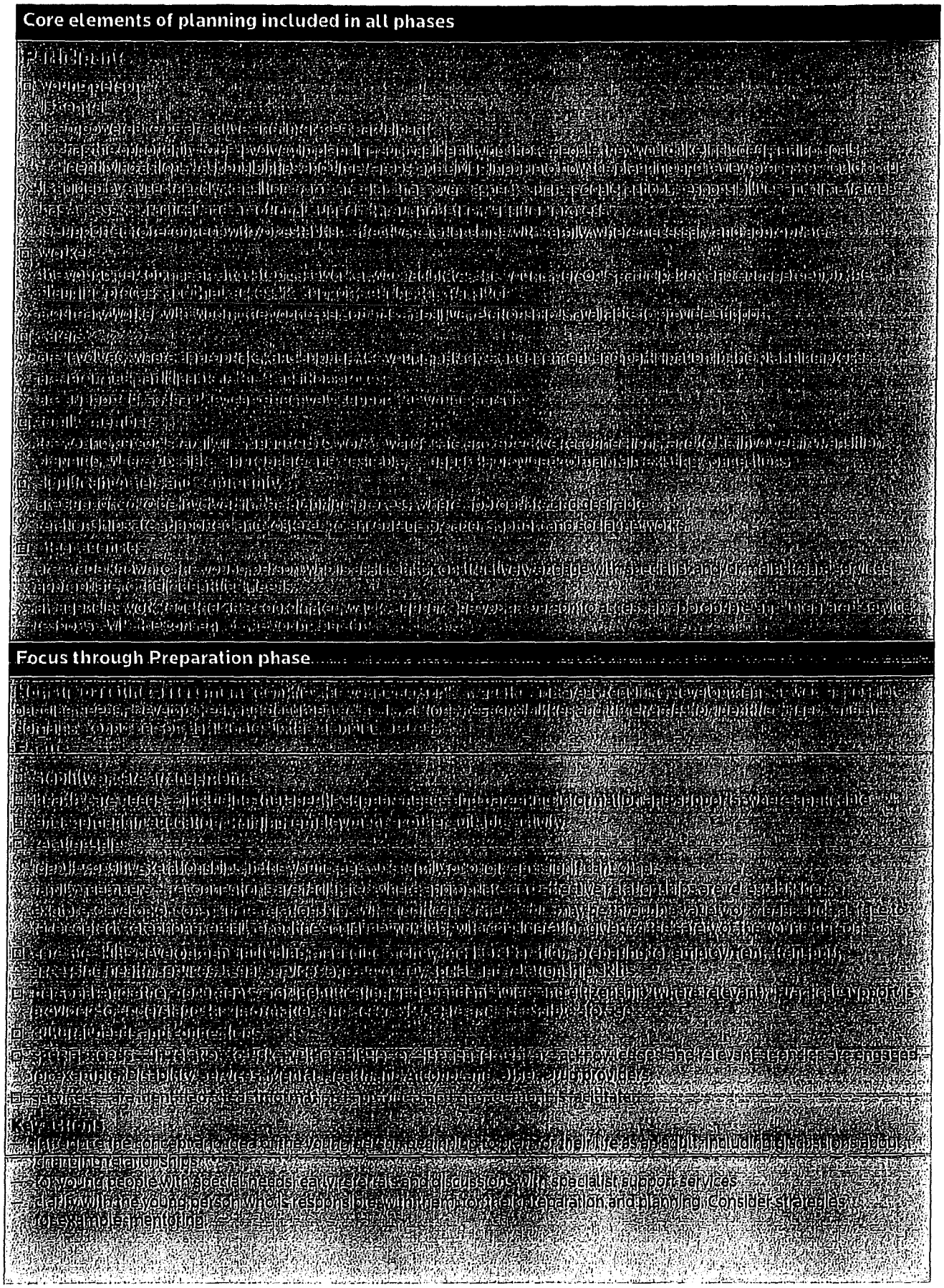
A nationally consistent approach to planning for young people transitioning from out-of-home care to independence is at Table 1.

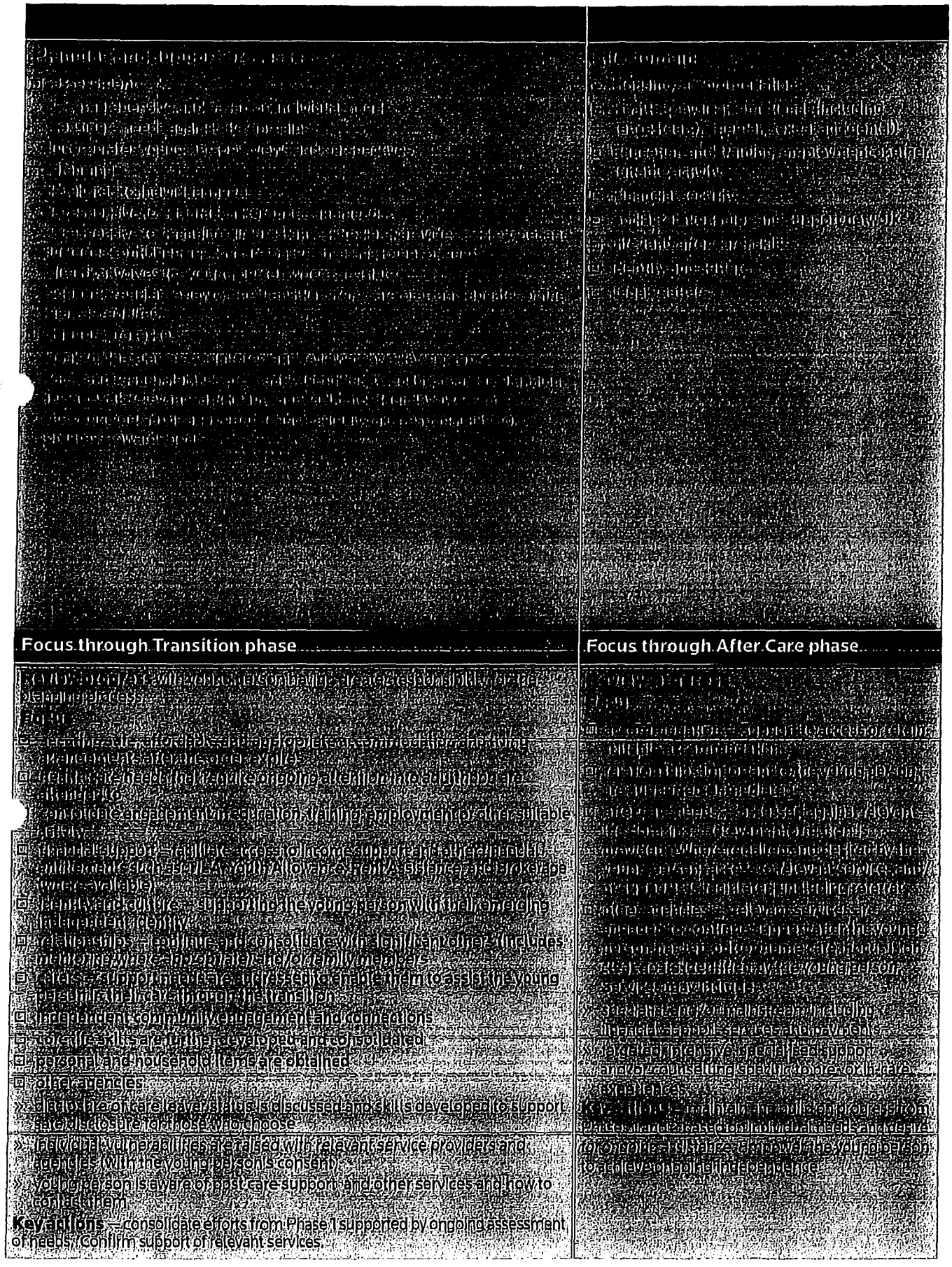
While it is recognised that there are some gaps and challenges to be overcome, this approach, for the first time, provides a national response to a common goal - a platform on which state and territory government efforts can be coordinated with those of the non-government sector and Australian Government programs, policies and payments; an integrated response to the needs of these vulnerable young people.

It is a first step towards the vision described in the paper released by Community and Disability Services Ministers in December 2010, *Transitioning from out of home care to independence:*

> All young people transitioning from out-of-home care to independence receive support from governments, non-government organisations, family members and/or carers, business and the community to experience an effective transition and reach their full potential for social and economic participation.

Table 1 Transitioning from out-of-home care to Independence: A Nationally Consistent Approach to Planning




Focus through Transition phase
Focus through After Care phase
Key actions – consolidate efforts from Phase 1 supported by ongoing assessment of needs. Confirm support of relevant services.

List of terms

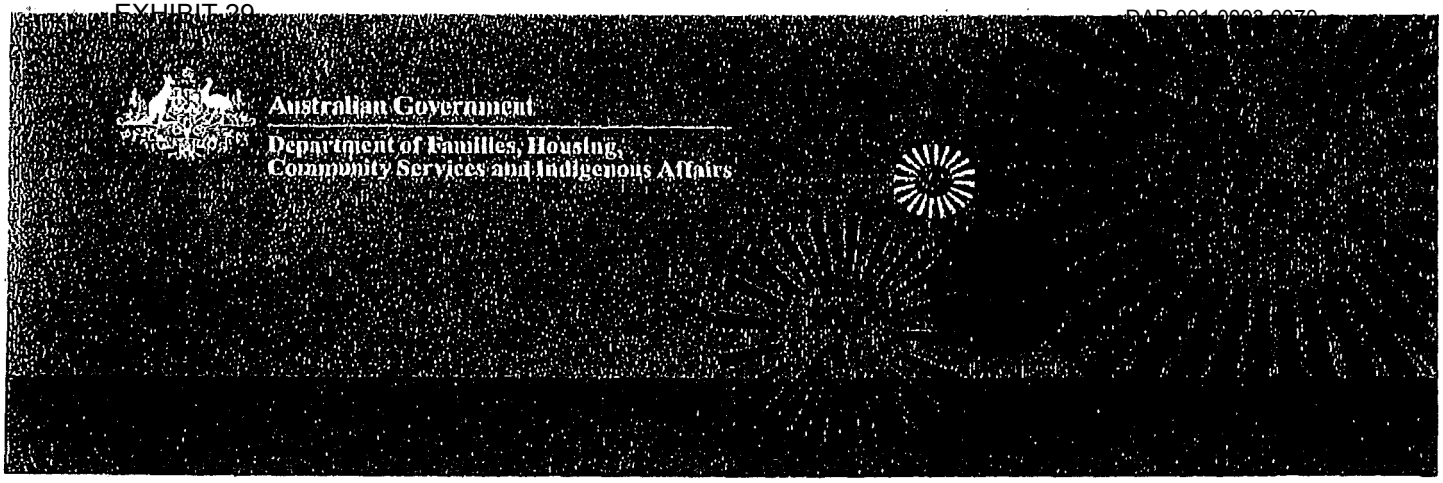
Core element
An essential, evidence based component of planning that supports the transition from out-of-home care to independence. The core elements to be considered are participants, planning and support processes and the life domains.

Out-of-home care (foster care, kinship care, therapeutic residential care): A nationally consistent approach to planning focuses on those children and young people with Children's Court ordered care arrangements, where the parental responsibility for the child or young person has been transferred to the Minister/Chief Executive. This includes:

> **Foster care:** Where placement is in the home of a carer who is receiving a reimbursement from a state or territory for caring for a child.
>
> **Relative or kinship care:** Where the caregiver is a family member or a person with a pre-existing relationship to the child, and the state makes a financial payment/reimbursement or where a financial payment/reimbursement has been offered but has been declined by the carer.
>
> **Therapeutic Residential Care:** is intensive and time limited care for a young person in statutory care within a residential setting that responds to the complex impacts of abuse, neglect and separation from family. This is achieved through the creation of positive, safe, healing relationships and experiences informed by a sound understanding of trauma, damaged attachment, and developmental needs.
>
> **Residential care:** Where placement is in a residential building whose purpose is to provide placements for children and where there are paid staff. This category includes facilities where there are rostered staff and where staff are offsite.
>
> **Independent living:** Such as private boarding arrangements.

Transitioning from out-of-home care to independence
A gradual process commencing no later than age 15 years, guided by a transition from care plan.

Transition from care plan
A planned and phased approach to transitioning from care for young people that identifies the required supports, based on individual needs, in areas such as safe and sustainable housing, education, employment, financial security, social relationships and support networks, health – physical, emotional (including self-esteem and identity), mental and sexual, and life and after care skills.



Homelessness and Leaving Care: the experiences of young adults in Queensland and Victoria, and implications for practice. Swinburne University of Technology

Evidence note no. 48

Key points

- Young people leaving care are at high risk of homelessness and other poor social outcomes
- This risk can be reduced through leaving care services that bridge the transition from care and extend through the clients' early twenties
- Services should include transition planning, access to stable accommodation and long term case workers

The issue

- In 2012, there were almost 40,000 children and young people in out of home care in Australia.
- Recent research suggests that one third of those young people will experience homelessness within a year of leaving care and up to a half will experience homelessness at some point.
- This research by Swinburne University of Technology examined "what happens when young people leave care."
- Researchers conducted interviews and focus groups with 27 young people aged between 19 and 23, interviews with service providers and analysis of post care support available in QLD and Victoria.

Findings

- Twenty four of the 27 young people who participated in the study had experienced primary homelessness – sleeping rough on the streets.
- All participants had experienced either primary homelessness or secondary homelessness in the form of couch-surfing.
- Several participants became homeless while ostensibly in care as a direct outcome of experiencing abuse by carers.
- Participants reported multiple factors that interacted with their experience of homelessness, including violent relationships, use of illicit drugs and financial hardship.
- Young people who experience a smooth transition from care had better outcomes than those who experience a volatile transition.
- A "smooth" transition from care is typically characterised by:
  - a sense of security and stability while in care
  - the development of a connection with a stable adult
  - a low number of placements
- Conversely, a "volatile" transition from care is typically characterised by:
  - a high number of placements
  - Poor or abusive relationships with carers
  - Lack of 'felt' security while in care
- Supportive relationships with a caring adult that bridge the transition from in-care to out-of-care are important to achieving successful outcomes.
- These relationships can be with a member of the family of origin, a foster carer or a professional service-provider (ideally all three but even one can make a difference to quality of outcomes).

- Participants emphasised the importance of forming a long term, stable relationship with a trusted case worker while in care.
- Ideally such workers would work with clients for at least two years and would support the clients through their transition to independent living.
- A leaving care plan based on stable accommodation is a significant factor in achieving positive education and employment outcomes.
- Many of the young people involved in the study did not have a leaving care plan, were unaware of having a leaving care plan or had a plan they considered inadequate.
- Of those with a plan, several noted the lack of involvement they had in its development and their consequent lack of ownership over the process and outcome.
- Victoria has a more comprehensive and systemic approach to care-leavers than Queensland. Victorian care leavers have priority access to transitional and public housing and formalised funded after-care services and support.
- This research strongly suggests that Victoria's approach leads to better outcomes for young people leaving care.
- While Queensland and Victorian participants had similar levels of high school participation, the Victorian sample had a far higher level of subsequent engagement in education, training and employment.
- Queensland is currently undertaking an Inquiry into Child Protection. This might provide an opportunity for stakeholders to advocate for stronger support structures in Queensland covering both pre and post care that lead to improved outcomes.
- This Report recommends the development of a national framework for young people leaving care.

Recommendations

This study's recommendations are as follows:

- **Recommendation 1**: That the Australian and State and Territory Governments (through COAG) develop and establish a cross sector working party to develop a National Consistent Leaving Care Framework with a focus on tackling homelessness for young people exiting the care system.
- **Recommendation 2:** That both the Queensland and Victorian Government develop a comprehensive housing policy for young care leavers, including improved referral pathways between Child Protection services and Public Housing services.
- **Recommendation 3:** Through the National Framework for Protection Australia's Children, a National Research study be undertaken to examine and explore the intersection of young care leavers and intergenerational homelessness.

Policy implications

Child protection systems need to facilitate a smoother, more stable in care experience which focuses on building young people's positive social connections.

State child protection systems, housing authorities and community services departments need to work together to deliver a comprehensive framework of pre and post care support services and housing.

Leaving care planning needs to begin early, be youth-friendly, fully engage the young person leaving care and reflect their aspirations to engage in education, training and employment.

Full report: *Homelessness and Leaving Care: the experiences of young adults in Queensland and Victoria, and implications for practice* (2013) Phil Crane, Jatinder Kaur and Judith Burton

Further information: Dr Phil Crane, Queensland University of Technology, Victoria Park Rd., Kelvin Grove Qld 4059, Australia. Email: p.crane@qut.edu.au

Indigenous young people leaving out of home care in Victoria: A Literature Review by Susan Baidawi, Philip Mendes and Bernadette Saunders, *Indigenous Law Bulletin*, 8(7), 2013, pp.24-27

Over-representation of Indigenous children and young people in the Australian child welfare system

Indigenous children and young people are over-represented at all stages of the child protection system. While this trend is paralleled in many developed countries with Indigenous populations, including New Zealand, Canada and the US, the disproportionality among Indigenous Australians is considerably higher.[1] Furthermore, the rate of Indigenous children on care and protection orders has been steadily increasing over the past five years.[2] At 30 June 2012, Indigenous children and young people comprised one third of the 39,621 children and young people in care nationwide.[3] Overall, the national rate of Indigenous young people in out of home care is ten times that of non-Indigenous young people.[4] These figures are likely to be an underestimate of the actual number of Indigenous young people in state care, given that some Australian jurisdictions report high proportions of clients whose Indigenous status is unknown.[5] While there are national guidelines pertaining to the collection of Indigenous status information, data information systems and forms in some jurisdictions do not always require users to specify this information.

Various underlying factors have been cited as drivers of the ongoing over-representation of Indigenous children in the Australian child welfare system, including consequences of past policies of forced removal of Indigenous children from culture and community, intergenerational trauma arising from these practices and resulting lower socioeconomic status.[6]

Age of entering care and types of maltreatment

National data is unavailable regarding the average age of entering care for Indigenous children and young people. In Victoria, compared to non-Indigenous young people in out of home care, Indigenous children entering care were more likely to be aged under ten years.[7]

Compared to non-Indigenous children and young people, their Indigenous counterparts are more likely to enter the child welfare system as a result of neglect; conversely, non-Indigenous children and young people were more likely to enter care as a result of physical, sexual or emotional abuse.[8] According to the (then) Human Rights and Equal Opportunities Commission,[9] the prevalence of neglect among the type of maltreatment experienced by Indigenous children in care is reflective of 'what we know about the socio-economic conditions of many Indigenous communities', and it is the disadvantage associated with these conditions which 'breeds neglect'.

Aboriginal Child Placement Principle and placement type

In accordance with Division 4 of the *Children, Youth and Families Act 2005* (Vic) (*'CYAF Act'*), Indigenous children and young people are allocated out of home care placements in accordance with the Aboriginal Child Placement Principle ('ACPP'), which outlines a preference for placement with other Aboriginal and Torres Strait Islander people.[10] This principle aims to protect Indigenous children's right to be raised within their own culture, and acknowledges the importance of family and kinship networks in raising Indigenous young people.[11] All Australian jurisdictions have adopted the ACPP in child protection legislation and policy.[12]

In 2012, 69 per cent of Indigenous children in out of home care were placed with relatives/kin, other Indigenous caregivers or in Indigenous residential care.[13] One of the issues in relation to the placement of Indigenous children is a shortage of sufficient numbers of Indigenous carers to meet the placement needs of the growing Indigenous out of home care population;[14] this issue is compounded for Indigenous young people with complex issues, such as physical or intellectual disabilities.[15] Additionally, each Indigenous child placed in care is required to have a cultural plan setting out how he or she is to remain connected to his or her Indigenous community and culture.[16]

Leaving care provisions in Victoria

Leaving care is defined as the cessation of the state's legal responsibility for young people living in out of home care.[17] Victoria legislated via the *CYAF Act* for the provision of leaving care and after-care services for young people up to 21 years of age.[18] The annual Victorian leaving care budget is approximately $4 million, which includes funding for both service delivery, and brokerage support for individual care leavers to cover accommodation, education, training and employment, and access to health and community services.[19] Leaving care and post-care services in Victoria are accessible to care leavers aged 16 to 21 years who were the subject of a Guardianship or Custody order, on or after their 16th birthday.[20]

The *CYAF Act* appears to oblige the Government to assist care leavers with finances, housing, education and training, employment, legal advice, access to health and community services, and counselling and support depending on the assessed level of need, and to consider the specific needs of Aboriginal young people. However, section 16(2) of the Act emphasises that these responsibilities 'do not create any right or entitlement enforceable at law', which suggests that leaving care programs are in fact discretionary, and care leavers do not actually have any legal right to seek or demand support services from government.[21]

Leaving care schemes in Victoria are technically able to be accessed by young people outside of the primary target group, this includes:

> exceptional circumstances where Aboriginal young people require support to transition from kinship care arrangements and they are not subject to custody, guardianship or long-term guardianship orders.[22]

At the same time, access under these conditions optimistically assumes that young people are aware of their right to seek these services, and that sufficient resources are available to assist their target group, let alone young people outside this population.

Indigenous care leavers in Victoria

In 2011/12 an estimated 3,034 young people aged 15 to 17 years exited state care across Australia; 857 of these were in Victoria.[23] National data is not available concerning the number of Indigenous care leavers. In Victoria, 13 per cent of the 590 young people aged 15 years and older who left care in 2009/10 were Indigenous (i.e. around 77 young people across the state).[24] Other information from the Victorian Department of Human Services ('DHS') indicates that there were 58 Indigenous young people aged 16 to 17 years on Guardianship or Custody orders in Victoria in June 2011, and it was concluded that approximately 29 Indigenous young people were annually exiting care in Victoria.[25] While this data was derived from the DHS electronic information system and is not Australian Institute of Health and Welfare ('AIHW') publishable data, it is concerning that this number so significantly deviates from the annual figure of Indigenous care leavers in Victoria which would be estimated from AIHW data (e.g. 13 per cent of 857 care leavers) or that published in the 'Report of the Protecting Victoria's Vulnerable Children Inquiry' (i.e. an estimation of 77 to 111 Indigenous care leavers per year).[26]

Age of leaving care

National information concerning the average age of leaving care for Indigenous care leavers is unavailable. Victorian research found only a slight difference between the proportion of Indigenous and non-Indigenous care leavers who were discharged from care before the age of 18 years (42 per cent Indigenous vs 38 per cent non-Indigenous).[27] Anecdotal evidence from peak indigenous bodies suggests that 'many Indigenous children leave out of home care to live independently from an earlier age than non-Indigenous children, many for example from the age of 14'.[28] Such young people may have difficulties accessing leaving care assistance if they were not subject to a statutory order (i.e. living under voluntary kinship arrangements).

Time spent in care and placement stability

There is a lack of consensus regarding the relative amount of time Indigenous and non-Indigenous young people spend in care. Some reports have found no significant difference in the time spent in care.[29] In contrast, others determined that Indigenous young people were in out of home care for longer periods, reflecting the greater use of kinship care with this population, which tends to be associated with longer and more stable placements.[30]

A recent report found that Indigenous young people in and leaving care experienced more placements and a shorter time in their current placement than non-Indigenous young people, and that placement stability was associated with entering care at a younger age.[31] This was

not consistent with another Australian study,[32] again pointing to a need for further investigations into Indigenous young people's experiences in care.

Outcomes for Indigenous care leavers

To date, there has also been limited research on the needs and outcomes of Indigenous Australian care leavers, but the available information outlines some of the challenges faced by this group.[33] Indigenous care leavers are more likely to report poorer educational experiences compared to non-Indigenous young people in care (e.g. less likely to have completed Year 12, and more likely to experience school exclusion).[34] Indigenous young people in care are also significantly over-represented in Australian youth justice systems, even more so than non-Indigenous young people in care.[35]

Despite policies attempting to maintain links to culture and community, approximately 30 per cent of Indigenous children and young people leaving care report having a poor connection to their cultural heritage.[36] Indigenous young people whose carer is of the same cultural background are more likely to report feeling in touch with their community compared to those with a carer of a different cultural background.[37] Indigenous young people in care experience significantly more contact with siblings and grandparents than non-Indigenous people in care.[38] This is likely to be attributable to the greater use of kinship care within the Indigenous care population. At the same time, other reports have highlighted the ongoing need for services for parents given that Indigenous care leavers are likely to return to their biological families after leaving care.[39]

Understanding one's personal history and having a positive sense of identity is understood as an important component of facilitating transitions from care.[40] Compared to young people from Anglo-Australian and other cultural backgrounds, Indigenous young people knew less about why they were in care, and reported receiving less information about what they could expect would happen during their time in care.[41]

Services and policy initiatives for Indigenous care leavers

The significant over-representation of Indigenous people in the out-of-home care system indicates the need for an Indigenous specific response to leaving care; specialist leaving care services based on partnerships with Indigenous agencies are required to address the particular needs of Indigenous care leavers in a culturally appropriate manner.[42] Some initiatives have been established which specifically provide services to Indigenous care leavers.[43]

In Victoria, the Aboriginal Leaving Care initiative aims to ensure culturally appropriate support for Aboriginal care leavers aged 16 to 21 years by providing transition support and post-care assistance.[44] It appears that the initiative comprises the provision of support from Aboriginal Community Controlled Organisations ('ACCOs')—for example the Victorian Aboriginal Child Care Agency—to mainstream leaving care and post-care services, or direct

provision of these services in a particular region.[45] It is unclear what proportion of Indigenous care leavers access these supports.

The Leaving Care Housing and Support Initiative is another Victorian program targeting care leavers aged 16 years and older who are at risk of homelessness.[46] The program couples the provision of housing support with case management services; specific resources target Indigenous young people leaving care in two Victorian regions.[47] A 2008 evaluation of the program found that the proportion of Indigenous young people accessing the program over a three year period (8 per cent) was less than the 12 per cent anticipated.[48] Other Indigenous-specific leaving care initiatives exist in various states and territories (e.g. the Assisting Aboriginal Young People Leaving Care Project in NSW) which aim to assist Indigenous care leavers to reconnect with family, culture and community.[49] There appears to be minimal evaluation of the uptake or efficacy of these targeted schemes.

Conclusion

There is a dearth of research concerning Indigenous children and young people in and leaving out of home care in Australia.[50] This is alarming given the current and historical significant over-representation, as well as the recent increases in the rate of Indigenous young people within the child welfare system. A lack of understanding of the needs and outcomes of Indigenous care leavers can diminish the chances of achieving the most positive outcomes, and further increases the possibility of perpetuating a cycle of disadvantage for current and future Indigenous peoples.

Susan Baidawi, Philip Mendes and Bernadette Saunders work in the Social Inclusion and Social Policy Research Unit at Monash University.

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[1] June Thoburn, 'Globalisation and child welfare: some lessons from a cross-national study of children in out-of-home care' (Social Work Monographs, UEA, Norwich, 2008); Clare Tilbury, 'The over-representation of indigenous children in the Australian child welfare system' (2009) 18(1) *International Journal of Social Welfare* 57, 62; Vandna Sinha et al, 'Understanding the investigation-stage overrepresentation of First Nations children in the child welfare system: An analysis of the First Nations component of the Canadian Incidence Study of Reported Child Abuse and Neglect 2008' (In Press, Corrected Proof, Available online 17 January 2013) *Child Abuse & Neglect*, DOI http://dx.doi.org/10.1016/j.chiabu.2012.11.010; Chantal Lavergne et al, 'Visible Minority, Aboriginal, and Caucasian Children Investigated by Canadian Protective Services' (2008) 87(2) *Child Welfare* 59.

[2] Australian Institute of Health and Welfare ('AIHW'), 'Child Protection Australia 2011-12' (Child Welfare Series No 55, AIHW, 2013) 34; Philip Cummins, Dorothy Scott, Bill Scales, Department of Premier and Cabinet (VIC), *Report of the Protecting Victoria's Vulnerable Children Inquiry* (State of Victoria, 2012).

[3] AIHW, above n 2.

[4] Ibid [41]-[42].

[5] Ibid [94].

[6] Ibid; Human Rights and Equal Opportunity Commission ('HREOC'), *Bringing them home. Report of the national inquiry into the separation of Aboriginal and Torres Strait Islander children from their families* (1997).

[7] Cummins et al, above n 2, 244.

[8] AIHW, above n 2, 17.

[9] Aboriginal and Torres Strait Islander Social Justice Commissioner, Human Rights and Equal Opportunities Commission, *Social Justice Report 2007* (2008) 13.
[10] *Children, Youth and Families Act 2005 (Vic) ('CYAF Act')*, ss 13-14.
[11] New South Wales Law Reform Commission, *The Aboriginal Child Placement Principle*, Research Project No 7 (1997); Rodney Monohan, Department of Human Services (VIC), 'Aboriginal Child Placement Principle Guide' (2002).
[12] AIHW, above n 2, 42.
[13] Ibid.
[14] Leah Bromfield et al, Australian Institute of Family Studies, 'Why is there a shortage of Aboriginal and Torres Strait Islander Carers? Perspectives of professionals from Aboriginal and Torres Strait Islander organisations, non-government agencies and government departments' (2007); Daryl Higgins, Leah Bromfield and Nick Richardson, Australian Institute of Family Studies, 'Enhancing out-of-home care for Aboriginal and Torres Strait Islander young people' (2005).
[15] Higgins et al, above n 14; Marilyn McHugh and Kylie Valentine, Social Policy Research Centre, 'Financial and non-financial support to formal and informal out-of-home carers' (2011).
[16] Department of Human Services ('DHS') (VIC), 'Cultural Support Plan Guide' (2005).
[17] Cummins et al, above n 2, 261; Judy Cashmore and Philip Mendes, 'Australia', in Mike Stein and Emily Munro (eds), *Young People's Transitions from Care to Adulthood: International Research and Practice* (Jessica Kingsley, 2008) 23.
[18] *CYAF Act*, s 16.
[19] Cummins et al, above n 2, 267.
[20] DHS (VIC), 'Leaving Care Support Services for Young People' (17 January 2013). http://www.dhs.vic.gov.au/for-individuals/children,-families-and-young-people/care-leavers/young-care-leavers/support-services-for-young-people-who-have-left-out-of-home-care.
[21] *CYAF Act*, s 16(2).
[22] DHS (VIC), 'Transitioning from out-of-home care: Support for Aboriginal young people - Guidance for Regions' (2012) 2.
[23] AIHW, above n 2, 77.
[24] Cummins et al, above n 2, 264.
[25] DHS (VIC), above n 20.
[26] AIHW, above n 2, 77; Cummins et al, above n 2, 264.
[27] David Maunders et al, *Young people leaving care and protection: a report to the National Youth Affairs Research Scheme* (Australian Clearinghouse for Youth Studies, 1999).
[28] Secretariat of National Aboriginal and Islander Child Care ('SNAICC'), 'Response to the Nationally Consistent Approach to Leave Care Planning' (2011) 6; see also Cummins et al, above n 2, 308.
[29] Cummins et al, above n 2; James Barber, Paul Delfabbro and Lesley Cooper, 'Aboriginal and non-Aboriginal children in out-of-home care' (2000) 25(3) *Children Australia* 5.
[30] Tilbury, above n 1.
[31] Joseph McDowall, CREATE Foundation, 'CREATE Report Card 2013 - Experiencing out-of-home care in Australia: The views of children and young people' (2013).
[32] Alexandra Osborn, Paul Delfabbro and James Barber, 'The psychosocial functioning and family background of children experiencing significant placement instability in Australian out-of-home care' (2008) 30(8) *Children and Youth Services Review* 847.
[33] Philip Mendes, Guy Johnson and Badal Moslehuddin, *Young People Leaving State Out-of-Home Care: Australian Policy and Practice* (Australian Scholarly Publishing, 2011) 30.
[34] Barber et al, above n 29; McDowall, above n 31; Joseph McDowall, CREATE Foundation, 'CREATE Report Card 2009 - Transitioning from care: Tracking progress' (2009).
[35] Barber et al, above n 29; McDowall, above n 31; The Youth Parole Board and Youth Residential Board of Victoria, 'The Youth Parole Board and Youth Residential Board Annual Report 2010-11' (2011).
[36] McDowall, above n 31; Commission for Children and Young People and Child Guardian. '2011 Views of Children and Young People in Foster Care Survey: Overview and selected findings' (2012).
[37] Commission for Children and Young People and Child Guardian, above n 34.
[38] McDowall, above n 31.
[39] Higgins et al, above n 14.

[40] Department of Families, Housing, Community Services and Indigenous Affairs ('FaHCSIA'), 'Transitioning from out of home care to independence' (2010); Anne Tweddle, 'Youth leaving care: How do they fare?' (2007) 113 *New Directions for Youth Development* 15.
[41] McDowall, above n 31, 46.
[42] See, eg, McDowall, above n 31; see also SNAICC, above n 28.
[43] Higgins et al, above n 14; FaHCSIA, 'Supporting young people transitioning from out-of-home care to independence in Australia: good practice in 2011-12' (2012).
[44] DHS (VIC), above n 20.
[45] Ibid; Victorian Aboriginal Child Care Agency ('VACCA'), 'Connected by Culture: Victorian Aboriginal Child Care Agency Annual Report 2011/2012' (2012).
[46] FaHCSIA, above n 40.
[47] Thomson Goodall and Associates, 'Evaluation of the Youth Homelessness Action Plan Stage 1' (2008) 26.
[48] Ibid, 27.
[49] FaHCSIA, above n 40.
[50] Mendes, Johnson and Moslehuddin, above n 33; Terri Libesman, SNAICC and Barnados, 'Cultural Care for Aboriginal and Torres Strait Islander Children in Out of Home Care' (2011).