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

Commissions of Inquiry Order (No.4) 2015

Barrett Adolescent Centre Commission of Inquiry

AFFIDAVIT

Emma Hart, of c/- Crown Law, 50 Ann Street Brisbane, Acting Program Manager/Nursing Director, solemnly and sincerely affirms and declares:

1. I have been provided with a Requirement to Give Information in a Written Statement dated 18 January 2016. **Exhibit A** to this affidavit is a copy of this notice.

2. .

3. I am a registered nurse, currently employed with Children's Health Queensland, Child and Youth Mental Health Service. I am the Team Leader of the Acute Response Team. I commenced in this role on 11 January 2016.

4. **Exhibit B** to this affidavit is my curriculum vitae which outlines my full qualifications and employment history.

5. Prior to this, I worked as the Nurse Unit Manager in the Adolescent Inpatient Unit and Day Service at the Hospital and Health Service. I commenced in this role in June/July 2011 and finished in the first week of December 2015. **Exhibit C** to this affidavit is a copy of the role description for my position with the Hospital and Health Service.

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

AFFIDAVIT

On behalf of the State of Queensland

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

6.

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

11.

12.

13.

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15.

Deponent

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

16. [redacted]

17. [redacted]

18. [redacted]

19. [redacted]

20. [redacted]

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

21.

22.

23. I was a member of the Expert Clinical Reference Group formed to review the future of the Barrett Adolescent Centre prior to its closure. I recall the meetings of the Expert Clinical Reference Group were chaired by Leanne Geppert. As far as I can recall, David Hartman and Trevor Sadler also attended these meetings. I attended about five meetings with the Expert Clinical Reference Group although I cannot recall the exact number. I never attended these meetings in person, rather, I attended via teleconference in . **Exhibit D** to this affidavit are copies of all documentation relevant to the Expert Clinical Reference Group that I have in my possession.

24. I also recall attending a one-off workshop with the Expert Clinical Reference Group in Brisbane although I cannot recall exactly where the workshop was held. I recall that the workshop was facilitated by Leanne Geppert with Ingrid Adamson as secretariat. Peter Steer and Bill Kingswell also attended the workshop for part of the day. The purpose of the workshop was to brainstorm and discuss transfer of care, the proposed models of care and review the tiers of the model to identify strengths, weaknesses and opportunities for future services.

25. The recommendations from the Expert Clinical Reference Group were supported within the group and everyone signed off on the new model. I believe it may have been Ingrid Adamson who drafted the recommendations for the Expert Clinical Reference Group but I cannot recall for certain. The recommendations were then sent to the Steering Committee. I was not a member of the Steering Committee. I believe David Hartman was a member of the Steering Committee. David is a child psychiatrist and was practising in [redacted] at that time.

26. I was also involved with a group responsible for looking at the State-wide model of service for Day Programs. As far as I can recall, this group formed after the closure of the Barrett Adolescent Centre. I recall Dan O'Brien, Team Leader of the Day Program at Mater Hospital, Brisbane was on this group, but I cannot recall who else attended. As far as I am aware, the group met 2-3 times. I attended the meetings via videoconference from [redacted] I do not have any documentation in my possession from these meetings.

27. I do not have access to any other information or documents relevant to the Commission's Terms of Reference.

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

Affirmed by Emma Hart on)
25 January 2016 at)
in the presence of:)

[redacted]

[redacted]

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

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

Commissions of Inquiry Order (No.4) 2015

Barrett Adolescent Centre Commission of Inquiry

CERTIFICATE OF EXHIBIT

Exhibit A to D to the Affidavit of Emma Hart affirmed on 25 January 2016.

[redacted]

Deponent

[redacted]

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

JUSTICE OF THE PEACE (QUALIFIED) QUEENSLAND GOVERNMENT Reg.No.: 88145 DEPT OF JUSTICE & ATTORNEY-GENERAL

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

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Barrett Adolescent Centre Commission of Inquiry

INDEX TO EXHIBITS

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BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

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

REQUIREMENT TO GIVE INFORMATION IN A WRITTEN STATEMENT

To: Ms Emma Hart

Of: c/- Mr Paul Lack, Crown Law, by email to

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

YOU MUST COMPLY WITH THIS REQUIREMENT BY:

Giving a written statement prepared either in affidavit form or verified as a statutory declaration under the *Oaths Act 1867* to the Commission on or before **9:00am, Wednesday 27 January 2016**, by delivering it to the Commission at Level 10, 179 North Quay, Brisbane.

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

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

DATED this 18th **day of** January **2016**

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

SCHEDULE

1. What are Ms Hart's current professional role/s, qualifications and memberships? Please provide a copy of Ms Hart's most recent curriculum vitae.

2.

a.

b.

c.

d.

e.

3.

a.

b.

c.

d.

e.

4.

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

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

Emma Hart

Objective

To be a transformational leader who crafts innovative strategies to harness challenges, and develop and lead successful teams to deliver strategic and operational outcomes.

To facilitate growth and development in the Mental Health Nursing Profession, and create a centre of learning and excellence.

Main Achievements

Awarded Mental Health Service Group Team of the Year 2015

Developing an innovative model of care that includes both inpatient and day services co located in the AIUDS facility

Member of the Child and Youth Mental Health Service Mobile Family therapy Team

Representing the MHSG at the Consumer and Carer Participation Committee

A member of the Working Party involved in developing the new MOSD post closing of The Barrett Adolescent Unit

A Member of the working party to develop the Statewide Admission Pathway for Children and Adolescents with Eating Disorders

A Member of the Working Party to develop the Statewide MOSD for Children and Adolescent Day Program

A Member of the Working Party to develop the Statewide MOSD for Children and Adolescent Acute Inpatient Unit

A member of the Working Party to develop the Referral and Admission to Children and Adolescent Inpatient Unit Guideline document

Implementing a Quality Meeting in AIUDS and a quality improvement culture in AIUDS

Awarded Gold and Silver CIMHA Outcomes Challenge awards

Through strong leadership using Transformational Leadership style and good conflict management I have developed a cohesive team environment that is able to deliver high quality Mental Health Care to young people from a diverse geographical area and diagnostic group.

Meet our ambulatory KPI target averaging at 350%

Lead Sponsor of the 'Governance' workstream in the Mental Health Service Group Project

Education

Certificate in Nursing (RN)	Princess Alexandra Hospital	1993

Emma Hart

Certificate in Psychiatric Nursing Wolston Park Hospital 1995

Credentialed Mental Health Nurse

Employment History

Current Employment

March 2015 – Current

Acting Program Manager/Nursing Director Rural, Remote, Indigenous, Child and Young Adult Services.

Operational Management of nine Community Mental Health Teams in both Rural and Remote settings and Child and Youth Mental Health and the AIUDS.

Operational Management of Indigenous Mental Health Services – Writing the MOSD for Mental Health Case Managers to work within the Aboriginal and Torres Straight Community Health Service.

Member of the Mental Health Service Group Executive

Chair of the Child and Youth Mental Health Working Group

Lead Governance change through Mental Health Improvement Plan – responsibilities include redesign of committee structure, review of MH operational structure, review Policy and Procedure maintenance.

Nurse Unit Manager
Adolescent Inpatient Unit and Day Service
Mental Health Service Group
Hospital and Health Service
March 2012 – Current

Main Responsibilities

- Manage initial Capitol Works of the Josephine Sailor Building and ongoing Building Manager
- Develop the Model of Care in line with the Statewide MOSD for both Inpatient Unit and Day Program
- Initial Employment of the complete Multidisciplinary Team including OSO and Administration Officer, Allied Health and Nursing Staff and ongoing HR Management off all staff.
- Identify, establish and maintain relationships with CYMHS Teams across
- Establish relationships with local stakeholders including NGO's, Paediatric Ward, Adult Acute Mental Health Services, and Allied Health Services in The Hospital.
- Assume financial management accountability for the AIUDS
- Manage equitable access to AIUDS beds and Day program places for
- Monitor and report on audits and KPI's
- Implement a culture that embraces the Quality Cycle in the AIUDS and meets all requirements of the National Mental Health Standards and National Safety and Quality Health Services Standards
- Provide strong leadership in implementing a culture that embraces Patient Centered Care and The Tidal Recovery Model across AIUDS
- Participate in HEAPS, RCA's and managing local risk
- Provide leadership in developing a culture of eliminating Seclusion and Restraint
- Providing an environment that embraces diversity and 'out of the box' thinking.
- Encouraging the Clinicians on the team to work to their Professional Discipline and to support clinicians to respect each area of expertise.

Emma Hart

- Implement ongoing specific training for AIUDS staff in house that includes Trauma Informed Care, Group Therapy, Tidal Model, Person Centred Care
- A member of the Child and Youth Mental Health Working Group

Previous Employment

Clinical Nurse Consultant / Team Leader
Adolescent Inpatient Unit and Day Service
Institute of Mental Health Services
June 2011 – March 2012

Registered Nurse – Part Time
Acute Mental Health Unit
Institute of Mental Health Services
October 2006 – June 2011

Clinical Nurse Consultant - CL
Mater Child and Youth Mental Health Service
Mater Health Services South Brisbane
September 2001 – September 2006

Clinical Nurse/Acting CNC
Mater Child and Youth Mental Health Service
Mater Health Services South Brisbane
September 1997 – September 2001

Acting Clinical Nurse
Mater Child and Youth Mental Health Service
Mater Health Services South Brisbane
June1997 – September 1997

Registered Nurse
Paediatric Medical Ward
Mater Children's Hospital South Brisbane
April 1997 – June 1997

Registered Nurse
Surgical Ward
Alice Springs Hospital
November 1996 – February 1997

Registered Nurse
Mental Health Unit
General Hospital
October 1995 – November 1996

Emma Hart

Professional Development

Seclusion and Restraint Reduction Forum 2015

SPUR Training 2015

EDOS Inpatient Training 2015

2 Day Open Dialogue Workshop 2014 with Jaakko Seikkula

Spectra Borderline PD training 2014

Hospital and Health Service Fraud Training 2013

Hospital and Health Service Financial Management Training 2013

Hospital and Health Service BPF Training 2013

Supervision of supervisors Workshop 2013

Research Paper

Maintaining Therapeutic Relationships in Paediatric Nursing 2003
Dr Phillip Darbyshire, Prahba Ramatlu and Emma Hart

Presentations

1998 Queensland Paediatric and Child Health Nursing Conference - Brisbane
Relaxation for Children - Workshop
Emma Hart and Desiree Meredith

2000 Association of Paediatric and Child Health Nursing Conference - Perth
Role of the Child and Youth Mental Health Nurse - Poster Presentation
Emma Hart and Desiree Meredith

2001 Association of Paediatric and Child Health Nursing Conference - Brisbane
Therapeutic Nurse Patient Relationships in the Paediatric Setting - Paper Presentation
Emma Hart and Katie Walker

2002 Association of Paediatric and Child Health Nursing Conference - Sydney
Maintaining Boundaries in Paediatric Nursing - Plenary Presentation
Emma Hart and Margaret Murphy

2003 Royal Australian and New Zealand College of Psychiatrists Conference - Hobart

Emma Hart

Somatoform Disorder In Children - Research Paper
Emma Hart, Christine Dyer, Dr Sue Wilson.

Professional Organisations

Member of the Australia College of Mental Health Nurses

Referees

Cara McCormack
A/Service Group Director
MHSG

John Baird
Nursing Director/Program manager Rehab
MHSG

Queensland Government

[redacted] HOSPITAL AND HEALTH SERVICE

Outstanding People – Genuine Care – Incredible Location

Role Description

Job ad reference:	Recruitment to Enter
Role title:	Nurse Unit Manager
Status:	Permanent full-time *(Please note: future vacancies of a permanent, temporary, full-time and part-time nature may also be filled through this recruitment process.)*
Unit/Branch:	Adolescent Inpatient Unit and Day Service
Division/Hospital and Health Service:	Mental Health Service Group [redacted] Hospital and Health Service
Location:	[redacted] Health Campus *Please note, appointments to future vacancies at other locations across the* [redacted]
Classification level:	Nursing Grade 7
Salary level:	
Closing date:	Recruitment to Enter (Applications will remain current for 12 months)
Contact:	Emma Hart
Telephone:	[redacted]
Online applications:	******Applicants are to apply online****** To apply or download an application kit visit: www.smartjobs.qld.gov.au *(If you are unable to apply online, please contact Recruitment Services on telephone number (07) 4750 6776).*

About our organisation

Queensland Health's purpose is to provide safe, sustainable, efficient, quality and responsive health services for all Queenslanders. Our behaviour is guided by Queensland Health's commitment to high levels of ethics and integrity and the following **five core values**:

- **Caring for people:** We will show due regard for the contribution and diversity of all staff and treat all patients and consumers, carers and their families with professionalism and respect.
- **Leadership:** We will exercise leadership in the delivery of health services and in the broader health system by communicating vision, aligning strategy with delivering outcomes, taking responsibility, supporting appropriate governance and demonstrating commitment and consideration for people.
- **Partnership:** Working collaboratively and respectfully with other service providers and partners is fundamental to our success.
- **Accountability, efficiency and effectiveness:** We will measure and communicate our performance to the community and governments. We will use this information to inform ways to improve our services and manage public resources effectively, efficiently and economically.
- **Innovation:** We value creativity. We are open to new ideas and different approaches and seek to continually improve our services through our contributions to, and support of, evidence, innovation and research.

Purpose

- The Nurse Unit Manager is a Registered Nurse who operationally leads, manages and is the single point of accountability for operational matters within the Adolescent In-Patient Day Services Inpatient (AIDUS) Unit.

- The position reports to the Program Manager Rural, Remote & Indigenous & Child Youth Mental Health Services (CYMHS) / Assistant Director Allied Health and the Clinical Director – AIUDS.

Your key responsibilities

- Fulfil the responsibilities of this role in accordance with Queensland Health's core values, and those of the Hospital and Health Service (HHS) as outlined.
- All employees with the Hospital and Health Service are required to take reasonable care for their own health and safety, including carrying out work in accordance with prescribed practices and procedures and in a manner that will not create health and safety hazards for either the employee or others in the workplace.
- This position promotes links with the Australian College of Mental Health Nurses (ACMHN) and ensures the maintenance of the ACMHN Standards of Practice for Australian Mental Health Nurses 2010. Ensures practice of self and others is in accordance with the code of ethics, professional standards and legislations affecting all clinical practice by maintaining a contemporary knowledge of Mental Health service delivery and relevant professional standards.
- Maintains own active clinical supervision, supervision of others and in collaboration with the relevant professional seniors ensures that all team members are receiving clinical supervision.
- To embed productive working relationships within the Multidisciplinary Team (MDT) of the unit and the Adolescent Inpatient Unit and Day Service and across other programs within the Mental Health Service Group so as to provide a therapeutic environment which conveys hope, optimism and a belief in recovery to consumers, their family and/or carers and the wider community.
- To provide leadership to the team in the implementation and provision of a services congruent with the State-wide Model of Service Delivery Framework for Mental Health Services.
- To ensure that the team environment fosters and supports the MHSG vision and values and that when there are issues to be discussed or raised that these are undertaken in an environment that is respectful and courteous to all individuals.
- Develops, implements and maintains a set of clinical & operational performance indicators for the service that are congruent with the Mental Health Service Group goals and strategic direction.
- To ensure that the Mental Health Act's operational and reporting requirements are adhered to and that data bases such as CIMHA are maintained and actively utilised for care planning.
- To ensure that Occupational Health and Safety requirements relating to legislations, team members, the work environment and service delivery are adhered to and that when incidents do occur that these are monitored, analysed, reported upon and recommendations are acted on appropriately where necessary.
- In consultation and collaboration with the clinical director and program manager of the unit works to ensure that clinical service delivery is congruent with the organisations' and consumer/carers expectations.
- In collaboration with the relevant professional seniors, ensures service delivery and practices are supported by an evidence-based learning environment and by participating in learning activities/opportunities for self and others.
- Ensures appropriate nursing resource allocation through utilisation of the Business Planning Framework.
- Provides oversight and coordination of referral, admission, care planning and discharge processes within the Adolescent Inpatient Unit and Day Program.
- Establish and maintain working relationships with key stakeholders throughout to ensure the needs of the Young People are met.

Qualifications/Professional registration/Other requirements

- Registration with APHRA as a registered nurse and possession of a current practising certificate
- Possession of relevant post-registration and/or tertiary qualifications in mental health nursing would be well regarded for a position at this level.
- Eligibility for credentialed status with the Australian College of Mental Health Nurses is expected for this position.
- Appointment as an Authorised Mental Health Practitioner under the Mental Health Act 2000 is expected for this position within 3 months of commencement..
- Appointment to this position requires proof of qualification and registration or membership with the appropriate registration authority or association. Certified copies of the required information must be provided to the appropriate supervisor/manager prior to commencement of clinical duties.
- Health Care Workers in Queensland Health whose occupation poses a potential risk of exposure to blood or body fluids must be immunised against Hepatitis B according to the National Health and Medical Research Council Australian Immunisation Handbook and the Queensland Health Infection Control Guidelines.

Are you the right person for the job?

You will be assessed on your ability to demonstrate the following key attributes. Within the context of the responsibilities described above, the ideal applicant will be someone who can demonstrate the following:

Clinical expertise
You will have an understanding of the Queensland Public Mental Health Services (QPMHS) Models of Service Delivery framework and how these models guide Mental Health service delivery within a Multidisciplinary Team setting. Within your scope of practice you will take on a caseload whilst having the co-ordination point of accountability for the day to day activity of diverse groups of Nursing and Allied Health professionals. This will be under the direction of and in consultation with the appropriate Clinical Director and Program Manager.

Supports strategic direction
You will be aware of the Vision, Mission and Objectives of the Institute of Mental Health Services and be able to communicate about and follow the direction provided by your supervisor whilst recognising how your own work contributes to the implementation of the overall organisational goals, strategies and work plans within the team. You will show an ability to contribute to the development of work plans and identify issues that may impact on your own work objectives whilst being able to think laterally, identify and implement work practices.

Achieves results
You will draw upon your own clinical expertise and in combination with the collaborative input of your professional colleagues help to maximise the team's potential capabilities in a transparent, safe and effective manner. You will with your team be able to collaboratively plan tasks and implement business plans with measurable milestones, be adaptable to a changing environment and be able to work within agreed time frames. Your work will demonstrate a commitment to achieving quality outcomes and will adhere to documentation and procedural guidelines.

Supports productive working relationships
You will show an ability to build and sustain positive relationships with team members and clients by actively participating in teamwork and activities in a transparent manner and under the direction of your program manager / clinical director. You will actively listen to colleagues and clients ensuring that information is shared and that others are kept informed of issues.

Displays personal drive and integrity
You will be expected to evidence and uphold the Institutes values in your everyday actions as well as adhering to the Code of Conduct to consistently behave in an honest, ethical and professional way. You will treat people fairly and equitably being transparent in dealings with them. You will listen when your ideas are challenged, provide accurate advice to colleagues, take responsibility for one's own actions and decisions and learn from mistakes. You will always seek advice from your supervisor whenever uncertain.

Communicates with influence
Your communication both written and verbal will be clear, focusing on key points succinctly and delivered with confidence. You will have the ability to understand your audience and tailor communication style and the message accordingly. Your thoughts and discussion will be portrayed and conducted with credibility and respect to all without getting personal or aggressive, by listening to, considering and acknowledging differing ideas.

Occupational health and safety
You shall, for your team be the central accountable point for issues related to Occupational Health and Safety as well as ensuring that the workplace environment and workflow issues are compliant with the relevant legislation, policies and guidelines. You will be responsible for the maintenance of workplace process and reporting requirements including Incident Reporting and PRIME. You will be responsible for ensuring that team members are conversant and compliant with their Occupational Health & Safety mandatory training requirements as well as overseeing analysis and reporting of incidents in the prescribed format.

How to apply
Please provide the following information to the panel to assess your suitability:

- **A short response** (maximum 1–2 pages) on how your experience, abilities and knowledge would enable you to achieve the key responsibilities and meet the key attributes.
- **Your current CV or resume, including referees.** Applicants must seek approval prior to nominating a person as a referee. Referees should have a thorough knowledge of your work performance and conduct, and it is preferable to include your current/immediate past supervisor. By providing the names and contact details of your referee/s you consent for these people to be contacted by the selection panel. If you do not wish for a referee to be contacted, please indicate this on your resume and contact the selection panel chair to discuss.

About the Hospital and Health Service

We have **five core values** that guide our behaviour:

Integrity
- Being open and transparent in dealing with our 'community'.
- Being honest, just, reasonable and ethical.
- Having the courage to act ethically in the face of opposition.

Compassion
- Taking time to show we care for our 'community', each other and those in need by being non-judgemental and responsive.
- Showing empathy and humility in order to make a difference.
- We will show due regard for the contribution and diversity of all staff and treat all patients and consumers, carers and their families with professionalism and respect.

Accountability
- Being responsible for our own actions and behaviours.
- Use and manage resources responsibly, efficiently and effectively.
- Promoting excellence, innovation and continual improvement.
- Developing the skills, knowledge and capability of all staff.
- Promoting safety and wellness of staff, patients and their families.

Respect
- Recognising individual needs, listening to others and understanding their differences.
- Showing tolerance, treating others as equals and acknowledging their worth.
- Valuing and honouring diversity.

Engagement
- Collaborating with patients and their families, health care providers, research and education institutions, government and the community.
- Involving community, clinicians and colleagues in meaningful ways.
- Listening to and considering ideas and concerns of others in decision making processes.

The Work Unit

The Adolescent Inpatient Unit and Day Service

The inpatient unit is an acute care adolescent mental health unit with a capacity of 8 beds. The unit is staffed 24 hours a day 7 days a week and provides for planned and emergency admissions. The unit accepts admissions from across the whole of the Northern Region.

The target population is 12-18 year olds with mental illness who are not able to be treated adequately in the community because of the complexity or acuity of their needs.

The Day Service Program is considered an important component on the continuum of care for young people with moderate to severe mental health issues. The Program provides multdisciplinary assessment and treatment for adolescents with mental illness who are unable to be treated as outpatients via the usual CYMHS because of complexity or acuity. The programme will able to accommodate up to 12 places and will work in conjunction with Education Queensland.

Visit the Hospital and Health Service website: - *www.health.qld.gov.au/townsville*

Model of nursing care

The model of care for nursing services in Hospital and Health Service is focused on patient/client care, and is based on a continuum of care model. Nurses function as equal members within a multidisciplinary team and are committed to advocating on behalf of patients/clients.

Nurses will provide total patient care within a professional partnership model, which is based on:

- Nurses working "together" to provide optimal patient outcomes.
- Support and development of all nurses including facilitating preceptorship for RN and EN transition programs.
- Creating a learning environment.
- Supporting the Hospital and Health Service novice to expert Skills Performance Framework.
- Maximising the clinical skills of all registered and enrolled nurses by a working partnership.
- Facilitating succession planning opportunities for nurses.

Visit the Health Service website: - www.health.qld.gov.au/

Smoke-Free Campus
In line with the Government's goal of smoke-free health facilities, the Hospital and Health Service is working towards smoke-free status at each health campus. We are happy to support our staff, patients and clients in quitting and proud to offer our visitors a smoke-free environment to help improve health outcomes for Queenslanders. All successful applicants to a facility that is smoke-free will need to adhere to the relevant requirements of the smoke-free environment.

Pre-employment screening
Pre-employment screening, including criminal history and discipline history checks, may be undertaken on persons recommended for employment. The recommended applicant will be required to disclose any serious disciplinary action taken against them in public sector employment. In addition, any factors which could prevent the recommended applicant complying with the requirements of the role are to be declared.

Roles providing health, counselling and support services mainly to children will require a Blue Card. Please refer to the Information Package for Applicants for details of employment screening and other employment requirements.

Health professional roles involving delivery of health services to children and youth
All relevant health professionals (including registered nurses and medical officers) who in the course of their duties formulate a reasonable suspicion that a child or youth has been abused or neglected in their home/community environment, have a legislative and a duty of care obligation to immediately report such concerns to Child Safety Services, Department of Communities.
All relevant health professionals are also responsible for the maintenance of their level of capability in the provision of health care and their reporting obligations in this regard.

Salary packaging
To find out whether or not your work unit is eligible for the Public Hospital Fringe Benefits Tax (FBT) Exemption Cap please refer to the Salary Packaging Information Booklet for Queensland Health employees available from the Queensland Health Salary Packaging Bureau Service Provider – RemServ at http://www.remserv.com.au. For further queries regarding salary packaging RemServ's Customer Care Centre may be contacted via telephone on 1300 30 40 10.

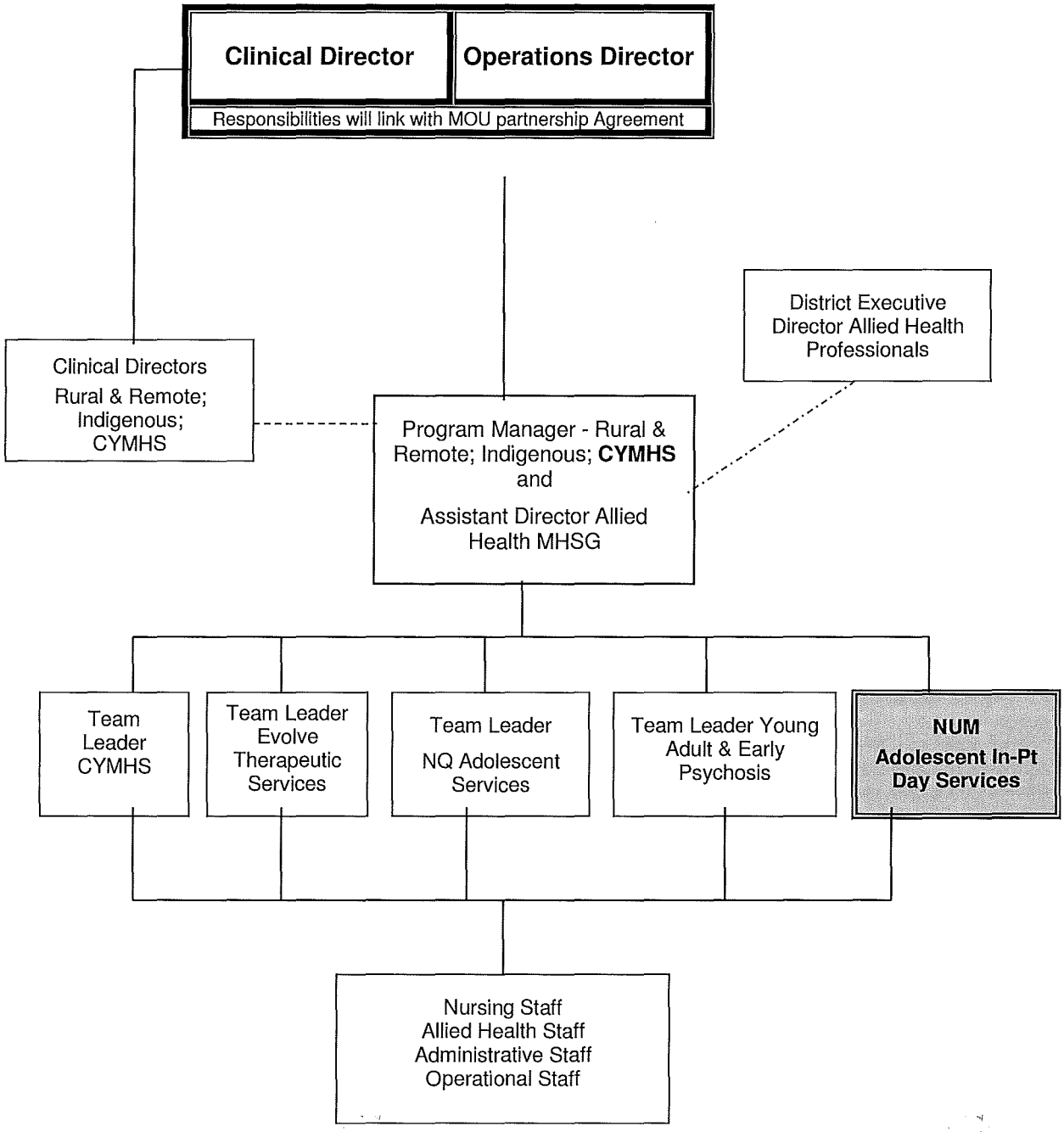
Disclosure of previous employment as a lobbyist
Applicants will be required to give a statement of their employment as a lobbyist within one (1) month of taking up the appointment. Details are available at
http://www.psc.qld.gov.au/library/document/policy/lobbyist-disclosure-policy.pdf

Probation
Employees who are permanently appointed to Queensland Health may be required to undertake a period of probation appropriate to the appointment. For further information, refer to Probation HR Policy B2
http://www.health.qld.gov.au/hrpolicies/resourcing/b_2.pdf

Pre-existing illness or injury
Applicants may be required to disclose any pre-existing illness or injury which may impact on their ability to perform the role. Details are available in section 571 of the *Workers' Compensation and Rehabilitation Act 2003* (http://www.justice.qld.gov.au/fair-and-safe-work/workers-compensation-and-rehabilitation/workers-compensation-and-rehabilitation-legislation/workers-compensation-and-rehabilitation-act-2003)

ORGANISATIONAL CHART

Organisational Chart – Adolescent Day In-Patient Services – Mental Health Services Group



Queensland Government

[redacted] Hospital & Health Service – Mental Health Service Group

Health Service Chief Operating Officer

MENTAL HEALTH SERVICE GROUP DIRECTOR (MHSG)

MENTAL HEALTH SERVICE GROUP MEDICAL DIRECTOR

Medical Services
- Clinical Directors
- Consultant Psychiatrists
- Psychiatric Registrars
- RMOs

PROGRAM MANAGER ATODS & SPECIALIST SERVICES / DIRECTOR ALLIED HEALTH

Specialist Services

Specialist Clinics
- Perinatal MH
- Dementia and Memory Disorders
- Recovery from Psychosis
- Mood
- Neuropsychiatry
- Personal Disorders Assessment
- Intellectual & Development Disability
- Psychotherapy
- Eating Disorders

Community Forensic MH
- Prison MH
- Community Forensic Outreach Service
- Court Liaison
- Forensic Liaison

Consultation Liaison & Resource
- Consultation Liaison Psychiatry
- Multicultural Coordinator
- Dual Diagnosis
- MH Intervention / Intellectual Disability
- Perinatal MH Coord
- Service Integration Coordinator
- Primary Care Liaison
- Psychology Services

Alcohol, Tobacco & Other Drugs Services

North Ward
- Intake Services
- Assessment and Counselling Services
- Opioid Treatment Program
- Health Promotion Team
- Needle & Syringe Program
- TTH Consultation Liaison
- Rural Outreach Services
- [redacted]
- Diversion and Recovery Team (DART)
- Withdrawal and Opiate Induction Services
- Youth Team
- Palm Island Team

PROGRAM MANAGER ADULT MENTAL HEALTH SERVICE / NURSING DIRECTOR

Adult Mental Health Services
- Homeless Health Outreach Team (HHOT)
- Acute Care Team
- [redacted] Community Care Team
- North Ward Community Care Team
- Adult Acute MH Inpatient Unit

PROGRAM MANAGER RURAL, REMOTE & INDIGENOUS MENTAL HEALTH SERVICES & CAYAS/ ASSISTANT DIRECTOR ALLIED HEALTH

Rural, Remote & Indigenous Mental Health Service (RRIMHS)
- MH Worker Coordinator
- [redacted]

Child, Adolescent & Young Adult Service
- Child & Youth MH Service (CYMHS)
- EVOLVE Therapeutic Services
- [redacted]
  - MH Youth Detention
  - C&Y Forensic Outreach
  - Court Liaison
- Young Peoples Early Intervention Team (yPEIT)
- Josephine Sailor Adolescent Inpatient Unit & Day Service
- Assertive Mobile Youth Outreach Service (AMYOS)

PROGRAM MANAGER REHABILITATION MENTAL HEALTH SERVICE / NURSING DIRECTOR

Rehabilitation Mental Health Services
- [redacted] Community Care Unit
- Acquired Brain Injury MH Unit (including Neuropsychiatry)
- Secure Mental Health Rehabilitation Unit
- [redacted] Rehabilitation Unit
- Mobile Intensive Rehabilitation Team (MIRT)

PROGRAM MANAGER SAFETY, EDUCATION, RISK AND QUALITY UNIT

Safety, Education, Risk & Quality Unit
- Quality Coordinator
- Patient Safety/ Suicide Prevention Officer
- MH Act Administration
- Information Management Team
- Communication & Marketing
- Staff Education Unit
- Consumer, Carer & Family Participation Team, Consumer Companions
- Research Coordinator
- Operational Services

BUSINESS SERVICES MANAGER BUSINESS SUPPORT UNIT

Business Support Unit
- Finance & Activity
- Service Group Administrative Support Teams
- Records Management

WORKFORCE HUMAN RESOURCES UNIT

Human Resources Unit

Workforce Advisor

Service Group Administrative Support

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PROPOSED Statewide Adolescent Mental Health Extended Treatment and Rehabilitation Service Continuum

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

Step Up to Acute Inpatient Care (out of scope)					
Service Element	**Assertive Community Treatment Service**	**Day Program**	**Step Up/Step Down Unit**	**Subacute Bed-Based Unit**	**Residential Rehab Unit**
Overview	Provides ongoing recovery-oriented assessment, assertive treatment, and care through intensive mobile interventions in a community or residential setting.	Provides a flexible range of intensive therapy, extended treatment and rehabilitation options within a therapeutic milieu.	Provides short term residential treatment with services from specialist trained mental health staff with NGO support.	Provides medium term intensive hospital-based treatment and rehabilitation services in a secure, safe, structured environment.	Provides long term accommodation and recovery-oriented treatment with inreach services from specialist trained mental health staff with NGO support.
Primary Referral	CYMHS	CYMHS	CYMHS / Acute Inpatient Unit	Statewide Admission Panel	CYMHS or Adult Mental Health Services
Profile	Supportive intensive services required out of hours. No fixed address or living in residential accommodation. High risk of disengagement from treatment services. Absence of bed-based or day program options in local community.	Home environment is supportive enough to ensure safety and/or access to CYMHS. Does not require inpatient care. History of school exclusion or refusal. Poor social skills requiring group-based work. Live within a geographical area in proximity to the day program.	Young person requires increased intensity of treatment to prevent admission into acute inpatient units (Step Up). Enables early discharge from acute/sub-acute inpatient units (Step Down). Safety not ensured at home. Does not allow for involuntary detention as not gazetted MH facility.	Level of acuity or risk requires inpatient admission. Improvement in mental health not expected to occur within short term: measured in weeks/months. Requires therapeutic milieu not provided by acute inpatient unit. Allows for involuntary detention.	16-21 year olds who are able to consent to treatment (Gillick competent). Home environment is not supportive enough to ensure safety and/or facilitate access to mental health services. Requires additional support to develop independent living skills. Does not require inpatient care.
Hours of Operation	Flexible, with capacity for extended hours	Business hours, Monday to Friday, with capacity for some extended hours.	24 x 7	24 x 7	Mental Health: Flexible, with capacity for extended hours. Residential: up to 24 x 7
Length of Stay	Case-by-case basis	120 days; maximum of 180 days	28 days	120 days; maximum of 180 days	Up to 365 days
Unit Size	Minimum 2 staff per service	10-15 adolescents per day	12-14 beds	8-10 beds; seclusion room	10 beds
Education Options	Support local schooling	In-reach; on-site; Distance Education and/or support local schooling	In-reach; Distance Education and/or support local schooling	On-site and/or Distance Education	Support local schooling
Location	Community CYMHS	Hospital campus or gazetted community mental health facility	Residential area located close to an acute mental health unit	Hospital campus	Residential area
Governance	Local. Some with CHQ HHS oversight	Local HHS	Local HHS with CHQ HHS Oversight	CHQ HHS	Local HHS with CHQ HHS Oversight NGO operated
Existing in Qld	Nil	Mater; Toowoomba; Townsville	Nil	Nil	Nil
Proposed sites with implementation taking place over 4 years, subject to funding* **	North Brisbane Logan Redcliffe-Caboolture Toowoomba Bundaberg/Wide Bay Mackay Cairns Central West Qld South Brisbane Gold Coast Ipswich Sunshine Coast Rockhampton Townsville Mt Isa South West Qld	North Brisbane (critical) South Brisbane (Logan) Gold Coast	North Brisbane South Brisbane North Qld [Dependent upon NGO sector appetite; provider agnostic]	1 BBU in CHQ catchment	Cluster based (North/Central/Southern) [Dependent upon NGO sector appetite; provider agnostic]
Evidence-Informed	Intensive Mobile Youth Outreach Services (IMYOS), Victoria Mobile Intensive Team (Adult), Qld Wraparound System of Care	Existing Qld Day Programs – endorsed state-wide Model of Service Adolescent Drug and Alcohol Withdrawal Service (ADAWS)	Y-PARC, Frankston and Dandenong, Victoria	Walker Unit, Concorde Hospital, NSW	Time Out House Initiative (TOHI), Cairns Therapeutic Residentials (DCCSDS) Victorian Youth Residential Models, Nous Group Report Evaluation of the Therapeutic Residential Care Pilot Program, VERSO (2011)
Underpinned by Community CYMHS (out of scope)**					

* Age range includes all young people completing high school

*** A phased approach to service implementation is under development.

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

Case Scenarios

SW AETR Service Options Implementation Working Group Consolidated Responses from Consumers and Carers

Case Scenario 1 - Ritchie

- Male aged 17years 1month
- Living in rental home with single mother and sister who is 10 years old
- Presenting problem: self harm, moderate to severe depression, severe generalised anxiety, limited social system, daily marijuana use, no school attendance for the last 2 years
- Significant life events: long term parental domestic violence, father left family 3 years ago and limited ongoing contact with children
- Two brief acute adolescent inpatient admissions over last 4 years – partial but short-term symptom resolution post discharge; difficulty reintegrating to home following acute admissions
- Sporadic Child and Youth Mental Health community outpatient treatment episodes of care – now refusing to attend

Response 1:
How you would like to be treated?

- As the mum I would really want someone to understand how tough my life has been and how worried I am about my son. I would probably be worried about my daughter and what influence her brother might be having. I have obviously tried to get help in the past but it hasn't worked because of numerous other stresses and now the problem seems entrenched. I want someone to work with the family and offer my son some hope for his future. I probably don't have transport or money to be spending on extra petrol so services need to be locally available or capable of coming to me. I don't want a lot of strangers in my life!!

What continuum of service do you believe is necessary?

- I really feel he needs some intervention promptly but he isn't going to want it. Therefore I think he needs a worker with experience, commitment and a degree of perseverance ready for the long journey and not a quick fix. I think the lad should be invited to set his own goals and priorities of what he thinks will benefit him. Start small and build some successes.
- Respite options and Counselling for mum/Support through COPMI for the daughter/
- Male role modelling for the lad as well as some education around drugs
- Relationships Australia could have a role
- Carers Queensland for mum/ ARAFMI run some good courses workshops but getting there may be difficult
- Centre link check to see all options are being delivered to the family
- Counselling for depression maybe a GP to work with who bulk bills
- Future discussion round TAFE options/employment pathways

What type of follow up would you prefer?

- At first some home visiting to meet the family and set some goals driven by them. Then move towards meeting the lad away from home and engaging in some activity while talking about the problem.
- Exploring vocational options/certificate courses/ Attend TAFE with him to make inquiries
- Ask for a disability support person to assist with study at TAFE

What type of information would you want to receive during treatment?

- Treatment plan signed off with joint goals and options
- Education about self -harm for mum and daughter and how best to respond

- Medication information if needed/Diary for lad to record medication to encourage some independence
- Names of people and organisations clearly recorded who are involved in this case
- Contact details for emergencies/crisis
- Social contacts investigated e.g. interests/hobbies/sport/music/ Volunteering
- Keep mum informed about progress and set backs and how to cope

Response 2:

How would you like to be treated?

- As a carer, the significant challenge is to ensure that his sister, aged 10 years, is able to develop socially and educationally in an environment where her brother has disengaged from education and has effectively removed himself from available health care.
- The challenge with regard to Ritchie himself is that time is running out to some extent as Ritchie is less than one year away from being an adult after which time possible influence on his conduct and activities will severely diminish.
- The number and seriousness of Ritchie's presenting problems possibly overwhelm the carer. There would be an enormous temptation for the carer to resign herself to it all "being too hard" and merely wait for Ritchie to become an adult when, to a certain extent, he becomes responsible for his own problems. However Ritchie needs care now and the carer requires support.
- As it is relatively clear that Ritchie has disengaged himself from the health services with regard to his treatment, the support needed is to assist Ritchie in accessing treatment on a regular basis.
- Being a single mother in a rental home it is possible that finances in the household may be stretched for the carer. In this sense actually getting Ritchie to attend outpatient services may be a challenge and the carer could do with the support of volunteer organisations that might be able to arrange travel for Ritchie to his appointments.

What continuum of service do you believe is necessary?

- The immediate service that Ritchie requires is to re-engage with outpatient treatment. If he is refusing to attend, then there may be the possibility for a social worker to come and collect Ritchie for the appointments or for the social worker to organise the volunteer organisation to provide transport as noted above.
- Further inpatient admissions would appear to be unlikely to have any long-term benefit in that there has previously been only short-term resolution of symptoms post-discharge. This may be due to many reasons including perhaps the difficulty in reintegrating him into the home following the acute admissions.

What type of follow up would you prefer?

- It should be evident to the health service that Ritchie is not attending scheduled outpatient appointments. As his mother, the carer is possibly having less and less influence on Ritchie's day-to-day behaviour and no amount of encouragement by her would possibly be successful in getting Ritchie to resume his outpatient appointments.
- In this environment the follow-up required would be for a representative of the health service to contact Ritchie directly with a view to attempting to encourage him to recommence his outpatient appointments.

What type of information would you want to receive during treatment?

- Ritchie's presenting problems are so significant that any improvement in one area may possibly go unnoticed. Should Ritchie recommence outpatient appointments, it would be beneficial for the treating professional each time to attempt to gauge whether or not Ritchie's symptoms are improving in any respect. Follow-up could involve reporting on any such improvement which might create a more positive environment within the family unit to encourage Ritchie to continue his treatment.

Case Scenario 2 - Lucy

- Female aged 15years 6months
- Living in family home with older parents from a high socioeconomic background. Older sister (19years old) and brother (22years old) left home
- Presenting problem: repeated suicidal attempts and ongoing self harm, depression and anxiety, eating disorder not otherwise specified (of anorexia/restrictive type), very poor social system, being home schooled but Lucy is not engaging
- Significant life events: sexual abuse by extended family member from age of 7y to 10y, expelled from 3 schools
- Limited response to several inpatient admissions following suicide attempts
- Reasonable attendance at CYMHS outpatient, but limited improvement in presenting problems
- Some history of attendance at headspace
- Currently on an anti-depressant and compliance is good

Response 1:
How you would like to be treated?

- I am sure Lucy might be feeling quite isolated in her family unit so it would be important to boost her self-confidence and recognise her as an individual. Her parents might be giving up hope as progress has been very slow. It will be important to keep them involved but at the same time respect Lucy's growing need for independence.

What continuum of service do you believe is necessary?

- Get on top of the physical problems of anorexia
- Work with Lucy on coping strategies for stress and anxiety and how to manage her self harming.
- Review medication
- Educate parents about what is going on and why Lucy is responding this way.
- Family meetings with a view to family therapy if needed
- Attempt to move into attending school rather than isolation of home schooling.
- Work on goal setting round social activities

What type of follow up would you prefer?

- Perhaps the family would be happy to work with a private therapist competent in the Maudsley Family method.
- Sexual abuse support Zig Zag??
- Headspace connection might work for Lucy

What type of information would you want to receive during treatment?

- As a parent I would want to know what treatment plan would help my daughter to recover.
- I would also want to know why she was acting the way she was.
- I would need someone who understood my stress to be there for me and give me advice and keep me informed of how she was travelling.
- I would hope my husband would be included and supported too.

Response 2:
How would you like to be treated?

- Lucy's reasonable attendance as an outpatients at CYMHS and a fairly good compliance with medication suggest that, perhaps, she would benefit from more regular contact with outpatient services and the ideal would be for an encouraging and supportive working relationship with, say, a case worker / manager as a familiar point of reference that would lead to not only trust being formed but, hopefully, be a catalyst in building self-esteem and a desire to want to be personally involved in her own health management and future.
- For this to work, Lucy's parents, being her carers, need to be involved in the delivery of the service. Then maybe any residual distrust by Lucy towards her parents concerning the sexual abuse by an

extended family member in her past might be addressed. Any future improved engagement by her parents in Lucy's life may well require exploration of any residual damage from this experience.

What continuum of service do you believe is necessary?

- Due to positive factors such as the patient taking medication regularly / compliantly and there being a reasonable attendance at CYMHS outpatient – this needs to be encouraged as much as possible and recognised. When patients receive positive feedback and acknowledgement of their own efforts it can be an enormous sense of self-pride and a desire to continue doing the right thing.
- The challenge is to ensure that, once removed from the medical services be they as an inpatient or as an outpatient, the contact within the system remains. If the continuum of service is there and maintained there are hopefully fewer admissions to acute wards and, most importantly, the constant awareness of their health and having someone, somewhere to identify with as a positive in this area may ultimately prevent despair that often can result in attempts of suicide.

What type of follow up would you prefer?

- Although perhaps not cost effective, for those less inclined to want to attend outpatients on a regular basis and for those still particularly unwell and in need of support, where necessary home visits may help. Many carers and consumers are so exhausted both pre and post admission that if it is not human contact, be it in person or at least by telephone, used as a follow up then there is not much point in written communication.
- For example, some carers and consumers are not inclined to complete surveys. These are more often than not discarded as being too impersonal and many carers have completed endless surveys in their lives about their child's behaviour and condition.
- The preferred follow up is that of a weekly or fortnightly appointment over a set period of time in order to keep the momentum going. Failing this, a follow-up series of telephone calls would be helpful. These are significant positives for the consumer and carers as they "are not forgotten" once they walk out of the service.
- Many consumers and their support network "fall through the cracks" when they leave intensive support environments and then are left to their own methods of problem-solving. This is the loneliest time for many patients and their families as they struggle to cope alone. This isolation can be a precursor to another possible incident occurring or a general feeling of insecurity.
- Although these services all come at a cost, they may reduce the need for attendance at the Emergency Departments for those desperate for assistance.

What type of information would you want to receive during treatment?

- Information received during all treatments is crucial for both consumers and carers, particularly when consideration is being given for post admission. The information received should encompass:
  (a) likely mood swings or general feeling of well-being
  (b) knowledge of the symptoms to watch for and be able to identify if the patient feels unwell
  (c) what, if any, medication changes have occurred and likely side-effects if applicable. Although a most obvious crucial point for discussion – this is often only spoken about with the consumer and not their support base (e.g. carers)
- In summary, respect and recognition of families as important people providing support to the patient and also as a conduit between the younger consumers and their treating teams is imperative. Good working relationships can impact significantly on patients' care and outcomes.

Response 3:

- Strengthening therapeutic relationship with CYMHS clinician, allowing for clinician to be in best possible position to encourage Lucy to engage with certain services and help her to make other important decisions. If headspace is benefitting Lucy, but she is attending only sporadically, CYMHS clinician attend headspace on 1 or 2 occasions with Lucy to help link her in with support there.
- Due to high socio economic background, possibly be provided with information about private healthcare services which may be able to offer additional support in conjunction with CYMHS and NGO support already being provided.
- Education options discussed with Lucy, however not pushed too hard, as treatment and recovery are incredibly important at this point and too much additional pressure may be counterproductive.

Possibly exploring the option of attending a school or flexible learning centre more for social connection with friends etc than to focus entirely on academic side.

- CYMHS clinician actively involved in Lucy's medication monitoring. I.e. attending psychiatrist appointments with Lucy (assuming it is a CYMHS psych she is seeing) and discussing options with her after psych appointments as she may not feel comfortable discussing directly and openly with psych.

- Lucy to be given clear message that least restrictive method of treatment will always be preferred, however, as she is aware (having been hospitalised after suicide attempts) there is a duty of care, and certain behaviours will result in further action being taken and will be done so against her will if necessary. Talking Lucy through behaviours that she is at risk of, that could lead to involuntary treatment. (This one is very tricky – it MUST be done by a clinician that she feels connected to, and care needs to be taken that it is not done in a threatening manner i.e. – if you do this we are going to put you on an ITO etc. etc. but more of a conversation with her so that she feels she can understand rationale behind actions that have been taken in the past, and that may be taken in the future if/when certain behaviours escalate.) Also giving her alternatives to this happening, i.e. letting her know that she could potentially come into hospital herself if she is feeling like she is suicidal or going to self harm BEFORE she acts, and has the option of a less restrictive, voluntary, short admission to keep her safe. And also if/when she does SI or make a suicide attempt, that she can also have a less restrictive admission if she voluntarily accepts treatment.

Case Scenario 3 - Paul

- Male aged 14years 6months
- Living with father, no siblings
- Presenting problem: aggression towards others, self harm, moderate depression, history of severe bullying at school, sporadic attendance at school in last 2 years, request by both Paul and father to help find 'alternative accommodation' as they cannot live together any longer
- Significant life events: mother died of cancer 5 years ago, father mostly absent due to work commitments, close relationship with grandmother who died 3 years ago
- No inpatient admissions
- Poor engagement in outpatient CYMHS – trouble with transport and parental support to attend
- Has recently begun experimenting with alcohol and marijuana
- Has been charged with shoplifting and two other minor offences over the last 6 months

Response 1:

How you would like to be treated?

- As a father I would want someone to understand how hard it has been and to be nonjudgmental about my parenting. I probably need some support but in a more helpful way. I might then be more open to having my son live with me.

What continuum of service do you believe is necessary?

- Parenting skills for dad
- Conflict resolution for son and dad
- Social connection that they could do together eg hobbies/sport/fishing/bmx
- Psycho education about drugs and alcohol for both parties
- Grief work

What type of follow up would you prefer?

- Someone to do some home visits at first to build a good working relationship and to make it easier to get
- some help
- Educational assistance to reengage son in schooling/ Look at vocational options
- Too young to move out unless totally no hope of improvement in dad son relationship

What type of information would you want to receive during treatment?

- Parenting tasks
- Advice on development and adolescent behaviour
- Role modelling other than dad for son
- Alcohol and drug education
- Strategies to stay calm and in control
- Legal rights for son

Response 2:

How would you like to be treated?

- The presenting problems have so overwhelmed the carer that the apparent only solution is to find alternative accommodation as the father and son can no longer live together. As this is a request by both the father and the son, it would appear that the relationship between them has broken down to perhaps an irretrievable extent.
- However Paul is relatively young at 14 years and 6 months and the father's role in Paul's life needs to be addressed as there is still over three years before Paul becomes an adult. In this time it would be beneficial to have his father's influence in his life and so the challenge for the health service for the father is to ensure that, after Paul is found accommodation elsewhere, the father is still encouraged to play an important role in Paul's developing adolescent years particularly in circumstances where Paul does not have a mother figure in his life.

What continuum of service do you believe is necessary?

- Because of no inpatient admissions recorded in spite of significant life events, along with reported poor engagement in outpatient services, an extended rehabilitation service would be preferable to provide medical and psychological support. Accommodation in an environment that provided this support while teaching the patient both personal and social responsibility would provide security through informative years. Because of his age, housing in care is important.

What type of follow up would you prefer?

- In this scenario, there would be a preference for constant care. With follow-up after discharge being some years away, a strong rehabilitation programme and support network would be off benefit.

What type of information would want to receive during treatment?

- How each of these areas of aggression, self harm, alcohol and marijuana use are being addressed, long term diagnosis, medications prescribed and how to deal with incidents such as self harm etc.

Case Scenario 4 - Mary

- Female aged 16years 7months
- Living with parents and 3 siblings (one older and two younger), low average socioeconomic background
- Presenting problem: aggression towards parents and others, self harm, severe depression, reasonable social system, some psychotic symptoms evident, sporadic attendance at school in last 2 years
- History of poly-substance misuse (marijuana, alcohol, and speed); pre-contemplative about changing
- Significant life events: moved house frequently as a child, history of physical and emotional abuse within family towards all children, father lost job and unemployed since last year
- 1 recent admission to an adult acute inpatient unit for 2 days observation
- Poor engagement in outpatient CYMHS
- Trials of anti-depressants and anti-psychotics have failed mainly due to poor compliance
- Parents are reluctant to have her continue to live at home, and are especially worried about her violent outbursts

Response 1:

How you would like to be treated?

- Acknowledge the difficulties Mary has had to cope with but also respect parent's concerns about her worrying behaviour
- Non blaming environment needs to be fostered but also work on building relationships and conflict management.
- Goal setting with Mary about her future and what her interests are and how she sees her life unfolding
- Check in with Centre link re entitlements but support the interview accompany parents etc if they would like someone to

What continuum of service do you believe is necessary?

- Get medication reviewed and establish some responsibility in Mary to be compliant
- Document her own medication and side effects experienced...involve her more in decision making but keep parents informed as well
- Work on change management program if ready
- Investigate headspace
- Parenting and family work in a non-judgemental way
- Once goals are set work with education options eg TAFE/ senior certificate/ certificates for pre work

What type of follow up would you prefer?

- Mary I think needs to develop some control over her life and be more independent of her parents in a positive mature way.
- Help getting employment or engaging in educational pathway...prepare CV etc
- Parents need some support with parenting tasks build on the family's strengths which have got them this far
- Family work for other siblings

What type of information would you want to receive during treatment?

- Medication information
- Benefits from centre link
- Educational pathways

Response 2:

How would you like to be treated?

- The significant challenge for the carer, assumed to be both father and mother in this instance, is to address the psychotic symptoms evident in Mary's behaviour. Given that medical intervention has failed mainly due to poor compliance, the immediate strategy must revolve around access for Mary to her medication and improving her compliance with taking it.
- Mary is in a situation with a very large number of presenting problems the weight of which perhaps intimidates her carers. The fact that her parents are reluctant to have her continue to live at home is a reasoned response to the fear they may well have of the consequences of a psychotic episode involving the two younger siblings. As there is no short term "fix", the carers in this instance need some idea of what the longer term holds in store for Mary. They may be concerned that, as Mary is only a little over a year away from being an adult, a positive plan for the future is required.
- The carers perhaps would like the health service to engage with them in developing the medium term strategy for Mary's treatment.

What continuum of service do you believe is necessary?

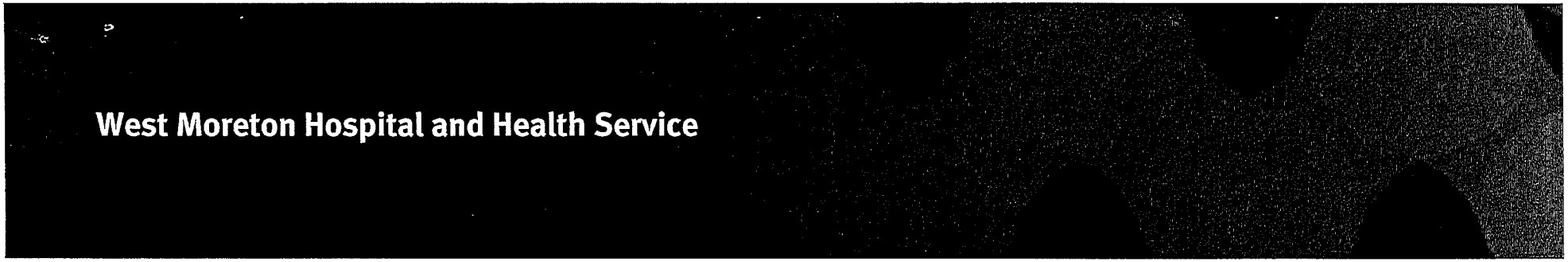
- Mary's poor engagement in outpatient care possibly raises the possibility of a longer admission to an acute inpatient unit in the first instance prior to a rehabilitative phase being commenced. The previous admission was to an adult unit and such may have been inappropriate even though at 16 years and 7 months, Mary is rapidly approaching adulthood. However an inpatient admission to CYMHS would appear to be a viable treatment suggestion.
- Given the history of physical and emotional abuse within the family towards all children, continued care within the family environment is unlikely to assist in improving Mary's symptoms.
- As Mary's home life is significantly challenging and shows little potential for improvement in the short term, Mary particularly requires residential inpatient rehabilitative care. It is not surprising that there is little engagement in outpatient care as it would be obvious to all, especially Mary, that the real problem is not being addressed.

What type of follow up would you prefer?

- The poor engagement in outpatient treatment is the starting point for follow-up in Mary's case. Whatever can be done to firstly encourage Mary to attend and secondly to assist her physical attendance would appear to be strategies worthwhile attempting.
- However with the appropriate care likely to be a residential inpatient rehabilitative facility for Mary, the appropriate follow-up with the carer would be to advise on the possibilities of such and to develop a strategy by which Mary would become eligible for such a facility.

What type of information would you want to receive during treatment?

- The immediate requirement for information during treatment would also involve the steps that are being taken to attempt to have Mary admitted to a residential inpatient rehabilitative facility. If there is some "light at the end of the tunnel" in this respect, Mary's response in other areas such as compliance with her medication and attendance at interim outpatient services might improve.



Expert Clinical Reference Group Recommendations

Barrett Adolescent Strategy

July 2013

Queensland Government

Adolescent Extended Treatment and Rehabilitation Services (AETRS) Recommendations Submitted to the West Moreton Hospital and Health Board

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

ECRG Recommendations	Planning Group Recommendations
a) Further work will be required at a statewide level to translate these concepts into a model of service and to develop implementation and funding plans.	**Accept with the following considerations.** The responsibility for this task at a statewide level sits with the Mental Health Alcohol and Other Drugs Branch and the Children's Health Services. A collaborative partnership is proposed.
b) Formal planning including consultation with stakeholder groups will be required.	**Accept with the following considerations.** This body of work should be incorporated into the statewide planning and implementation process (as above).

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

ECRG Recommendation	Planning Group Recommendation
a) A Tier 3 service should be prioritised to provide extended treatment and rehabilitation for adolescents with severe and persistent mental illness.	**Accept with the following considerations.** Further work is needed to detail the service model for a Tier 3. Models involving a statewide, clinical bed-based service (such as the Barrett Adolescent Centre) are not considered contemporary within the National Mental Health Service Planning Framework *(in draft)*. However, there are alternative bed-based models involving clinical and non-clinical service components (e.g., Y-PARC in Victoria) that can be developed in

ECRG Recommendation	Planning Group Recommendation
	Queensland to meet the requirement of this recommendation. Contestability reforms in Queensland may allow for this service component to be provider agnostic.

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

ECRG Recommendations	Planning Group Recommendations
a) Safe, high quality service provision for adolescents requiring extended treatment and rehabilitation requires a Tier 3 service alternative to be available in a timely manner if BAC is closed.	**Accept.**
b) Interim service provision for current and 'wait list' consumers of BAC while Tier 3 service options are established must prioritise the needs of each of these individuals and their families/carers. 'Wrap-around care' for each individual will be essential.	**Accept with the following considerations.** While this may be a complex process for some consumers and their individual needs, it was noted that this course of action could start immediately, and that it was feasible. The potential to utilise current BAC operational funds (temporarily) to 'wrap-around' each consumer's return to their local community was noted as a significant benefit. The relevant local community should play a lead role in the discharge of the consumer from BAC and their return to home. The local services need to be consulted around their ability to provide 'wrap-around' care.
c) BAC staff (clinical and educational) must receive individual care and case management if BAC closes, and their specialist skill and knowledge must be recognised and maintained.	**Accept.** The ECRG and the Planning Group strongly supported this recommendation.

4. Duration of treatment

ECRG Recommendation	Planning Group Recommendation
a) 'Up to 12 months' has been identified by the ECRG as a reasonable duration of treatment, but it was noted that this depends on the availability of effective step-down services and a suitable community residence for the young person. It is important to note that like all mental health service provision, there will be a range in the duration of admission.	**Accept with the following considerations.** This issue requires further deliberation within the statewide planning process. The duration of treatment needs some parameters to be set, however, this is primarily a clinical issue that is considered on a case-by-case basis by the treating team and the consumer.

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

ECRG Recommendations	Planning Group Recommendations
a) Access to on-site schooling (including suitably qualified educators), is considered essential for Tiers 2 (day programs) and 3. It is the position of the ECRG that a Band 7 Specific Purpose School (provided by Department of Education, Training and Employment) is required for a Tier 3 service.	**Accept with the following considerations.** The Planning Group recommends removing *"Band 7"* from the ECRG recommendation. All educational services need to be evaluated by Department of Education, Training and Employment (DETE) on a case-by-case basis, taking into consideration service model, location, student numbers and complexity. The Planning Group supports the statement that educational resources are essential to adolescent extended treatment and rehabilitation services. The Planning Group recommends consultation with DETE once a statewide model is finalised.

ECRG Recommendations	Planning Group Recommendations
b) As an aside, consideration should also be given to the establishment of a multi-site, statewide education service for children/adolescents in acute units (hub and spoke model).	**Accept with the following consideration.** The Planning Group recommends this statement should be changed to read as: Strong consideration should be given to the establishment of a multi-site, statewide education service for children/adolescents in acute units (hub and spoke model).

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

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

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

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

7

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Meeting Agenda

Statewide Adolescent Extended Treatment and Rehabilitation Service Options Implementation Working Group Forum

Date:	Tuesday 1st October
Time:	10.30am to 3.00pm
Venue:	Training Room 1, Ground Floor, 15 Butterfield Street, Herston

Chair:	Leanne Geppert	Director Strategy, Mental Health and Specialised Services, West Moreton, HHS
Secretariat:	Ingrid Adamson	Project Manager SW AETRS, Office of Strategy Management, CHQ HHS
Attendees:	Amelia Callaghan	State Manager, Headspace
	Bernice Holland	Administration Officer, MHSS WM HHS
	Deb Miller	A/Executive Director, Office of Strategy Management, CHQ HHS
	Emma Hart	Team Leader, Adolescent Inpatient Unit And Day Service, Townsville HHS
	Erica Lee	CYMHS, Service Manager, Mater Hospital
	Gerry Howe	Team Leader, CYMHS, Fraser Coast Integrated Mental Health, Wide Bay HHS
	Ian Williams	Director of Adolescent Psychiatry, Adolescent Psychiatry Mental Health, RB&WH
	Jackie Bartlett (proxy for Janet Martin)	Principal Project Officer, Clinical Governance, Office of the Chief Psychiatrist, MHOADB
	Janelle Bowra	Nursing Unit Manager, Metro South HHS
	Laura Johnson	SW AETRS Project Officer, MHSS West Moreton HHS
	Mary-Anne Morgan	Partnerships Manager, Mental Illness Fellowship Queensland
	Michelle Fryer	Child Psychiatrist, CYMHS, Gold Coast HHS
	Naysun Saeedi	Staff Consultant, Mental Health, Cairns HHS
	Raymond Ho	Clinical Services Program Manager, Metro South Addiction and Mental Health Service, Metro South HHS
	Vanessa Clayworth	A/Nurse Unit Manager, Barrett Adolescent Centre
Apologies:	Janet Martin	Manager, Clinical Governance Office of the Chief Psychiatrist, MHAODB
	Kimberly Curr	A/Manager, CYMHS Toowoomba HHA
	Sean Hatherill	Child Psychiatrist, CYMHS Metro South HHS
	Shannon March	Consultant, CYMHS Toowoomba HHS
	Stephen Stathis	Clinical Director, CYMHS CHQ HHS

The purpose of this Workshop is to explore the current and future service options for adolescent mental health extended treatment and rehabilitation in Queensland.

The aim of this platform of services is to provide medium term, recovery-oriented treatment and rehabilitation for young people aged 13 – 17 years with severe and persistent mental health problems, which significantly interfere with social, emotional, behavioural and psychological functioning and development

The target group:

- 13 - 17 years, with flexibility in upper age limit depending on presenting issue and developmental (as opposed to chronological) age.
- Severe and persistent mental health problems that significantly interfere with social, emotional, behavioural and psychological functioning and development.
- Treatment refractory/non responsive to treatment - have not been able to remediate with multidisciplinary community or acute inpatient treatment.
- Mental illness is persistent and the consumer is a risk to themselves and/or others.
- Medium to high level of acuity requiring extended treatment and rehabilitation.

Workshop Agenda

Time	Item	Action Officer
10.30am	Morning Tea and Welcome	LG
10.45am	Introductions and Apologies Statement of Conflict/Interest	LG
10:55am	Session 1 – Current Service Options, including: • Geography • Exclusion criteria • Referral Source • Pathways in and out • Length of Stay • Treatment Modalities • Skills required • Environment of delivery Exploring the current strengths and weaknesses of the service options, and any gaps in the referral interface between service options.	LG IA LJ
12:15pm	Lunch	All
12:45pm	Session 2 – Future Service Options, including: • What could be included to provide a more comprehensive model of service to adolescents? • What evidence-based, best practices should we consider or research? • What are our counterparts in other states and countries doing? • What are appropriate service standards and benchmarks?	LG IA LJ

Workshop Agenda		
Time	**Item**	**Action Officer**
2:15pm	Afternoon Tea, where we will be joined by: • Peter Steer, Health Service Chief Executive, CHQ HHS • Lesley Dwyer, Health Service Chief Executive, West Moreton HHS • Sharon Kelly, Executive Director, Mental Health and Specialised Services, West Moreton HHS • Bill Kingswell, Executive Director, Mental Health Alcohol and Other Drugs Branch	All
2:30pm	Workshop Debrief • Review of service options – current and future • Where to from here? • Next meeting	All IA IA
3.00pm	Workshop Conclusion	

Terms of Reference

Statewide Adolescent Extended Treatment and Rehabilitation (SW AETR) Barrett Adolescent Centre Consumer Transition Panel

1. Purpose

The purpose of the SW AETR Barrett Adolescent Centre (BAC) Consumer Transition Panel is to ensure the continuity of care for adolescents currently admitted to the BAC, and support their transition to the most appropriate care option/s that suit their individual needs and are located in (or as near to) their local community.

2. Guiding principles

- The *Health Services Act 1991*
- *Fourth National Mental Health Plan*
- *Queensland Plan for Mental Health 2007-2017*
- *Mental Health Act 2000*

3. Functions

The functions and objectives of the SW AETR Barrett Adolescent Centre (BAC) Consumer Transition Panel include:

- Develop a Transition Plan for adolescents currently admitted to the BAC.
- Develop a Communication Plan for stakeholders, including but not limited to consumers, families, HHSs, education/vocation providers, and other service providers/stakeholders.
- Oversee the discharge process for adolescents currently admitted to the BAC and ensure continuity of care.
- Proactively advocate and support the transition of adolescents, currently admitted to the BAC or on the waitlist, to more appropriate care option/s that suit their individual needs and are located in (or as near to) their local community.
- Define the waitlist group and oversee their individual care, where appropriate/required.
- Facilitate expert discussion and communication from clinician and consumer stakeholders around planning, transition activities.
- Prepare and provide fortnightly Status Reports to the SW AETR Steering Committee, or as required.
- Develop a Risk Mitigation Plan for adolescents currently admitted to the BAC to ensure safe transition to other appropriate care option/s.
- Manage risks associated with the transition of adolescents currently admitted to the BAC, and escalate where resolution is required to successfully transition consumers.
- Provide the Secretariat with information regarding risks, as they arise, for recording and management in the Project Risk Register.

4. Authority

Members are individually accountable for their delegated responsibility, and collectively responsible to contribute to recommendations to the SW AETR Steering Committee.

Decision making capability rests with the Chief Executive and Department of Health Oversight Committee.

5. Frequency of meetings

Meetings will be held on a fortnightly basis, or as required. The Chair may call additional meetings as necessary to address any matters referred to the Panel, or in respect of matters the Panel wishes to pursue within the Terms of Reference.

Attendance can be in-person or via teleconference mediums.

The Panel is life-limited for the duration of development and implementation of SW AETR service options and their transition to CHQ HHS. The Chair will advise Panel members approximately one month prior to the dissolution of the Panel.

6. Membership

Acting Clinical Director, Barrett Adolescent Centre
2 x Barrett Adolescent Centre Clinical Staff
Barrett Adolescent Centre School Representative
Consultant Psychiatrist, High Secure West Moreton HHS
Project Manager, SW AETRS, Children's Health Qld HHS
Project Officer, SW AETRS, West Moreton HHS (as Secretariat)
And as required:
- HHS Northern Representative (as required)
- HHS Central Representative (as required)
- HHS Southern Representative (as required)

Chair:
The Panel will be chaired by the Acting Clinical Director, Barrett Adolescent Centre, or their delegate. The delegate must be suitably briefed prior to the meeting and have the authority to make decisions on behalf of the Chair.

Secretariat:
Secretariat support will be provided by the Project Officer, SW AETRS WM HHS, or an alternate officer nominated by the Chair.

Proxies:
Proxies are not accepted for this Panel, unless special circumstances apply and specific approval is given for each occasion by the Chair.

Other Participants:
The Chair may request external parties to attend a meeting of the Panel. However, such persons do not assume membership or participate in any decision-making processes of the committee.

7. Quorum

As this is not a decision making group, a quorum is not applicable.

8. Performance and Reporting

The Secretariat is to circulate an Action Register to Panel members within three business days of each Panel meeting. Chair will determine the resolution of outstanding action items as they arise.

The Secretariat will coordinate the endorsement of fortnightly status reports, and other related advice to be provided as required, to the SW AETR Steering Committee.

Members are expected to respond to out of session invitations to comment on reports and other advice

within the timeframes outlined by the Secretariat. If no comment is received from a member, it will be assumed that the member has no concerns with the report/advice and it will be taken as endorsed.

9. Confidentiality

Members must acknowledge and act accordingly in their responsibility to maintain confidentiality of all information that is not in the public domain.

10. Risk Management

A proactive approach to risk management will underpin the business of this Panel. The Panel will:

- Identify risks and mitigation strategies associated with the development and implementation of SW AETR service options; and
- Implement processes to enable the Panel to identify, monitor, manage, and escalate critical risks as they relate to the functions of the Panel.

Document history

Version	Date	Author	Nature of amendment
1.0	18/09/13	Ingrid Adamson	First draft
1.0	19/09/13	Ingrid Adamson	Comments from Deb Miller, A/ED OSM
FINAL	23/09/13	Ingrid Adamson	Comments from SW AETR Steering Committee

Previous versions should be recorded and available for audit.

Emma Hart

From: Ingrid Adamson

Sent: Wednesday, 16 October 2013 5:32 PM

To: Emma Hart; Mikaela Moore; Deborah Miller; Gerard Howe; Ian Williams; Jackie Bartlett; Janelle Bowra; Janet Martin; Judi Krause; Kimberly Curr; Laura Johnson; Leanne Geppert; Michelle Fryer; Naysun Saeedi; Raymond Ho; Sean Hatherill; Shannon March; Vanessa Clayworth; Erica Lee; Mary-Anne Morgan

Cc: Bernice Holland; Stephen Stathis

Subject: Service Options Working Group - Case Scenarios

Attachments: AETR Case Scenarios.doc

Good Afternoon,

As mentioned in my previous email, attached are four case scenarios for your consideration.

For the **clinical and NGO representatives**, with your current level of knowledge of mental health services, please answer the following questions:

1. How would you manage these scenarios given your current local resources and services?
2. What would be the top three resources or services that could be added for you to ideally manage these scenarios?
3. What do you think is a realistic outcome in your health service district or cluster (southern, central, northern) given the current constraints on resourcing?

For the **consumer and carer representatives**, with your current level of knowledge of mental health services, please answer the following questions from your viewpoint:

1. How you would like to be treated?
2. What continuum of service do you believe is necessary?
3. What type of follow up would you prefer?
4. What type of information would you want to receive during treatment?

Please add your responses under each scenario in the word document attached. Please then save this document with your initials at the end of the file name (so we can identify you if we have further questions about your responses).

Due to our tight time frames, I would be really grateful if you could provide your feedback to me by **close of business next Wednesday 23rd October 2013.**

Should you have any questions regarding the four scenarios, please email Stephen Stathis (cc'd above).

Thanks and warm regards,
Ingrid

Ingrid Adamson
Project Manager - SW AETR
Office of Strategy Management

Children's Health Queensland Hospital and Health Service

Level 1, North Tower
Royal Children's Hospital

HERSTON QLD 4029
www.health.qld.gov.au/childrenshealth

Queensland Government

West Moreton Hospital and Health Service

Enquiries to: Leanne Geppert
Telephone:
Facsimile:
Our Ref: LG

Ms Emma Hart
Nurse Unit Manager
Adolescent Inpatient Unit and Day Service
CYMHS Townsville HHS Mental Health Service

Dear Emma

As a member of the Expert Clinical Reference Group (ECRG) for the Barrett Adolescent Strategy (the Strategy), I would like to provide you with an update.

The West Moreton Hospital and Health Board considered the documentation put forward by the ECRG in May 2013 and all seven recommendations made by the ECRG were accepted with covering comment by the Planning Group. Further key stakeholder consultation was then conducted with the Department of Health, the Queensland Mental Health Commissioner, the Department of Education Training and Employment, and Children's Health Queensland.

The work of the ECRG and the subsequent consultation process has enabled us to progress the Strategy to the next phase. As identified in a joint announcement today by West Moreton Hospital and Health Service Chief Executive Lesley Dwyer and Children's Health Queensland Chief Executive Dr Peter Steer, adolescents requiring extended mental health treatment and rehabilitation will receive services through a new range of contemporary service options from early 2014. Young people receiving care from the Barrett Adolescent Centre at that time will be supported to transition to other contemporary care options that best meet their individual needs.

Importantly, our goal in West Moreton Hospital and Health Service continues to be to ensure that adolescents requiring mental health extended treatment and rehabilitation will receive the most appropriate care for their individual needs. We will also continue to provide information and support as needed to staff at the Barrett Adolescent Centre. The transition process will be managed carefully to ensure that there is no gap to service provision.

For further information about Barrett Adolescent Centre and the planning for new statewide service options in adolescent mental health extended treatment and rehabilitation, please find attached a media statement, a copy of the ECRG recommendations submitted to the West Moreton Hospital and Health Board, and a FAQ sheet. You are also welcome to access this information via http://www.health.qld.gov.au/westmoreton/html/bac/

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West Moreton Hospital and Health Service

I would like to once again take the opportunity to acknowledge your significant contribution to the Barrett Adolescent Strategy as an ECRG member, and assure you that the work of the ECRG will form the foundation of the next phases in the Strategy. Your expertise and dedication of time has been sincerely appreciated, and enabled us to work towards ensuring the best outcomes for young people requiring extended mental health treatment and rehabilitation in Queensland.

If you have any further queries, please do not hesitate to contact me on .

Yours sincerely

Dr Leanne Geppert
A/Director of Strategy
Mental Health and Specialised Services
West Moreton Hospital and Health Service

06/08/13

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West Moreton Hospital and Health Service
Children's Health Queensland Hospital and Health Service

Media Statement

Queensland Government

6 August 2013

Statewide focus on adolescent mental health

Statewide governance around mental health extended treatment and rehabilitation for adolescents will be moving to Children's Health Queensland.

West Moreton Hospital and Health Service Chief Executive Lesley Dwyer and Children's Health Queensland Chief Executive Dr Peter Steer today said adolescents requiring extended mental health treatment and rehabilitation will receive services through a new range of contemporary service options from early 2014.

Ms Dwyer said the young people who were receiving care from Barrett Adolescent Centre at that time, would be supported to transition to other contemporary care options that best meet their individual needs.

She said West Moreton Hospital and Health Service had heard the voices of staff, consumers and their families, and engaged an expert clinical reference group over the past eight months.

"After taking into consideration the recommendations of the expert clinical reference group and a range of other key issues in national and state mental health service delivery, the West Moreton Hospital and Health Board determined that the Barrett Adolescent Centre is no longer an appropriate model of care for these young people," Ms Dwyer said.

"The board also determined that a number of alternative models will be explored over the coming months under the leadership of Children's Health Queensland.

"It is important to put the safety and individual mental health needs of these adolescents first by providing the most contemporary care options available to us in the most suitable environment.

"It is time for a new statewide model of care. We are also striving to provide services closer to home for these young people, so they can be nearer to their families and social networks," Ms Dwyer said.

Dr Steer said as part of its statewide role to provide healthcare for Queensland's children, Children's Health Queensland would provide the governance for any new model of care.

"This means that we will work closely with West Moreton HHS as well as other hospital and health services and non-government agencies to ensure there are new service options in place by early 2014," Dr Steer said.

"This model of care may include both inpatient and community care components.

"Understanding what options are needed has already begun with the work of the expert clinical reference group, and now we can progress this further and implement the best options for these young people," he said.

"This is a positive step forward for adolescent mental health care in this state," Dr Steer said.

To view the expert clinical reference group recommendations visit http://www.health.qld.gov.au/westmoreton/html/bac/

ENDS

Media contact:

West Moreton Hospital and Health Service –
Children's Health Queensland -

Emma Hart

From: Cara McCormack
Sent: Friday, 7 February 2014 4:05 PM
To: Emma Hart
Subject: RE: Re

My plan was to talk to Leanne Geppert about this, which I started on Tuesday but didn't have update from Liz. Can try to phone her now to clarify this is ok.
Thanks
Cara

Cara McCormack

Program Manager Rural, Remote and Indigenous Mental Health Services & Child, Adolescent and Young Adult Services/ Assistant Director of Allied Health

Mental Health Service Group

Hospital and Health Service

Ph:

From: Emma Hart
Sent: Friday, 7 February 2014 4:00 PM
To: Cara McCormack
Subject: Re
Importance: High

Hi Cara,

Thanks,

Emma Hart

Nurse Unit Manager