BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

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

STATEMENT OF ASSOCIATE PROFESSOR JAMES SCOTT

Name of Witness:	Associate Professor James Graham Scott
Date of birth:	
Current address:	C/- Level 3 UQCCR, Royal Brisbane and Women's Hospital, Herston QLD 4029
Occupation:	Consultant Psychiatrist
Contact details (phone/email):	
Date and place of statement:	26/11/2015 Block 7 Royal Brisbane and Women's Hospital
Statement taken by:	Paul Freeburn QC and Rachel Cornes

I **Associate Professor Dr James Scott** make oath and state as follows:

1. On or about 19 November 2015, I was contacted by Ms Sophie Pettigrew (Senior Lawyer, Legal Services, Metro North Hospital and Health Service) who advised me that an interview request had been received for me, from the Barrett Adolescent Centre Commission of Inquiry (**the Commission**).

2. On 26 November 2015 I participated in an interview at the Royal Brisbane and Women's Hospital (**RBWH**) with Commission staff. I was accompanied at this interview by my legal representatives, Ms Pettigrew and Mr John Allen of Counsel.

Employment and qualifications

3. Attached and marked **'JS-1'** is a copy of my most recent curriculum vitae.

4. Since 2010 I have been employed in the position of Consultant Psychiatrist, at the RBWH. Prior to that, I was a consultant psychiatrist at the Royal Children's Hospital Child and

Youth Mental Health Service (2007-2010) and the Director of Hospital Services for Child and Youth Mental Health Services at the Mater Children's Hospital (from 2003 to 2006).

5. In addition to my work at the RBWH, since 2010, I have been a Senior Lecturer (2010-2013) and Associate Professor (2014 to date) in psychiatry at The University of Queensland. I have developed a programme of research broadly encapsulated under child and adolescent mental health and early psychosis.

6. My formal qualifications include a Bachelor of Medicine, Bachelor of Surgery (MBBS), a PhD and a Fellowship of the Royal Australian and New Zealand College of Psychiatrists (FRANZCP).

Barrett Adolescent Centre

7. Although I have never worked at the Barrett Adolescent Centre (**BAC**), during my career as a Psychiatrist, I have referred several patients to the BAC (which I discuss further below).

8. The BAC was a medium to long term hospital-based treatment and rehabilitation service that integrated an educational facility. It provided individual therapy for patients and families and had a focus on improving a patient's mental health, and their social and educational functioning.

9. Sometime between 2002 and 2009 I attended The Park Centre for Mental Health, which included the BAC, to conduct training site accreditations. I had no cause to, and did not, assess the adequacy or otherwise of the operations of the BAC during this accreditation process.

Model of Care

10. I was never asked to, and did not ever have any input into, the model of care developed for, or implemented at, the BAC.

11. However, based on my experience referring patients to the BAC, I would describe the BAC as having an 'eclectic' model of care. I observed the BAC to accept the admission of young persons who needed long-term mental health intervention for a mental health disorder.

12. In response to being asked as to the training BAC staff received, I am uncertain whether or not BAC staff received training in the mental health care requirements for different mental health disorders. I did not have the opportunity to ascertain this information.

Inpatient and Acute Mental Health Facilities

13. At the time when the BAC closed in January 2014, there existed several acute inpatient mental health facilities for children and adolescents in Queensland, including at the RBWH, RCH, Logan Hospital and the Mater Children's Hospital (MCH). As reflected in my curriculum vitae, I have been the Director or Acting Director of units at the RBWH, RCH and MCH facilities, at various stages of my career.

14. Based on my experience as Director of inpatient facilities, I am aware that Queensland acute units generally have a mean length of stay of around 13 days. This length of stay is driven by a combination of:

    (a) budgetary restraints (inpatient care is very expensive and there is a high demand for beds); and

    (b) National Performance Indicators, which require mental health care to be carried out in the least restrictive setting with a model of social inclusion. Acute inpatient facilities operate to reduce symptomology. The aim is to have a patient's stay in hospital as short as possible and to return the patient back into the community for ongoing care.

15. Based on my experience as a child and adolescent psychiatrist, I am aware that adolescent patients do not do well with extended admissions (in terms of their recovery) in the acute inpatient setting. This is primarily because:

    (a) the constant turnover of patients in an acute unit is often distressing to an adolescent mental health patient who remains in the hospital for a prolonged period of time;

    (b) acute settings sometimes involve exposure to threatening and self-injurious behaviour by other patients, which may be damaging for an adolescent's wellbeing. As mental health services for adolescents have developed in Queensland, it has been my observation that community mental health services are becoming increasingly skilled at treating adolescent mental health problems. The result is that adolescents with lower acuity mental health illnesses (such as anxiety and depression) who are less likely to engage in aggressive behaviours or seriously self-injure are less likely to be admitted to hospital as they are treated in the community, leaving a greater percentage of 'higher acuity' patients with mental illnesses within acute units who are more likely to have serious aggressive or self-harming behaviours; and

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(c) the provision of education for any extended period in an acute inpatient facility is inadequate.

16. In order to be admitted into a Queensland inpatient mental health facility (including the BAC, prior to its closure), an adolescent patient must generally satisfy one of two criteria, namely:

(a) a diagnosis with a severe (often life threatening) mental health illness;

(b) a less severe mental health problem that has emerged in a young person where the family and other systems are unable to meet the health and/or disability needs of the young person. The rationale for this second criterion is that most families are able to support a family member with even moderate to sometimes severe mental ill health in the home setting, without the requirement for an admission into an inpatient facility.

Referral of patients to the BAC

17. Prior to its closure, when I was working in the acute inpatient units, I referred on average, one to two adolescents per year to the BAC. The majority of these referrals were patients who had not improved sufficiently in the acute inpatient facilities and were unable to be safely discharged home.

18. I had occasionally referred patients from my private practice or from the Child and Youth Mental Health Service (**'CYMHS'**) community mental health services. In order to refer a patient to the BAC I would send detailed information to the clinicians of the BAC directly. As the referring clinician, I would then have the opportunity to remain informed of the patient's care and be invited to attend case conferences (by phone) approximately every three months.

19. Attendance at these case conferences enabled me to keep up to date on the patient's progress. This allowed the patient to be transitioned back to my care if appropriate at least one month prior to their discharge, so as to facilitate a smooth transition back into the community.

Circumstances in which I have referred a patient to the BAC

20. For the reasons I have stated at paragraph 15 above, my preference is generally always for an adolescent patient to receive mental health treatment in the community (and stay in their home environment) wherever possible. Consequently, I only referred a patient to the BAC in circumstances where I was satisfied that:

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(a) the patient had a mental illness requiring a high level of support over a long period of time (meaning acute care would have been counter-productive to recovery for the reasons I have outlined above); and

(b) the family was unable to meet the needs of the health or disability needs of the young person which meant that community care (in the home environment) was inappropriate (in the sense that the patient was unlikely to improve).

21. Examples of the patients whom I have referred to the BAC are as follows:

[redacted]

[redacted]

[redacted]

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Decision to close the BAC

22. In around March 2008, I had some involvement in the selection of Redlands as a possible alternative site for the BAC. My impression from the discussions I was involved in, was that there were few options from a Queensland Health/resourcing perspective, and that it was a 'Redlands or nothing' type situation. I do recall that there was some (limited) discussion about the Prince Charles Hospital site.

23. Whilst I do not recall any of the specifics, I do have some recollection of having attended a meeting in around 2008 at which time the 'pros and cons' of the Redlands site were discussed. I recall a discussion about the physical locality of the site and, specifically, the fact that it was close to a train line. I considered the proximity of the train station to be a good thing in terms of the transport needs of day patients who would be attending the facility.

24. I did not have any involvement in the decision not to proceed with the relocation of the BAC to the Redlands site. I have no recollection of when, or from whom, I became aware of the fact that the relocation was no longer to proceed.

25. Sometime prior to or around November 2012, I recall receiving a group email sent to a Child Psychiatry Group of which I am a member. Although I do not recall the specifics of the email, I recall that the key message was that the BAC was to be closed. I have searched for, but have been unable to locate, a copy of this email. I have been supplied with a copy of this email by Commission staff. It is attached and marked **'JS-2'**.

26. Queensland child and adolescent psychiatrists are a small, collegiate group many of whom have had some contact with the BAC at some stage of their career. I am aware of a number of psychiatrists who undertook training at the BAC (for between 6 to 12 months) during their studies. Many others have referred patients to the BAC.

27. The possibility that the BAC was to be closed was received by the group with significant concern. I recall concerns being raised about where patients could be referred once there was no longer a long-stay inpatient facility (also referred to as a tier 3 facility).

28. I was personally concerned about the possibility of the BAC being closed because I recognised it to be the only long-stay inpatient facility for adolescents in Queensland. Without the BAC, there was nothing else available at that time for patients who had severe mental health problems that could not be managed in the community.

29. For the reasons outlined below, I consider that for one sector of the BAC patient cohort, this remains to be the case.

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Voicing my concerns

30. On 11 November 2012, I sent a letter to the former Health Minister, Mr Lawrence Springborg, outlining my concerns about the reported forthcoming closure of the BAC.

31. The reason I sent this letter was because I wanted to ensure that the Minister was thinking carefully about the decision being made. Before making a decision to shut down a service, it is important to map out the patient population, plan services to cater for that population, and consult with stakeholders.

32. In my letter, I explained to Mr Springborg, my concern that:

    (a) without the BAC, there would be an enormous gap in care;

    (b) acute inpatient units cannot provide the same care as the BAC as they are driven by performance indicators such as short lengths of stay, and the mental health problems that trouble adolescents admitted to the BAC will not respond to brief admissions and existing community care; and

    (c) the BAC plays an important role in preventing young people from suicidal acts or committing offences that result in lengthy incarceration.

33. Attached and marked **'JS-3'** is a copy of my letter to Mr Springborg, dated 11 November 2012. To the best of my recollection, I received an acknowledgment letter back from Mr Springborg but I received no further response from Mr Springborg's office.

34. Also on 11 November 2012, I sent an email to Ms Lesley Dwyer, prompting her to give the decision to close the BAC further consideration, and advising her that I considered without the BAC, adolescents would 'die or end up in some other form of institutional care that would be very expensive and of little therapeutic benefit'. Attached and marked **'JS-4'** is a copy of my email to Ms Dwyer sent on 11 November 2012.

35. On 19 November 2012, I received a response from Ms Dwyer advising that no decision had been made by the West Moreton Hospital and Health Board and that it had been decided a small working party would be formed, assisted by an Expert Clinical Reference Group, to look at the various options for the longer term needs of adolescent mental health services currently provided at the BAC. Ms Dwyer assured me, in her email, that she would keep me informed and enable me the opportunity to have input into the process.

36. On 20 November 2012, Ms Sharon Kelly sent me an email promising to include me in the consultation process as the working group moved forward.

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37. Attached and marked **'JS-5'** is an email chain containing my email to Ms Dwyer on 11 November 2012 and Ms Dwyer and Ms Kelly's responses of 19 and 20 November 2012.

Reasons for the closure

38. I was a member of an Expert Clinical Reference Group (**'ECRG'**) (which I discuss below), however I did not have any input into the decision to ultimately close the BAC in January 2014.

39. Based on discussions with colleagues between around 2012 up until early 2014, and my involvement as a member of the ECRG, my understanding is that the expressed reasons why the BAC was closed were:

    (a) the buildings were old, run-down and dilapidated and in need of capital works investment; and

    (b) as The Park had become a forensic mental health facility, it was expressed that it would be inappropriate to maintain an adolescent unit in this precinct.

40. Around this same period, I recall public statements about the State's financial problems and budget blow-outs.

41. I am not persuaded that the condition of the building or the co-location of forensic patients were the decisive reasons for the closure. The Park has always been a large adult psychiatric asylum with adult mental health patients. None of the patients who I referred to the BAC ever expressed any concern to me about their co-location with adult or forensic mental health patients. I am not aware of any incidents involving adult patients and patients of the BAC.

Expert Clinical Reference Group

42. Although I cannot recall the specifics, I do recall that in around early December 2012, I was invited to be a member of an ECRG with respect to the BAC. Attached and marked **'JS-6'** is a letter which I received from Ms Kelly on 3 December 2012, formally inviting me and thanking me for agreeing to be a member of the ECRG.

43. The expertise amongst the members of the ECRG was significant and the different areas of child and adolescent mental health were appropriately represented.

44. The ECRG came together quickly and meetings were convened over a period of several months (between December 2012 until around May 2013). Meetings of the ECRG were

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held fortnightly, with some instances towards the latter months, of the ECRG meeting weekly.

45. I attended my first meeting of the ECRG on 9 January 2013. Attached as a bundle and marked **'JS-7'** are the Minutes of the ECRG.

Role of the ECRG

46. The Terms of Reference for the ECRG directed the ECRG to, among other tasks, consider a model of care that would replace the BAC. Attached and marked **'JS-8'** is a copy of the Terms of Reference for the ECRG.

47. Dr Leanne Geppert had been appointed as the Chair of the ECRG. My impression from Dr Geppert's direction during initial meetings of the ECRG in early 2013, was that the role of the ECRG was essentially to support a model of care that the Government or the Department or someone within those bodies had already developed. However, there was nonetheless an opportunity for the ECRG to express their views (as is discussed below).

48. The model of care put forward to the ECRG involved housing adolescent mental health patients in the community near an acute unit, with the idea being that the patient will be admitted to the acute unit when needed. From my recollection, there was to be a strong reliance on the use of existing acute inpatient facilities for patients who would have previously been admitted to the BAC.

49. The concept of BAC patients utilising acute facilities (as an alternative to a model such as the BAC) was, in my view, very problematic from a clinical perspective. For the reasons I have outlined at paragraph 15 above, acute inpatient units cannot appropriately manage the type of patients who were being cared for at the BAC.

50. After I had attended a number of ECRG meetings, and heard the model proposed by Dr Geppert, I expressed my view to the ECRG that I considered the model of care put forward to be inadequate. I recall that I said words to the effect of 'That won't work'. I recall that there was agreement from the other members of the ECRG. Dr Geppert then sought the views of the ECRG as to what would be required to replace the BAC.

51. I recall what felt to me a sense of defiance to the proposed model of using acute inpatient services developing amongst members of the ECRG and in response, members proposing a model of care that maintained many of the features of the BAC.

52. I subsequently felt that Dr Geppert seemed initially concerned about the model that was being proposed. She made a comment to the effect that the proposed model would not

be well received by corporate office. However, she then agreed to incorporate the recommendations of the ECRG. From my recollection of the model proposed by ECRG, it was suggested there be a new long stay inpatient unit for adolescents, with accommodation available for family who were from outside Brisbane and educational facilities for the adolescents

53. During such discussions, concerns were being voiced (with which I agreed) that if the BAC model of care were to be replaced with something new, then the timeframes for the development of new services were unrealistic. I am of the belief that we were advised the BAC would shut later in 2013 leaving less than twelve months to establish services to replace the existing service. In my experience, it takes considerable time (approximately 24 months) to establish and implement a new service, taking into account the need to design and build facilities and recruit and train staff. Even if the facilities were built and available, it would take at least 12 months' lead in time in order to plan the service model, recruit and train staff to provide the service.

54. In around April 2013, ECRG members were invited to provide feedback on draft versions of the ECRG report. Attached and marked **'JS-9'** are two tables which set out some of the feedback which I provided to Dr Geppert in respect of the draft ECRG report. My recollection assisted with the information in the tables was that various members of the ECRG including myself were not comfortable with aspects of the draft versions.

Concerns about the ECRG process

55. The ECRG was established with a sense of urgency from the start and the process by which the model was to be developed and the way in which the ERCG interfaced with those responsible for planning the model was unclear.

56. In order to properly review and devise a model of care to support the most severely impaired adolescents in Queensland, the first step should have been to conduct a systematic search of all potential care options for adolescents with complex needs and gather the available literature and information on those options.

57. It is only then that the experts should be consulted to consider the options and make recommendations. That is, it is necessary to look at all of the options potentially available, and then consider which would be the most appropriate model of care for adolescents severely impaired by mental ill health.

58. The application of more time and research and a broader consideration of available options, would have in all probability resulted in better outcomes from the ECRG. If I am ever to be invited to participate in a similar process again, I will most certainly require

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that a full review of care option be conducted which would then inform the final model to be established.

Recommendations of the ECRG

59. On 17 April 2013, Ms Vaoita Turituri sent a final draft of the proposed service model and other documents to the ECRG members for review and final comments. I have searched for, but have been unable to locate, a copy of this email. I have been supplied with a copy of this email by Commission staff. It is attached and marked **'JS-10'.**

60. Dr Trevor Sadler responded to Ms Turituri by email dated 22 April 2013, raising a number of issues and concerns about the documents provided to the ECRG for review. I have also been supplied with a copy of this email by Commission staff. It is attached and marked **'JS-11'.**

61. Although I do recall receiving these documents, I do not remember if I or any other ECRG members provided feedback separately. I expect the issues raised by Dr Sadler in his email of 22 April 2013 were discussed at an ECRG meeting but I cannot recall any specific details. Certainly, the issues were consistent with the feedback provided to Dr Geppert by the ECRG during the previous ECRG meetings.

62. On or about 8 May 2013, the ECRG finalised and endorsed its report on the proposed service model elements. A copy of the ECRG report is attached and marked **'JS-12'.**

63. The key recommendation made by the ECRG was that inpatient extended treatment and rehabilitation care (tier 3) was an essential service component and interim service provision if BAC closes and tier 3 is not available, was associated with risk.

64. The ECRG's reference to 'risk' was a reference to the view of the ECRG that, without a tier 3 facility, there will exist young people with severe and complex needs who are a risk to themselves and without adequate supports to manage their social and mental health needs.

65. Knowing the patients who I had referred to the BAC, I was firmly of the view that without high level care such as the BAC,

66. The ECRG expressed a view that a tier 3 level of care was needed. This was in part because the group was not aware of any other options other than the existing care options that had historically been available in Queensland and what had been proposed,

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particularly with the ECRG agreeing that reliance on acute inpatient facilities was not appropriate for this group of adolescents with severe and complex needs.

Involvement following provision of ECRG report

67. Following the delivery of the ECRG's report in May 2013, I did not have any further involvement in respect of decisions made about the BAC nor any replacement models of care. I did not ever receive a copy of the recommendations which I understand were made by a Planning Group in respect of the recommendations of the ECRG.

68. Commission staff have provided me with a copy of a table which records the ECRG's recommendations and the Planning Group's responses. As to those, it would appear that the ECRG's recommendations regarding a Tier 3 model of care were ignored.

69. On 9 August 2013, I received an email from Ms Susan Daniel (Community Liaison, Clinical Nurse, Barrett Adolescent Centre) which was copied to Dr Trevor Sadler and Ms Vanessa Clayworth.

70. Ms Daniel referred to the review conducted by the ECRG and stated, 'Fortunately a decision has been made to continue to provide an extended care mental health service to adolescents. However we will not continue to operate at our present site. A new site is yet to be determined but it is proposed that it will continue to be located in the South-East Queensland area'. Attached and marked **'JS-13'** is a copy of Ms Daniel's email of 9 August 2013 (together with my reply of 10 August 2013).

71. It appeared form this email that the BAC was to relocate, rather than close. I had no other knowledge of the plans to relocate the BAC.

Transition Arrangements

72. I had no further involvement in the transition of patients from the BAC to the community upon its closure in January 2014.

Alternative services

73. I am unaware of any new tier 3 services established in Queensland to replace the BAC.

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74. There were no specific identified services available for adolescents who would have previously been admitted to the BAC after it closed in January 2014. [redacted]. To the best of my knowledge, no new facilities or services were available until after some months following the BAC closure.

AMYOS

75. In the second half of 2014, the Assertive Mobile Youth Outreach Services (**AMYOS**) were established in Queensland as part of the broader Children's Health Queensland Statewide Adolescent Mental Health Extended Treatment Initiative.

76. AMYOS are not one of the services which were considered by the ECRG. AMYOS is not an inpatient service but rather an intensive community support service.

77. AMYOS provide recovery-oriented assessment and assertive treatment and care for young people with complex mental health needs. Services are delivered by multidisciplinary mental health clinicians either in the family home or in the community. In an operational sense, clinicians will meet with a patient and their family very regularly (up to a few times a week if required) and focus on the needs of the family and the young person.

78. The AMYOS service is underpinned by a theoretical psychotherapeutic model known as Mentalisation Based Therapy (otherwise known as MBT). MBT teaches skills to adolescents and their families on how to manage their emotions and interpersonal interactions better. MBT involves both the parent and the young person and trains them to mentalise and think about themselves and their actions and also to think about the responses and actions of those around them. It assists patients to respond more reflectively to difficult situations.

79. By way of example, an adolescent might be rejected by a peer and feel suicidal. This does not mean that an adolescent has to go into hospital. By mentalising, the adolescent can learn skills to consider why the other person might have rejected them and to consider how they might respond to this. Mentalising also allows the parents to think about how best to respond to the suicidality and what they can do to helpfully support their adolescent. These responses will influence whether the suicidal thoughts are acted upon and specifically, whether they escalate or de-escalate, which determines whether hospitalisation is required.

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80. Based on my experience having referred patients to AMYOS, having spoken to patients who are being treated by AMYOS and having discussed the model of care at length with Dr Michael Daubney, the director of AMYOS, I would assess AMYOS:

(a) to be a good alternative for patients who I would previously have referred to the BAC who have a home environment where parents are motivated to try and understand their adolescent and acquire skills to support their adolescent;

(b) to not be a good alternative (particularly in isolation) for patients who have a home environment with parents who are unwilling to accept that they might need to change in order to support their adolescent. In my opinion, AMYOS is unable to support those adolescents who remain in households where a family member is acting in an intentionally harmful way towards the adolescent or where parents are unwilling to make changes to accommodate the special needs of their adolescent. In these circumstances, the patient is at risk of remaining in a dysfunctional environment which will generally prevent any meaningful recovery or rehabilitation (and not 'fixable' by AMYOS services); and

(c) to potentially be unsuitable for those adolescents whose severe mental health problem is refractory to treatment, for example treatment refractory psychosis or treatment refractory Anorexia Nervosa.

81. In respect of those patients for whom I consider AMYOS to be an appropriate BAC alternative, I consider AMYOS to have some advantages for the patient, as compared the BAC model of care. In particular:

(a) AMYOS enables the patient's family to receive support which, in turn, lifts the functioning of the family and has the potential to result in better rehabilitation outcomes for the patient, their siblings and the parents. 'Skilling-up' a family means that they can better support the mental health of the adolescent;

(b) treatment in the home environment is generally safer for a young person as it allows the patients to avoid the risks of hospital (which include risks of exposure to medications that are not needed, sexual assault by other patients, adverse staff reactions (for example, seclusion) and institutionalisation).

82. Institutionalisation is an enormous problem in mental health care generally. In my experience, the inpatient care of adolescent risks the patient regressing and becoming 'de-skilled'.

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83. In respect of those patients for whom I do not consider AMYOS to be a satisfactory alternative to the BAC (in isolation), I consider mental health care must necessarily be accompanied by a meaningful partnership of services from other government departments (including health, child safety, education, housing etc), Non-Government Organisations and potentially the private sector. In my experience, currently this wraparound care is generally done poorly in Queensland.

OATHS ACT 1867 (DECLARATION)

I ASSOCIATE PROFESSOR DR JAMES GRAHAM SCOTT do solemnly and sincerely declare that:

(1) This written statement by me dated 4/2/16 is true to the best of my knowledge and belief: and

(2) I make this statement knowing that if it were admitted as evidence, I may be liable to prosecution for stating in it anything I know to be false.

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

....Signature

Taken and declared before me at Merston this 4th day of February 2016.

Taken By ... .

Justice of the Peace / Commissioner for Declarations / Lawyer

....

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BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

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CURRICULUM VITAE

James Graham Scott

Researcherid D-5900-2012

Contents

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Part A

Current Appointments:

- **Consultant Psychiatrist**; Royal Brisbane and Women's Hospital Early psychosis service.
- **Associate Professor**; Discipline of Psychiatry, The University of Queensland.
- **Director of Research in Child and Youth Mental Health**; Queensland Cente for Mental Health Research.

Postal Address:

The UQ Centre for Clinical Research
Level 3, Building 71/918
Royal Brisbane and Women's Hospital
Herston, QLD 4029

Phone:

Fax:

E-Mail:

Date of Birth:

Nationality:

Marital Status:

Dependants:

Education: St Peters Lutheran College 1981-1985.
The University of Queensland 1986-1993.

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Undergraduate Activities:

1987- 1991	Night Duty Officer Red Cross Blood Bank
1987- 1992	Karate Instructor Renbukan Shito Ryu Karate
1989- 1991	Member of Qld Kumite Team
1990	1st Place Qld Kumite Championship (75- 80 kg)
1990	3rd Place Australian National Kumite Championship (75- 80 kg)
1991	Gold Medallist Kumite Oceania Cup New Caledonia
1992	Author "Lost in The Himalayas"
1992-1996	Professional Motivational Speaker

Qualifications

1993	The University of Queensland **Bachelor of Medicine, Bachelor of Surgery**
2000	Royal Australian and New Zealand College of Psychiatrists Training Program **Fellowship of the Royal Australian and New Zealand College of Psychiatry (FRANZCP)**
2001	Royal Australian and New Zealand College of Psychiatrists: Faculty of Child and Adolescent Psychiatry Training Program **Certificate in Advanced Training in Child and Adolescent Psychiatry**
2009	The University of Queensland **Doctor of Philosophy**: *"The prevalence and correlates of psychotic-like experiences in the Australian community".*

Awards

2001	Dr. Helen Rowe Zonta International Memorial Prize in Psychiatry
2005	UQ School of Medicine Central Clinical Division Post Graduate Student Conference "Best Presentation- Second Year Category"
2005	Australasian Society for Psychiatric Research "Best Debut Presentation"
2007	The Australian Society of Traumatic Stress Studies "Queensland Chapter Award for Research"
2009	The University of Queensland Dean's Award for Research

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	Excellence
2015	Best Clinical, Education or Health Services Oral Presentation 24th Annual RBWH Health Care Symposium.
2015	National Health and Medical Research Council Clinical Practitioner Fellowship.

Appointments

1993 – 1995	**Resident Medical Officer** Royal Brisbane Hospital
1996- 2000	**Registrar in Psychiatry** Queensland Health
1996 – 2000	**Visiting Senior Medical Officer** Sir Leslie Wilson Youth Detention Centre
2001 – 2003	**Consultant Psychiatrist** Royal Brisbane Hospital Royal Children's Hospital Pine Rivers Child and Youth Mental Health Service Rural Clinics Longreach
2003 – 2003	**Deputy Director** Royal Brisbane and Women's Hospital: Eating Disorder Outreach Service
2004 – 2006	**Director of Inpatient Services** Mater Child and Youth Mental Health Services
2007 – 2010	**Consultant Psychiatrist** Director: Child and Family Therapy Unit Evolve Therapeutic Services North Brisbane E-CYMHS (Video-psychiatry)
2010 – 2013	**Conjoint Senior Lecturer and Consultant Psychiatrist** The University of Queensland Discipline of Psychiatry The Royal Brisbane and Women's Hospital

Other Professional Activities

1996 – 2000	**Executive Member**; Queensland Association of Psychiatrists in Training.
1998	**Chair**; Queensland Association of Psychiatrists in Training
2001 – 2003	**Co-ordinator**; Senior Registrar Module for Queensland Psychiatry Trainees

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2001 – 2004	**Co-ordinator**; First Year Assessment of Queensland Psychiatry Trainees
2008 – 2010	**Chair**; QLD Working Party Child and Youth Mental Health Services and Department of Child Safety
2008 – 2010	**Co-Chair**; Partnership Committee Queensland Child & Youth Mental Health and Department of Child Safety
2009	**Convenor**; Queensland Child Psychiatry Annual Weekend Workshop
2010	**Convenor** Queensland Child Psychiatry Annual Weekend Workshop
2009 – 2011	**Chair**; Qld Branch of the Faculty of Child and Adolescent Psychiatry
2010 – 2013	**Chair**; Autism Early Intervention Outcomes Research Advisory Group
2010 – 2011	**Member**; Scientific Committee for 2011 RANZCP Congress
2013	**Member**; Barrett Centre Advisory Group
2013	**Member**; Organising Committee National Youth Mental Health
2001 – Present	**Member**; Training Monitoring Sub Committee for Psychiatry
2009 – Present	**Member**; Queensland Health Psychotropic Medication Advisory Committee
2010 – Present	**Executive Member** Qld Branch of the Faculty of Child and Adolescent Psychiatry
2010 – Present	**Member**; Queensland Statewide Early Psychosis Advisory Group
2011 – Present	**Member Steering Committee** 2nd Child and Youth National Survey of Mental Health and Well Being.
2010 – Present	**Academic Editor** PLoS One.
2011– Present	**Expert Advisor for Childhood Mental Disorders** Global Burden of Disease Project.
2012 – Present	**Elected Executive Member** Binational Youth Special Interest Group.
2013 – 20	**Lead Author** Childhood Mental Behavioural and Developmental Disorders: Disease Control Priorities 3rd Edition.

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2013 – Present	**Principal Investigator** Mater University of Queensland Study of Pregnancy
2013 – Present	**Chair** Nundah Headspace Clinical Reference Group
2014 – Present	**Member** Australian Early Psychosis Research Network
2014	**Convenor** Binational Youth Mental Health Forum
2015 – Present	**Member** Queensland Family and Child Commission Advisory Council
2015 – Present	**Member** Queensland Child Death Review Panel
2015 – Present	**Member** Reference Group Queensland Indigenous mental and substance use disorder prevalence and service utilisation study

Professional Memberships

1993 – Present	Australian Medical Association
2001 – Present	Royal Australian and New Zealand College of Psychiatry
2001 – Present	Faculty of Child and Adolescent Psychiatry (RANZCP)
2005 – Present	Australian Society of Psychiatric Research (ASPR)/ The Society of Mental Health Research (SMHR)
2005 – Present	Schizophrenia International Research Society
2012 – Present	Youth Mental Health Special Interest Group (RANZCP)
2014 – Present	Neurodevelopmental and Behavioural Paediatric Society of Australia (NBPSA)

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Part B

Teaching

2001 – Current RANZCP
Clinical supervision of Psychiatry Registrars

2001 – Current RANZCP Qld Training Programme
Lecturer

- Psychiatry (Child and adult)
- Statistics and Research methodology
- Public Health
- Ethics

2001 – Current **The University of Queensland**

Lecturer and Examiner

- Discipline of Psychiatry
- Discipline of Child Health
- School of Population Health
- School of Psychology (Post Graduate)

Postgraduate Student Supervision

Completed Students

Name	Degree	Administering Institute	Date of Completion	Research topic and Published Papers – See peer reviewed publications for details.
Moore, S	Masters of International Public Health	The University of Queensland	2012	Bullying and peer aggression in adolescence (P66, P86)
Castellini, J.	Doctorate of Clinical Psychology	The University of Queensland	2013	Emotion Regulation and Emotional Expression in Adolescence: A Comparison of Clinical and Non-Clinical Adolescents (P 81)
Duhig, M.	Masters of Educational and Developmental Psychology	Queensland University of Technology	2014	The Prevalence and Correlates of Childhood Trauma in Patients with Early Psychosis (P75)

MNH.900.003.0024

Capra, C.	PhD	Queensland University of Technology	2011-2015	Measuring, understanding and reducing psychotic-like experiences (PLEs) in young people

Students in Progress

Name	Degree	Administering Institute	Dates of Enrolment	Research topic
Erskine, H.	PhD	The University of Queensland	2013-2015	The epidemiology of conduct disorder and implications for interventions
Mills, N.	PhD	The University of Queensland	2010-2016	The role of cytokines in depression and cognition in adolescents
Thomas, H.	PhD	The University of Queensland	2014-2016	Beyond the classroom and into the cyber world, next generation research into adolescent bullying
Meddick, T.	PhD	The University of Queensland	2014-2020	Exploring family mental health as predictors of children's education and vocational outcomes across the lifespan
Banney, R	PhD	The University of Queensland	2013-2016	Specific language impairment across the lifespan: A retrospective and prospective study.
Moore, P.	Masters of Clinical Psychology	The University of Queensland	2014-2016	An investigation into the efficacy of prospective memory reminders in individuals with schizophrenia
Suetani, S.	PhD	The University of Queensland	2015-2020	Physical activity and people with psychosis
Burgher, B.	PhD	The University of Queensland	2015-2020	Microglial activation in early onset psychotic disorders

External Examiner:

Deakin University PhD Examiner
Royal Australian and New Zealand College of Psychiatrists Clinical Examiner
The University of Auckland PhD Examiner
The Royal College of Surgeons Ireland Doctor of Medicine Examiner
The University of Melbourne PhD Examiner
The University of Otago PhD Examiner
The University of Adelaide PhD Examiner

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Reviewer - Journals

1. Acta Psychiatrica Scandivanica
2. Australasian Psychiatry
3. American Journal of Psychiatry
4. American Journal of Preventative Medicine
5. Archives of General Psychiatry
6. Australian & New Zealand Journal of Psychiatry
7. BJPych Open
8. British Journal of Psychiatry
9. British Journal of Psychology
10. Development and Psychopathology
11. Early Interventions in Psychiatry
12. European Child and Adolescent Psychiatry
13. JAMA Psychiatry
14. Journal of Child Health and Paediatrics
15. Journal of Child Psychology, Psychiatry and Other Disciplines
16. Journal of Clinical Psychology
17. Journal of Psychiatric Research
18. Journal of Nervous and Mental Disease
19. International Journal of Epidemiology
20. The Lancet
21. Medical Journal of Australia
22. Public Library of Science (PLoS) One
23. Psychiatry Research
24. Psychopathology
25. Schizophrenia Research
26. Schizophrenia Bulletin
27. Social Psychiatry and Psychiatric Epidemiology
28. Suicide and Life-Threatening Behavior
29. The BMJ

Reviewer – funding agencies

Medical Research Charities Group and Health Research Board (Ireland)
National Health and Medical Research Council (Australia)
New Zealand Health and Research Council (New Zealand)

Editorial Boards

2009 – Present	Public Library of Science (PLoS) One
2011 – Present	Australian and New Zealand Journal of Psychiatry
2015 – Present	Advances in Mental Health

MNH.900.003.0026

Part C

Research Grants

G1. Astra Zeneca Investigator Initiated Trial Scott, J. Safety and tolerability of Quetiapine in First Episode Psychosis. (2002) **$220,000**

G2. Queensland Health Allied Health Research Grants: Dean,A. Scott, J. Safety and efficacy of *prn* sedation in children and adolescents – a naturalistic trial in a mental health inpatient unit: (2005) **$7,617**

G3. RBWH Foundation Grant. Scott J., Dark, F. Capra, C. Stathis, S. Turner K. McGrath, J. Does exposure to childhood trauma alter the presentation and clinical outcomes of patients with early psychosis? (2011) **$38,000**

G4. RBWH Foundation Grant Pritchard, M. Hovey, D. Bella, E. Cartwright, D. Scott, J. A longitudinal study of autism, development and parenting in preterm infants (<29weeks) from 2 to 4-years (2012) **$25,000**

G5. Bryan Foundation Scholarship Scott, J. Funding available through Clear Thinking for a PhD Scholarship. (2013-15) **$75,000**

G6. Private Donation Youth Mental Health Schizophrenia Initiative Scott, J. Investigating NMDAR antibody encephalitis in Patients with FEP (2013-15) **$54,000**

G7. National Health and Medical Research Council. Scott, J., McGrath, J. Najman, J., ALati, R., Mamun, A., Clavarino, A. Outcomes of Adolescents who hallucinate (2013-15) **$603,000**

G8. RBWH Foundation Grant: Scott, J. Patterson, S, Martin, N., Medland, S. Breakspear, M. Wright, M. Predicting mental health outcomes in young adults from brain imaging and adolescent personality and psychiatric symptoms (2013) **$40,000**

G9. RBWH Foundation Grant: Scott, J. Patterson, S Modelling Psychiatric Readmissions (2013) **$37,500**

G10. RBWH Foundation Grant: Blum, S. Scott, J. Gillis, D. Patterson, S Prevalence, clinical and serological characterization of first episode psychosis associated with NMDAR antibodies (2014) **$40,000**

G11. National Health and Medical Research Council. Hickie, I., Martin, N., Scott, J., Gillespie, N., Hermens, D. Clinical and neurobiological predictors of onset of major mental disorders (mania, psychosis, severe depression), and associated functional impairment, in adolescent and young adult twins: A prospective longitudinal study" (2014-2019) **$1,291,586**

G12. Stanley Medical Research Institute. Berk, M., McGrath, J., Dean, O., Lapau, W., Dodds, S., Scott, J., Dark, F. The efficacy of adjunctive Garcinia mangostana Linn (Mangosteen) pericarp for the treatment of schizophrenia. A double blinded randomized, placebo controlled trial (2015-2018) **US$899,398**

MNH.900.003.0027

G13. National Health and Medical Research Council. Greer, J., Mowry, B., Scott, J. "Investigating the aetiopathogenic role of autoantibodies against the M1 muscarinic acetylcholine receptor in patients with first episode of schizophrenia" (2015) **$830,986**

G14. National Health and Medical Research Council. Mihalopoulos, C., Richardson, J., Scott, J.G., Viney, R., Brazier, J., Chen, G. Determining the Best Outcome Measures for Assessing Cost-Effectiveness of Interventions for Childhood Mental Disorders (2015) **$473,837**

G15. National Health and Medical Research Council Scott, J.G. Clinical Practitioner Fellowship Prevention and Management of Youth Mental Illness (2015) **$334,258**

G16. RBWH Foundation Grant: Scott, J. Anti-Neuronal Antibodies in patients with treatment refractory psychotic disorders (2016) **$44,000**

MNH.900.003.0028

Part D

Peer Reviewed Publications

P1. Zimmerman, M., Appadurai, K., Scott, J., Jellett, L. B., & Garlick, F. (1997). Survival. *Ann Intern Med, 127*(5), 405-409.

P2. McGrath, J., & Scott, J. (2006). Urban birth and risk of schizophrenia: a worrying example of epidemiology where the data are stronger than the hypotheses. *Epidemiol Psychiatr Soc*, 15(4), 243-246.

P3. Scott, J., Chant, D., Andrews, G., & McGrath, J. (2006). Psychotic-like experiences in the general community: the correlates of CIDI psychosis screen items in an Australian sample. *Psychol Med*, 36(2), 231-238.

P4. Dean, A., Duke, S., George, M., & Scott, J. (2007). Behavioral management leads to reduction in aggression in a child and adolescent psychiatric inpatient unit. *J Am Acad Child Adolesc Psychiatry*, 46(6), 711-720.

P5. Scott, J., Chant, D., Andrews, G., Martin, G., & McGrath, J. (2007). The association between trauma exposure and delusional experiences in a large community-based sample. *Brit J Psychiat*, 190, 339-343.

P6. Scott, J., Pache, D., Keane, G., Buckle, H., & O'Brien, N. (2007). Prolonged anticholinergic delirium following antihistamine overdose. Australas Psychiatry, 15(3), 242-244.

P7. Scott, J., Nurcombe, B., Sheridan, J., & McFarland, M. (2007). Hallucinations in adolescents with post-traumatic stress disorder and psychotic disorder. Australas Psychiatry, 15(1), 44-48.

P8. Catts, S., Frost, A., Gifford, S., & Scott, J. (2008). Real-world use of quetiapine in early psychosis: An acute inpatient and community follow-up effectiveness study. *Int J Psychiatry Clin Pract*, 12(1), 65-73.

P9. Dean, A., Duke, S., Scott, J., Bor, W., George, M., & McDermott, B. (2008). Physical aggression during admission to a child and adolescent inpatient unit: predictors and impact on clinical outcomes. *Aust N Z J Psychiatry*, 42(6), 536-543.

P10. Jessop, M., Scott, J., & Nurcombe, B. (2008). Hallucinations in adolescent inpatients with post-traumatic stress disorder and schizophrenia: similarities and differences. Australas Psychiatry, 16(4), 268-272.

P11. Scott, J., Welham, J., Martin, G., Bor, W., Najman, J., O'Callaghan, M., . . . McGrath, J. (2008). Demographic correlates of psychotic-like experiences in young Australian adults. *Acta Psychiatr Scand*, 118(3), 230-237.

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P12. Swannell, S., Martin, G., Scott, J., Gibbons, M., & Gifford, S. (2008). Motivations for self-injury in an adolescent inpatient population: development of a self-report measure. Australas Psychiatry, 16(2), 98-103.

P13. Varghese, D., Scott, J., & McGrath, J. (2008). Correlates of delusion-like experiences in a non-psychotic community sample. *Aust N Z J Psychiatry*, 42(6), 505-508.

P14. Dean, A. J., Scott, J., & McDermott, B. M. (2009). Changing utilization of pro re nata ('as needed') sedation in a child and adolescent psychiatric inpatient unit. *Aust N Z J Psychiatry*, 43(4), 360-365.

P15. Scott, J., Martin, G., Bor, W., Sawyer, M., Clark, J., & McGrath, J. (2009). The prevalence and correlates of hallucinations in Australian adolescents: results from a national survey. *Schizophr Res*, 107(2-3), 179-185.

P16. Scott, J., Martin, G., Welham, J., Bor, W., Najman, J., O'Callaghan, M., . . . McGrath, J. (2009). Psychopathology during childhood and adolescence predicts delusional-like experiences in adults: a 21-year birth cohort study. *Am J Psychiatry*, 166(5), 567-574.

P17. Welham, J., Scott, J., Williams, G., Najman, J., Bor, W., O'Callaghan, M., & McGrath, J. (2009). Emotional and behavioural antecedents of young adults who screen positive for non-affective psychosis: a 21-year birth cohort study. *Psychol Med*, 39(4), 625-634.

P18. Welham, J., Scott, J., Williams, G., Najman, J., O'Callaghan, M., & McGrath, J. (2009). Growth in young adults who screen positive for non-affective psychosis: birth cohort study. *Aust N Z J Psychiatry*, 43(1), 61-67.

P19. Aird, R., Scott, J., McGrath, J., Najman, J. M., & Mamun, A. (2010). Is the New Age phenomenon connected to delusion-like experiences? Analysis of survey data from Australia. *Ment Health Relig Cult*, 13(1), 37-53.

P20. Dean, A., Gibbon, P., McDermott, B., Davidson, T., & Scott, J. (2010). Exposure to aggression and the impact on staff in a child and adolescent inpatient unit. *Arch Psychiatr Nurs*, 24(1), 15-26.

P21. McGrath, J., Welham, J., Scott, J., Varghese, D., Degenhardt, L., Hayatbakhsh, M., . . . Najman, J. (2010). Association between cannabis use and psychosis-related outcomes using sibling pair analysis in a cohort of young adults. *Arch Gen Psychiatry*, 67(5), 440-447.

P22. Scott, J., Varghese, D., & McGrath, J. (2010). As the twig is bent, the tree inclines: adult mental health consequences of childhood adversity. *Arch Gen Psychiatry*, 67(2), 111-112.

MNH.900.003.0030

P23. Welham, J., Scott, J., Williams, G. M., Najman, J., Bor, W., O'Callaghan, M., & McGrath, J. (2010). The antecedents of non-affective psychosis in a birth-cohort, with a focus on measures related to cognitive ability, attentional dysfunction and speech problems. *Acta Psychiatr Scand*, 121(4), 273-279.

P24. Hollingworth, S., Nissen, L., Stathis, S., Siskind, D., Varghese, J., & Scott, J. (2011). Australian national trends in stimulant dispensing: 2002-2009. *Aust N Z J Psychiatry*, 45(4), 332-336.

P25. McGee, T., Scott, J., McGrath, J., Williams, G., O'Callaghan, M., Bor, W., & Najman, J. (2011). Young adult problem behaviour outcomes of adolescent bullying. *J Aggress Confl Peace Res*, 3(2), 115-120.

P26. Saha, S., Scott, J., Varghese, D., & McGrath, J. (2011). The association between physical health and delusional-like experiences: a general population study. *PLoS One*, 6(4), e18566.

P27. Saha, S., Scott, J., Johnston, A., Slade, T., Varghese, D., Carter, G., & McGrath, J. (2011). The association between delusional-like experiences and suicidal thoughts and behaviour. *Schizophr Res*, 132(2-3), 197-202.

P28. Saha, S., Scott, J., Varghese, D., Degenhardt, L., Slade, T., & McGrath, J. (2011). The association between delusional-like experiences, and tobacco, alcohol or cannabis use: a nationwide population-based survey. *BMC Psychiatry*, 11, 202.

P29. Saha, S., Scott, J., Varghese, D., & McGrath, J. (2011). The association between general psychological distress and delusional-like experiences: a large population-based study. *Schizophr Res*, 127(1-3), 246-251.

P30. Saha, S., Varghese, D., Slade, T., Degenhardt, L., Mills, K., McGrath, J., & Scott, J. (2011). The association between trauma and delusional-like experiences. *Psychiatry Res*, 189(2), 259-264.

P31. Varghese, D., Saha, S., Scott, J., Chan, R., & McGrath, J. (2011). The association between family history of mental disorder and delusional-like experiences: a general population study. Am J Med Genet B *Neuropsychiatr Genet*, 156B(4), 478-483.

P32. Varghese, D., Scott, J., Welham, J., Bor, W., Najman, J., O'Callaghan, M., . . . McGrath, J. (2011). Psychotic-like experiences in major depression and anxiety disorders: a population-based survey in young adults. *Schizophr Bull*, 37(2), 389-393.

P33. Al Mamun, A., O'Callaghan, F., Scott, J., Heussler, H., O'Callaghan, M., Najman, J., & Williams, G. (2012). Continuity and discontinuity of trouble sleeping

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behaviors from early childhood to young adulthood in a large Australian community-based-birth cohort study. *Sleep Med*, 13(10), 1301-1306.

P34. Hollingsworth, K., Callaway, L., Duhig, M., Matheson, S., & Scott, J. (2012). The association between maltreatment in childhood and pre-pregnancy obesity in women attending an antenatal clinic in Australia. *PLoS One*, 7(12), e51868.

P35. Murray, C., Vos, T., Lozano, R., Naghavi, M., Flaxman, A., Michaud, C., . . . Memish, Z. (2012). Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990-2010: a systematic analysis for the Global Burden of Disease Study 2010. *Lancet*, 380(9859), 2197-2223.

P36. Norman, R., Byambaa, M., De, R., Butchart, A., Scott, J., & Vos, T. (2012). The long-term health consequences of child physical abuse, emotional abuse, and neglect: a systematic review and meta-analysis. *PLoS Med*, 9(11), e1001349.

P37. Paynter, J., Scott, J., Beamish, W., Duhig, M., & Heussler, H. (2012). A Pilot Study of the Effects of an Australian Centre-Based Early Intervention Program for Children with Autism. *Open Pediatr Med Journal*, 6(1), 7-14.

P38. Saha, S., Scott, J., Varghese, D., & McGrath, J. (2012). Anxiety and depressive disorders are associated with delusional-like experiences: a replication study based on a National Survey of Mental Health and Wellbeing. *BMJ Open*, 2(3).

P39. Saha, S., Scott, J., Varghese, D., & McGrath, J. (2012). Social support and delusional-like experiences: a nationwide population-based study. *Epidemiol Psychiatr Sci*, 21(2), 203-212.

P40. Stark, A., & Scott, J. (2012). A review of the use of clozapine levels to guide treatment and determine cause of death. *Aust N Z J Psychiatry*, 46(9), 816-825.

P41. Vos, T., Flaxman, A. D., Naghavi, M., Lozano, R., Michaud, C., Ezzati, M., . . . Memish, Z. A. (2012). Years lived with disability (YLDs) for 1160 sequelae of 289 diseases and injuries 1990-2010: a systematic analysis for the Global Burden of Disease Study 2010. *Lancet*, 380(9859), 2163-2196.

P42. Ahire, M., Sheridan, J., Regbetz, S., Stacey, P., & Scott, J. (2013). Back to basics: Informing the public of co-morbid physical health problems in those with mental illness. *Aust N Z J Psychiatry*, 47(2), 177-184.

P43. Betts, K., Williams, G., Najman, J., Scott, J., & Alati, R. (2013). The association between lower birth weight and comorbid generalised anxiety and major depressive disorder. *J Affect Disord*, 146(2), 231-237.

P44. Capra, C., Kavanagh, D., Hides, L., & Scott, J. (2013). Brief screening for psychosis-like experiences. *Schizophr Res*, 149(1-3), 104-107.

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P45. Cotton, S., Lambert, M., Schimmelmann, B., Mackinnon, A., Gleeson, J., Berk, M., . . . Conus, P. (2013). Differences between first episode schizophrenia and schizoaffective disorder. *Schizophr Res*, 147(1), 169-174.

P46. Duhig, M., Saha, S., & Scott, J. (2013). Efficacy of risperidone in children with disruptive behavioural disorders. *J Paediatr Child Health*, 49(1), 19-26.

P47. Erskine, H., Ferrari, A., Nelson, P., Polanczyk, G., Flaxman, A., Vos, T., . . . Scott, J. (2013). Epidemiological modelling of attention-deficit/hyperactivity disorder and conduct disorder for the Global Burden of Disease Study 2010. *J Child Psychol Psychiatry*, 54(12), 1263-1274.

P48. Hamlyn, J., Duhig, M., McGrath, J., & Scott, J. (2013). Modifiable risk factors for schizophrenia and autism - Shared risk factors impacting on brain development. *Neurobiol Dis*, 53, 3-9.

P49. Hollingworth, S., Duhig, M., Hall, W., & Scott, J. (2013). National trends in the community prescribing of second-generation antipsychotic medications in Australian children and youth: the incomplete story. *Australas Psychiatry*, 21(5), 442-445.

P50. Mills, N., Scott, J., Wray, N., Cohen-Woods, S., & Baune, B. (2013). Research review: The role of cytokines in depression in adolescents: a systematic review. *J Child Psychol Psychiatry*, 54(8), 816-835.

P51. Mills, R., Scott, J., Alati, R., O'Callaghan, M., Najman, J., & Strathearn, L. (2013). Child maltreatment and adolescent mental health problems in a large birth cohort. *Child Abuse Negl.*

P52. Norman, R., Carpenter, D., Scott, J., Brune, M., & Sly, P. (2013). Environmental exposures: an underrecognized contribution to noncommunicable diseases. *Rev Environ Health*, 28(1), 59-65.

P53. Norman, R., Veerman, J., Scott, J., Fantino, E., Bailie, R., Sly, P., & Cleghorn, G. (2013). Invited Commentary: Environmental Contributions to The Leading Causes of Disease Burden Among Australian Children. *J Pediatr Gastroenterol Nutr.*

P54. Saha, S., McGrath, J., & Scott, J. (2013). Service use for mental health problems in people with delusional-like experiences: a nationwide population based survey. *PLoS One*, 8(8), e71951.

P55. Saha, S., Scott, J., Varghese, D., & McGrath, J. (2013). Socio-economic disadvantage and delusional-like experiences: a nationwide population-based study. *Eur Psychiatry*, 28(1), 59-63.

MNH.900.003.0033

P56. Saha, S., Stedman, T., Scott, J., & McGrath, J. (2013). The co-occurrence of common mental and physical disorders within Australian families: a national population-based study. *Aust N Z J Psychiatry*, 47(8), 754-761.

P57. Scott, J., Duhig, M., Hamlyn, J., & Norman, R. (2013). Environmental contributions to autism: Explaining the rise in incidence of autistic spectrum disorders. *J Environ Immunol Toxicol*, 1(2), 75-79.

P58. Varghese, D., Scott, J., Bor, W., Williams, G., Najman, J., & McGrath, J. (2013). The association between adult attachment style and delusional-like experiences in a community sample of women. *J Nerv Ment Dis*, 201(6), 525-529.

P59. Varghese, D., Wray, N., Scott, J., Williams, G., Najman, J., & McGrath, J. (2013). The heritability of delusional-like experiences. *Acta Psychiatr Scand*, 127(1), 48-52.

P60. Betts, K., Williams, G., Najman, J., Scott, J., & Alati, R. (2014). Exposure to stressful life events during pregnancy predicts psychotic experiences via behaviour problems in childhood. *J Psychiatr Res*.

P61. Betts, K., Williams, G., Najman, J., Scott, J., & Alati, R. (2014). Maternal prenatal infection, early susceptibility to illness and adult psychotic experiences: a birth cohort study. *Schizophr Res*, 156(2-3), 161-167.

P62. Duke, S., Scott, J., & Dean, A. (2014). Use of restrictive interventions in a child and adolescent inpatient unit - predictors of use and effect on patient outcomes. *Australas Psychiatry*.

P63. Erskine, H., Ferrari, A., Polanczyk, G., Moffitt, T., Murray, C., Vos, T., . . . Scott, J. (2014). The global burden of conduct disorder and attention-deficit /hyperactivity disorder in 2010. *J Child Psychol Psychiatry*, 55(4), 328-336.

P64. Ferro, M., Boyle, M., Scott, J., & Dingle, K. (2014). The child behavior checklist and youth self-report in adolescents with epilepsy: testing measurement invariance of the attention and thought problems subscales. *Epilepsy Behav*, 31, 34-42.

P65. Johns, L., Kompus, K., Connell, M., Humpston, C., Lincoln, T. M., Longden, E., . . . Laroi, F. (2014). Auditory verbal hallucinations in persons with and without a need for care. *Schizophr Bull*, 40 Suppl 4, S255-264.

P66. Moore, S., Norman, R., Sly, P., Whitehouse, A., Zubrick, S., & Scott, J. (2014). Adolescent peer aggression and its association with mental health and substance use in an Australian cohort. *J Adolesc*, 37(1), 11-21.

P67. Najman, J., Khatun, M., Mamun, A., Clavarino, A., Williams, G., Scott, J., . . . Alati, R. (2014). Does depression experienced by mothers leads to a decline in

MNH.900.003.0034

marital quality: a 21-year longitudinal study. *Soc Psychiatry Psychiatr Epidemiol*, 49(1), 121-132.

P68. Norman, R., Ryan, A., Grant, K., Sitas, F., & Scott, J. (2014). Environmental contributions to childhood cancers. *J Environ Immunol Toxicol*, 1(4), 190-202.

P69. Patterson, S., Duhig, M., Connell, M., & Scott, J. (2014). Successful recruitment to a study of first-episode psychosis by clinicians: a qualitative account of outcomes and influences on process. *J Ment Health*, 1-6.

P70. Rowe, C., Spelman, L., Oziemski, M., Ryan, A., Manoharan, S., Wilson, P., . . . Scott, J. (2014). Isotretinoin and mental health in adolescents: Australian consensus. *Australas J Dermatol*, 55(2), 162-167.

P71. Salom, C., Betts, K., Williams, G., Najman, J., Scott, J., & Alati, R. (2014). Do young people with comorbid mental and alcohol disorders experience worse behavioural problems? *Psychiatry Res*.

P72. Scott, J., Moore, S., Sly, P., & Norman, R. (2014). Bullying in children and adolescents: a modifiable risk factor for mental illness. *Aust N Z J Psychiatry*, 48(3), 209-212.

P73. Baxter, A., Brugha, T., Erskine, H., Scheurer, R., Vos, T., & Scott, J. (2015). The epidemiology and global burden of autism spectrum disorders. *Psychol Med*, 45(3), 601-613.

P74. Capra, C., Kavanagh, D., Hides, L., & Scott, J. (2015). Current CAPE-15: a measure of recent psychotic-like experiences and associated distress. *Early Interv Psychiatry*.

P75. Duhig, M., Patterson, S., Connell, M., Foley, S., Capra, C., Dark, F., . . . Scott, J. (2015). The prevalence and correlates of childhood trauma in patients with early psychosis. *Aust N Z J Psychiatry*, 49(7), 651-659.

P76. Erskine, H., Moffitt, T., Copeland, W., Costello, E., Ferrari, A., Patton, G., . . . Scott, J. (2015). A heavy burden on young minds: the global burden of mental and substance use disorders in children and youth. *Psychol Med*, 45(7), 1551-1563.

P77. Ferro, M., Boyle, M., Alati, R., Scott, J., & Dingle, K. (2015). Maternal psychological distress mediates the relationship between asthma and physician visits in a population-based sample of adolescents. *J Asthma*, 52(2), 170-175.

P78. Ferro, M., Van Lieshout, R., Scott, J., Alati, R., Mamun, A., & Dingle, K. (2015). Condition-Specific Associations of Symptoms of Depression and Anxiety in Adolescents and Young Adults with Asthma and Food Allergy. *J Asthma*, In Press (Accepted 3 Oct)

MNH.900.003.0035

P79. Forouzanfar, M., Alexander, L., Anderson, H., Bachman, V., Biryukov, S., Brauer, M., . . . Murray, C. (2015). Global, regional, and national comparative risk assessment of 79 behavioural, environmental and occupational, and metabolic risks or clusters of risks in 188 countries, 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. *Lancet.*

P80. Henry, J., Castellini, J., Moses, E., & Scott, J. (2015). Emotion regulation in adolescents with mental health problems. *J Clin Exp Neuropsyc.*

P81. Henry, J., Moses, E., Castellini, J., & Scott, J. (2015). Mental health problems in adolescence and the interpretation of unambiguous threat. *PLoS One, 10*(6), 1-11.

P82. Martin, G., Thomas, H., Andrews, T., Hasking, P., & Scott, J. (2015). Psychotic experiences and psychological distress predict contemporaneous and future non-suicidal self-injury and suicide attempts in a sample of Australian school-based adolescents. *Psychol Med*, 45(2), 429-437.

P83. McGrath, J., Alati, R., Clavarino, A., Williams, G., Bor, W., Najman, J., . . .Scott, J. (2015). Age at first tobacco use and risk of subsequent psychosis-related outcomes: A birth cohort study. *Aust N Z J Psychiatry.*

P84. Mills, N., Wright, M., Henders, A., Eyles, D., Baune, B., McGrath, J., . . . Vinkhuyzen, A. (2015). Heritability of Transforming Growth Factor-beta1 and Tumor Necrosis Factor-Receptor Type 1 Expression and Vitamin D Levels in Healthy Adolescent Twins. *Twin Res Hum Genet*, 18(1), 28-35.

P85. Moore, S., Scott, J., Ferrari, A., Mills, R., Dunne, M., Erskine, H., . . . Norman, R. (2015). Burden attributable to child maltreatment in Australia. *Child Abuse Negl*, 48, 208-220.

P86. Moore, S., Scott, J., Thomas, H., Sly, P., Whitehouse, A., Zubrick, S., & Norman, R. (2015). Impact of adolescent peer aggression on later educational and employment outcomes in an Australian cohort. *J Adolesc*, 43, 39-49.

P87. Murray, C., Barber, R., Foreman, K., Ozgoren, A., Abd-Allah, F., Abera, S., . . . Vos, T. (2015). Global, regional, and national disability-adjusted life years (DALYs) for 306 diseases and injuries and healthy life expectancy (HALE) for 188 countries, 1990-2013: quantifying the epidemiological transition. *Lancet.*

P88. Naghavi, M., & et al. (2015). Global, regional, and national age-sex specific all-cause and cause-specific mortality for 240 causes of death, 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. *Lancet*, 385(9963), 117-171.

MNH.900.003.0036

P89. Najman, J., Alati, R., Bor, W., Clavarino, A., Mamun, A., McGrath, J., . . . Wray, N. (2015). Cohort Profile Update: The Mater-University of Queensland Study of Pregnancy (MUSP). *Int J Epidemiol*, 44(1), 78-78f.

P90. Newman, M., Blum, S., Scott, J. G., Wilson, R., Prain, K., Wong, R., & Gillis, D. (2015). Autoimmune Encephalitis. *Intern Med*, In Press (Accepted 19 Nov).

P91. Patel, V., Chisholm, D., Parikh, R., Charlson, F., Degenhardt, L., Dua, T., . . . Whiteford, H. (2015). Addressing the burden of mental, neurological, and substance use disorders: key messages from Disease Control Priorities, 3rd edition. *Lancet.*

P92. Paynter, J., Riley, E., Beamish, W., Scott, J. G., & Heussler, H. (2015). Brief Report: An evaluation of an Australian autism-specific, early intervention programme. *Int J Spec Educ*, 30(2), 1-7.

P93. Pritchard, M., de Dassel, T., Beller, E., Bogossian, F., Russo, S., Johnstone, L., . . . Scott, J. (2015). Autism in Toddlers Born Very Preterm. *Pediatrics*, In Press (Accepted 27 Oct).

P94. Suetani, S., Rosenbaum, S., Scott, J., Curtis, J., & Ward, P. (2015). Bridging the Gap: What have we done, and what more can we do to reduce the burden of avoidable death in people with psychotic illness? *Epidemiol Psychiatr Sci*, In Press (Accepted 28 Nov).

P95. Thomas, H., Chan, G., Scott, J., Connor, J., Kelly, A., & Williams, J. (2015). Association of different forms of bullying victimisation with adolescents' psychological distress and reduced emotional wellbeing. *Aust N Z J Psychiatry.*

P96. Thomas, H., Connor, J., & Scott, J. (2015). Integrating Traditional Bullying and Cyberbullying: Challenges of Definition and Measurement in Adolescents - a Review. *Educ Psychol Rev*, 27, 135-152.

Book Chapters

B1. Scott, J., McClean, D., & McGrath, J. (2003). Families where a Parent has schizophrenia: Opportunities for Prevention. In A. Grispini (Ed), *Preventative Strategies for Schizophrenic Disorders* (pp. 210-224) Rome, Giovanni Fiorti Editore.

B2. Nurcombe, B., Scott, J., & Jessop, M. (2008). Dissociative Hallucinosis. In P. Dell & J. O'Neil (Eds.), *Dissociation and the Dissociative Disorders: DSM-V and Beyond.* New York: Routledge

B3. Nurcombe, B., Scott, J., & Jessop, M. (2008) Trauma- based Dissociative Hallucinosis: Diagnosis and Treatment. In A. Moskowitz, I. Schafer, & M. Dorahy (Eds.) *Psychosis, Trauma and Dissociation* (pp 271-280) West Sussex: Wilet-Blackwell.

MNH.900.003.0037

B4. Scott, J., Jessop, M., & Nurcombe, B. (2011) Hallucinations. In R. Levesque (Ed) *Encyclopedia of Adolescence* (pp 1246-1252) New York, Springer.

B5. Ash, D., Bland, R., Brown, P., Oakley Browne, M., Burvill, P., Davies, J., Grigg, M., Gurr, R., Hughson, B., Meadows, G. . . . Emmerson, B. (2012). Mental health services in the Australian states and territories. In G. Meadows, J. Farhall, E. Fossey, M. Grigg, F. McDermott, & B. Singh (Eds.) *Mental health in Australia: collaborative community practice* 3rd ed. (pp. 118-154) Melbourne, Australia: Oxford University Press.

B5. Patel, V., Chisholm, D., Parikh, R., Charlson, F., Degenhardt, L., Dua, T., Ferrari, A., Hyman, S., Laxminarayan, R., Levin, C. . . . Whiteford H, (2015) Chapter 1. In V. Patel, D. Chisholm, T. Dua, R. Laxminarayan, and M. E. Medina-Mora (Eds.) *Disease Control Priorities (third edition): Volume 4, Mental, Neurological, and Substance Use Disorders: Conference edition.* Washington, DC: World Bank.

B6. Scott, J., Mihalopoulos, C., Erskine, H., Roberts, J., & Rahman, A. (2015) Chapter 8, Child Developmental and Mental Disorders. In V. Patel, D. Chisholm, T. Dua, R. Laxminarayan, and M. E. Medina-Mora (Eds.) *Disease Control Priorities (third edition): Volume 4, Mental, Neurological, and Substance Use Disorders: Conference edition.* Washington, DC: World Bank.

B7. Scott, J., Ross, C., Dorahy, M., Read, J.,& Schäfer, I. (2015) Childhood Trauma in Psychotic and Dissociative Disorders. In A. Moskowitz, I. Schafer, & M. Dorahy (Eds.) *Psychosis, Trauma and Dissociation.* West Sussex: Wiley- Blackwell (In Press).

Letters

L1. Scott, J., & Dean, A. (2008). Tailoring seclusion policies to the patient group. *British Journal of Psychiatry*, 192(3):232.

L2 Scott, J., Najman, J., & McGrath, J. (2009). Influence of socioeconomic status on delusional-like experiences in adults. *Am J Psychiatry*, 166: 1063.

L3. Cox, A., Emmerson, B., Collyer, B., & Scott, J. (2012). Why change injection sites for depot antipsychotic medication? *Aust N Z J Psychiatry*, 46(8):794.

L4. Doyle, C., Patterson, S., & Scott, J. (2014) Electronic cigarettes and smoking cessation: a quandary? *Lancet*, 383(9915): 408.

Non-peer reviewed publications

N1. Scott, J. & Duhig, M. (2011). Take drugs out of disorders. *Med J Aust: Insight, 43*

N2. Scott, J. & Duhig, M. (2011). Diagnostic dilemma of ADHD. *Med J Aust: Insight, 33.*

MNH.900.003.0038

Part E

Published Abstracts

A1. Catts, S., Frost, A., Shaune, G., & Scott, J. (2005). *Quetiapine in early psychosis: An acute inpatient and community follow-up effectiveness study.* Paper presented at the Joint CINP/ASPR Scientific Meeting, Brisbane, Queensland.

A2. Scott, J., Chant, D., Andrews, G., Martin, G., & McGrath, J. (2005). *The association between trauma exposure and psychotic-like experiences in a large community-based sample.* Paper presented at the School of Medicine Postgraduate Student Conference, Herston, QLD, Australia.

A3. Scott, J., Chant, D., Andrews, G., Martin, G., & McGrath, J. (2005). *The association between trauma exposure and psychotic-like experiences in a large community-based sample.* Paper presented at the Joint CINP/ASPR Scientific Meeting, Brisbane.

A4. Scott, J., Chant, D., Andrews, G., Martin, G., & McGrath, J. (2006). *The association between personal trauma and psychotic-like experiences in a large community sample.* Paper presented at the 13th Biennial Winter Workshop on Schizophrenia Research, Davos, Switzerland.

A5. Scott, J., Chant, D., Andrews, G., & McGrath, J. (2006). *Psychotic-like experiences in the general community: The correlates of CIDI psychosis screen items in an Australian sample.* Paper presented at the XIIIth Biennial Winter Workshop on Schizophrenia Research, Davos, Switzerland.

A6. Scott, J., Chant, D., Andrews, G., Martin, G., & McGrath, J. (2007). *The association between trauma exposure and quasi-psychotic experiences in a large community-based sample.* Paper presented at the 42nd RANZCP Congress 2007, Gold Coast, Queensland.

A7. Scott, J., Chant, D., Andrews, G., & McGrath, J. (2007). *Quasi-psychotic experiences in the general community: The correlates of CIDI psychosis screen items in an Australian sample.* Paper presented at the The 42nd RANZCP Congress 2007, Gold Coast, Queensland.

A8. Scott, J., Welham, J., Martin, G., Bor, W., Najman, J., O'Callaghan, M., . . . McGrath, J. (2008). *Psychopathology during childhood and adolescence predicts delusional-like experiences in adults: A 21 year birth cohort study.* Paper presented at the RANZCP Faculty of Child & Adolescent Psychiatry Annual Conference: child2008 - Challenges in the Digital Age, Port Douglas, Australia.

A9. Scott, J., Welham, J., Martin, G., Bor, W., Najman, J., O'Callaghan, M., . . . McGrath, J. (2009). *Psychopathology during childhood and adolescence predicts*

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delusional-like experiences in adults: A 21 year birth cohort study. Paper presented at the 12th International Congress on Schizophrenia Research, San Diego, CA, United States.

A10. Scott, J., McGrath, J., & Najman, J. (2010). *The influence of maternal sensitivity, parental relationship and childhood sexual abuse on adult delusional-like experiences: A birth cohort study*. Paper presented at the 2nd Biennial Schizophrenia International Research Conference, Florence, Italy.

A11. McGrath, J., Saha, S., Scott, J., & Varghese, D. (2011). *The association between general psychological distress and delusional-like experiences: A large population-based study*. Paper presented at the 13th International Congress on Schizophrenia Research (ICSR), Colorado Springs, CO, U.S.A.

A12. McGrath, J., Welham, J., Scott, J., Varghese, D., Degenhardt, L., Hayatbakhsh, R., . . . Najman, J. (2011). *Modelling cognitive symptoms in the DVD-deficient rodent model of schizophrenia*. Paper presented at the 13th International Congress on Schizophrenia Research (ICOSR), Colorado Springs, CO, United States.

A13. McGrath, J., Welham, J., Scott, J., Varghese, D., Degenhardt, L., Hayatbakhsh, R., . . . Najman, J. (2011). *Sibling-pair analysis confirms an association between cannabis use and psychosis-related outcomes in a cohort of young adults*. Paper presented at the International Congress on Schizophrenia Research (13th, ICSR, 2011), Colorado Springs, CO, U.S.A.

A14. Cotton, S., Lambert, M., Schimmelmann, B., Mackinnon, A., Gleeson, J., Berk, M., . . . Conus, P. (2012). *First episode schizophrenia and schizoaffective disorder: a psychiatric nosology*. Paper presented at the 8th International Conference on Early Psychosis: From Neurobiology to Public Policy, San Francisco, CA, USA.

A15. Scott, J., Norman, R., Moore, S., & Sly, P. (2013). *Bullying: the Most Important Risk Factor for Mental Illness?* Paper presented at the RANZCP 2013 Congress, Sydney, NSW Australia.

A16. Mills, N., Nelson, E., Scott, J., Whitfield, J., Martin, N., Wright, M., . . . Byrne, E. (2015). *Investigating the Relationship Between C-Reactive Protein Genetic Profile Scores and Depression*. Paper presented at the The Royal Australian and New Zealand College of Psychiatrists 2015 Congress: Measurers and Thinkers: Psychiatry as Science and Art, Brisbane, QLD Australia.

A17. Mills, N., Nelson, E., Scott, J., Whitfield, J., Martin, N., Wright, M., . . . Martin, J. (2015). *Early Career Psychiatrists Special Interest Group Symposium*. Paper presented at the The Royal Australian and New Zealand College of Psychiatrists 2015 Congress: Measurers and Thinkers: Psychiatry as Science and Art, Brisbane, QLD Australia.

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A18. Mills, N., Scott, J., Whitfield, J., Wright, M., Martin, N., Wray, N., & Byrne, E. (2015). *Using C-Reactive Protein Genetic Profile Scores to Predict Risk of Anxiety.* Paper presented at the The Royal Australian and New Zealand College of Psychiatrists 2015 Congress: Measurers and Thinkers: Psychiatry as Science and Art, Brisbane, QLD Australia.

A19. Rowe, C., Byrom, L., Scott, J., & Zappala, T. (2015). *Psychological impact of chronic childhood skin disease on caregivers and families: a review.* Paper presented at the 48th Annual Scientific Meeting of the Australasian College of Dermatologists, Adelaide, SA Australia.

A20. Scott, J. (2015). *From Consulting Rooms to Global Research: Clinical Psychiatrists Who Research.* Paper presented at the The Royal Australian and New Zealand College of Psychiatrists 2015 Congress: Measurers and Thinkers: Psychiatry as Science and Art, Brisbane, QLD Australia.

A21. Scott, J., Mamun, A., Najman, J., & McGrath, J. (2015). *Increased Maternal Pre-Pregnancy Bmi Is Associated with Offspring Psychosis-Related Outcomes: a Birth Cohort Study.* Paper presented at the 15th International Congress on Schizophrenia Research (ICOSR), Colorado Springs, CO United States.

A22. McGrath, J., Najman, J., Williams, G., Bor, W., & Scott, J. (2013) Age at first tobacco use and risk of subsequent psychosis-related outcomes: a birth cohort study and nested sibling-pair study. *Schizophr Bull* S69.

A23. Scott, J., Thomas, H., Martin, G., Hasking, P., & Andrews, V. (2013) Suicidal ideation and behaviours in Australian adolescents with psychotic experiences: A worrying example of unmet need for intervention. *Schizophr Bull* S77.

Part F

Scientific Presentations at Conferences

C1. Scott, J. (2003) Against All Odds, RANZCP College Congress Brisbane, Australia (Invited Speaker)

C2. Scott, J., Nurcombe, B., McFarlane, M., & Sheridan J. (2004) A comparison of hallucinations in adolescents with Schizophrenia and post traumatic stress disorder, International Association of Child and Adolescent Psychiatrists and Allied Professionals (IACAPAP), Berlin, Germany

C3. Scott, J. (2005) Misdiagnosis arising from psychotic symptoms in PTSD, The University of Queensland Post Graduate Student Conference. Brisbane, Australia

MNH.900.003.0041

C4. Scott, J., Chant, D., Andrews, G., Martin, G., & McGrath, J. (2005) The association between trauma exposure and quasi-psychotic experiences in a large community-based sample, Joint Regional CINP and ASPR Annual Conference Brisbane, Australia

C5. Scott, J., Chant, D., Andrews, G., Martin,G., & McGrath, J. (2005) The association between trauma exposure and quasi-psychotic experiences in a large community-based sample. Winter Workshop on Schizophrenia, Davos,

C6. Scott, J. (2006) The role of Medications in children with autism, National Conference of Autism, Brisbane, Australia

C7. Scott, J., Chant, D., Andrews, G., Martin, G., McGrath, J. (2007). The association between trauma exposure and quasi-psychotic experiences in a large community-based sample, RANZCP Annual Conference Gold Coast. Australia

C8. Scott, J., Chant, D., Andrews, G., Martin, G., & McGrath, J. (2007). Quasi-psychotic experiences in the general community: The correlates of CIDI psychosis screen items in an Australian sample, RANZCP Annual Conference Gold Coast. Australia

C9. Scott, J., Welham J., Martin, G., Bor, W., Najman, J., O'Callaghan, M., Williams, G., Aird, R., & McGrath, J. (2008). Psychopathology during childhood and adolescence predicts delusional-like experiences in adults: A 21 year birth cohort study Child 2008 (RANZCP) Port Douglas. Australia

C10. Scott, J., Welham, J., Martin, G., Bor, W., Najman, J., O'Callaghan, M., Williams, G., Aird, R., & McGrath, J. (2009). Psychopathology during childhood and adolescence predicts delusional-like experiences in adults: A 21 year birth cohort study. 12th International Society of Schizophrenia Research, San Diego, United States.

C11. Scott, J., Welham, J., Bor, W., Najman, J., O'Callaghan, M., Williams, G., Aird, R., McGrath, J. (2009) Attentional Problems in childhood predict psychosis at 21 years World ADHD Congress, Vienna, Austria.

C12. Scott, J. Therapeutic options for abused children in care Queensland Child Safety Research Conference Brisbane Australia (Invited Plenary Speaker)

C13. Scott, J. (2009) Attachment relationships and Emotional Regulation, National Conference of Youth Mental Health, Melbourne, Australia (Invited Plenary)

MNH.900.003.0042

C14. Scott, J., McGrath, J., & Najman, J. (2010). The influence of maternal sensitivity, parental relationship and childhood sexual abuse on adult delusional-like experiences: A birth cohort study. *2nd Biennial Schizophrenia International Research Conference* Florence, Italy

C15. McGrath, J., Varghese, D., & Scott, J. (2010). The association between psychotic-like experiences and depression and anxiety. 2nd Schizophrenia International Research Society Conference, Florence, Italy.

C16. Scott, J. (2010) Does childhood trauma cause psychosis? A review of the evidence, National Conference of Youth Mental Health Brisbane, Australia, (Invited Plenary)

C17. Scott, J. (2010) Use of time out to reduce behavioral disturbance in a child psychiatry inpatient unit Sydney, Australia (Invited Plenary)

C18. Scott, J. (2011) Childhood trauma and risk of psychosis in later life Annual Workshop Qld Branch of RANNZCP. Kingscliffe, Australia, (Invited Plenary)

C19. Scott, J. (2011) Assessing and managing psychosis in children and adolescents Qld Branch RACP: Paediatrics **&** Child Health Annual Conference Brisbane, Australia, (Invited Plenary)

C20. Scott, J. (2011) Does childhood trauma cause psychosis? A review of the evidence, Australasian Conference of Child Trauma, Gold Coast, Australia, (Invited Plenary)

C21. Scott, J., Mills, R., Strathearn, L., Najman, J., & McGrath, J. (2012) Emotional abuse predicts hallucinations at 14 years: A birth Cohort 3rd Biennial Schizophrenia International Research Conference Florence, Italy

C22. Scott, J. (2012) Trauma in childhood and risk of adult psychosis Rotary Early Psychosis Forum. Gold Coast Australia (Invited Speaker)

C23. Scott, J. (2012) Substance use and psychotic disorders: Assessment and Management. Walk on the Wild Side Substance Abuse Conference Brisbane, Australia (Invited Plenary Speaker)

C24. Scott, J. (2012) Does Childhood Trauma, Cause Psychosis? A review of the evidence International Society for Psychological and Social Approaches to Psychosis, Auckland, New Zealand. (Invited Key Note Speaker)

C25. Scott, J. (2012) Risk factors for autism: Can they explain the rising incidence AEIOU Autism Research Conference. Brisbane, Australia, (Invited Plenary)

C26. Scott, J. (2013) Strategies to reduce Childhood mental and behavioural

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disorders Disease Control priority Network. New Delhi, India (Invited Speaker)

C27. Scott, J., Martin, G., Thomas, H., Andrews, T., & Haskings, P. (2013) Psychotic Experiences in adolescents predict current and future suicidal behaviours, 14th International Congress of Schizophrenia Research, Orlando, United States.

C28. Scott, J., & Moore, S. (2013) Early childhood and familial risk factors for self-reported bullying in adolescence No2Bullying National Conference, Gold Coast Australia

C29. Scott, J. (2013) Modifiable Risk Factors for Mental Disorders in Children and Youth Royal Australian and New Zealand College Congress, Sydney, Australia

C30. Scott, J. (2013) Bullying: The most Important risk Factor for Mental Illness RBWH Health Care Symposium Brisbane(Invited Speaker)

C31. Scott, J. (2013) Market Mechanisms to Reduce Mental Disorders Bi National Youth mental Health Symposium, Melbourne Australia.

C32. Scott, J. (2014) Psychosis in Adolescence Inaugural National Neurodevelopmental and Behavioural Paediatric Society of Australia Conference, Brisbane, Australia (Invited Plenary)

C33. Scott, J. (2014) NMDA receptor Antibodies and Psychosis: A cause of schizophrenia? Princess Alexandra Hospital Health Care Symposium, Brisbane Australia (invited Keynote for Mental Health)

C34. Scott, J. (2014) Immune dysregulation; NMDA receptor Antibodies and Psychosis: Rotary Early Psychosis Forum. Gold Coast Australia (Invited Keynote)

C35. Scott, J. (2014) It is easier to build strong children than to repair broken men. The RANZCP Faculty of Child and Adolescent Psychiatry Bi-National Conference, Gold Coast Australia. (Invited Plenary)

C36. Scott, J. (2014) Surveying infants and young children: A First World problem. The RANZCP Faculty of Child and Adolescent Psychiatry Bi-National Conference, Gold Coast Australia.

C37. Scott, J., Martin, G., Thomas, H., Andrews, V., & Hasking, P. (2014) Psychotic experiences and psychological distress predict contemporaneous and future non-suicidal self-injury and suicide attempts in a sample of Australian school-based adolescents. The RANZCP Faculty of Child and Adolescent Psychiatry Bi-National Conference, Gold Coast Australia.

C38. Scott, J., Martin, G., Thomas, H., Andrews, V., & Hasking, P. (2014) Psychotic

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experiences predict future suicide attempts in a sample of Australian school-based adolescents. RBWH Health Care Symposium, Brisbane Australia.

C39. Scott, J., Mamun, A., Najman, J. & McGrath, J. (2015). Increased maternal pre-pregnancy BMI is associated with offspring psychosis-related outcomes. 15th International Congress of Schizophrenia Research, Colorado Springs, Colorado. United States.

C40. Scott, J. (2015) From consulting rooms to global research: Clinical psychiatrists who research. Royal Australian and New Zealand College of Psychiatrists (RANZCP) 2015 Congress, Brisbane Australia (Invited Keynote).

C41. Scott, J., Duhig, M., & Hides, L. (2015). The prevalence and correlates of childhood trauma in patients with early psychosis. Royal Australian and New Zealand College of Psychiatrists (RANZCP) 2015 Congress, Brisbane Australia (Oral Presentation).

C42. Scott, J. (2015) Causes and Care of Anxiety in Adolescents. Association of Counsellors of Catholic Secondary Schools of Queensland (ACCSSQ) Annual Conference. (Invited Keynote)

C43. Scott, J. (2015) Psychotic like experiences in the general community. Australasian Schizophrenia Research Conference (Invited Plenary Speaker)

C44. Scott, J., Gillis, D., Ryan, A., Prain, K., Newman, M., Wong, R. & Blum, S. (2015) The prevalence of autoimmune encephalitis in patients presenting with first episode psychosis RBWH Health Care Symposium, Brisbane Australia.

C45. Scott, J. (2015) Bullying in Australia, Prevention and Intervention Victorian State Branch Conference of the Royal Australian and New Zealand College of Psychiatrists, Lorne, Victoria.(Keynote Speaker)

C46. Scott, J. (2015) Barriers and Options in the Treatment of Schizophrenia in Australia, World Psychiatric Association International Congress, Taipei, Taiwan (Invited Speaker)

C47. Scott, J. (2015) Preventing mental illness in Australian Children and Youth. Australasian Society for Mental Health Research, Brisbane Australia (Keynote Speaker)

C48. Scott, J., Mamun, A., Najman, J., & McGrath, J. (2015). Increased maternal pre-pregnancy BMI is associated with offspring psychosis-related outcomes. Australasian Society for Mental Health Research, Brisbane Australia (Oral Presentation)

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Part G

Invited Lectures and Seminars (other than conference presentations)

2008 **Pharmacotherapy for Children in Care**
Queensland Department of Child Safety- Brisbane Region
Brisbane

2009 **Mental Illness in Youth**
Rotary Health Community Forum.
Brisbane

2010 **Research opportunities in Autism**
Inaugural Opening QIMR Division of Mental Health.
Brisbane, Australia.

Attachment and Emotional regulation
UQCCR Seminar Series
Brisbane

2011 **Attachment and Emotional regulation**
Prince Charles Hospital Grand Rounds
Brisbane

2012 **Does Childhood Trauma Cause Psychosis?**
Prince Charles Hospital Grand Rounds
Brisbane

Treatment Refractory Patients with First Episode Psychosis
RBWH Grand Round
Brisbane

Post Mortem Clozapine levels
RBWH Grand Round
Brisbane

The continuum of Psychosis
UQCCR Seminar Series
Brisbane

Psychopharmacology in the Classroom
APS College of Educational and Developmental Psychologists
Brisbane

Bullying. A modifiable risk factor for mental illness.
Bostock Oration
Brisbane

MNH.900.003.0047

The continuum of Psychosis in Adolescents
Orygen Youth Health Service
Melbourne

Parenting Adolescents
Hillbrooke Anglican College Parent Information Evening
Brisbane

2013 **Research Opportunities in Psychiatry**
RBWH Grand Rounds
Brisbane

Bullying: The most modifiable risk factor for mental illness
Canaan Institute Lecture Series
Brisbane

Using Market mechanisms to prevent Mental Illness
The University of Queensland CCR Seminar Series
Brisbane

Workshop: Youth Mental Health in Universities
University Colleges Australia National Conference
Gold Coast

Keynote Address: Optimising Mental Health in School Students
Independent Schools Queensland Conference
Brisbane

2014 **Medications for Children with Autism**
AEIOU Annual Conference
Brisbane

Personal Resilience
AMAQ Inaugural Junior Doctor's Conference
Brisbane

The immune system and schizophrenia
Queensland Forensic Mental Health Seminar
Brisbane

Bullying: The Most Important Risk Factor for Mental Illness
The Barton Pope Lecture
Adelaide

ADHD: The Most Treatable Neurodevelopmental Disorder
RIS Equity Meeting
Brisbane

2015 **Neuronal Autoantibodies in Psychosis**
Lady Cilento Children's Hospital
Brisbane

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Clinical Trials in Early Psychosis
Metro South Mental Health Grand Rounds
Brisbane (1/6/15)

Clinical Trials in Early Psychosis
Prince Charles Hospital Grand Rounds
Brisbane (11/6/15)

Clinical Trials in Early Psychosis
Royal Brisbane and Women's Hospital Grand Rounds
Brisbane (23/6/15)

Clinical Trials in Early Psychosis
Grand Rounds Lady Cilento Children's Hospital Grand Rounds
Brisbane (17/7/15)

Auto immune encephalitis. A cause of psychosis.
Secrets of your brain revealed:a research update.
UQCCR Community Symposium
Brisbane (22/08/15)

Preventing Mental Disorders in Children and Adolescents
Invited Presentation to the Queensland Mental Health and Drug Advisory Council
Brisbane (19/10/15)

Optimising recovery in persons with serious mental illness
Invited Workshop PsyAcademy II (Janssen Cilag)
Sydney (24/10/15)

Psychotic like Experiences, Research and clinical applications
UQCCR Seminar Series
Brisbane (29/10/15)

Psychosis – What is it and how is it treated?.
Unravelling Psychosis Consumer and Carer Conference
Brisbane (26/11/15)

"JS-2"

MNH.900.003.0049

DBK.001.001.0093

From: [redacted] **On Behalf Of** Trevor Sadler
Sent: Friday, 2 November 2012 7:13 PM
To: [redacted]
Subject: RE: [QFCAP] BAC impending closure

Dear Colleagues,

I meant to add that this information is confidential at the moment, until after discussions with the other inpatient units. I cannot inform any staff.

Kind regards,

Trevor

From: [redacted] **On Behalf Of** Trevor Sadler
Sent: Friday, 2 November 2012 6:42 PM
To: [redacted]
Subject: [QFCAP] BAC impending closure

Dear Colleagues,

I was informed today that the Mental Health Alcohol Tobacco and other Drugs Directorate (MHATODD) has made the decision to close Barrett Adolescent Centre. I got the impression that it is to be sooner rather than later – a date of 31 December was mentioned.

The decision to do this was because of alleged occupancy rates of about 60% in the acute inpatient units, and less than 50% for our unit. I cannot speak for the acute inpatient units, of course, but I know that currently we are managing 13 inpatients and 7 day patients (+ 1 outpatient whom I may need to readmit soon). We have 15 inpatient beds. (MHATODD has never recognised we have day patients for the last 30 years.) Adolescents who go on leave for the weekend or for school holidays or adolescents who are partial inpatients while in transition back to the community are not counted as occupied beds when they do not spend the night with us, [redacted]. We have trialled other adolescents as day patients for several weeks, but then needed to readmit them. During their absence, they are a vacancy. All of this adds up, of course over the period of a year, and MHATODD averages out our occupancy, hence the figure of less than 50%.

MNH.900.003.0050

DBK.001.001.0094

They believe our adolescents can be redistributed among the other inpatient units and seek out some NGO services.

The decision has just about been made. However, they will first talk to senior staff in the other inpatient units to determine their capacity to take up our adolescents.

I thought, however, that I needed to let you know ahead of the official announcement so you can carefully consider the alternatives

- For any patients you may have with us
- For any services which will provide services in lieu of our service. I must confess that because my thinking has been along the lines of how to best provide an inpatient/day patient services, I am a bit stumped to think quickly of alternatives. My narrow thinking was reinforced at the recent FCAP conference, when there was a presentation by the Walker Unit (which is our NSW counterpart opened 2 years ago) where they were able to argue the need for a longer term unit, and Bob Adler's comments at that presentation that they absolutely needed one in Victoria. I thought the alternatives probably aren't that obvious. I also visited 13 inpatient units in the UK and 2 in Switzerland. Those that had a mix of acute/medium-long term patients really struggled. Again, for the patient groups we see that require longer term treatment and intensive rehabilitation, there weren't clear alternatives.

So it will require some careful thinking as to how best we can help adolescents with severe and persistent disorders with resulting impairments. There isn't apparently much time to come up with ideas.

Sorry to trouble you. I know you are all busy. I just want to make sure the adolescents we see have a viable alternative.

Kind regards,

Trevor

MNH.900.003.0051

"JS-3"

WMS.0011.0001.17030

Dr James Scott
MBBS QLD. FRANZCP, PhD
Consultant Psychiatrist

[redacted] [redacted]

11st November 2012

Hon Lawrence Springborg
GPO Box 48
BRISBANE QLD 4001

Dear Mr Springborg

I am writing to express my concerns about the reported forthcoming closure of the Barrett Adolescent Centre. I am a child and adolescent psychiatrist who has been a past director of the Mater Inpatient Unit at the Mater Children's Hospital (2003-2006) and the Child and Family Therapy Unit at the Royal Children's Hospital (2007-2010).

The Barrett Centre provides medium to long term treatment and rehabilitation to the most seriously mentally ill adolescents in Queensland. Without this facility, there will be an enormous gap in the care that can be provided to these young Queenslanders and their families. The acute inpatient units cannot provide the same care as the Barrett as they are driven by performance indicators such as short lengths of stay. The mental health problems that trouble adolescents admitted to the Barrett will not respond to brief admissions and community care. Generally speaking, these are young people who have either experienced ongoing and severe abuse throughout childhood or they have a serious mental illness that is refractory to other treatments.

The Barrett centre plays an important role in preventing these young people from suicidal acts or alternatively committing offences that result in lengthy incarceration. I urge you to carefully consider the problems that will arise if this facility is closed without an alternative medium term inpatient unit to provide ongoing care to these very vulnerable adolescents

Yours Sincerely

[redacted]

Dr James Scott
Consultant Psychiatrist

MNH.900.003.0052

"JS-4"

From: James Scott
Sent: 11 Nov 2012 22:21:01 +1000
To: Lesley Dwyer
Subject: FW: Concerns about the reported closure of the Barrett Centre
Attachments: Concerns regarding the Barrett Centre Closure.pdf

Dear Ms Dwyer

I have written to The Minister today to express my concerns about the reported closure of the Barrett Adolescent Centre. Each year, I refer 1 to 2 adolescents to the Barrett Centre. Realistically, without the Barrett, these adolescents would die or end up in some other form of institutional care that would be very expensive and of little therapeutic benefit (youth detention, One on one youth worker support).

I hope that there is still an opportunity for this decision to be further considered

kind regards

James

Dr James Scott
Consultant Psychiatrist
Metro North Mental Health

Level 3 UQCCR
Royal Brisbane and Women's Hospital
Herston Qld 4029

MNH.900.003.0053

"JS-5"

WMS.0011.0001.14514

From: Sharon Kelly
Sent: 20 Nov 2012 21:48:52 +1000
To: James Scott;Lesley Dwyer
Subject: Re: FW: Concerns about the reported closure of the Barrett Centre

Thanks James,
I will be certain to include you in the consultation processes as we move forward. Our first small planning group is to occur tomorrow morning so from there we will have some further agreed direction and steps to move forward.

Regards
Sharon

Sharon Kelly
Executive Director
Mental Health and Specialised Services

West Moreton Hospital and Health Service

Chelmsford Avenue, Ipswich, QLD 4305
PO Box 878, Ipswich, QLD 4305
www.health.qld.gov.au

>>> James Scott 11/20/2012 9:39 pm >>>
Dear Lesley and Sharon

thank you for your response. I would be very pleased to assist in any way I can in considering other options to the Barrett

kind regards
James

>>> Lesley Dwyer 11/19/2012 11:50 am >>>
Recent media reports have raised to the forefront the role and future of the Barrett Adolescent Centre at The Park.

I am seeking your support, advice and collaboration in relation to developing an alternative model or models of service to replace the services currently provided at the Barrett Adolescent Centre (BAC), at The Park - Centre for Mental Health.

Initial high level discussion had commenced with Mental Health Branch and senior staff at The Park, as you would be aware, the Redlands Adolescent Extended Treatment capital project has been recently cancelled.

Dear Dr Scott
Firstly apologies for not responding earlier to your email.

The following is information that we have sent to invitees that attended a meeting last Thursday to discuss how we resolve the issues facing us at The BAC.

"*The BAC facility at The Park is approaching 40 years of age and has been identified by the Australian Council of Healthcare Standards as unsafe and necessitating urgent replacement. Further, there is concern regarding its co-location with adult forensic and secure services at The Park.*

MNH.900.003.0054

At this point in time, no decision has been made by the West Moreton Hospital and Health Board and the purpose of the planned meeting tomorrow, Thursday, is to provide some clarity and commence discussions in regards to the next steps for determining the solution and alternate services for this consumer group."

At the meeting it was agreed that a small working party be formed, assisted by an Expert Clinical Reference Group, to look at the various options for the longer term needs of Adolescent Mental Health Services currently provided at the BAC.
A communication strategy for key stakeholders will be developed and I would be pleased to ensure that you are kept informed and have the opportunity to input into this process.

Sharon Kelly is the Executive Director, Mental Health and Specialised Services who will lead the process.

Thank you for taking the time to write to me.

Kind Regards

Lesley Dwyer

Lesley Dwyer
Chief Executive

West Moreton Hospital and Health Service

PO Box 73, Ipswich, QLD 4305

>>> James Scott 11/11/2012 10:21 pm >>>
Dear Ms Dwyer

I have written to The Minister today to express my concerns about the reported closure of the Barrett Adolescent Centre. Each year, I refer 1 to 2 adolescents to the Barrett Centre. Realistically, without the Barrett, these adolescents would die or end up in some other form of institutional care that would be very expensive and of little therapeutic benefit (youth detention, One on one youth worker support).

I hope that there is still an opportunity for this decision to be further considered

kind regards

James

Dr James Scott
Consultant Psychiatrist
Metro North Mental Health

Level 3 UQCCR
Royal Brisbane and Women's Hospital
Herston Qld 4029

EXHIBIT 114

MNH.900.003.0055

MNH.900.003.0055

WMS.0011.0001.14516

MNH.900.003.0056

"JS-6"

Enquiries to: Sharon Kelly
Executive Director Mental Health & Specialised Services
Telephone:
Facsimile:
Our Ref: CT:KA

Dr J Scott
Consultant Psychiatrist Early Psychosis
Metro North Hospital & Health Service

Dear Dr Scott

I would like to formally invite you and to thank you for agreeing to be a member of the Expert Clinical Reference Group that has been established to recommend a model of care that will meet the needs of adolescents requiring sub-acute mental health care in Queensland.

As you maybe aware, West Moreton Hospital and Health Service in partnership with Mental Health Alcohol and Other Drugs Branch, wants to consider alternative model(s) of care to the current model at Barrett Adolescent Centre (BAC). You have been nominated to be a part of this group due to your specialist skills and expertise in this area.

It is proposed that the Expert Clinical Reference Group consist of:

- Dr Michelle Fryer, Faculty Child and Adolescent Psychiatry
- Dr James Scott, Consultant Psychiatrist Early Psychosis, Metro North HHS
- Dr David Hartman, Clinical Director, CYMHS, Townsville HHS
- Dr Trevor Sadler, Clinical Director, BAC, West Moreton HHS
- Dr Ray Cash, Consultant Psychiatrist, CYMHS, Children's Health Qld HHS
- Professor Philip Hazell, Director, Infant Child and Adolescent Mental Health Services, Sydney and South Western Sydney Local Health Districts
- Ms Josie Sorban, Director of Psychology, CYMHS, Children's Health Qld HHS
- Ms Amanda Tilse, Operational Manager, Alcohol Other Drugs and Campus Mental Health Services, Mater Children's Hospital
- Ms Amelia Callaghan, State Manager Qld NT and WA, Headspace.
- Ms Emma Hart, Team Leader, Adolescent Inpatient Unit and Day Service, Townsville HHS
- Mr Kevin Rogers, Principal, BAC School

.../2

Office
Division of Mental Health & Specialised Services
West Moreton Health
Ipswich Hospital
Chelmsford Avenue
Ipswich Qld 4305

Postal
PO Box 73
Ipswich Qld 4305

Phone **Fax**

MNH.900.003.0057

It is also proposed that the Chair of the Expert Clinical Reference Group will be Dr Leanne Geppert, Director Planning and Partnerships Unit, Mental Health Alcohol & Other Drugs Branch.

The Chair, through the Expert Clinical Reference Group, will invite additional nominated National experts on an as needs basis to provide further input into the development of a contemporary evidence based model of care.

The Chair will be in contact with you in the near future regarding the first meeting time. Given the expected short duration of this forum, it is anticipated that the Expert Clinical Reference Group will meet initially on at least a fortnightly basis (in person or tele/videoconference).

I would like to thank you in anticipation of your contribution to the model of care that will meet the needs of adolescents requiring sub-acute mental health care in Queensland.

Yours sincerely

Sharon Kelly
Executive Director Mental Health & Specialised Services
03/12/2012

MNH.900.003.0058

"JS-7"

Queensland Government

Barrett Adolescent Strategy

Expert Clinical Reference Group

MINUTES

Chair	Dr Leanne Geppert	Date	Friday 07 December 2012
Executive Sponsor	Chief Executive West Moreton HHS and A/Executive Director MHAODB	Time	9.00 – 10.30am
Secretariat	Emma Foreman/Vaolta Turituri		
Venue	Butterfield St Level 2 Conference Room (Room 2.2 LMR)		
Tele/Videoconference Details	Local Dial In no. National Dial In no. Participant code		
Attendees	▪ Amanda Tilse, Operational Manager, Alcohol Other Drugs and Campus Mental Health Services, Mater Children's Hospital ▪ Amelia Callaghan, State Manager Qld NT and WA, Headspace. ▪ Dr Cary Breakey, Clinical Director, Barrett Adolescent Centre West Moreton HHS Mental Health Service (Proxy for Dr Sadler) ▪ Josie Sorban, Director of Psychology, Child & Youth MHS Children's Health Qld HHS ▪ Kevin Rodgers PSM, Principal, Barrett Adolescent Centre School, Education Queensland ▪ Dr Leanne Geppert, Director, Planning & Partnerships Unit ,QH Mental Health Alcohol & Other Drugs Branch (MHAODB) ▪ Dr Michelle Fryer Chair, QLD Branch of the Faculty Child & Adolescent Psychiatry (QFCAP), The Royal Australian and New Zealand College of Psychiatrists (RANZCP)		
Guests			
Apologies	▪ Dr James Scott Consultant Psychiatrist, Early Psychosis Service Metro North HHS Mental Health Service ▪ Dr Trevor Sadler, Clinical Director, Barrett Adolescent Centre West Moreton HHS Mental Health Service		
Teleconference	▪ Dr David Hartman Clinical Director, Child & Youth MHS Townsville HHS Mental Health Service – *joined the meeting at 10.00am* ▪ Emma Hart, Nurse Unit Manager, Adolescent Inpatient Unit And Day Service, Child & Youth MHS Townsville HHS Mental Health Service ▪ Professor Philip Hazel, Director, Infant Child and Adolescent Mental Health Services, Sydney and South Western Sydney Local Health Districts,		

MNH.900.003.0059

Queensland Government

Barrett Adolescent Strategy

Expert Clinical Reference Group

Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
1.1	**Open and Welcome** ▪ Welcome and introduction of invited members brought together for their particular expertise and specialist areas in adolescent mental health. ▪ Chair provided brief background and historical context to events leading to the establishment of the reference group – o Noted cancellation of Redlands capital works project, the redirection of capital funds to other capital projects and the hope that operational funds will remain for the use of child and youth mental health purposes. o Noted the condition of the current facility and its co-location with adult secure and forensic service. o Noted the *Queensland Plan for Mental Health 2007-2017* (QPMH) and clear policy direction to ensure that young people are treated close to their homes in the least restrictive environment with the minimum possible disruption to their families, educational, social and community networks. **Where to from here?** ▪ Task of the ECRG is to recommend a statewide model of care for adolescents requiring longer term mental health care. This means identifying the cohort of adolescents that access BAC and identifying options for service models. ▪ Governance is provided by the Barrett Adolescent Strategy Planning Group. The Planning Group has developed a Project Plan under which the ECRG is identified. This project plan was tabled for the ECRG. ▪ West Moreton Hospital and Health Service (WMHHS) will be responsible for responding to consumers and their families and ensure that they are kept informed of plans and developments. WMHHS will work closely with the Director General, Queensland Health and Minister for Health. **Housekeeping** 1. Members present noted the short time frames between invitation and the first meeting. Despite this, members are keen to participate and contribute to this undertaking. 2. Noted that Dr Ray Cash has not responded to the invitation to participate. 3. Agreement that **meetings will be weekly and 1.5 hours in duration.** 4. Proxies will not be acceptable due to the time limited nature of the group and a risk of loss of consistency and continuity. 5. **There will be no further meetings before Christmas.** **Actions** 1. Follow up with Dr Ray Cash. 2. Confirm and send out scheduled dates and times for 2013.	ECRG Secretariat	
2.1 **Action Sheet**	▪ Will be used to track tasks and actions of the group		

MNH.900.003.0060

Queensland Government

Barrett Adolescent Strategy

Expert Clinical Reference Group

Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
3.0	Standing agenda		
3.1 Communication Log	▪ Noted the log of letters to the Minister for Health raising concerns about the possible closure of the BAC. ▪ Need to note the salient points in these communications and ensure that they are addressed or considered where appropriate.		
4.0	New business		
4.1 Introduction of purpose and parameters	• Of the highest priority are the current consumers of BAC (and any future consumers) and what is planned for them in the interim while decisions and plans are being made. ▪ Risk of dispersal of clinical expertise and possible loss of this expertise to Queensland with possible BAC closure. Noted that this has already begun to happen due to uncertain future of BAC. Erosion of confidence of consumers with staff due to lack of consistency and boundaries provided by inexperienced casual staff. ▪ ECRG members agreed that any model that is recommended will **retain the education component**. The challenge is ensuring how this will be incorporated. ▪ ECRG noted the endorsed **Terms of Reference** for the group and provided the following feedback to the Planning Group for consideration: o The TOR does not clearly articulate the complexity and severity of the consumer group being addressed. o Noted that the scope does not articulate alignment with current state models of service and frameworks. o Any model of care that is recommended will need to 'fit' closely with state models of service and national mental health planning frameworks as future funding will be determined by these. o Noted that the timeframes identified in the Project Plan are ambitious. Action: 3. Chair to forward feedback to the Barrett Adolescent Strategy Planning Group regarding changes/recommendations to the ECRG terms of reference. ▪ Concern was raised regarding an assumption that the current BAC model of care is not contemporary. o It was noted that the current BAC model has been refined over many years to meet the needs of this cohort. Further that the model is robust and comparable to international models. o Suggestion that rather than re-developing a new model, group should identify gaps and recommend innovative strategies to address these. o Chair noted that there have been a number of attempts to re-develop the current BAC model *however* the difference now is BAC cannot continue on the current site and there is no funding to build another BAC. ▪ ERCG noted that this was an opportunity to start afresh with respect to model development. o It provides an opportunity to look at innovative strategies and models such as using the Non government sector and developing partnerships and opportunities with other stakeholders. o Provides an opportunity to address service gaps for adolescents on the waiting list for BAC and for those young	ECRG Chair	

MNH.900.003.0061

Queensland Government

Barrett Adolescent Strategy

Expert Clinical Reference Group

Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
	people that currently don't 'fit' such as those with developing chronic psychiatric disorders and intellectual disabilities etc. o ECRG acknowledged that there is a lot to learn from BAC model. The BAC day program has been drawn on heavily to model the day program for adolescents at Townsville Child and Youth Mental Health Service hence the ECRG should consider what components of the BAC model to take forward.		
4.2 Definitions	* The profile of consumers accessing BAC has changed and the service is not dealing with the same group or type of consumer as in the past. This may be as a result of increased access to child and youth acute units. * In order to better understand the target client group, ECGR agreed that members needed to inform themselves about the following: 1. Service models for adolescents that have been developed including; o Barrett Adolescent Centre Model of Service (MOS) o Draft Adolescent Extended Treatment and Rehabilitation MOS o Draft Acute Adolescent Inpatient Unit MOS o The Walker Unit MOS, Concord Centre for Mental Health, NSW. 2. Profile of current BAC consumers. 3. Cumulative demographic profile of consumers in BAC over a period of 1-2 years. 4. Client profile of possible consumers that services would like to refer to BAC. 5. Any BAC consumer or carer satisfaction surveys. 6. Any investigations of reports by students etc on longer term outcomes of BAC consumers. **Actions:** 4. Members will contribute to the package and forward identified documentation to the ECRG secretariat 5. The ECRG secretariat will disseminate these documents by 14/12/2012. Discussion to determine the consumer profile was initiated using the following domains: 1. Age range 2. Diagnostic profile 3. Referral sources and pathway 4. Complexities of presentation **Age range** * The current age criterion is 13-17 years old. This is seen as an artificial divide. The recommendation is to consider the conceptual developmental age i.e. when the individual begins to deal with adolescent issues. * ECRG agreed that the lower age range should be retained at 13 years but upper age limit should be flexible. * Average age range now seen at BAC is 15-16 year olds which has an impact on the type of curriculum offered at the BAC school. * Agreement in principle that the presenting issue rather than the age range flexibility should be the determinant at the higher age range. Further, that the developmental age of the young person rather than chronological age should be considered. * Noted a higher ratio of females to males at BAC. * Sexuality and gender issues need to be addressed both in the	ECRG members (see action sheet for detail)	14/12/2012.

MNH.900.003.0062

Queensland Government

Barrett Adolescent Strategy

Expert Clinical Reference Group

Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
	recommended model and at this stage of development.		
	Other discussion points: ▪ Noted again that any model of care that is recommended will need to 'fit' closely with state models of service and national mental health planning frameworks as future funding will be linked to these. ▪ Possible scenarios for distribution of this service could include: o One specific HHS funded to provide statewide service o Stand alone statewide service o Individual flexible funding packages within the Non government sector o Day program places ▪ A cost benefit analysis would be required for each proposed model. This is a high service user group. Noted that there is no highly visible system cost to the population of adolescents and young people that are house bound, invisible and hard to find. There is however, a 'huge cost to society'. Note also the impact of adolescent suicide on families. ▪ % population that the service will meet needs to be defined.		
[illegible]	[illegible]		
5.1	1. Target group/Client profile 2. Service analysis across adolescent mental health continuum ▪ Existing services ▪ Gap analysis		
Next Meeting:	Date: 9 January 2013 Time: 9:00 – 10:30 am Venue: Butterfield St Level 2 Conference Room (Room 2.2 LMR)		

Queensland Government

Barrett Adolescent Strategy

Expert Clinical Reference Group

Expert Clinical Reference Group: Action Table – 2012 - 2013

Item	Action	Responsible Officer	Due date	Status
1.	Follow up and confirm with Dr Ray Cash acceptance of invitation to participate in the ECRG.	Vaoita Turituri		Invitation letter was forwarded to Dr Cash's private practice email and message left with reception requesting a response on 5.12.2012. Follow up phone call and message left with reception. Message also left with Dr Cash's support officer, Child & Youth MHS.
2	Confirm and send out scheduled dates and times for 2013	Vaoita Turituri	14/12/12	Dates for 2013 have been scheduled and sent out to members.
3	Forward feedback to the Barrett Adolescent Strategy Planning Group regarding changes/recommendations to the ECRG terms of reference.	Leanne Geppert		
4	Examples of adolescent mental health service models to be forwarded to the secretariat for compilation. • Barrett Adolescent Centre Model of Service (MOS) • Draft Adolescent Extended Treatment and Rehabilitation MOS • Draft Acute Adolescent Inpatient Unit MOS • The Walker Unit MOS, Concord Centre for Mental Health, NSW	Cary Breakey Vaoita Turituri Vaoita Turituri Philip Hazel	14/12/2012	Walker Unit MOS received Draft Adolescent Extended Treatment & Rehabilitation MOS received Draft Acute Adolescent Inpatient Unit MOS received
5	• Profile of current BAC consumers. • Cumulative demographic profile of consumers in BAC over a period of 1-2 years. • Any BAC consumer or carer satisfaction surveys. • Any investigations of reports by students etc on longer term outcomes of BAC consumers.	Cary Breakey Kevin Rodgers	14/12/2012	
6	• Client profile of possible consumers that services would like to refer to BAC	Amanda Tilse	14/12/2012	Received

MNH.900.003.0063

MNH.900.003.0064

Queensland Government

Barrett Adolescent Strategy

Expert Clinical Reference Group

MINUTES

Chair:	Dr Leanne Geppert	Date:	09 January 2013
Executive Sponsor:	Chief Executive West Moreton HHS and A/Executive Director MHAODB	Time:	9.00 – 10.30am
Secretariat:	Emma Foreman/Vaoita Turituri		
Venue:	Butterfield St Level 2 Conference Room (Room 2.2 LMR)		
Tele/Videoconference Details	Local Dial In no. National Dial in no. Participant code:		
Attendees:	▪ Amanda Tilse, Operational Manager, Alcohol Other Drugs and Campus Mental Health Services, Mater Children's Hospital ▪ Dr James Scott, Consultant Psychiatrist, Early Psychosis Service Metro North HHS Mental Health Service ▪ Josie Sorban, Director of Psychology, Child & Youth MHS Children's Health Qld HHS ▪ Dr Leanne Geppert, Director, Planning & Partnerships Unit, QH Mental Health Alcohol & Other Drugs Branch (MHAODB) ▪ Dr Trevor Sadler, Clinical Director, Barrett Adolescent Centre West Moreton HHS Mental Health Service		
Teleconference:	▪ Amelia Callaghan, State Manager Qld NT and WA, Headspace. ▪ Emma Hart, Nurse Unit Manager, Adolescent Inpatient Unit And Day Service, Child & Youth MHS Townsville HHS Mental Health Service ▪ Professor Philip Hazel, Director, Infant Child and Adolescent Mental Health Services, Sydney and South Western Sydney Local Health Districts,		
Guests:			
Apologies:	▪ Dr David Hartman Clinical Director, Child & Youth MHS Townsville HHS Mental Health Service ▪ Kevin Rodgers PSM, Principal, Barrett Adolescent Centre School, Education Queensland ▪ Dr Michelle Fryer Chair, Qld Branch of the Faculty Child & Adolescent Psychiatry (QFCAP), The Royal Australian and New Zealand College of Psychiatrists (RANZCP)		

MNH.900.003.0065

Queensland Government

Barrett Adolescent Strategy

Expert Clinical Reference Group

Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
1.0	Welcome, Apologies and Introductions		
1.1	**Open and Welcome** × Welcome to reference group members. Special welcome to Drs Trevor Sadler and James Scott who are attending for the first time.	Leanne Geppert	
1.2	**Previous minutes** × The minutes of the previous meeting held on 07.12.12 were accepted as an accurate record. × Minutes were endorsed by Josie Sorban and Amanda Tilse.		
2.0	Business Arising		
2.1 **Action Sheet**	**Outstanding actions to be addressed:** × Feedback on ECRG TOR to be considered by the Planning Group at their next meeting on 18.01.2013 × Dr Sadler to forward consumer vignettes and profiles	Leanne Geppert Trevor Sadler	18/01/2013 Due
3.0	Standing Agenda		
3.1 **Communication**	**ECRG Media Protocol** × Members were reminded of the media protocol developed by West Moreton HHS (WMHHS). Furthermore, a request had been made for the names of reference group members to be made publicly available. All members present agreed for their names to be publicly available. Acknowledgement and acceptance is still to be confirmed by some members. × Clarification was sought regarding the duration of the media protocol. An ad infinitum request is not acceptable to the group; agreement that members will abide by the media protocol until the conclusion of the ECRG. × It was acknowledged that each member was present as an individual expert in their discipline and a leader in their particular field. To some extent though, they also represent their particular Hospital & Health Service (HHS) or organisation and with that may come certain pressures and expectations. × Members therefore agreed that each individual will forward a Declaration of Interest to the Secretariat for noting to avoid any potential conflict of interest. **Action:** 7. Members to confirm acceptance of media protocol and for their names to be publicly available. 8. Declaration of Interest document will be developed by the Secretariat for use by members. *Please see attached draft* declaration of interest template_ad 9. Chair to report back to the Planning Group that the members will abide by the media protocol until the conclusion of the ECRG. **Communication Log** × Reference was made to communications received by West Moreton HHS (WMHHS) from Child and Youth Mental Health experts. × A summary of these is collated in the Communications Log. Hard	Group members Secretariat Leanne Geppert Group members	18/01/2013 asap 18/01/2013 Each

MNH.900.003.0066

Queensland Government

Barrett Adolescent Strategy

Expert Clinical Reference Group

Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
	copies are available for ECRG members to read in detail if required. * ECRG members are asked to read the Communications Log prior to each meeting as it is a requirement of the ECRG to consider this communication in the development of a future service model.		meeting
3.2 Updates	* An update from the Planning Group will be provided at the next meeting.	Leanne Geppert	
[redacted]	[redacted]		
4.1 Consumer and Carer Representation	* Reference was made to inclusion of consumer and carer representation in the ECRG. * General consensus is that this is appropriate and integral to service planning. Furthermore, this is the internationally accepted practice in mental health. * Questions about whom and whether it should be a former consumer of Barrett Adolescent Centre (BAC) or whether a general consumer would suffice was debated. Noted that it was important that the consumer representative have an appreciation of the degree of unwellness and severity that this consumer group experience. Such a representative would provide invaluable input and insight. * Noted that the consumer representative will need to be linked to or understand the experience and severity of the target group and service type but is not necessarily limited to those who are past or present consumers of BAC.The target group and service type was yet to be determined. * Decision to nominate a consumer or carer rep. should be based on the target group and service profile. **Action:** 10. Chair to forward to the Planning Group a recommendation for the inclusion of a consumer and carer representative on the ECRG membership.	Leanne Geppert	18/01/2013
4.2 Target group/Client profile	1. The ECRG used a structured approach to address the service elements to be considered in developing a service model and determining the client profile. A template was developed to assist in this process. 2. The following was discussed: o The acuity of some consumers in BAC was compared in relation to those in adolescent acute units. The severity of issues for some clients is persistent and from a young age, leading to deficits and impacts both at home and later on at school and into adulthood. By this point, there is a broad spectrum of persistent and severe symptomatology. o Consensus that a feature of the target group was that adolescent consumers have **persistent and severe symptomatology.** o Noted that the ERCG need to consider existing national frameworks and use language and terms consistent with these in determining a proposed model. o Models need to be consistent with national frameworks to ensure that funding is not at risk; also need to remember Activity Based Funding (ABF) in these discussions. o Noted that the Walker Unit in Sydney is designated as a non acute and non severe service however the funding model is acute based. The challenge is to provide the context within		

MNH.900.003.0067

Queensland Government

Barrett Adolescent Strategy

Expert Clinical Reference Group

Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
	which to develop the rationale. o Noted that there was varying degrees of knowledge of current adolescent services whether private, non government or public available across the state. Current knowledge seems to be localised and specific to district Child & Youth Mental Health Services (CYMHS). Agreement to commence a mapping exercise. The mapping exercise will assist in identifying current gaps. o A draft adolescent mental health continuum service analysis has been developed and will indicate at which point of the spectrum these services and gaps, identified from the mapping exercise, are located. **Action:** 11. Secretariat to commence mapping of current adolescent mental health services available. *Please refer to Agenda Item 4.3* **A question was raised as to what could be offered in the absence of the BAC and possible solutions included:** o Management of possible BAC consumers would be devolved to the current adolescent acute units as a default position. o Or alternatively, all services would need to develop and acquire the capacity and capability to manage these and current consumers across the state. o Alternatively, **Day Programs** could be developed across services. **Day Programs** * Noted that for day programs to be successful for this client group the following was essential in ensuring consumers were supported. o Accessible for young people with residential support available if required. May be difficult to access day programs even within the Brisbane metropolitan area due to travel distance. If well funded and well staffed, a day program can manage this client group. After hours support and therapy needs to continue for some at risk clients. o Family support is essential – families need to be stable, committed and 'non-toxic'. Families may be required to transport the adolescent and help with their treatment at home. o Cater for adolescents that are 'unsafe' at night and at risk of suicide. Management outside hours of the day program may be required. * A possible day program model may include partnership with an acute inpatient unit or with a Non Government (NGO) residential provider or both. * A possible configuration could thus be: o Consumer attends day program and goes home o Consumer attends day program and goes to a residential facility provided by a NGO provider and spends the weekends at home o Consumer attends day program and stays in an acute inpatient facility. * Noted that the current Draft Acute Adolescent Inpatient Unit MOS allows for short admissions only. This model will need to be changed	Secretariat	16/01/2013

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Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
	if a decision is made to utilise adolescent acute units in this way. Further, queried the feasibility of doing this. × Experience from New South Wales and overseas has shown that a mix of acute and persistent presentations within an acute unit was destabilising and often to the detriment of consumers with severe and persistent symptomatology. Further, it was noted that in 12 such units across the UK; acute patients received better treatment. The programs were repetitive and there were neither targeted programs nor intensive rehabilitation for long stay patients. × The physical environment was deemed important with units located on a significant amount of land. × There was a question concerning the need to provide this high level of service to regional areas. A comparison was made with liver transplants where there is low prevalence and high severity and an acceptance that such a highly specialised service would not be available regionally. × The demographic profile of BAC clients indicate that in the past 10 years, there have been only a small percentage of referrals from North Queensland and few from Toowoomba and the south west. The majority have been from south east Queensland. × *Please note the attached demographic data for BAC from January 2011 – December 2012 provided by Dr Sadler.* Demographics_BAC_TSadler_Jan13.doc × Noted that there may be in fact **two target groups.** 1. High intensity, severe needs group requiring long term therapeutic care which is currently catered for by BAC. (Accessed mainly by Southern QLD although available statewide). × The group requiring step down sub acute adolescent mental health supported day program and not requiring 24 hour residential support but still high intensity. × Further noted that there are **three main gaps** related to accessibility o lack of access to BAC services o lack of access to step down, sub acute mental health program. o lack of access to both programs. × Further discussion ensued regarding persistent and severe disorders and treatment within a day program model. From Dr Sadler's experience of the current BAC day program the following issues were noted: o Many adolescent consumers have not attended school on a regular basis. o Most do not have contact with adolescents of their own age group. o Disruption of social networks. o Ongoing continuing longer term care with evening		

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Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
	supervision to maintain health in a therapeutic residential facility. o Severity of impact from severe anxiety disorders and avoidant personality disorders can account for a significant number of adolescents not accessing services or accessing them too late in adulthood. ▪ With reference to the domains identified in the draft service elements table, the BAC is identified as a sub acute service. It was suggested that BAC would 'fit' under an intensive care sub acute service. Such a service would provide medium term treatment and rehabilitation. Consumers would receive specialist behavioural and symptom management programs, individualised and group rehabilitation programs aimed at improving individual functioning. There would also be planned transition back into the community. ▪ Due to time constraint it was agreed that the draft template would be populated by the secretariat using the information discussed and linked to the national frameworks. **Action:** 12. Draft service elements template to be populated and sent to ECRG members for comment out of session. *Please see attached document* Service Elements_V1.doc	Secretariat Members	11/01/2013
4.3 **Service analysis across the adolescent mental health continuum**	▪ Please see above discussion related to the mapping exercise. BAC Service Analysis.vsd BAC Service Analysis 2.vsd.pdf		
[illegible]	[illegible]		
5.1	1. Service model options 2. Budget and staffing profile		
Next Meeting:	Date: 30 January 2013 Time: 9:00 – 10:30 am Venue: Butterfield St Level 2 Conference Room (Room 2.2 LMR)		

MNH.900.003.0070

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Barrett Adolescent Strategy

Expert Clinical Reference Group

Expert Clinical Reference Group: Action Table – 2012 - 2013

Item	Actions	Accountable Officer/s	Due Date	Status
3	Forward feedback to the Barrett Adolescent Strategy Planning Group regarding changes/recommendations to the ECRG terms of reference.	Leanne Geppert	18/1/2013	Recommendations have been forwarded. Planning Group to consider at meeting on 18/1/2013.
4	Examples of adolescent mental health service models to be forwarded to the secretariat for compilation. * Barrett Adolescent Centre Model of Service (MOS) * Draft Adolescent Extended Treatment and Rehabilitation MOS * Draft Acute Adolescent Inpatient Unit MOS * The Walker Unit MOS, Concord Centre for Mental Health, NSW	Cary Breakey/Trevor Sadler Vaolta Turituri Vaolta Turituri Philip Hazell	14/12/2012	* Walker Unit MOS received * Draft Adolescent Extended Treatment & Rehabilitation MOS received * Draft Acute Adolescent Inpatient Unit MOS to be sent * Barrett Adolescent MOS to be sent
5	* Profile of current BAC consumers. * Cumulative demographic profile of consumers in BAC over a period of 1-2 years. * Any BAC consumer or carer satisfaction surveys. * Any investigations or reports by students etc on longer term outcomes of BAC consumers.	Cary Breakey Kevin Rodgers	14/12/2012	Demographic data received for January 2011 – December 2012 from Dr Sadler.
7	Members to confirm acceptance of media protocol and for their names to be publicly available.	Group members	18/01/2013	
8	Declaration of Interest document will be developed by the Secretariat for use by members.	Secretariat.	asap	Draft document developed and forwarded to the Planning Group for approval
9	Chair to report back to the Planning Group that the members will abide by the media protocol until the conclusion of the ECRG.	Leanne Geppert	18/1/2013	
10	Chair to forward to the Planning Group a recommendation for the inclusion of a consumer and carer representative on the ECRG membership.	Leanne Geppert	18/1/2013	
11	Secretariat to commence mapping of current adolescent mental health services available	Secretariat	16/1/2013	Draft document developed and disseminated with the minutes.
12	Draft service elements template to be populated and sent to ECRG members for comment out of session.	Leanne Geppert & Secretariat	16/1/2013	Draft document has been developed and dissminated with the minutes.

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MNH.900.003.0072

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MINUTES

Chair:	Dr Leanne Geppert	Date:	16 January 2013
Executive Sponsor:	Chief Executive West Moreton HHS and A/Executive Director MHAODB	Time:	9.00 – 10.30am
Secretariat:	Vaolta Turiturl/Rachael Brown		
Venue:	Butterfield St Level 2 Conference Room (Room 2.2 LMR)		
Tele/Videoconference Details:	Local Dial in no. National Dial in no. Participant code:		
Attendees:	▪ Kevin Rodgers PSM, Principal, Barrett Adolescent Centre School, Education Queensland ▪ Josie Sorban, Director of Psychology, Child & Youth MHS Children's Health Qld HHS ▪ Dr Trevor Sadler, Clinical Director, Barrett Adolescent Centre West Moreton HHS Mental Health Service ▪ Dr Leanne Geppert, Director, Planning & Partnerships Unit, QH Mental Health Alcohol & Other Drugs Branch (MHAODB)		
Teleconference:	▪ Amelia Callaghan, State Manager Qld NT and WA, Headspace. ▪ Professor Philip Hazell, Director, Infant Child and Adolescent Mental Health Services, Sydney and South Western Sydney Local Health Districts. ▪ Dr Michelle Fryer Chair, QLD Branch of the Faculty Child & Adolescent Psychiatry (QFCAP), The Royal Australian and New Zealand College of Psychiatrists (RANZCP)		
Guests:			
Apologies:	▪ Dr David Hartman Clinical Director, Child & Youth MHS Townsville HHS Mental Health Service ▪ Dr James Scott, Consultant Psychiatrist, Early Psychosis Service Metro North HHS Mental Health Service ▪ Emma Hart, Nurse Unit Manager, Adolescent Inpatient Unit And Day Service, Child & Youth MHS Townsville HHS Mental Health Service ▪ Amanda Tilse, Operational Manager, Alcohol Other Drugs and Campus Mental Health Services, Mater Children's Hospital		

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Barrett Adolescent Strategy

Expert Clinical Reference Group

Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
1.0	Welcome, Apologies and Introductions		
1.1	**Open and Welcome** × Leanne opened by welcoming reference group members.	Leanne Geppert	
1.2	**Previous minutes** × Leanne requested that members peruse the draft minutes from the previous meeting held on 9 January 2013. It was acknowledged that due to the short timeframe members' may not have had the opportunity to review the minutes. × The draft minutes were endorsed by Dr Sadler as an accurate record.		
2.0	Business Arising		
2.1 **Action Sheet**	**Outstanding actions to be addressed:** × Feedback on ECRG TOR to be considered by the Planning Group at their next meeting on 18.01.2013. × Feedback on recommendation to include a consumer or carer representative in the membership of the ECRG. × Declaration of Interest template to be forwarded to West Moreton HHS for approval. × All members to indicate their agreement for their names to be made publicly available.	Leanne Geppert Leanne Geppert Leanne Geppert All members	18/01/13 18/01/13 18/01/13 ASAP
3.0	Standing Agenda		
3.1 **Communication**	**ECRG Media Protocol** × Confirmation of individual names to be made publicly available is still to be confirmed by some members. × A Declaration of Interest document has been developed. This document needs approval from West Moreton HHS before it can be used. × It was acknowledged that each member was present as an individual expert in their discipline and a leader in their particular field. To some extent though, they also represent their particular Hospital & Health Service.(HHS) or organisation and with that may come certain pressures and expectations. × Members therefore agreed that each individual will forward a Declaration of Interest to the Secretariat for noting to avoid any potential conflict of interest. **Action:** 13. Secretariat to send a reminder email to those members that have not sent back a response. 14. Declaration of Interest document to be forwarded to West Moreton HHS for approval. **Communication Log** × No further communication received	Members Secretariat Leanne Geppert	ASAP ASAP 18/01/13
3.2 **Updates**	× An update from the Planning Group will be provided at the next meeting. × Confirmation from Dr Trevor Sadler that permission to distribute material he has provided to the Secretariat for distribution is implicitly understood by contributors. × The Acute Adolescent Inpatient Unit MOS will not be distributed to	Leanne Geppert	30/01/13

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Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
	the reference group members as this document is still in draft from and is not significant to the current discussions. ▪ Agreement to change meeting schedule to **fortnightly** to allow members to 'digest' reading material and for the secretariat to progress actions arising out of meetings. **Action:** 15. Secretariat to forward updated schedule of meetings	Secretariat	ASAP
4.	NEW BUSINESS		
4.1 **Target group/Client profile cont'd**	▪ There was further discussion concerning the service elements table which was populated by the Secretariat based on the discussion from the previous meeting. ▪ Dr Sadler forwarded to the Secretariat patient profiles examples of some of the BAC consumers. o It was felt that the service elements table does not capture the complexity or severity of this client group; a simple diagnosis does not indicate the persistence and level of impairment that may be present. o The profiles forwarded by Dr Sadler try to encapsulate this and includes identification of the individuals unique strengths which is important to build on as a component of the therapeutic mix. Further, it attempts to encapsulate the complexity and interaction of a number of variables that make for change and highlight that clinical treatment is not linear in progression. o Dr Sadler was keen to receive feedback from group members as how this could be presented better. o It was suggested that the use of quantitative and qualitative data would be useful to address this. Further, looking at the length of stay (LOS), the services being utilised by adolescents and the type of treatment they were receiving. o It was further noted that this should be considered also for those consumers that have not accessed BAC. Moreover, it was questioned whether there was indeed another group of adolescents that are missing out and not getting their needs met. ▪ A question was raised regarding whether evidence or research exists that links the achievement of optimal therapeutic treatment to LOS. o Members present were not aware of any research indicating an optimal LOS to achieve optimal therapeutic treatment. o Noted that in the Walker Unit[1] the LOS is identified as up to 6 months, however, they have had people for longer. Similar units in the United Kingdom have had LOS of 2 years. o For BAC, time seems to be a factor in the improvement of an adolescent. It is not clear what particular factors have really worked; whether it be the therapeutic milieu, that the adolescent is kept alive long enough for them to be able to reflect and contemplate other options or being in the		

1 Walker brochure.pdf Walker Unit brochure The Walker Unit.pdf The Walker Unit

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Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
	company of their peers who are going through similar situations. o What is clear however, is that not having anywhere to go after discharge from BAC or other step down facility has a detrimental effect and leads to a deterioration in the progress made by an adolescent. o Acknowledgement that there will be a small group ('outliers') that would require more time. ▪ A suggestion was put forward for consideration by the group of a smaller residential bed based unit (8 beds) with a limited time frame (up to 6 months). The step up/step down component would be undertaken by the relevant adolescent acute unit. ▪ Suggested that the ECRG should define the young people that need the service first and the coordination of services required at different levels. ▪ Furthermore, flexibility in the duration of service should be determined by focusing on factors necessary for the young person to progress and the barriers that must be overcome to continue or move towards discharge. ▪ Need to look at barriers to shortening LOS; one of these as mentioned is lack of alternative and appropriate accommodation for adolescents once discharged. ▪ It may be that the LOS is identified as 6 months as this fits with national frameworks however that there is flexibility to allow the barriers identified to be addressed. ▪ Noted inclusion of 'emotions' in the draft service descriptor. Agreed that adolescents have difficulty in articulating and expressing emotions. Moreover, there is difficulty in recognising and understanding emotions. After further discussion regarding the service element content, it was agreed that the revised version would be sent to the members for further thought and perusal. Members were requested to use track changes if possible to add, amend or edit the current content and forward back to the Secretariat. Please see attached draft table  Service Elements_4_16.01.13 **Action** 16. Secretariat to forward revised draft service elements to ECRG members 17. Members to review the draft service elements table using track changes and forward to the Secretariat for collating.	Secretariat ECRG members	ASAP 30/01/13

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Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
4.3 **Service analysis across the adolescent mental health continuum**	× No further discussion × Please note the updated draft adolescent mental health service continuum. BAC Service Analysis 4.pdf BAC Service Analysis 4.vsd NGO Adolescent MH services_2.doc		
5.	**Review Agenda Items**		
5.1	1. Service model options 2. Budget and staffing profile		
Next Meeting	**Date: 30 January 2013** **Time: 9:30 – 10:30 am** **Venue: Butterfield St Level 2 Conference Room (Room 2.2 LMR)**		

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Expert Clinical Reference Group

Expert Clinical Reference Group - Action Table – 2012 - 2013

Item	Actions	Responsible officer/s	Due Date	Status
3	Forward feedback to the Barrett Adolescent Strategy Planning Group regarding changes/recommendations to the ECRG terms of reference.	Leanne Geppert	18/1/2013	Recommendations have been forwarded. Planning Group to consider at meeting on 18/1/2013.
5	▪ Profile of current BAC consumers. ▪ Cumulative demographic profile of consumers in BAC over a period of 1-2 years. ▪ Any BAC consumer or carer satisfaction surveys. ▪ Any investigations or reports by students etc on longer term outcomes of BAC consumers.	Trevor Sadler Kevin Rodgers	14/12/2012	Demographic data received for January 2011 – December 2012 from Dr Sadler.
7	Members to confirm acceptance of media protocol and for their names to be publicly available.	Group members	18/01/2013	Reminder email sent 18/01/13 to those members that have not responded.
9	Chair to report back to the Planning Group that the members will abide by the media protocol until the conclusion of the ECRG.	Leanne Geppert	18/1/2013	
10	Chair to forward to the Planning Group a recommendation for the inclusion of a consumer and carer representative on the ECRG membership.	Leanne Geppert	18/1/2013	
14	Declaration of Interest document to be forwarded to West Moreton HHS for approval.	Leanne Geppert		
16	Secretariat to forward revised draft service elements to ECRG members for review and comment	Secretariat		
17	Members to review the draft service elements table using track changes and forward to the Secretariat for collating	ECRG members		

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MINUTES

Chair:	Dr Leanne Geppert	Date:	13 February 2013
Executive Sponsor:	Chief Executive West Moreton HHS and A/Executive Director MHAODB	Time:	9.00 – 10.30am
Secretariat:	Vaolta Turituri		
Venue:	Level 2 Conference Room (Room 2.2 LMR), 15 Butterfield St, Herston		
Tele/Videoconference Details:	Local Dial In no. National Dial in no. Participant code:		
Attendees:	* Amanda Tilse, Operational Manager, Alcohol Other Drugs and Campus Mental Health Services, Mater Children's Hospital * Josie Sorban, Director of Psychology, Child & Youth MHS Children's Health Qld HHS * Dr James Scott, Consultant Psychiatrist, Early Psychosis Service Metro North HHS Mental Health Service * Kevin Rodgers PSM, Principal, Barrett Adolescent Centre School, Education Queensland * Dr Leanne Geppert, Director, Planning & Partnerships Unit, QH Mental Health Alcohol & Other Drugs Branch (MHAODB) * Dr Trevor Sadler, Clinical Director, Barrett Adolescent Centre West Moreton HHS Mental Health * Service		
Teleconference:	* Dr David Hartman Clinical Director, Child & Youth MHS Townsville HHS Mental Health Service * Emma Hart, Nurse Unit Manager, Adolescent Inpatient Unit And Day Service, Child & Youth MHS Townsville HHS Mental Health Service		
Guests:			
Apologies:	* Amelia Callaghan, State Manager Qld NT and WA, Headspace. * Professor Philip Hazell, Director, Infant Child and Adolescent Mental Health Services, Sydney and South Western Sydney Local Health Districts. * Dr Michelle Fryer Chair, QLD Branch of the Faculty Child & Adolescent Psychiatry (QFCAP), The Royal Australian and New Zealand College of Psychiatrists (RANZCP)		

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Expert Clinical Reference Group

Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
1.0	Welcome, Apologies and Introductions		
1.1	**Open and Welcome** × Members present and on teleconference were welcomed by the Chair	Leanne Geppert	
1.2	**Previous minutes** × The draft minutes of the last meeting (16.01.2013) were endorsed by Dr Sadler and Josie Sorban as an accurate record.		
2.0	Business arising		
2.1 **Action Sheet**	**Outstanding actions to be addressed:** × Awaiting response back from the Planning Group regarding the amendments to the ERCG terms of reference. × The Planning Group has endorsed the inclusion of a consumer and carer representative. West Moreton HHS will develop a process for the support and debrief of these individuals as required. × Declaration of Interest template has been approved. All members to indicate their agreement for their names to be made publicly available.		
3.0	Standing agenda		
3.1 **Communication**	**Communication Log** × No further communication received		
3.2 **Updates**	× Nil noted		
4.0	New Business		
4.1 **Consumer and carer representation**	× West Moreton HHS has approved the inclusion of a consumer and a carer representative on the ECRG. However, there is an unclear commitment from them in regards to remuneration for these representatives. × The ECRG recognise the need to provide adequate support for the prospective consumer and carer representative and identified the following : **Up brief** o To support the consumer and carer rep. by providing background information and context for the meeting; processes and responsibilities of members etc. This will be a responsibility of the Chair and secretariat. **De-brief** o To support the representatives with issues such as obstacles, dilemmas etc that may arise during the course of meetings. **Remuneration** o It is standard practice to remunerate consumer and carer representatives for meeting, reading time and travel. × The ECRG will seek clarification from West Moreton HHS regarding commitment to remuneration of these representatives. × The ECRG have agreed on [redacted] as suitable carer and consumer representatives; their names will be forwarded to West Moreton HHS for invitation to the group. × Further, ECRG members agreed that [redacted], carer		

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Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
	consultant at Mater CYMHS will be approached to provide support and debriefing for the consumer and carer representatives as required. **Representation** ▪ [redacted] ▪ The ECRG are seeking a broader perspective that includes the perspectives of the parents of clients that have not or cannot access BAC. **Actions** 18. Progression of consumer and carer nominations and proposal for their support to the Planning Group	Leanne Geppert	By next meeting
4.2 Broader group of consumers	▪ Identifying the broader group of adolescent consumers that meet the criteria of severe and persistent symptoms but not accessing local CYMHS or BAC. ▪ Not improbable that there may be up to 10-15 adolescents, as in Townsville, in every town that may be sitting at home, not attending school with psychiatric symptoms that may be difficult to identify, engage with services or if they are, not able to access BAC. ▪ Townsville CYMHS have aspirations to look after this high needs group within their alternative model of service. This model proposes a partnership between the local acute adolescent mental health unit, child and youth community services and a non government residential provider. ▪ Consider whether this alternative model would have utility elsewhere in Queensland especially the south east corner. ▪ Noted the Adolescent Drug and Alcohol Withdrawal Service (ADAWS) residential facility works very well and recognise the value of using an alternate workforce such as non clinical support staff. ▪ Noted that an alternative model should have its governance managed by a consortium. **Actions** 19. Forward ADAWS model of service to secretariat for distribution to the group 20. Further development of service elements with reference to alternative models in preparation for discussion at the next scheduled meeting.	Amanda Tilse Chair & Secretariat	Asap By next meeting
	Forward Agenda Items		
5.1	1. Service model options 2. Budget and staffing profile		
Next Meeting:	**Date:** 30 January 2013 **Time:** 9:00 – 10:30 am **Venue:** Butterfield St Level 2 Conference Room (Room 2.2 LMR)		

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Expert Clinical Reference Group Action Table – 2012 - 2013

Item	Actions	Responsible Officer	Due Date	Status
3	Forward feedback to the Barrett Adolescent Strategy Planning Group regarding changes/recommendations to the ECRG terms of reference.	Leanne Geppert	18/1/2013	Recommendations have been forwarded. Planning Group to consider at meeting on 18/1/2013. Changes made to the TOR and forwarded to Sharon Kelly for the Planning Group 25/01/2013
5	× Profile of Profile of current BAC consumers. × Cumulative demographic profile of consumers in BAC over a period of 1-2 years. × Any BAC consumer or carer satisfaction surveys. × Any investigations or reports by students etc on longer term outcomes of BAC consumers.	Trevor Sadler Kevin Rodgers	14/12/2012	Demographic data received for January 2011 – December 2012 from Dr Sadler.
17	Members to review the draft service elements table using track changes and forward to the Secretariat for collating	ECRG members	Ongoing	Chair and Secretariat to further develop service elements table based on comments received from members and in reference to current models including the Oslo Model
18	Chair to follow up with WMHHS re: remuneration and support processes consumer and carer representatives.	Leanne Geppert	By next meeting	
19	Chair to forward consumer and carer rep. names to WMHHS for invitation to the ECRG.	Leanne Geppert	By next meeting	
20	Forward ADAWS model of service to secretariat for distribution to the group	Amanda Tilse	Asap	

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Barrett Adolescent Strategy

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MINUTES

Chair:	Dr Leanne Geppert	Date:	13 March 2013
Executive Sponsor:	Chief Executive West Moreton HHS and A/Executive Director MHAODB	Time:	9.00 – 10.30am
Secretariat:	Vaolta Turituri		
Venue:	Level 2 Conference Room (Room 2.2 CR), 15 Butterfield St, Herston		
Tele/Videoconference Details:	Local Dial In no. National Dial In no. Participant code:		
Attendees:	* Amanda Tilse, Operational Manager, Alcohol Other Drugs and Campus Mental Health Services, Mater Children's Hospital * Amelia Callaghan, State Manager Qld NT and WA, headspace * Carer representative * Dr James Scott, Consultant Psychiatrist, Early Psychosis Service Metro North HHS Mental Health Service * Kevin Rodgers PSM, Principal, Barrett Adolescent Centre School, Education Queensland * Dr Leanne Geppert, Director, Planning & Partnerships Unit, QH Mental Health Alcohol & Other Drugs Branch (MHAODB) * Dr Trevor Sadler, Clinical Director, Barrett Adolescent Centre West Moreton HHS Mental Health Service		
Teleconference:	* Dr David Hartman Clinical Director, Child & Youth MHS Townsville HHS Mental Health Service * Emma Hart, Nurse Unit Manager, Adolescent Inpatient Unit And Day Service, Child & Youth MHS Townsville HHS Mental Health Service * Professor Philip Hazell, Director, Infant Child and Adolescent Mental Health Services, Sydney and South Western Sydney Local Health Districts		
Guests:			
Apologies:	* Consumer representative * Josie Sorban Director of Psychology, Child & Youth MHS Children's Health Qld HHS * Dr Michelle Fryer Chair, QLD Branch of the Faculty Child & Adolescent Psychiatry (QFCAP), The Royal Australian and New Zealand College of Psychiatrists (RANZCP)		

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Barrett Adolescent Strategy

Expert Clinical Reference Group

Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
1.0	Welcome, Apologies and Introductions		
1.1	**Open and Welcome** ▪ Members present and on teleconference were welcomed by the Chair	Leanne Geppert	
1.2	**Previous minutes** ▪ The draft minutes of the last meeting (27.02.2013) were endorsed as an accurate record of proceedings by [redacted] and Kevin Rodgers		
2.0	Outstanding Actions		
2.1 **Action Sheet**	**Outstanding actions to be addressed:** ▪ Nil of note ▪ Amanda Tilse to forward ADAWS model of service to secretariat for dissemination. **Action** Secretariat to disseminate ADAWS model to members.	Secretariat	
2.2 **Clarification of parameters and scope of proposed model**	▪ Clarification was sought in relation to determining whether the proposed service model should be an aspirational model that depicts the ideal without budgetary constraints. ▪ Funds to implement a proposed model will be limited to operational funds from the BAC and operational funds allocated to the cancelled Redlands facility. ▪ Agreement that only one model will be presented to the Planning Group. ▪ It was noted that there may be elements within the recommended model that may not be supported or implemented by the Planning Group e.g. inpatient beds or residential component.		
3.0	Communication		
3.1 **Communication**	**Communication Log** ▪ No further communication received.		
3.2 **Updates**	▪ The e-petition has well over 1900 signatures and was tabled in Parliament on 5 March 2013. ▪ The Planning Group has not met since the last ECRG meeting, hence, nothing to report.		
4.0	New Business		
4.1 **Final meeting & write up**	▪ Agreement that the recommended service model will be presented to the Planning Group as a written report and power point presentation. ▪ A presentation by the ECRG will provide the ability to capture the nuances and complexities that are often difficult to convey in a text narrative.		
4.2 **Workshop**	▪ As in the previous meeting, a workshop format was used to work through the service description and critical elements of the service model. ▪ Feedback from current and past BAC clients indicates that there is a need for consistency in staffing. This is supported by carers and families.		

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Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
	▪ Agreement that the proposed model should have an emphasis on: 1. flow through 2. family involvement 3. medium term therapy ▪ Inclusion of the Non Government sector as a component of the recommended model was not unanimously supported by members. The risks and benefits were robustly debated. **The risks were as follows:** 1. Noted that an NGO partnership arrangement with public services is a comparatively new concept to Queensland as compared to other states such as Victoria. 2. There was a concern that an NGO will not be able to manage the acuity and crises in this particular cohort. 3. In addition, there was concern regarding the 'quality' and stability of the NGO workforce given the traditionally lower pay scales. **The benefits were as follows:** 1. The NGO sector has indeed managed a high level of complexity with the support of the public sector and clinical teams 2. The public sector can support the NGO sector to maintain and improve the residential component and enable 24 hour support. 3. This is an opportunity to enhance the mental health component in the NGO sector and develop greater partnership and better flow and continuum of care to and from the community. 4. Will address the 'flow through' issues associated with existing CYMHS bed based services. ▪ Agreement that while contentious, the NGO option will be included in the proposed model. ▪ Noted that there were basically three components required for the NGO option to be viable: 1. balance – equity in pay rates 2. support within roles – from clinical services 3. culture and underlying philosophy ▪ Other options include capacity for families/carer/support worker to stay within the unit to support the adolescent. This option could be included in the inpatient/NGO component.		
4.3 **Closing discussions**	▪ The Chair reinforced the need to deliver a proposal for an alternative model at the earliest possible time so that BAC staff can access opportunities associated with the West Moreton HHS restructure and to lessen the impact on consumers and carers. ▪ Noted that an alternative and feasible model needs to be endorsed before BAC can close. There will no gaps in service delivery. ▪ Presentation will be developed by the Chair and Secretariat based on collated discussion and feedback. Will attempt to send out a draft presentation as soon as possible. Action Draft power point presentation to be developed and sent to members as		

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Barrett Adolescent Strategy

Expert Clinical Reference Group

Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
	soon as possible.	Leanne Geppert Secretariat	
5.0	Next Meeting		
5.1	1. Service model options 2. Budget and staffing profile		
Next Meeting:	Date: 27 March 2013 Time: 9:00 – 10:30 am Venue: Butterfield St Level 2 Conference Room (Room 2.2.CR) Future dates: 10 April (TBC)		

MNH.900.003.0086

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Expert Clinical Reference Group

Expert Clinical Reference Group: Action Table – 2012 - 2013

No.	Action	Responsible Person	Due Date	Status
19	Forward ADAWS model of service to secretariat for distribution to the group	Amanda Tilse	Asap	
20	Further development of service elements with reference to alternative models in preparation for discussion at the next scheduled meeting	Members	By next meeting	Revised service elements with reference to alternative models developed for discussion **27.02.2013** Members to work out of session to revise the service elements table. **13.03.2013** Workshop to progress service elements and model components
21	Develop a draft power point presentation of a proposed service model based on workshop discussions	Chair Secretariat		

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Expert Clinical Reference Group

MINUTES

Chair:	Dr Leanne Geppert	Date:	27 March 2013
Executive Sponsor:	Chief Executive West Moreton HHS and A/Executive Director MHAODB	Time:	9.00 – 10.30am
Secretariat:	Vaoita Turituri		
Venue:	Level 2 Conference Room (Room 2.2 CR), 15 Butterfield St, Herston		
Tele/Videoconference Details:	Local Dial in no. National Dial in no. Participant code:		
Attendees:	• Amanda Tilse, Operational Manager, Alcohol Other Drugs and Campus Mental Health Services, Mater Children's Hospital • , Carer representative • Dr James Scott, Consultant Psychiatrist, Early Psychosis Service Metro North HHS Mental Health Service • Josie Sorban, Director of Psychology, Child & Youth MHS Children's Health Qld HHS • Kevin Rodgers PSM, Principal, Barrett Adolescent Centre School, Education Queensland • Dr Leanne Geppert, Director, Planning & Partnerships Unit, QH Mental Health Alcohol & Other Drugs Branch (MHAODB) • Dr Michelle Fryer Chair, QLD Branch of the Faculty Child & Adolescent Psychiatry (QFCAP), The Royal Australian and New Zealand College of Psychiatrists (RANZCP) • Dr Trevor Sadler, Clinical Director, Barrett Adolescent Centre West Moreton HHS Mental Health Service		
Teleconference:	• Amelia Callaghan, State Manager Qld, NT and WA, headspace • Emma Hart, Nurse Unit Manager, Adolescent Inpatient Unit And Day Service, Child & Youth MHS Townsville HHS Mental Health Service • Professor Phillip Hazell, Director, Infant Child and Adolescent Mental Health Services, Sydney and South Western Sydney Local Health Districts		
Guests:			
Apologies:	• Dr David Hartman Clinical Director, Child & Youth MHS Townsville HHS Mental Health Service • , Consumer representative		

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Expert Clinical Reference Group

Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
[redacted]			
1.1	**Open and Welcome** ▪ Members present and on teleconference were welcomed by the Chair	Leanne Geppert	
1.2	**Previous minutes** ▪ The draft minutes of the last meeting (13.03.2013.) were endorsed as an accurate record of proceedings by [redacted].		
[redacted]			
2.1 **Action Sheet**	**Outstanding actions to be addressed:** ▪ Amanda Tilse to forward ADAWS model of service to secretariat for dissemination. **Action** Secretariat to disseminate ADAWS model to members.	Amanda Tilse Secretariat	
E-petition	▪ It was noted that there is a second e-petition regarding the Barrett Adolescent Centre. ▪ Please see attached link to this petition for information. ▪ http://www.communityrun.org/petitions/don-t-close-the-barratt-centre-for-adolescents-with-severe-mental-health-issues		
[redacted]			
3.1 **Communication**	**Communication Log** ▪ No further communication received.		
3.2 **Updates**	**Planning Group** ▪ The Chair spoke to the proposed the draft service elements table noting only the salient points of the proposed model. ▪ The Planning Group were not provided with a written draft as it has not been discussed by the ECRG. ▪ The Planning Group are purported to be agreeable to the presentation of an ideal model however, some of the elements included in the ideal may not be supported (although may be implemented in the future). ▪ It was reiterated that there is no funding for a capital project and no identified location.		
[redacted]			
4.1 **Revised time frames**	▪ Changes to the time frames for completion of tasks and objectives were noted and highlighted by the Chair. ▪ Noted that the construction of the Extended Forensic Treatment Unit (EFTRU) at Wacol has been completed and due to open in July 2013. ▪ With the opening of EFTRU, it is likely that there will be forensic patients on the grounds with access to BAC. This is seen as a risk for young people. ▪ EFTRU is a new model of service and there is uncertainty as to whether the risks to adolescents in BAC have been assessed for patients likely to transition to EFTRU. ▪ It was noted that there are differing opinions to whether these		

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Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
	consumers will pose a risk to the adolescents on site and a comment that there are ongoing myths being perpetuated about forensic consumers. * Furthermore, it was noted by staff from BAC that currently, forensic patients on leave already have access to the BAC grounds with no incident and question the validity of the claim around increased risk due to forensic consumers.		
4.2 **Draft model of service**	The following discussions were noted in reference to the draft model of service. (Please see attached) Service Elements_LMG_22 Ma **Discussion** **Education components** * A concern was raised regarding the sustainability of a stand alone school with proposed changes to the current model. * An 8 – 10 bed adolescent unit would not have the critical mass required for a school and would not be sustainable. Queensland Education (QED) would require at least 15 beds before it will allocate funds for a school. * In this scenario, responsibility for adolescent schooling is with the locality where the consumer is from or the local high school. There are issues with this arrangement particularly regarding continuity, priority and time commitment from teachers. **Actions** Kev Rodgers to provide further words to the core educational component to strengthen this statement **Child & Youth funding** * Concern was raised regarding the allocation of any future funds that may become available to child and youth mental health services with proposed changes particularly in reference to Tier 2a. * Confirmed that funding for child based services would not be transferred to adult mental health services. **Tier 2 - Day Program Services (Mon – Fri business hours)** * There are already several day programs available across the state. The recommendation is to fund further additional programs. * The challenge will be to determine where these additional programs will be located and the supporting infrastructure that may be required. * The introduction of the term 'tiers' could cause confusion and should be aligned with the Clinical Services Capability Framework * Noted that Level 6 of the CSCF aligns closer to the Tier 3 option. * There was discussion regarding possible locations and configurations of day programs across the state. Funds from BAC could be used to establish day programs in areas such as the Gold Coast, Children's Health QLD CYMHS, West Moreton etc. However, any proposed locations, funding etc would need to be determined through a planning process. * The addition of new day programs across the state i.e. Tier 2a and possibly the addition of a residential component (Tier 2b) should	Kev Rodgers	ASAP

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Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
	meet the needs of these adolescents. ▪ There was a question regarding whether acute child & youth inpatient units could be utilised in the interim to meet the needs of adolescents prior to the establishment of a Tier 3 service. ▪ It was suggested that adolescents requiring more intensive services than possible from a Tier 2 service would not have their needs met if only Tier 2 is available. ▪ Furthermore, the issue of having long stay adolescent consumers in a short stay environment with unintentional consequences in an inpatient setting was again highlighted. o Staff burnout o Acutely unwell adolescents mixing with long stay patients o Increased incidence of seclusion **Tier 2b – Residential component** ▪ Some members were concerned with the Tier 2b option (NGO residential component). Primarily, that there were good and not so good benefits for this option. ▪ The residential component needs to be considered and explored in further detail. There will be some adolescent consumers that will require Tier 3 type services but not be acutely unwell however may require accommodation. ▪ Noted that if this was an option put forward, governance needed to remain with the Department of Health to maintain quality. ▪ One option considered is for the Department of Health (DoH) to have a residential contract. A service provider (whether private or non government) provides back up staff and accommodation and DoH provides clinical staff. ▪ A day program and accommodation provider combination would be similar to a step down arrangement. The accommodation provider does not necessarily have to be an NGO, it could be a private provider. **Tier 3** ▪ The majority of members were supportive of both Tier 2 and 3 with some concern regarding the inclusion of a NGO residential component. There is value in having a Tier 3 service because of long term benefits due to the constant care provided. ▪ Day programs need to be an appendage to a 24/7 model. The extended nature of such a program is conducive to development of culture and consistency and dedicated staff. ▪ The Chair clearly clarified with the ECRG members that Tier 3 will be included in the recommended model however, in the short term, the Tier 3 option will not be considered due to the absence of capital funding and location. ▪ Therefore, the ECRG needs to consider how to make Tier 2 work. ▪ Kevin Rodgers, PSM noted the following: o There is a cost to losing BAC including 25 years of culture, knowledge and experience. o There is a seamless relationship between education and health that will be forever lost.		

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Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
	✖ The Chair acknowledged this statement and clarified again that the reality is that in the foreseeable future, Tier 3 will not be progressed. **Member opinions** ✖ A possible impact on inpatient beds if the Tier 3 is not implemented is that long stay patients will take up acute beds. This will need to be managed carefully and should include scoping of the current occupancy rates of adolescent units across the state. ✖ It was suggested that the current bed stock is not the issue but rather increasing capacity and having a combination of acute presentations with long term patients in the same unit. ✖ Hence, mixing two the types of consumers is not helpful. ✖ There is currently no evidence based alternative model for adolescents with mental health issues at the very severe end of the spectrum. It was suggested that rehabilitation cannot be implemented in an acute inpatient unit without the inclusion of activities and programs required. ✖ If however, there is no Tier 3/Level 6 available, the acute inpatient unit may be the only option. ✖ In reply to the two main reasons for BAC to close, Dr Sadler noted the following: o The Australian Council on Healthcare Standards (ACHS) regarding facility issues were not serious in his opinion o The Extended Forensic Treatment Unit (EFTRU) will open soon. However, most patients of BAC have suicidal ideation and the risk of not having BAC as opposed to chance of an incident with a forensic client has not been weighed up. ✖ **Members of the ECRG unanimously supported the retention of the Tier 3 option in the recommended service model.**		
Current Day Programs	1. **Townsville** – 12 places in the day program. There is physical ability for more however the limiting factor is staff capacity. 2. **Mater** – 12 -15 places; always full 3. **Toowoomba** – approximately 14 places in its day program		
Preamble	✖ Dr Sadler offered to develop a preamble to include with the service model recommendations. Suggested that the following should be included: ✖ Existing service needs to be expanded rather than contracted ✖ Statements regarding the challenges faced by the ECRG in developing a recommended model ✖ The ideal model includes a full spectrum of services; this includes Tier 3. ✖ Combination of Tier 2 and Tier 3 as a compromise	Trevor Sadler	ASAP
[illegible]	[illegible]		
5.1	1. Budget and staffing profile	MHAOD	
Next Meeting	**Date:** 24 April 2013		

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Agenda Item	Action/Outcome/Update	Accountable Officer	Due Date
	Time: 9:00 - 10:30am Venue: Butterfield St Level 2 Conference Room (Room 2.2 CR)		

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Expert Clinical Reference Group

Expert Clinical Reference Group: Action Table – 2012 - 2013				
Item	Actions	Accountable Officers	Due Date	Status
19	Forward ADAWS model of service to secretariat for distribution to the group	Amanda Tilse	Asap	
20	Further development of service elements with reference to alternative models in preparation for discussion at the next scheduled meeting	Members	By next meeting	Revised service elements with reference to alternative models developed for discussion **27.02.2013** Members to work out of session to revise the service elements table. **13.03.2013** Workshop to progress service elements and model components
21	Develop a draft power point presentation of a proposed service model based on workshop discussions	Chair Secretariat		

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"JS-8"

West Moreton Hospital and Health Service
TERMS OF REFERENCE

Terms of Reference: Expert Clinical Reference Group – Barrett Adolescent Strategy					
Date:	30.11.12	Review Date:	N/A	Version:	Final

1. Purpose:

1.1 The purpose of the Expert Clinical Reference Group is to:
Provide expert clinical advice to promote the development of a contemporary evidence based model of care to meet the needs of adolescent mental health consumers who experience severe and persistent psychiatric symptomatology that significantly interferes with social, emotional, behavioural and psychological functioning and development.

2. Scope and functions:

2.1 The Expert Clinical Reference Group will consider that the model(s) of care:

- will clearly articulate a contemporary model(s) of care for subacute mental health treatment and rehabilitation for adolescents in Queensland
- will be evidenced based, sustainable and align with Queensland mental health policy, current statewide models of service, National mental health policy, National mental health service planning frameworks and future funding models.
- will take into account the Clinical Services Capability Framework (for Mental Health) and
- will replace the existing Statewide services provided by Barrett Adolescent Centre – The Park.

3. Membership (position held only):

3.1 Members:

- Dr Michelle Fryer, Faculty Child and Adolescent Psychiatry
- Dr James Scott, Consultant Psychiatrist Early Psychosis, Metro North HHS
- Dr David Hartman, Clinical Director, CYMHS, Townsville HHS
- Dr Trevor Sadler, Clinical Director, BAC, West Moreton HHS
- Professor Philip Hazell, Director, Infant Child and Adolescent Mental Health Services, Sydney and South Western Sydney Local Health Districts
- Ms Josie Sorban, Director of Psychology, CYMHS, Children's Health Qld HHS
- Ms Amanda Tilse, Operational Manager, Alcohol Other Drugs and Campus Mental Health Services, Mater Children's Hospital
- Ms Amelia Callaghan, State Manager Qld NT and WA, Headspace
- Ms Emma Hart, NUM, Adolescent Inpatient Unit and Day Service, Townsville HHS
- Mr Kevin Rodgers PSM, Principal, Barrett Adolescent Centre School
- consumer representative
- , carer representative

Carer Consultant will provide support to the consumer and representative will on the Expert Clinical Reference Group.

The Chair on behalf of the Expert Clinical Reference Group, will invite additional nominated National experts on an as needs basis to provide additional input into the development of a contemporary evidence based model of care.

3.2 Proxies:
Due to the time limited nature of this reference group, it is unlikely that the use of proxies will be effective.

4. Chairperson

4.1 Dr Leanne Geppert, Director Planning and Partnerships Unit, Mental Health Alcohol & Other Drugs Branch (MHAODB)

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5. Secretariat (position held only):

5.1 MHAODB will provide the secretariat to the Expert Clinical Reference Group.

6. Reporting relationships:

6.1 The Expert Clinical Reference Group will provide its recommendation regarding contemporary model(s) of care to the planning group as per the Project Plan for the Barrett Adolescent Strategy.

7. Sub Committees:

7.1 Nil.

8. Frequency of meetings:

8.1 Given the expected short duration of this forum, it is anticipated that the Expert Clinical Reference Group will meet on at least a fortnightly basis (in person or tele/videoconference) until a recommended model of care is developed. It may reconvene on an as needs basis to examine plans regarding the implementation of an endorsed model of care.

9. Quorum:

9.1 The quorum for Expert Clinical Reference Group meetings will be half of membership plus one.

10. Authorisation:

These Terms of Reference may be altered following committee consultation and endorsement by the Chief Executive West Moreton HHS and A/Executive Director MHAODB on the recommendation of the Expert Clinical Reference Group.

Chairperson: Dr Leanne Geppert, Director Planning and Partnerships Unit, MHAODB

Date: Signature:

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Barrett Adolescent Strategy

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17.04.13	James Scott	Comments Re preamble × Mental illnesses do carry the greatest burden of illness into adult like, in fact only after back pain, depression causes the greatest loss of disability adjusted life years globally according to our GBD2010 study (published last year in the lancet). × So I'd advise deleting "have the potential to" in the preamble. × Secondly, health care funding to adolescent is minute in Australia. × The historical lack of funding should be stated in the preamble to explain why we are in this current dilemma of asking for more	Preamble document amended to reflect suggested changes. × 'have the potential to" deleted Added the following: *It should be noted that child and youth mental health services are historically under funded both at national and state levels. The constraints in resource and funding availability have therefore also been a key consideration in the final determination of the proposed service model elements.*
17.04.13	Philip Hazell	No comments	
19.04.13	David Hartman	Happy to support these documents but note the following: × Tier 2: Townsville has a site for day program but doesn't at this time have a funded day program. × Length of stay: I would suggest the same length of stay for tier 2 and tier 3, i.e. six months. One term may be sufficient for some clients but it is unduly optimistic to expect this to be an average. × Agree with James's comments on the Preamble. Slide 39 defining need - the % of population requiring this service. × This is a difficult one to answer because the number of clients going through BAC is not an accurate reflection of state-wide need for this kind of service, and it would be a significant piece of work to do thorough state-wide needs assessment. × I am not aware of any literature that would give population numbers for adolescents with this level of mental health problems.	Amend service element document to reflect the following: × Added day program + residential to Townsville × Amended Tier 2a length of stay to 'up to 6 months' × Amended slide 39 to include: o At least equivalent to current BAC level of activity o BAC is not equitably accessed by regional QLD

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		[redacted]	
23.04.13	James Scott	Leanne, I would really like the people who make the decisions to hear this feedback from parents and consumers. In other areas of health care, patients aren't excluded from services because their illnesses don't respond to arbitrary time frames. Can you imagine the outcry if we did this to adolescents with leukaemia who don't go into remission quickly enough. I am an apology for tomorrow (I am overseas) but the contributions by [redacted] deserves some serious consideration	
23.04.13	David Hartman	I would like to particularly support Amanda's point about education.	*Any redeployment of BAC resources should ideally come*

Proposed service model elements_AETRS

From:

To:

Cc:

Date: Wed, 17 Apr 2013 09:46:32 +1000

Attachments: Proposed service model_AETRS.ppt (276.48 kB); V1 Preamble_draft_April 13.doc (25.09 kB); V2 Proposed Service Model Elements_April 2013.doc (295.94 kB)

Dear Reference Group Members,

Please find attached the following:

- FINAL preamble
- FINAL Proposed service model elements for Adolescent Extended and Rehabilitation Services
- DRAFT power point

AS previously advised, your final comments are due by **COB Monday 22nd April** and our final meeting is scheduled for 24 April 2013.

Kind regards
Vaoita

Vaoita Turituri
Planning and Partnerships Unit
Mental Health Alcohol and Other Drugs Branch
Health Services and Clinical Innovation Division
Level 2, Queensland Health Building
15 Butterfield Street
BRISBANE QLD 4006
GPO Box 2368
FORTITUDE VALLEY BC QLD 4006

MNH.900.003.0099

Preamble

Mental health disorders are the most prevalent illnesses affecting adolescents today and have the potential to carry the greatest burden of illness into adult life.

In the past 25 years, a range of child and youth mental health services have been established and provided by the Department of Health to address the mental health needs of children and adolescents. These services endeavour to deliver mental health assessment and treatment across the spectrum of mental illness and need. Child and Youth Mental Health Service (CYMHS) clinics are located across regional and rural Queensland. Adolescent acute mental health inpatient units are located at Royal Brisbane, Logan, Robina, Mater and Toowoomba, and a new unit in Townsville is due to open in June 2013. The Barrett Adolescent Centre (BAC) located at The Park Centre for Mental Health (TPCMH) provides a statewide specialist multidisciplinary assessment and integrated treatment and rehabilitation to adolescents between 13 and 17 years of age with severe, persistent mental illness.

The current policy context and direction for mental health services is informed by the National Mental Health Policy (2008) which articulates that 'non acute bed-based services should be community based wherever possible'.

The key principle for child and youth mental health services is that young people are treated in the least restrictive environment possible, which recognises the need for safety and cultural sensitivity, with the minimum possible disruption to their family, educational, social and community networks

Consistent with state and national mental health reforms, the decentralisation of services; including BAC at TPCMH will result in this site offering only forensic and secure services. Therefore, BAC can no longer operate into the future. In addition, alternative models of care need to be considered to align adolescent mental health services with the current policy and direction for mental health.

Accordingly, contemporary evidence based models of care including additional day programs and alternatives provided by community-based mental health services have been considered by an Expert Clinical Reference Group (ECRG). The ECRG comprises of consumer and carer representation and distinguished child and youth mental health clinicians across Queensland and New South Wales.

The attached model of service has been proposed by the ECRG as a way forward for adolescent extended treatment and rehabilitation services.

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Barrett Adolescent Strategy

Expert Clinical Reference Group

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

Attribute	Details
Service Delivered	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 AETRS continuum is offered across a range of environments tailored to the individual needs of the young person with regard to safety, security, structure, therapy, community participation, autonomy and family capacity to provide care for the young person. The AETRS functions as part of the broader, integrated continuum of care provided for young Queenslanders, that includes acute and sub acute inpatient, day program and community mental health services (public, private and other community-based providers).
Over-arching Principles	The delivery of an Adolescent Extended Treatment and Rehabilitation Service continuum will: • develop/maintain stable networks • promote wellness and help young people and their families in a youth oriented environment • provide services either in, or as close to, the young person's local community • collaborate with the young person and their family and support people to develop a recovery based treatment plan that promotes holistic wellbeing • collaborate with other external services to offer continuity of care and seamless service delivery, enabling the young person and their family to transition to their community and services with ease • integrate with Child and Youth Mental Health Services (CYMHS), and as required, Adult Mental Health Services • recognise that young people need help with a variety of issues and not just illness • utilise and access community-based supports and services

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	where they exist, rather than re-create all supports and services within the mental health setting • treat consumers and their families/carers in a supportive therapeutic environment provided by a multidisciplinary team of clinicians and community-based staff • provide flexible and targeted programs that can be delivered across a range of contexts and environments • have the capacity to deliver services in a therapeutic milieu with family members; support and work with the family in their own environment and keep the family engaged with the young person's problems • have capacity to offer intensive family therapy and family support • have flexible options from 24 hour inpatient care to partial hospitalisation and day treatment with ambulant approaches; step up/step down • acknowledge the essential role that educational/vocational activities and networks have on the recovery process of a young person • engage with a range of educational or vocational support services appropriate to the educational needs of the young person and the requirements of their treatment environment, and encourage engagement/reengagement of positive and supportive social, family, educational and vocational connections.
Key Distinguishing Features of an AETRS within the Public Sector	Services are accessed via a tiered, least-restrictive approach, and may involve combinations of service types across the tiers. **Tier 1: Public Community Mental Health Services (Sessional)** • Existing Locations: Access at HHS level. • Access ambulatory care at a public community-based mental health service, within the local area. • Interventions should consider shared-care options with community-based service providers including General Practitioners and *headspace*. **Tier 2a: Day Program Services (Mon – Fri business hours)** • Existing Locations: Townsville, Mater, Toowoomba. • Possible New Locations: Gold Coast, The Prince Charles Hospital (TPCH), Sunshine Coast. Funds from existing operational funds from BAC and Redlands Facility. Final locations and budget to be determined through a planning process.

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	• Individual, family and group therapy and rehabilitation. programs operating throughout school terms. • Core educational component for each young person – partnership with Education Queensland and vocational services required. This may be provided at the young person's school/vocational setting, or from the day program site. • Flexible and targeted programs with attendance up to 5 days (during business hours) a week, in combination with integration into school, community and/or vocational programs. • Integrated with local CYMHS (acute inpatient and public community mental health teams). • Programs are delivered in a therapeutic milieu (from a range of settings including day program service location, the family home, school setting etc.). • Programs will support and work with the family, keeping them engaged with the young person's recovery. • Consumers may require admission to Adolescent Acute Inpatient Unit, (and attend the Day Program during business hours). • Proposal of 12 - 15 program places per Day Program (final places and budget should be determined as part of formal planning process). **Tier 2b: Day Program Service + [1]Community Residential Provider (24h/7d)** • Existing Locations: Nil service that includes both a Day Program and Community Residential Service for this age group. Note: Cairns TOHI for 18y+. • Possible New Locations: Townsville (for residential), Gold Coast (for day program + residential), Toowoomba (for residential), Sunshine Coast (for day program + residential). Funding from existing operational funds of BAC and Redlands Facility. Final locations and budget to be determined through a planning process. • Day Program attendance as in Tier 2a during business hours. • After-hours and weekend care and support provided by a

[1] Note: The Department of Health takes a 'provider agnostic' view in determining non clinical support and accommodation services; decisions to utilise specific service providers will be determined by service merit, consumer need and formal planning processes.

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	community-based service provider that provides 4-bed residential component. • Integrated with local CYMHS (acute inpatient, day program and public community mental health teams). • Residential to be a partnership model for service delivery between a community-based service provider and QH – multidisciplinary staffing profile including clinical (Day Program) and community support staff (community-based provider). Partnership to include clinical governance, training and in-reach by CYMHS. • Residential component only provides accommodation; it is not the intervention service provider. • On-site extended hours visiting service from QH Day Program staff. **Tier 3: Statewide In-patient Extended Treatment and Rehabilitation Unit (24h/7d)[2]** • Possible Location: SE Qld. Source of capital funding and potential site not available at current time[3]. Acknowledge accessibility issues for young people outside SE Qld. • For young people whose needs could not be met by Tiers 1 and 2 above, due to risk, severity or need for inpatient extended treatment and care. • These young people's needs are not able to be met in an acute setting. • In-patient therapeutic milieu, with capacity for family/carer admissions. All other appropriate and less restrictive interventions considered/tested first. • Proposal for approximately 10 beds – this requires formal planning processes. • Medium term admissions, up to approximately 6 months. • Delivers integrated care with the local CYMHS of the young person. • Individualised, family and group rehabilitation programs delivered through day and evening sessions, available 7

[2] The Department of Health acknowledges the dedicated school and expertise provided by the Department of Education Training and Employment (DETE). The Department of Health values and supports partnership with DETE to ensure that adolescents have access to appropriate educational and vocational options to meet their educational/vocational needs.

[3] Until funding and location is available for Tier 3, all young people requiring extended treatment and rehabilitation will receive services through Tiers 1 and 2a/b (ie., utilising existing CYMHS community mental health, Day Programs and Acute Inpatient Units until the new Day Programs and residential service providers are established).

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	days/week. These must include activity based programs that enhance the self esteem and self efficacy of young people to aid in their rehabilitation. As symptoms reduce, there is a focus on assisting young people to return to a typical developmental trajectory. • Consumers will only access the day and evening sessions (i.e. Day Program components) of the service if they are an admitted consumer. • Programs maintain family engagement with the young person, and wherever possible adolescents will remain closely connected with their families. • Young people will have access to a range of educational or vocational support services delivered by on site school teachers and will be able to continue their current education option[4]. There is an intentional goal that young people are integrated back to mainstream community and educational/vocational activities. • Flexible and targeted programs that can be delivered across a range of contexts including individual, school, community, group and family.
Service specifications and other descriptors to illustrate service elements	
Target Age	• 13 - 17 years, with flexibility in upper age limit depending on presenting issue and developmental (as opposed to chronological) age.
Diagnostic Profile	• 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, day program 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.
Suggested modelling attributes	

[4] The provision of education at this level requires focused consideration; an on site school is one option, however, other options may also need to be considered.

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% Occupancy	• Staffing profile and funding to be based on a 95% occupancy rate.
Average Length of Stay	**Tier 2a: Day Program Services (Mon – Fri business hours)** • 1 to 2 school terms. **Tier 2b: Day Program Service + Residential Provider (24h/7d)** • 1 to 2 school terms in Day Program, but flexibility important. • Up to 6 months in community residential. • Day Program attendance may continue following discharge from community residential. **Tier 3: Statewide In-patient Extended Treatment and Rehabilitation Unit (24h/7d)** • Up to 6 months. • Young people may be discharged from this Unit to a Day Program in their local community.
Staffing Profile	**Tier 2a: Day Program Services (Mon – Fri business hours)** • Multidisciplinary, clinical. • Plus staffing from community sector. • DETE. **Tier 2b: Day Program Service + Residential Provider (24h/7d)** • Multidisciplinary, clinical. • Plus staffing from community sector. • DETE. **Tier 3: Statewide In-patient Extended Treatment and Rehabilitation Unit (24h/7d)** • Multidisciplinary, clinical. • DETE.
Referrals	
Referral Sources and Pathways	**Tier 2a: Day Program Services (Mon – Fri business hours)** • CYMHS **Tier 2b: Day Program Service + Residential Provider (24h/7d)** • CYMHS **Tier 3: Statewide In-patient Extended Treatment and Rehabilitation Unit (24h/7d)**

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	• CYMHS • Statewide Clinical Referral Panel – all referrals to be received and assessed by the Panel, which has statewide representation from multidisciplinary mental health clinicians and community sector.
Complexities of Presentation	• Voluntary and involuntary mental health patients who present with the highest level of risk and complexity.

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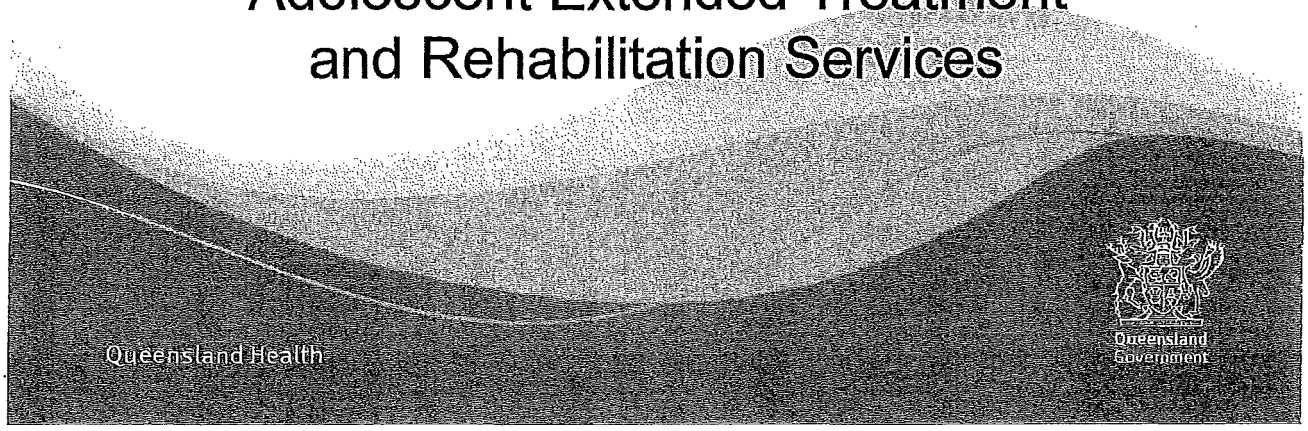
Proposed Service Model

Adolescent Extended Treatment and Rehabilitation Services



Mental health disorders are the most prevalent illnesses in adolescence and have the potential to carry the greatest burden of illness into adult life.

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Background

A range of child and youth mental health services are provided by the Department of Health to deliver mental health assessment and treatment across the spectrum of mental illness and need.

- **Community Child and Youth Mental Health Services**
  - Teams located throughout the state – single practitioner to large multidisciplinary teams.
  - Moderate to severe and complex mental health disorders.
- **Acute adolescent inpatient units**
  - Acute mental health needs; involuntary admissions regulated by the *Mental Health Act (2000).*
  - Royal Brisbane, Logan, Robina, Mater, Toowoomba and Townsville (June 2013).
- **Barrett Adolescent Centre**
  - Located at The Park Centre for Mental Health (TPCMH)
  - Statewide
  - Specialist multidisciplinary assessment and integrated treatment and rehabilitation to adolescents between 13 and 17 years of age with severe, persistent mental illness.

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- In the 2010 – 11 financial year, community CYMHS in Queensland had a face to face service with over 9,000 children and adolescents. In addition, specialised CYMHS – Evolve Therapeutic Services provide therapeutic services to young people in the Care of the Department of Child Safety in most Health and Hospital Services.

- Private child and adolescent psychiatrists see more than 4,000 young people. They are predominantly in south-east Queensland, from the Sunshine Coast to the border and west to Toowoomba.

- An unknown number of young people see private psychologists and social workers under the Better Access scheme. They are more likely to be in all major regional areas.

Policy Context

National Mental Health Policy (2008)

– 'non acute bed-based services should be community based wherever possible'

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Key Principle for Child & Youth Mental Health Services

Young people are treated in the least restrictive environment possible which recognises the need for safety and cultural sensitivity, with the minimum possible disruption to their family, educational, social and community networks.

Policy direction

- National and state mental health reforms supports the decentralisation of services.
- Only forensic and secure services will be offered at TPCMH.
- Barrett Adolescent Centre can no longer operate into the future at this location.
- Alternative models of care need to be considered to align adolescent mental health services with the current policy and direction for mental health.

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Expert Clinical Reference Group

- Consumer and carer representation.
- Child and Youth mental health clinicians across QLD and New South Wales.
- Consideration of contemporary evidence based models of care including additional day programs and alternatives provided by community based mental health services.
- Proposed model of service – way forward for adolescent mental health extended rehabilitation services.

Proposed Service Model Elements

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Service Delivered

- Medium term, recovery oriented treatment and rehabilitation for young people aged 13- 17 years with;
- Severe and persistent mental health problems which significantly interferes with;
- Social, emotional, behavioural and psychological functioning and development.

Service Delivered cont'd

- Offered across a range of environments
- Tailored to individual needs with regard to:
  - Safety
  - Structure
  - Therapy
  - Community participation
  - Autonomy and
  - Family capacity to provide care for the young person

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Service Delivered cont'd

- Functions as part of the broader, integrated continuum of care that includes:
  - Acute and subacute inpatient units
  - Day programs
  - Community mental health services (public, private and other community based providers)

Overarching Principles

The delivery of an AETRS will:

- Provide service in or close to the young persons community.
- Is recovery based; promotes holistic well being.
- Collaborate with the young person and their family or support people.
- Integrate with other services as required.

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Overarching Principles cont'd

The delivery of an AETRS will:

- Offer continuity of care and seamless service delivery.
- Recognise that young people need help with a variety of issues; not just illness.
- Utilise and access community based supports and services.
- Encourage engagement of positive and supportive social, family educational and vocational connections.

Overarching Principles cont'd

The delivery of an AETRS will:

- Provide flexible and targeted programs that can be delivered across a range of contexts and environments.
- Have flexible options from 24 hour inpatient care to partial hospitalisation and day treatment with ambulant approaches.
- Treat consumers and their families/carers in a supportive therapeutic environment.

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Key Distinguishing Features of an AETRS within the Public Sector

Services are accessed via a **tiered**, least-restrictive approach, and may involve **combinations of service types across the tiers.**

Tier 1

Public Community Mental Health Services (Sessional)

- Existing Locations: Access at HHS level.
- Access ambulatory care at a public community based mental health service within a local area.
- Interventions should consider shared-care options with community based service providers including General Practitioners and *headspace.*

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Tier 2a: **Day Program Services**

(Mon – Fri business hours)

Existing locations

- Townsville,
- Mater,
- Toowoomba

Possible new locations

- Gold Coast
- The Prince Charles Hospital (TPCH)
- Sunshine Coast

Tier 2a – Distinguishing features

Funds

- From existing operational funds from Barrett Adolescent Centre and Redlands facility

Locations

- Final locations to be determined through a planning process

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Tier 2a – Distinguishing features

- Individual, family and group therapy.
- Core educational/vocational component for each young person.
- Flexible and targeted programs in combination with integration into school, community and/or vocational programs.
- Integration with local child & youth mental health services (acute inpatient and community support services).

Tier 2a – Distinguishing features

- Therapeutic milieu delivered in a range of settings e.g. family home, school etc.
- Supports and work with family to assist in the young persons recovery.
- Consumers may require admission to the Adolescent Acute Inpatient Unit and attend the Day Program during business hours.
- Proposal of 12-15 places per Day Program (final places and budget to be determined as part of formal planning process).

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Tier 2b: **Day Program + Community Residential Provider (24h/7d)**

Existing Locations:

- Nil service that includes both Day Program and Community Residential Service for this age group.
- NB: Cairns TOHI for 18+

Possible new locations:

- Toowoomba (for residential)
- Sunshine Coast (for Day Program + Residential)
- Townsville (for residential)
- Gold Coast (for Day Program + Residential)

Funds

- From existing operational funds of BAC and Redlands facility.

Tier 2b: Distinguishing Features

- Day Program attendance as in Tier 2a during business hours.
- After-hours and week end care and support provided by a community-based support service provider that provides a **4-bed residential component.**
- Integration with local child & youth mental health services (acute inpatient and public community mental health teams)

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Tier 2b: Distinguishing Features

- Partnership model between Queensland Health (QH) and residential provider.
- Multidisciplinary staffing profile including clinical (Day Program) and community support staff (community-based provider).
- Clinical governance, training and in-reach by QH staff.
- Residential component only provides accommodation, not service provision.
- On-site extended hours visiting service from QH Day Program staff.

Tier 3:**Statewide in-patient Extended Treatment and Rehabilitation Unit (24h/7d)**

Features:

- <u>Location</u>: **SE Qld. Source of capital funding and potential site not available.**
- For young people whose needs could not be met by Tiers 1 and 2 above, due to risk, severity or need for inpatient extended treatment and care.
- These young people's needs are not able to be met in an acute setting.
- In-patient therapeutic milieu, with capacity for family/carer admissions. All other appropriate and less restrictive interventions considered/tested first.
- Proposal for approx. 10 beds – this requires formal planning processes.
- Medium term admissions, up to approximately 6 months.
- Delivers integrated care with the local CYMHS of the young person.
- Individualised, family and group rehabilitation programs delivered through day and evening sessions, available 7 days/week.
- Activity based programs
- Focus on assisting young people to return to a typical developmental trajectory.
- Consumers will only access the day program if admitted
- Programs maintain family engagement with the young person.
- Flexible and targeted programs that can be delivered across a range of contexts.

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Tier 3

Education component

- Young people will have access to a range of educational or vocational support services delivered by on site school teachers and will be able to continue their current education option.
- There is an intentional goal that young people are integrated back to mainstream community and educational/vocational activities
- Queensland Health acknowledges the dedicated school and expertise provided by the Department of Education Training and Employment (DETE). The Department of Health values and supports partnership with DETE to ensure that adolescents have access to appropriate educational and vocational options to meet their educational/vocational needs.
- Until funding and location is available for Tier 3, all young people requiring extended treatment and rehabilitation will receive services through Tiers 1 and 2a/b (i.e. utilising existing CYMHS community mental health, Day Programs and Acute Inpatient Units until the new Day Programs and residential service providers are established).
- The provision of education at this level requires focused consideration; an on site school is one option, however, other options may also need to be considered.

Service specifications

Target Age:

- 13 - 17 years, with flexibility in upper age limit depending on presenting issue and developmental (as opposed to chronological) age.

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Service specifications

Diagnostic Profile

- Severe and persistent mental health problems that significantly interfere with social, emotional, behavioural and psychological functioning and development.

Service specifications

Diagnostic Profile

- Treatment refractory/non responsive to treatment:
  - have not been able to remediate with multidisciplinary community, day program or acute inpatient treatment.

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Service specifications

Diagnostic Profile

- Mental illness is persistent and the consumer is a risk to themselves and/or others.
- Medium to high level of acuity

Suggested modelling attributes

% Occupancy

- Staffing profile and funding based on a 95% occupancy rate.

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Suggested modelling attributes

Average Length of Stay:

Tier 2a: Day Program Services (Mon – Fri business hours)

– 1 to 2 school terms.

Suggested modelling attributes

Average Length of Stay

- **Tier 2b: Day Program Service + Residential Provider (24h/7d)**
  - 1 to 2 school terms in Day Program, but flexibility important.
  - Up to 6 months in community residential.
  - Day Program attendance may continue following discharge from community residential.

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Suggested modelling attributes

Average Length of stay

- **Tier 3: Statewide In-patient Extended Treatment and Rehabilitation Unit (24h/7d)**
  - Up to 6 months.
  - Young people may be discharged from this Unit to a Day Program in their local community.

Suggested modelling attributes

Staffing Profile

- **Tier 2a: Day Program Services (Mon – Fri business hours)**
  - Multidisciplinary, clinical.
  - Staffing from community sector.
  - Department of Education Training and Employment (DETE)
- **Tier 2b: Day Program Service + Residential Provider (24h/7d)**
  - Multidisciplinary, clinical.
  - Staffing from community sector.
  - DETE
- **Tier 3: Statewide In-patient Extended Treatment and Rehabilitation Unit (24h/7d)**
  - Multidisciplinary, clinical.
  - DETE

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Referral Sources and Pathways

- **Tier 2a: Day Program Services (Mon – Fri business hours)**
  - CYMHS
- **Tier 2b: Day Program Service + Residential Provider (24h/7d)**
  - CYMHS
- **Tier 3: Statewide In-patient Extended Treatment and Rehabilitation Unit (24h/7d)**
  - CYMHS
  - Statewide Clinical Referral Panel – all referrals to be received and assessed by the Panel, which has statewide representation from multidisciplinary mental health clinicians and community sector.

Complexities of presentation

- Voluntary and involuntary mental health patients who present with the highest level of risk and complexity.

Defining need - the % of population requiring this service

- XXX

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Key Considerations and Issues

- Contemporary models of care for adolescent extended treatment and rehabilitation services.
- Educational/vocational components.
- Alignment with national and statewide reforms.
- Accessibility issues for young people outside SE QLD
- Decentralisation and transition of consumers closer to their local communities
- National Mental Health Service Planning Framework.
- Consumer and carer perspectives.

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Thank you

Acknowledgements

- ECRG members
- Sponsors
- Adolescent consumers and their families

Questions ?

"JS-11"

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Dillon, Lucy

From: [redacted]
Sent: Monday, 22 April 2013 12:13 PM
To: [redacted]; Kevin Rodgers; Amelia Callaghan; David Hartman; Emma Hart; James Scott; Josie Sorban; Leanne Geppert; Michelle Fryer; Vaoita Turituri; Tilse, Amanda; Philip Hazell; [redacted]
Cc: Emma Foreman; [redacted]
Subject: Re: FINAL Proposed service model elements for Adolescent Extended and Rehabilitation Services
Attachments: RESPONSE TO THE DRAFT MODEL.docx

Dear All,

Thank you all for your participation in this review. I am sure we are all glad to see the end.

However, I do have major concerns about the documents sent through, and the proposed draft. The question continually in my mind is "If we were to close on 30 June, would the proposed model provide an acceptable alternative for the adolescents we have?" The answer is no.

I have outlined my concerns in the attached document. I will briefly highlight/outline the issues here.

1. of the 54 adolescents admitted since 2008, none could have been avoided by a Level 2a or 2b in Toowoomba or the Sunshine Coast, one would have been avoided by a Level 2a facility at the Gold Coast, 6 from a Level 2b admission to [redacted] and 3 from a Level 2b facility on the [redacted]. On the other hand 8 would miss out from the current Level 2a facility at BAC because they live at [redacted] In other words, 80% of adolescents admitted in this period required the CSCF Level 6 inpatient facility. Opening Level 2 a programs in the Gold and Sunshine Coasts is an important step which will meet a currently unmet need in those areas. The evidence is that it will not divert admissions away from the need for an inpatient unit. The document is a good future planning document from the Directorate perspective. It does not provide an alternative model for BAC.
2. It does not incorporate decisions made at ECRG meetings. This has been outlined in the attached document
3. there are many statements which are not evidenced based. This is a clear mandate of the ECRG
4. while acknowledging the long term need for an inpatient unit, it really glosses over interim arrangements for adolescents who either are in inpatient care or will require it in the future.
5. It does not outline risks if certain levels only are adopted, or the risks associated with various interim arrangements.
6. It appears that funding form the current + Redlands service will be re-allocated to future Level 2 a/b services. Although the evidence suggests that a replacement model for BAC requires an inpatient unit (which may be operated by a private provider under Government policy), there are no mechanisms to preserve this funding. Again, this reflects the strengths of this document as a Directorate planning document, rather than as an alternative to BAC document.

Kind regards,

Trevor

Dr Trevor Sadler
Director
Barrett Adolescent Centre
The Park – Centre for Mental Health
Locked Bag 500
Sumner Park BC
Queensland 4074
[redacted]

****

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RESPONSE TO THE DRAFT MODEL – THE LACK OF EVIDENCE BASE

1. Demographics.

The draft model does not refer to demographics. While there are repeated references to being in or close to the local community, it is not spelt out what this means in the Queensland environment.

For instance, the area from Ingham in the north to Ayr in the south and southwest to Charters Towers (the closest towns to Townsville) contains about 6% of the adolescent population between 13 – 17.11 years. The same area from BAC (west to Toowoomba, south to the border and north to the southern end of the Sunshine Coast) contains about 70% of Queensland's population, in that age group.

Assuming the Gold Coast gets an adolescent day patient unit immediately (11%), that Toowoomba gets a residential facility to cater for all of south-west Queensland in Tier 2b (Level 5 Day Program) (7%), that Townsville gets a residential facility to cater for all of Queensland north of Mackay (16%), that Mater/QCH Day program continues to be fully occupied by young people from the same catchment area (9%), the replacement unit will still need to cater for 57% of Queensland. These include areas such as Rockhampton, Gladstone, Bundaberg, Maryborough and Harvey Bay, as well as Moreton Regional Council, Logan, Ipswich and the Lockyer Valley and Redlands. If a Sunshine Coast Tier 2a or be program came on line sometime after 2016, 50% of Queensland still needs to be served by the replacement unit.

The notion of another 12 – 15 place tier 2a unit at Prince Charles that only serves the Brisbane north region (about 8% of the population) cannot be supported. It must have a super-regional capacity.

2. Lack of clarity about Diagnostic Profile

The terms of the diagnostic profile both in the Word and Power Point documents indicate that this refers to the Level 3 (CSCF AETRC Level 6) service. It does not specify the diagnostic profile for those treated in the Tiers 2a and 2b services (CSCF Day Program Level 5 services). The current Models of Service Delivery are clear on these issues. Without reference to this, there is ambiguity about whom may be treated in each level of service.

3. Residential Component

We were very clear about the residential component in the last meeting – it is accommodation provided for those who cannot access the service locally.

It is not an alternative to inpatient admission for Level 6 patients. There is simply no evidence base for this.

The reference to the Hot House in Cairns lacks any evidence base for adolescents who may currently present to BAC which has been presented to the ECRG.

Accommodation is necessary for day programs like Townsville and Toowoomba which may serve regional and extended regional populations. No rationale is given as to why the Gold and Sunshine Coasts should have a residential component.

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1. Those who have been traumatised. *"Develop tailored mental health care responses for highly vulnerable children and young people who have experienced physical, sexual or emotional abuse, or other trauma."*
2. Those at high risk of suicide *"Coordinate state, territory and Commonwealth suicide prevention activities through a nationally agreed suicide prevention framework to improve efforts to identify people at risk of suicide and improve the effectiveness of services and support available to them."*
3. *Service options need to be responsive to the needs of different age groups, including young children and older people, and to the differing needs of those who suffer particular illnesses such as perinatal mental health problems and eating disorders"* (my emphasis)

While the National Mental Health Plan is predominantly an adult focussed document, (and so the concept of non acute bed-based services have in mind adult solutions such as the Community Care Units), it also says *"Mental health should be provided at a standard at least equal to that provided in other areas of health."* One of the distinctions about Child and Youth Mental Health Services is that they have a truly increasing level of service provided for those with the most severe and complex needs, similar to paediatric services. This is why Day Patient programs are Level 5 services, and BAC a Level 6 service. Adult services do not have the same level of intensity and breadth of intervention that CYMHS does. Recognition of the National Mental Health Plan is to acknowledge that we are providing the same tiered level of care available to children and adolescents with medical illness.

The document really does not underscore the severe impairments that adolescents admitted to BAC have, nor the necessity under the National Mental Health Plan to address these. The implications are that at times the attention to addressing recovery may be at odds with providing a community based service. It mandates approaches that promote recovery and social inclusion *"Mental health service providers should work within a framework that supports recovery .... — both as a process and as an outcome to promote hope, wellbeing and autonomy. They should recognise a person's strengths including coping skills and resilience, and capacity for self determination."* and *"Recovery in the context of mental illness is often dependent on good clinical care, but means much more than a lessening or absence of symptoms of illness. Recovery is not synonymous with cure. For many people who experience mental illness, the problems will recur, or will be persistent. Adopting a recovery approach is relevant across diagnoses and levels of severity. It represents a personal journey toward a new and valued sense of identity, role and purpose together with an understanding and accepting of mental illness with its attendant risks. A recovery philosophy emphasises the importance of hope, empowerment, choice, responsibility and citizenship. It includes working to minimise any residual difficulty while maximising individual potential. This is relevant to all ages, including the elderly, and to all those involved – the individual consumer, their family and carers, and service providers."* and *"Adopt a recovery oriented culture within mental health services, underpinned by appropriate values and service models."* and *"Recognition of the importance of social, cultural and economic factors to mental health and wellbeing means that both health and social issues should be included in the development of mental health policy and service development. The principle includes support to live and participate in the community, and effort to remove barriers which lead to social exclusion ....."* and *"People should feel a valued part of their community, and be able to exert choice in where and how they live. Some groups are at risk of entrenched social exclusion, including those with chronic and persistent mental illness. Developing pathways that support community participation and that allow movement towards greater independence minimises the risk of social exclusion. Policy and*

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Current Government policy outlined in the *"Blueprint for better health care for Queensland"* enshrines the principles of Contestability and non-Government provision of infrastructure. These documents do not refer to these principles or the implications it could have for developing an inpatient unit.

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"JS-12"

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

Preamble

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

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

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

Between 1 December 2012 and 24 April 2013 the ECRG met regularly to define the target group and their needs, conduct a service gap analysis, consider community and sector feedback, and review a range of contemporary, evidence-based models of care and service types. This included the potential for an expanded range of day programs across Queensland and community mental health service models delivered by non-government and/or private service providers. The ECRG

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have considered evidence and data from the field, national and international benchmarks, clinical expertise and experience, and consumer and carer feedback to develop a service model elements document for Adolescent Extended Treatment and Rehabilitation Services in Queensland. This elements document *is not a model of service* – it is a conceptual document that delineates the key components of a service continuum type for the identified target group. As a service model elements document, it will not define how the key components will function at a service delivery level, and does not incorporate funding and implementation planning processes.

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

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

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

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

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

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Queensland Government
Barrett Adolescent Strategy
Expert Clinical Reference Group

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

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

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

Recommendations:

a) Further work will be required at a statewide level to translate these concepts into a model of service and to develop implementation and funding plans.

b) Formal planning including consultation with stakeholder groups will be required.

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

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

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Recommendation:

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

[redacted]

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

Recommendations:

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

[redacted]

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

Recommendation:

a) 'Up to 12 months' has been identified by the ECRG as a reasonable duration of treatment, but it was noted that this depends on the availability of effective step-down services and a

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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.

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

- Comprehensive educational support underpins social recovery and decreases the likelihood of the long term burden of illness. A specialised educational model and workforce is best positioned to engage with and teach this target group.
- Rehabilitation requires intervention to return to a normal developmental trajectory, and successful outcomes are measured in psychosocial functioning, not just absence of psychiatric symptoms.
- Education is an essential part of life for young people. It is vital that young people are able to access effective education services that understand and can accommodate their mental health needs throughout the care episode.
- For young people requiring extended mental health treatment, the mainstream education system is frequently not able to meet their needs. Education is often a core part of the intervention required to achieve a positive prognosis.
- Band 7 school – add definition from KR

Recommendations:

a) Access to on-site schooling (including suitably qualified educators), is considered essential for Tiers 2 (day programs) and 3. It is the position of the ECRG that a Band 7 Specific Purpose School (provided by Department of Education, Training and Employment) is required for a Tier 3 service.

b) As an aside, consideration should also be given to the establishment of a multi-site, statewide education service for children/adolescents in acute units (hub and spoke model).

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

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

Recommendations:

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a) It is considered vital that further consultation and planning is conducted on the best service model for adolescent non-government/private residential and therapeutic services in community mental health. A pilot site is essential.

b) Governance should remain with the local CYMHS or treating mental health team.

c) It is essential that residential services are staffed adequately and that they have clear service and consumer outcome targets.

7. Equitable access to AETRS for all adolescents and families in high priority areas (specifically in North Queensland and regional areas)

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

Recommendations:

a) Local service provision to North Queensland should be addressed immediately by ensuring a full range of CYMHS services are available in Townsville, including a residential community-based service.

b) If a decision is made to close BAC, this should not be finalised before the range of service options in Townsville are opened and available to consumers and their families/carers.

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Proposed Service Model Elements Adolescent Extended Treatment and Rehabilitation Services (AETRS)	
Attribute	Details
Service Delivered	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 AETRS continuum is offered across a range of environments tailored to the individual needs of the young person with regard to safety, security, structure, therapy, community participation, autonomy and family capacity to provide care for the young person. The AETRS functions as part of the broader, integrated continuum of care provided for young Queenslanders, that includes acute inpatient, day program and community mental health services (public, private and other community-based providers).
Over-arching Principles	The delivery of an Adolescent Extended Treatment and Rehabilitation Service continuum will: • develop/maintain stable networks • promote wellness and help young people and their families in a youth oriented environment • provide services either in, or as close to, the young person's local community • collaborate with the young person and their family and support people to develop a recovery based treatment plan that promotes holistic wellbeing • collaborate with other external services to offer continuity of care and seamless service delivery, enabling the young person and their family to transition to their community and services with ease • integrate with Child and Youth Mental Health Services (CYMHS), and as required, Adult Mental Health Services • recognise that young people need help with a variety of issues and not just illness • utilise and access community-based supports and services

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	where they exist, rather than re-create all supports and services within the mental health setting • treat consumers and their families/carers in a supportive therapeutic environment provided by a multidisciplinary team of clinicians and community-based staff • provide flexible and targeted programs that can be delivered across a range of contexts and environments • have the capacity to deliver services in a therapeutic milieu with family members; support and work with the family in their own environment; and keep the family engaged with the young person and the mental health problems they face • have capacity to offer intensive family therapy and family support • have flexible options from 24 hour inpatient care to partial hospitalisation and day treatment with ambulant approaches; step up/step down • acknowledge the essential role that educational/vocational activities and networks have on the recovery process of a young person • engage with a range of educational or vocational support services appropriate to the needs of the young person and the requirements of their treatment environment, and encourage engagement/reengagement of positive and supportive social, family, educational and vocational connections.
Key Distinguishing Features of an AETRS	Services are accessed via a tiered, least-restrictive approach, and may involve combinations of service types across the tiers. [redacted] • Existing Locations: All Hospital and Health Services (HHSs). • Access ambulatory care at a public community-based mental health service, within the local area. • Interventions should consider shared-care options with community-based service providers, e.g. General Practitioners and *headspace*. [redacted] • Existing Locations: Townsville (near completion), Mater, Toowoomba, Barrett Adolescent Centre (BAC). • Possible New Locations: Gold Coast, Royal Children's Hospital CYMHS catchment, Sunshine Coast. Funds from existing

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	operational funds of BAC and Redlands Facility. Final locations and budget to be determined through a formal planning process. • Individual, family and group therapy, and rehabilitation programs operating throughout (but not limited to) school terms. • Core educational component for each young person – partnership with Education Queensland and vocational services required. This may be provided at the young person's school/vocational setting, or from the day program site. • Flexible and targeted programs with attendance up to 5 days (during business hours) a week, in combination with integration into school, community and/or vocational programs. • Integrated with local CYMHS (acute inpatient and public community mental health teams). • Programs are delivered in a therapeutic milieu (from a range of settings including day program service location, the family home, school setting etc.). • Programs will support and work with the family, keeping them engaged with the young person's recovery. • Consumers may require admission to Adolescent Acute Inpatient Unit (and attend the Day Program during business hours). • Proposal of 12 - 15 program places per Day Program (final places and budget should be determined as part of formal planning process).
	[redacted] • Existing Locations: Nil services currently. Note: Cairns Time Out House initiative for 18y+. • Possible New Locations: Sites where Day Programs are currently delivered; Townsville identified as a priority in order to meet the needs of North Queensland families. Funding from existing operational funds of BAC and Redlands Facility. Final locations and budget to be determined through a formal planning process.

[1] Note: The Department of Health takes a 'provider agnostic' view in determining non clinical support and accommodation services. Decisions to contract service providers will be determined by service merit, consumer need and formal planning and procurement processes.

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	• Day Program attendance as in Tier 2a during business hours. • This tier incorporates a bed-based residential and respite service for adolescents after-hours and on weekends (in the community). • There is potential for one or more of these services to provide 'family rooms', that will temporarily accommodate family members while their young person attends the Day Program or the Adolescent Acute Inpatient Unit (for example, in Townsville). • Integrated with local CYMHS (acute inpatient, day program and public community mental health teams). • Residential to be a partnership model for service delivery between a community-based service provider and QH – multidisciplinary staffing profile including clinical (Day Program) and community support staff (community-based provider). Partnership to include clinical governance, training and in-reach by CYMHS. • Residential component only provides accommodation; it is not the intervention service provider but will work closely with the intervention service provider to maintain consistency in the therapeutic relationship with the young person. • On-site extended hours visiting service from CYMHS Day Program staff. [redacted] • Possible Location: S.E. Qld. Source of capital funding and potential site not available at current time[3]. Acknowledge accessibility issues for young people outside S.E. Qld. • For young people whose needs could not be met by Tiers 1

[2] The Department of Health acknowledges the dedicated school and expertise provided by the Department of Education Training and Employment (DETE). The Department of Health values and supports partnership with DETE to ensure that adolescents have access to appropriate educational and vocational options to meet their educational/vocational needs.

[3] Until funding and location is available for Tier 3, all young people requiring extended treatment and rehabilitation will receive services through Tiers 1 and 2a/b (i.e., utilising existing CYMHS community mental health, Day Programs and Acute Inpatient Units until the new Day Programs and residential service providers are established). It is emphasised that this is not proposed to be a clinically preferred or optimal solution, and significant risks are associated with this interim measure.

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	and 2 above, due to risk, severity or need for inpatient extended treatment and care. These young people's needs are not able to be met in an acute setting. • In-patient therapeutic milieu, with capacity for family/carer admissions (i.e. family rooms). • All other appropriate and less restrictive interventions considered/tested first. • Proposal for approximately 15 beds – this requires formal planning processes. • Medium term admissions (approximately up to 12 months; however, length of stay will be guided by individual consumer need and will therefore vary). • Delivers integrated care with the local CYMHS of the young person. • Individualised, family and group rehabilitation programs delivered through day and evening sessions, available 7 days/week. These must include activity based programs that enhance the self esteem and self efficacy of young people to aid in their rehabilitation. As symptoms reduce, there is a focus on assisting young people to return to a typical developmental trajectory. • Consumers will only access the day sessions (i.e. Day Program components) of the service if they are an admitted consumer. • Programs maintain family engagement with the young person, and wherever possible adolescents will remain closely connected with their families and their own community. • Young people will have access to a range of educational or vocational support services delivered by on-site school teachers and will be able to continue their current education option[4]. There is an intentional goal that young people are integrated back to mainstream community and educational/vocational activities. • Flexible and targeted programs will be delivered across a range of contexts including individual, school, community, group and family.
Service specifications and other descriptors to illustrate service elements	
Target Age	• 13 - 17 years, with flexibility in upper age limit depending on

[4] The provision of education at this level requires focused consideration; an on-site school and education program is proposed as a priority.

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	presenting issue and developmental (as opposed to chronological) age.
Diagnostic Profile	• 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, day program 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.
Suggested modelling variables	
Average duration of treatment	**Tier 2a:** **Level 5 Day Program Services (Mon – Fri business hours)** • Up to 12 months; flexibility will be essential. • There will be wide variation in individual consumer need and their treatment program; length of stay will need to be responsive to this. **Tier 2b:** **Community Residential (24h/7d)** • Up to 12 months; flexibility will be essential. • There will be wide variation in individual consumer need and their treatment program; length of stay will need to be responsive to this. • Access to a community residential service requires the young person to be actively participating in a program with CYMHS. **Tier 3:** **Level 6 Statewide Inpatient Extended Treatment and Rehabilitation Service (24h/7d)** • Up to 12 months; flexibility will be essential. • There will be wide variation in individual consumer need and their treatment program; length of stay will need to be responsive to this. • Young people may be discharged from this Service to a Day Program in their local community.

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Staffing Profile	**Tier 2a:** **Level 5 Day Program Services (Mon – Fri business hours)** • Multidisciplinary, clinical. • Plus staffing from community sector. • DETE. **Tier 2b:** **Community Residential Service (24h/7d)** • Multidisciplinary, clinical. • Plus staffing from community sector. **Tier 3:** **Level 6 Statewide In-patient Extended Treatment and Rehabilitation Service (24h/7d)** • Multidisciplinary, clinical. • DETE.
Additional notes	
Referral Sources and Pathways	While service provision across all Tiers of this AETRS continuum is based on interdisciplinary collaboration and cross-agency contribution, a referral to Tiers 2a, 2b and/or 3 will require a CYMHS assessment (i.e., single point of entry). Increased accessibility to AETRS for consumers and their families across the State is a key priority. The Tier 3 statewide service will establish a Statewide Clinical Referral Panel. All referrals will be received and assessed by the Panel, which has statewide representation from multidisciplinary mental health clinicians and the community sector.
Complexities of Presentation	• Voluntary and involuntary mental health consumers. • The highest level of risk and complexity.

This document was endorsed by the Expert Clinical Reference Group of the Barrett Adolescent Strategy on 8 May 2013.
Please read in conjunction with the v5 Preamble.

Dr Leanne Geppert

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Chair, Expert Clinical Reference Group

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From:	Susan Daniel
Sent:	12 Aug 2013 09:31:20 +1000
To:	Scott, James
Cc:	Sadler, Trevor;Clayworth, Vanessa
Subject:	RE: Future of Barrett Adolescent Centre

Thanks for your support James. Now that our registrar has had one week to settle in, I hope to sort out the next batch of interviews dates this week. I'll let you know when dates are booked.

Thanks,
Sue

>>> "James Scott" 10/08/2013 6:16 pm >>>

Thanks Sue, Trevor and Vanessa

I am very sorry that the extended mental health services are having to be relocated. Trevor has witnessed my views on this and I think we got the best outcome that was available under the circumstances.

Kind regards

James

From: Susan Daniel
Sent: Friday, 9 August 2013 4:21 PM
To: James Scott
Cc: Trevor Sadler; Vanessa Clayworth
Subject: Future of Barrett Adolescent Centre

Hello James,

I am writing to you as either the referrer or the current mental health service looking after an adolescent on our referral or admission wait list As you may be aware the Barrett Adolescent Centre has been under a cloud of uncertainty regarding our future. An intensive review process was conducted from December 2012 to May 2013. Fortunately a decision has been made to continue to provide an extended care mental health service to adolescents. However we will not continue to operate at our present site. A new site is yet to be determined but it is proposed that it will continue to be located in the South-East Queensland area. It is hoped to start the transition to the new service at the beginning of next year and we will then fall under the governance of Children's Health Queensland.

At this stage, there are some unknown factors on how the new site or transition might affect us (e.g. bed numbers, initial staffing levels, and building structure/layout). The transition may be disruptive to some degree. However I wanted to reassure you that no restrictions have been issued on current

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adolescents [redacted]

A mail out has been sent to [redacted] of which I have attached for your information - it includes a letter from myself, message from the District Executive Director for Mental Health and Specialised Services for our District (West Moreton), fact sheet, media statement and the recommendations from the review process.

If there are other stakeholders who you feel would benefit from this information, please feel free to forward this on.

Thank you so much for ongoing support and patience during this process. If you have any questions, please do not hesitate to contact myself, Dr Trevor Sadler or the Nurse Unit Manager. Thanks.

Kind regards,
Sue

Susan Daniel
Community Liaison, Clinical Nurse
Barrett Adolescent Centre | The Park - Centre for Mental Health | Orford Drive | Wacol Q 4076
Alternative Postal Address: Locked Bag 500, Sumner Park BC Q 4074
[redacted]