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Mental Health Act 2016 Investigation Report

Investigation into the Child and Youth Mental Health Service, Gold Coast Authorised Mental Health Service

March 2026

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Queensland Government

Investigation into the Child and Youth Mental Health Service, Gold Coast Authorised Mental Health Service

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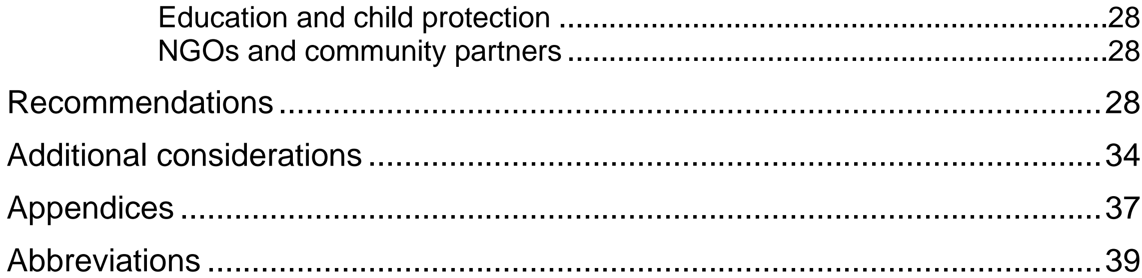

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Acknowledgement

We would like to acknowledge the bravery and courage of those who engaged in the process with honesty, humility and rigour.

We recognise that the review is occurring in the context of recent adverse events and media reports, with ongoing impacts on families, as well as staff and the broader community, particularly those who have experienced the loss of a loved one.

This investigation cannot change the outcome of past events; however, it seeks to support the essential ongoing process in mental health care of service review, learning and change. This process will take time and will require strong leadership and partnerships to facilitate transformational change.

We remain optimistic that the system can be strengthened through these processes, informed and supported by those with a lived experience of mental health illness, mental health crisis, and suicidality, and their families, carers and support persons.

Summary

The purpose of the investigation was to review and report on matters relating to the administration, management and delivery of the Child and Youth Mental Health Service (CYMHS), Gold Coast (GC) Authorised Mental Health Service (AMHS) within the scope of the investigation terms of reference.

In accordance with section 555(2) of the *Mental Health Act 2016* (MHA) four Inspectors were appointed by the Chief Psychiatrist on 5 November 2025 to conduct the review and prepare a report (this report) for the delegate Chief Psychiatrist in accordance section 309 of MHA.

The service has recently been affected by the tragic deaths of two young people who were using the service which has led to the commissioning of this review. It needs to be acknowledged that the service embraced this review with an open mind, open to learning and being challenged, with a desire to improve and learn. Like all services it was noted that there were strengths and areas for growth.

GC CYMHS impressed as a service dedicated to quality and safety improvement with a culture of continuous learning at its core. This was evident in responses from staff at all levels seeking pathways for service improvement. Staff were committed and passionate about supporting young people and their families, whilst also candid regarding concerns, and open to the opportunity and need for service development to improve care and safety. The Inspectors acknowledged how easy it would be for the service to become increasingly risk averse and inward looking, however this was not evident.

This report includes 11 priority recommendations focused on addressing core issue areas. These recommendations have been strongly informed by the voices of consumers, families and carers, recognising the essential role lived experience voices have in supporting service system improvement and reform. While the scope of the investigation did not allow for considering how individual's treatment or care should have been delivered, it did allow for individual’s matters to be considered to understand how the GC CYMHS model of care was operating.

Priority recommendations address CYMHS governance and structure, including integration and partnerships, and clinical practice and safety. Recommendations also aim to strengthen family engagement, through recommended process changes, workforce development and workforce enhancements to strengthen the role of Lived Experience Peer Workforce (LEPW) (consumer and carer). A key priority recommendation relates to the decisions required to enable an evidence-informed, early intervention and community focused eating disorders service.

In addition to the priority recommendations, the report details additional opportunities and considerations

for service development and improvement. These opportunities are highlighted for consideration by the service as they progress through implementation of the recommendations.

It is recognised that GC CYMHS is undergoing major reform and growth, building towards leading an integrated 0 to 25 child and youth mental health service. The reform will help in aligning the service with federal initiatives including the headspace expansion to help ensure there is a strong and integrated system of care in the Gold Coast region. They will be moving to a new purpose-built facility which will assist in consolidating the start of this new era and supporting coordinated and collaborative approaches to care across the CYMHS teams. Whilst several quality and safety improvement initiatives have been initiated, more time is required to fully embed these initiatives.

Prior to the review the service had identified that family engagement and becoming a family focused service was something that needed strengthening. To address this, they had created a family specialist position (advanced practice systemic family practitioner) to help early in career practitioners develop more confidence and skill working with whole of family groups. The service is also establishing a Director of Person-centred Care that will oversee the delivery of LEPW and re-establish the Family Advisory Council. Embedding meaningful engagement of lived experience practitioners into the core business of the service is challenging for all CYMHS, with recommendations made about how to build on the good work done so far.

The Inspectors felt there needed to be a close examination at both the leadership and co-ordination of the GC HHS response to eating disorders in particular anorexia nervosa. It appeared that it was currently a paediatric or medically led response rather than psychiatric or mental health led response which may lead to missed opportunities for early intervention and family led responses.

We were left with the feeling that GC CYMHS needed time to consolidate the new resources around different age groups, move into their new premises and build partnerships with new partner agencies given new age group responsibilities.

In line with the service's values of continual learning and improvement, the recommendations and additional considerations in this report aim to support the delivery of quality and safe services to young people and families on the Gold Coast.

Table 1. *Investigation into the Gold Coast Child and Youth Mental Health Service Report Recommendations*

Recommendation 1	a) Revise Child and Youth Mental Health Service models of care and procedures to support the prioritisation of family engagement at the first face to face appointment and to continue throughout care, leveraging the expertise, strengths and resources of the family to support recovery. b) Ensure skill development and supervision program led by advanced practice systemic family practitioner is supported by a clear workplan. This plan should identify resources and professional development program required to ensure strengthening of skills in family engagement across the whole of Child and Youth Mental Health Service. c) Review of Lived Experience Peer Workforce structure considers role of Lived Experience Peer Workforce in family engagement, communication and education.
Recommendation 2	The Gold Coast Hospital and Health Service Chief Executive to undertake a process to consider the pros and cons of the treatment approaches and decide as to whether the Gold Coast Hospital and Health Service model of care for young people with an eating disorder is to be led and governed by paediatrics or psychiatry. This decision will need to then inform a process of service system alignment and model of care review. A first step could be for the Gold Coast Mental Health Service leadership to visit examples of psychiatry led approaches across Australia including intensive home based and early intervention models to try and avoid hospitalisation.
Recommendation 3	Redesign the leadership structure and internal Child and Youth Mental Health Service governance and meeting structure to ensure alignment with the Child and Youth Mental Health Service operational plan to integrate the 0-25 model and enable integration and strong partnerships within Gold Coast Mental Health Specialist Service broadly, across Gold Coast Child and Youth Mental Health Service and with external stakeholders.
Recommendation 4	a) Post recruitment of the Director of Person-centred care, modify the structure and interface of the Lived Experience Peer Workforce to align with the above enablers and Lived Experience Peer Workforce considerations and opportunities raised within the report, including Recommendation 1c. b) Examine therapeutic models to embed into the model of care that will facilitate improved family and carer engagement and empower young people and their supports in their recovery journey, such as open dialogue.
Recommendation 5	Clarify the governance and escalation processes for the Child and Youth Mental Health Service Reflective Practice Forum within the broader Gold Coast Mental Health Specialist Service governance and ensure processes

	consider multidisciplinary team, including Lived Experience Peer Workforce engagement and family input with clear feedback mechanism.
Recommendation 6	Review of staff resourcing and processes for Access team to support timely and consistent decision making whilst also enabling clinicians to be empowered to make decisions with families regarding referrals pathways and access to care. In reviewing Access processes related to psychiatry led clinical governance, consideration could be given to these processes more broadly across Child and Youth Mental Health Service programs.
Recommendation 7	a) Ensure all Authorised Mental Health Service staff maintain recency of training and practice regarding the *Mental Health Act 2016*, patient rights, including access to second opinions and engaging Lived Experience Peer Workforce (role and processes). b) Ensure all Authorised Mental Health Service staff are aware that Ryan's Rule applies to all patients admitted to any Queensland Health public hospital, including the emergency department, and are aware of processes to support families.
Recommendation 8	a) The Office of the Chief Psychiatrist consider the concerns raised in this report regarding root cause analysis, which could include a review of root cause analysis practices, and provide statewide guidance on best practice methodologies for the review of community suicides. b) Revise post-incident processes for staff noting the importance of both timing and type of support to meet individual needs across all staffing groups is recommended. c) Establish a post-incident support process for consumers, families and carers that stands up immediately post incident and provides ongoing support for up to six months.
Recommendation 9	Gold Coast Mental Health Specialist Service should consider options to expand access to child and youth and family crisis support, including ensuring training and professional development programs on child and youth mental health is part of non-Child and Youth Mental Health Service clinicians role requirements when working in the emergency department after hours.
Recommendation 10	a) Ensure consumer, family and carer awareness of current feedback mechanisms, whilst exploring the option for a time-limited enhanced process led by Lived Experience Peer Workforce. b) Re-establish the Family Advisory Council.
Recommendation 11	Gold Coast Authorised Mental Health Service could be supported by the Office of the Chief Psychiatrist to consider these recommendations, including considering statewide learning opportunities.

Introduction

Background

The investigation purpose was to review the model of care currently used in the GC CYMHS and identify themes, lessons and actions that can inform system improvements and strengthen mechanisms to mitigate preventable harm. At the time of the review being established there had been significant media attention regarding the GC CYMHS following the death by suicide of individuals who had been receiving care from the service. The scope of the investigation did not extend to individual incidents of harm, and Inspectors were not required to make recommendations in respect of the ways in which any individual patient care should be delivered.

The scope of the investigation included the following areas, insofar as they relate to identifying the standard of care expected to be provided in GC CYMHS (list non-exhaustive),

- Models of Service, models of care and application including pathways, guidelines and other generally accepted clinical standards of care (local, statewide or national).
- Implementation and operation of a CYMHS model of service by the GC AMHS including:
    - continuity of care, including at time of admission, discharge and transition of care,
    - care planning,
    - risk assessment and risk management practices,
    - local unit-based interventions including recovery programs, access to inpatient therapies,
    - therapeutic visual observations, ligature and environmental risks,
    - specific structured evidence-based care and improvement activities, including current therapeutic approaches and any lessons learnt from them,
    - application and use of the MHA, including the appropriateness of use of treatment authorities.
- Workforce capacity and capability
- Role of tele-monitoring
- Clinical incident management processes and governance arrangements
- Consumer and carer engagement in care
- Specific strategies or approaches when caring for First Nations people and culturally and linguistically diverse populations
- Clinical information gathering and recording requirements.
- How the GC CYMHS model of care has been operationalised, including:
    - areas of variability (positive and negative), inconsistency or non-compliance with best practice frameworks, statewide and national models, guidelines and other generally accepted clinical standards of care,
    - any trend/s indicating inadequacy or inadequacies in the safety and quality of the care provided
    - best practice and alternative models of inpatient care.

In accordance with section 555(2) of the MHA the following Inspectors were appointed by the Chief Psychiatrist on 5 November 2025 to conduct the review and prepare a report (this report) for the delegate Chief Psychiatrist in accordance section 309 of the MHA.

- Lead Inspector – Dr Paul Denborough, Director, Infant Child, Youth & headspace Alfred Health
- Allied Health – Ms Rachel Phillips, Acting Executive Director of Mental Health, Darling Downs Hospital and Health Service,
- Nursing – Ms Emma Hart, Nursing Director, CYMHS, Children's Health Queensland
- Lived Experience – Ms Yasmin Grono, Director of Lived Experience, CYMHS and Chair,

Queensland Health Lived Experience (Peer) Workforce Leadership Group.

The Investigation commenced on the 24 November 2025 and concluded on 3 February 2026 (date of final interview). It was informed by site visits, stakeholder interviews, and data and documentation analysis. Further details are provided in the Review methodology section.

Gold Coast CYMHS

Gold Coast Hospital and Health Service (HHS) CYMHS provide specialist mental health services for children, young people up to the age of 25 and their families who are at risk of, or are experiencing, severe and complex mental health problems, and where their needs cannot be met by other services. Both voluntary and involuntary patients can access CYMHS. The GC AMHS is gazetted under the MHA as an AMHS to provide involuntary examination, assessment and treatment to persons with mental illness. GC CYMHS provides a child, adolescent, young adult model of care with programs providing services up to the age of 25 years (with variability in age across programs areas), which is not the case for all Queensland CYMHS.

The GC CYMHS includes two dedicated inpatient mental health services at the Robina Hospital that provide specialist inpatient mental health care:

- Wattle Unit – for young people under 18 years of age.
- Acacia Unit – Acute Young Adult Unit provides assessment and treatment of young adults (18–25 years of age).

In the hospital setting the CYMHS Consultation Liaison Psychiatry Service provides specialised mental health services to children and young people within hospital and paediatric outpatient settings.

The GC CYMHS also provides comprehensive and specialised mental health care within community, outreach and specialist care services. Community teams include:

- Access Team – provide community-based assessment and acute care service for children and young people aged 0 to 18 years of age and their families.
- Community CYMHS Continuing Care Team (CCT) – provide support to children and young people aged 0 to 18 years of age experiencing severe and complex mental health challenges.
- Young Adult Continuing Care Service – provides care for young people between 18 to 21 years of age who are experiencing severe and complex mental health difficulties.

Specialist programs include:

- Assertive Mobile Youth Outreach Service (AMYOS) – provides flexible and assertive mental health care to young people aged 13 to 18 years of age who are experiencing severe and/or complex mental health challenges and require an intensive approach. Care is provided in settings the young person can attend and feel comfortable.
- Early Psychosis Service (EPS) – provides support to young adults aged 15 to 25 years of age who are navigating their first episode of psychosis.
- Youth Eating Disorder Specialist Service (Youth EDSS) – provides evidence-based care in the community for young people up to 22 years of age who are experiencing eating disorders.
- Evolve Therapeutic Services (ETS) – provides mental health assessment and therapeutic interventions for children and adolescents under 18 years of age who are involved with Queensland Child Protection Services and experiencing severe and/or complex mental health challenges.
- headspace in-reach – provides consultation liaison and clinical in-reach to assist with access to care at the most suitable level and to strengthen the service pathways between headspace and Gold Coast health services for young people aged 12 to 25 years, and their families when moving between mental health services and settings.

- Head to Health Kids Queensland (H2HK-Q) – supports children under 12 years of age and their families who are experiencing mild to moderate mental health challenges.
- Yangah Adolescent Day Program (YADP) – provides family-centred support and clinical interventions for families and carers to optimise a young person's functioning within their home environment. Young people undertake an individualised educational program that enables re-engagement with education and to undertake meaningful education or employment in the future.

As of 22 October 2025, there were 267 young people (0 to 25 years old) open to GC CYMHS.

The Gold Coast City covers 1334 square kilometres and has an estimated resident population of 681,389 as of 2024.In addition to the resident population Gold Coast City is known to have a large transient population influenced by its interstate border with New South Wales. According to the 2021 *Australian Bureau of Statistics Census of Population and Housing* 15.8% of the population were aged 12-24 years. A higher proportion of young people on the Gold Coast (19%) were born overseas compared to Queensland, with New Zealand being the highest country of birth. Indigenous young people represented 3.6% of young people on the Gold Coast compared with 7.2% for Queensland. A mental health condition (including depression or anxiety) was the most common long-term health condition for young people, reported by 9.4% of young people aged 12–24 reported.[1]

Queensland legislative and policy context

Mental health services in Queensland are delivered under the legislative framework of the *Hospital and Health Boards Act 2011* (HHBA) and the *Mental Health Act 2016* (MHA). A primary objective of the MHA is to improve and maintain the health and well-being of people who have a mental illness who cannot consent to treatment. The MHA requires treatment and care to be provided in a way that is least restrictive of an individual's rights and liberties. Administration of the MHA is supported by Chief Psychiatrist Policies that must be adhered to in the delivery of mental health alcohol and other drug (MHAOD) care. Application of the MHA and associated policies are relevant across the lifespan.

The delivery of CYMHS in Queensland is informed by the Clinical Services Capability Framework as an element of the broader public MHAOD services system. CYMHS must adhere to the aforementioned legislative framework and align service delivery with National Standards for Mental Health Services, statewide models of care and statewide policies and guidelines.

Review methodology

The methodology of the review was intended to support broad stakeholder engagement to provide a fulsome understanding of the current GC CYMHS model of care. Inspectors sought to hear multiple perspectives, importantly including the voice of consumers, families and carers who have experience with GC CYMHS. Further the methodology sought to identify opportunities for learning and improvement.

Site visits and interviews

Inspectors attended the GC AMHS between 24 to 27 November 2025 visiting multiple service delivery sites and meeting with staff, and families and carers. Follow-up online interviews and site visits occurred from 2 December 2025 to 3 February 2026.

Opportunities for consumer and family and carer participation was provided via multiple methods including, individual invitation to participate in interviews, four forums, online feedback form, written feedback with option for follow-up with an Inspector. Timeframes for the investigation impacted engagement for the first forums scheduled for 26 November 2025 with subsequent forums held on 15

[1] Australian Bureau of Statistics (2021) Census of Population and Housing reported by Gold Coast City Council https://www.goldcoast.qld.gov.au/About-our-city/Population-data/Statistics-for-young-people

December 2025. The Inspectors acknowledge the support of ARAFMI and the Mental Health Lived Experience Peak Queensland in facilitating awareness of these forums and for support offered to consumers, families and carers through the process.

Opportunities for staff engagement were also provided via team interviews and two open staff forums held during one of the site visits. Further staff that engaged in interviews were also offered the opportunity to provide written feedback.

An open feedback and engagement process was used whereby all individuals who requested to input into the investigation were afforded an opportunity. Interviews were also offered to peak bodies and relevant CYMHS service partners. Further, a process to confirm information with the service and request additional information to address any identified gaps was established and continued as required throughout the report drafting process. This occurred to ensure comprehensiveness of information used to inform the report and recommendations.

Documentation and data

The investigation included review of relevant statewide and local (GC HHS) policies, guidelines and standards. Relevant service data, including activity data, staffing establishment, incident and complaint data. MHA compliance and non-compliance data also informed the review.

Further, a randomised clinical documentation audit was conducted. Methodology for identification of clinical files included production of a Mental Health Additions Portal '*Mental Health Episode Data Report (All Treating Units) v1.0 - Power BI Report Server*' with the only identifier a consumer identification code. The report was limited to 'Gold Coast' service organisation, all treatment settings (community, inpatient), and then filtered on CYMHS special service types for the date range 27 November 2024 to 27 November 2025 with the treating unit 'Infant Mental Health Service' and consumers aged outside the age range 12 to 25 years removed. This provided a report for all consumers who had a service episode opened in the past 12 months from, each of the CYMHS inpatient and community services. Each service type was filtered and a consumer randomly selected. This process was managed by the Office of the Chief Psychiatrist (OCP), with approval provided by the data custodian (Executive Director, Mental Health Alcohol and Other Drugs Branch) to access these records for the quality improvement purpose of undertaking the investigation.

Limitations

Notwithstanding the comprehensive engagement of stakeholders in the investigation the timeframe of the investigation was identified as a limiting factor. It is recognised that individuals who did not have an opportunity to participate in the staff, consumer and, family and carers forums would have had valuable contributions to the process. The process did however enable identification of key themes and areas for review and improvement, with clear consistency in feedback for these areas from staff, consumers, families and carers.

Findings by domain

Models of service and clinical governance

Structure

All CYMHS programs/services report to the CYMHS Service Director. Within the GC HHS operational and governance structure these positions report into the executive for Gold Coast Mental Health Specialist Services (GC MHSS). All staff operationally report through to their business unit and professionally to the relevant Director including, Director of Nursing MHSS and Executive Director of

Allied Health via the Directors of the profession and local professional leads (Social Work, Psychology and Occupational Therapy). See Appendix for organisational charts.

Whilst this structure is reported as consistent across AMHSs in Queensland it is important to recognise that the specialty area of child and youth does not necessarily align with adult models of care, with it essential to consider the broader system in which a young person exists, in particular their family system. The review identified opportunities to strengthen child and youth models of care from a family systems framework and strengthen CYMHS specific governance processes.

Whilst the majority of CYMHS programs are tertiary mental health services, the H2HK-Q program is a primary care model with governance provided by a tertiary service. This has tremendous potential to help address the “missing middle” by a full integration of primary care and tertiary services. To fully reach its potential there will need to be flexibility in how this part of the system is run compared with the tertiary service which will likely have different governance requirements.

Models of Service

In considering models of service and access to care we had feedback that historically CYMHS had a greater early intervention focus. Possibly in the context of system demand pressures, including post-COVID pressures, access to earlier intervention is now limited. Opportunities to consider earlier intervention and increased access to therapeutic interventions were raised by several stakeholders. There would be benefit in considering how early intervention and therapeutic intervention fits within the GC CYMHS model of service and the broader mental health service system on the Gold Coast. Including strengthening links with other agencies to assist in transitioning between stepped care levels aligned with individual care needs.

The expansion of speciality mental health teams within the MHAOD service system brings both benefits and challenges, particularly the risk of deskilling of general mental health staff and subsequent limitations in early intervention and access. This was noted as a particular risk within the eating disorder service, however, likely has broader relevance. For example, it is noted that statewide guidance on establishment of eating disorder speciality services in Queensland MHAODS is to complement and not replace current supports and services provided by CYMHS, with a primary focus on intensive time-limited focused treatment and consultation rather than case management, crisis support or emergency care service that are provided by other parts of the system. Consideration of structure and integration of speciality services and their role and function with the continuum of care by CYMHS should be considered further.

Review of local models of care, procedures and other relevant documentation in line with the terms of reference identified on balance a consistent expectation of service delivery in line with statewide and national models, policies and guidelines. There were however some areas that require further review and development. These areas are addressed in relevant sections throughout the report, notably the eating disorder service, clinical incident review and documentation.

Governance

There are opportunities to strengthen CYMHS internal processes and governance. This is inclusive of clinical escalation and review of complex care matters. Current processes occur within the broader GC MHSS structure in line with the *Complex Care Review Gold Coast Hospital and Health Service/Mental Health and Specialist Service Procedure*. The Complex Care Review meeting provides an opportunity to improve service delivery and strengthen clinical governance in supporting clinical teams working with individuals who present with complex needs and reduce risk of harm. This process provides for a clear escalation pathway for all MHSS lines including CYMHS. With the Clinical Director (or Delegate) / Medical Directors MHSS of the respective service lines as the designated coordinator for reviews within

their service line.

It was also reported that internally CYMHS has been establishing a CYMHS Reflective Review forum to support review of CYMHS complex care matters. How these meetings fit within the broader GC MHSS structure and governance is unclear, however an approach to supporting a multidisciplinary team (MDT) reflective practice approach that is also family focused is commended. Ensuring clear governance internal to CYMHS and within the broader GC MHSS, including escalation processes will be an important next step.

In considering CYMHS and GC MHSS governance committees and meetings it is important to ensure that there is both First Nations and Lived Experience Peer Workforce representation in addition to current multidisciplinary representation.

Eating disorder services

An identified priority area was the model of care for the GC HHS eating disorder service/s. A recent review of the eating disorder service was undertaken in 2023. The 2023 review report noted several concerns regarding the models of care that were subsequently identified in the current investigation.

2023 Gold Coast HHS Eating Disorder Services Review

Concerns raised in the review included fundamental differences in styles of assessment and formulation of individual patients, splitting and siloing of team roles and confusion in treatment direction. Further, split clinical governance across paediatrics and CYMHS with lack of structure and clear process for clinical governance, challenges in transitions of care and handover was identified as leading to inconsistent and confusing messaging to families. Resourcing deficits in the CYMHS eating disorder service and opportunities for increased training, education and supervision for staff were identified. The report also raised concerns regarding the impact of the therapeutic intervention from meal support psychologists on the paediatric ward on other team members and treatment delivery after hospitalisation.

It was reported that all but four review recommendations were implemented with the outstanding four recommendations either partially complete or yet to be commenced. Those four are:

- This leadership team to consider drafting a model of care that encompasses all new and existing services with a particular focus on service integration. The reviewers feel it will be important to engage with staff from all disciplines, key stakeholders across GC HHS and consumers and carers with this process.
- Consider opportunities for a more integrated eating disorder program that is embedded within the wider mental health service continuum.
- Consider the value of reinstating a multidisciplinary outpatient service inclusive of a paediatrician/ special interest GP and dietitian in collaboration with the CYMHS teams.
- Consider alternative in reach options to allow patients access to dietetics and/or paediatrics when being treated by community CYMHS teams for any eating disorder diagnosis, keeping the consumer journey and clinical needs of the child in mind.

Current investigation

Within the context of the current investigation, it appeared that it was likely that the community would view the paediatric team and medical ward as a central focus of care for young people particularly with anorexia nervosa. They had a comprehensive care program on the inpatient ward including staff who provided detailed psychological assessments as well as a day program. There was also a consultation psychiatry presence on the ward.

This seemed in contrast to quite limited resources within the community CYMHS team which consisted of 0.5 FTE psychiatry registrar and 0.5 FTE consultant psychiatrist (not filled for over 12 months) and two clinicians one of whom had been on extended leave. There was also access to 0.4 FTE of dietician.

Where a young person is considered too challenging to care for in the paediatric inpatient setting due to multimorbid mental health concerns, at-risk behaviours, or not responding to treatment, transfer to an acute mental health inpatient unit occurs, where nasogastric tube (NGT) feeding may continue. It was noted that many requests for assistance from security staff (recorded as Code Blacks) by the Wattle Unit were for assistance with NGT feeds.

The Inspectors noted extended lengths of stay for young people, raising questions regarding the impact on the current paediatric model of care. This includes lack of early intervention in community setting with first point of contact medical for resuscitation, with extended stay, and psychological input in the paediatric setting as opposed to psychiatry led in community. A lack of role clarity and disconnect between models of care for paediatrics versus mental health was noted, as well as lack of clarity in governance at points of care which contribute to clinical and service risk.

Inconsistent feedback was provided to the Inspectors regarding the relationship between the paediatric and CYMHS teams with some suggesting that things have improved significantly since the 2023 review and others noting limited relationship between the teams and lack of understanding of the respective models of care and boundary of roles.

All clinicians involved in the delivery of eating disorder services across GC HHS impressed as dedicated and patient-focused and passionate about the framework in which they are practicing.

Across Australia there are essentially three approaches to eating disorder treatment programs, a paediatric led specialist approach, partnership between psychiatry and paediatrics, and psychiatry led approach. It is understood that the primary model in Queensland is psychiatry led and eating disorder speciality services are guided by the *Assessment and treatment of children and adolescents with eating disorders in Queensland* and *Service Description: Eating Disorder Speciality Services* document. There are pros and cons to different treatment models. The limitations associated with a medical led model include that it is not an early intervention focused model; hospital admissions can lead to family disempowerment and limitations on trauma informed approaches with young people re-telling their stories multiple times across treatment settings. All of these were issues and risks identified in the investigation. An additional limitation to a medically led model is the risk of deskilling of mental health clinicians and gaps in capacity and skill of medical teams in managing risk of harm to self and others and psychiatric co-morbidities. Models of care should include early intervention, multidisciplinary care, service coordination, evidence-based treatments and model fidelity, involvement of family/significant others, personalised approach to care, education and psychoeducation incorporated into all interventions. Further, evidence-based eating disorder services require highly skilled workforce trained and supervised in evidence-based treatments and continuous evaluation and research.[2]

A key recommendation of this review is therefore for the GC HHS Chief Executive to undertake a process to consider the pros and cons of the treatment approaches and decide as to whether the GC HHS model of care for young people with an eating disorder is to be led and governed by paediatrics or psychiatry. This decision will need to then inform a process of service system alignment and model of care review.

It would seem that a first step could be for the GC CYMHS leadership to visit examples of psychiatry led approaches across Australia including intensive home based and early intervention models to try and

[2] Service Description: Eating Disorder Speciality Services Published by the State of Queensland (Metro North Hospital and Health Service), July 2023

avoid hospitalisation.

Family engagement

Delivery of CYMHS care should take into consideration the strengths and resilience within the individual, their family and community. It should include appropriate interventions which address the individual and family needs and foster individual and family well-being.

A consistent theme across interviews was an acknowledgement that CYMHS could strengthen the way they engage and work with families. Whilst family engagement is a current element of the model of service, delivery of care appears more individualistic as opposed to family oriented. Further concerns were raised by consumers, families and carers that they were silenced or didn't have a voice.

CYMHS model of care review should consider the timing and type of engagement that occurs with the family unit, with it recommended that this occurs by default at the outset i.e. first contact, unless individual factors indicate a clear reason why this approach would not be appropriate. LEPW for consumers, and carers and families were also highlighted as an important core element of service delivery. Whereby engagement with LEPW should also occur at the outset of care with consent of families and consumers.

Opportunities to strengthen family engagement include models of care that include family and LEPW at the outset of care, flexibility in service delivery, both how and where, that recognises the complexity of the family unit and family needs i.e. transport limitations, parental work schedules, sibling engagement, variability in communication methods and that clinic spaces are not ideal or conducive to everyone.

On a broader scale the Department of Health could consider opportunities to further embed and champion the important role that families and carers play in their loved ones' care and the commitment to listening to them. This could be via a charter similar to that developed in the United Kingdom https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2024/06/Family-and-Carers-Charter-for-Health-and-Justice.pdf

Care pathways

Access

It is understood that there is an ongoing review and transition process occurring within CYMHS with a longer-term goal of transitioning to a child, youth and young adult model across all program areas (0-25 years). It was reported that a starting point in this journey was supporting clearer functions and pathways across the program areas and services, with an initial focus on the Access team. This has resulted in defining the function of the Access team to what appears to be a primary phone triage service. Stakeholder feedback on these changes and the current model of care for Access were variable but overall positive.

This is still quite a relatively new development, and it was still a little unclear about where decision making sat regarding whether families were accepted into the service. Current procedure documents indicate initial decision making by a triage clinician. However, this decision must be later approved by a consultant psychiatrist led MDT. If a consumer is referred on to a CYMHS team for an intake assessment a subsequent decision could be made to refer out of CYMHS, or to an alternate CYMHS team. This can lead to confusion and delay for consumers and families who see the CYMHS as a single service.

With the expansion of CYMHS to 25 years across the service, access to CYMHS services will also come

via adult mental health services (MHS). The linkages and care pathways between CYMHS and adult MHS therefore also need to be considered.

Acute care and crisis response

There appears to be a gap in acute care with Access appearing to function as a primary triage and referral point to either CYMHS CCTs, specialty teams or external care providers. Opportunities to reduce this gap could include further consideration of the functions of Access including brief intervention and outreach to aid in formulation and risk assessment.

Crisis responses for young people are either via triage with Access or Emergency Department (ED) assessments. It is understood that there is not a 24 hours CYMHS presence in ED resulting in either adult MHS Acute Care Team (ACT) clinicians assessing young people or young people and their families waiting in ED overnight for assessment in the morning by CYMHS. To support this model the service should determine the minimum expertise on child and youth mental health assessment of ACT clinicians working after-hours in the ED. Further ACT clinicians should have access to regular professional development and supervision on child and youth issues, with these training and supervision requirements embedded into ACT model of care.

Positive feedback was received regarding the adult Crisis Stabilisation Unit (CSU) with some suggesting the need for an adolescent equivalent. Consideration could be given to expanding the age range or considering the establishment of a CSU for young people and families in crisis as an alternative to ED.

Community care

Community care is provided via CCTs and specialty programs including AMYOS, EPS, Youth EDSS, ETS, headspace in-reach, H2HK-Q and YADP. Across all program areas staff were committed to supporting young people and their families. Challenges identified included gaps in care during periods of transition across teams, with transitions involving re-assessment, and discontinuity of care and therapeutic relationships. Families reported experiencing difficulties when care was provided by multiple teams. The review team suggest that there are opportunities to consider how the specialty teams are embedded within the CYMHS model to maximise skill development across staff, minimise transitions of care and improve efficiency, consistency, and equity of access. This could include a care management model with consistent primary clinician and/or peer navigator model with a consistent LEPW who remains alongside the young person throughout their care journey.

In considering equity of access, it was identified that with the exception of AMYOS, outreach care in community is limited. It is important to recognise the psychosocial and system challenges that can impact engagement and address these barriers in order to minimise risk of early discharge from services and ensure young people and their families have access to care. There is an opportunity for CYMHS in considering models of care to enable improved access through flexibility of service delivery. This could include increased outreach into community (home and schools), use of technology (with clear processes and safeguards) and drop-in clinic options to meet young people and their families where they are at both within their recovery journey and practically within the community to address barriers in accessing clinic-based services.

Inpatient

Acacia

The Acacia Unit is a young adult (18-25 years of age unit) with an open ward and a psychiatric intensive care unit (PICU). The PICU was referred to by stakeholders inconsistently as an 18–25-year-old unit that may take outliers in response to bed capacity demands, and as an all-ages unit, the later seems to align more closely with local procedure documents.

The benefit of having a young adult inpatient unit which is not common across Australia is noted. As are the challenges of maintaining a young adult model in the context of bed pressures for adult beds, which are potentially increased when trying to do this with a PICU attached. Recognising likely infrastructure limitations, the benefits of considering the location of the PICU are raised.

Review of data over a two-year period between 1 January 2024 and 7 December 2025 identified that 312 admissions to Acacia were for consumers aged over 25 years of age with an age range from 26 to 65 years of age. This accounts for 35% of admissions to Acacia. The majority were aged 26 to 40 years of age. There were also three admissions for consumers under the age of 18 and three over the age of 65 in 2024.[3] A limitation of this data is the ability to identify admission to the open ward versus the PICU, however based on stakeholder feedback it is assumed these older adult admissions are for the PICU.

One of the challenges reported by an all-age model of care for a section of a unit (the PICU) under the governance of CYMHS is clinical governance over the delivery of individual consumer care. It appears a hybrid model exists whereby operationally staff in the unit report to CYMHS leadership, however psychiatric care on the most part is delivered by adult MHS psychiatrists. With this lack of clarity comes inconsistency in decision making regarding admissions and discharges informed by what is reported to be a standing agreement without a formal work instruction or process.

Additional concerns relate to the therapeutic milieu and capacity to deliver a CYMHS model of care with older adults on a ward with young adults, and on the rare occasion adolescents. Concerns were raised regarding risk issues associated with the current model that allows the current age mix on the ward, with it suggested that a separate adult PICU under the governance of adult MHS is required. It is recognised that the current practice is likely influenced by ED processes and pressures seeking to have consumers discharged or admitted within 24 hours.

Admission to an inpatient unit in Gold Coast HHS is informed by a local procedure namely the *Admission to a Mental Health Inpatient Unit: including vital signs* and admission to a PICU informed by the *Psychiatric Intensive Care Unit (PICU) Management* procedure. Both documents are very comprehensive and inclusive of sections specific to the management of minors, with escalation pathways, consent considerations and sexual safety and staffing considerations. Whilst recognising the importance of addressing these factors in a procedure it does not negate the potential impact for young vulnerable people admitted to a ward with older adults, particularly those with a trauma history. Further based on some feedback through the review the procedures may align more closely with work as imagined as opposed to work that is done, recognising resourcing limitations contribute to this.

Noting the aforementioned outliers and risks associated with age mix it is recommended that an update to the procedure documents includes a separate section under outlier management for over 25-year-old consumers admitted to Acacia. Further, review of the document should also minimise the reproduction of Chief Psychiatrist Policies and instead solely link to the policy documents as the sole source of truth to minimise the risk of incorrect translation of legislative and policy requirements.

Wattle

Recent developments in the unit regarding environment and staff training were reported. It is however also noted that information shared from consumers and families raised concerns and supported the identification of areas for ongoing development.

A key theme related to the primary safety and containment function of the ward, with limitations in access to therapeutic intervention raised. It was reported that due to concerns related to iatrogenic harm from extended admission that discharge pathways were the focus of care. Whilst it is recognised that care should be provided in the least restrictive setting possible, with a preference for community

[3] Data source: MHAP report, Mental Health Admitted Patients, and filtered to Acacia Unit, date range 01/01/2024 – 07/12/2025 (2 years)

care, this also needs to be balanced against and informed by comprehensive risk assessment and individualised care and discharge planning that engages the young person, their family, and supports to ensure appropriate risk management and access to community care prior to discharge.

Feedback also included gaps in transition and post discharge processes to support crisis responses and the significant shift from 24/7 containment in an inpatient setting to one hour per week of community care input. There is a future service development opportunity in identifying equitable access to youth step-up/step-down (SUSD) programs for young people (up to 25 years of age) and their families when transitioning from inpatient care.

Another challenge in Wattle relates to a prior issue raised in the report regarding the eating disorder services models of care. With paediatrics delivering an extended inpatient program and mental health services focus on community care (albeit under resourced) the CYMHS inpatient units become stuck between two competing models of care, leading to inconsistencies in care approach.

A theme across the investigation, with a primary focus in the inpatient setting, was the processes related to family meetings. Inconsistency in access and process for family meetings was reported, with some reporting their experience was a tick and flick exercise as opposed to genuine engagement, support and psychoeducation to assist their child's recovery. Opportunities to improve family engagement are addressed elsewhere in the report, however it is important to highlight specifics with regards to the inpatient setting, including consistent access to LEPW. This could be supported by access to a dedicated space (family room) and LEPW staff member, improved orientation to unit, including ensuring awareness of processes (communication, escalation and care), rights and responsibilities (including MHA processes), expectations (standardised processes around treatment to ensure consistency of care and predictability) and who is providing care (meeting treating team). Young people and their families need to be seen as experts and partners with a genuine process to develop a shared story and care plan via collaboration with family and when engaged external services, to support consistency of care and ongoing access to community supports.

Young people shared their experience of admission to Wattle being like a prison, with security officers, locked metal doors and feeling scared and punished for needing and seeking help. All mental health care should be delivered in a least restrictive manner as possible and informed by individual clinical and risk assessment informed formulation. Whilst there may be a need for security staff to support in some instances of admission, this should not be a default process for admission with an individualised and trauma-informed process at the centre of all care decisions.

Step-up/step-down and day programs

With the exception of access to the YADP for some consumers on transition from an inpatient ward there are no SUSD options for young people on the Gold Coast. Youth SUSD services are community bed-based (sub-acute) mental health services operating in a rehabilitative and residential environment where the HHS provides clinical services alongside provision of non-clinical support services by a non-government organisation (NGO). It is understood that currently there are youth SUSD services in Cairns, Caboolture and Logan, with funding for the establishment of two new services in Rockhampton and Townsville. It was reported that at-risk criteria, lack of school engagement and admission times (no rolling program) are barriers to access YADP.

Transition to adult services

The Gold Coast HHSs unique model in Queensland that provides some CYMHS services for young adults up to 21 or 25 years of age is considered a positive service development, as is the intent to work towards consistency of this model across CYMHS. It is a significant piece of work that requires core foundational structures to be in place and a comprehensive change management plan to support staff

and consumers with the transition.

One of the key benefits to young adult services is a recognition of the differing care needs within a model for young adults, which supports future transition to adult services and minimises discontinuity of care. It also aligns with federal government funding initiatives, providing opportunities for GC HHS.

It is recognised that there is further work to occur in supporting transitions to adult services as CYMHS embeds the new models of care with extended age range.

Interface with broader mental health services system and stakeholders

Effective mental health care occurs within a broader mental health system. Relationships and care pathways with stakeholders are essential to supporting the well-being of the community.

Gaps that are unfortunately not unique to GC CYMHS were raised including what is often referred to as the “missing middle,” young people whose care needs are assessed as not severe enough for CYMHS and too complex for primary care services. Gaps at points of transition to ensure continuation of support for young people and their families as they transition from specialist mental health care to primary health care services were also raised, as was limitations in shared care arrangements between the private and public sector, with access to the private sector limiting the ability to access CYMHS care e.g., work procedure noting that CYMHS does not provide concurrent care with private services unless it is part of a shared care agreement that has been arranged prior to referral. Whilst noting these issues are likely broader than GC CYMHS, the opportunities to minimise these gaps on the Gold Coast exist in recommendations and considerations throughout this report.

Workforce

The review sought to include comprehensive engagement with staff at all levels and across all roles. This was facilitated through seeking to engage with all core GC CYMHS teams as well as two open staff forums. All staff that engaged in the process demonstrated a dedication and intent to provide the best care to young people and families on the Gold Coast. Staff consistently spoke of a positive learning culture, and many embraced the review as an opportunity for quality and safety service improvement. Whilst staff passion for child and youth mental health care was clear, so was the vicarious trauma that many staff were experiencing in the context of recent critical incidents and media reports. Staff candour towards the review and their feedback to support consumer and family care and engagement is acknowledged.

Staffing profile vs demand

Opportunities to increase staffing across MHSs to meet demand was a common theme across the review and likely consistent with broader MHAOD service system needs within Queensland and across Australia. Key areas for consideration regarding staffing include, dedicated consultant for the Access team, significant FTE uplift across disciplines in the community CYMHS Youth EDSS, increase access to allied health, particularly in inpatient settings, increased FTE and staffing profile aligned with Acacia (including PICU) model of care, and significant FTE uplift of LEPW to ensure access throughout care (admission to discharge/transfer of care) across all services/programs inpatient and community.

Recruitment/retention challenges

Linked with staffing profile and demand are unfortunately the not uncommon challenges of recruitment and retention. Whilst these challenges are not unique to GC CYMHS the impact on young people and families of inconsistent treating psychiatrists and other team members needs to be acknowledged, and

considerations for how to better support recruitment and retention challenges explored.

The Inspectors received feedback that inpatient units had up to five consultants over a six-month period and that some consultants are covering multiple teams, limiting their capacity for direct patient care. Similar concerns were raised regarding leadership positions (team leaders and nurse unit managers) and across allied health. Inconsistent staffing in treating teams leads to young people and their families needing to re-tell their stories over again, an approach that does not align with trauma informed care. It is acknowledged that there remains an ongoing risk and likelihood of staff turnover and whilst this should be minimised where possible strategies to moderate the impact on young people and their families should also be considered. This should include considering how the MDT supports assessment and care review processes, and the role of LEPW.

Skill mix and role clarity

Gold Coast CYMHS intent to deliver a multidisciplinary model of care was evident from the investigation. Providing mental health care within a multidisciplinary framework requires experienced discipline specific leadership, governance structures and education and training programs to support workforce development. It was reported that across some program areas both leadership roles and clinical staff are relatively early in either their leadership or clinical career. Opportunities to scaffold whilst supporting professional development across the service would be beneficial to explore. This could include considering senior clinicians holding a portfolio in an area of expertise that provide consultation liaison services and professional development opportunities across the full workforce. An example of this already established is the advanced practice systemic family practitioner, which has been reported as being very successful in supporting clinicians especially early in career with confidence and skill in working with families.

Review of the eating disorder programs offered by GC HHS will result in improved role clarity across paediatrics and mental health, particularly regarding the role of psychology at different periods of care within the eating disorder programs.

Family therapy

It is understood that the service has already identified the need to improve family engagement and options for family interventions through the establishment of an advanced practice systemic family practitioner (currently 0.7 FTE) in April 2025. Whilst there is further to be achieved by this role some initial progress reported includes the development of systemic practice guidelines, and evidence-based training (key skills in family therapy) for systemic practice champions in all teams to facilitate integrated family work and prioritise this within the multidisciplinary care plan for each consumer. It was reported that the role is anticipated to have a caseload once capacity has been established more broadly across CYMHS teams.

The risk of unintended consequence with specialty services and speciality positions, that whilst aiming to build workforce capacity can sometimes lead to deskilling of the broader workforce where the speciality services/roles function outside a consultation liaison or brief/acute intervention framework is raised for the GC MHSSs ongoing consideration. Opportunities for portfolio positions that lead and supervise and remain embedded within core teams across the service are an alternate way to support professional development whilst not risking the deskilling of the broader workforce.

Additional opportunities for training that support family therapy and family engagement more broadly included information sharing and consent processes.

Supervision and professional development

Supervision and continuing professional development are integral to the delivery of safe and evidence

informed care. There is a dual responsibility on the mental health workforce to drive their professional development, and on the organisation to ensure access to both mandatory and recommended training to facilitate the delivery of high standards of care. This includes a robust orientation process, and a coordinated and comprehensive education and training framework embedded within all MHSs. A review and update of the orientation manual is required noting significant out of date information and need to align with current work structure and clinical priorities.

GC MHSS had a comprehensive education plan for 2025 that was inclusive of early career training for nurses and face-to-face education workshops on a broad range of topics across the year for all staff. The 2025 education plan noted variable staff attendance to the 2024 in-service and clinical education support program due to clinical acuity, staff availability, and reduced expert presenter availability resulting from increasing clinical demands on time. It is unclear whether changes to the plan in 2025 led to improved staff engagement. Translation of learnings from the 2025 program to support a sustainable and beneficial 2026 program will be important considerations for GC MHSS, including ensuring it meets the needs of the CYMHS workforce and supports cross team skill development to reduce fragmentation in care.

Culture, morale, burnout indicators

In meeting with CYMHS teams there was a strong sense of team culture and support for colleagues. What was also apparent was a fragility regarding psychological safety in some teams with an adverse impact of the recent media reports on staff well-being, and a decrease in confidence in decision making.

Positive steps by the service to support staff have included establishment of a workforce well-being officer, doctors' welfare committee, and systemic supervision training and provision of supervision. Amid ongoing media reports, engagement, support and messaging from leadership will remain integral to supporting staff well-being and re-enabling professional self-efficacy.

Clinical Practice and safety

Adherence to clinical guidelines, policy and legislation

Mental Health Act 2016

The application of the MHA is less common in child and youth mental health care than adult mental health care. However, the MHA applies across the life span and at times is required to ensure access to mental health assessment and treatment and to reduce the risk of harm to self and others. It is a requirement that care provided under the MHA occurs in the least restrictive manner possible, considers an individual's human rights and ensures the individual, and their family, carer, or support people are engaged in care and informed of decisions made under the MHA.

The investigation considered the application of the MHA, as well as any incidents of non-compliance over the past five financial years. In accordance with the Chief Psychiatrist *Policy Notifications to the Chief Psychiatrist of critical incidents and non-compliance with the Mental Health Act 2016*, administrators of AMHS are required to notify the Chief Psychiatrist of all instances of non-compliance that significantly impact on the rights of patients. Over the past five financial years GC CYMHS reported three incidents of non-compliance, two relating to seclusion and one the detention of a consumer not in accordance with the MHA. In each incident the service ensured there was appropriate remedial action and engagement with the consumer and their family regarding the incidents.

Over the past five financial years GC CYMHS consumers accounted for 6% of minors who received

involuntary care under the MHA in Queensland.[4] Data indicates that seclusion events for minors on the Gold Coast are rare with events accounting for 3% of all seclusion events for minors statewide.[5]

Further, 8% of physical restraint events statewide were for GC CYMHS consumers. An increase in physical restraint for 2024-2025 was noted with 99 events for six unique consumers.[6] As the investigation did not include review of individual consumer treatment and care it is not clear if these events relate to NGT feeds on Wattle, however review of code black data highlighted the use of physical restraint to facilitate NGT feeds.

Review of data at a service level resulted in a lack of clarity regarding the legislative mechanism and procedures to facilitate NGT feeds in the CYMHS inpatient setting. Review of incident data and attendance of protective services officer (PSO – security staff) suggests the use of restraint by PSOs to facilitate NGT feeds. It appears that these restraints predominantly refer to the use of planned physical restraint however language used in report data reviewed is unclear.

Mental health care should be provided via the least restrictive means and in a trauma-informed manner. Use of restrictive practices needs to be justifiable from a last resort perspective to ensure the safety to the consumer and others. Whilst comparably the rates of physical restraint for the GC CYMHS are low, the impact of repeated restraint in the provision of care for young vulnerable consumers, many of whom have trauma histories, is of concern. As the GC HHS considers the most appropriate model of care for young people with eating disorders, considerations need to be given to how this care can be provided in a trauma informed and least restrictive manner in adherence with legislation and policy.

During periods of crisis and/or acute risk families and/or carers may make decisions to ensure the well-being of their young person. During these times it can be difficult to understand the nuances and effect of relevant legislation relied upon to provide care. It is essential that time and support is afforded to individuals, their family and carers to understand their rights and responsibilities when accessing mental health care and when receiving care under the MHA. Time should also be taken post crisis to revisit any information shared and decisions made to support understanding, particularly with regards to an individual's rights.

Independent Patient Rights Advisers were established under the MHA to support these processes, further there is a key role for LEPW. However, these roles do not negate the responsibility of authorised doctors and mental health clinicians in ensuring young people, their family, carers and support people are aware of their rights under the MHA. Feedback during the investigation raised this as an area for further consideration via quality and safety improvement processes.

Policies and Procedures

Review of local procedure documents raised concerns regarding the reproduction of Chief Psychiatrist Policies in local procedures, including inaccurate or inconsistent reproduction of content and the need for more regular review to ensure alignment when Chief Psychiatrist policies are updated. It is recognised that there is a need for additional procedure content to support operationalisation of the policies at a local level however this process should solely reference statewide policies with correct working links to the statewide documents to ensure a single source of truth and consistent application of the legislation and associated policies. Review of local procedures should also ensure that all documents align with the current comprehensive care documentation requirements and current clinical form terminology.

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[4] Mental Health Additions Portal Report Open MHA Consumers As At Specified Date, 30 June each reporting year, consumers filtered by age
[5] Mental Health Additions Portal Report Seclusion of Minors Report v1.1, 01/07/2020-30/06/2025
[6] Mental Health Addictions Portal Report Physical Restraint of Minors Data Report v2.4, 01/07/2020-30/06/2025

Comprehensive Care

Opportunities for improvement were identified in the application of comprehensive care guidelines and principles informed by the National Safety and Quality Health Service Standards, and *Queensland Health Statement on comprehensive integrated care: mental health alcohol and other drugs services* and supported by the *Comprehensive Care: Partnerships in Care and Communication resources*. These include the importance of formulation driven care, individualised approach to care, family and carer engagement, information sharing and consent processes, transitions of care and discharge planning.

Documentation

The Comprehensive Care: Partnerships in Care and Communication resources include the *Comprehensive Care Documentation Framework and Guide* and *Comprehensive Care Clinical Documents and Forms*. These resources detail both required and recommended documentation of clinical care.

The investigation included a random file audit to inform understanding of the application of comprehensive care in line with statewide guidelines and best practice care. On balance the file audit demonstrated adherence with the comprehensive care documentation framework. There was evidence of comprehensive assessment, risk assessment and risk management, care planning, discharge planning and engagement with families through these processes. As is often identified via file audits and clinical reviews there are always opportunities for improvement in documentation standards.

The file audit highlighted the issue raised in the investigation regarding multiple transitions of care across CYMHS clinicians and teams increasing the risk of fragmented care and lack of clarity regarding clinical governance and decision making. This was particularly noted for consumers receiving care for an eating disorder, with fragmented care between paediatrics and mental health, including extended paediatric admissions/out-patient care, delays in transfer to mental health and language in clinical notes that did not reflect collaborative care between the services.

Risk assessment and management practices

Risk assessment and management processes in mental health care in Queensland are informed by the *Zero Suicide in Healthcare framework* and the *Assessment of Violence Risk framework*. Local procedures and statewide guidelines support the operationalisation of both frameworks within clinical practice, including access to, and requirements to complete training on risk assessment and risk management, including specific training on the suicide prevention pathway.

Options to support the small cohort of consumers who present with complex and high-risk needs were discussed during the investigation. It is understood that GC MHSS have a robust clinical escalation pathway to review complex care matters as a whole of service approach. Further CYMHS leadership reported that they recently established a CYMHS Reflective Practice forum with the intent for this to be held fortnightly to support complex and complicated presentations, or situations where there exists team impasse, team burnout or barriers to transition or discharge that are not able to be resolved at a local team level. The link between these two forums and clarity regarding escalation pathways has been raised earlier as a consideration for GC MHSS clinical leadership.

A common challenge services face post clinical incident is an increase in risk aversion that impacts informed clinical decision making. Risk aversion can occur at an individual clinician level, within a treating team or at a broader service level. It can lead to the implementation of additional processes outside standard risk management and governance in attempt to control and increase visibility, which in turn can further contribute to risk averse clinical practice. The process of returning to baseline post clinical incident requires the support and confidence of leadership. It is suggested that enhancing awareness and use of the complex care review process by CYMHS provides a mechanism of providing

support and confidence for staff and leadership, whilst ensuring robust review processes for complex care matters.

Management of risk is inextricably linked with the clinical processes of information sharing, consumer and family engagement in care planning, including discharge planning, completion of care plans, discharge plans (transfers of care), recovery plans and crisis intervention plans including Acute Management Plans and Police Advice and Intervention Plans. Alignment with Queensland's comprehensive care framework supports these clinical processes.

Service outcomes and quality and safety

Clinical Incident data and processes

Data

In the context of concerns regarding outlier (adult) admissions to child and youth inpatient settings incident and code black data for this consumer cohort was considered in further detail.

Between 1 January 2021 and 30 November 2025 there were 455 incidents for consumers aged 25 to 68 years in Acacia, including the PICU. Incidents related to behavioural concerns account for 65% of incidents in Acacia and 71% in the PICU.[7] Noting the aforementioned impacts on young vulnerable people exposed to older adults, the additional impact of exposure to behavioural incidents is acknowledged.

In considering incident data in the CYMHS inpatient setting, incidents recorded as 'personal or facility threat' resulting in a PSO presence were considered further. An identified theme included the use of PSO in supporting consumer medication administration and NGT feeding. Several incidents related to NGT procedures, where it appears that PSO presence was requested for "routine" NGT procedures prior to consumer engagement. It is assumed this was to enable a prompt response should the consumer decline or become dysregulated in the context of the administration of medication and/or NGT procedure. In other instances, it appeared that there was planned PSO involvement from the outset with restraint of the patient for the NGT procedure. Considering the trauma histories of many young people in mental health care, including those with eating disorders, the use of PSOs in the delivery of medical and mental health care can be triggering and have adverse impacts for ongoing engagement and recovery. When considering the most appropriate eating disorder model for GC HHS it would be beneficial to consider the optimal location and process for NGT procedures and consider the use of PSO in clinical service delivery.

Incident management and review

In Queensland incident review processes are guided both by legislation, policy, and statewide best practice guidelines. Queensland Health does not mandate or prescribe the type of analysis to be conducted for a clinical incident (inclusive of reportable events as defined in the *Hospital and Health Boards Regulation 2023*), however provides recommended approaches to clinical incident reviews with statewide endorsed methodologies and templates. HHSs should have established documented local process to conduct clinical incidents that include the incident/s that will be subject to analysis, the method of analysis and the roles and responsibilities for those involved with the incident analysis process. Certain reviews processes are informed by legislation, including root cause analyses (RCA).

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[7] Acacia Adult Clinical Incidents - Date range – 1 January 2021 – 30 November 2025 provided by Gold Coast HHS

The HHBA informs what an RCA includes and does not include, requirements for appointments to RCA team, including that it does not include individuals who were directly involved in providing the relevant health service, RCA report requirements and guiding principles. GC HHS local procedure documents for the management of incidents, including incident reporting and review process demonstrated comprehensive processes and governance that aligned with statewide guidelines. Local procedures include guidance on working with consumers, carers, families, and detail and support open disclosure processes.

Review after suicide is a difficult task with the aim being to facilitate both a process of learning and healing. GC MHSS had a reputation of doing this well involving both staff and families. Feedback received from families suggested that procedures may not reflect actual practice with concerns regarding the robustness and objectivity of incident review processes raised. Via this feedback process we were provided with one RCA. It appeared that the service may have moved away from previous methodology as the review report was extremely lengthy with seemingly unprocessed file notes in a timeline and not involving staff or family (whilst recognising the approach chosen was an RCA limiting the capacity for engagement).

RCAs are an outdated methodology to review community suicide. The reasons why people take their own life are often complex and multifaceted. A linear methodology is not fit for purpose. Further, not involving people who knew the person, including family and practitioners limits the opportunity for learning and healing.

Incident review processes should be trauma-informed and aligned with a quality and safety learning culture that maintains the consumer experience at the centre, recognises the important role of family, and considers the impact of these processes on the consumer and their loved ones. The investigation team encourages mental health leaders to consider whether their process for reviewing suicide still promotes learning and healing.

Post incident processes

An identified area for improvement is post incident support for both families and staff. The support offered during care by the LEPW was praised by one family, however the loss of this support post clinical incident was raised as a flaw in the system. It was acknowledged by both staff and families that there is a need for a better process for holding and supporting families after a clinical incident event. This support needs to be tailored to CYMHS, recognising there are differences in an event involving a child.

From a staff perspective the process also needs to recognise the care continuum and that different teams have different contact with families across time and all can be impacted by an event involving a child, inclusive of clinical and non-clinical staff.

Post incident processes should also consider steps to minimise risk of contagion effects. This could include the application of the Circles of Vulnerability model[8] to support a clear process for identification and follow-up with young people at increased risk.

Complaint management

It is understood that the complaints management process across GC HHS is the same for all service areas. Feedback from the unit who manages these processes included a positive culture of continuous

[8] Circles of Vulnerability model is adapted from Rosenfeld, L.B., Caye, J., Ayalon O., Lahad, M. (2005) When their World Falls Apart: Helping Families and Children Manage the Effects of Disasters. Washington DC: NASW Press.pp32-36 & 357-358. It is a model to identify those who may be potentially more vulnerable to suicide contagion than others. This model advocates screening those who were in geographical or psychosocial proximity to the event and also a third general population, those already considered at risk of engaging in suicidal behaviour prior to the event occurring.

improvement in response to complaints at the GC HHS, and that MHS were comparatively good at following up directly with families and supporting engagement and resolution of complaints.

Complaint management appears to be informed by comprehensive processes and governance with complaints managed in accordance with a complaint severity assessment. Consumer complaints and compliments are reported through the RiskMan system and directed to the appropriate service line to manage. Staff are encouraged to resolve negligible, minor and some moderate complaints received at the front line to the greatest extent practicable, with all complaints and compliments required to be recorded via the RiskMan system.

However, without a culture of psychological safety there is a risk of underreporting of complaints. Concerns regarding psychological safety, particularly in the wake of recent events, raises the importance of strengthening psychological safety within the workforce and continuing to support a positive reporting culture.

There is also a need to consider complaint management in the context of clinical escalation pathways for consumers who present with complex care and high-risk needs. Whilst there may be separate escalation processes for complaint management and complex care management, from a consumer and family/carer perspective there is one system with these processes inextricably linked. This highlights the importance of strong governance and oversight for complex care matters across GC MHSS and the importance of a family systems approach in CYMHS for both processes.

The Inspectors were advised of new strategies to support responses to complaints including an Ethical Standards Unit (ESU) established in 2024 that has been fully resourced since March 2025, with complaints regarding misconduct directed straight to ESU, changes to the management of Office of the Health Ombudsman (OHO) complaints which now ensure visibility at an executive level, and the ongoing process of internal audit regarding complaints management.

Partnerships and Integration

Gold Coast HHS

Internal CYMHS integration is a work in progress given the rapid growth and addition of the older age group. GC CYMHS needs to be strongly commended for taking on this challenge and they are making significant headway.

Key areas for focus for CYMHS as they continue on this journey include interface and integration with H2HK-Q, with model inconsistencies noted in feedback and opportunities to strengthen transitions of care and care management or shared care models across all program areas.

Throughout this report the pivotal role of LEPW has been raised. Currently there appears to be a mixed model of operational and professional governance for the workforce. Further concerns have been raised regarding how well LEPW has been embedded into standard care, including concerns regarding lack of structure for workforce, and lack of understanding between clinicians and LEPW regarding roles and boundaries. Whilst the establishment of the Director Person-Centred Care is a key step towards supporting integration and partnerships with LEPW, a comprehensive change management plan that brings all staff and stakeholders along in the embedding of these roles in standard care is required.

Additional considerations for improving partnerships with LEPW include mandatory training and orientation processes, models of care, process (service delivery and governance/escalation) and policy review to ensure clarity of LEPW role. It is suggested that change options could even extend to infrastructure requirements that enables LEPW presence in wards and space for LEPW and families.

Training considerations relate both to staff in understanding the scope and value of LEPW roles and how to work with LEPW, and training for LEPW to ensure that they can deliver their roles in line with role description. This includes relevant training to be able to access inpatient units and engage with consumer in line with role functions.

Primary care/private practitioners

The investigation did not include engagement with primary care services and/or private practitioners and is limited in being able to comment on interface between these services and GC CYMHS. Whilst the importance of partnerships to support referral pathways was noted, gaps in referral options within the broader MHS system were raised as were opportunities for shared care arrangements across public and private systems.

Education and child protection

Historical challenges in the relationship between the Department of Education and the Department of Child Safety were reported. Significant work is reported to have occurred to build and maintain positive working relationships. This has included the establishment of clear processes, governance and regular interface meetings to support working relationships and best outcomes for young people and their families. It is suggested that there are ongoing opportunities to build partnerships and support engagement including increased outreach into schools and increased stakeholder engagement in assessment, treatment and care planning processes

NGOs and community partners

As noted above regarding primary care and private practitioners there are opportunities to improve partnerships with community providers. This is not considered unique to GC MHSS.

A positive partnership that was reported with possible opportunities for expansion was the CYMHS headspace in-reach team and headspace. It was reported that this partnership has improved flow, consultation and shared assessments and care processes, and strengthened referral processes between the services.

Whilst reported as a positive initiative the teams also reported opportunities to continue to strengthen the interface with greater integrity to stepped care models and working towards more seamless transitions of care. An option to improve transfers of care links back to prior comments regarding entry point to CYMHS via Access and ED. For example, it was reported that if a young person is experiencing a deterioration in mental state and requires tertiary care input referral is via ED or Access. Further, which service is leading care impacts a young person's access to services offered e.g., peer support and group programs offered by headspace are not accessible by young people engaged with the CYMHS EPS and case management is not provided by headspace.

Recommendations

The Inspectors identified 11 priority recommendations to address immediate issues and support service system development and strengthen GC CYMHS. These recommendations are provided in order of priority; however, it is recognised that there are dependencies across recommendations that will inform implementation considerations.

1. **Workforce development/Family engagement**

Our impression is that the service needs to rebalance the orientation from a primary focus on the young person to more of a family orientation. The CYMHS tends to see the most complex of presentations and it seems difficult for young people to navigate these challenges without family or social network involvement. One suggestion would be to try to prioritise seeing the family at the first face to face

appointment and then see the young person on their own after this. Although there will always be exceptions to this it seems it will be necessary to have a focus on this to get more family involvement which was seen as a relative weakness.

1a) Revise Child and Youth Mental Health Service models of care and procedures to support the prioritisation of family engagement at the first face to face appointment and to continue throughout care, leveraging the expertise, strengths and resources of the family to support recovery.

In many CYMHS clinicians can have a lack of confidence or experience in working with family groups or networks. It seemed that a general strengthening of skills when engaging with families and an increased focus on family therapy skill development may be required. It was noted that the service recently established an advanced practice systemic family practitioner who will take a lead in service development in this area. Ensuring a clear workplan and the required resources to meet the required skill development at a whole of CYMHS service level will be important.

1b) Ensure skill development and supervision program led by advanced practice systemic family practitioner is supported by a clear workplan. This plan should identify resources and professional development program required to ensure strengthening of skills in family engagement across the whole of Child and Youth Mental Health Services.

The role of the LEPW is considered an essential component to support family engagement, communication and education. Workforce development strategies should also consider opportunities to increase the workforce, improve working relationships between LEPW and clinical staff through education and inclusion of workforce deliverables in models of care, and ensure role clarity, responsibilities and expectations to actively support family and carer engagement, including improving communication between services and families, providing relational and navigational support and delivering education that demystifies mental health systems and recovery pathways.

1c) Review of Lived Experience Peer Workforce structure considers role of Lived Experience Peer Workforce in family engagement, communication and education.

2. Eating disorders

Across Australia there are essentially three approaches to eating disorder treatment programs including, paediatric led specialist approach, partnership between psychiatry and paediatrics and psychiatry led approach. It was the impression of this team that in the Gold Coast the community is likely to view the leadership in this space to be hospital/paediatric led.

This model appears similar to the Royal Children's Hospital in Melbourne and the model appears to provide local CYMHS little capacity to manage eating disorders in the community with several risks in the current approach identified.

Advantages of a psychiatric led model are a higher chance for early intervention and continuity of care. However, there would be major structural change and resourcing needed for this to occur at the Gold Coast. The GC HHS needs to be clear which model is operating to avoid conflict and role confusion.

2) The Gold Coast Hospital and Health Service Chief Executive to undertake a process to consider the pros and cons of the treatment approaches and decide as to whether the Gold Coast Hospital and Health Service model of care for young people with an eating disorder is to be led and governed by paediatrics or psychiatry. This decision will need to then inform a process of service system alignment and model of care review.

A first step could be for the Gold Coast Mental Health Service leadership to visit examples of psychiatry led approaches across Australia including intensive home based and early intervention models to try and avoid hospitalisation.

3. Partnerships and integration

Gold Coast CYMHS is a relatively large service which has grown rapidly in recent years. It is attempting to develop an integrated 0 to 25 model in line with Commonwealth initiatives and some other states. Advantages of this approach include increased potential for more meaningful family engagement and taking a more developmental perspective with young adults. The Headspace integration funding is also seen as an excellent example of partnership with the NGO sector. We feel there is still more work to be done by the CYMHS leadership to build integration within the service. One example of this would be a need to free up the CYMHS Medical and Service Directors to meet with each team regularly to share knowledge and drive integration between service areas.

3) Redesign the leadership structure and internal Child and Youth Mental Health Service governance and meeting structure to ensure alignment with the Child and Youth Mental Health Services operational plan to integrate the 0-25 model and enable integration and strong partnerships within Gold Coast Mental Health Specialist Services broadly, across Gold Coast Child and Youth Mental Health Service and with external stakeholders.

4. Lived experience workforce

Embedding lived experience into clinical teams can be challenging and GC CYMHS are relatively early on this journey. Enablers include the prioritisation of recruitment to the Director of Person-centred care and facilitating stability within the LEPW leadership positions (AO6 Team Leader), and/or the establishment of an educator position for LEPW. Other possible mechanisms for embedding lived experience include developing clinical approaches like Open Dialogue which flattens hierarchies and values different perspectives and strengthening the use of the wisdom of lived experience to help engage families and provide practical advice and support in partnership with clinicians.

Future consideration of the advantages and disadvantages of an identified Lived Experience role also leading First Nations and multicultural workforce. Merging these responsibilities may unintentionally reinforce tokenism, ostracism and the assumption that Lived Experience leadership can “stand in” for cultural leadership and may undermine the principles of cultural governance.

4a) Post recruitment of the Director of Person-centred care, modify the structure and interface of the Lived Experience Peer Workforce to align with the above enablers and Lived Experience Peer Workforce considerations and opportunities raised within the report, including Recommendation 1c.

4b) Examine therapeutic models to embed into the model of care that will facilitate improved family and carer engagement and empower young people and their supports in their recovery journey, such as open dialogue.

5. Clinical practice and safety

Clear escalation pathways support confidence and strengthen CYMHS governance and ensure delivery of evidence informed care and risk management responses. It is understood that there is a clear escalation procedure within GC MHSS for complex care matters and that CYMHS has been establishing a reflective practice care review forum. Consideration of how the CYMHS reflective practice forum fits within in the broader service system governance and complex care pathways is required. As is increased awareness to support access to both pathways. Further the CYMHS forum should ensure a multidisciplinary panel, including LEPW, with family input expected either directly or via questionnaire, with a mechanism for feedback to the young person and family.

5) Clarify the governance and escalation processes for the Review of Child and Youth Mental Health Service Reflective Practice Forum within the broader Gold Coast Mental Health Specialist Services governance and ensure processes consider multidisciplinary team, including Lived Experience Peer Workforce engagement and family input with clear feedback mechanism.

6. Clinical governance

In the highest functioning CYMHS clinicians are empowered to make decisions with families which leads to greater collaboration and safety. It is noted on the Access team all decisions about individual referrals have to be brought to a psychiatrist and there is a different one rostered every day. If possible, it would seem more sensible to have one psychiatrist on the Access team who was consulted in a timely way about tricky decisions which would lead to greater consistency and collaboration with referrers by the access clinicians. In most cases the access clinicians could be empowered to make collaborative decisions with families. Empowering a clinician to make collaborative decisions with families is another pathway to facilitating family engagement from the outset of care.

6) Review of staff resourcing and processes for Access to support timely and consistent decision making whilst also enabling clinicians to be empowered to make decisions with families regarding referrals pathways and access to care.

In reviewing Access processes related to psychiatry led clinical governance, consideration could be given to these processes more broadly across Child and Youth Mental Health Service programs.

7. Patient rights

Provision of mental health care should occur in the least restrictive manner possible and in partnership with consumers and their family, carers and support persons. Restrictive practices should occur only as a last resort option and in compliance with legislation and policy. Ensuring consumers, family, carers and supports persons are aware of patients' rights, avenues for support and escalation pathways is essential to the delivery of health care. In CYMHS this can be strengthened via the increased engagement of Independent Patient Rights Advisers for all consumers under the *Mental Health Act 2016*, embedded

LEPW (consumer and family/carer) across all CYMHS inpatient and community teams and ensuring awareness for all of the access and processes for Ryan's Rule.

7a) Ensure all Authorised Mental Health Service staff maintain recency of training and practice regarding the *Mental Health Act 2016*, patient rights, including access to second opinions and engaging Lived Experience Peer Workforce (role and processes).

7b) Ensure all Authorised Mental Health Service staff are aware that Ryan's Rule applies to all patients admitted to any Queensland Health public hospital, including the emergency department, and are aware of processes to support families.

8. Incident management and post-incident support

Queensland Health does not mandate or prescribe the type of analysis to be conducted for a clinical incident, though provides recommended approaches and associated guiding documents and resources. It is suggested that greater guidance and even direction needs to be provided for the approach to reviews of community suicide. This includes that RCAs are not an appropriate methodology to support learning and healing.

8a) The Office of the Chief Psychiatrist consider the concerns raised in this report regarding root cause analysis, which could include a review of root cause analysis practices and provide guidance on best practice methodologies for the review of community suicides.

A comprehensive post-incident system response that considers support needs across all levels is required. This is inclusive of family and staff (micro level), social networks and teams (meso level) and community (macro level). The review identified the need for further work particularly at the micro level to support staff and families. The importance of psychosocial safety and staff well-being was raised with a particular focus on post-incident responses, as well as the need to improve support for families and family engagements across the continuum of care, including access to CYMHS specific post-incident support process.

8b) Revise post-incident processes for staff noting the importance of both timing and type of support to meet individual needs across all staffing groups.

8c) Establish a post-incident support process for consumers, families and carers that stands up immediately post incident and provides ongoing support for up to six months.

9. Crisis Responses

Positive feedback was received regarding the establishment of a CSU that provides for LEPW led crisis support. A gap in services for young people in crisis was reported with suggestion to explore lowering the age limit for the current model and/or establishment of CYMHS CSU that would also support a family/carer, social network response. Alternate options for consideration included a CYMHS drop-in

centre, during business hours to relieve ED pressure.

Further it is suggested that the service should determine the minimum expertise on child and youth mental health assessment for mental health clinicians working after-hours in the ED. These clinicians should have access to regular professional development and supervision on child and youth issues.

9) Gold Coast Mental Health Specialist Services should consider options to expand access to child and youth and family crisis support, including ensuring training and professional development programs on child and youth mental health is part of non-Child and Youth Mental Health Service clinicians role requirements when working in the emergency department after hours.

10. Consumer, family and carer engagement

The importance of transparent and easily accessible pathways for consumers, families and carers to provide feedback to services is essential to supporting person-centred care, positive care outcomes, and trust in the mental health system. Further lived experience voice is vital to driving and informing service system reform. Whilst recognising that GC HHS has an established mechanism to support feedback processes, which should be publicised and encouraged, it is suggested that there could be an additional process established for a period of time to enable direct feedback to support lived experience voice for CYMHS consumers, families and carers.

It is suggested that this process should be led by LEPW leadership, perhaps the yet to be established Director of Person-Centred care. The service could also consider the benefits of the process occurring in partnership with a party external to GC HHS, such as with the OCP. Ongoing support for family engagement could also occur via the re-establishment of the Family Advisory Council.

10a) Ensure consumer, family and carer awareness of current feedback mechanisms, whilst exploring the option for a time-limited enhanced process led by Lived Experience Peer Workforce.

10b) Re-establish the Family Advisory Council.

11. Statewide learnings

11) Gold Coast Authorised Mental Health Service could be supported by the Office of the Chief Psychiatrist to consider these recommendations, including considering statewide learning opportunities.

Additional considerations

Throughout the report the Inspectors have identified opportunities and additional considerations to support the strengthening of GC CYMHS. In implementing the report recommendations, the following opportunities should be considered and inform ongoing service development. Key considerations highlighted in the report are summarised below for ease of reference.

Table 2. *Summary of additional considerations and opportunities*

Report section	Considerations
Models of service	Consideration for how early intervention and therapeutic intervention fits within the GC CYMHS model of service and the broader MHS system on the Gold Coast. Including strengthening links with other agencies to assist in transitioning between stepped care levels aligned with individual care needs.
	Consideration of structure and integration of speciality services and their role and function with the continuum of care.
Governance	Ensure that there is both First Nations and Lived Experience Peer Workforce representation.
Family engagement	Opportunities to strengthen family engagement include flexibility in service delivery, both how and where, that recognises the complexity of the family unit and family needs i.e. transport limitations, parental work schedules, sibling engagement, variability in communication methods and that clinic spaces are not ideal or conducive to everyone
Acute care and crisis response	Consideration of the functions of Access including opportunities for brief intervention and outreach to aid in formulation and risk assessment.
	Service should determine the minimum expertise on child and youth mental health assessment for mental health clinicians working after-hours in the ED.
	Consideration could be given to expanding the age range or considering the establishment of a CSU for young people and families in crisis as an alternative to ED.
Community care	Consideration of how the specialty teams are embedded within the CYMHS model to maximise skill development across staff, minimise transitions of care and improve efficiency, consistency, and equity of access. This could include a care management model with consistent primary clinician and/or peer navigator model with a consistent LEPW who remains alongside the young person throughout their care journey.
	Opportunity for models of care to enable improved access through flexibility of service delivery, including increased outreach into community (home and schools), use of technology (with clear processes and safeguards) and drop-in clinic options to meet young people and their families where they are at both within their recovery journey and practically within the community to address barriers in accessing clinic-

	based services.
Inpatient	Separate adult PICU under the governance of adult MHS is required.
	Update to the procedure documents for admission to a mental health inpatient unit and PICU management including a separate section under outlier management for over 25-year-old consumers admitted to Acacia.
	Consistent access to LEPW. This could be supported by access to a dedicated space (family room) and LEPW staff member, improved orientation to unit, including ensuring awareness of processes (communication, escalation and care), rights and responsibilities (including Act processes), expectations (standardised processes around treatment to ensure consistency of care and predictability) and who is providing care (meeting treating team).
Step-up/Step-down	Service development opportunity in considering equitable access opportunities to youth step-up/step-down (SUSD) programs for young people (up to 25 years of age) and their families when transitioning from inpatient care.
Staff profile	Key areas for consideration regarding staffing include, dedicated consultant for the Access team, significant FTE uplift across disciplines in the community CYMHS Youth EDSS, increase access to allied health, particularly in inpatient settings, increased FTE and staffing profile aligned with Acacia (including PICU) model of care, and significant FTE uplift of LEPW to ensure access throughout care (admission to discharge/transfer of care) across all services/programs inpatient and community.
Skill mix	Opportunities to scaffold early career clinicians and new leaders. This could include considering senior clinicians holding a portfolio in an area of expertise that provide consultation liaison services and professional development opportunities across the full workforce.
Family therapy	Opportunities for portfolio positions that lead and supervise and remain embedded within core teams across the service as an alternate way to support professional development.
Supervision and Professional development	A review and update of the orientation manual noting out of date information and need to align with current work structure and clinical priorities.
	Translation of learnings from the 2025 program to support a sustainable and beneficial 2026 program for GC MHSS, including ensuring it meets the needs of the CYMHS workforce and supports cross team skill development to reduce fragmentation in care.
Policies and Procedures	Review of local procedures to reduce duplication of statewide policy content via inclusion of correct links to statewide polices as opposed to duplication of content to ensure a single source of truth and consistent application of the legislation and associated policies. Review of documents should also ensure that all documents align with the current comprehensive care documentation requirements and current

	clinical form terminology.
Comprehensive care	Opportunities for improvement in the application of comprehensive care guidelines including formulation driven care, individualised approach to care, family and carer engagement, information sharing and consent processes, transitions of care and discharge planning.
Clinical incident	When considering the most appropriate eating disorder model for GC HHS it would be beneficial to consider the optimal location and process for NGT procedures and consider the use of PSO in clinical service delivery.
	Mental health leaders consider whether the process for reviewing suicide still promotes learning and healing.
Complaint management	Importance of strengthening psychological safety within the workforce and continuing to support a positive reporting culture.
	Consideration of complaint management in the context of clinical escalation pathways for consumers who present with complex care and high-risk needs.

SIGNED_________________

Dr Paul Denborough

Director, Infant Child, Youth & headspace Alfred Health

Date 06/03/2026

SIGNED_________________

Ms Rachel Phillips

Acting Executive Director of Mental Health, Darling Downs Hospital and Health Service

Date 06/03/2026

SIGNED_________________

Ms Emma Hart

Nursing Director, CYMHS, Children's Health Queensland

Date 06/03/2026

SIGNED_________________

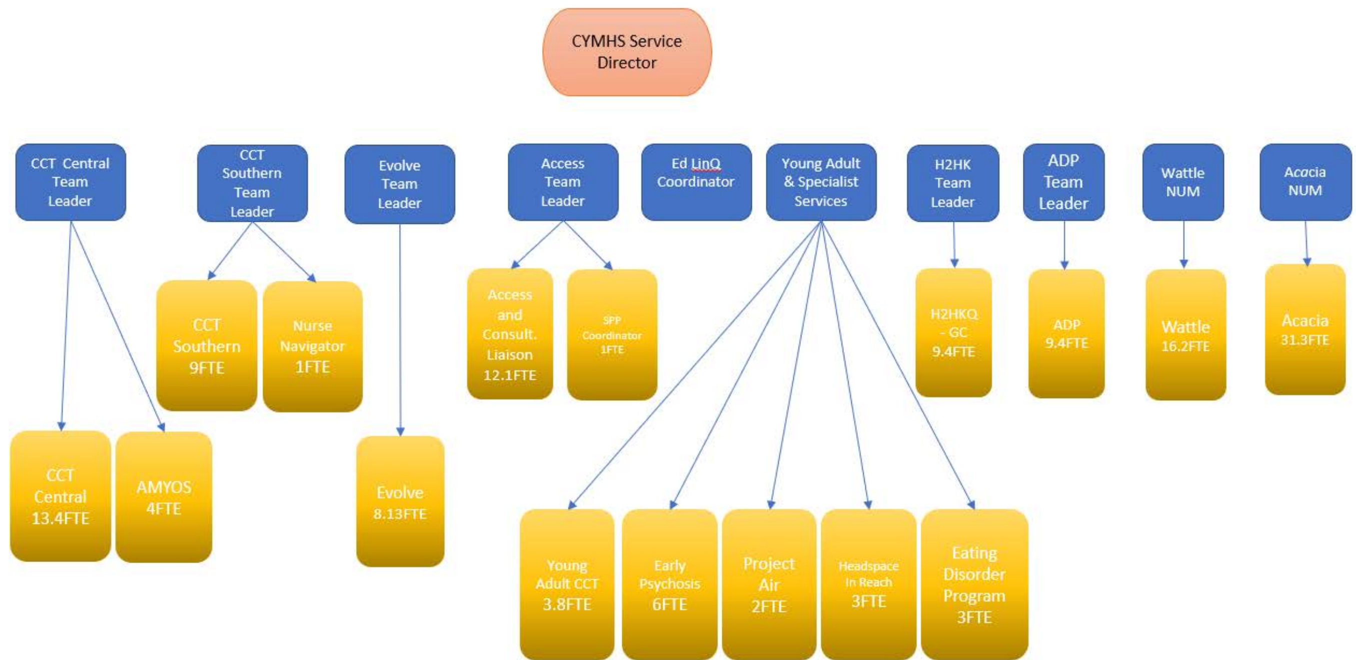
Ms Yasmin Grono

Director of Lived Experience, CYMHS and Chair, Queensland Health Lived Experience (Peer) Workforce Leadership Group

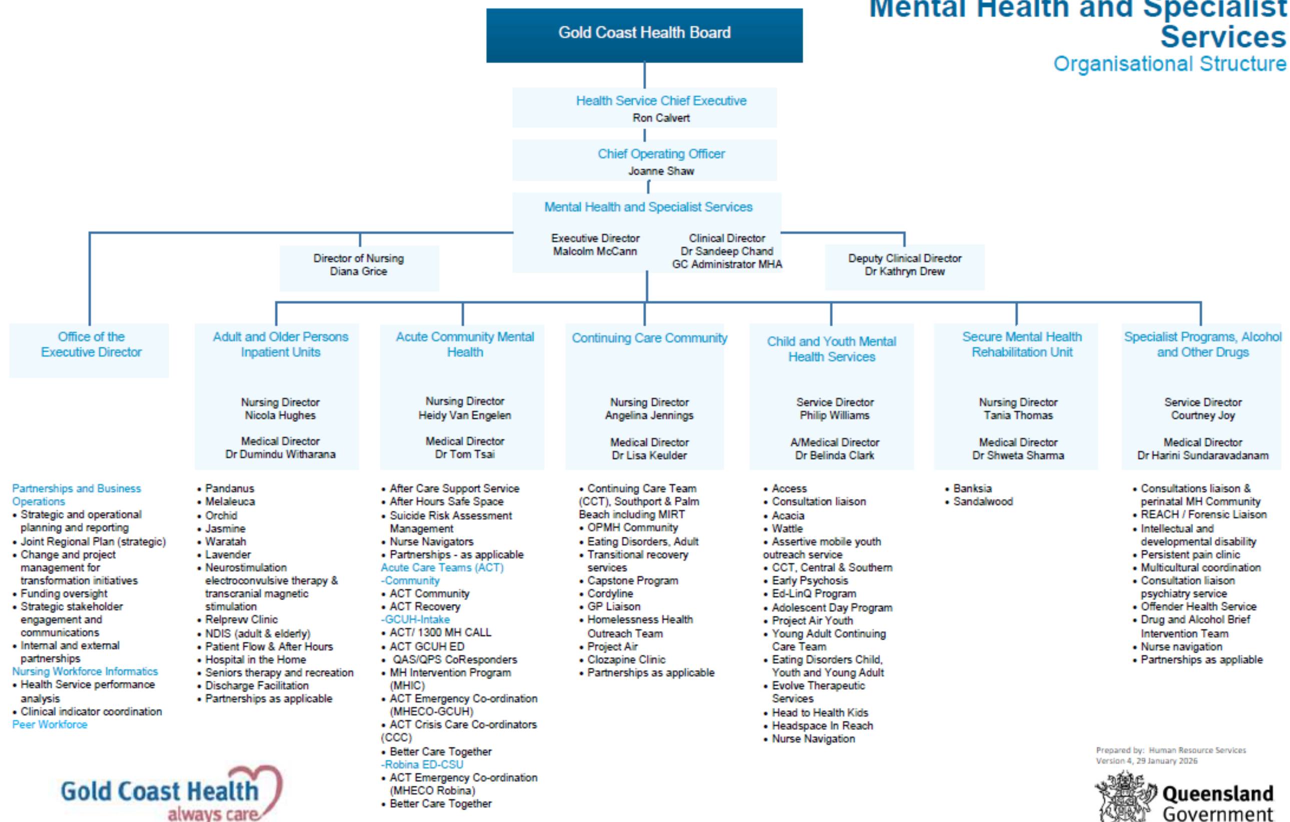
Date 10/03/2026

Appendices

Appendix 1 *Gold Coast Child and Youth Mental Health Service Organisational Chart*



Appendix 2 *Gold Coast Mental Health Specialist Services Organisational Chart*



Abbreviations

AMHS	Authorised Mental Health Service
AMYOS	Assertive Mobile Outreach Service
CCT	Continuing Care Team
CSU	Crisis Stabilisation Unit
CYMHS	Child and Youth Mental Health Service
ED	Emergency Department
EPS	Early Psychosis Service
ESU	Ethical Standards Unit
GC	Gold Coast
ETS	Evolve Therapeutic Service
FTE	Full-time equivalent
GC MHSS	Gold Coast Mental Health Specialist Service
H2HK-Q	Head to Health Kids Queensland
HHBA	*Hospital and Health Boards Act 2011*
HHS	Hospital and Health Service
LEPW	Lived Experience Peer Workforce
MHA	*Mental Health Act 2016*
MDT	multidisciplinary team
MHAOD	mental health alcohol and other drug
NGO	Non-government organisation
NGT	Nasal-gastric tube
OCP	Office of the Chief Psychiatrist
OHO	Office of the Health Ombudsman
PICU	Psychiatric Intensive Care Unit
PSO	protective services officer
RCA	Root cause analysis
SUSD	Step-up/Step-down
YADP	Yangah Adolescent Day Program
Youth EDS	Youth Eating Disorder Specialist Service