



## Statewide Mental Health Network Child and Youth Subgroup




### MINUTES


<b>Chair:</b>	Ms Denisse Best	<b>Date:</b>	21 April 2008
<b>Secretariat:</b>	Jackie Bartlett/ Guest minute takers: Vaoita Turituri/ Anna Johnston	<b>Time:</b>	9.00am - 3.30 pm
<b>Venue:</b>	Royal Children's Hospital Auditorium		
<b>Apologies:</b>	<p>Dr Aaron Groves, Director of Mental Health – Mental Health Branch          Judi Krause, Team Leader, –North West CYMHS          Dr Ian Munt, C&amp;A Psychiatrist – Townsville CYMHS          Mark Amos, CYMHS Co-ordinator –Bowen          ██████████ Consumer Representative          Prof Graham Martin, Clinical Director, CYMHS – RCH&amp;HSD          Hazel Goodenough, Team Leader, Redcliffe, Caboolture CYMHS          Dr Michael Daubney, Clinical Director, Logan , CYMHS (Chair QCH consultation group)          Tania Withington, Team Leader – Evolve Therapeutic Services, Brisbane North          Erica Lee, Manager CYMHS, Mater</p>		
<b>Absent</b>	<p>Abigail King, A/Service Coordinator, Mater CYMHS, St Brisbane          Helen Troy, A/G Project Manager, Mental Health Branch          Marion Gibbons, Seclusion and Restraint Advisory Group          Wendy Hoey, Seclusion and Restraint Advisory Group          Garth Richards, Seclusion and Restraint Advisory Group</p>		
<b>Present:</b>	<p>Denisse Best, Executive Director, CYMHS, RCH.          Jackie Bartlett, A/Principal Project Officer MHB Child Safety, Mental Health Branch          David Hartman, Clinical Director, CYMHS, Townsville          Judith Piccone, Statewide Principal Project Officer, CYMHS          Gerry Howe, CYMHS Team Leader – Fraser Coast          Ingrid Wagner, Principal Social Worker CYMHS RCH &amp; HSD</p>		
<b>Present:</b>	<p>Amanda Gilmour, Program Coordinator, CYMHS, Townsville          Christina Gobbo, CYMHS Team Leader – Bundaberg</p>		



	<p>Dr Nigel Collings, Director of C&amp;A Psychiatry – Gold Coast Mental Health Service  Dr Elisabeth Hoehn – Program Director, Child Psychiatrist, Future Families/Acting Statewide Director for Perinatal and Infant Mental Health  Josie Sorban, A/Principal Psychologist CYMHS, RCH&amp;HSD  Gail Harvey, NUM/Coordinator, Toowoomba and Darling Downs HSD, CYMHS  Dr Geoff Beames Director Adolescent Inpatient Unit RBWH  Dr Brett McDermott Director Mater CYMHS  Elizabeth Truong, PPO, Mental Health Branch  Janet Martin, A/Manager, Strategic Policy Unit, Mental Health Branch  Judy Skalicky, Team Leader, Rural and Remote Area MHS  [REDACTED] Consumer Representative  Linda Ryan, PPO Mental Health, SAHS  Ngari Bean- Program Coordinator CYMHS, Rockhampton  Nicole Mikulich, A/Team Leader, C&amp;Y Forensic Outreach Service  Raymond Ho, Team Leader, Southside CYMHS (Logan-Beaudesert Campus)  Shaune Gifford, PO Child &amp; Youth Seclusion &amp; Restraint Project  Sophie Morson, Coordinator Minding Young Minds Early Intervention Program – RCH&amp;HSD  Tanya Wright, Child Psychiatrist, Toowoomba CYMHS  Tony Biggin, T/L CYMHS Toowoomba.  Dr Trevor Sadler, Director, Barrett Adolescent Centre – West Moreton South Burnett District  Valda Dorries, A/ Statewide Allied Health Professional Leader (CYMHS)  Vaoita Turituri, A/PPolicy Officer, Statewide MHN  James Scott C&amp;A Adolescent Psychiatrist E-CYMHS &amp; Evolve TS Nth Brisbane  Anna Johnston, A/Senior Policy Officer Clinical Services, Mental Health Branch  Leanne Geppert Project Officer, Clinical Services Capability Framework (Statewide Mental Health Project)  Regina Mullins, APPO Mental Health  Kevin Fjeldsoe, Director, Mental Health Plan Implementation Team  Abigail King, Acting Service Coordinator Mater CYMHS  Paul Clare Principal Project Officer MHPIT</p>
<p><b>Guests:</b>  (C&amp;Y  Seclusion&amp;Restraint  Working Subgroup  Members)</p>	<p>Kristy Young Guest Presenter NUM Adolescent Inpatient Unit. Austin, Vic.  Xerxes Ustick, Mater CYMHS  Michelle George, NUM, CYMHS Inpatient Unit Mater Hospital  Chrissy Hubbard, RBWH – Adolescent Unit  Varian Aston, RBWH – Adolescent Unit  Janelle Bowra, NUM Adolescent Unit, Logan  Christie Burke, Adolescent Unit, Logan  Anthony Carr, Adolescent Unit, RBWH  Sharon Dillon, C&amp;YMH Unit, Robina  Diane Gibson, C&amp;YMH Unit, Robina  Dan Sullivan, Mental Health, Gold Coast  Philippa Critchley, Child and Youth MH Inpatient Unit, Robina  Dan O'Brien, Mater Day Program</p>

Amanda Tilse, Mater CYMHS  
 Jolene Cox, RCH - CFTU  
 Kellie Prefol, Senior Project Officer Clinical Support SAHS

## MINUTES







Time	Topic	Discussion	Action
0915-1015	<p><b>“Alternatives to Seclusion/Restraint in Child &amp; Adolescent Mental Health Units”</b></p> <p>Presenter: Ms Kristy Young, NUM, Adolescent Mental Health Unit, Austin Hospital, Melbourne</p> <p>Minutes: Jackie Bartlett</p>	See Attached Presentation.	 sedusion and restraint reduction
1030-1100	<p><b>Clinical Services Capability Module for Mental Health in Queensland</b></p> <p>Presenter: Leanne Geppert</p> <p>Minutes: Vaoita Turituri</p>	<p>See Attached Presentation.</p> <ul style="list-style-type: none"> <li>▪ Presented at the Area Health Services and Statewide Mental Health Network</li> <li>▪ Implementation and auditing against this framework will occur in 2009</li> <li>▪ Six level of criteria; the definitions of which are not driven by MH but defined by QH CSCF steering committee</li> <li>▪ Western Australia document is one of the primary reference for this particular document. It is also useful as it covers across the age spectrum i.e. from birth to old age.</li> </ul> <p>Questions:</p> <ul style="list-style-type: none"> <li>▪ ‘Voice’ within QH organisation</li> <li>▪ Map service continuum across state</li> <li>▪ Time line for C&amp;Y? – C&amp;Y subgroup to look at this</li> <li>▪ Component related to Indigenous MH</li> <li>▪ Issues re: age range in IMH and how it impacts</li> <li>▪ Not a part of the definition of levels but MH need to consider this</li> <li>▪ Steering &amp; advisory groups should drive this</li> <li>▪ Currently there is nothing specific for IMH</li> <li>▪ This is the minimal document in terms of setting basic framework.</li> <li>▪ Representative of community based healthcare hence emphasise the IMH issue even more. Leanne will raise this at the advisory group</li> </ul>	 F:\CSCF Overview\_Leanne Geppert.pp
1100-1130	<p><b>Model of Service for Mental Health in Queensland</b></p> <p>Presenter: Regina Mullins</p> <p>Minutes: Vaoita Turituri</p>	<p>See Attached Presentation.</p> <ul style="list-style-type: none"> <li>• Whether clinical governance frameworks should sit within this document</li> <li>• Linked to Safety Plan</li> <li>• Prescriptive in nature</li> <li>• Linking with outcome measurements (indicators)</li> <li>• What about consumer outcome measures</li> <li>• How does it influence practice?</li> </ul>	 F:\Models of Service\_Regina Mullins.ppt

<p>1030-1230</p>	<p><b>Workshop: Alternatives to Seclusion/Restraint in Child &amp; Adolescent Mental Health Units</b></p> <p>Presenter: Kristy Young (SMHN C&amp;Y Seclusion/Restraint working sub-group members)</p> <p>Minutes: Jackie Bartlett and Anna Johnston</p>	<p>See Attached Presentation and website address.</p> <p><b>Discussion</b></p> <p><b>Therapeutic Touch</b></p> <ul style="list-style-type: none"> <li>• Has been used well in many areas –though it is clearly stated in Qld Health Code of Conduct that touch is not allowed and wouldn't be supported by the organisation.</li> <li>• Must be used with caution and users of this model need to look at whether policy and procedure supports this – we need a strong evidence base to prove that therapeutic touch is useful.</li> <li>• Therapeutic touch needs to be endorsed at a state level before it can be considered into practice.</li> </ul> <p><b>Non Smoking Policy</b></p> <p>There are concerns over the trigger of kids not being able to smoke – does the group have and ideas about how to deal with this?</p> <ul style="list-style-type: none"> <li>• The Mater has managed this by needing to obtain parental consent re: kids smoking and then if they have that they have to go to designated smoking area like all other patients in the hospital. There is rarely an issue at the Mater – as most parents don't give consent for their kids to smoke.</li> <li>• This is managed at Austin unit by cigarettes being sent home with families – this leads to no blame being passed onto nursing staff. It is clear that the unit is a no smoking unit and there has been a push to have more things to do to combat smoking i.e.: having lollies around unit and a treadmill. Staff also provide positive encouragement re: not smoking.</li> </ul> <p><b>Locked Units</b></p> <p>Why was the Austin unit open and then locked?</p> <ul style="list-style-type: none"> <li>• The unit was locked due to occupational health and safety concerns. OHS said the unit needed to be locked for better staff safety due to it being an old building and there are lots of places for intruders to hide and people to be out of line of sight because of the design of the building.</li> </ul> <p>Are the units in the U.S locked?</p> <ul style="list-style-type: none"> <li>• some of them are – but there is no change in treatment regardless of whether they are locked or not.</li> </ul> <p>At the Austin unit are the children allowed to leave despite the unit being locked and are they under the MHA?</p> <ul style="list-style-type: none"> <li>• Some of the kids are under the MHA but some aren't. For those who want to leave there is family involvement and discussion – and it is a case by case scenario.</li> </ul> <p><b>Seclusion</b></p> <p>Kristy can you comment on seclusion?</p> <ul style="list-style-type: none"> <li>• The Austin doesn't have a seclusion room, however one is being built due to OHS.</li> </ul> <p><b>U.S.A Model :</b></p> <p>Can you elaborate on staffing levels of units in the USA?</p> <ul style="list-style-type: none"> <li>• There are 5 staff on morning shift, 5 staff on afternoon shift and three on night shift – this is for 10-12 patients – there is often additional allied health staff in some units.</li> <li>• Mostly crisis admissions.</li> <li>• More likely to use chemical restraint. Though there is a big focus on ensuring the kids are on correct Rx. They definitely medicate more that we do here – they also give adult Dx to children and then prescribe accordingly i.e.: a 10yr old with BPAD would be prescribed lithium.</li> </ul> <p><b>Organisational Model</b></p> <p>This model is obviously more resource intensive – currently we are saying "how does the kid fit in with the organisation" but with this model is</p>	 <p>restraint and seclusion[1].ppt</p>
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		<p>how does the organisation fit in with the kid.</p> <ul style="list-style-type: none"> <li>In Massachusetts each unit was able to establish their own model and this was part of the reason it worked so well.</li> </ul> <p><b>Staff turnover</b> How has staff turnover been in Victoria? How has the unit managed with this turn over?</p> <ul style="list-style-type: none"> <li>there has been about a 50% turnover of staff – some have embraced the changes some have had difficulty taking on the change – but generally there has been support of the model and that it was time for a change. Overall there hasn't been a huge turnover of staff at the child unit – but there has been at the adolescent unit due to the change.</li> </ul> <p>Is there data on the levels of stress and/or sick leave in the unit?</p> <ul style="list-style-type: none"> <li>Yes overall there has been less – once the staff stabilised the sick leave was less and the moral of the staff was good.</li> </ul> <p><b>Safety</b> Previously safety was of the number one concern – but now it is nurturing?</p> <ul style="list-style-type: none"> <li>safety comes after all the other things are given. Safety comes when the adults stop being the enforcers – and be clear it isn't reducing the level of or priority of safety. The incidents of violence have significantly decreased on our unit.</li> </ul> <p><b>Families/Carers</b> Has there been any feedback from families?</p> <ul style="list-style-type: none"> <li>We have found a higher level of satisfaction from families (measured in post D/C survey).</li> </ul> <p>Families want – Communication, Care and Respect- the model seems like common sense – and it is what carers, families and kids are looking for.</p> <p><b>Executive support</b> How would you envisage getting the executive on board with this model because without support it wouldn't happen?</p> <ul style="list-style-type: none"> <li>A good relationship with management is important – they need to trust that this is in the best interest of the service and you need to mount a good case with firm evidence.</li> </ul>	
1130-1200	<p><b>State-wide Child and Youth Planning: Funding and Staffing Priorities</b></p> <p>Presenter: Judith Piccone Minutes: Vaoita Turituri</p>	<p>See Attached Presentation.</p> <ul style="list-style-type: none"> <li>Funding &amp; Staffing priorities</li> <li>14/100,000 = 572 FTE for population statewide</li> <li>100 FTEs in first four years; includes doctors, registrar etc but not service managers and admin staff. They are included separately under Quality &amp; Safety</li> <li>?A&amp;TSI considerations.</li> </ul>	 <p>C&amp;Y Mental Health Statewide Enhancement</p>
1200-1230	<p><b>Evolve Therapeutic Services Steering Committee</b></p> <p>Presenter: Janet Martin Minutes: Vaoita Turituri</p>	<p>See Attached proposed Evolve governance structure.</p> <p>Add Chair of Child Safety Subgroup of the SWMHN CYMHS Subgroup (Dr James Scott) to the membership.</p> <p>Query re consumer representation. For further consideration regarding whether to invite a representative from the Create Foundation or aim for an Evolve Therapeutic Services consumer or ex-consumer. Initial meeting of the Evolve Therapeutic Services subgroup to address this issue.</p> <p>Query re other stakeholder representation, e.g. Department of Child Safety, Foster Care Queensland. For further consideration at the initial meeting of the Evolve Therapeutic Services subgroup. Note that this subgroup will also relate to the Evolve Interagency Services Statewide Steering Committee which has representation from the Department of Child Safety, the Department of Education, Training and the Arts, and Disability Services Queensland.</p>	 <p>Evolve Governance structure</p>
1300-1345	<p><b>Headspace Update – Southern Downs: Warwick, Gold Coast, Townsville, Fraser Coast and</b></p>	<p><b>Townsville headspace - David Hartman –</b></p> <p>Townsville headspace is in early stages of development – a steering committee has been established and a service co-ordinator has been appointed.</p>	

<p><b>Hervey Bay</b></p> <p>Presenters: Tracey Morgan, Nigel Collings, David Hartman, Gerry Howe.</p> <p>Minutes: Anna Johnston</p>	<p>Looking at employing clinical staff and is currently speaking with local GPs to engage them to provide services.</p> <p>Official opening will be June 2008 with clients being seen soon after that.</p> <p><b>Issues –</b></p> <ul style="list-style-type: none"> <li>• There is concern that funding is due to run out – is the program sustainable if funding doesn't continue.</li> <li>• Currently trying to engage other clinicians to provide services.</li> </ul> <p><b>Discussion –</b></p> <p><b>D.B</b> – when the tender documents went out they said that no direct clinicians were going to be employed with the headspace money –all clinical hours would come from better outcomes program.</p> <p><b>D.H</b> – yes that is what the documents indicate – though two positions are from headspace money and the others are from Medicare money.</p> <p><b>D.B</b> – are there referral pathways in and out of child and youth services?</p> <p><b>D.H</b> – Currently looking at referral pathways both for child and youth and for adult services. We have also established a clinical network. Townsville headspace is aiming at the mild to moderate end of the spectrum and plans to refer on in relation to serious mental illness (the moderate to severe end of the spectrum).</p> <p><b><u>Gold Coast headspace – Nigel Collings</u></b></p> <p>Gold Coast headspace has established a consortium including – Qld Health, Education Qld, Division of General Practice, Australian Psychological Society, Griffith University, Gold Coast Drug Council and the Wesley Mission.</p> <p>The CEO is Mary Alcorn from Gold Coast Drug Council. Kevin McNamara will chair the clinical committee.</p> <p>One of the main aims of headspace Gold Coast is to provide drug and alcohol services for the under 18yrs age group as this is an age bracket where D&amp;A have been lacking.</p> <p>Staffing: (headspace covers half)</p> <ul style="list-style-type: none"> <li>• Operational Manager</li> <li>• Community Development Officer</li> <li>• Clinical Services Manager</li> </ul> <p>CHIC have a program called heads up so they will be funding the other half of these positions.</p> <p>The Division of General Practice will be providing:</p> <ul style="list-style-type: none"> <li>• Medical receptionist</li> <li>• Youth worker</li> </ul> <p>Two FTE positions with the Gold Coast Drug Council sit in the same building as headspace</p> <p>Grants from the Division of General Practice continue to fund the program.</p> <p>Currently negotiations are underway to see if Option A can be done through headspace. There are also currently negotiations to retain a half time Occupational Therapist and Social Worker using 'left over' Division of General Practice funding and then the plan is to offer them the option of using the facilities to run private practice for the other half of the time.</p> <p>Gold Coast headspace has also recently had a breakfast at the Radisson to increase its public profile and to try and attract private sector investment and funding.</p> <p><b>Questions</b></p> <p><b>James (Mater)</b> – there are a range of providers coming in offering services – is there going to be clinical collaboration?</p> <p><b>Nigel</b> – we are trying to establish a MoU to encourage clinical conferencing and there is the position of community manager who ideally should facilitate internal/external integration.</p> <p><b>Kerry (Mater)</b> – In the package, will there be support for families and parents?</p>	
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		<p><b>Nigel</b> – this area hasn't been forgotten by Gold Coast or Melbourne headspace – it is an area which we are conscious of.</p> <p><b><u>Fraser Coast headspace</u></b></p> <p>The Division of General Practice put in an application for headspace funding and was successful in obtaining funding. There will be youth workers who will be working on the ground – these positions have been funded by headspace money – with an additional social worker, psychologist and occupational therapist being funded through medicare. Services will be set up in Bundaberg and Hervey Bay with outreach to Eidsvold. The connection with Child and Youth Mental Health is not firmly established but this should be set up by end of 2008.</p> <p><b><u>Warwick –headspace – Tracey Morgan</u></b></p> <p>Warwick has a very similar set up to Townsville. A clinical services manager, education officer and program officer have been appointed. A mental health nurse is still to be appointed. The service will cover Warwick, Goondiwindi and Stanthorpe and it will be seen as a “one stop shop” for young people in relation to mental health and drug and alcohol issues. There will be capacity to provide support to families and parents. Clinical governance to be set up with a large cross over between all services involved. Practice manuals will be established that look at a Youth Mental Health Wellness approach rather than Mental Illness approach. There is also hope for joint case conferencing between all services in the district. The future of headspace in Warwick is that headspace and mental health will meet and liaise about division of services (i.e. who does what). The plan is to launch headspace in June 2008.</p> <p><b><u>Discussion</u></b></p> <p><b>Judith Piccone</b> - The reason for headspace services in Qld meeting here is to hopefully establish a Qld interaction – or to see whether people just want to liaise with headspace Melbourne rather than each other. Is there a way to interact? How can we establish connections between the services. What are the opportunities for Child and Youth Mental Health Services. Warwick – it is important to liaise with local CYMHS to ensure appropriate referrals. Gold Coast – has brought together NGOs to work together – talking to each headspace service around the state would be beneficial. Fraser – opportunities for agencies for agencies to work together at specific programs. There have been concerns about sustainability of the program (only 18mth of funding) and also issues around clinical supervision.</p> <p><b><u>Issues</u></b></p> <ul style="list-style-type: none"> <li>• Sustainability – only 18mths of funding</li> <li>• Boundaries/referral</li> <li>• Youth workers as front line staff – preferably professional clinical staff</li> <li>• Clinical Supervision</li> <li>• No risk Ax in Ax package</li> <li>• Tight collaborative frameworks with mental health services need to be established.</li> <li>• Concerns that if headspace just looks at mental health problems kids will fall through the gaps – needs to widen scope.</li> </ul>	
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1345-1415	<b>International Initiative for Mental Health Leadership</b> Presenter: Helen Troy	Presenter Unable to attend. DB/JB To follow up re: presenting at C&Y Subgroup meeting.	
1415-1500	<b>Child Safety Working Group Update</b> Presenter: James Scott, Judith Piccone (RCH Auditorium) Minutes: Anna Johnston	See Attached Presentation. <u>Discussion</u> Already many informal relationships between child safety and mental health – Problem with a MoU is that it may have too many details and become too prescriptive. <ul style="list-style-type: none"> <li>• <b>Judith</b> – MoU would be signed at DMH, DG level. MoU would then have local partnership agreements so when informal networks do work well they can continue. They will also provide resources to help areas where there are no networks, to aid in establishing better lines of communication.</li> </ul> liaison with local child safety offices is important along with regular meetings with them – it is difficult to establish strong relationships because of high turn over of staff.  It is important to also liaise with the NGOs who are providing child and youth services. There needs to be an established pathway to navigate – a frame work for dealing with NGOs needs to be established.  There are some issues re: Lack of resources – especially in Child safety, positions are often not filled, inexperienced staff with little or no supervision, little support and different case management model. Is it possible to provide some clinical support or supervision/training to Child Safety as Child and Youth Mental Health are better funded? <ul style="list-style-type: none"> <li>• <b>Judith</b> – the Mou will provide Child Safety with the permission to collaborate and work in partnership with CYMHS.</li> </ul>	 ChildSafety Judith Piccone _ James Scot
1300-1330	<b>Practice Supervision Deliverables</b> Presenter: Valda Dorries Minutes: Jackie Bartlett	See Attached Presentation. For Rural and remote teams – costs for accessing Supervisors must be submitted by June 08. Credentialing of supervisors wether by district or state being considered within project and will be addressed within policy. Supervision policy framework in draft 1 only considered Allied Health the fact that Nurses are now included represents a changing organisational culture.	 Practice Supervision Deliverables   Supervision Audit Database - Adult MH
1330-1500	<b>Child and Youth Capital works: BAC Redevelopment, Toowoomba Day Program/Inpatient Unit, Townsville Day Program/Inpatient Unit, Sunshine Coast</b>   Session Agenda	Kevin Fjeldsoe – Implementation of Mental Health Plan over next 3-4 years – only those funded within plan. State Plan – evolved from C&Y and Capital Works Aim – to improve capacity C&Y Services <ul style="list-style-type: none"> <li>• Inpatient Units (TVlll &amp; SC)</li> <li>• Another inpatient in Toowoomba –</li> </ul> Previous debate was held over centralised over decentralised – agreed to decentralise. Issues: <ul style="list-style-type: none"> <li>• Now 12 months in – no project set off so losing funding 3-10% each year and less time to complete. Need to complete these projects in a timely manner.</li> </ul>	 Day Inpatient units David Hartman   The predicament in Toowoomba



	<p>Presenters: Kevin Fjeldsoe, Paul Clare, Amanda Tilse, Lynne Taylor, Trevor Salder, David Hartman, Amanda Gilmour, Tanya Wright, Tony Biggin, SC Rep.</p> <p>Session Chair: Denisse Best</p> <p>Minutes: Jackie Bartlett and Vaoita Turituri</p>	<ul style="list-style-type: none"> <li>• DB: Re the continued delays: 121 million was allocated for 17 projects was immense pressure to include other projects in scope – if keep delaying other areas will push harder to get their project in.</li> <li>• Longer delays will effectively increase costs over time. If have to go back for more money will incur further delay and also run risk of Treasury either saying no or accepting other project. Recurrent \$ is a problem -treasury may not be prepared to offer further funding unless building is started and commissioned.</li> </ul> <p><b>Day program @ Mater – Amanda Tilse</b></p> <ul style="list-style-type: none"> <li>▪ No MH beds, Children’s Paediatric ward with up to 9 mental health clients looked after by clinical staff so group program started i.e. partial hospitalisation programme. Early discharge for psychotic children</li> <li>▪ 2002 – 12 bed unit with day program progressed to intensive service</li> <li>▪ Program for people with long term psychiatric treatment resistant family &amp; group intervention program at the QLD Children’s Hospital.</li> <li>▪ Inpatient unit <ul style="list-style-type: none"> <li>○ Welcoming environment</li> <li>○ Secure but not custodial</li> <li>○ Adequate space - single rooms</li> <li>○ Storage space</li> <li>○ Male &amp; female capacity</li> <li>○ Family suite</li> <li>○ AV rooms</li> <li>○ Rec</li> <li>○ Car parking</li> </ul> </li> <li>▪ Day programme <ul style="list-style-type: none"> <li>○ Space required for individual, group &amp; family therapy</li> <li>○ Cater for 5-18 age group</li> <li>○ Group therapy is basic foundation of intervention</li> <li>○ Most clients are on verge of school exclusion therefore priority to inclusion</li> <li>○ Campus model – access to other resources on site</li> <li>○ Separate identify – community feel</li> <li>○ Outreach model – parking close to unit for parents picking up children &amp; dropping off</li> <li>○ Need to be close to public transport</li> <li>○ Lots of different therapies – parent group</li> <li>○ Day programme/inpatient unit connection <ul style="list-style-type: none"> <li>▪ Day programme &amp; partial hospitalisation</li> <li>▪ Step down model</li> <li>▪ Referrals are from community clinics</li> </ul> </li> </ul> </li> </ul> <p><b>David Hartman, Amanda Gilmour Townsville (presentation)</b></p> <p>C&amp; Y model presented by David Hartman</p> <ul style="list-style-type: none"> <li>▪ Day hospital to build capacity; inpatient once critical mass is reached</li> <li>▪ this has been included and funded in plan</li> <li>▪ Process of achieving day/inpatient unit</li> <li>▪ 2003 submission in Townsville</li> <li>▪ Issues <ul style="list-style-type: none"> <li>○ Sustainability</li> <li>○ Want to model it against Mater model</li> <li>○ Inpatient beds seen as ‘add on’ to day program</li> <li>○ Competing agendas</li> <li>○ Health politics</li> <li>○ Townsville, Cairns &amp; Mackay – dispersed population, no critical mass in either</li> <li>○ Communication between MHB and NAHS, don’t know who answerable to</li> <li>○ Ideological positions</li> </ul> </li> </ul>	
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1500-1530	Summary & Close Denisse Best	<p>Denisse Best thanked presenters and all attendees.</p> <p>Lots of interesting discussions and valuable input by all.</p> <p>Presentation by Kristy Young particularly thought provoking – great to hear about other models being implemented interstate.</p> <p>Update on International Initiative for Mental Health Leadership to be followed up via usual C&amp;Y Subgroup meeting –? A short presentation.</p> <p><b>Next C&amp;Y Subgroup meeting: 22.5.08 10am -12pm.</b></p>	