249.	Records for 249.1. CIMHA records 249.2. General records	Various	Hospital and Health Service	Hospital and Health Service	30
Further documents from West Moreton Hospital and Health Service					
250.	Letter from Sharon Kelly, Executive Director Mental Health and Specialised Services, to Kristi Geddes, Minter Ellison re Health Service Investigation – Barrett Adolescent Centre	19.09.2014	Sharon Kelly, Executive Director Mental Health and Specialised Services	West Moreton Hospital and Health Service	31
251.	Case Coordinator's Role for Barrett Adolescent Centre	Unknown	Barrett Adolescent Centre	West Moreton Hospital and Health Service	31
252.	West Moreton Hospital and Health Service Mental Health and Specialised Services, The Park – Centre for Mental Health, Care Planning Package – Tool Kit (Adult Services)	August 2013	West Moreton Hospital and Health Services	West Moreton Hospital and Health Service	31
253.	The Park Centre for Mental Health – Individual Care Plan Checklist: Adolescent	April 2010	West Moreton Hospital and Health Services	West Moreton Hospital and Health Service	31
254.	Extract from titled The Barrett Adolescent Centre – Information for Teenagers	08.09.2006	West Moreton Hospital and Health Services	West Moreton Hospital and Health Service	31
255.	Extract from document titled The Barrett Adolescent Centre	08.09.2006	West Moreton	West Moreton	31

	– Information for Parents and Carers		Hospital and Health Services	Hospital and Health Service	
256.	Untitled document summarising purpose and requirements of the Consumer Integrated Mental Health Application (CIMHA)	Undated	Unknown	West Moreton Hospital and Health Service	31
257.	Queensland Health Procedure – Inter-district Transfer of Mental Health Consumers within Southern Queensland Health Service Districts, Division of Mental Health, Darling Downs – West Moreton Health Service District	08.11.2010	Darling Downs – West Moreton Health Service District	West Moreton Hospital and Health Service	31
258.	West Moreton Hospital and Health Service Procedure, Mental Health Divisional – Inter Hospital and Health Service Transition of Care of Mental Health Consumers from one Hospital and Health Service to another	13.05.2014	West Moreton Hospital and Health Service	West Moreton Hospital and Health Service	31
259.	~~Further extract from document titled The Barrett Adolescent~~ Centre – Information for Parents and Carers	~~08.09.2006~~	~~West Moreton~~ Hospital and Health Services	~~West Moreton~~ Hospital and Health Service	31
260.	Role description for Nurse Unit Manager, Barrett Adolescent Unit, The Park Centre for Mental Health	October 2012	West Moreton Hospital and Health Services	West Moreton Hospital and Health Service	31
261.	Role description for Clinical Nurse Consultant, Medium Secure/Dual Diagnosis, The Park – Centre for Mental Health	Undated	West Moreton Hospital and Health Services	West Moreton Hospital and Health Service	31

262.	West Moreton Hospital and Health Service – BAC Staff Communique 1	03.10.2013	West Moreton Hospital and Health Services	West Moreton Hospital and Health Service	31
Further documents from Hospital and Health Service					
263.	Letter from Hospital and Health Service, to Kristi Geddes, Minter Ellison	19.09.2014	Hospital and Health Service	Hospital and Health Service	31
264.	Records held by re	Various		Hospital and Health Service	31
265.	Access Manual	Undated		Hospital and Health Service	31
266.	Pre-referral Guidelines – Health Services	Undated		Hospital and Health Service	31
Documents provided by DSQ Ipswich					
267.	Email from	15.09.2014			31

	Kristi Geddes, Minter Ellison re : Intake Policy and Procedures				
268.	– Needs assessment	November 2011			31
269.	– Eligibility	July 2011			31
Documents provided by					
270.	Letter from to Whom It May Concern re Health Service Investigation – Barrett Adolescent Psychiatric Centre	19.09.2014			31
271.	Records held by re	Various			31
272.	Unapproved version of Clinical Practice Manual	January 2013			31
Other material considered					
273.					

Appendix B – Schedule of Interviews

Monday 13 October 2014		
9:15am	RN Mara Kochardy	Care coordinator for
10:00am	RN Moira Macleod	Care coordinator for
11:00am	RN Brenton Page	Care coordinator for (by phone)
11:45am	RN Matthew Beswick	Care coordinator for Attending with Judy Simpson from QNU
1:00pm	RN Peta-Louise Yorke	Care coordinator for
1:45pm	CN Susan Daniel	Care coordinator for
2:45pm	Dr Anne Brennan	Clinical Director from September 2013 Attending with Harry McCay from Avant
Tuesday 14 October 2014		
9:00am	RN Rosangela Richardson	Care coordinator for
9:45am	RN Victoria Young	Care coordinator for Attending with QNU representative
10:45am	Megan Hayes	OT, active role in transition planning Attending with Lisa Harris from Coors Chambers Westgarth Lawyers (in instruction from WMHHS)
11:45am	Dr Stephen Stathis	Director Children's Health Queensland (Telephone interview)
1:30pm	Dr Trevor Sadler	Clinical Director until September 2013 Attending with David Watt from K&L Gates Lawyers (on instruction from Avant)

Appendix C - Transition Planning Evidence Checklist

Transfer of Care Principles (Qld Health Procedure)*						
Completion and transfer of documentation including:						
MH Act status						
Referral forms (including MHA2000 docs) completed	N/A	✓	✓	N/A	N/A	✓
Transfer of ITO complete	✓	✓	✓	✓	✓	✓
Assessment including forensic History and Risk Assessment and management plan	✓	✓	✓	✓	✓	✓
Outcome Measures	✓	✓	✓	✓	✓	✓
Recovery Plan	✓	✓	✓	✓	✓	✓
End of episode/ Discharge summary	✓	✓	✓	✓	✓	✓
Documents forwarded 3 days prior	✓	✓	✓	✓ at time	✓ at time	✓
Documented appointments	✓	✓	✓	✓	✓	✓
Family/carers notified and/or consulted	✓	✓	✓	✓	✓	✓
Receiving PSP face to face contact within 7 days	N/A	✓	✓	N/A	N/A	✓
Receiving District/mental health service						
Transition planning reflects evidence of:						
Assessment of client future service needs	✓	✓	✓	✓	✓	✓
Direct consumer assessment and consultation	✓	✓	✓	✓	✓	✓
Review of consumer medical charts	✓	✓	✓	✓	✓	✓
Contact with referring agency and local mental health service	✓	✓	✓	✓	✓	✓
Clinical need and Risk taken into account	✓	✓	✓	✓	✓	✓
Length of stay of client was considered	✓	✓	✓	✓	✓	✓
Age of client was considered	✓	✓	✓	✓	✓	✓
Demographics were considered	✓	✓	✓	✓	✓	✓
Family engagement considered/ Contact was made with family	✓	✓	✓	✓	✓	✓
Additional considerations (unrelated to the Policy):						
Funding was sourced to provide comprehensive care						
Additional supports sourced eg: housing and disability supports						

* Reference: *Inter-district Transfer of Mental Health Consumers within South Queensland Health Service Districts* (Version No. 1.0), by the Division of Mental Health, Darling Downs – West Moreton Health Service District.

Appendix D - Client Profiles and Transition Planning Evidence Summary

SKIPPEN, Tania

From: Kristi Geddes [redacted]>
Sent: Friday, 22 August 2014 3:31 PM
To: KOTZE, Beth; SKIPPEN, Tania
Subject: RE: Barrett Adolescent Psychiatric Centre - Health Service Investigation [ME-ME.FID2743997]

Thanks Beth.

The issues have been drawn to my attention today by Tania, as has the limitation in availability for you both over the next couple of weeks, so I've raised it with the Department and am waiting to hear how they propose to proceed.

I will let you both know as soon as I hear.

Kind regards,
Kristi.

Kristi Geddes Senior Associate
[redacted]
Minter Ellison Lawyers Waterfront Place • 1 Eagle Street • Brisbane • QLD 4000
[redacted] www.minterellison.com

From: KOTZE, Beth [redacted]]
Sent: Friday 22 August 2014 03:22 pm
To: Kristi Geddes; SKIPPEN, Tania
Subject: RE: Barrett Adolescent Psychiatric Centre - Health Service Investigation [ME-ME.FID2743997]

Dear Kristi
The original time-table was sketched out as follows:

Week of 11 August
-paper based review
- Identification and scheduled appointments for interviews
Week of 18 August
- Review team in Brisbane for interviews
Week of 25 August
- 28, 29 available for additional interviews if required
Could push out into weekend 30,31 Aug if absolutely necessary.
Week 1 September
-potential for any additional interviews to be completed without Tania this week
Week 8 September
- Beth Kotze to sign off review ahead of leave from 11 September
Week 15 September
- Tania to review the report on her return from and sign off if satisfied.

With the delay in securing the paperwork, we've actually yet to commence with the paper-based review so the time-frames now don't work.

I am wondering if we need to check with John/Bill that the revised time-frames are going to work for their purposes. Have spoken with John and will await his feedback.

Regards
B.

Associate Professor Beth Kotze
MBBS FRANZCP FRACMA Cert Child Psychiatry MMed (Psychotherapy) MHA (UNSW)
Acting Associate Director, Health System Management
Mental Health and Drug and Alcohol Office
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From: Kristi Geddes [
Sent: Friday, 22 August 2014 1:16 PM
To: KOTZE, Beth; SKIPPEN, Tania
Subject: RE: Barrett Adolescent Psychiatric Centre - Health Service Investigation [ME-ME.FID2743997]

Sorry Beth, but unfortunately I'm not available on Wednesdays.

Perhaps if I send through an email on Monday with a proposed plan, for your consideration and comment, and then we can discuss together on Thursday if necessary.

Anticipating that arrangements will need to be made for you to interview staff, could you both let me know your availability over the coming two weeks for interviews and if you will be available to attend in person (where possible) or will need to conduct the interviews via tele/video conference?

Kind regards,
Kristi.

Kristi Geddes Senior Associate
Minter Ellison Lawyers Waterfront Place • 1 Eagle Street • Brisbane • QLD 4000
www.minterellison.com

From: KOTZE, Beth
Sent: Friday 22 August 2014 01:07 pm
To: SKIPPEN, Tania; Kristi Geddes
Subject: RE: Barrett Adolescent Psychiatric Centre - Health Service Investigation [ME-ME.FID2743997]

Dear all
I am on leave Monday and Tuesday but back and available on Wednesday.
9.30 am is possible for me on Wednesday
Beth

Associate Professor Beth Kotze
MBBS FRANZCP FRACMA Cert Child Psychiatry MMed (Psychotherapy) MHA (UNSW)
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From: SKIPPEN, Tania
Sent: Friday, 22 August 2014 1:06 PM
To: 'Kristi Geddes'; KOTZE, Beth
Subject: RE: Barrett Adolescent Psychiatric Centre - Health Service Investigation [ME-ME.FID2743997]

Dear Kristi and Beth,
I will have 10.30-11am, 12.30-1.30pm and 3-3.30pm free on Monday if any of those times suit for the discussion.
Kind regards,
Tania

From: Kristi Geddes [
Sent: Friday, 22 August 2014 12:50 PM
To: SKIPPEN, Tania; KOTZE, Beth
Subject: Barrett Adolescent Psychiatric Centre - Health Service Investigation [ME-ME.FID2743997]

ear Beth and Tania,

Unfortunately, despite much chasing, I am yet to receive any material in relation to this investigation. However, I have been assured that it will start to come through this afternoon.

Anticipating then that we will have some information after today, I was hoping to arrange a time for a teleconference with you both on Monday to discuss where we are at, what we have and what steps we will need to take from here.

I am available anytime from 9:30am. Please let me know your availability and the best contact number for you.

I look forward to hearing from you.

Kind regards,
Kristi.

Kristi Geddes Senior Associate
Minter Ellison Lawyers Waterfront Place • 1 Eagle Street • Brisbane • QLD 4000
www.minterellison.com

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SKIPPEN, Tania

From: Kristi Geddes <
Sent: Thursday, 28 August 2014 9:43 AM
To: KOTZE, Beth
Cc: SKIPPEN, Tania
Subject: RE: Barrett Centre Investigation [ME-ME.FID2743997]

Thanks Beth.

Once we get approval for the investigation to progress according to the new timeframe, we will make arrangements for you to attend our offices here in Brisbane before you go on leave, to start a hard copy review of material.

The volume of printed material is much larger than expected. The material from West Moreton HHS alone has filled 22 level arch folders and we are yet to start printing the material from HHS, though that appears much smaller and likely to be limited to only one or two folders.

I will keep you both updated as I hear further from the Department about where we are going from here.

Kind regards,
Kristi.

Kristi Geddes Senior Associate
Minter Ellison Lawyers Waterfront Place • 1 Eagle Street • Brisbane • QLD 4000
www.minterellison.com

From: KOTZE, Beth [
Sent: Wednesday 27 August 2014 03:49 pm
To: Kristi Geddes
Cc: SKIPPEN, Tania
Subject: RE: Barrett Centre Investigation [ME-ME.FID2743997]
Importance: High

Thanks Kristi
The timeframe may work bearing in mind that we really won't know the volume until we start doing the review and also there is the other component to the ToR re governance and oversight arrangements.
Given the very large volume of material for review I am even wondering about the feasibility of me flying up one day before I go on leave to make a start? Given the very large volume the first task will be eliminating the redundant material from the clinical files and developing time-lines for the patients – its work better suited to hard copy review where you can move back and forth between pages, highlight and cross-reference and take out pages that are not material for a separate file.
The other option would be hard-copy delivery by courier of the first lever arch file and I can get the flavour of the material and how to most efficiently process.
If not possible we'll just have to start as you suggest
Address as per below.
Regards
Beth

Associate Professor Beth Kotze
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From: Kristi Geddes [redacted]
Sent: Wednesday, 27 August 2014 1:33 PM
To: KOTZE, Beth
Subject: Re: Barrett Centre Investigation [ME-ME.FID2743997]

Hi Beth,

Just touching base to confirm the proposed timeframe below would be feasible for you, if approved.

Also, the best postal address for us to forward a copy of the bundle of material (on USBs) to you.

I look forward to hearing from you.

Kind regards,
Kristi.

Kristi Geddes
Senior Associate
Minter Ellison

On 25 Aug 2014, at 2:08 pm, "Kristi Geddes" <[redacted]> wrote:

> Dear Beth and Tania,
>
> We have been asked to submit a timeframe for the proposed extension for this investigation.
>
> As I am unfortunately not available for the first two weeks in November, I have proposed the following:
>
> 1. From now until 26 September 2014 - commence document review (for Beth, that will provide two weeks until planned leave from 11 September 2014 and for Tania, that will provide two weeks from return from leave on 15 September 2014)
> 2. Two weeks from 29 September 2014 - staff interviews and further document review (with Tania to commence in Beth's absence)
> 3. Two weeks from 13 October 2014 - finalise investigations and prepare draft report
> 4. 24 October 2014 - draft report to be submitted to Minter Ellison for review and finalising
> 5. 31 October 2014 - final report to be submitted to Department
>
> Could you please let me know as soon as possible if these timeframes are feasible for you.
>
> I've now received a second bundle of material from the [redacted] Hospital and Health Service. To give you an idea of the volume, we anticipate these together with the material received from West Moreton this morning will fill approximately 12 lever arch folders.
>
> There were 20 current inpatient and day patients during the relevant period and 36 members of staff. I am hoping that following a review of patient records, we can narrow the list of relevant staff to be interviewed.
>
> In addition to confirming the above timeframes as acceptable, could you please both also provide postage addresses for me to forward the material (on USBs) to this week?

I look forward to hearing from you.

Kind regards,
Kristi.

Kristi Geddes Senior Associate
[redacted]
Minter Ellison Lawyers Waterfront Place • 1 Eagle Street • Brisbane • QLD 4000
[redacted] www.minterellison.com

From: Kristi Geddes
Sent: Monday 25 August 2014 11:40 am
To: 'KOTZE, Beth'; SKIPPEN, Tania
Subject: Barrett Centre Investigation [ME-ME.FID2743997]

Dear Beth and Tania,

I have this morning received the first bundle of relevant material, from the West Moreton Hospital and Health Service.

Based on my initial review of that material, I have now prepared the enclosed draft framework for the investigation and report. Until we have had the chance to review patient records in further detail, I have included all relevant staff as potential witnesses, however I am hoping that this list can be shortened after the key care providers have been identified from the charts.

I was advised on Friday afternoon that an extension for the investigation has been foreshadowed, but a decision is yet to be made. I will provide this investigation plan to the Department, together with advice that the 3 weeks we now have remaining for the final report to be prepared is simply not sufficient for the plan to be implemented, particularly in light of the leave arrangements you both have in place for the coming weeks and the fact that further relevant documentation is yet to be received.

I will continue to keep you both updated.

Kind regards,
Kristi.

Kristi Geddes Senior Associate
[redacted]
Minter Ellison Lawyers Waterfront Place • 1 Eagle Street • Brisbane • QLD 4000
[redacted] www.minterellison.com

SKIPPEN, Tania

From: Kristi Geddes
Sent: Tuesday, 23 September 2014 4:19 PM
To: KOTZE, Beth; SKIPPEN, Tania
Subject: RE: Barrett Centre Investigation - interviews [ME-ME.FID2743997]
Attachments: 20140919 -letter to Minter Ellison re SGE KXMM 1084936.pdf; 20140919 - BAC - Attachments.pdf; Barrett - interview schedules.DOCX; Investigation and report framework.DOCX

Dear Tania and Beth,

We have received the **enclosed** response from WMHHS regarding the queries raised below (Tania this is what I had in hard copy for your review). We have also now received responses from all of the receiving agencies for the 6 complex patients under detailed review, some of which are quite large in volume, so they have been printed and included in the hard copy files we have here.

I **enclose** an updated witness schedule. All of the witnesses have now been advised of their scheduled time and advised to contact me as soon as possible if there are any issues. I have noted where we are aware of the support person they are bringing with them.

I also **enclose** an updated framework for investigation/report, which includes the flowcharts of governance and details of the further discussions I had with some key personnel from WMHHS.

Finally, I have had a discussion with Dr Sadler this afternoon regarding his changed interview time and he indicated that he thinks the Barrett Ward Record Book and PRIME incident reports would be relevant for our review. He explained that the ward was quite unsettled following the announcement and there were a number of incidents of self harm among the patients. Having not reviewed the clinical records myself, I just wanted to check whether either of you have come across any such incident reports and, if not, whether you consider these records for the transition period would be relevant for consideration in the report. If you think they will be, I will issue a further specific request to WMHHS for copies.

Kind regards,
Kristi.

Kristi Geddes Senior Associate
Minter Ellison Lawyers Waterfront Place • 1 Eagle Street • Brisbane • QLD 4000
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From: KOTZE, Beth
Sent: Wednesday 10 September 2014 11:34 am
To: Kristi Geddes
Cc: SKIPPEN, Tania
Subject: RE: Barrett Centre Investigation - interviews [ME-ME.FID2743997]

Dear Kristi
I have now touched base with Tania and this is what we've agreed:

1. Tania will use the 2 days when she comes up in September to finalise the review of the clinical files and to write up the clinical summaries that will be required for the report for all the patients in scope. These will be in the nature of brief over-view of each clinical scenario with particular comment on the documented transition plans.
2. In relation to the care coordinators can you please clarify:
    a. A number of the patients have 2 care coordinator names written beside them on the summary sheet – what does this mean? Was there a principal coordinator and a buddy? Or were there 2 care coordinators with clearly delineated roles? Some names have 'associate cc' written beside them – but in other cases there are 2 names and no difference noted.
    b. Is there a written statement of duties for the care coordinators?

   c. Vanessa Clayworth's name isn't against any of the patients as care coordinator – what was the nature of her role? Was it formalised? If so can we please have a copy of the statement of duties?
   d. What is 'business as usual' transition/discharge practice for the service as articulated in formal policies and procedures? If there is a service transition/discharge policy and procedure? Can we please have a copy?
   e. Were there any specific policies/procedures/statement of duties put in place for the transition coordination for these particular patients? If so can we please have a copy?
3. Re the BAC review (?2008) can we please have any excerpt relevant to the topic of transition/discharge planning? Given the very long length of stay of the service one would expect that this would be a major field of activity even during 'business as usual', let alone in preparation for the closure. Did BAC routinely conduct followup of former patients? If so is a summary report available?
4. We will conduct the interviews together – so Tania will come up with me on Monday 13th October. The priorities for the interviews that day are the 2 medical officers (Clinical Director and Acting CD) and the care coordinators for the patients [redacted] Looking through the sheet, it looks like all the patients in question had at least 2 care coordinators and some 3 but the same care coordinators were involved with more than 1 of the patients – by my calculations it looks like there are 8 care coordinators involved with these 5 patients? That would be 10 witnesses. I think we should try for 1 hour each for the medical interviews and 45 minutes for the care coordinators.
5. In relation to the ToR and particularly noting 3.1.4 which refers to the information available to clinicians and is quite specific about the care planning for the pts who have been involved in serious critical incidents, we definitely need to get information from the services to which they were referred. Can we obtain some general information about each one (what does the service provide etc) and if they have intake forms or assessments and initial care plans or equivalent? Tania and I can follow up with telephone calls to verify or clarify anything that we need to – so a key contact name and telephone number for each would be helpful.

In essence we are proposing that:

- the medical interviews and the file review and the information from the receiving services deal with the patient cohort overall (ToR 3.1.2;3.1.3,3.1.4)
- the medical interviews, the care coordinator interviews and the file reviews and the info from the receiving services deal with the specific cases identified as having poor outcome or complex transitions (ToR 3.1.4)

Can you clarify your interpretation of 3.1.2 – it could be read to mean that we would have to interview all the patients and their families to get the other side of the story – ie what did they think their needs were and how well were they met? It could also be limited to, based on the documented care planning and interviews, were the psychobiosocial needs of the patients and families identified comprehensively and comprehensively planned for?

Regards
Beth

Associate Professor Beth Kotze
MBBS FRANZCP FRACMA Cert Child Psychiatry MMed (Psychotherapy) MHA (UNSW)
Acting Associate Director, Health System Management
Mental Health and Drug and Alcohol Office
NSW Ministry of Health
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From: Kristi Geddes [
Sent: Tuesday, 9 September 2014 7:56 AM
To: KOTZE, Beth
Subject: Re: Barrett Centre Investigation - interviews [ME-ME.FID2743997]

Thanks Beth.

I will do my best to group the care coordinators according to patients, however there may be some overlap issues. Would you like to speak with RN Vanessa Clayworth or would you prefer leave that to Tania? Unfortunately, I do not have specific details of the extent of her involvement with any particular patients, I've just been advised that she played a key role in the transition planning and would therefore be someone we need to speak with.

In the interests of time, do you think it would be possible to obtain the information you require from the receiving agencies via information requests instead of interviews? If so, if you are able to provide me with a list of the specific information you require, I can attend to those requests and hopefully have the information for you upon your return from leave.

I look forward to hearing from you.

Kind regards,
Kristi.

Kristi Geddes
Senior Associate
Minter Ellison

On 8 Sep 2014, at 5:23 pm, "KOTZE, Beth" < wrote:

> Thanks Kristi
> If at all possible we need to have the clinicians grouped by patients so that I do all the interviews associated with patient x and Tania does all the interviews associated with patient y.
> If we start with the medical staff and the care coordinators for the 6 patients whose files I reviewed that would be good – there were the and then
> I've had a look at the ToR again and I think it may be difficult to answer 3.1.2 and 3.1.3 in general and 3.1.4 in particular without talking to the agencies that received the referrals because appropriateness goes to the issue of the capacity and capability at the receiving end and the quality of the communication – I am wondering if some of these interviews could be done by telephone if the staff of these agencies are comfortable and willing to cooperate.
> What do you think?
> Beth
>
> **Associate Professor Beth Kotze**
> **MBBS FRANZCP FRACMA Cert Child Psychiatry MMed (Psychotherapy) MHA (UNSW)**
> **Acting Associate Director, Health System Management**
> **Mental Health and Drug and Alcohol Office**
> **NSW Ministry of Health**
> **Direct Dial:**
> **Address:**
> **Email:**
> **Website:** www.health.nsw.gov.au/mhdao
> <image003.png>
>
> **From:** Kristi Geddes
> **Sent:** Monday, 8 September 2014 11:40 AM

To: KOTZE, Beth
Subject: Barrett Centre Investigation - interviews [ME-ME.FID2743997]

Hi Beth,

I hope you had a lovely weekend after your trip up on Friday.

As discussed, I am currently arranging staff interviews for you on Monday, 13 October 2014. You had requested meeting with Dr Brennan, Dr Sadler and then each of the care coordinators for the three deceased patients. In total, that would be 9 witnesses.

I'm allowing an hour for each interview and based on your flight times last Friday, unfortunately that would only leave time for 6. I just wanted to check how you would therefore prefer I prioritise interviews. I have currently prioritised Dr Brennan and Dr Sadler and then at least one care co-ordinator for each patient. That leaves us with one spot left over.

I've been advised by WMHHS that RN Vanessa Clayworth, although not a care coordinator, played an integral role in transition planning.

I just wanted to check if perhaps I fill the last spot for that day with RN Clayworth and/or if you would prefer stay on an extra day and speak with all care coordinators for those complex patients?

Obviously, I will endeavour to instead arrange for Tania to interview the other care coordinators for those patients if you are not able to.

I look forward to hearing from you.

Kind regards,
Kristi.

Kristi Geddes Senior Associate

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MinterEllison LAWYERS

File Note

Author	Kristi Geddes
Matter	Queensland Health Health Service Investigation - Barrett Adolescent Psychiatric Centre 1084936
Date	25 August 2014
Subject	Investigation and report framework

Introduction

1. Background
2. Terms of Reference
3. Methodology
4. Evidence
5. Key Findings

Part A – Governance Model

1. Background

1.1 Timeline of key events

(a) provided by WMHHS

1.2 Summary

(a) Phase 1 (November 2013 to August 2013)

(b) Phase 2 (August 2013 to January 2014)

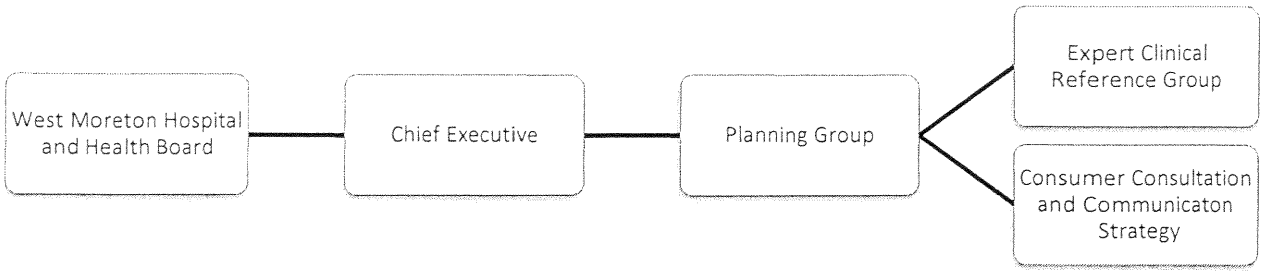
(c) Phase 3 (January 2014 onwards)

2. Summary of governance structures

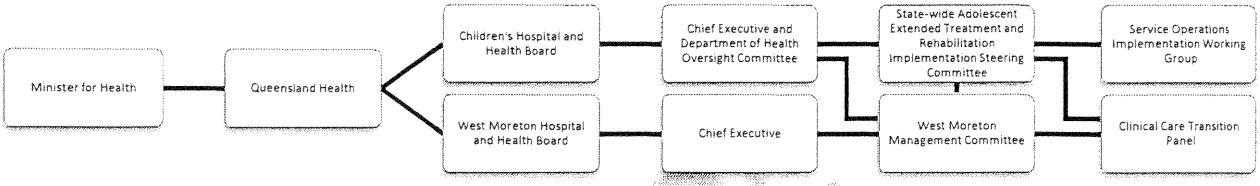
(a) Phase 1 of Barrett Adolescent Strategy

EXHIBIT 117

TSK.900.001.0448



(b) Phase 2 of Barrett Adolescent Strategy



3. Issues to be considered

3.1 Assess the governance model put in place within Queensland Health (including the Department of Health and relevant Hospital and Health Services, including West Moreton, Metro South and Children's Health Queensland and any other relevant Hospital and Health Service) to manage and oversight the healthcare transition plans for the then current inpatients and day patients of the BAC post 6 August 2013 until its closure in January 2014;

3.2 Advise if the governance model was appropriate given the nature and scope of the work required for the successful transition of the then patients to a community based model.

4. Review of relevant documents

(a) Project Plan – 'Barrett Adolescent Strategy' *(provided by WMHHS)*

(b) Minutes, agendas, reports and other papers from Adolescent Strategy Planning Group

(c) Expert Clinical Reference Group Recommendations *(provided by WMHHS)*

(d) Minutes, agendas, reports and other papers from Expert Clinical Reference Group

(e) Minutes, agendas, reports and other papers from Steering Committee *(provided by Children's HHS)*

(f) Minutes, agendas, reports and other papers from Chief Executive and Department of Health Oversight Committee *(provided by Children's HHS)*

(g) West Moreton Management Committee (BAC weekly update) *(provided by WMHHS)*

(h) Minutes, agendas, reports and other papers from Clinical Care Transition Panel *(provided by Children's HHS)*

(i) Minutes, agendas, reports and other papers from West Moreton Complex Care Review Panel

(j) WMHHS and Children's HHS Board Papers *(provided by WMHHS and Children's HHS)*

(k) Other Project documents *(provided by WMHHS)*

(l) Minutes, agendas, reports and other papers from Young Persons Extended Treatment and Rehabilitation Initiative Committee *(provided by Children's HHS)*

(m) Minutes, agendas, reports and other papers from Service Operations Implementation Working Group

5. Further information provided

5.1 A meeting was convened between Kristi Geddes, Investigator, Sharon Kelly, Executive Director Mental Health and Specialist Services at WMHHS, and Dr Leeanne Geppert, Director of Strategy Mental Health and Specialised Services WMHHS, on 4 September 2014 to confirm the above governance arrangements.

5.2 During that meeting:

(a) the Barrett Adolescent Centre Timeline – Key Events was utilised to further explain the governance structure in place during the different phases of the project and changes that were made;

(b) it was confirmed that during phase 2 of the project, the governance structure overseen by the Children's HHS was focussed on and responsible for the future of mental health services for adolescents in Queensland, post the closure of BAC and the governance structure overseen by WMHHS was focussed on and primarily responsible for the transition and discharge of patients from BAC up until its closure;

(c) it was confirmed that the West Moreton Management Committee was a less formal Committee than the previous Planning Group, but had membership from various stakeholders and met once a week to address any concerns raised during the transition process and assist in developing solutions;

(d) it was confirmed that the following was in place to ensure communication between the two governance structures, primarily between the WMHHS Management Committee and Children's HHS Steering Committee:

(i) mutual committee membership by a number of practitioners from each HHS, including:

(A) Dr Leeanne Geppert;

(B) Dr Stephen Stathis (or his occasional proxy, Dr Elizabeth Hoehn;

(C) Dr Bill Kingswell;

(ii) informal input sought and received on the drafting and development of key material;

(iii) informal and open communication and sharing of documentation;

(iv) regular formal reporting by both committees to the Department of Health and Minister for Health;

(v) formal monthly reporting from Clinical Care Transition Panel to Steering Committee.

6. Findings

Part B – Transition Plans

1. Background and summary

   (a) Generally of method employed to prepare and implement transition plans

   (b) Relevant patients

2. Issues to be considered

3. Review of relevant documents – general

   (a) Records from Clinical Care Transition Panel *(provided by Children's HHS)*

   (b) Transition planning documents *(provided by WMHHS)*

   (c) Communication with parents *(provided by WMHHS and Children's HHS)*

   (d) Communication with staff *(provided by WMHHS)*

   (e) Communication with aftercare providers *(provided by WMHHS)*

   (f) Communication with other relevant stakeholders *(provided by WMHHS)*

4. Review of relevant documents – patient specific (complex patients)

   (a) [redacted]

   (b) [redacted]

   (c) [redacted]

   (d) [redacted]

   (e) [redacted]

   (f) [redacted]

5. Interviews with relevant staff

   (a) RN Vanessa Clayworth

   (b) RN Matthew Beswick

   (c) RN Mara Kochardy

   (d) RN Peta-Louise Yorke

   (e) CN Susan Daniel

(f) RN Rosangela Richardson

(g) RN Moira Macleod

(h) RN Brenton Page

(i) RN Victoria Young

(j) Dr Anne Brennan

(k) Dr Trevor Sadler

(l) Megan Hayes (OT)

6. Findings

(a) General

(b) Patient specific

Findings and Recommendations

Issues Register

Issue No.	Issue	Raised By	Date Raised	To be actioned By	Urgency	Outcome	Date of Completion
1	Observational categories used on ward	Will & Pedralo	11.09.2013	Anne & Elisabeth	Immediate	5 minute obs category ceased. Only to use standard Cat red/blue/green to avoid confusion & miscommunication, placing young people at risk	11.09.2013
2	After hours adolescent mental health consultant cover for BAC	Darren & Sharon	11.09.2013	Elisabeth & Darren	Immediate	Consultants on CHQ after hours child & adolescent consultant roster to provide cover. All consultants notified, credentialled to work in WMHS & approved as Authorised Doctors in WMHS. Anne to brief consultants of any issues each day & consultants to provide Anne with email feedback if called.	completed
3	Will placement at BAC be sufficient to meet registrar training requirements	Elisabeth	11.09.2013	Elisabeth & Darren	Immediate & ongoing	RANZCP child & adolescent training requires registrar to see at least 5 adolescent cases & 5 prepubescent cases. Registrar to remain at BAC until end of November and then transfer to CFTU for rest of placement to have opportunity to see younger children. Also to undertake site visit to CHQ infant mental health team to participate in case conference. Anne to supervise Barrett part of placement & Elisabeth to supervise CFTU part. WMHS to continue funding for CFTU transfer, with registrar returning to BAC to cover Anne over Christmas/New Year if required. Registrar to be given support by Anne, Darren & Elisabeth to manage the disruption surrounding the placement and ensure a positive training experience. Registrar commenced at CFTU 2/12/2013. Elisabeth to provide supervision for remaining part of placement.	completed
4	Management of media following Health Minister announcement in parliament	Sharon	12.09.2012	Sharon & Leanne	Immediate	Media briefed appropriately with generic information, not identifying patients or families	
5	Management of BAC school staff, including their attitudes & behaviour, development of Personal Education Plans for patients and closure of school	Anne & Elisabeth	12.09.2013	Sharon & Leanne	Ongoing to closure of school	Education team to provide a handover of patient's educational needs from health perspective. School to be transferred off site at end of school year, to continue at Yeronga State High School as Barrett Special Purpose School.	
6	Anxiety of parents about future management of their young people	Sharon & Leanne	12.09.2013	Sharon, Leanne & Anne	Ongoing until closure of BAC	Officer to offer ongoing support to parents. Communication strategy with fact sheets to continue with regular updates. Parents invited to submit thoughts about future service planning to Steering Committee.	
7	Need for directive from WMHS stating clearly plans for closure and a decision about not accepting any further admissions (inpatient or day program) due to the instability & inability to plan discharge or manage the waiting list in the context of ongoing uncertainty	Elisabeth & Anne	13.09.2013	Sharon & Leanne	Immediate	Including verbal briefing of patients, parents, staff & school; followed by staff communique & factsheet & email memo to all HHS MHS executive staff	22.10.2013
8	Weekly Meetings - regular date x attendees		13.09.2013				
9	Strategy - Key Issues 1) Separate from clinical BAC 2) Parents need to see options sooner - Propose 1/2 day forums x 2		13.09.2013				
10	Notify other HHS's (Print Out)	Sharon Kelly	13.09.2013				
11	Waitlist msgs - wording re: from here on						

12	Anne spoke with all parents today except 2 (will do these tonight)		13.09.2013	Anne Brennan Leanne ?			
13	Containment & pt safety - no more admissions - closure date / period - reduce beds problematic - ind wrap around services		13.09.2013	Need position from Board			
	CYMHS sector Psychiatrist not happy						
	Observation protocols						
	Significant improvement in documentation required						
	School - major issue						
	Plenty of staff - what are they doing?						
	Case conference needs to be shorter but involve family						
	Increase occupation of kids						
	Change roles of staff eg. Wait list management						
	Going to unlock doors next week						
14	Safety of patients with growing instability, staff anxiety	Anne & Elisabeth	16.09.2013	All	Ongoing until closure of BAC	Regular clinical review & risk assessments & emotional containment of patients by Anne & registrar & appropriate clinical responses. Support of staff to contain ward milieu. Regular communication with parents to contain anxiety. Comprehensive discharge planning and complex case discussions where required.	
15	File review has identified other WMHS lawyers to review regarding response.	Will & Padraig	16.09.2013	Will	Immediate	Patient management plan reviewed & to be followed. Police liaison meeting to occur to educate	
16	Safety of patients with growing instability, staff anxiety	Anne & Elisabeth	16.09.2013	All	Ongoing until closure of BAC	Regular clinical review & risk assessments & emotional containment of patients by Anne & registrar & appropriate clinical responses. Support of staff to contain ward milieu. Regular communication with parents to contain anxiety. Comprehensive discharge planning and complex case discussions where required.	
17	File review has identified other WMHS lawyers to review regarding response.	Will & Padraig	16.09.2013	Will	Immediate	Patient management plan reviewed & to be followed. Police liaison meeting to occur to educate patients about appropriate	completed
18	0.5 FTE insufficent consultant psychiatrist time	Anne & Elisabeth	16.09.2013	Darren	Immediate	Increase Anne's hours to 36 hours per week	completed
19	Increased support needed for nursing staff; Vanessa overwhelmed with administrative duties & required to be involved in discharge planning	Anne & Elisabeth	16.09.2013	Will	Immediate	Vanessa returned to CNC role to support Anne & new acting NUM appointed to manage administrative tasks on ward.	14.10.2013
20	Increased administrative support for Anne & computer access for Anne	Anne & Elisabeth	16.09.2013	Sharon	Immediate	Anne informed of availability of AO on ward & AO line manager to be notified, dictaphone & additional laptop organised for Anne's office	completed
21	Concerns regarding roles of allied health staff going forward	Anne & Elisabeth	16.09.2013	Michelle & Lorraine	Ongoing	Senior allied health staff reviewed current situation and provide ongoing staff support toward closure	
22	Limited activities for young people resulting in boredom & potential for deteriorating mental health	Anne & Elisabeth	16.09.2013	Will & Padraig	Ongoing	Explore with staff opportunities to plan regular appropriate therapeutic activities appropriate to this age group	
23	Inadequate clinical documentation	Anne & Elisabeth	16.09.2013	Anne & Padraig	Immediate	Clinical reviews documented in CIMHA and file notes appropriately updated in timely fashion	

	24	Need for clear transition care plans for patients to support discharge	Anne & Leanne	19.09.2013	Anne, Elisabeth & Leanne	immediate	Establish collaboartive care management panels around each young person to be called Transition Care Panels, Elisabeth to become a member of Steering Committee in place of Trevor, Leanne to review transition working group as part of future planning process and replace with transition Care Panels.Need core medical, nursing, allied health & education representation on panels with additional coopted members specific to each young person.	completed	

25	Workforce decommissioning	Sharon & Leanne	25.09.2013	WMHS Executive	Ongoing	Briefing of unions has occurred. HR will manage decommissioning individually with staff. Liaise with Regional Director of Education to close BAC school - will need to develop a timeline around this. Staff will need clear communication and information at each step of the way and then ongoing support to manage not only the change but issues of grief surrounding the closure of BAC.	
26	Management boundaries	Sharon	25.09.2013	WMHS Executive	Ongoing	Clinical management of young people at BAC & decommissioning of BAC is the responsibility of WMHS. Confine membership of this weekly review meeting to members supporting work of WMHS in decommissioning BAC	
27	Engagement with other HHS and external service providers to ensure wrap around packages for the safe and appropriate discharge of young people from BAC	Anne	16.10.2013	Anne, Elisabeth, Leanne	Ongoing	transition care panels have identified deficit in knowledge of existing services; difficulty in engaging services to accept ongoing care og young people, resistance of young people, parents & staff in engaging with transition processes, lack of available services in communities in this transition phase	
28	Patient files stored inappropriately on ward	Anne	16.10.2013	Will, Padraig, Sharon	Immediate	Files to be relocated to appropriate storage services, administration directive to be provided	
29	Mitigate risk of fire management on ward	Anne	16.10.2013	Ward NUM	Immediate	Potential for self-harm and/or property damage by young person using fire, NUM organising fire safety training for ward to ensure processes and skills are current and risks can be mitigated	
30	Commitment of support to family of young person transferred to Mater inpatients unit at beginning of crisis	Leanne	16.10.2013	Leanne	Ongoing	Provide support through consultation and liaison with Mater with parental consent	
31	Independent meetings involving unions, parents, school staff and young people	Anne	17.10.2013	WMHS Executive, Education Regional Director	Ongoing	Need to have clear boundaries in place to maintain mental health of young people & safety & stability of ward milieu. Directive from Anne advising not medically recommended for young people to be involved. Anne to provide weekly updates & contact with most anxious parents to support them in managing transition. WMHS executive to work with regional director of education to manage transition for education staff and provide them with greater containment. Union meetings not to occur on site.	
32	Difficulty in getting services to collaboratively work together to create care packages for young people	Anne	23.10.2013	Anne & Leanne	Ongoing	Continue to meet and negotiate to achieve appropriate clinical outcomes and escalate to higher levels if required. May need to send staff to Townsville to scope potential services	
33	Complex care panel required for [redacted]	Leanne	23.10.2013	Anne & Leanne	Ongoing	Invite Stephen Stathis to chair the panel & Anne & Laura to coordinate	
34	Nursing & allied health staff increasingly distressed about inquiry & impending closure & their futures, their concerns for patients & their grief	Anne	23.10.2013	Michelle & Will	Ongoing	Monitor & support staff as required	
35	One of patients has a photo of self & staff member without staff member's consent	Staff Member	23.10.2013	Alex	Immediate	Alex has sent an email requesting [redacted]	
36	[redacted]	Anne	23.10.2013	Anne	Immediate	CYFOS Consultant will be providing consultation & therapeutic session to patient. Risk mitigation strategies to be clearly documented.	
37	Patients have unescorted ground leave of The Park which is not safe due to the escalating risk of the broader Park population	Anne	23.10.2013	Anne & Alex	Immediate	Notification to be given to staff & patients that there is no further unescorted ground leave	
38	Staff requesting to escort patients to an MA15+ movie	Anne	23.10.2013	Anne & Alex	Immediate	Notification to all staff (nursing & education) & patients that it is not appropriate for young people to attend or view MA15+ movies	
39	Referrals of patients are being made to psychology staff to see patients privately while staff are also working for WMHS, raising issues of conflict of interest	Anne	23.10.2013	Michelle	Immediate	Senior Allied health staff to investigate and manage	
40	Need to improve communication with broader mental health community	Sharon	23.10.2013	Sharon	Immediate	Establish a mailing list and regularly distribute updates using factsheets	

						This will need to be organised and the timing will need to be carefully considered with staff finishing, school closing and patients being discharged	
41	Dispersion of building and education assets	Anne	30.10.2013	WMHHS	Ongoing		
42	Christmas leave and staffing	Anne	30.10.2013	Anne, Will, Alex	Ongoing	Need to plan staff leave over Christmas to ensure appropriate and safe cover for remaining patients.	
43	Concern that CHQ won't have new services up and running quickly enough to cover end of services at BAC and there being insufficient services available for adolescents in the transition	WMHHS	13.11.2013	WMHHS & CHQHHS	Ongoing	WMHHS has established a model of transitional programs in collaboration with Aftercare, including a holiday program for current BAC patients and a residential service. Continue to work collaboratively across both HHS to integrate WMHHS transitional model and programs into new SWAETR in a timely fashion and without service delivery gaps.	
44	Inadequate nursing staff as been identified as an issue on some shifts	Leanne	26.11.2013	Will	Immediate	Ensure adequate nursing staff are rostered on each shift.	4.12.2013
45	Handing over management of any remaining waiting list and assessment list patients to CHQHHS for ongoing management	Anne & Elisabeth	22.01.2014	WMHHS & CHQHHS	Ongoing	Ensure any patients remaining on these lists receive timely and appropriate management and are not lost in the transition process. Handover to be implemented between Anne and Stephen Stathis.	
46	Risk of losing wisdom and experience gained from the closure of BAC	Leanne & Anne	22.01.2014	All	Ongoing	WMHHS to provide opportunities for debriefing and recording of the lessons and collective wisdom gained from the process of closing BAC	

SKIPPEN, Tania

From: SKIPPEN, Tania
Sent: Sunday, 28 September 2014 4:06 PM
To: Kristi Geddes
Cc: KOTZE, Beth
Subject: RE: PRIVATE & CONFIDENTIAL - Health Service Investigation - Barrett Adolescent Psychiatric Centre [ME-ME.FID2743997]

Dear Kristi,
we would be interested in receiving any documents that were current policies, procedures or provided guidance for staff in implementing transitions for these consumers at the time. The documents would need to have been endorsed by the West Moreton executive and/or Qld Department of Health for implementation - I note one document was still in draft form.
Kind regards,
Tania

From: Kristi Geddes
ent: 25 September 2014 11:08
To: SKIPPEN, Tania; KOTZE, Beth
Subject: FW: PRIVATE & CONFIDENTIAL - Health Service Investigation - Barrett Adolescent Psychiatric Centre [ME-ME.FID2743997]

Dear Tania and Beth,

I have received the following email from Dr Sadler summarising a number of issues and concerns he considers relevant for the investigation. While a number of these may be out of the scope of our Terms of Reference, they will no doubt be raised in the interview with him, so thought it best to bring them to your attention.

In relation to the Clinical Services Capability Framework (CSCF) for mental health and Model of Service Delivery for the Adolescent Extended Treatment and Rehabilitation Service he has referred to, I have not personally come across these in the material but note that they are publicly available online. I believe the second document may have been created during the transition period for application following the transition of patients, but I could be wrong.

Please let me know if you would like for me to make any further queries in this regard, or in relation to any of the other issues/concerns raised by Dr Sadler in his email.

Kind regards,
Kristi.

Kristi Geddes Senior Associate

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www.minterellison.com<http://www.minterellison.com>

From: Trevor Sadler
Sent: Wednesday 24 September 2014 02:56 pm
To: Kristi Geddes
Subject: RE: PRIVATE & CONFIDENTIAL - Health Service Investigation - Barrett Adolescent Psychiatric Centre [ME-ME.FID2743997]

Dear Ms Geddes,

Thank you for informing me of the change. I am sorry I couldn't take your call when you first rang.

Just to explain why I thought the additional documents were relevant into an investigation into the transitional plans.

I presume you were given a copy of the Clinical Services Capability Framework (CSCF) for mental health, and the draft Model of Service Delivery for the Adolescent Extended Treatment and Rehabilitation Service. Both these documents are Queensland Health documents which define service provision, and by which Health and Hospital Services are required to abide. Both these documents attempt to capture the severity and complexity of adolescents admitted to Barrett. From referral patterns over more than a decade, I estimate the a community clinician (including private child psychiatrists) would only see a young person of this degree of severity and complexity once in every five years or more.

The CSCF describes the capabilities services need to have to be able to treat and manage a person with varying levels of severity and complexity of their mental illness. Barrett was classified as a CSCF Level 6 service. It had to have the highest levels of capabilities to manage the young people being admitted. The Tier 3 service recommended by the Expert Clinical Reference Group (ECRG) report is identified in that report as a CSCF Level 6 service.

This is highly relevant to the transition plans. If the service to which a young person is being transitioned has the same level of capability, the transition plan is around continuity of staffing expertise, and relocation on the day of transition. An example of this is the closure of the Mater Children's Hospital on 29 November, and the transition to Lady Cilento Children's Hospital.

However, if the only services available to which the adolescents can be transitioned have a lower capability to provide services, those developing the transition plans must include a component of improving "wellness" prior to transition so that the receiving service has the capability to manage the young person.

Ideally the service/system managers would work with the transition plan clinicians to determine when the service could close. This would ensure that levels of "wellness" matched the capability of receiving services. Ideally, service managers would ensure that treatment and rehabilitation services were optimised to facilitate "wellness". They could gain some crude measure of the "unwellness" of adolescents by monitoring the frequency and nature of PRIME reports. Ideally, they would then discuss with the clinicians factors – whether in clinicians, the adolescent or the health service – which may impair some young people from proceeding to gain in "wellness".

These issues move from being an ideal to critically essential if service/system managers pre-determine the closure date. The problems are

- the transition time may be less than what adolescents need to achieve wellness and
- if, during this process, transition clinicians are forced to focus on managing continuing high levels of "unwellness" (captured in PRIME reports), there may a moratorium on transition plans facilitating "wellness".

Consequently, when time for closure comes, even though a young person is transitioned to the highest level of available capability, they are still too unwell for the receiving service.

A number of factors contribute to continuing levels of "unwellness" and impair progress to "wellness" in this situation.

- If there is loss of hope and despair in adolescents on hearing the news of the closure (as evidenced in one young person's testimony on www.patientopinion.org.au<http://www.patientopinion.org.au>) this may result in withdrawal from therapy, [redacted] or a withdrawal from the service. The impact of the news of the closure can be gauged from the nature and frequency of PRIME reports from 1/1/2013 – 5/8/2013 cf 6/8/2013 – 31/12/2013.

- High levels of "unwellness", as indicated by [redacted] requires high levels of observations. This is staff intensive. It therefore stretches the resources available to facilitate "wellness" in other adolescents. These incidents may include adolescents whose charts are not being reviewed. The ward report books provide further information on the situation with the whole ward.

- The need to optimise resources includes the need to provide staffing stability. The impacts of staffing instability on adolescents are recorded in their submissions to a Business Unit Meeting. This was an issue raised with various levels of service management in the preceding two years. High levels of casual nurses result in utilisation of a workforce who are largely unskilled in adolescent mental health; who do not know the adolescents well; whom adolescents do not readily approach with issues and who are not skilled in detecting incidents early. This means that the capacity to manage crises associated with high levels of "unwellness" is impaired, regular staff are more stretched in their capacity to provide therapeutic and rehabilitation interventions because there are fewer of them, and they are managing crises. Crises are more likely to occur because adolescents will not approach unfamiliar staff. This can be a significant contributing factor to a moratorium on transition plans. Staffing lists provide an indication of the level of non-regular staff employed during this period, and be an indication of what service managers did to address this issue. The Quality Network of Inpatient CAMHS (QNIC) of the Royal College of Psychiatrists has established recommendations for acceptable levels of casual staffing, with notes on the implications for patient care.

- If PRIME incidents increased after the announcement of the closure, it may suggest the closure caught adolescents unawares. If clinicians were forced to manage crises because of sudden distress of the announcement, instead of implementing transition plans, this is a severe limitation on the capacity to facilitate "wellness" to a level that the capability of receiving services can manage. This raises the issue of why adolescents (and perhaps parents) were caught unaware. Was information from the consultation process with adolescents and parents/carers prior to the closure (identified in the Project Plan of the Planning Group) not disseminated more broadly? Did clinical leaders have information which should have been known to adolescents and parents/carere prior to 6 August? What was the process of consultation with adolescents and parents/carer regarding service design and delivery in the transition period? (Involvement of "consumer" and carers is a key element of the National Mental Health Plan, of the Mental Health Directorate, and the West Moreton HHS. Active involvement has the capacity to reduce anxiety; provide a collaborative working together towards transition and identify potential issues. This facilitates transition plans.)

I was only involved for the first 5 weeks of the approximately 25 week transition period. I do not have information as to what happened on the unit, and how these issues were managed after mid-September. I do know that three young people with whom I worked are now dead. Others, while not having the same tragic outcome, have experienced far worse outcomes than I had to reason to expect.

Thank you for your time in considering these matters.

Kind regards,

Trevor

From: Kristi Geddes [redacted]
Sent: Tuesday, 23 September 2014 3:43 PM
To: Trevor Sadler
Subject: RE: PRIVATE & CONFIDENTIAL - Health Service Investigation - Barrett Adolescent Psychiatric Centre [ME-ME.FID2743997]

Dear Dr Sadler,

Would it be possible to change your interview time to 1:30pm on Tuesday, 14 October 2014? It will still be at our offices and with both A/Prof Beth Kotze and Ms Tania Skippen.

My apologies for the change.

Kind regards,
Kristi.

Kristi Geddes Senior Associate

Minter Ellison Lawyers Waterfront Place • 1 Eagle Street • Brisbane • QLD 4000
>
www.minterellison.com<http://www.minterellison.com>

P Please consider the environment before printing this email

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SKIPPEN, Tania

From: Kristi Geddes <[redacted]>
Sent: Thursday, 25 September 2014 11:08 AM
To: SKIPPEN, Tania; KOTZE, Beth
Subject: FW: PRIVATE & CONFIDENTIAL - Health Service Investigation - Barrett Adolescent Psychiatric Centre [ME-ME.FID2743997]

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Kind regards,
Kristi.

Kristi Geddes Senior Associate
[redacted]
Minter Ellison Lawyers Waterfront Place • 1 Eagle Street • Brisbane • QLD 4000
[redacted] www.minterellison.com

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- If there is loss of hope and despair in adolescents on hearing the news of the closure (as evidenced in one young person's testimony on www.patientopinion.org.au) this may result in withdrawal from therapy, [redacted] or a withdrawal from the service. The impact of the news of the closure can be gauged from the nature and frequency of PRIME reports from 1/1/2013 – 5/8/2013 cf 6/8/2013 – 31/12/2013.
- High levels of "unwellness", as indicated by [redacted] requires high levels of observations. This is staff intensive. It therefore stretches the resources available to facilitate "wellness" in other adolescents. These incidents may include adolescents whose charts are not being reviewed. The ward report books provide further information on the situation with the whole ward.
- The need to optimise resources includes the need to provide staffing stability. The impacts of staffing instability on adolescents are recorded in their submissions to a Business Unit Meeting. This was an issue raised with various levels of service management in the preceding two years. High levels of casual nurses result in utilisation of a workforce who are largely unskilled in adolescent mental health; who do not know the adolescents well; whom adolescents do not readily approach with issues and who are not skilled in detecting incidents early. This means that the capacity to manage crises associated with high levels of "unwellness" is impaired, regular staff are more stretched in their capacity to provide therapeutic and rehabilitation interventions because there are fewer of them, and they are managing crises. Crises are more likely to occur because adolescents will not approach unfamiliar staff. This can be a significant contributing factor to a moratorium on transition plans. Staffing lists provide an indication of the level of non-regular staff employed during this period, and be an indication of what service managers did to address this issue. The Quality Network of Inpatient CAMHS (QNIC) of the Royal College of Psychiatrists has established recommendations for acceptable levels of casual staffing, with notes on the implications for patient care.
- If PRIME incidents increased after the announcement of the closure, it may suggest the closure caught adolescents unawares. If clinicians were forced to manage crises because of sudden distress of the announcement, instead of implementing transition plans, this is a severe limitation on the capacity to facilitate "wellness" to a level that the capability of receiving services can manage. This raises the issue of why adolescents (and perhaps parents) were caught unaware. Was information from the consultation process with adolescents and parents/carers prior to the closure (identified in the Project Plan of the

Planning Group) not disseminated more broadly? Did clinical leaders have information which should have been known to adolescents and parents/carere prior to 6 August? What was the process of consultation with adolescents and parents/carer regarding service design and delivery in the transition period? (Involvement of "consumer" and carers is a key element of the National Mental Health Plan, of the Mental Health Directorate, and the West Moreton HHS. Active involvement has the capacity to reduce anxiety; provide a collaborative working together towards transition and identify potential issues. This facilitates transition plans.)

I was only involved for the first 5 weeks of the approximately 25 week transition period. I do not have information as to what happened on the unit, and how these issues were managed after mid-September. I do know that three young people with whom I worked are now dead. Others, while not having the same tragic outcome, have experienced far worse outcomes than I had to reason to expect.

Thank you for your time in considering these matters.

Kind regards,

Trevor

From: Kristi Geddes
Sent: Tuesday, 23 September 2014 3:43 PM
To: Trevor Sadler
Subject: RE: PRIVATE & CONFIDENTIAL - Health Service Investigation - Barrett Adolescent Psychiatric Centre [ME-ME.FID2743997]

Dear Dr Sadler,

Would it be possible to change your interview time to 1:30pm on Tuesday, 14 October 2014? It will still be at our offices and with both A/Prof Beth Kotze and Ms Tania Skippen.

My apologies for the change.

Kind regards,
Kristi.

Kristi Geddes Senior Associate

Minter Ellison Lawyers Waterfront Place • 1 Eagle Street • Brisbane • QLD 4000

SKIPPEN, Tania

From: Kristi Geddes <[redacted]>
Sent: Wednesday, 22 October 2014 8:40 AM
To: KOTZE, Beth; SKIPPEN, Tania
Subject: Fwd: Belated response to question
Attachments: COMMUNITY TREATMENT OPTIONS IN TRANSITION PLANNING.docx; ATT00001.htm; SEEKING AN EVIDENCE BASE TO DETERMINE THE REQUIREMENTS FOR RESIDENTIAL CARE.docx; ATT00002.htm

Kristi Geddes
Senior Associate
Minter Ellison

Begin forwarded message:

From: Trevor Sadler <[redacted]>
Date: 22 October 2014 2:30:22 am AEST
To: 'Kristi Geddes' <[redacted]>
Subject: Belated response to question

Dear Ms Geddes,

At the recent interview regarding transition plans for patients who were in Barrett, A/Prof Kotze asked a question along the lines of whether I considered community treatments as part of my transition plan? (Perhaps the way I interpreted it at the time, and now recall in retrospect.)

I replied that I did not, and gave an inadequate answer as to why not. At the time, I can recall thinking of community treatment as seeing staff in a community CYMHS or seeing a private psychiatrist + private psychologist and perhaps some NGO support. She may have had in mind more than that. My mind went somewhat blank – in part because the answer is somewhat complex, and thinking of how to edit it, condense it and communicate it effectively was challenging.

I also went in to the interview with only a partial recall of my thinking with respect to the transition plans. Thinking through this question afterwards helped me gain a clearer recall into my line of thinking at the time.

The attached document both elaborates on my answer to this question, and my approach to early transition planning.

If it is permissible to pass this on, and not too late, could you please forward it to A/Prof Kotze and Ms Skippen? Thank you.

This may be somewhat incidental, but I have also attached a document I submitted to the Expert Clinical Reference Group and forwarded to Stephen Stathis. It describes the challenges of community based treatment for this sub-population of adolescents. This was written in March 2013, so the adolescents would have moved on in the 10 months from then until closure. However, there was a strong possibility some would have required an inpatient service.

Kind regards,

Trevor

****

IMPORTANT INFORMATION - PLEASE READ

****

COMMUNITY TREATMENT OPTIONS IN TRANSITION PLANNING

I was asked a question along the lines of if I considered community treatments may or not be an appropria option for an individual adolescent's treatment plan, or whether I could have been working towards that ir the five weeks I was there after the announcement. I replied that I had not considered it was appropriate but did not adequately explained why.

However, the question jogged my memory. In the days since, I have greater clarity of recall of my thinking from the time of the announcement until I was stood aside.

I considered that the transition plans for most of the adolescents would necessitate

- access to rehabilitation programs including a specialised school component,
- tangible incorporation of key elements of recovery,
- continuing access to staff whom they had known to those working through issues of difficult parenting and continuation of the recovery elements as well as
- treatment and
- safe accommodation.

My primary tasks above my clinical role at that time were to

- support staff at a time of great uncertainty for themselves professionally to provide the best clinical care in the circumstances,
- have a very active input into the State-wide Adolescent Extended Treatment and Rehabilitaion Implementation Group (SAETRIG) and two of the working groups – the Patient Transition Working Group and the Services Options Working Group so that the transition plans would incorporate as far as possible the above key elements and
- support particularly vulnerable patients in their treatment so that they could survive a probable lower level of care than was provided during the preceding six months.

During the time that I was there transition plans were only considered in broad conceptual terms rather than in detailed planning.

<u>Anticipated Challenges</u>

I regarded the second task as being particularly challenging.

- Dr Bill Kingwell wrote in May to confirm that he was not an expert in child and adolescent psychiatry, yet his recommendations adopted by the Planning Group included the wraparound service and the Y-PARC model. The latter was fundamentally different to Barrett with no patients on an Involuntary Treatment Order and none who self harmed. As Director of Mental Health he had a key role in guiding the process but from my perspective had little understanding of the clinical issues of the Barrett young people.
- The SAETRIG was fundamentally different in composition from the Expert Clinical Reference Group (ECRG) which produced recommendations for alternative services to replace Barrett. Although from a different Health District I had worked with Judi Krause on a number of committees and had known Stephen Stathis since he was a registrar. Both were the co-chairs of the SAETRIG. Unlike the ECRG,

the SAETRIG had only two people with experience in longer term treatment and rehabilitation. (That was reduced to one when I left the SAETRIG.)

- The SAETRIG was not provided with a full copy of the recommendations of the ECRG by mid September, although the name implies its role was to implement the recommendations of the ECRG. There was no guidance as to what transition services may be possible, the exact nature of and the reasoning behind the ECRG recommendations was unclear, and pressure was being placed by high level sources to provide a model which was contrary to the ECRG recommendations.
- The Royal Children's Hospital CYMHS in which both Stephen and Judi worked provided only short term interventions. Neither had a good grasp of extended treatment and rehabilitation. They visited the AMYOS in Melbourne the day before we toured the Y-PARC facilities. They were impressed with this service, but did not appear to appreciate that it targeted a different sub-population of adolescents to those seen at Barrett.

This is not intended as a criticism of individuals. They are my perceptions of challenges in high level transition planning to ensure the transition plans incorporated the key elements listed above.

It was clear that there was no reduction in funding for the new services, and indeed funding would be enhanced. The Barrett budget would be transferred from WMHHS to CHQHHS.

I assumed (perhaps naively) that it would be a reasonable plan to utilise the existing Barrett staff in enabling the transition plans (in conjunction with a relocated school staffed by the Barrett teaching staff) and staff forming the core of new services to be developed. Not only would there be funding for this, retaining the expertise of staff was a recommendation of the full ECRG report. It would provide some continuity of care for the adolescents.

This arrangement could operate with adolescents in home, transitional accommodation or an acute hospital bed, but attending either a day program (there were possibly buildings at Prince Charles Hospital which could be available) or as a school based program with former Barrett clinical staff providing ongoing clinical care and facilitating transitional programs to adolescents in the community. By late August an inpatient unit at Logan Hospital also appeared to be a possibility if a significant number still required hospitalisation, or if new patients were to be admitted into the service.

In retrospect, my focus in those early weeks was trying to establish what I considered to be an adequate broad transitional framework, rather than specific transitional plans for individual adolescents.

I foresaw significant obstacles. I tried to get an Education Queensland representative appointed to the SAETRIG. They were identified in the original Work Plan of the WMHHS Planning Group as a key stakeholder, and had representation on both that Planning Group and the ECRG. It was apparent decisions were being made by Queensland Health with little reference to Education Queensland. A representative would be appointed to the Patient Transition Working Group.

I also anticipated difficulties in people on the various groups understanding what challenges the young people faced. Had I stayed on, I would have encouraged the Patient Transition Working Group to meet with the young people and their parent(s)/carers in separate groups. This involvement was a key policy of the Mental Health Directorate, the WMHHS and any recovery model ("lived experience").

I also intended to liaise regularly with Stephen Stathis and encourage him to also meet with both these groups. I reckoned that if he had a thorough appreciation of the clinical issues, he would be able to advocate

for an appropriate service at the higher levels to which he had access. His advocacy would be particularly important, in my opinion to the SAETRIG, where he carried far more weight than I. This was a critical group, with potentially little appreciation of the clinical conditions.

Rationale for Service Elements

The literature lacks research which would provide guidance about the management of those who do not respond to certain treatment interventions. The following rationale is developed from more than two decades of observations about

- what interventions are useful in managing young people with severe and complex mental illness resulting in either profound risk to self, or profound impairment or both,
- the interrelationships between treatment, rehabilitation, developmental tasks, parenting styles, staff characteristics and relationships with staff and
- routes to recovery in this population.

In addition, we were informed by

- feedback from young people who were previous users of the service who spoke at the quadrennial school reviews,
- conversations with colleagues and researchers at national and international conferences (which afforded closer inquiry into aspects of service delivery than reading literature alone) and
- conversations with colleagues in units in the UK and Switzerland.

Rehabilitation Component

These adolescents were very impaired from their mental illness. Over the preceding 5 years, prior to admission,

- 98% had disengaged from school for > 6 months
- 90% had not had face to face contact with peers
- 83% had disengaged from community networks – shops, public transport
- 55% had adequate family supports. 12% had minimal contact with parents.

Tasks of Adolescent Development

Cope with physical changes
Develop cognitive maturity
Negotiate school
Negotiate peer relationships
Develop emotional maturity
Care for the self
Develop moral maturity
Occupy leisure time
Establish boundaries
Develop competencies to become independent
Develop identity
Individuate
Develop life schemas
Develop a sense of future

Notes and observations

- In the virtual absence of literature on adolescent rehabilitation in mental health, a program was developed around a construct of the developmental tasks of adolescence (see box). This allowed all activities – whether generated from the school, the health clinicians or both, to be conceptualised within a common framework. Strengths in development could be identified as well as deficits.
- We observed that the cognitions, behaviours and emotions of a mental illness often had a direct impact on developmental tasks. Conversely, the resultant moratoriums in developmental tasks often negatively reinforced the mental illness. In addition, developmental tasks were often fundamentally

affected by biological developmental issues e.g. learning problems, ADHD, receptive-expressive language disorders, temperament, sensory motor problems.

- Rehabilitation activities were both generic and individualised.
- Rehabilitation activities were generated by the school (which ran a broad set of activities beyond offering formal academic tuition), health professionals, (particularly occupational therapists), in groups and individual activities, and more unstructured activities on the ward and with nursing staff. We observed a combination of group and individual rehabilitation interventions were more effective than either on their own.
- Unlike rehabilitation in physical medicine, where rehabilitation follows acute treatment, rehabilitation and treatment at times coincided. For example, a social anxious adolescent without peer contact for two years or more, was both desensitised to social contact simply by being admitted (treatment) while undertaking a rehabilitation activity by learning to re-establish peer contact and enhance social skills.
- In some cases, progress in rehabilitation preceded treatment, for example, the extremely socially anxious, alexithymic adolescent made many gains in developmental tasks attending school, participating with peers (even as an active participant), broadening their leisure interests, developing competencies to become independent (including washing, preparing meals) which altered their perception of themselves and facilitated capacity to talk.
- Progress in treatment often occurred in bursts which were interspersed with progress in rehabilitation and vice versa. The two seldom ran a linear course. At times they may be concurrent and interdependent.
- Although every effort was made to transition gains in rehabilitation to community services as early as possible (e.g. attendance at school, independently attending a community fitness centre or youth group), our observations were that typically adolescents required considerable facility based rehabilitation support and practice before they were ready.
- Treatment and rehabilitation activities were varied, intensive, complementary and coordinated. This intensity constantly reinforced the gains which were being made.

For all of these reasons, I anticipated that some/many of the adolescents by February would require an active rehabilitation component as part of their transition package. A treatment only transition (either with CYMHS or private providers), even with some NGO rehabilitation support in targeted areas would be insufficient because

- it would lack intensity – at most once a twice a week for an hour seeing the treating clinician
- lack integration between treatment and rehabilitation components
- outside the Mater Day Program which had a waiting list, alternative intensive rehabilitation programs were not available in the south east Queensland (where 70# of the adolescent population live)
- NGO's do not provide the intensity, coordination of programs, range of programs or mix of group and targeted individual programs
- the alternative to an integrated rehabilitation program was accessing multiple rehabilitation components in various settings which would prove challenging and often confusing.

Recovery Components

Multiple elements of what is now identified as components of recovery were identified as important elements in the progress of adolescents in the 1990's – before recovery was formally articulated as a

process. It may seem at first counterintuitive that spending a long time in a mental health facility actually initiates and promotes recovery. I maintain this was so for this group. Their route to recovery was very different to what I observed in private or outpatient practice, and am now observing in adolescents in an acute inpatient setting.

The *National Mental Health Recovery Framework* was only released in November 2013, but I refer to it as it clearly articulates many of the elements which were essential to the adolescents' progress. As this is getting longer than I wanted it to be, I'll just refer to four elements.

Hope

This is common to all concepts of recovery. Most adolescents entered Barrett with hope of recovery after experiencing severe and incapacitating mental illness for a considerable period. This hope was maintained through the positive attitudes of regular staff (at least most of them); through learning new ways of coping; through participating in activities which enhanced skills and confidence and through engagement in therapies which offered significant amelioration of symptoms.

I considered that transition programs must incorporate elements which assisted, as much as possible, the continuation of hope. Hope became a very fragile commodity after the announcement. Patient when considering the announcement of the closure said something like ' The loss of hope was reflected in comments made by a patient on https://www.patientopinion.org.au/opinions/59116.

For those adolescents for whom community only services (referring to treatment appointments in the community) were not appropriate, I considered an environment of hope was an essential component. It was unthinkable in my mind to leave them to cope with anxiety, depression for much of the week, and only to be able to offer hope for an hour or two. That hope included access to staff who had assisted them to whatever point they were at, and who could facilitate further progress.

Looking back at the process post-closure, the prime embodiment of hope was the school, which Education Queensland had the foresight to support. Outcomes would be considerably worse, particularly with the suicides of three of their friends.

Connectedness

In my opinion, this was a critical component of the recovery process, but totally underrated in the research literature of inpatient units and treatment of individual disorders. Connectedness was both an individual and a group dynamic. Connectedness to peers. Connectedness to staff who facilitated recovery, and through that connectedness to the larger community. Connectedness to people and programs at Barrett was the only passage to connectedness to the community.

By transition time, some adolescents would be ready to leave the Barrett connectedness to connect to the community. A tenuous connection to Barrett was often still important, though.

I considered the proposal I outlined previously to provide some vehicle for connectedness for those for whom some connectedness was important.

In retrospect, this has proved to be true for those who could access schooling run by the former Barrett school.

Empowerment

Some may consider the being in Barrett over an extended period the very antithesis of empowerment. I often heard comments that long term hospitalisation encouraged dependency. Undoubtedly it did. At times that was important therapeutically. But a long term environment which focussed on enhancing tasks of adolescent development ultimately resulted in adolescents being empowered sufficiently to want to move away, and stand on their own feet.

For many adolescents it was the beginning of the process of empowerment. Empowerment over the nightmares of past abuse; over emotions that threatened to take one's life, over social isolation. Empowerment that enabled an adolescent to resume school, commence vocational training, have conversations with peers, catch public transport, cook a meal.

Empowerment occurred in a combination of group and individual activities, through both treatment and rehabilitation. Empowerment was supported by hope and by and environment which encouraged progress rather than languish in inactivity.

I considered a continuing active rehabilitation program essential to continue the hope, the environment, the activities which promoted empowerment, perhaps in collaboration with external providers who supported the treatment. (Collaborating with external providers was already a model we utilised over the years.)

Identity

This is not only a challenging and variable process for many adolescents but adolescents who were admitted to Barrett often struggled with impairments to their identity because of the mental illness or assaults on identity from disruptive home environment. Some had core elements of identity on which to build while in others identity formation was very diffuse. Certainly constructing or reconstructing identity was an important task to begin while at Barrett and continued for years afterwards. Our observations were that progression in other developmental tasks and validation from staff as well as personal reflection were key elements in consolidating identity.

Whilst individual community based treatment could offer some validation as well as personal reflection it could not supplement identity formation with practical assistance in progression in developmental tasks nor in in vivo validation.

In summary many recovery elements inherent in the Barrett process could not be replicated by once or twice a week community treatments whether they were office based as in CYMHS or private providers or offered in the community such as by an Assertive Mobile Youth Outreach Service (AMYOS). In my view they needed to be supplemented by access to a day program with integrated schooling.

Unfortunately, I found that the West Moreton Mental Health Service at some level did not appreciate key aspects of recovery. Perhaps the release of the *National Mental Health Recovery Framework* would change this attitude. The lack of appreciation of recovery principles was a significant impediment to developing transition plans. I will outline three examples.

- Loss of hope after the announcement was described in the link below, but not actively enquired about at management level while I was there.

- My understanding of the Gant chart of the Work Plan of the WMHHS Planning Group indicated there would be a 3 week consultation period with key stakeholders prior to a decision being made. Consumers and carers were among the key stakeholders to be consulted. The communication strategy to both groups, the lack of consultation while I was there undermined any sense of empowerment.
- Some measure of risk can facilitate recovery. For years I took risks in the management of patients if it would facilitate an aspect of development which progressed both treatment and rehabilitation. For example, I sometimes authorised (after consultation with staff) an adolescent who was on continuous observations for [redacted] to go on an outing in the car, or go on a high ropes course because I believed the evidence pointed to it being in the best interests of development. There was never an adverse incident from these decisions. They did indeed facilitate progress. However in the three months prior to the closure, and in the time I was there, edicts came defining progression from continuous observations. For example, [redacted]

Continuing Access to Staff

The role of continued access to staff in promoting ongoing recovery was outlined above. Some degree of continuity of care could also help rehabilitation programs.

There was a more fundamental dynamic for a number of adolescents. These experienced a range of adverse parental environments – ranging from being a "poor fit" within a family with certain characteristics, emotional unavailability, enmeshment with a parent or poor supervision to abandonment, physical, sexual or emotional abuse, or domestic violence.

Tasks of Parenting

Level of commitment
Adequacy of nurturance
Attachment/bonding styles
Met dependency needs
Met protection needs
Levels of consistency, supervision, monitoring
Correction styles
Communication of schemas, values
Adequate boundaries
Emotional containment
Capacity to facilitate transitions
Capacity to understand

We constructed a list of the Tasks of Parenting (see box) from longitudinal studies of parenting, with cross cultural validity and evident in literature spanning many centuries. (This has not been otherwise validated. It was developed before the concepts of attachment were better articulated. Its utility is that it can be fairly readily operationalised, was readily understood by clinical and teaching staff and was relatively free of jargon.

Our observations suggested that

- many of these qualities were applicable to staff qualities;
- the more qualities a staff member had the better they related to adolescents and comprehended the interactions;
- it provided an adequate explanatory model for many observations of the dynamics of the interactions between adolescents and staff;

- and being in an environment in which many of these characteristics predominated amongst the adults in the environment was a significant factor in working through important issues of their own home environment and in some important developmental tasks such as individuation and identity.

During the interview I supplied a diagrammatic representation of stages of change in adolescents who self harmed who experienced trauma. These tasks of parenting were inserted into the diagram between the pre-connection and connection phases. Our observations suggested that these were important staff qualities in both outpatient and inpatient settings in facilitating this transition between phases.

I considered a model which incorporated continuing contact with at least some key staff whom the adolescents knew well and who understood the issues of the adolescents were working through to be critical to assist adolescents individuating from an adverse environment to achieve independence. We also observed over the years that it was important for adolescents who needed to transition to independent living to have ad hoc continuing access to the unit for support although they would have their primary treatment within the community. The lack of parental support was significant in times of crisis even up until their early 20s.

Embedded is a letter I wrote on 14/10/2014 to Lorraine Dowell, senior OT at The Park advocating for the retention of staff.


Letter to Lorraine.rtf

Again some of these needs have been met by former Barrett teaching staff in the transition arrangements developed by the Department of Education.

Treatments

Typically adolescents received multiple, complimentary psychological therapies. For instance a DBT group was run regularly and elements of this would be incorporated into individual therapy is and in supportive counselling in the ward environment. An adolescent with social anxiety might examine cognitions with the psychologist while undertaking graded exposure activities with the occupational therapist. Gains would be generalised in family therapy sessions. An adolescent with PTSD, while undergoing trauma focused therapy with the psychologist, would have expert counselling and support from select nursing staff if they were experiencing dissociative phenomena during the evening.

While it is possible to have a range of therapeutic approaches in community settings, in practice it is difficult to achieve the same level of coordination and intensity.

Safe Accommodation

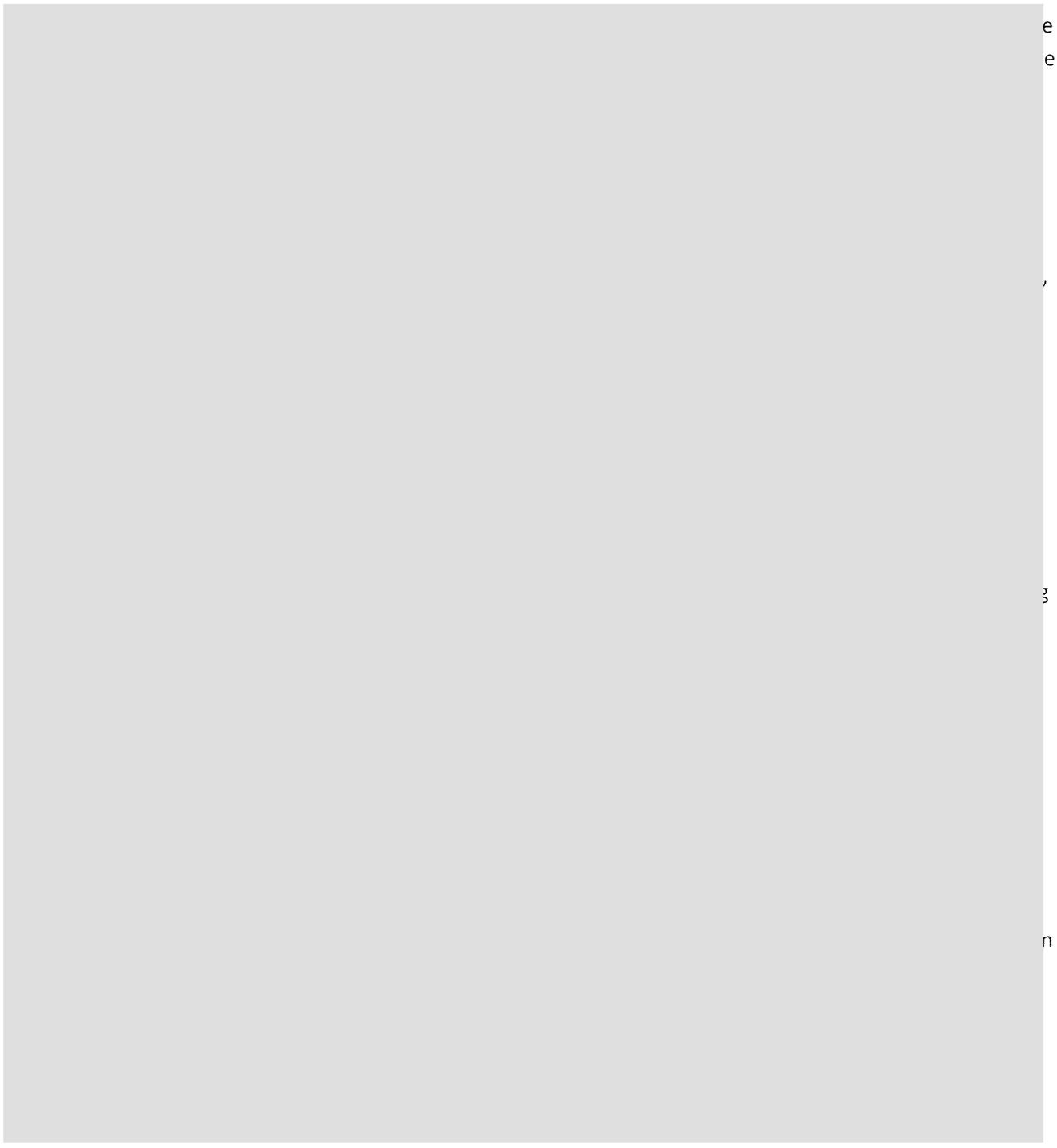
I envisaged that adolescents would access a range of accommodation after discharge. If inpatient beds were available at Logan Hospital, there were some who may still need that level of accommodation. Some were already in transition away from the Centre and some could live in either home or residential accommodation and attend a day program is adequate transport arrangements were included as part of their transition package.

Issues for Individual Adolescents in Developing their Transition Plan

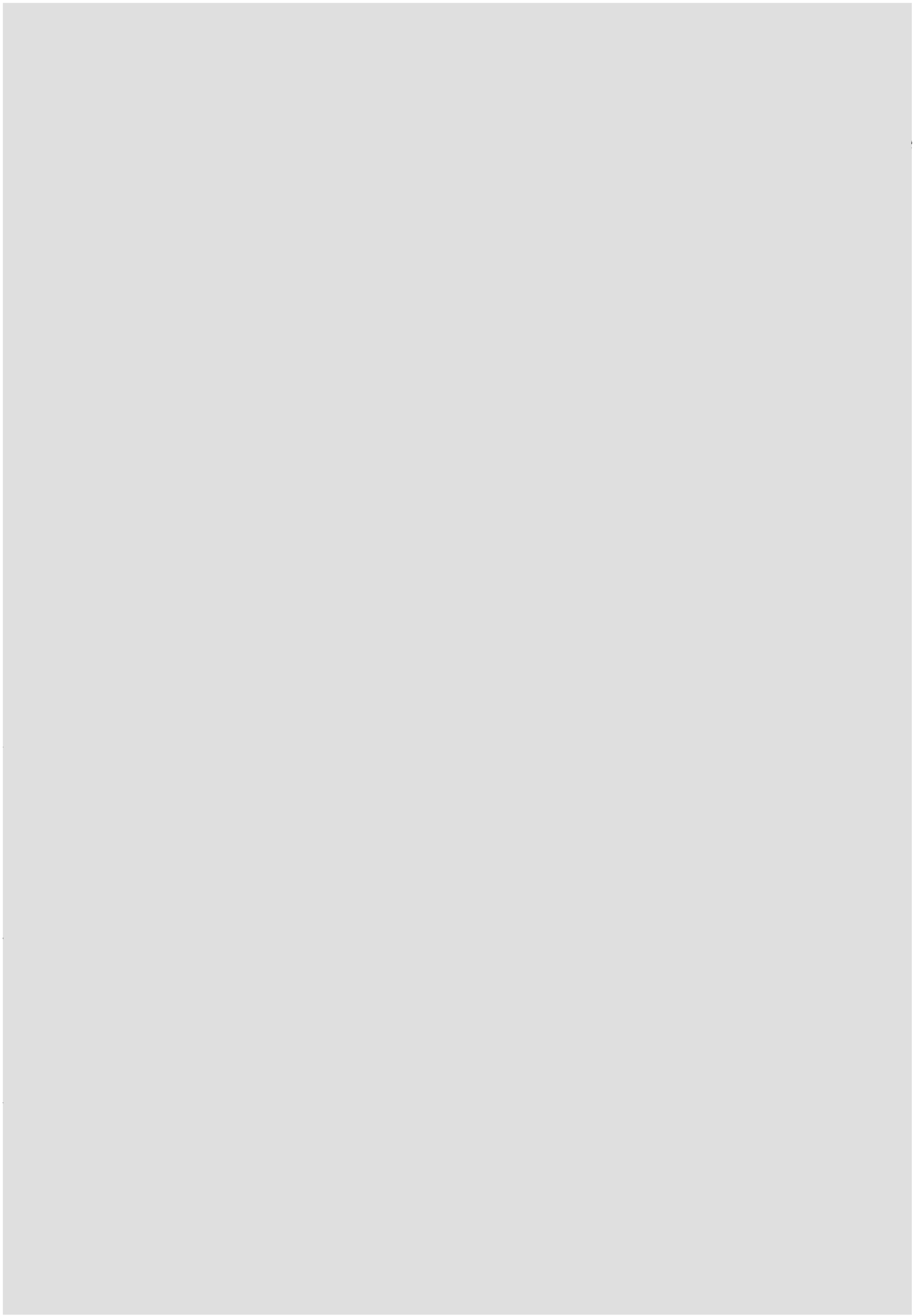
My early focus was on developing adequate transition systems and hopefully facilities into which adolescents could be optimally transitioned. I will briefly outline the transition processes I can remember for the adolescents at the time of the announcement to illustrate how these various components would be used in developing transition plans had I continued. The main intention is to illustrate the range of interventions necessary beyond community based treatments.

Adolescents are identified only by their initials and grouped into male and female. I may have missed one or two.

Males



Females



SEEKING AN EVIDENCE BASE TO DETERMINE THE REQUIREMENTS FOR RESIDENTIAL CARE

(SHOULD INPATIENT CARE BE A COMPONENT OF THE NEW MODEL?)

SUMMARY

The literature on alternatives for adolescent inpatient admission is reviewed. The literature identifies a number of interventions appropriate to either adolescents presenting for acute admission, or young people who have different disorders to those admitted to Barrett or of a predominantly different age group. This literature describes a group of adolescents who do not respond to these interventions, or have a level of severity of presentation where the described intervention would not be appropriate. The literature does not describe alternative interventions for those with severe, persistent disorder.

The literature on length of stay is largely contextual, set against a background of changes in therapeutic approaches, third party influences necessitating change in the length of stay and changes in the disorders treated in inpatient units. Some patient and family variables related to length of stay are described. These are largely contextual to the cohort of adolescents admitted to that unit.

There is considerable evidence from observations over the past 25 years of the level of skills needed in staff to manage adolescents with the severity, persistence and complexity of those admitted to Barrett Adolescent Centre. These include:

- Levels of acuity in some adolescents requiring high levels of continuous and close observations
- Adolescents on an Involuntary Treatment Order requiring admission to an Authorised Mental Health Service
- In rare instances having the capacity to offer seclusion as a necessary intervention
- Observations to the therapeutic process from providing continuity of care vs breaks in continuity by transferring adolescents with high acuity to other units
- Observations from changes in the stability and permanency of staff
- Observations on the contributions of staff of various skill levels
- Observations on the necessary skills registered nurses bring to the unit which are required to manage adolescent of this level of complexity and severity. These skills include knowledge of mental illness, skills in assessing mental state, skills in assessing level of risk, knowledge of and capacity to generalise skills developed in specific therapeutic interventions, capacity to manage emotional dysregulation, capacity to manage behaviours, capacity to monitor and manage impaired medical states, capacity to provide therapeutic interventions as necessary across settings and across time, and capacity to provide care coordination.

It is concluded that substantial evidence exists to recommend that an inpatient service is a necessary component of care to manage adolescents with the severity, complexity and persistence of disorders of those currently admitted to the Barrett Adolescent Centre

THE LITERATURE

Medline and PsycInfo databases were searched for articles related to adolescent inpatient admission. Several papers were identified which consider the characteristics of innovations in inpatient admission and alternatives to admission, at times in randomised controlled trials of the alternative intervention vs inpatient admission. These can be grouped into interventions for general disorders, interventions for specific behaviours and interventions for specific disorders. In addition, several papers were identified that examined issues around length of stay.

Papers were examined for their relevance to the population of adolescents currently seen at Barrett in terms of age, the range of disorders treated, persistence of symptoms, and persistence of impairment. Some reviewers (Gowers & Rowlands, Inpatient services, 2005) noted differences in the range of acuity among the papers they surveyed. Examples of the criteria for admission are contained in the current Model of Service Delivery for the Adolescent Extended Treatment and Rehabilitation Service.

"Severe and complex mental illness in adolescents occurs in a number of disorders. Many adolescents present with a complex array of co-morbidities. AETRC typically treats adolescent that can be characterised as outlined below:

- *Adolescents with persistent depression. This is often in the context of childhood abuse. These individuals frequently have concomitant symptoms of trauma eg. PTSD, dissociation, recurrent self harm and dissociative hallucinoses.*
- *Adolescents diagnosed with a range of disorders associated with prolonged inability to attend school in spite of active community interventions. These disorders include Social Anxiety Disorder, Avoidant Disorder of Childhood, Separation Anxiety Disorder and Oppositional Defiant Disorder. It does not include individuals with truancy secondary to Conduct Disorder.*
- *Adolescents diagnosed with complex post traumatic stress disorder. These individuals can present with severe challenging behaviour including persistent deliberate self harm and suicidal behaviour resistant to treatment within other levels of the service system.*
- *Adolescents with persistent psychosis who have not responded to integrated clinical management (including community-based care) at a level 4/5 service.*
- *Adolescents with a persistent eating disorder such that they are unable to maintain weight for any period in the community. These typically have co-morbid Social Anxiety Disorder. Treatment will have included the input of practitioners with specialist eating disorders experience prior to acceptance at AETRC. Previous hospital admissions for treatment of the eating disorder may have occurred."*

Some papers were excluded from this review because they described interventions for young people with a behaviour disorder or young people who were 6 – 12 years of age.

Interventions for General Disorders

Two European studies (Mattejat, Hirt, Wilken, Schmidt, & Remschmidt, 2001; Schmidt, Lay, Gopel, Naab, & Blanz, 2006) conducted trials of allocation to inpatient treatment vs home treatment for children and adolescents aged 6 -17 years.

The mean age of the Mattejat et al trial was 11 years and 9 months at the time of the intervention, and 15 years and 6 months at follow up. Young people were randomly allocated to home treatment

or inpatient interventions. Disorders treated at two centres included (in order of frequency) emotional disorders, conduct disorders, anorexia and other eating disorders, encopresis and enuresis, neuroses and ADHD. Because the early papers describing exclusion criteria (e.g. need for hospitalisation because of safety) were in German, it is difficult to gauge the numbers who may have needed hospitalisation and thus excluded from the randomised process. Because the follow up was an analysis of each group, they did not address the issue of varying trajectories within each group, including the need for subsequent admission.

The mean age of the Schmidt et al trial was 10.9 years in the home treatment group and 11.3 years in the inpatient group. This study excluded young people with cachetic anorexia, who were acutely psychotic or suicidal. Nearly 65% of the young people had a primary diagnosis of an externalising disorder, and 14% were admitted for a developmental disorder. Over 85% of young people in both groups had prior inpatient or outpatient treatments. 17% in the home treatment group and 13% in the inpatient group had subsequent inpatient admissions. Overall 17% in both groups declined in functioning.

A Community Intensive Treatment Team was developed in Firth, Scotland in response to the closure of the adolescent inpatient unit (Simpson, Cowie, Wilkinson, Lock, & Monteith, 2010). The age of young people described and the presenting disorders were more equivalent to the Barrett population. The HoNOSCA scores on admission were significantly elevated, characteristic of those admitted to acute inpatient units. Both the problems with family life and relationship and impairment subscales on the HoNOSCA were less than in Barrett on admission. This seems to be a population who were acutely unwell and who may be treated otherwise in an acute inpatient unit. As yet, impairment was not established. 3 of the 57 deteriorated over the time, and a further 6 required hospitalisation out of area.

The value of this study is its application to young people who may be otherwise admitted to an acute inpatient unit. The mean length of time in treatment was 23 weeks, substantially more than the average time in CYMHS outpatient treatment.

Multi-systemic Therapy (MST) is an intensive community based treatment introduced initially for delinquent youth. This was subsequently extended in a randomised trial comparing MST to hospitalisation to youth presenting to emergency departments with self harm or suicide intent, homicide ideation and psychosis. (Henggeler, et al., 1999). The average age of youth was 13 years, 85% had previous mental health care, 35% had previous hospitalisation. More than half had either Oppositional Defiant Disorder or Conduct Disorder and 25% had contact with the juvenile justice system. At one year follow up (Henggeler, et al., 2003), 49% of those in the MST required hospitalisation in the first four months, and 47% of both groups required out of home care. Periods of hospitalisation were brief (< 14 days). There were initial gains for those in the MST group in a number of measures, but these dissipated after a year. A subsequent paper (Halliday-Boykins, Henggeler, Rowland, & DeLucia, 2004) noted the heterogeneity of outcomes among the youth, with 17% showing marked deterioration. No papers have been published for this group since 2005, in contrast to continuing research for MST for delinquent and substance abusing youth.

Three crisis interventions were trialled (Evans, Armstrong, Greenbaum, Brown, & Kuppinger, 2003) with young people from 5 – 17 years (mean age 12.9 years) who would otherwise have been hospitalised with a range of disorders and behaviours including disruptive, adjustment, mood,

psychotic and anxiety disorders. 82% were maintained in the community. 5 – 10% were hospitalised because they were a danger to themselves.

Interventions for Specific Behaviours

Alternatives to inpatient admission for adolescents with self harm behaviours continue to be evaluated. A rapid response outpatient model for reducing inpatient admission is described (Greenfield, Larson, Hechtman, Rousseau, & Platt, 2002). This is a specific intervention evaluated in a controlled trial against routine evaluation in an emergency department. Rates of inpatient hospitalisation following attempted suicide or presentation with self harm were decreased using this intervention. Follow up was for 6 months. Some young people required readmission during that period.

Interventions for Specific Disorders

Treatment for anorexia was evaluated in a multi-centre trial of specialist community based eating disorder services vs generalist CAMHS vs inpatient treatment (Gowers S. G., et al., 2007; Gowers S. , et al., 2010). First line inpatient treatment showed no advantage over either specialist community treatment or generalist CAMHS treatment. The value of long term admission for those requiring subsequent hospitalisation for either community group was doubtful, although the lead author continues to consult at a longer term inpatient unit.

Literature on Length of Stay

Up until the 1980's, length of stay was often determined by the type of therapy, in particular psychoanalytically informed therapy (Nurcombe, 1989) which continues to be a factor in some European inpatient units (Hoger, et al., 2002). In the USA in particular, pressures from the health insurance industry necessitated dramatically curtailed lengths of stay (Nurcombe, 1989; Larson, Miller, Fleming, & Teich, 2007; Butts & Schwartz, 1991; Gifford & Foster, 2008; Case, Olfson, Marcus, & Siegel, 2007). Units changed practices in number of ways including the types disorders for which young people were admitted (Pottick, Barber, Hansell, & Coyne, 2001) and a shift from treatment to crisis intervention, short term stabilisation and transition to community treatment (Gold, Heller, & Ritorto, 1993). The UK has faced pressures to admit acute admissions in to what were previously longer stay wards, resulting in a mix of lengths of stay (Corrigall & Mitchell, 2002).

One study (Hoger, et al., 2002)noted that diagnosis is not an indicator of length of stay, although there is some evidence (Hanssen-Bauer, et al., 2011; Swadi & Bobier, 2005) that psychosis predicts a longer length of stay in acute inpatient units.

Factors described as being associated with longer lengths of stay include persistent aggression (Dean, et al., 2008), callous-unemotional traits (Stellwagen & Kerig, 2010), having a co-morbid disorder with an eating disorder (Lievers, et al., 2009), variation in the response rates in those with a depressive disorder (Subramaniam, Lewis, Stitzer, & Fishman, 2004) – although the causes of this variation is unclear - and active suicidal preoccupation without active preparation or attempt. (Lesaca, 1992). Because of the individual characteristics of these units, it is difficult to extrapolate many of these factors to an adolescent extended treatment unit.

Conclusions from the Literature

Numerous naturalistic and controlled studies have described alternatives to inpatient care. However, these are characterised by:

- predominantly being alternatives to acute admission for a cohort of adolescents with first or early presentations
- often being interventions for a younger age group to those at Barrett
- often being interventions for disorders which would not be a primary reason for admission to Barrett
- often excluding from the study a cohort who were severe enough to absolutely require admission
- often identifying a cohort who deteriorated from baseline after 4 – 6 months (on average) of the intervention under investigation
- not providing details of further interventions for this latter cohort.
- not adequately describing factors contributing to longer lengths of stay in a unit utilising multimodal interventions for a cohort of adolescents with severe, persistent disorders with severe impairment.
- did not consider residential treatment as an alternative to admission

Since adolescents admitted to Barrett are likely to be either those who were too unwell to participate in the interventions described in the literature, or deteriorated in spite of the intervention, the literature does not provide guidance regarding alternatives to admission.

Moreover, the literature provides little guidance regarding length of stay for adolescents with severe and persistent disorder with impairment.

ALTERNATIVE EVIDENCE TO CONSIDER FOR THE NEED FOR INPATIENT ADMISSION

Various observations from Barrett Adolescent Centre provide a range of evidences for the necessity for an appropriately staffed inpatient service.

1. Continuous Observations

Continuous observations are one measure of acuity. It is a carefully considered measure, because it is an expensive resource, is potentially aggravating to the young person at a time when they are already in considerable distress and is demanding on staff. It is an indication of a level of acuity which is not tolerated in units staffed by residential workers (e.g. ADAWS), and would necessitate transfer to an inpatient unit.

The decision to utilise continuous observations is made most often because of [redacted] whether in the context of profound depression or psychotic illness. This may be associated at times with extreme anxiety and agitation. Uncommonly adolescents who are nutritionally impaired due to a range of eating disorders may be placed on continuous observations for a period after meal times, or to support physical health. The decision is made with consideration to other measures available including locking the ward (it is normally an open unit where adolescents have free access to outside spaces).

Average hours of continuous observations per year for the following five year periods

1998 = 2002	4510 hours per year
2003 – 2007	4580 hours per year
2008 – 2012	5200 hours per year

In addition, to continuous observations, an equal number of hours may be spent in a state of "high acuity" – 5 minute observations, or restricted to an area of the ward where they are readily visible.

Changes in the permanency of staff in the unit during the period of uncertainty of relocation of the unit since 2008 allow conclusions to be drawn about staff who know an adolescent doing continuous observations vs those who may be contracted for a shift or for a series of shifts.

Skilled permanent staff

- continually monitor mental state for improvements (to enable lessening of the conditions of continuous observations) or deterioration. During periods of deteriorated mood, adolescents show considerable ingenuity in obtaining means for a [redacted] if a staff member is unaware of their usual behaviours and early warning signs.
- have a thorough understanding of the history and course of the adolescent's illness
- develop judgment when to leave an adolescent, and when to attempt to engage them
- help to implement strategies to assist with distress tolerance or contain emotional dysregulation
- avoid attempts at rescue
- utilise relationships that have previously developed to engender trust and hope during periods of profound hopelessness and despair
- utilise relationships developed during periods of continuous observations to consolidate therapeutic relationships and enhance ongoing interventions once the crisis has eased and in future states of distress

2. Adolescents on an Involuntary Treatment Order (Inpatient Status)

The Model of Service Delivery states that *"The AETRC is gazetted as an authorised mental health service in accordance with Section 495 of the Mental Health Act 2000 [http://www.health.qld.gov.au/mha2000]"*

52% of adolescents admitted to Barrett from January 2008 – December 2012 were either admitted with, or at some point during their treatment placed on an involuntary treatment disorder. Two thirds were because of their [redacted]

3. Seclusion

Seclusion is an intervention of the last resort. In the five years in which comparative data was collected by the Seclusion and Restraint Benchmarking Project, and later the CYMHS Clinical Collaborative, Barrett had the lowest rates of seclusion of the adolescent inpatient units in Queensland, although the adolescents often presented with sustained high acuity. Seclusion has most often been used for an adolescent who is not only at extreme risk to themselves, but also to

staff. It is not used to manage aggressive behaviours per se, because of the availability of open spaces and other measures for de-escalation.

Under the *Mental Health Act 2000,* seclusion can only be used on an involuntary patient in an Authorised Mental Health Service.

4. Observations on Continuity of Care

Over the years, various interventions have been trialled with adolescents including managing high acuity in acute inpatient units e.g. highly suicidal behaviours or the need for nutritional restoration where the medical condition is such that it could be managed in an mental health unit rather than a medical unit.

There are perhaps five instances in the last 25 years where this has aided therapeutic progress. In most instances, it has proved to be a significant disruption to therapeutic alliances important for treatment and rehabilitation. This is particularly significant for those adolescents whose history of loss has contributed significantly to their current psychopathology.

Having skilled staff who can manage high levels of acuity is important.

5. Observations on Stability of Staff

A closed roster for nursing staff has 21 permanent staff on a fortnightly roster to cover the three shifts over seven days a week. Nursing numbers are reduced over the weekend because some adolescents are on leave.

Over the past two years we have had 14 permanent staff, with 3 or 4 graduate nurses on 4 month rotations, and other positions filled by contract and casual staff. Recently we have been able to secure the services of some excellent contract staff. However, for the 12 months from June 2010, we were only able to have staff on 6 week contracts. With holidays, sick leaves etc, and the demand for staff if several adolescents were on continuous observations, there were some shifts that had only one or two permanent staff. In addition, there were two vacant Clinical Nurse positions, so clinical leadership on a shift was inconsistent.

These variations in staff stability and permanency allow observations about the importance of stable skilled workforce to the unit. Briefly, we observed:

- adolescents and their parents complained about inconsistencies in management. Adolescents complained about the lack of staff with whom they built trust and rapport
- therapeutic interventions (described below) did not occur
- the use of prn medication increased, because staff on a shift may have lacked skills for more appropriate interventions
- rates of seclusion increased a little
- adolescents were placed on continuous observations at a lower threshold, because staff lacked the experience of patients to recognise early warning signs
- graduate nurses did not benefit from their placement because of the lack of mentoring and staff cohesion

6. Observations on Skill Mix for the Inpatient Unit

The majority of staffing for the residential section has been Registered Nurses. The exceptions are

- two long term Enrolled Nurses have made an invaluable contribution
- 3 – 4 graduate nurses undertaking their mental health training have been a regular part of the nursing establishment for the past decade. Observations of the performance of this group of staff who have considerable training provide some evidence for staffing with residential workers.

Graduate nurses report the skills they develop on the unit include:

- learning to observe mental state and behaviours for early warning signs of distress
- learning the skills of therapeutic relationships including boundaries, promoting and monitoring developmental tasks, application of a range of interventions
- developing a range of behavioural interventions for specific behaviours

Some are observed to develop these skills from early in their rotation, but the majority are beginning to grasp the basic concepts by the end of a four month rotation. Those who return to the unit after they have finished their formal training continue to develop over the next twelve months. This is consistent with internships in other areas.

These observations that registered nurses offer the necessary skills for an inpatient unit compared to being staffed with a majority of pre-graduate residential workers is consistent with overseas experience (Greenfield, Larson, Hechtman, Rousseau, & Platt, 2002). In this study, the intervention was conducted utilising experienced mental health nurses or final year medical students, both supervised by a child and adolescent psychiatrist. Improvements were greater on all measures with experienced mental health nurses.

7. Observations on Skills Utilised by Registered Nurses During 24 Hours of Care

Skills observed to be necessary in staff, and available through registered nurses include:

- Possessing knowledge of the presentations of mental illness. Often adolescents admitted to Barrett have complex presentations which makes diagnosis unclear. For example, some adolescents become elevated in mood and behaviour for a few days. Skilled observations of the range of behaviour and continuing assessment of mental state is necessary to determine whether this is a picture of an emerging bipolar illness or a transient elevation in mood.
- The unit is an open unit, with free access to outside areas. Careful observations of mental state are necessary to enable decisions to be made as to whether a potentially suicidal adolescent may require either closer monitoring, or is at risk of absconding. Conversely, some distressed adolescents will benefit from time out in the open spaces. A high capacity to assess risk is necessary to determine which interventions are the most appropriate.
- Generalisation of skills learnt in groups or individual therapy to the adolescent's day to day living situation. Skills include those that are part of Dialectical Behaviour Therapy, skills from Social Skills group or maintenance of graduated exposure through activities.
- Managing emotional dysregulation. This is a complex set of skills because staff need to be able to recognise the impact of their own emotional responses, know when to allow to

ventilate, when to set limits, when to simply sit with an extremely sad adolescent, when to offer hope or simply contain an affect, when to offer specific interventions e.g the sensory room or the opportunity to do art and when to use the opportunity to process the current emotion. This is one of the most important therapeutic processes in adolescents who are very distressed. The relationships built up during these periods are a necessary function of furthering therapeutic interventions from both nursing staff and other professionals.

- Managing behaviours. Again, this requires a complex set of skills of observing antecedents, utilising an appropriate behavioural intervention and monitoring the outcome.
- Monitoring and managing compromised medical states. It is not unusual for adolescents with histories of complex trauma to have significant difficulties for periods of maintaining an adequate oral intake. The impact of this on nutritional status ranges from a barely adequate intake resulting in weight loss, but no changes in physical signs to severe dehydration to severe malnourishment. Interventions are difficult. At the most basic level, staff must be able to monitor basic physical signs, and note changes indicative of deterioration. Skilled staff with an understanding of the impact of trauma can negotiate (in conjunction with advice from the dietitian) a basic level of intake to maintain homeostasis. At times, intravenous hydration or parenteral nutrition may be required. Although this may be initiated in a medical setting, it may need to be continued at Barrett if it continues for any length of time. The success of this intervention is dependent on a skill level to be able to manage intravenous or parenteral nutrition administered by staff with whom the adolescent has already developed a sound therapeutic relationship.
- Providing therapeutic interventions. For example, an adolescent with a severe Social Anxiety Disorder may be phobic eating with other adolescents. Skilled staff will be able to negotiate a process for eating meals with progressive gradual exposure to being able to tolerate eating with others. They must be able to recognise whether a reluctance to proceed to increased contact with others at meal times is simply entrenched avoidant behaviour, or whether the anxiety is still too high. Another example is managing symptoms of Post Traumatic Stress Disorder in adolescents with histories of severe and complex trauma. Frequently dissociation and flashbacks occur in the evening, and interrupt sleep if the adolescent is woken by nightmares. This requires a complex set of skills in staff from grounding, emotional containment, allowing appropriate exploration of the trauma if the adolescent needs to do that at that time and encouraging the adolescent to employ strategies and skills they have been developing.
- Provide Care Coordination. Relationships are built with adolescents and their families across shifts and in a variety of situations not available to other professions. This, together with the skills of nursing staff enables them to function in the complex role of Care Coordinator.

8. Observations on Referrals from the Mater Acute Inpatient Unit/Day Program

There have been occasions where adolescents have had extended inpatient care in the Mater CYMHS Acute Inpatient Unit and attended the Day Program. Although this has continued for a time, they have been referred to Barrett for further treatment and rehabilitation due to the unsuitability of being in an Acute Inpatient Service. Although this is an unusual pathway for referral, it does illustrate the limitations of acute inpatient care for this population.

In summary, multiple lines of evidence – high acuity, the need for an appropriate level of care as an Authorised Mental Health Service, the need for continuity of care and the requirements for the skills of registered nurses – together with lack of alternative models described in the literature for this population, suggests that inpatient care must be a component of the new service.

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SKIPPEN, Tania

From: Kristi Geddes >
Sent: Wednesday, 22 October 2014 11:26 AM
To: KOTZE, Beth; SKIPPEN, Tania
Subject: Fwd: Amendment to this morning's email
Attachments: COMMUNITY TREATMENT OPTIONS IN TRANSITION PLANNING amended.docx; ATT00001.htm; Letter to Lorraine.rtf; ATT00002.htm

Further email from Dr Sadler.

Kind regards,
Kristi.

Kristi Geddes
Senior Associate
Minter Ellison

Begin forwarded message:

> **From:** Trevor Sadler <
> **Date:** 22 October 2014 9:39:50 am AEST
> **To:** 'Kristi Geddes' <
> **Subject: Amendment to this morning's email**
>
> Dear Ms Geddes,
>
> In the email I forwarded earlier this morning, I attached two files. I wish to amend a date in the file "COMMUNITY TREATMENT OPTIONS IN TRANSITION PLANNING". Half way down page 8 I embedded a file. The text above it said that this was a letter I wrote to Lorraine Dowell on 14/10/2014. It should have been 14/10/2013. (Actually, I wrote these letters in WordPerfect on 3/10, and converted this to file to rich text on 14/10.) I have attached an amended file and the embedded file separately.
>
> Obviously this letter was written during the time frame being examined by your investigation. Among other things, it expresses my concerns about potential outcomes for adolescents.
>
> Yours sincerely,
>
> Trevor

COMMUNITY TREATMENT OPTIONS IN TRANSITION PLANNING

I was asked a question along the lines of if I considered community treatments may or not be an appropriate option for an individual adolescent's treatment plan, or whether I could have been working towards that in the five weeks I was there after the announcement. I replied that I had not considered it was appropriate but did not adequately explained why.

However, the question jogged my memory. In the days since, I have greater clarity of recall of my thinking from the time of the announcement until I was stood aside.

I considered that the transition plans for most of the adolescents would necessitate

- access to rehabilitation programs including a specialised school component,
- tangible incorporation of key elements of recovery,
- continuing access to staff whom they had known to those working through issues of difficult parenting and continuation of the recovery elements as well as
- treatment and
- safe accommodation.

My primary tasks above my clinical role at that time were to

- support staff at a time of great uncertainty for themselves professionally to provide the best clinical care in the circumstances,
- have a very active input into the State-wide Adolescent Extended Treatment and Rehabilitaion Implementation Group (SAETRIG) and two of the working groups – the Patient Transition Working Group and the Services Options Working Group so that the transition plans would incorporate as far as possible the above key elements and
- support particularly vulnerable patients in their treatment so that they could survive a probable lower level of care than was provided during the preceding six months.

During the time that I was there transition plans were only considered in broad conceptual terms rather than in detailed planning.

Anticipated Challenges

I regarded the second task as being particularly challenging.

- Dr Bill Kingwell wrote in May to confirm that he was not an expert in child and adolescent psychiatry, yet his recommendations adopted by the Planning Group included the wraparound service and the Y-PARC model. The latter was fundamentally different to Barrett with no patients on an Involuntary Treatment Order and none who self harmed. As Director of Mental Health he had a key role in guiding the process but from my perspective had little understanding of the clinical issues of the Barrett young people.
- The SAETRIG was fundamentally different in composition from the Expert Clinical Reference Group (ECRG) which produced recommendations for alternative services to replace Barrett. Although from a different Health District I had worked with Judi Krause on a number of committees and had known Stephen Stathis since he was a registrar. Both were the co-chairs of the SAETRIG. Unlike the ECRG,

the SAETRIG had only two people with experience in longer term treatment and rehabilitation. (That was reduced to one when I left the SAETRIG.)

- The SAETRIG was not provided with a full copy of the recommendations of the ECRG by mid September, although the name implies its role was to implement the recommendations of the ECRG. There was no guidance as to what transition services may be possible, the exact nature of and the reasoning behind the ECRG recommendations was unclear, and pressure was being placed by high level sources to provide a model which was contrary to the ECRG recommendations.
- The Royal Children's Hospital CYMHS in which both Stephen and Judi worked provided only short term interventions. Neither had a good grasp of extended treatment and rehabilitation. They visited the AMYOS in Melbourne the day before we toured the Y-PARC facilities. They were impressed with this service, but did not appear to appreciate that it targeted a different sub-population of adolescents to those seen at Barrett.

This is not intended as a criticism of individuals. They are my perceptions of challenges in high level transition planning to ensure the transition plans incorporated the key elements listed above.

It was clear that there was no reduction in funding for the new services, and indeed funding would be enhanced. The Barrett budget would be transferred from WMHHS to CHQHHS.

I assumed (perhaps naively) that it would be a reasonable plan to utilise the existing Barrett staff in enabling the transition plans (in conjunction with a relocated school staffed by the Barrett teaching staff) and staff forming the core of new services to be developed. Not only would there be funding for this, retaining the expertise of staff was a recommendation of the full ECRG report. It would provide some continuity of care for the adolescents.

This arrangement could operate with adolescents in home, transitional accommodation or an acute hospital bed, but attending either a day program (there were possibly buildings at Prince Charles Hospital which could be available) or as a school based program with former Barrett clinical staff providing ongoing clinical care and facilitating transitional programs to adolescents in the community. By late August an inpatient unit at Logan Hospital also appeared to be a possibility if a significant number still required hospitalisation, or if new patients were to be admitted into the service.

In retrospect, my focus in those early weeks was trying to establish what I considered to be an adequate broad transitional framework, rather than specific transitional plans for individual adolescents.

I foresaw significant obstacles. I tried to get an Education Queensland representative appointed to the SAETRIG. They were identified in the original Work Plan of the WMHHS Planning Group as a key stakeholder, and had representation on both that Planning Group and the ECRG. It was apparent decisions were being made by Queensland Health with little reference to Education Queensland. A representative would be appointed to the Patient Transition Working Group.

I also anticipated difficulties in people on the various groups understanding what challenges the young people faced. Had I stayed on, I would have encouraged the Patient Transition Working Group to meet with the young people and their parent(s)/carers in separate groups. This involvement was a key policy of the Mental Health Directorate, the WMHHS and any recovery model ("lived experience").

I also intended to liaise regularly with Stephen Stathis and encourage him to also meet with both these groups. I reckoned that if he had a thorough appreciation of the clinical issues, he would be able to advocate

for an appropriate service at the higher levels to which he had access. His advocacy would be particularly important, in my opinion to the SAETRIG, where he carried far more weight than I. This was a critical group, with potentially little appreciation of the clinical conditions.

Rationale for Service Elements

The literature lacks research which would provide guidance about the management of those who do not respond to certain treatment interventions. The following rationale is developed from more than two decades of observations about

- what interventions are useful in managing young people with severe and complex mental illness resulting in either profound risk to self, or profound impairment or both,
- the interrelationships between treatment, rehabilitation, developmental tasks, parenting styles, staff characteristics and relationships with staff and
- routes to recovery in this population.

In addition, we were informed by

- feedback from young people who were previous users of the service who spoke at the quadrennial school reviews,
- conversations with colleagues and researchers at national and international conferences (which afforded closer inquiry into aspects of service delivery than reading literature alone) and
- conversations with colleagues in units in the UK and Switzerland.

Rehabilitation Component

These adolescents were very impaired from their mental illness. Over the preceding 5 years, prior to admission,

- 98% had disengaged from school for > 6 months
- 90% had not had face to face contact with peers
- 83% had disengaged from community networks – shops, public transport
- 55% had adequate family supports. 12% had minimal contact with parents.

Tasks of Adolescent Development

Cope with physical changes
Develop cognitive maturity
Negotiate school
Negotiate peer relationships
Develop emotional maturity
Care for the self
Develop moral maturity
Occupy leisure time
Establish boundaries
Develop competencies to become independent
Develop identity
Individuate
Develop life schemas
Develop a sense of future

Notes and observations

- In the virtual absence of literature on adolescent rehabilitation in mental health, a program was developed around a construct of the developmental tasks of adolescence (see box). This allowed all activities – whether generated from the school, the health clinicians or both, to be conceptualised within a common framework. Strengths in development could be identified as well as deficits.
- We observed that the cognitions, behaviours and emotions of a mental illness often had a direct impact on developmental tasks. Conversely, the resultant moratoriums in developmental tasks often negatively reinforced the mental illness. In addition, developmental tasks were often fundamentally

affected by biological developmental issues e.g. learning problems, ADHD, receptive-expressive language disorders, temperament, sensory motor problems.

- Rehabilitation activities were both generic and individualised.
- Rehabilitation activities were generated by the school (which ran a broad set of activities beyond offering formal academic tuition), health professionals, (particularly occupational therapists), in groups and individual activities, and more unstructured activities on the ward and with nursing staff. We observed a combination of group and individual rehabilitation interventions were more effective than either on their own.
- Unlike rehabilitation in physical medicine, where rehabilitation follows acute treatment, rehabilitation and treatment at times coincided. For example, a social anxious adolescent without peer contact for two years or more, was both desensitised to social contact simply by being admitted (treatment) while undertaking a rehabilitation activity by learning to re-establish peer contact and enhance social skills.
- In some cases, progress in rehabilitation preceded treatment, for example, the extremely socially anxious, alexithymic adolescent made many gains in developmental tasks attending school, participating with peers (even as an active participant), broadening their leisure interests, developing competencies to become independent (including washing, preparing meals) which altered their perception of themselves and facilitated capacity to talk.
- Progress in treatment often occurred in bursts which were interspersed with progress in rehabilitation and vice versa. The two seldom ran a linear course. At times they may be concurrent and interdependent.
- Although every effort was made to transition gains in rehabilitation to community services as early as possible (e.g. attendance at school, independently attending a community fitness centre or youth group), our observations were that typically adolescents required considerable facility based rehabilitation support and practice before they were ready.
- Treatment and rehabilitation activities were varied, intensive, complementary and coordinated. This intensity constantly reinforced the gains which were being made.

For all of these reasons, I anticipated that some/many of the adolescents by February would require an active rehabilitation component as part of their transition package. A treatment only transition (either with CYMHS or private providers), even with some NGO rehabilitation support in targeted areas would be insufficient because

- it would lack intensity – at most once a twice a week for an hour seeing the treating clinician
- lack integration between treatment and rehabilitation components
- outside the Mater Day Program which had a waiting list, alternative intensive rehabilitation programs were not available in the south east Queensland (where 70# of the adolescent population live)
- NGO's do not provide the intensity, coordination of programs, range of programs or mix of group and targeted individual programs
- the alternative to an integrated rehabilitation program was accessing multiple rehabilitation components in various settings which would prove challenging and often confusing.

Recovery Components

Multiple elements of what is now identified as components of recovery were identified as important elements in the progress of adolescents in the 1990's – before recovery was formally articulated as a

process. It may seem at first counterintuitive that spending a long time in a mental health facility actually initiates and promotes recovery. I maintain this was so for this group. Their route to recovery was very different to what I observed in private or outpatient practice, and am now observing in adolescents in an acute inpatient setting.

The *National Mental Health Recovery Framework* was only released in November 2013, but I refer to it as it clearly articulates many of the elements which were essential to the adolescents' progress. As this is getting longer than I wanted it to be, I'll just refer to four elements.

Hope

This is common to all concepts of recovery. Most adolescents entered Barrett with hope of recovery after experiencing severe and incapacitating mental illness for a considerable period. This hope was maintained through the positive attitudes of regular staff (at least most of them); through learning new ways of coping; through participating in activities which enhanced skills and confidence and through engagement in therapies which offered significant amelioration of symptoms.

I considered that transition programs must incorporate elements which assisted, as much as possible, the continuation of hope. Hope became a very fragile commodity after the announcement. Patient when considering the announcement of the closure said something like ' The loss of hope was reflected in comments made by a patient on https://www.patientopinion.org.au/opinions/59116.

For those adolescents for whom community only services (referring to treatment appointments in the community) were not appropriate, I considered an environment of hope was an essential component. It was unthinkable in my mind to leave them to cope with anxiety, depression for much of the week, and only to be able to offer hope for an hour or two. That hope included access to staff who had assisted them to whatever point they were at, and who could facilitate further progress.

Looking back at the process post-closure, the prime embodiment of hope was the school, which Education Queensland had the foresight to support. Outcomes would be considerably worse, particularly with the suicides of three of their friends.

Connectedness

In my opinion, this was a critical component of the recovery process, but totally underrated in the research literature of inpatient units and treatment of individual disorders. Connectedness was both an individual and a group dynamic. Connectedness to peers. Connectedness to staff who facilitated recovery, and through that connectedness to the larger community. Connectedness to people and programs at Barrett was the only passage to connectedness to the community.

By transition time, some adolescents would be ready to leave the Barrett connectedness to connect to the community. A tenuous connection to Barrett was often still important, though.

I considered the proposal I outlined previously to provide some vehicle for connectedness for those for whom some connectedness was important.

In retrospect, this has proved to be true for those who could access schooling run by the former Barrett school.

Empowerment

Some may consider the being in Barrett over an extended period the very antithesis of empowerment. I often heard comments that long term hospitalisation encouraged dependency. Undoubtedly it did. At times that was important therapeutically. But a long term environment which focussed on enhancing tasks of adolescent development ultimately resulted in adolescents being empowered sufficiently to want to move away, and stand on their own feet.

For many adolescents it was the beginning of the process of empowerment. Empowerment over the nightmares of past abuse; over emotions that threatened to take one's life, over social isolation. Empowerment that enabled an adolescent to resume school, commence vocational training, have conversations with peers, catch public transport, cook a meal.

Empowerment occurred in a combination of group and individual activities, through both treatment and rehabilitation. Empowerment was supported by hope and by and environment which encouraged progress rather than languish in inactivity.

I considered a continuing active rehabilitation program essential to continue the hope, the environment, the activities which promoted empowerment, perhaps in collaboration with external providers who supported the treatment. (Collaborating with external providers was already a model we utilised over the years.)

Identity

This is not only a challenging and variable process for many adolescents but adolescents who were admitted to Barrett often struggled with impairments to their identity because of the mental illness or assaults on identity from disruptive home environment. Some had core elements of identity on which to build while in others identity formation was very diffuse. Certainly constructing or reconstructing identity was an important task to begin while at Barrett and continued for years afterwards. Our observations were that progression in other developmental tasks and validation from staff as well as personal reflection were key elements in consolidating identity.

Whilst individual community based treatment could offer some validation as well as personal reflection it could not supplement identity formation with practical assistance in progression in developmental tasks nor in in vivo validation.

In summary many recovery elements inherent in the Barrett process could not be replicated by once or twice a week community treatments whether they were office based as in CYMHS or private providers or offered in the community such as by an Assertive Mobile Youth Outreach Service (AMYOS). In my view they needed to be supplemented by access to a day program with integrated schooling.

Unfortunately, I found that the West Moreton Mental Health Service at some level did not appreciate key aspects of recovery. Perhaps the release of the *National Mental Health Recovery Framework* would change this attitude. The lack of appreciation of recovery principles was a significant impediment to developing transition plans. I will outline three examples.

- Loss of hope after the announcement was described in the link below, but not actively enquired about at management level while I was there.

3rd October, 2013

Dear Lorraine,

I write because I heard that you were to be asked to be a member of the Working Group on Workforce and Finance. My being stood aside means that I cannot be involve d in patient care, but I do believe I can advocate for staff.

The ECRG, in its full report stated "Of concern to the ECRG is also the dissipation and loss of specialist staff skills and expertise in the area of adolescent extended care in Queensland if BAC closes and a Tier 3 is not established in a timely manner. This includes both clinical staff and education staff." This does not come across as strongly in the recommendations. Professor Philip Hazell, the interstate expert on the ECRG was adamant on this point. All other members agreed.

I have had the opportunity to do locums with other services, including Mater and Logan acute inpatient units. I interact with many community colleagues. I am absolutely convinced that there is a skill set among many permanent (and some temporary) Barrett clinicians which is not routinely found elsewhere. They incorporate a strong rehabilitation focus as well as strong expertise in managing trauma, self harm, disordered eating behaviours, and extreme social anxiety - often in the context of Aspergers and other developmental disorders.

From the rate of referrals from various Districts (compared to the number of young people they see annually), the average community CYMHS clinician or private child psychiatrist would only see a young person of Barrett level severity every 3 - 5 years. Clinicians in acute inpatient units may see them yearly. Since over half of CYMHS clinicians are there less than 5 years, many will not have seen even one. Yet this level of severity is our bread and butter. I know from doing workshops with the Townsville and Toowoomba day programs, that the level of severity which they see is not comparable to even our day program young person. The level of expertise at Barrett is generally what one would expect in a Clinical Services Framework Level 6 service.

Outside the ECRG, this expertise is really quite devalued. There was no recognition of this in the last Transition Steering Committee meeting I attended on 9/9/2013.

This email is to list a number of precedents which could be referred to.

1. The current approach in the Queensland Children's Hospital is to recognise expertise in the Royal Children's and Mater Children's staff. I forget if they refer to the various levels as Tiers or Divisions. The second Tier - Directors of various Departments was an open merit selection process. The third Tier (equivalent to Team Leader, NUM or CNC) is a closed contestable process. The fourth Tier - ordinary clinicians like myself - is people slotting into equivalent positions, if there is no duplication of position, in which case there would be a closed merit selection process. Since Barrett is an add on service, which comes with its own funding, the same process could and should apply.

2. I would be interested to know what the process was when the Children's Cardiology service was transferred from Prince Charles to the Mater Children's. I cannot imagine that one would scrap expertise built up in children's cardiology, and the Mater (which is a private entity) bring in its own staff. That would devalue the whole service, and risk problems. Why should mental health be any different?
3. There was a smaller process when the gastroenterology department transferred from the Mater Children's to the Royal Children's. Apart from specialists, I don't know who else went across.
4. Finally I would be interested to know about the staffing of the Children's Emergency at Prince Charles. I am not sure if this comes under Metro North or Children's Health Queensland. If it is Metro North, were staff transferred from RCH (which would be the sensible first option), or did they employ totally new staff?

I am not writing out of self interest. Even if I was to be cleared of the allegations against me, the damage to my reputation is such that I doubt anyone in CHQ would be interested in having me. I am really concerned for two things.

1. Trying to maintain the best service for adolescents in whatever form that service takes. The time frames are incredibly short, and totally unrealistic. Adolescents were beginning to panic before I left because the future is so uncertain. Whatever service replaces Barrett, it will not be a CSCF Level 6 service. At best it will be between Levels 4 and 5. Some will be permanently impaired by their mental illness. The best hope of ameliorating the detrimental effects of this process is by maintaining the expertise of staff.
2. To maintain the expertise of staff. Through mentoring, selection of staff which show promise, and developing a strong team culture and ethos, as well as understanding of the processes of treatment and rehabilitation, I believe the team as a whole is unique. It is a total waste of experience to see that dissipated. Sure, it would be useful in community teams or acute inpatient units. Acute inpatient units have a very different focus, and will not utilise the skills at all. Community CYMHS functions as a team clinicians from individual disciplines, not as a multi-disciplinary team. Both of these settings will minimise the transfer of skills of our staff. Moreover, these skills will be totally underutilised because of the infreqeuncy of presentation of severe and longer term cases. They will therefore diminish with time. In addition, the significant feature of Barrett is that the contributions of every individual are integrated into the whole skill set of the team. This will not happen if they are dispersed.

I strongly implore you then to advocate for the retention of our staff into the new service(s), in the same way that the skills of staff from RCH and the Mater is recognised and will be incorporated into the new Queensland Children's Hospital.

I am also writing to Paul Clare and Padraig McGrath who I understand were to be invited on to the Working Group.

Kind regards,

Trevor Sadler

Queensland Health

Health Service Investigation - Barrett Adolescent Centre

1084936

Interview with Dr Anne Brennan, Clinical Director (from September 2013), 13 October 2014

Parties: Beth Kotze (BK), Tania Skippen (TS), Dr Anne Brennan (AB), Harry McCay - Avant (HMC)

Part 1 of 4

BK: [?] details.

HMC: I've got the original and a couple of copies.

BK: [?] that would be just great.

HMC: So, that's the originals and two copies.

BK: Thank you very much. Okay. So ah I'm a Child & Adolescent Psychiatrist from New South Wales. Tania and I work in Mental Health Children's and Young Peoples Unit in New South Wales. So, can we just start by confirming with you your understanding of this process?

AB: I understood that there's been an inquiry convened because there are three of the young people who are patients at Barrett last year have died since its closure, they decided to look at has something gone wrong, what needs to be done differently, and so forth.

BK: You've got a copy of the terms of reference?

AB: Yes.

BK: Do you have any questions about the terms of reference at all?

AB: No.

BK: No, okay. So, you're.

AB: Could I just interrupt?

BK: Yes, certainly.

AB: One question I had was what will happen to the report in that Is it [?]

BK: Look I don't know the answer to that, I know that we provide the report to Queensland Health, but we can certainly make sure that it is clear that any

[?] word/s cannot be identified
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concerns about releasing the report broadly. There's nothing in the material that's been given to us that indicates what Queensland Health intend to do with it. But we will definitely make sure that, and if there's anything in particular that you would, you know, request that we keep in a separate file, refer to separately, we can certainly do that.

AB: Okay. Thanks.

BK: But we will clarify that [?]. And you're currently working for Children's Health Queensland?

AB: That's right.

BK: Where's that Unit based?

AB: Royal Children's Hospital.

BK: Okay, okay. So, in terms of just the organisational arrangements, were you seconded to?

AB: No.

BK: No, right.

AB: I had had a private practise which I closed, I was essentially retired, but that had only been a matter of weeks and I was actually doing, I'd suppose you'd call it almost volunteer work.

BK: Right.

AB: And I was also in negotiations with Headspace about maybe doing some work with them, and then I got a phone call from Peter Steel at Children's Health Queensland, saying could you do this. So, I wasn't working in public health. I refute that point.

BK: I had the impression that it was at very short notice and, is that correct?

AB: Less than 24 hours.

BK: Right.

AB: Yeah, it was can you start this tomorrow?

BK: Mmm.

AB: And told me the context in which it was happening and I didn't think that, I think my words were, those shoes are too big for me to fill. And then he was reassuring that no, he wanted me to do the job. And he said it would be overseen by Elizabeth [?] who was employed by Children's Health Queensland.

BK: Mm. So, we do have your statement and it's extremely helpful and comprehensive. But I wonder if you would perhaps start by [?] question telling us what you found when you started.

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AB: Um. That first day was quite overwhelming really. I spoke to Elizabeth on the phone the previous night, and then she picked me up at my house. We talked in the car going out to Wacol. Have you been to West Moreton?

BK: I haven't, no.

AB: So, it's quite a drive but anyway, we talked on the way out there, we went straight to the administration building, we had a meeting with the executive, we went from there down to the ward, and there was palpable hostility. We then convened a meeting of the kids in the hope, I am not being disrespectful calling them kids, they were kids.

BK: Look, I'd call them kids, yeah.

AB: So, we had a meeting with the kids. I was much more familiar with Barrett than Elizabeth because I'd worked there 20 years ago.

BK: Right.

AB: And, I guess, I would say I had a great affection for the place then and a lot of the staff were still exactly the same. So, there'd been this kind of warm embrace of me in some ways, but then because I didn't behave in the way the staff hoped I would, there was an immediate perception that I somehow had now become 'oh now you're a psychiatrist now', because I wasn't on a training program with [?] and then I went and joined it the following year and come back. And we then had a meeting of the kids and we just wanted to talk to the kids and that generated a lot of animosity from the get-go because we had a nurse standing at the door, because the kids were really, really distressed. But we didn't include the teachers. By not including the teaching staff, we had immediately broken one of the kind of traditions of the place and that really upset people. And so there were sort of battle lines almost drawn at that moment and as well as that, there was the distress of the kids over Trevor Sadler being stood down. And we finished that meeting and we said we would then go over and talk to the teachers. So between that meeting and going to the teachers, we had a brief chat with the nursing staff, Elizabeth had never been in the place, it was just a matter of just meeting who was who. And then we were gong over to the school which is an adjacent building, they're attached, but by just a covered walkway. So, we were going over there and at that point, just as we walked into that building, the AO said it's in Parliament now and that was the announcement of about Trevor. So we immediately walked back into the ward because we thought, we knew the kids that will be there, they've all gathered around with radios on waiting. So, we went back And in doing that, we kept the teachers waiting an hour and a quarter and they were hostile after that and we had shown professional disrespect and so forth. So, that wasn't a good way to start. And with kids, it wasn't a good way to start because particularly they were crying and very

upset and they viewed us as evil and Elizabeth's communication style is, I suppose, she comes across as sort of more authoritarian I think than I did at that point. And so they were a bit more hostile towards her and then in the end, she decided I think two weeks down the track it was better for her not to be two [?]. So, better for her not to be seen and then she started only coming out irregularly and then once a week. But yeah, it was not a good way to start.

BK: So, how did you understand the task when you first started?

AB: I understood that Trevor had been stood down and I needed to look after, provide clinical care for those kids and that's all. Oh, and the closing, and I assumed that that was a process already in place and I would step in and continue it. But I found out by the end of that day, that it was clear there was no process in place, nothing was happening, and that I had to start it and then a meeting the next day with the executive again, it was clear I not only had to start it, I had to finish it. And it was a matter of then working out how we were going to do that.

TS: Okay, so how did you go about doing that?

AB: I wrote it in there, but I think the phrase, 'had to get to know them', that should have sort of gone for about 10 pages.

BK: Yeah, yeah.

AB: It was the trying to understand each child, there's nothing, you know, you can talk about the Barrett kids, but there wasn't a lot really that most of them had in common except that they'd had long admissions and a lot of family disadvantage and difficulties along the way. They were all very different to each other, they also had very different, obviously, different skill sets, different capacities for tolerating the thought of doing something different, etc. So, it was getting to know them while managing for a few of them and just intense distress over the fact that it wasn't that they were moving on, at that point, it wasn't they were moving onto something good, it was they were being abandoned and they were having everything taken away from them. So, they were distressed and then they also needed to communicate their level of distress to me in case I didn't get it, I think. And to everybody else. So, the process was really, I thought, get to know them. Work out where they're at now, what their needs are, what can be done for them, what is out there for them, and then start moving them onto that. To do that, obviously, I had to also get to know their families and any other, you know, what had worked so far for them, what hadn't, who were their current service providers cause a lot of them did have other people involved.

BK: Can I just [?], how open was your access to resources? How, you know, what position were you in to pull together whatever you needed in terms of a team, just you were using only senior medical officers.

AB: There was a Registrar who was, I think, at best [?] for that first couple of weeks. He was very upset about what had happened to Trevor. He didn't

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cope well at all at the beginning. He then got anxious about his placement, Elizabeth stepped in to kind of take over looking after him, rather than me, like I was still supervising, but she had an hour with him each week, but she tried to define his training goals and so forth.

BK: Yep.

AB: She then organised a meeting with Darren Nealey who was the Acting Director of Clinical Services at the time, so he could go and have a meeting with him, and just clarify for him what that could provide and where he would go. So, that is in the medical person, as I say, Darren Nealey was Acting Director of Clinical Services who said to me, the clinical governance here has been terrible, if things happen, please let me know. So I would ring him from time to time and tell him there were what I thought was significant events. There was Elizabeth who I eventually I think got to the point where I would ring her every night almost. Often during the day as well, but at least every night. And then there were the executive meetings on a Wednesday morning where Darren Nealey was for the first few weeks and then Terry Steadman whose place he was filling came back and he was Director of Clinical Services so he would be at that meeting. But no other medical services or back up. In terms of resources, one of the OTs had just come back from maternity leave, the other OT was going off on sick leave. But the one who came back was all enthused because she'd gone away and worked in some other places as well, and I suspect I think you know who she is because she told me she was coming here this morning, but she was quite sort of enthusiastic about positive new things, and moving forward and so forth. So, she seemed to me like somebody who might be helpful. The Acting CNC, Vanessa, who I think is not going to come and talk to you, she was very motivated about helping kids get out of Barrett to somewhere new, there was almost nobody else who kind of was really supportive of the idea that Barrett should close or could close. So, within the staff, towards the end, some of them sort of came out of the woodwork and said, oh no, no, no, I think this is really good. But it certainly wasn't the majority. In terms of finding out what was in community I think it was within the first week it's written into, did we tender the Barrett register?

HMC: Which was the register?

AB: That's the, it's documented, there [?] little boxes, the themes that were, issues that were raised about difficulties, it's really badly constructed, it's just something Elizabeth had put together because nobody it seemed was minuting those executive meetings, but she would write some things down and kept it as a sort of register of ideas, and then right at the end, she'd finish it off and gave it to them, but it's not very detailed towards the end and it's not.

BK: This was about sort of managing the environment?

AB: Yeah.

BK: Within the unit it looks like, is that right?

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AB: It was about the issues that got brought up at the executive meetings on Wednesday mornings. So, I'm just going to look at the day when it got brought up where I said the resources we don't know what is out there, and we need help.

BK: Is that in your statement? Yes.

AB: To do this. So, and people said, well, you know Lifeline will have a database and somebody else will have this and, oh, what about Department of Health and what about, so I delegated people to try and find those things, they couldn't, so I tried, couldn't. We couldn't actually find anything. We did get some lists of accommodation services and so forth, and, you know, like we would have days where Megan and Vanessa would send out 32 emails and make between them 50 phone calls.

BK: What do you make of that, this Unit had open for a very long time, the kids, yes, they're a very mixed group, but all very complex with lots of sort of issues, many staying on til they're over 18 and even some we're hearing about, you know, for some years. So, this kind of needing to find resources in the community for this particular group, it wouldn't, it doesn't fit easily. It wouldn't have been a new issue. And yet, there wasn't, it doesn't sound like there was a body of knowledge. What do you make of that?

AB: It was very disappointing.

BK: Yes, [?]

AB: There was, they had a position within the staff called community and liaison, so Susan Daniel was the nurse doing that at this point. Before her, Vanessa had done that job, and I thought she would be somebody who would be ideally placed to do that sort of work. Part of the issue for her, though, was that she was so traumatised by Barrett closing, in the end she left and went on 500 hours sick leave. But she had worked there for 18 years, and her heart was just in Barrett. But she had I presume in the past been the person who would have linked kids into other services. I think part of the issue and I wondered a lot about this, particularly, like if you look at the three who are now dead, [?].

But I wondered whether, had they stayed in Barrett for that long because they didn't have somewhere they could go back to. And so, is it about, like, where are the big holes in services? And I would argue that the first big hole State-wide is, if you are under 18 and you can't live at home.

BK: Yeah.

AB: You cannot access intensive mental health support unless you live in Brisbane and you are in the care of the Department. If you are outside of the care of the Department, you require supported accommodation. Where can you live, you can't. And if you've got significant mental health needs,

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there are no trained staff to support you. [redacted] But if you're 19, you know, there's still nothing for young people in terms of supported residences within the mental health sort of framework and it looks to me like we're depending more and more on NGOs to provide that and what we know from doing this, is the NGOs are not trained up to do it. So, some of them say they can do mental health support, but when it came to the individual ones, you know, [redacted] The next one I think is if you can provide them with accommodation, they then need some kind of intensive support and if it's a day program or whatever, that might be good but then case management and they need, you know, I guess, I started to think the last few days, should have used the word transfer in that what we're talking about transitional plans, they're really just transfer plans, that's just the last bit that you sign off on. The real issue is it was transition from day one, well, maybe day three, of me meeting and the first couple of days was just [?]. I think the term is poison chalice I think [?] from my colleagues and I [?] of three days, they were right. But I think it was, they needed to transition in their own minds about what was going to happen. They were transitioning from being children into being expected to be adults, you couldn't rehabilitate them, they hadn't be habilitated, you know, they hadn't learned developmental skills. I mean, what happened the first weekend, so I started I think on a Wednesday.

BK: What month was it? September?

AB: September 11. I remember the date.

BK: [?] yeah.

AB: And that first weekend I sat down and thought, right, what does an 18 year old need to be able to do? Came back with this great enthusiasm Monday morning and I said, right, for these ones, this is what they need, for these ones, this is what they need. Now, that wasn't about mental health services, it was: they need to be able to use a bank account, they have to be able to cook, or shop, or they needed, we need to clarify their educational aspirations, vocational skills, whatever. Every one of them who was over 15, must have a resume. It was the one job I gave to the school and said, I want them all to have a resume. I mean, I can't write my own resume [?] wasn't going to be able to beef up a 14 or 15 year old who hasn't done anything, but I knew school would be able to. But even that didn't get done. It was, yeah, so it was kind of frustrating that the things you knew they needed as a skill set for life, they couldn't or just weren't going to get. And then the next challenges were about who would be their mental health providers, who would be their accommodation providers, and so forth. And then it was almost they had to, for some of them, not all of them, some of them already had connections that they could continue, but they needed to work out how they were going to access that independently themselves, not

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everything be provided, what they'd kind of learned to do was to live at Barrett.

BK: Yes.

AB: They hadn't learned while at Barrett, you know, like can you imagine, this is being talked about around the edges by various people, but a lot of people have said, well, if Barrett had just stayed open, we could have got, for instance, and there was for some of them, once you gave them a little bit of a taste of that outside world if you like, or a bit of responsibility or autonomy, it was amazing how they then sort of ran with it. And even But, you know, I'm probably getting a bit off the track there.

TS:

AB:

TS: yeah.

AB: How was the risk communicated by us to them?

TS: Yes, yes.

AB:

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BK:

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AB: We'd have to make it.

BK:

AB: Yeah, no, no, you'd have to make a judgment of based on what had been going on at Barrett in some ways.

BK: Yes, mmm.

AB:

BK: Yes.

AB: But that was a sort of a subsequent proposal, that hadn't been started.

BK: Okay.

AB: And it was felt that needed to first.

BK: Right.

AB: So.

BK: Yeah.

AB: So.

TS: We've heard from a couple of people that there might have been some talk about nursing staff from Barrett actually staffing shifts at other places while the transition period was happening but that didn't eventuate.

AB: No.

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TS: Has that happened?

[Part 2 of 4]

AB:

BK: Yeah.

TS: So the original plan had been to try and get the kids out by the 13th of December.

AB: [?] here.

TS: Yep, is that why there, we've heard a hearing about an NGO was brought into run the Christmas program or something like that?

AB: No, there's always been a holiday program at Barrett.

TS: Right yep.

AB: And in early December I'd been complaining a lot about, I thought it was becoming unsafe and I think that was the staff numbers were going down, the skills of the staff were reducing because they were from agency staff, and almost sort of paradoxically the number of kids was going down and I think that was making it less safe. While there's a sort of a critical body, there's at least some, you know, naughty stuff or fun happening at times, that sort of buoyed them along. So it was thought that they would bring in an NGO to provide a holiday program. Now again, and I don't think, I don't know that it's documented anywhere officially, I thought it was a ridiculous experiment myself, I probably shouldn't use such strong words but I thought this is not, it's a bit like the wisdom or otherwise of conducting a CMC enquiry into the director at the same time as you're closing somewhere. Like, that just is, defies belief, but for whatever reason they had to do it. Anyway, that, this was similar, they were bringing in, this is going to be a kind of a pilot model of new ways of doing things which was the partnership of NGOs and mainstream health services. Now that may be a legitimate thing in the future, but in such a traumatised community, that was so rejecting of new people and of change and had so much on their plate already, to bring in a new service to provide something was problematic, and then they came, it was Aftercare, was the organisation, you know within the first week they were making complaints about, you know, the sort of senior staff which were the sort of transition team people, and that was because we weren't spending enough time with them and we weren't welcoming enough of them and I'd have to sit them down and say, have any idea what we are dealing with at the moment? We have kids with nowhere to live in a month's time, with no mental health providers, with etc etc. Our priority is not you guys. We really don't care whether they're having a good time, just get on with it. There were almost no kids going to that program anyway,

TS: Is this Is that the name?

AB: No no, So in many ways, it felt like this program accommodated needs and also politically we could say we are providing the services. But the reality of what it provided was another hurdle for these kids to jump and some of them didn't bother coming, some who came, were a bit reluctant to get involved. When it was looking like this is not working very well at all, I then sat Aftercare down and said okay, let's use you guys to do something else. Could you work on skills acquisition individually for these few kids that you've got. And I went through each kid with them and said what I thought they needed to be able to do, could you do that, but it didn't, it really didn't work.

TS: So in that period of time then, obviously a huge amount of time was spent just trying to identify possible services and to undertake negotiations, it also would have been a very bad time of year to be trying to do that [?]

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AB: That's right, Christmas.

TS: Christmas. And it does sound like there was perhaps sort of internal disarray in terms of actually focusing on the kinds of skills etc. preparations that might have been helpful for the kids, that sort of issue though that these kids in a sense, they're misfits, and that difficulty in finding services that were able to, okay from even that example of short-term admission to an acute inpatient unit kind of doesn't quite sort of fit with that's how they see their role. We did pick it up also possibly in the example with in some ways there were a number of service providers but the missing element seemed to be the mental health follow up and I think we noticed

AB: It was case.

TS:

AB: No, it's definitely not went

TS: It was a. Do you remember that one?

BK: Would it have been couldn't take because of the

TS: No, one of the one that

AB:

TS:

AB: Yeah that's

TS: was it?

AB: Yeah. That was, and that was subsequent to closure but it was,

TS: That's right.

AB:

TS: And they took

AB: [redacted]

TS: In that process

AB: Sorry

TS: Was that a colleague-to-colleague negotiation or were there additional resources from the transitional process brought to bear by decision-makers or was it a colleague-to-colleague?

AB: Um the [?] from the executive, it was Moreton I think, got involved in that as well.

TS: Mm.

AB: It is after the closure but spoke to me and then I rang people. So it was colleague to colleague to convince them that yes please do it. And then also colleague to colleague [redacted] I spoke to about the families needs.

BK: There was this very small transition team really running as fast as you could with the number of kids and the amount of negotiating to be done. How did the next layer in the governance of the process articulate with the transition team, [?] more transition team, how did that sort of work together?

AB: Um, the next layer I guess would have been Elizabeth Holland and so there was, she was the Childrens Health Queensland arm and at West Moreton would have been Sharon Kelly and Leanne Geppert. And their Allied Health Senior, there were two of those, Michelle Giles and Lorraine Dowd. They were, they were supported but they weren't intimately involved, they were really involved, the allied health ones were involved in really kind of trying to sort out the HR distress and stuff about stuff, it wasn't about the kids. In terms of involvement about kids, Leanne Geppert was helpful, in escalating things. For instance, about [redacted] It wasn't always effective. Where it really fell down was, and it was identified quite early, that no one was documenting the transition panels that we were having and nobody was documenting executive meetings and so they then appointed a project officer, Laura Johnson, who was to document all of that. And I guess I would say from the day I spent, once this inquiry was going to happen, I was going to go out to West Moreton and sit down with them and the lawyers and so forth and look at the documentation and then I said well that's okay. Is it okay if I bring my lawyer along with me, and after that there was some kind of split in that they were doing things separately from me. Then they rang that night, and said *'well we can't find this, this and this, can you come and help us?*' So I went out there and helped them go through the files and find what they were looking for. And I guess what struck me

then was, in the back of each file was a sort of a table which was a transition plan. They were clearly very not up-to-date because like on [redacted] So they didn't get updated. Laura did go on maternity leave before the closure, but they clearly were not being updated, so I don't know whether that's hers or whether she has got another file of documents that I have not seen that are somewhere that the executive has access to. But certainly, I don't think in those volumes that have been printed off from the electronic form that we've all got. And what happened then was, Holly was trying to put together something to give to you guys so she was then populating those tables with information. So, as well as the original one which is close to useless, it is the next one which is Holly the lawyer's attempt to put in information into there to give to you. But, again, that's not contemporaneous documentation of the transitional process or plans. And all through that information is contained within individual people's emails. So I think Leanne Geppert's are accessible. Megan Hayes, some of hers are in those charts because she had a day, maybe two days at the end [redacted] and she is trying to archive all her stuff because there was, you know, if anyone told you about this, there was a migration of emails from GroupWise to Outlook and it went from having a dash to a dot and I didn't archive mine. I was never going to work for QHealth again. So it didn't matter, and I got an email on Friday saying '*Any time now, they might be able to retrieve it for me*'. I [?] do it for this process. So there is a lot of information in emails but there is no central, as far as I could see, documentation. So if that's part, I don't know whether that's part of governance but to me that was a deficit.

BK: Yeah, yeah.

AB: There were times when at the next level of governance, and I know I was an Indian not a chief, but I felt like there were two things. One was, I've got a lot of responsibility here, where is the next person up in terms of medically or anything else. There didn't seem to be an expert you could turn to. Stephen Stathis, who was the director of Childrens Health Queensland and now my boss. He would ring me up and say '*What's going on with such and such?*' and I would tell him and he'd make some suggestions or, but he wasn't kind of in charge. He didn't have power…

BK: Was he a director or?

AB: No, there was Terry Steadman and then when we tried to [redacted] – as far as I understand – has no structure of command in mental health. I went to Terry Steadman. Terry Steadman discussed it with Leanne Geppert and Sharon Kelly but he went to Bill Kingswell as the director and said '*Can you get Brett Emerson as director of that service to do this, this and this*'. And it was up to Brett to decide whether he wanted it or not. And I thought, how does that work? But it just didn't seem to me that there was a central point of authority and maybe there isn't anywhere! But that's a hole

BK: [?] service. Who is the clinical director of the service?

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AB: Terry Steadman

BK: Okay. Okay. And that is a single point of accountability or is it director and a clinical director?

AB: He's the director of Clinical Services and then there is an executive director.

BK: Of mental health.

AB: Yeah, which is Sharon Kelly.

BK: Okay. Okay.

AB: And then the other thing we had was, I thought, interference from the Board. Now I know that the service is answerable to the Board, but when particularly

TS: So in the governance of the process, where did the Board fit in. Was this transitional process being reported to the Board? Did the Board own the decision for the service to be closed?

AB: I don't think they did.

TS: [?] Board right, okay.

AB: They owned the decision for it to be closed, they would give directives which Sharon Kelly would communicate, but they wouldn't, they wouldn't publicly own some of the decisions. For instance, we will no longer take, I think the 5th of October or 8th of October as the date, we will no longer take new referrals because there was well no that's not fair.

And we needed to say, '*We are not taking new patients*'. So, at the beginning, for the first couple of days of that, I could quite with full integrity say '*We can't possibly take a new patient at the moment because of the high acuity of the ward*'. We had that was just behavioural at that stage they're planning to burn the place down And there was just this going on. And so, and running away. So that was okay, but then when this decision was made that

we wouldn't take new patients, there was well maybe we can't really say that though yet because we can't afford to scale down the number of beds and that was some political thing about however medical funding happens, I don't know. But so the Board was often trying to look like they're saying the right things and there was always this bit that would come up, Barrett will not close until there are lap around services available. Well, to my simple way of thinking, we are now more than 12 months on from when they said that they would be provided and that was the new services under SWAGR, their acronym for State Wide Adolescent Extended Treatment & Rehabilitation. [redacted] So I guess you could say they were up and running! But the residential wasn't and still isn't.

TS: And what's the difference between their residential and what Barrett was providing?

AB: Their residential is not co-located.

TS: Right.

AB: Its not a one-stop shop. The idea is I think that you have more community-based care, that you live in a community and access other services. They are going to have wide park model care and step up and step down models. At this stage, they are not in existence. They've got the pilot residential at Greenslopes, but that's all.

TS: And what's the age range for that unit?

AB: It was 15 to 18. Now it's going to be 15 to 21. I think it's going to change because they also thought it was going to be six months max. [redacted] I don't think they will leave within six months, unless somebody is focusing on, from the beginning, where's their next residence going to be and are they equipped to live independently. That is the aim that they give, but they also I didn't think had good psychiatric input. It was going to be point one of a psychiatrist and they asked me if I'd do it. I said no way, um I just thought it was an unsafe model. You know I think they just need to get it clear, are we going to continue to provide 24 hour supervised essentially subacute or long stay acute beds. Is that what we're really providing in these residentials for providing accommodation in the community.

BK: Yeah.

AB: For kids with mental health needs but their therapeutic results were and I'm not sure how.

BK: Whether they might.

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AB: They might have been thought through but I don't think it's been implemented.

BK: [redacted] If you think about all of the other kids, was there any other case where you felt there was um an unsatisfactory um even if it was interim it was unsatisfactory what was able to be achieved in transition.

AB: [redacted]

BK: Yeah.

AB: But I think if there's any kids who died some levels say well their needs haven't been met. Um and I think for all of them, so there's those particular ones and then, you know you could always say, well that's they're being missed or whatever but I think the other part of it is I didn't feel for any of them that they got adequate educational and vocational support.

BK: Mm.

AB: Or opportunities. They just didn't happen.

BK: How much did you think that was inherent in the Barrett model as opposed to part of the problem in the transition process?

AB: Well you're right it probably is within that model. So within the transition process, let me just think this through. [redacted]

BK: Right.

AB: [redacted]

TS: [redacted]

AB: [redacted]

TS: Yes.

AB: [redacted]

TS: Had you negotiated [redacted] would see [redacted] for a period of time?

AB:

TS:

AB:

TS: I've got it down here that but I have written here was with a question mark, was

AB: No.

TS: She [?].

AB: She was

BK: She was a

AB: Sorry.

TS:

AB: Yes.

BK: Do you know why that didn't happen?

AB: I would be speculating but from bits I've heard I think it was. Look all I can tell you. I can tell you one piece of fact.

TS: Yeah.

AB:

TS: Do you know if there was any other um ah kind of platform in the transition plan that didn't eventuate? Apart from the staffing one

AB: Yeah that um when we

TS:

AB: For all of the kind of big ones. Um so that's about of them

TS: Yep.

AB: Um we made recommendations what they required in terms of supervision and so [redacted] And each of those receiving services it was up to them I guess to decide really what they could or would provide and they deemed that not appropriate. [redacted]

[redacted]

TS: Yeah.

AB: And that was the other thing. There was no continuity. There seemed to be no thought that you would fund somebody to remain the person that might oversee you know at the transition had not occurred. Yes we got them to the end when the place closed but there was no, no one then monitoring what went on. For a while I stayed employed by the West Moreton [?]. I went to Ipswich CYMHS for a month. I would then just check when I could on [?] or ring people up and just see what was going on. To keep an eye on things as much as I could but once I left there, that role didn't exist.

BK: Just as a matter of interest, in the, any of the governance processes or the role of project officer, I don't know, um but was there ever any, ever any discussion of or reference to um the literature on transitioning kids out of [?] services into adult services?

AB: No.

BK: Um okay.

TS: Could we now talk about [redacted] um and um your reflections on the process with [redacted] Process of transition.

AB: [redacted]

[redacted]

BK: Mm.

AB: [redacted]

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[redacted]

BK: Yep.

AB: [redacted]

BK: Yep.

AB: [redacted]

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BK: Yeah.

AB:

BK: I need to understand they had been providing with, when they said they would take what was the range of services you thought

AB:

BK: Yes.

AB:

BK: Mm, mm.

AB:

BK: Yeah, yeah.

AB:

BK: That sort of that had, in the thinking, if it had been required, who would have provided with a kind of response, in terms of all the services.

AB: Who could have?

BK: Yeah, yeah. In terms of all the services that were to be involved or thought to be involved in ongoing care?

AB:

BK: Yeah, yeah.

AB:

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BK: Yeah, yep, yep.

AB:

TS: Can we now talk about your reflections on the process with

AB: what the books say within the hospital of who, when people go from being inpatient to day patient, isn't always accurate.

BK: Oh right, we've had.

TS: We were wondering about that.

BK: Some confusing information

AB: Yes.

BK: Particularly with actually.

AB: Well certainly by at least, I can't give you a date,

BK: In your report it says

AB: Yeah.

BK: But other reports said

AB: Yeah, see, the AO wouldn't process various things, so when I arrived they would give you a list of patients, or, sorry, you could get given if you asked for it, a list of patients and I looked at this list and I said that's not accurate, yes it is, and I said no it's not, and I said because

BK: Oh.

AB: Clearly that's not the case. So those things were not accurate.

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BK: Mm.

AB:

BK: Sorry, was or on a

AB: I always thought was

BK: Okay, yeah, okay.

AB: I'm pretty sure. Gosh, I hope so, maybe you know something I don't know.

BK: Mm!

AB:

BK: Okay, yep, yeah.

AB:

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BK: Yeah.

AB:

BK: Yes.

TS: And that according to

AB: Yeah. And so, and at

BK: Mm.

AB:

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BK: Mm.

AB: it's another Barrett kid who's just a bit of whinger, cause I think that was the perception, that these kids just live out there for a long, long time, but none of them have a mental health diagnosis.

BK: Yeah, yeah, I mean it certainly sounds like you had more than enough on your plate, but I'm just wondering, having found this, that there's

AB:

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BK: Yeah, yeah, yeah.

AB: [redacted]

BK: Traumas.

AB: [redacted]

BK: Yeah.

AB: There was another one, [redacted] was I think [redacted] by that stage.

BK: Yes, yes.

AB: [redacted]

BK: Yes, I saw that.

AB: [redacted]

[?] word/s cannot be identified
… dialog overlaps with other/s or trails away