EXHIBIT 540

{ SEQ CHAPTER \h \r 1}**REFERRAL SOURCES**

The decision to take referrals only from CYMHS raise grave concerns on a number of areas.

- The AITRC would be the only Level 6 child and adolescent unit to admit on the basis of referral source as well as severity of the illness and need for specialised treatment.
- Some Queensland adolescents would be ineligible for the most intensive levels of intervention of simply on the basis that they chose private treatment rather than public treatment. Currently all the service is available to all Queensland adolescents who require it.
- Some families we have seen at the Mater initially go to a CYMHS, and then opt for private treatment, steadfastly refusing to return to the original CYMHS. They are thus ineligible for the service because fo this decision.
- Under current Medicare arrangements, private child and adolescent psychiatrists have the option of working closely with other professionals - psychologists, social workers, dietitians, nurses. I know some have taken up this option, essentially replicates the function of a multidisciiplinary team. Yet they would not be eligible to refer to a service.
- If a competent child psychiatrist feels that admission to the AITRC is indicated, they would have no option bit to refer to the local CYMHS. There is a fair chance that this will be difficult for the adolescent to establish relationships with a new therapist, and may not add anything in treatment, but simply prolong the time until admission.
- We regularly involve CYMHS clinicians in the management of ongoing management of their adolescents. I observe that many CYMHS clinicians are the sole case manager, with little involvement of other clinicians in the team. This concurs with observations when I have provided cover for community CYMHS. Rather than being true multidisciplinary teams with discipline specific functions and utilising discipline specific strengths, some CYMHS are essentially multiple solo practitioners from a range of disciplines. Multidisciplinary input is largely limited to comments at case reviews, case conference. This comment is often more generic than discipline specific. Yet these solo practitioners have access to the AITRC, whereas a private child psychiatrist does not.
- CYMHS teams operate with considerable differences in levels of expertise and experience. Because clinicians often perform generic roles, some will perform functions outside of that for which their undergraduate training has prepared them. With time their knowledge and experience will develop. A CYMHS team with a significant proportion new graduates, or clinicians new to CYMHS will have the right to refer to the AITRC. A private child and adolescent psychiatrist with at least six years of supervised clinical training does not. They would need to refer to the CYMHS.
- Private child psychiatrists are able to admit to adolescent acute inpatient units

A well functioning multidisciplinary team is undoubtedly the ideal. It may not be the rule. A competent child psychiatrist may make an equally valid referral as a CYMHS clinician in a poorly functioning team.