# BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

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

## STATEMENT OF TREVOR BRUCE SADLER

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| **Name of Witness:** | **Trevor Bruce Sadler** |
| **Date of birth:** | |
| **Current address:** | |
| **Occupation:** | **Psychiatrist** |
| **Contact details (phone/email):** | **Phone**<br>**Mobile** |
| **Date and place of statement:** | **12 February 2016 and Brisbane** |
| **Statement taken by:** | **K & L Gates** |

I **Trevor Bruce Sadler** make oath and state as follows:

1. This is a supplementary statement provided at the request of the Commission. Prior to the completion of it and at the request of the Commission, on 9 February 2016 I attended the Commission of Inquiry rooms on North Quay, to speak with Commission staff.

2. The responses to the questions posed by the Commission in correspondence received by my solicitors on 22 January 2016, 10 February 2016 and 11 February 2016 are detailed below. For my responses to questions 1-39, I have referred to the paragraph numbers and/or exhibits in my earlier statement to which the respective questions apply. For the remainder of the responses I have referred to the question number in the Commission's request to which each response relates. Attached and marked "**A**" is a copy of the correspondence from the Commission dated 22 January 2016, 10 February 2016 and 11 February 2016.

3. I have been requested to explain why I have referred to the persons who were admitted to BAC as adolescents. Doctors and nurses in inpatient settings use the term "patients", nurses in community settings and allied health staff use the term "client". Teachers naturally refer to "students". Administrators and mental health service documents refer to "consumers". Nursing staff from adult wards or who were close to administration tended

to use the term "consumers". Adolescents disliked this term. I encourage the use of the term "adolescent". It is acceptable to all disciplines and can be used by all in conversations with each other, or in conversations with the adolescents themselves. Secondly, it does not distinguish them from other young people in the community, with or without mental health problems.

4. In this statement I use the term "young adult" to refer to young people who have turned 18 years of age.

***Specialist Knowledge***

*Paragraph 1*

5. From 1998 until November 2014, I was Senior Visiting Psychiatrist, Child and Youth Mental Health Service, Mater Health Service and performed this role for seven hours per week. For the majority of this time, up until September 2013 I also worked at BAC. I was contracted to work 24 hours per week at BAC but routinely worked approximately 30 hours per week. I was not paid for the additional hours. From July 2014 until November 2014, I was also a locum Senior Staff Psychiatrist, Child and Youth Mental Health Service, Mater Health Service to cover the acute inpatient unit. Child and Youth Mental Health Services at the Mater ceased on 28/11/2015, with the transfer of services to Lady Cilento Children's Hospital. I have amended the relevant page of Exhibit A to my earlier statement to reflect these inadvertent omissions. It is attached and marked '**B**' to this statement.

*Paragraph 28(a)*

6. The units in the UK were therapeutic units which relied on a high level of psychological interventions, including family, individual, group and verbal or non-verbal. These interventions occur over months rather than days. Acute inpatients have an average length of stay of 10 days. They require crisis intervention, brief family interventions and sometimes medication changes. The units found the acute inpatient adolescents did not fit in with the longer term interventions, they would be disruptive to groups while not benefiting from them and would sometimes be disruptive to longer term adolescents. These adolescents required short, intensive interventions, which could not readily be fitted in to a timetable of longer term interventions. They were not well engaged with the school program.

*Paragraph 28(g)*

7. The model is that referred to under *paragraph 34(h)* below.

*Paragraph 34(d)*

8. The weekly Case Conference was attended by the registrar, the Nurse Unit Manager, the Community Liaison Clinical Nurse (**CLCN**), the Clinical Nurse rostered on for the Monday morning shift and nursing staff who were Care Coordinators for the adolescents to be discussed at the weekly meeting. At least one psychologist, one occupational therapist, the speech and language pathologist and the social worker would also attend. The school was represented by the Principal and a teacher, who collated information from other staff about adolescents to be discussed at the meeting. The adolescents were always welcome to be present for that part of the meeting relevant to them. Even those with social anxiety attended on occasions. Parents would occasionally attend.

9. As the chair of the weekly Case Conference, I reviewed decisions from the previous week, and enquired of the outcomes. I asked all relevant staff in turn to present their information, I synthesised the information, and gave some perspective on progress. Based on the information presented, the group collaborated on making decisions regarding leave, activities in which the adolescent was involved, directions for interventions, levels of observation and risks and any other relevant matters.

*Paragraph 34(g)*

10. Attached and marked '**C**' is a PowerPoint summary of the model referred to. It is titled 'Development and Psychopathology'. It is a model for predicting whether an adolescent required community, day patient, acute inpatient or extended treatment and rehabilitation services. It is trans-diagnostic, suited to a variety of therapeutic interventions, identifies strengths, identifies issues of concern, identifies moratoriums in progress, informs treatment decisions, informs decisions about settings for care and is not evidence based treatment. The PowerPoint discusses key indicators as to the level of treatment required, including for example, inherent biological issues such as temperament, family environment, changes in behaviour and the extent development tasks are achieved.

11. I have presented this model to workshops for Cairns Evolve Therapeutic Services, Toowoomba and Townsville Day Program training, advanced trainees in child and adolescent psychiatry and Dr Patrick Hammerle from Switzerland. I also presented it to the Grand Round of child and adolescent psychiatrists. The Grand Round was attended by child and adolescent psychiatrists from all over Queensland. There were quarterly meetings. I made several presentations regarding the model. I routinely provided examples to illustrate the points. The feedback was largely positive and it was felt the model validly explained which service was most appropriate.

*Paragraph 34(h)*

12. Attached and marked '**D**' is a PowerPoint summary of the pathways referred to. It is titled 'Understanding Recurrent Self Harm in Adolescents with Complex Trauma'. They provide for 3 levels of assessment for determining the necessary intervention and then discusses stages of change for adolescents who self-harm in the context of trauma. The stages (or pathways) can be pre-connection, awareness, working through and recovery or pre-connection, awareness, working through and accommodation. Some adolescents find the re-experiencing phenomena of working through the issues of abuse too difficult, and find that the most they are able to do is accommodate the abuse and reduce the self-harm. This enables them to at least begin again to move on with developmental tasks and into the accommodation phase, as opposed to the recovery phase.

13. This model was presented to the workshops referred to under *paragraph 34(g)* above. It was also presented to a Grand Round of child and adolescent psychiatrists in November 2006 and most recently to the Logan CYMHS in October 2015.

14. A psychiatrist from the UK who worked in an inpatient unit there said she recognised this process, but they attributed the increase in symptoms from the pre-connection to the connection phase as the emergence of a developing Borderline Personality Disorder. Once clinicians at the workshops who had worked with this population in whatever stage saw the stages, they produced examples of how it fitted in to their experience. They discussed the way they conceptualised these changes previously. The information they provided was consistent with the model. At times I met those clinicians in other settings.

***BAC in the CYMHS setting***

*Paragraphs 41, 51 and 52*

15. Attached and marked '**E**' is a PowerPoint regarding 'TS – Analysis'. It is the source document for the statistics referred to and some extrapolations were made. The PowerPoint relates to the number of child and adolescent cases opened by Community CYMHS.

16. The figures were supplied by Mr John Anderson, data analyst for the CYMHS Collaborative, when it was tasked to explore case management in CYMHS. The data was compiled from CYMHS community clinics throughout Queensland. It excluded those in inpatient units, day programs and Evolve Therapeutic services. I cannot recall the difference between "cases" and "consumers".

*Paragraph 46 and Exhibit C*

17. I oversaw the collation of data by asking the administration assistant to record the names of adolescents into a spreadsheet, along with various demographic data such as referring agency, date of admission and date of discharge. She then emailed this back to me. I recorded diagnosis, and a number of clinical characteristics such as self-harm and whether they were on an ITO. I emailed it through to the speech pathologist, Ms Angela Clarke who recorded details of her assessments. (Ms Clarke also kept her own detailed records.) She then emailed it back to me. I cannot be sure from whom else I obtained data. This spreadsheet was used to collate most of the data about adolescents at BAC that I have referred to. I believe that up until 2012, Ms Susan Daniel, CLCN kept records of referrals. I updated and maintained the collection of data with the use of the spreadsheet until approximately June or July 2013.

18. The data was stored on my work PC in a folder titled "Research". Computers were updated every three to four years, so I presume this is no longer available. I also stored a backup copy on the West Moreton G drive, in a directory to which only I had access. I believe this may have been a directory titled "Sadlert". I no longer have access to this directory. If information from it can still be retrieved, it will be in the sub-directory "Research".

*Paragraphs 47 and 50*

19. I am referring to both the CSCF dated 20 April 2012 and 14 August 2013.

***Organisational structure within BAC and The Park – Centre for Mental Health***

*Paragraphs 58, 59, 64, 68 and 71*

20. The staff numbers referred to in paragraphs 58, 64 and 71 are based on my recollection.

21. The figures and percentages referred to in paragraph 68 were compiled from Staffing Lists. I simply went through the names of nursing staff and calculated the percentage of those each fortnight who were not regular staff. I can recall numerous shifts where between two to four of the six staff on a shift were not regular staff. I tend to think that if I had calculated those percentages by the number of hours worked of each staff, the percentages are likely to have been higher. In other words, I believe the numbers quoted are likely to be conservative. I have been unable to locate the staffing lists in the limited time available to provide this statement.

*Paragraph 61*

22. Mandatory continuing professional development did not appear to be as formal a requirement for nursing staff as for other disciplines. I can remember holding discussions

with a Nurse Educator from the School of Mental Health. The Australian College of Mental Health Nursing had CPD requirements, but not all nurses working at BAC belonged to this College.

23. Nurses at BAC were provided with training through a number of avenues. Examples of these are as follows:
    (a) The University of Queensland, in association with The Park, offered a Master of Mental Health. A number of nursing staff enrolled in this, and conducted studies for their projects on subjects relevant to BAC.
    (b) BAC held a Recovery Symposium in 2009, and obtained permission from management for temporary nursing cover for the two days to enable as many nursing staff to attend as possible.
    (c) Internal training was offered on the uses of the multisensory room. This was initially provided by the occupational therapists, and then by senior nursing staff who had been trained.
    (d) Over the years, the Specialist Clinical Supervisors offered training in the basic use of non-verbal therapies (art, sand play), managing dissociation and symptoms of trauma.
    (e) Some nursing staff sought supervision with the Specialist Clinical Supervisors, or an external supervisor.
    (f) I routinely forwarded notices of conferences and workshops of interest. Some nursing staff attended relevant conferences and workshops from time to time.
    (g) Some nursing staff pursued training in a relevant area by an external training organisation e.g. art therapy and sand play.
    (h) I regularly received emails from both the Royal Children's and the Mater Child and Youth Health Services regarding training opportunities, which I forwarded to all staff. The training provided by the Mater was often limited to Mater staff. Some nursing staff attended training provided by the Royal Children's, which included an overview of CYMHS throughout Queensland.
    (i) The School of Mental Health at The Park offered modules for training. We sought to collaborate with them in developing relevant packages. However, there were occasions where staff enrolled in courses, only to have the course cancelled due to low numbers.

24. Mr Will Brennan, Director of Nursing sought to implement a training package for new staff in 2012. However, because of delays in appointing staff and the subsequent announcement of the closure, this did not eventuate.

25. Allied health staff pursued external supervision and training relevant to their discipline. They attended national conferences, peer supervision groups and individual supervision. Lorraine Dowell may be better placed to provide further information in this regard.

***Impact of restructure of health services; Government priorities***

*Paragraph 73*

26. In approximately April 2007, the CYMHS Clinical Collaborative was established. It was a clinical network established and funded by the MHAODD Directorate for the purpose of examining clinical issues and improving clinical responses to those issues. Clinicians from throughout the State were invited to partake in it. It was comprised of clinicians from most major regional areas, as well as the Greater Brisbane Area. I was the Chair and this was a separate responsibility and in addition to my workload at BAC.

27. The CYMHS Clinical Collaborative had a state-wide focus. It reported to the State-wide Mental Health Advisory Group and the State-wide CYMHS Advisory Group. It employed a full time Principal Project Officer who met with as many clinicians in teams as possible, to ensure wide engagement. From 2011, it also employed a part-time data analyst. Data entered by clinicians on CIMHA was used for the analysis.

28. Clinicians from throughout the State were invited to be on a Steering Committee. These were clinicians from most major regional areas as well as the Greater Brisbane Area. The Steering Committee was part of the CYMHS Clinical Collaborative, with the collaborative being the overall process. The Steering Committee convened monthly via video conference to define the issues to be studied, to consider proposed methodology and to discuss issues with implementation. Twice yearly forums of interested clinicians and team leaders were convened to discuss the issues and clinical approaches to addressing these issues. Issues examined included the importance of accurate data, clinical approaches to the adolescent who self-harmed, timeliness of follow up within seven days of young people discharged from acute inpatient units, the use of seclusion in acute inpatient units, changes in case load and issues of case management.

*Paragraph 87*

29. Each wing of the residential building at BAC contained four single rooms. Two of the single rooms in each of the two wings were bedrooms. In the eastern wing, the third room was the sensory room and the fourth room was the art therapy/sand play room. In the western wing, the third room was the CLCN office and the fourth room was a "sick" room for adolescents who felt physically unwell, or when adolescents just wanted a period of quiet time.

30. The western wing also contained the de-escalation suite, which was also known as the blue room or the high dependency unit. It was not equivalent to an adult high dependency unit. Rather, it was an integral component of the ward. It contained a small lounge area, two single rooms and an en suite. Adolescents could opt to go there if they recognised they needed space to de-escalate. Adolescents requiring high levels of supervision were cared for there, depending on the level of distress and risk to themselves or others. It offered a quieter, safer area. The door was not usually locked.

31. Any incident requiring seclusion was recorded in PRIME. Incidents of self-harm which led to an adolescent being placed on higher observations were recorded in PRIME. If an adolescent communicated significant distress and the need for closer observation (which happened in a collaborative environment), a record was made in the clinical notes and ward report book, but it was not recorded in PRIME.

***Referral and admission***

*Paragraph 103*

32. The adolescents are those identified as '[redacted]' and "[redacted]".

***Model of interventions, treatment and rehabilitation at BAC***

*Paragraph 110*

33. 'Transition activities' is a more accurate term than "transition program". Transition activities included attending an external school or other education provider, attending work experience, attending part time work, trialling staying at supported accommodation if not returning to home or attending an external health care provider to whom they would transition.

*Paragraph 112*

34. Up until 2012, the relevant data was available on a Desktop application called "Monthly Indicators". I no longer have access to this. However, attached and marked '**F**' is a PowerPoint titled 'Built Environment and the Adolescent Extended Treatment Centre Model of Care'. The graph at slide 33 indicates that the number of self-harm attempts in 2008 was between 90 and 100. This was compiled from the Monthly Indicators.

35. The system that was in place was that all incidents of self-harm, attempted suicide, aggression or absconding were required to be recorded in PRIME.

*Paragraph 120*

36. It is relevant that most of the adolescents at BAC with persistent anorexia nervosa were older and were not transitioning back into the care of their family. Therefore FBT was not appropriate for these adolescents. Further, all but one of the adolescents with anorexia nervosa admitted to BAC had severe co-morbid social anxiety. These co-morbidities resulted in severe impairments in tasks of adolescent development. BAC found that attention to the adolescent's developmental tasks reduced the focus on the eating disorder. Multiple interventions around eating including supported eating, cooking and then eating foods they cooked, eating in social situations and dietetic advice and support enabled them to resume eating, in spite of their persistent eating disordered cognitions. In addition, BAC utilised some aspects of CBT and other psychological therapies for eating disorders, to enable the adolescent to adjust to eating. These approaches to therapy for this sub-cohort of adolescents was found to most effective, including for those minority who were transitioned back into the care of their families.

*Paragraph 123*

37. The rehabilitation model I developed is referred to under the *Paragraph 34(g)* heading above.

38. As explained above, I have presented this model in multiple forums. From a rehabilitation perspective I have also presented it on several occasions to clinicians in the context of Grand Round presentations. I presented it at the 2006 forum to examine the need for a rebuilt unit. I presented it at the initial meeting to discuss the AETRC MOSD in February 2010 attended by A/Prof David Crompton, A/Prof B McDermott and Ms Judi Krause. I have also presented it to Dr P Hammerle, psychiatrist from an inpatient unit in Switzerland, Professor L Bickman of Vanderbilt University, Tennessee and an administrator of Child and Adolescent Mental Health Services in Edmonton, Calgary.

39. Most clinicians provided positive feedback. There were some clinicians who did not provide any feedback. Ms Krause indicated to me that she did not understand the model. A/Prof McDermott suggested that I may wish to rethink my model, but did not explain his reservations or identify potential alternatives. Staff at BAC, including senior clinicians, found it useful. Dr Breakey used it in presentations overseas. Dr Hammerle asked me for a copy of it for use in Switzerland. As explained in my earlier statement, I was invited to provide training in Edmonton to child and adolescent mental health clinicians as I was intending to visit Canada at the end of 2012. However, I was unable to accommodate this request on account of pre-existing commitments.

*Paragraph 137*

40. The funding was provided under the "Building the Education Revolution", an initiative of the Rudd government. It was initially allocated for a sports hall at the Redlands proposed site. After the Redlands build was cancelled, the step-down house was mooted, but permission was not granted for it by West Moreton Health District. An outdoor kitchen area was built instead. Mr Kevin Rodgers and Ms Debbie Rankin will be able to provide further information, if considered necessary.

***Transitioning back into the community***

*Paragraph 142*

41. It is my recollection that BAC did have a list of accommodation providers and services. The occupational therapists, the social worker and the CLCN all had lists of resources. In addition, the school had a list of educational resources.

*Paragraph 146*

42. On occasions BAC would resume services in the circumstances described. One specific example is

Another example is

*Paragraph 147*

43. The phase of cross engagement involved the initial referral to the AMHS, the AMHS making a decision as to whether to accept the adolescent into their service, and then allocating a case manager. The case manager from the AMHS was provided with information, both at the time of referral and at the care planning meeting.

*Paragraph 148*

44. Both young adults referred to were over 18 years of age. They both had persistent long-term conditions which were likely to persist well into adult years. Adequate services were available in the AMHS to manage these young adults.

45. There were different challenges treating a young adult once they had turned 18. These related to the fact that the young adult could determine the nature and extent of information conveyed to their parents or carers, if any.

***Evaluation of BAC interventions***

*Paragraph 183*

46. Exhibited and marked '**G**' is a copy of the BAC 2005 paper referred to.

***Relevant policies and plans and their impact on the development of the model of care provided at BAC***

*Paragraph 197*

47. I seem to recall that I may have emailed Associate Professor Kotze during this time for the purposes of understanding the National Mental Health Services Planning Framework. I do not recall receiving a response.

***The National Framework for Recovery Oriented Mental Health Services ("NFROMHS")***

*Paragraph 215*

48. The Independent Hospital Pricing Authority released Development of the Australian Mental Health Care Classification – public consultation paper 1 and 2 in 2015. It was the first in a series of public consultation papers to inform the final stage in the development of the first iteration of the Australian Mental Health Care Classification (AMHCC). The IHPA was seeking responses to questions regarding the classification of mental health care. I did not make submissions in respect to the public consultation papers. However, I have reviewed the submissions made and available on the website.

***Prior considerations regarding closing or relocating BAC***

*Paragraph 218*

49. In 2002, it was again proposed to close BAC. This issue is addressed in paragraph 220 of my earlier statement.

50. I understand there is some suggestion that closure again was proposed in 2009. This is not my recollection of events. At this time, Redlands was in the planning stages with the budget having allocated the funds in 2007. There was the review in 2009. This was because ACHCS conducted a review of West Moreton and noted that some of the recommendations that had previously been made in relation to BAC (including those relating to the state of the buildings), had not been implemented.

*Paragraph 223*

51. I wrote by traditional mail to Dr Bill Kingswell. Attached and marked "**H**" is a copy of this letter. I have been unable to locate a copy of Dr Bill Kingswells's response in the limited time available.

52. I was involved in the planning for the development of the model of service proposed for Redlands. However, I was on a trip to Switzerland and the UK visiting inpatient units when the bulk of this model was developed. I kept up an email correspondence with the group. I feel that being there in person would have been far preferable.

53. My involvement was from September 2007 to April 2012. I continued my clinical role during that time, but made myself available for meetings with the architects and with the re-development teams, first, at The Park and then at Redlands.

54. Essentially the proposed model was to replicate many of the features of the inpatient component of the BAC model. One difference was that we were trying to negotiate opportunities for greater self-reliance by adolescents in preparing meals, particularly breakfast and lunch. It was not to include day patients as there was insufficient funding available. I was very disappointed about this as I considered it was an underutilisation of resources and there were no other day programs in the Redlands area. Further, an integral component of BAC was the day program.

55. I considered the need to review after six months to be reasonable. I felt that at the very least, it would assist in educating people who were not overly familiar with the issues encountered with the sub-cohort of adolescents treated at BAC. I thought there would be a frequent need to extend the treatment beyond six months. There were other adolescents

who would benefit from an admission to an extended inpatient facility for less than six months.

56. Between 2008 and 2010 I presented to various meetings my thoughts as to a suitable model for the proposed redevelopment. A copy of one such PowerPoint presentation is referred to at Paragraph 34..

57. I attended both the Facility Planning Team Meetings and the user Group meetings. Staff had an active input into the proposed design of the building. I believe the architects supplied a very good initial design, which circumvented many of the problems I had observed in the overseas units referred to in paragraphs 27 and 28 of my earlier statement.

58. I understood there was a need to contract the footprint of the site and reduce costs. One of the reasons for this was the requirement to have a clear zone around the building. There were others. I was concerned because the associated modifications reduced the size of the school building. I believed it would limit the functionality of the school if a day program was agreed to at a later stage, which I was hopeful of. I was also concerned that part of the building was to be two storey.

59. It was my understanding that the Redlands proposal did not proceed because there were overruns in the capital works budget for mental health, and it was a priority of the new government to reduce expenditure. I believe I was informed of this decision in August 2012 by Dr Terry Stedman. I was obviously disappointed by the decision as I viewed it as a lost opportunity.

***November 2012 onwards***

*Paragraph 229*

60. As explained in my earlier statement, I informed my professional colleagues by email of the closure. They were those colleagues on a child and adolescent internet forum.

*Paragraph 226*

61. At the meeting on 2 November 2012, it is my recollection that Ms Kelly informed me that BAC would close on 31 December 2012. Ms Kelly explained that the reasons for the closure were the low occupancy rates and that it could not remain on the grounds of The Park because it was to be solely a forensic facility.

62. By the time of the meeting on 20 November 2012 referred to in paragraph 231 of my earlier statement, it appears that a decision had been made to delay the closure date of 31

December 2012. I was not provided with any explanation as to the reasons for the delay. It came as a surprise to me.

*Paragraph 236-237*

63. The email I forwarded to Dr Kingswell in May 2013 details some of my concerns regarding the 'wrap-around' model of care.

64. It was my understanding that the services which could be provided to the adolescents involved them living in accommodation over a wide area. I was concerned as it would isolate them from a community they knew. Those with social anxiety ("[redacted], '[redacted]) would likely withdraw without the repeated exposure to their peers whom they had come to know. Some adolescents came from regional Queensland where there were a lack of relevant services ("[redacted]"). [redacted] I was concerned for those with severe trauma symptoms [redacted]) in that they would be unable to receive the level of therapeutic interventions in acute inpatient units. Nor could they access rehabilitation activities. Relationships with staff for nearly all the adolescents were critical to their progress and this would be diminished or lost, which I feared would severely impede their rates of progress. Staff could be employed in a mobile intensive team to try to have contact, but contact would be severely reduced. This service would be limited.

65. BAC provided multiple interventions, engaging the adolescent in the community wherever possible (similar to elements of a community wrap around service), while at the same time providing opportunities for social contact, intensive, integrated therapeutic interventions delivered in conjunction with a rehabilitation program. BAC offered a mix of "in house" interventions, plus exposure to outsourced providers such as going with the group to an outside gym or swimming pool, plus outsourced interventions such as going to an external school. One of the key differences was that typical wrap-around services outsource all therapeutic and rehabilitation services. These are not necessarily integrated. They may be delivered in environments which an adolescent would find threatening e.g. an alternate education program may have a proportion of young people with substance use. As explained at paragraph 262 of my earlier statement, great work has been and continues to be done by CYMHSs. However, a combination of the severity of the impairments due to mental illness, severity of the mental illness and impacts on safety or health and in some cases family factors, limit the degree to which any community interventions can be effective for this sub-cohort of adolescents.

66. The Fourth National Mental Health Plan defines a wrap-around service as "... individualised and integrated services provided through a single coordinated process to comprehensively meet the needs of a person with a mental illness." This typically refers to multiple community supports to enable a person with mental illness to live within the community. My professional career has been in child and adolescent mental health. Adult psychiatrists are much better placed to talk about the adult wrap-around model of care. My observations of adolescent wrap-around service stems from my involvement with Evolve clinicians, and the clinical services I provided to Logan Evolve. The Evolve clinician engaged with a number of others, including Child Safety, school guidance officers, a range of NGO's to secure accommodation and a range of other service providers. The Evolve clinician would be mindful of developmental tasks, advocate for stability, as well as provide some therapeutic interventions and engage the young person with the Evolve team if others could provide other interventions.

67. I do not have a detailed recollection of the meeting on 5 or 6 August 2013. It was an exceptionally hectic time. This is because staff, adolescents and then parents needed to be notified before the former Health Minister's announcement. I cannot recall being provided with any reason why it was being planned to close BAC by January or February 2014. It may have had something to do with the timing of the opening of the adult forensic unit at The Park. I also cannot recall any reasons being given as to why it was to close before alternate services were redeveloped. My recollection is that both Ms Dwyer and Dr Kingswell considered the wrap-around services would be sufficient.

***Impact of decision to close on staff and adolescents***

*Paragraph 250*

68. During the afternoon, after learning I was stood aside, I remember making four telephone calls: to my wife, Dr Anne Brennan, A/Prof Brett McDermott (because I was also employed at the Mater) and to Ms Vanessa Clayworth, the acting NUM. I cannot recall the specifics of any of those conversations. I was shocked by the decision to stand me aside and I was very distressed about the implications of this decision on the adolescents at BAC. There had been considerable turmoil with the announcement of the closure and I felt this further development would have adverse implications for many of the adolescents, where a sense of stability was essential to their progress.

69. I have had the opportunity to read Dr Brennan's statement. While I have no specific recollection of telling her that I would provide a written handover, I accept this could well be correct. This is because I can recall on the following day sitting down to write notes regarding the progress and potential plans for each adolescent. However, I was still in some shock and was unable to adequately focus on the task at hand. I did not have access

to the clinical notes in relation to any adolescent. I had intended to revisit this the following day, after what would hopefully be a better night's sleep. However, it was on that day that the former Health Minister made the announcement of the closure in Parliament. I decided then that it was inappropriate to provide the written notes given the directive which had been provided to me by Ms Kelly.

70. The question as to the adequacy of the transition arrangements is a very complex one and from my perspective can only be responded to in a general sense. On the one hand, my concerns were not addressed because of the constraints imposed by the early 2014 closure. Having said this, it seems that given the time constraints, the planning for the transition was carefully and thoughtfully done. I have known Dr Brennan, Ms Clayworth and Ms Rankin for a number of years and have every confidence in them. They are all very committed to prioritising the needs of adolescents with mental health issues. I am sure they would have been thorough in their attention to detail with respect to each adolescent. If I had been given a similarly short time frame to work towards for the closure, I may well have come up with very similar transition plans. Having said this, I would have felt compromised.

71. As to the investigation, the investigators quoted from "international literature". This was limited to papers from one research team looking at the study of transition from CAMHS to AMHS, not from an intensive inpatient unit such as BAC into the community.

72. Prior to my interview, I emailed Ms Geddes outlining what I believe was a reasonable approach to closing the unit. Exhibited and marked '**I**' is a copy of the email. This email raised the issue of gauging levels of crisis at BAC. The investigators identified one important point from their research, namely that transition should not be undertaken at a time of crisis. The investigators noted that in the context of transitioning the BAC adolescents, there was crisis as was evident from the PRIME reports. Despite this, the investigators did not question why there was not a moratorium on the closure.

73. There were other limiting aspects of the investigation. It is not clear that the investigators sought feedback from senior clinicians involved in the transition, such as Dr Brennan, Ms Clayworth, Ms Danielle Corbett, psychologists and senior education staff including Ms Rankin as to the issues confronting adolescents which may affect the timing. This would have been important. The investigators did not interview the parents/carers/families or adolescents, which was a key plank of National Mental Health Policy and Standards, and of the transition research from which they quoted? These were the very people who were most affected by the transition, yet their input was not sought. Irrespective of the reason for this, it meant that the 'full picture' was not available to the investigators in arriving at

their conclusions. The investigators examination of governance appeared to be limited to the processes, and communication between two health services.

74. The investigators observed that it is not possible to quantify the contribution of the impact of my standing down to the atmosphere of crisis. Some adolescents, families and staff have addressed this issue in their respective statements and I do not consider it appropriate for me to comment on this. It is best left to others. All I can say is that from my long history working with this sub-cohort of adolescents, I would imagine there would have been at least some consequences, particularly with respect to the continuity of care. I do not seek in any way to overstate the extent of my clinical input. Rather, given the circumstances as they unfolded, it would have taken Dr Brennan some weeks to come to grips with the issues and even then, it would be surprising if she had the opportunity to fully understand them. I tend to think that my continued presence in the light of the closure announcement may have assisted in terms of containing anxiety, which is important when such adolescents are faced with significant change. Further, had I remained in my position I would have continued participating in the various working groups and advocated for better integration with the school and to have an interim, post closure service which retained key staff, to provide an outreach and support service to the adolescents.

75. The adolescents in the various sections are identified are as follows:
    (a)
    (b)
    (c)
    (d)
    (e) ’.

***Exhibits***

*Exhibit H*

76. In compiling Exhibit H, I had the benefit of a CD containing over 3000 scanned pages of clinical records provided by the Coroner’s Office. I was informed by the Coroner’s Office that it was not necessary at the time of preparing Exhibit H, to reference where in in the clinical records particular information came from. I have not had the time to revisit the CD for this purpose. However, my recollections are as follows:

(b) [redacted]

(c) [redacted]

*Exhibit I*

77. At the time of the 'experiment' there were no adolescent acute inpatient units in Queensland. My recollection is that BAC was asked to admit [redacted] girls for acute admission who were at risk of abuse by males in the adult ward. BAC admitted them, and they did well. I spoke with senior nursing staff at the time about extending our admission criteria to include acutely unwell adolescents. The next few acutely unwell adolescents who were admitted were behaviourally disruptive, absconded on occasions and presented other challenges. They did not settle into the school environment, because they saw they were there short term and would go back to their own school. Overall there was a detrimental effect on other adolescents.

***Additional questions from the Commission's legal team***

78. As to question 40(a), as explained above, I have limited knowledge of adult services in Queensland. However, I can say that BAC experienced several difficulties in transitioning young adults to adult mental health services. These included the following:
    (a) An "adult" approach continued with the developmentally immature young adult making no adjustment for the need for them to take responsibility for their management.
    (b) Adult services for the young adult with severe social anxiety and impairment were lacking.
    (c) Adult services for those young adults with severe anorexia nervosa were patchy.
    (d) Young adults find adult wards distressing. A young adult ward would be preferable.

79. As to question 40(b), I note the comments in the paper, Transition from CAMHS to Adult Mental Health Services (TRACK): A Study of Service Organisation, Policies, Process and User and Carer Perspectives that "there has been long standing concern about young people with mental health problems who fall between child and adolescent mental health services (CAMHS) and adult mental health service (AMHS) and may get 'lost' during their move from CAMHS to AMHS (hereby called transition). Disruption of care during transition adversely affects the health, wellbeing and potential of this vulnerable group".

Whilst this paper is based on observations made in the UK, I considers that the comments are also relevant in the Australian context and that a young adult mental health service would assist in the transition process. There is such a service at Robina on the Gold Coast.

80. As to question 41, I oversaw the collation of demographic data collected by the BAC as referred to in relation to *paragraph 46* above. I used this data in multiple ways. For example, for the Redlands redevelopment process, I constructed the table on diagnostic profile to enable a determination of the range of treatment interventions. I reviewed this data to determine characteristics of adolescents with social anxiety disorders, eating disorders and histories of recurrent self-harm to consider both treatment and rehabilitation needs. For the ECRG, I used the data in various submissions to determine the age on admission, demographics of original residence, the rates of referral from north Queensland, domains of impairment and the number of adolescents admitted on an Involuntary Treatment Order.

81. As to question 42(a), at the time I provided this response in December 2013, I had access to the Business Planning Framework. However, after an extensive search on my computer, I am now unable to locate it. I do not have an accurate recall as to what the issues were.

82. As to question 42(b), in April 2012, there was a general centralisation of responsibility from the business unit level to executive level. This accelerated markedly after July 2012. I wrote that *"a fog descended on my role as Clinical Director"* in the context of my role becoming less clear in relation to senior management, and for what I was responsible. There were disagreements with allied health seniors about the most appropriate mix of allied health staffing. Decisions impacting on clinical care were made at an executive level, without consultation and they were communicated through the NUM. I did not consider some of these decisions relevant to clinical care were in the best interests of the adolescents. One example was a directive to implement a series of restrictions on activities in which adolescents could engage once they came off continuous observations. This was contrary to Health Service guidelines on continuous observations, and directly impacted the care of adolescent ' ' in August/September 2013.

83. As to question 43, it is my experience from talking with colleagues in acute inpatient units and the community, that there is a common perception that contagion effects for self-harm or attempted suicide are a significant risk in adolescent inpatient hospitalisation. I briefly reviewed my literature searches on "inpatient hospitalisation" and "self-harm and suicide". I was only able to identify three articles, one which did not support this perception and the other two gave limited support. I have read Dr Breakey's most recent statement and tend

to agree with most of his comments at paragraph 18 relevant to this issue. Acute inpatient units existed in the last 16 years of my time at BAC. This had the effect of reducing admissions of those who were most vulnerable to contagion effect. This differed from the early years at BAC when Dr Breakey was Director.

84. As to question 44, I cannot recall any instruction to that effect. It would not make sense, because the alternative to reporting to me would be to report to senior management at The Park, not CYMHS. I asked staff to report all incidents to me when I was on call for BAC and I was permanently on call apart from when I was on leave. Perhaps it refers to the period after I was stood aside. I was no longer to have anything to do with the adolescents. There was a roster of CYMHS psychiatrists from south east Queensland CYMHS providing the on call cover which had previously been provided by me.

85. As to question 45, I used the data on the spreadsheet to which I refer in response to *paragraph 46* above. I no longer have access to the spreadsheet. As to the concerns, I can recall thinking the recommendations for a Tier 3 unit, and the warning of severe risk if this was not available, addressed them to a large degree.

86. My comment referred to in question 45(b) is specifically in relation to those who experienced severe trauma. This was a smaller cohort than those adolescents with anxiety. This anecdotal evidence would have been taken from the spreadsheet to which I refer in response to *paragraph 46* above.

***Additional questions from the Commission's research team***

***Impact of significant reforms on Queensland Health in 2012***

87. As to question 46(a), my recollection of the impact of the *National Health Reform Agreement 2011* was that the application of activity based funding (**ABF**) was still in the process of being worked through. I was concerned that if bed occupancy was used as the measure of BAC activity, this would severely impact on the care BAC provided. I can recall encouraging staff to record all Point of Service on CIMHA. This would establish existing activity levels of staff, in comparison with other units in The Park. It also would provide an alternative model on which to base funding. After November 2012, concerns regarding ABF were no longer relevant.

88. As to question 46(b), BAC had not exceeded its traditional staffing establishment, so staff cuts for those reasons did not affect BAC as they did in some services. In August 2012, BAC continued to operate within budget, and recruited several new nursing staff. However, those who were eminently suitable only received three month contracts. This created considerable uncertainty. I can recall that the nursing establishment at the time

may have been 22.9, to cover those on continuous observations. This was reduced in 2013 to 20.9, although BAC remained under budget. Some nurses took a VER which was offered to staff. The contracts of temporary allied health staff began to be terminated from April 2013.

***Clinical Governance – Patient safety and quality of service***

89. As to question 47, I was aware of the Clinical Senate, and knew two members on it, namely Dr Aaron Groves and Dr Ross Pinkerton. I had no involvement with it.

90. As to question 48, I was a member of the State-wide CYMHS Clinical sub-Network (later Advisory Group) from its inception in September 2006 as Medical Director of BAC and later also as Chair of the CYMHS Clinical Collaborative. I continued to attend meetings until it was disbanded in July 2012. I was also on a number of working parties e.g. the high risk adolescent sub-group, the eating disorders reference group. As chair of the CYMHS Clinical Collaborative, I was also a member of the State-wide Mental Health Clinical Network (later Advisory Group) from 2009 to 2011. I was a member of the CYMHS COAG group from 2006 to 2008. No other BAC staff were on these groups.

91. As to question 49, members of the State-wide CYMHS Advisory Group reviewed the AETRC MOSD from March to May 2010. It was then endorsed by the SW CYMHS AG, and by the State-wide Mental Health Advisory Group and accepted by the Director of the MHAODD Directorate, Dr Aaron Groves. I do not have a copy of this version. From memory, the admission criteria were similar or the same as in the 2012 draft. A revised version of the document was to be submitted to the SW CYMHS AG in June 2012, but that group was disbanded.

92. As to question 50(a), I understood the Clinical Capability Service Framework to be a description of the service, against which BAC could be assessed at a higher administrative level to ensure there was adequate capacity to provide such a service.

93. As to question 50(b), The Park provided overall governance of systems and processes to ensure patient safety and ensure quality and other persons are best placed to respond to this. However, BAC as part of The Park was a component of this. It was accredited by the Australian Council of Healthcare Standards (**ACHS**). As part of the accreditation process, ACHS assessed BAC's compliance with many of the National Standards for Mental Health. The process required the provision of documentation against which compliance was assessed for both the mid-term review and a four yearly full accreditation. There was also a site visit by an ACHS surveyor for the purposes of the four year accreditation. Documentation relevant to the processes of quality and safety from across the unit was

collated and submitted by the CLCN. As well, the NUM attended meetings of the Service Improvement Council and the Clinical Steering Committee.

94. I read through the National Standards for Mental Health when they were released in 1997 and 2010. BAC actively adopted processes after the release of the 1997 standards to ensure compliance in those areas over which BAC had responsibility. I recall that BAC was awarded a form of recognition at the inaugural ACHS accreditation. BAC maintained these processes so that with continued development of the service, only relatively minor adjustments were required to meet the 2010 standards.

95. From an operational perspective, standing items on the BUMC meetings included clinical incident reviews; PRIME incident reports; quality, safety and risk, education and training; research presentations, service development/future planning and the school report. The BAC school was assessed against Education Queensland criteria.

96. Compliance with the Mental Health Act was reviewed by Mr Warren Storey on a regular basis. In 2013, Mr David Kelly was the local A/Coordinator of Quality, Safety and Governance. I did not have contact with him on any occasion even though there were a number of incidents of attempted suicide and self-harm during this time. I was unsure of his role. Ms Renee Harwood reviewed BAC's compliance with the care planning processes, as part of a facility wide review of compliance with that process in the period March to June 2013.

97. As to question 51, I am not aware of the Health Community Council or of any review undertaken by it.

98. As to question 52, I initially sat on the Hospital Management Committee (**HMC**) from 1997 to 2004, and was involved in the development of strategic planning from 2003 to 2006. HMC meetings were held on Monday mornings. With the increasing complexity of adolescents being treated at BAC, I could no longer afford the time to attend. The NUM attended in my place and I attended external meetings which had an impact on service development at BAC, such as the State-wide CYMHS sub-Network (later Advisory Group) and the Facility Team Planning Meetings for the redevelopment of BAC.

99. As to question 53, I was aware of the Queensland Mental Health Reform Committee but had no involvement with it. I am not aware of any other staff member having any involvement with it.

***Models of care***

100. As to question 54, I have visited neither the Walker nor Rivendell units. I have read the statement of Professor Hazell. It is my impression that the patient cohort at BAC was a mix of adolescents who would be seen in Rivendell, and those who would be treated in the Walker Unit. Both the BAC and Walker Units were for extended rehabilitation for adolescents with severe and persistent mental illnesses who had not been successfully treated in other mental health settings, whether in the community or an acute inpatient unit. They both had generous outdoor spaces. Neither unit arbitrarily discharged an adolescent simply because they had turned 18. Unlike the BAC, the Walker Unit does not have a day patient program. However, adolescents can transition to Rivendell, which is a step-down facility from units such as the Walker Unit. Further, the Walker Unit can accommodate 12 inpatient adolescents, whereas BAC could accommodate 15 inpatients. Similar to the Walker Unit, BAC rejected any adolescent who it was believed could be treated in a less restrictive setting. I do not have the figures for the number of referrals rejected on this basis.

101. There were occasions when an adolescent in an acute inpatient unit who was suitable for admission experienced homelessness due to the family being unwilling to have them return, or because their placement (if in care) broke down. We admitted these adolescents because of their clinical need. Placement on discharge was often a problem. BAC did not take adolescents whose primary reason was a need for accommodation after an acute inpatient stay. Similar to Professor Hazell's statement in paragraph 39, all admissions required the involvement of a child and adolescent psychiatrist as a member of a CYMHS team or as a private practitioner.

102. As to the cohort of adolescents at BAC I have addressed this in response to question 59(b) below. At paragraph 36 of his statement, Professor Hazell has set out the four main groups who are admitted to the Walker Unit. There are differences in the frequency of disorders. I am unable to explain why so few adolescents with either psychosis or bipolar disorder were referred to BAC compared to the Walker Unit. One potential explanation may be the comprehensiveness of community services in Queensland when compared to NSW.

103. With regards to Professor Hazell's comments in paragraph 37 – I find the diagnosis of emerging borderline personality disorder is often made based on limited information, short term observations and limited application of criteria. Most adolescents presenting with this diagnosis on referral had severe complex PTSD. The characteristics of the adolescents with complex PTSD who benefitted from admission to BAC are described below in response to Question 59(a). From conversations with Dr Starling, and Prof Hazell's admission criteria, this group appears to be absent in the Walker cohort. However, if there

was well documented evidence of borderline personality disorder (which occurred on occasions), I considered admission was inappropriate.

104. As to the operations and models of care, I have not seen the models of care of either the Walker or Rivendell Units.

105. Professor Hazell explains in paragraph 43 of his statement that there are one or two people waiting for admission to the Walker Unit, and they are generally admitted within one month. The adolescent is not offered an assessment until there is a reasonable chance of admission. The BAC had a waiting list of up to 10 adolescents. There are three potential reasons for this. Certainly, length of stay affected the waiting list. However, an adolescent who was potentially suitable was offered an assessment soon after referral, even although admission may not be imminent. This was to provide some indication to the family and the referrer of whether BAC was likely to be suitable. Finally, the BAC cohort at capacity typically had up to 14 adolescents with anxiety disorders and neurodevelopmental disorders as day patients and inpatients. These would be admitted to Rivendell in Sydney, which has a capacity of 30 places. The remaining six to seven adolescents in BAC would be admitted to the Walker Unit, which has 12 beds. NSW has approximately 1.6 times the population of Queensland. Even taking this in to account, the combined Sydney units had a 25% greater capacity than BAC.

106. Some of the issues which contributed to increased length of stay at BAC such as staffing and accommodation were not issues for the Walker Unit. In addition, Professor Hazell does not address the issue of any adolescents who became homeless during the course of the admission, or who could not return home. These factors contributed significantly to the lengths of stay of a number of adolescents at BAC.

107. As to question 55, family therapy was used at BAC. Families need to know how to manage an adolescent with severe mental illness. Dr Breakey is a skilled family therapist, and established BAC with family therapy as an integral part of the process. I trained in family therapy in the early 1980's and used it in the private practice setting. However, with time and on account of other commitments, I was unable to keep up the level of skill needed for the complexity of the adolescents being treated at BAC and the family interventions required. For this reason family therapy was usually provided by the social worker with the case coordinator. There would be occasions where the medical registrar would participate.

108. David Ward was the social worker at BAC up until 2013. He would be in a position to address this question in significant detail. I know that he would attempt to see families at regular intervals. He had attended family therapy training courses and obtained external

supervision in the provision of this therapy. He was very flexible with times, sometimes attending BAC on a day off if that was the only time a meeting could be arranged.

109. It is perhaps not surprising that some families could be difficult to engage. Some examples are as follows. [redacted] My attitude was that if we could still provide treatment of benefit to the adolescent, they should not be excluded by the lack of family involvement. This contributed to longer waiting times.

110. As to question 55(b), after Mr Ward left BAC in 2013, the provision of family therapy became a significant challenge. It was far from ideal. This is because BAC was without a social worker for nearly five months and once this position was filled, the replacement social worker was not as active or skilled in the provision of family therapy.

111. The Walker Unit has a dedicated family therapist, as well as a social worker. This was typical of many of the units I visited in the UK. I sought to have Mr Ward replaced with a dedicated family therapist. I could not obtain agreement on this. One of the Senior Specialist Clinical Supervisors employed at BAC was an eminent family therapist. He worked at BAC in approximately 2008. My intention was to enable nurses who were care coordinators to obtain skills to conduct family meetings. I saw this as an intervention we could do as part of weekend leave – to sit with the family and adolescent prior to leave to discuss and problem solve potential issues, or to review leave on return and learn from the strong points and conflicts. Unfortunately, this occurred at times, but never became entrenched. In part, this was because of the turnover and instability of nursing staff.

112. With reference to other statements by Professor Hazell about the Walker Unit:
    (a) In regard to paragraphs 48 and 49, it is difficult to comment on lengths of stay. Adolescents at the Walker Unit have a different diagnostic profile, family engagement appears to be strong and I do wonder about comparative levels of severity. I consider we had a very active program for adolescents with school refusal, but they would only be in the early stages of recovery after six months, and not sustainable. [redacted]
    (b) In regards to paragraph 51(c), BAC did not have access to music therapy and art therapy unless was a skilled staff member available.

(c) In regards to paragraph 51 (g), family leave from the third week was regarded as the rule if the adolescent was not at risk and could access it, but this probably was more applicable to those adolescents who were equivalent to the adolescents treated at Rivendell.

113. As to question 56(a), paragraph 28(b) of my earlier statement refers to a three to four month length of stay.

114. As to question 56(b), the therapeutic programs were designed around those adolescents who were most likely to be admitted. About half the UK units had a reasonable proportion of adolescents with an eating disorder. In those areas, inpatient admission appeared to be at least as common as FBT in the community. Programs in the units where inpatient admission was a common first line setting for treatment, included a number of weekly groups running over a 12 to 15 week period. I formed the impression that group work was more of a mainstay of the treatment than it was at BAC. Many groups were more structured (e.g. briefer versions of DBT), some were more psychodynamic, while others were expressive therapies groups. Some had group FBT, offered weekly. It was likely that adolescents who were admitted for an eating disorder would improve sufficiently in three to four months to be discharged for community management. Some, however had a more persisting eating disorder, so would stay longer or have repeated admissions. The cycle of group interventions, being for the average length of stay was then repeated, for those whose admissions were longer. DBT was also used for those with self-harm. I heard the term "emerging borderline traits fairly commonly". These adolescents with self-harm behaviours were conceptualised more as in the personality spectrum because this is the only diagnosis which has this criteria. Although abuse may be known about or considered, treatment of complex trauma did not seem to be a high priority in some units.

115. Due to the fact that admissions to BAC for those with eating disorders only occurred after a period of community and acute inpatient treatment, the cohort of adolescents who presented to BAC had more persistent eating disorders. Likewise, those with known or unknown histories of trauma who repeatedly self-harmed, required repeated inpatient admissions for attempted suicide but showed capacity for therapeutic engagement in the community were regarded as being potentially suitable for admission. Those admitted with PTSD symptoms, were often in the connection phase of our model of trauma. . Indeed, I formed the conclusion, towards my later years at BAC that those with PTSD symptoms were more likely to benefit from extended inpatient treatment, than those without such symptoms. The process of previous acute inpatient admissions ensured a selection of a different cohort of adolescents with both eating disorders and self-harm to those in the UK, and possibly in Switzerland, which did

not appear to have a strong community based network. Consequently, there was greater impairment among the BAC group, which also included those with severe anxiety disorders, which was relatively absent in the UK.

116. I came to the view that BAC had a better articulated rehabilitation system, than was available in the UK and Switzerland. Although the basic elements were similar, there was a stronger focus at BAC on an integrated treatment and a rehabilitation approach. The approach at BAC was more individualised. The DBT group ran in blocks of eight weeks/term over a one year cycle, which is consistent with the original description of DBT. At BAC, allied health met at the beginning of each term to determine the nature and content of group activity, given the treatment and rehabilitation needs of that particular cohort, and which adolescents were likely to work best together. I did not form the impression that the UK units incorporated this degree of flexibility.

117. As to question 57(a), we did not provide weekly progress reports.

118. As to question 57(b), BAC did have other mechanisms to keep referring agencies/providers involved in the care of adolescents referred to BAC. The communication avenues were varied and depended on the particular circumstances. This is best illustrated with examples.

These few examples illustrate that BAC facilitated a range of contacts with the referring agency. There were some cases depending on the particular circumstances of the adolescents when the predominant

contact was mainly the two three monthly care planning meeting. Having said this, the CLCN often provided interim feedback in arranging these meetings.

119. As to question 58(a), it is very difficult to provide an estimate of the average numbers of day patients. This is because the numbers were so variable from year to year. Providing an estimate is further complicated by the fact that while some adolescents were solely inpatients, other inpatient adolescents spent a significant proportion of their admission as day patients after an inpatient stay. There were others who were partial day and partial inpatient adolescents. There were also other adolescents who alternated between day and inpatient status, depending on their level of functioning. I can recall that there was one period where there were no day patients. I cannot recall when this was. On the other hand, in 2012 and 2013 BAC had the highest numbers of day patients, which was in the order of seven to eight.

120. As to question 58(b), there may have been a decrease in the number of day patients from about 2000 with the establishment of the Mater Day Program, taking adolescents in the southwest part of their catchment (centred around Inala CYMHS). My recollection is that numbers were gradually offset as Ipswich/Goodna CYMHS staff gained more experience in engaging social isolated adolescents.

121. As to question 59(a), from my experience in working at BAC there were four broad categories of adolescents for whom interventions appeared to be of benefit. There were of course exceptions. The first category was those adolescents with severe and persisting anxiety, to the extent that they had withdrawn from most community activities. Admission offered the opportunity for a range of intensive graduated exposure to peers, to school and to community. The second category was those adolescents with severe and persistent trauma, with a history of suicidality and repeated self-harm, with or without emerging signs of PTSD. They only benefitted if they had a history of being able to engage well with a therapist in the community, and without a significant history of substance use. The third category was those adolescents with persisting anorexia nervosa, who generally maintained their weight above a critically low threshold, and did not require medical admission. Queensland was somewhat unique in Australia between 1996 and about 2008, in that many acute inpatient units considered naso-gastric re-feeding the first line of treatment. I did not find this substantiated in the literature, nor was it the practice of units which presented at conferences I listed in my CV. BAC gained expertise working with these adolescents to resume sufficient oral feeding to maintain weight. The BAC approach of integrating rehabilitation with maintaining weight was validated at two conferences listed on my CV. Most therapeutic units in the UK, which were stand alone units, admitted adolescents with anorexia. The fourth category was those with severe persistent

psychosis severely impacting on cognitive functioning. The rehabilitation program was useful in attaining a better level of functioning.

122. Adolescents with anorexia nervosa at BAC generally maintained their weight above a critically low threshold, and did not require medical admission. However, their weight deteriorated if on leave for longer than a few days. .

123. As to question 59(b), those adolescents who were less likely to benefit from the interventions provided at BAC were those with a primary diagnosis of oppositional defiant disorder or conduct disorder; those who simply required long term placement or were homeless; those with heavy substance use; those with a history of sexual assault or severe aggression who may pose a danger to others; and those with limited commitment with histories of frequent absconding. Further, it became apparent over time that a lack of engagement with a therapist in the community seemed to be a poor prognostic factor for successful rehabilitation at BAC and I made the decision to not admit a number of adolescents with this history.

124. As to question 59(c), it is important to understand that there are many adolescents with anxiety, with an eating disorder, with psychosis or who have been exposed to trauma, who can be successfully treated in the community and acute inpatient units. The adolescents with these conditions who were successfully treated at BAC were at the severe and persistent end in terms of presentation of symptoms and response to treatment. Adolescents were referred to BAC because unsuccessful attempts had been made to manage them in community settings and/or acute inpatient units. They had not responded to treatment in these settings.

125. The reasons why those adolescents with severe and persisting anxiety could not be successfully treated outside BAC is because their intense avoidance secondary to anxiety was difficult to overcome because of the intensity of interventions required. Most community settings to which they could be exposed caused a flooding of anxiety which they found intolerable. A number simply did not engage with the therapists because of their anxiety.

126. The reasons why those adolescents with severe and persistent trauma, particularly with a history of suicidality and repeated self-harm and with a history of being able to engage well with a therapist in the community could not be successfully treated outside BAC is because their risks were too high to maintain them in the community. They spent long periods in acute inpatient units without an integration of trauma focussed treatments and rehabilitation activities.

127. The reasons why those adolescents with persisting anorexia nervosa could not be successfully treated outside BAC is because they lost weight whenever they were discharged from acute inpatient units. This combined with moratoriums on their tasks of adolescent development, meant considerable regression and risk to health with a combination of community and acute inpatient management. Adolescents with anorexia nervosa that had become life were not suitable for BAC.

128. The reasons why those adolescents with severe and persistent psychosis severely impacting on cognitive functioning could not be successfully treated outside BAC is because there are limited coordinated rehabilitation activities in which they can engage in their local communities.

129. I have explained in paragraph 74 above and in response to question 71 below why these adolescents are unable to be successfully treated in acute inpatient settings.

130. As to question 60, I held concerns regarding the classification of three tiers of service. This is because it neither aligned with the only existing classification model in Queensland, namely the CSCF, nor with the four tiered system of which I was familiar in the UK. I agree that BAC would have been classified as a 'Tier 4' facility under the system in the UK. I raised my concerns in a submission to the ECRG which is annexed and marked '**J**' to this statement.

131. There was strong agreement at the last ECRG meeting about the level of risk in the absence of a Tier 3 facility. It was specifically mentioned that people would die. One of the problems with the minutes of these meetings are that not all views are documented. I considered at the time that a warning about risk would be noted. In retrospect, it was a mild warning. I do not think the final document, dated 8 May 2013, some 15 days after the last ECRG meeting of 23 April 2013, written by Dr Leanne Geppert conveys the strength of that warning.

132. The ECRG unanimously ruled out using acute beds as a component of the Tier 3 service. ECRG Preamble says "*The risk of institutionalisation is considered greater if the young person receives medium-term care in an acute unit (versus a design-specific extended care unit)*" and "*Clinical experience shows that prolonged admissions of such young people to acute units can have an adverse impact on other young people admitted for acute treatment.*" However, it reads in one sentence. *"It is understood that the combination of day program care, residential community-based care and acute inpatient care has been identified as a potential alternative to the current BAC or the proposed Tier 3 in the*

*following service model elements document".* I cannot recall the ECRG agreeing to that sentence.

133. I was not invited to any Planning Group meetings after 15 May 2013. I linked into this meeting from Townsville while delivering a workshop. There was no indication at that meeting that "*interim service position could start immediately.*" I was not aware of this statement until 6 August 2013, which was the first time I saw the Planning Group recommendations.

134. It was after the 15 May 2013 Planning Group meeting that I wrote to Dr Bill Kingswell, Ms Sharon Kelly and Dr Stephen Stathis expressing my concerns about a wrap-around service.

135. As to question 61(a), my best estimate is that if BAC had 15 inpatients, eight or nine had a primary diagnosis of severe anxiety disorder; three or four had a primary diagnosis of severe depression and most often complex PTSD and one or two had a primary diagnosis of anorexia nervosa. There was also probably about a two in three chance that one bed would be occupied by an adolescent with a severe psychosis. If BAC had five day patients, four were likely to have had a severe anxiety disorder and the fifth would be a step down from one of the other groups of diagnoses.

136. As to question 61(b), in my experience there was an increase in the proportion of adolescents presenting with psychosis. It was probably under-diagnosed as a disorder because community teams were not as familiar with it in the adolescent population. Self-harm and anorexia nervosa were less common in the early 1990s. There was an increase in the rate of referrals for anorexia nervosa with naso-gastric re-feeding as the first line of treatment in acute inpatient units. In the 1980's the impacts of abuse were suspected in a number of adolescents, but the phenomenology of complex PTSD was not fully appreciated. Recognition of the impacts of anxiety have increased over the years.

137. As to question 61(c), typically there was a high incidence of neurodevelopmental disorders associated with the anxiety disorders. Those with Complex PTSD also showed a range of neurodevelopmental function. Co-morbid anxiety was very high. Eating disorders, namely bulimia, eating disorders not otherwise specified ('EDNOS') and anorexia nervosa (in that order of frequency) were very common in this group. I reviewed my list of patients prior to going to visit overseas units. In that list only one adolescent with anorexia nervosa did not have a severe co-morbid social anxiety disorder.

138. As to question 62, the role of each of the allied health professionals varied according to the particular needs of each adolescent. The social workers provided family therapy, negotiate with Centrelink, find appropriate accommodation, run some groups such as the boys to men group aimed at exploring male identity and provide individual therapy. The psychologists undertook assessments, provided individual therapy, facilitated the DBT group and other ad hoc groups and provided staff training. The occupational therapists oversaw designated "leisure" and "life skills" activities, performed assessments, designed/implemented and oversaw multiple rehabilitation activities such as adventure therapy on an individual and group basis, and often facilitated transition to an external education provider and establishing alternate accommodation. The speech pathologists conducted assessments, provided individual language remediation assistance, facilitated cognitive remedial therapy for concentration deficits and ran social skills groups.

139. As to question 62(b), as a general statement, the allied health professionals predominantly worked on weekdays between 9am and 5pm. However, they tended to be very flexible so that they would be present if an activity was required to be arranged on the weekend. Further, the occupational therapists ran a cooking group which extended into the evenings. They accrued Time Off in Lieu if they needed to be flexible beyond working rostered hours.

140. As to questions 63(a) and (b), I use the term acuity for acute emotional distress, predominantly self-harming behaviours, attempted suicide, severe panic attacks and some symptoms of PTSD, such as dissociation or flash backs associated with a strong affective reaction. They are particular exacerbations of emotional distress or self-destructive behaviours occurring in an adolescent with a severe illness. Severity reflects the degree to which an adolescent is affected by a mental illness. I conceptualise it as a mix of persistence and the extent to which multiple symptoms are manifest for a disorder, or the number of functional domains on which they impact. There have been attempts to classify the severity of disorders, although there has not been a great deal of consensus. Complexity includes a variety of factors which make treating the primary disorder more complex, such as the presence of neurodevelopmental disorders, the presence of one or more co-morbid mental illness and significant family factors.

141. As to question 64(a), I have no documents detailing admission criteria prior to 2003. However, I recall in the 1980's that the majority of admissions to BAC were those adolescents with school refusal. Other admissions comprised adolescents with anorexia nervosa, with psychotic disorders or persistent suicidal ideation. (Although there was a lower incidence of each of these, because they required longer admissions, we admitted all

adolescents with these disorders in the absence of acute adolescent inpatient units.) These groups remained the core of our BAC admissions until its closure.

142. As to question 64(b), the four core groups continued in 2003. The 2003 documents, added in adolescents with trauma and those who may be a danger to others.

143. As to question 65, The 2009 initial version was the first development of AETRC. A new template was then introduced which required a revision of the initial version to be undertaken. This process of revision occurred in late 2009 to late 2010. The final version of the AETRC was to align with the child and adolescent day program MOSD, which was being revised in late 2011 to late 2012.

144. As to question 66, I am ambivalent about the use of the term "milieu therapy". The term is often used, but poorly understood. It was a nebulous concept, difficult to measure and thus to research. I collated the available literature on the therapy and was not convinced by what I read. Most articles were descriptive, of a philosophical nature. I considered it lacked evidence as claim for a form of therapy. Having said this, I recognised many of the principles in the way BAC operated. Further, I believe that the agency of community was a tool for change in the lives of the adolescents. (This is not unique to Barrett. Schools foster a sense of community as an agent for change. On the other hand, acute inpatient units are dealing with transient communities.) It seemed to provide the carriage in which social learning occurred, so necessary for many of the adolescents in which social isolation was so difficult to overcome. It appeared to be one of the factors which contributed to hope. Certainly relationships were important to change, both relationships with peers (when positive) and with staff. For those who experienced complex PTSD, the quality of relationships with staff appeared to be an essential pre-requisite to enduring the distressing emotions therapy engendered. It was one of the reasons I was concerned about the "wrap-around model". Any wrap-around service would struggle to provide the sense of community which appeared to be a necessary therapeutic component.

145. As to question 67(a), the sensory room was an area of about four by three metres with windows covered, so that the only light in the room could be controlled by the person in it. My recollection is that there were several lights. It had a bean bag, cushions and a number of materials to offer different tactile experiences. A range of aromas were available e.g. peppermint, floral, cinnamon etc. A CD player was available for sound. It was used to modulate distress of any type and had varied uses. An adolescent could ask to be taken there by the nurse, and were free to use any sensory modalities they found useful. If an adolescent felt themselves about to dissociate or wanted to self-harm, they were offered the sensory room. It was also used by some adolescents who had been abused. Physical

and sexual abuse involves intense multimodal sensory experiences to which an adolescent becomes averse. Exposing the adolescent to sensory experiences outside those experienced in the abuse, enabled the adolescent to experience a sensation without blocking it off or dissociating from it. Further, some adolescents were offered experiences in the sensory room outside of a time of distress to experiment with the sensations.

146. As to question 67(b), a former occupational therapist, Mrs Lyndall McCasker and another occupational therapist pioneered the use of a multisensory room in The Park. This was originally in another building but BAC utilised it more than other units. BAC recognised its value, and decided to convert a single room within BAC to the multisensory room. It is my recollection that Ms McCasker presented at various forums in relation to the sensory room. She also trained a number of staff in its use. In later years, the Mater and Royal Brisbane Acute Adolescent Inpatient Units began to use such a room within their respective facilities.

147. As to question 68, my understanding of the residential homes model as used in the USA is based on both the literature and conversations with Professor Len Bickman, who conducted research in respect of them. The similarity between the residential homes and a BAC type model is that with both models, a group of adolescents live together over a period of months. However, the residential homes are not primarily for the cohort of adolescents seen at BAC. Young people in the residential homes are often referred by courts for behavioural disturbance or substance use. Whilst depression and anxiety is present in residential homes, it seems to not be at the same level of severity as adolescents who were at BAC. Staffing in residential homes appears to be more a youth worker model, with only a small proportion of professional staff. I recall that Professor Bickman was concerned about the lack of articulation of programs, and the lack of evidence base for interventions.

148. As to question 69, staff in community settings are rarely faced with the levels of distress seen frequently at BAC. When they do, their role is to arrange an emergency admission. With respect to an acute inpatient unit, while a number of staff engage with adolescents as opportunities arise, it is possible to go to work and to expect to interact minimally with adolescents while on shift. Staff in inpatient units such as BAC need to manage more distressed adolescents and provide closer observations when compared to an acute inpatient unit. Managing this distress and being on close observations can be demanding on staff and can sometimes cause burn out.

149. I consider the staff who are best suited to units like BAC are those with a calm demeanour, who do not feel personally responsible to reduce the distress, who are able to provide the

right mix of tolerance of distress, utilise their knowledge of what the adolescent finds useful because they know the adolescent well and utilise a mix of silence where appropriate and talking (rather than just reassurance). It is emotionally draining to sit with an adolescent in intense emotional pain and to be able to provide no other healing in the moment than to sit with them. Staff have differences in their expectations for change, and tolerance of slow change. I observe impatience in a number of staff in acute inpatient units if change appears to occur too slowly. Finally, acute inpatient units rely on reasonably rapid assessments of an adolescent with the information presenting from ED or from the referrer. The skill set I valued was the person who sought out a good understanding of the adolescent, and who could incorporate new information into their understanding. While it is desirable in an acute inpatient unit, it is essential in a longer term unit. The tendency to foreclose on one's thinking about an adolescent is not as important if the adolescent is in a short stay unit. However, it may affect the management if the adolescent is requiring extended rehabilitation. There is little to no individual therapy, apart from managing occasional distress. The assumption is that the therapeutic engagement occurs with the community team. While some staff may have the skill set for more intensive psychological interventions, it is infrequently utilised.

150. As to question 70, there are several types of interventions that were available at BAC but are not available in the acute inpatient settings. The average length of stay in an adolescent acute inpatient unit is around 10 days. Those adolescents with severe and persisting anxiety, were rarely admitted to an acute inpatient unit, because of the length of time required for change. Day programs are much more appropriate, if they could access them, or BAC if they could not because they offered the level of intensity of interventions, in a stable community with a low stimulus environment which helped to prevent flooding with anxiety. Community therapies for anxiety are often office based, and may incorporate both verbal and non-verbal (art, play) therapies. Behavioural interventions are less common, for example in vivo progressive exposure. Home visits may be uncommon, so that they do not have exposure to a severely anxious, house bound adolescent, with lack of experience in how to engage them. There is simply not the capacity to provide the repeated levels of exposure necessary. Often available community settings are too anxiety provoking, and do not allow for the same level of graded exposure from a very low level of stimulus.

151. For adolescents with suicidal ideation, the aim in an acute inpatient unit is to stabilise the adolescent so that psychological treatments can continue in the community. The interventions are time out in a safe place, review of the factors leading up to the suicide, developing a safety plan, brief crisis interventions and brief family interventions. Impairments in developmental tasks are not addressed. However, for the small group of

adolescents with a history of suicidality and repeated self-harm resulting from severe and repeated trauma, and a capacity to engage well with a therapist in the community, the interventions unique to BAC were the capacity to tolerate change at the adolescent's pace, to trust staff and then build strong relationships which enabled them to tolerate the strong emotions working through the abuse, and to integrate treatment with a strong rehabilitation program to decrease the inevitably high levels of anxiety on discharge from hospital and establish a positive sense of identity outside the hospital. Community clinicians do not have the same opportunities to provide interventions of the type provided at BAC. For example, because PTSD symptoms are usually manifest at night, community clinicians will not be present to manage the adolescent with dissociation or flashbacks. While certain levels of working through trauma can be managed in community settings, the emotions may be so intense that the adolescent can become intensely suicidal. Because the adolescent with severe, persistent suicidal ideation requires frequent hospitalisation, often for longer periods, they do not have the opportunity of continuity in working through the issues with this cohort of adolescent.

152. For those adolescents with persisting anorexia nervosa with a BMI of around 14, the interventions unique to BAC were the capacity to provide a range of rehabilitation interventions which enabled them to become less preoccupied with body image, to regain function where developmental domains were stalled, to enable them to build an identity outside having an eating disorder. This was integrated with a range of interventions to enable them to tolerate sufficient oral intake to maintain weight – support at meal times, education about food, opportunities to desensitise to food, and concerns about other's perceptions of the eating, rest if necessary, psychological therapies to address a number of issues including eating cognitions, family therapy and a healthy exercise routine. For a variety of reasons, family based therapies were unsuccessful prior to coming in to the centre. This limits the extent of community involvement in a number of CYMHS. Current acute inpatient services offer a behavioural program which balances establishing an adequate oral intake with measured weight gain balanced with bed rest if the adolescent struggles with these.

153. Medication is the primary therapeutic intervention in an adolescent in an acute inpatient unit with a psychotic disorder, followed by psychoeducation. For those adolescents with severe and persistent psychosis severely impacting on cognitive functioning, the interventions unique to BAC were the capacity to provide a comprehensive range of rehabilitation interventions to reduce impairments of function.

154. As to question 71, both acute and extended inpatient units will utilise the sensory room, time out and continuous observations to modulate distress. However, distress is for much

longer periods for adolescents in an extended inpatient unit making the skill level of staff a critical component of successful treatment. The presentation of PTSD symptoms in an acute inpatient unit is much less common and therefore staff do not have the same opportunities to acquire and maintain skills to manage these symptoms. While both types of units have a school, for adolescents with longer term admissions, the range of educational opportunities afforded by teachers at BAC enabled them to actively pursue educational and vocational options. There may be a cooking group in both types of units, but the BAC one was much more skills oriented and focussed on rehabilitation. Finally, broader rehabilitation activities, beyond what the school provides, are not possible in an acute inpatient unit.

155. As to question 72(a), I did not consider there were any other options for an 'interim solution' to the closure of BAC. Dr Stathis and Ms Krause flew to Melbourne in August to visit the Acute Mobile Youth Outreach Service (AMYOS) as an alternative model. I joined them the next day to visit Y-PARC facilities in Frankston and Dandenong. The latter was not an alternative because not only was it a model not suitable to the BAC cohort, but it required a building.

156. As to question 72(b), although Logan Hospital could be used as it was, ideally it required some modifications to make it suitable for adolescents. Mr Rodgers, Ms Clayworth and I endorsed it. As I understand it, no money was available for any modifications. I otherwise do not know why it was not progressed.

157. As to question 73, the Services Options Implementation Working Group and the BAC Consumer Transition Working Group were to be tasked with identifying potential services to which adolescents would transition. These groups had not been established until after 9 September 2013.

158. As to questions 74(a) and (b), the Mater acute inpatient unit employed a music therapist for one session a week, and an art therapist for two days a week. The art therapist did both art and sand play therapy. The RBWH adolescent inpatient unit has a music therapist for one session a week. However, his input does not appear to be integrated into an overall therapeutic program. Of course, pharmacotherapy and on occasions ECT are available in acute inpatient units. Further, acute inpatient units have access to a school.

159. As to question 75, the responses are as above.

160. As to question 76, this was a presentation at a conference. I am unaware of any paper in relation to it.

161. As to question 77(a), my responses have been provided in my earlier statement. There was regularly a waiting list for adolescents to be admitted to BAC.

162. As to question 77(b), my responses have been provided in my earlier statement. The buildings for BAC were not purpose built, were not ideal and were old.

163. As to question 77(c), no concern was ever expressed to me by staff members, adolescent or family member regarding the proximity of BAC to the adult mental health incident and I am unaware of any issue that it created. Forensic patients, including Special Notification Forensic Patients (SNFP) regularly accessed leave, including any part of the grounds. After the high secure unit moved to its current location in 2000, we were not notified of SNFP movements, advised to develop any risk or contingency plans or advised to restrict where adolescents walked on the grounds.

164. As to question 77(d), I agree with what Professor Hazell has said at paragraphs 87 and 88. Ultimately the questions to be answered are not primarily derived from a quota of descriptions of models of care. They are derived from a focus on the individual patient, in this case, an adolescent. How severe is this mental illness in this adolescent? How is it impacting their lives? Are current treatments effective? If not, why not – what stops them? What are the interventions we need to bring about effective change? What range of interventions? What intensity is necessary? How often? How do we integrate them? In what setting can this be done? This is what happens in all other areas of medicine. A focus on patients, not on policy drives the range of services. We do not have a National Burns Services Planning Framework which says "*hospitals are full of antibiotic resistant bacteria, so we will avoid admissions, limit admissions where unavoidable to two weeks and treat everyone at their local hospital.*" Rather, the clinical needs of the patient determine the service. Those with the most severe burns are sometimes taken over 1000 km from their home for months to enable them to receive the appropriate level of care in a facility with the necessary resources with a whole range of expertise from a multidisciplinary team. Along the way the medical team take all measures they can to minimise infection with antibiotic resistant bacteria. Decades of experience in Walker, Rivendell and BAC provide some answers to these questions, even if the literature does not.

165. As to question 77(e), I agree the length of stay was too long for some adolescents. Some of the reasons for this were staffing issues, I identified in my previous submission at paragraph 136 factors contributing to an increased length of stay. Over the years I also identified issues within the adolescent and with the family as contributing factors. Some adolescents have enormous difficulty describing emotions and being able to work

psychologically. It took six months or more before they could utilise psychological interventions. Adolescents with complex PTSD reported it took them up to six months just to trust staff. Anxiety at the most severe end of the spectrum can be very persistent, and requires multiple interventions over a long period to be sustained, and then generalised into the community. For a number of adolescents, family factors were significant. While many parents offered incredible support and sacrifice, others virtually abandoned the adolescent once in BAC, some were subtly neglectful, or applied inappropriate pressure. Some did not have the resources to manage the high needs of the adolescent. For the adolescent, a considerable period of time could be spent working through the grief of realising their parent would never be able to provide what they needed. The adolescent had to be equipped to live independently and then appropriate accommodation needed to be obtained. These three factors added significantly to length of stay.

166. As to question 77(f), I acknowledged this in paragraph 138 of my previous statement. On reflection, some adolescents in the period between 2008 and 2010 were among the most complex I had treated. Staffing issues were exacerbated from a decision to redeploy staff in The Park from units that would transition out to those units which stayed. BAC lost staff over the next three years. I have identified the impact of staffing issues on adolescent care and length of stay in other documents. A small cohort, [redacted] were affected by cyberbullying when each was on leave on the weekend. My recollection is that it took about four months before this issue was resolved. It had impacted on others. However, having observed some long stay adolescents in acute inpatient units, I consider that there is a small sub-population who would benefit from the integrated treatment interventions BAC provided in preference to languishing in acute adolescent inpatient units. I would anticipate the length of admission of these would be three to six months.

167. As to question 77(g), BAC sought to integrate into the CYMHS State-wide CYMHS network. The CLCN liaised frequently with referrers prior to admission. I have described BAC's contact with the referring service during admission. BAC were part of the site visits for new staff to CYMHS from throughout the State. BAC provided State wide training. Some of these were workshops organised by BAC, workshops I attended in a locality, or speaking at a forum. I initiated a joint research program with Mater CYMHS day program on anxiety disorders. As chair of the Clinical Collaborative, I had the opportunity to interact with many clinicians throughout the State, and to discuss management of clinical issues. I attended child and adolescent psychiatry Grand Rounds and registrar supervisor sessions regularly. The speech pathologist, Ms Angela Clarke liaised regularly with other speech pathologists. I understood the importance of trying to be an integral part of the CYMHS network. The comment about isolation in governance is

only partly true. Our governance structure related to an AMHS governance structure, as did Ipswich CYMHS. At that level, there was little communication with the governance structures of the Mater Children's or the Royal Children's CYMHS. However, all Health Districts were autonomous, with complete separation of governance of District CYMHS. I regularly attended meetings of the SW CYMHS sub-Network (later AG), which was conceivably the only state wide governance forum. Our MOSD was approved by that body in 2010 or 2011, and the 2012 revision was to be submitted to it. I was aware of discussions between senior staff of the RCH and Mater CYMHS outside of that forum with the MHAODD Branch, which had implications for services. Yet the majority of CYMHS were outside of those services. At no point was I invited to provide comment on issues, nor was it suggested I make myself available outside of meetings of the SW CYMHS AG to discuss further issues of governance. I suggested to A/Prof Brett McDermott on several occasions, the last being in 2012, that we come under the Mater umbrella if possible, so that we were integrated with at least one major service.

168. A few other issues have been raised about the BAC. It is simply incorrect that it did not have rehabilitation as an element. It was an integral component of the BAC model. It has been said that one of the downsides of BAC is that spending large periods of time, with other adolescents who experience highly challenging behaviours runs the risk of learning and reinforcing dysfunctional ways of coping. I agree with Professor Hazell's comments in paragraphs 90 and 91 of his statement. In relation to self-harm, it is my experience from talking with colleagues in acute inpatient units and the community, that there is a common perception that contagion effects for self-harm or attempted suicide are a significant risk in adolescent inpatient hospitalisation. I briefly reviewed my literature searches on "Inpatient hospitalisation" and "Self-harm and suicide". There were only three articles, one which did not support this perception and the other two gave limited support. Our observations were that adolescents who were admitted to BAC with long histories of suicide attempts or self-harming behaviours, did so as a way to cope with their own distress. They were often aware of the effects on others, and sought to minimise their distress.

169. It has also been said that BAC was restrictive by its nature as an inpatient unit, but also from its geographical isolation. The term "restrictive" is an interesting one. Hospitalisation is more restrictive than living in the community. But was BAC, which had predominantly an open door policy more or less restrictive from the adolescent's perspective than being in an acute inpatient unit where any access to the outside (in the Brisbane units at least) requires swipe card access. Many units in the UK considered a high fence a prerequisite to "duty of care". Adolescents stayed because BAC collaborated with them. The best evidence to answer this question will be provided by former adolescents who have made submissions to, or will appear before the Commission.

170. I understand that one of the significant drivers in moving away from a model of care such as that which was provided at BAC is the desire to provide care closer to home close to their peers, schools and community networks. It has been said that the advantages of this are as follows:
    (a) There is less stigma associated with seeking treatment;
    (b) The prospects of reintegration are optimised;
    (c) There is access to ongoing services some of which they will use on a long term basis;
    (d) It maintains connection to the support structures.

171. I do not agree this is correct for many of the adolescents with persistent, severe and complex mental health conditions. I tend to think the adolescents and families who were a part of BAC can provide valuable insights.

172. As to question 78, the question which has been posed is whether the AMHETI service elements, individually or as a continuum, provide adequate replacement services for the BAC cohort of patients? In short, the answer is no, particularly for those adolescents with severe and persistent anxiety disorders, eating disorders and complex trauma. Mental health in unique in health services in that it is driven by policy rather than patient need. By and large, the policy is good, and is derived to a large extent from the focus on the adolescents. However, I believe that planners need to have the confidence to see that planning for all mental health patients comes from an understanding of their needs. It is imperative that policy does not get in the way of the very small sub-cohort of adolescents with persistent, severe and complex mental disorders. I reiterate that one can only speculate the cost to the community for these extremely unwell adolescents if they are not to be given the best chance of recovery.

173. I have spoken to Commission staff at some length regarding this issue and have therefore detailed a brief summary below.

174. Adolescents with severe anxiety disorders do not generally respond well to treatment in adolescent acute or sub-acute inpatient units. These adolescents usually require six to 12 months of treatment, are particularly difficult to engage and require continuous treatment. Services such as AMYOS are not able to provide continuous and extended treatment. Mental health day programs may be an option for such adolescents, however many adolescents suffering severe anxiety disorders may be unable to travel to or attend day programs, even with support. In addition, to be able to attend a day program, the adolescent's home environment must be stable enough to facilitate such attendance. Step-

up and step-down facilities and youth residential rehabilitation cannot offer the continuous and extended treatment required by this cohort of adolescents.

175. In respect of adolescents suffering from depression and complex trauma, these adolescents cannot easily be accommodated in the AMHETI. My experience with acute inpatient units is that there is a focus on discharging the adolescent as soon as possible. Stability of relationships and stability of environment are essential to the treatment of these adolescents. This stability cannot be found in sub-acute beds located at the Lady Cilento Children's Hospital as these beds are located within the acute inpatient unit and, as such, there would necessarily be a certain level of instability in the cohort of adolescents. These adolescents may also require continuous treatment as they suffer increased symptoms whilst working through the trauma towards recovery.

176. Acute inpatient units may be suitable for adolescents suffering anorexia who maintain stable social relationships but may not suited to those who suffer anorexia co-morbid with an anxiety disorder as they have often withdrawn from society. This in turn may trigger more severe symptoms as the adolescent focuses on the control of their weight as a way to become less anxious in a social setting. While a physical-medical environment may allow these adolescents to gain weight, the treatment does not minimise the triggers for the symptoms of anorexia for these adolescents. It is my experience that treating these adolescents within a stable cohort at BAC, reduced the social anxiety and therefore facilitated recovery.

177. As a general statement, BAC accommodated those adolescents who do not easily fit within the services provided by other models. BAC allowed adolescents to seek treatment within a stable cohort of adolescents and I believe that continuity of care, coupled with a stable cohort of adolescents is lacking in the AMHETI. I also understand that the AMHETI places emphasis on the treatment of adolescents close to home. In accordance with this model for example, an adolescent may receive treatment in an adolescent acute inpatient unit before being stepped down into community based care. While I am generally in agreement with emphasis being placed on the treatment of adolescents close to home and within the community, I consider that a small cohort of BAC patients benefited from the geographical distance of BAC from home. For example, those adolescents who were being abused at home or preferred that their peers remained ignorant of the treatment they were receiving. Given the geographical size of Queensland, it will never be possible for all adolescents with mental health conditions to be provided with adequate treatment close to home. For some adolescents, the benefit of receiving treatment at a centre with a model of care similar to BAC will be more beneficial than the community based care that may be available closer to home.

178. I would be only too happy to expand on my concerns when giving evidence at the hearing, by reference to specific examples.

**MISCELLANEOUS MATTERS.**

179. I am aware that a number of statements have been provided by BAC adolescents and their families. I am reluctant to comment on them. The primary reason for this is that I consider it is important for the Commission to consider their views from their respective perspective, irrespective of my take on them.

180. The transition process of adolescents had begun and continued throughout 2013 in the sense that the focus was to ensure that the adolescents were as well as possible to reduce the effect of the ultimate transition. This focus on the wellness of the adolescents continued while the range of potential services to which the adolescents may be transitioned were being considered.

181. Attached and marked "**K**" is a copy of a document outlining the steps that were taken at BAC to rectify the concerns that were identified by Professor McDermott in his review in 2003.

182. I would be only too happy to provide further information if considered necessary.

## *OATHS ACT* 1867 (DECLARATION)

**I Trevor Bruce Sadler do solemnly and sincerely declare that:**

**(1) This written statement by me dated 12 February 2016 and contained in pages numbered 1 to 44 is true to the best of my knowledge and belief: and**

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

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

**..... .....Signature**

**Taken and declared before me at** Brisbane **this 12th day of February 2016.**

**Taken By ..**

~~**Justice of the Peace / Commissioner for Declarations /**~~ **Lawyer**

**Matters requiring further clarification from Dr Trevor Sadler**

*Questions in the Commission's Draft Statement*

The Commission understands that the language used to describe adolescents who were admitted to the Barrett Adolescent Centre (**BAC**) over the years included terms such as "patient", "client", "consumer", "young person" and "adolescent". The Commission notes that Dr Sadler uses the term "adolescent". Please explain why he has used this term.

*Questions arising from matters contained the Statement*

*Specialist Knowledge*

1. In paragraph 1 of the Statement Dr Sadler states that "*I am employed as a psychiatrist at Mater Health Services. I have occupied this position since 9 April 1989*". However, in Exhibit A to the Statement, Dr Sadler states that he was employed as a Visiting Psychiatrist with the Child and Youth Mental Health Service, Mater Health Service from 1989 to 1998. Please confirm the period and nature of Dr Sadler's employment with the Mater Health Service.

2. In paragraph 28(a) of the Statement, Dr Sadler states "*[t]here was generally an unsatisfactory mix of patients in general adolescent inpatient units, with a combination of acute and longer stay adolescents*". Please explain why it is unsatisfactory to mix these categories of patients.

3. In paragraph 28(g) of the Statement, Dr Sadler states "*BAC had a clear model of the conceptualising changes experienced by adolescents with complex trauma as they progressed through treatment*". Please explain, identify or provide the Commission with a copy of this model.

4. In paragraph 34(d) of the Statement, Dr Sadler states that he chaired the weekly Case Conference multidisciplinary team meetings. Please confirm who attended these meetings (for example, did all BAC staff attend)?

5. In paragraph 34(g) of the Statement, Dr Sadler states that he "*developed a model which proved to be effective in predicting whether an adolescent required community, day patient, acute inpatient or extended treatment and rehabilitation services*" and that he presented this model to a number of forums.

    a. Please explain, identify or provide the Commission with a copy of this model.

    b. Please identify the forums to which Dr Sadler presented this model, and explain any feedback he received in relation to this model.

6. In paragraph 34(h) of the Statement, Dr Sadler states that he "*developed and articulated pathways of recovery for adolescents who had experienced complex trauma*" and he "*presented these to clinicians external to BAC for review*".

    a. Please explain, identify or provide the Commission with a copy of this model.

b. Please identify the clinicians to whom Dr Sadler presented these pathways, and explain any feedback he received.

*BAC in the CYMHS setting*

7. In paragraphs 41, 51 and 52 of the Statement, Dr Sadler refers to a number of statistics. Please identify the source/s consulted and method/s used to produce these statistics, and provide copies of any relevant documents in his possession.

8. In paragraph 46 and Exhibit C to the Statement, Dr Sadler refers to a number of percentages based on his review of the adolescents admitted to the BAC from 2007 to 2012. Please identify the source/s consulted and method/s used to produce this review, and provide copies of any relevant documents in Dr Sadler's possession.

9. In paragraphs 47 and 50 of the Statement, Dr Sadler mentions the Clinical Services Capability Framework (**CSCF**). Please confirm the version of the CSCF to which Dr Sadler is referring.

*Organisational structure within BAC and The Park – Centre for Mental Health*

10. In paragraph 58, 59, 64, 68 and 71 of the Statement, Dr Sadler refers to staff numbers. Please identify the source/s consulted and method/s used to produce these numbers, and provide copies of any relevant documents in Dr Sadler's possession.

11. In paragraph 61 of the Statement, Dr Sadler states that the requirement for the Clinical Nurse Co-ordinator to attend facility wide meetings "*was less than ideal for BAC because the Clinical Nurse Co-ordinator's time was taken away from staff training, development and supervision, all of which are critically important in the complex clinical environment that existed at BAC*".

    a. What formal and informal training and development activities did the BAC nursing staff undertake? How often did the BAC nursing staff undertake these training and development activities?

    b. What, if any, training and development activities were available to other BAC staff (medical, allied health and administrative)?

*Impact of restructure of health services; Government priorities*

12. In paragraph 73 of the Statement, Dr Sadler refers to the "CYMHS Clinical Collaborative". What was the CYMHS Clinical Collaborative and its role? What data did it collect? Did it have a state-wide focus or a limited focus on South East Queensland or certain regions of the State?

13. In paragraph 87 of the Statement, Dr Sadler refers to the BAC building containing single rooms. The Commission understands that those rooms were referred to as "high acuity" rooms. Please explain the circumstances and frequency in which an adolescent would be placed in a single or "high acuity" room. Is such seclusion recorded in the PRIME records?

*Referral and admission*

16. In paragraph 103 of the Statement, Dr Sadler states that "*four of the last group of the adolescents, (including ), stated this at the time of their respective admissions*". Please identify the adolescents to whom Dr Sadler refers.

*Model of interventions, treatment and rehabilitation at BAC*

17. In paragraph 110 of the Statement, Dr Sadler states that "*[t]he expectation was that they would attend school and other programs that were running unless they were involved in the transition program...*" Please explain what is meant by "transition program". What would the adolescents involved in the transition program do while the other adolescents attended school and other programs?

18. In paragraph 112 of the Statement, Dr Sadler states that "*[m]any adolescents at BAC were at risk of self-harming or attempting suicide*". Generally, what was the frequency and degree of seriousness of these incidents? Were detailed records of such incidents kept? If so, were they kept in the PRIME records?

19. In paragraph 120 of the Statement, Dr Sadler states that the BAC adopted a "*ward based approach...where nursing staff rather than parents encouraged an adolescent to eat*" instead of Family Based Therapy (**FBT**), to treat adolescents with persisting anorexia nervosa. Please explain how adolescents with this diagnosis transitioned back into their families' care if the BAC did not use FBT.

20. In paragraph 123 of the Statement, Dr Sadler states that he developed a 'rehabilitation model'.

    a. Please explain, identify or provide the Commission with a copy of this model.

    b. Please identify the clinicians to whom Dr Sadler presented this model, and explain any feedback he received.

21. In paragraph 137 of the Statement, Dr Sadler refers to the school at BAC obtaining funding in about 2011 to cover the cost of a modular home, which could have been used as a "step-down unit" for the adolescents, and says that the proposal was ultimately not accepted. Please explain where the BAC school obtained this funding from, who rejected this proposal and why. What was Dr Sadler's understanding of what this funding was applied to instead?

*Transitioning back into the community*

22. In paragraph 142 of the Statement, Dr Sadler states that "*there was no formal documentation about the transition process at BAC*". However, did the BAC maintain any documentation that would assist in the transition process (for example, a list of external agencies including local mental health providers)?

23. Also in paragraph 146 of the Statement, Dr Sadler states that "*[i]f a local service was unable to meet the needs of the adolescent at any stage in the transition process, BAC would resume providing the service while the situation was rectified or an alternative*

*service provider was arranged"*. Please provide specific examples of when this occurred, and explain how often this occurred.

24. In paragraph 147 of the Statement, Dr Sadler states that "*the phase of cross engagement with the AMHS was usually over a period of two months or more*". What is meant by 'crossover engagement'? Dr Sadler states that a clinician from the appropriate AHMS would be invited to the Care Planning Workup. Did this engagement include anything else?

25. In paragraph 148 of the Statement, Dr Sadler states that he can recall that adolescents were required to transition to an Adult Community Care Unit (CCU) on two occasions. Can Dr Sadler recall what the circumstances of these transitions were? Why were these adolescents "required" to transition? What were the needs of these patients?

***Evaluation of BAC interventions***

26. In paragraph 183 of the Statement, Dr Sadler refers to a "*BAC 2005 paper on the use of the HoNOSCA in an adolescent inpatient unit*". Please identify or provide the Commission with a copy of this paper.

***Relevant policies and plans and their impact on the development of the model of care provided at BAC***

27. In paragraph 197 of the Statement, Dr Sadler refers to communications between May or July 2012 with Professor Philip Hazell, who "*reported to Associate Professor Beth Kotze*". Does Dr Sadler recall Associate Professor Kotzé during this time? If so, please set out Dr Sadler's recollection of that communication and explain what steps (if any) he took subsequent to that communication with Associate Professor Kotzé.

***The National Framework for Recovery Oriented Mental Health Services ("NFROMHS")***

28. In paragraph 215 of the Statement, Dr Sadler states that submissions have been made to the Independent Hospital Pricing Authority regarding mental health and definitions of acute, subacute and non-acute care, and that these definitions could be used to determine the level of funding provided to CYMHS inpatient services. Please elaborate on what Dr Sadler means by this statement, including explaining who made these submissions and for what purpose.

***Prior considerations regarding closing or relocating BAC***

29. In paragraph 218, Dr Sadler states that "*In 1997 it was it was announced that BAC was to close*". The Commission is aware that there may have been other threats to the existence of the BAC in the subsequent years. Please confirm whether this is correct, and if so, elaborate on your recollection of when this occurred and what occurred.

30. In paragraph 223 of the Statement, Dr Sadler refers to an email exchange with Dr Kingswell in April 2012 in which Dr Kingswell stated that "*Redlands was the only option*". Does Dr Sadler have copies of these emails?

31. In relation to the proposed Redlands facility:

a. Is Dr Sadler able to explain in more detail, his involvement in the development of the model of service proposed for Redlands including the period/s in which he was involved (including whether or not this involvement was for discrete or continuous periods) and the nature of his involvement (including details of the meetings he attended and feedback he provided in relation to the various iterations of the model of service).

b. Is Dr Sadler able to elaborate on his understanding of the difference between the Redlands model and the BAC model?

c. The Commission understands that the model of service proposed for Redlands excluded day patients. Please confirm whether this is correct and explain Dr Sadler's understanding of the reasoning behind this, and his clinical opinion regarding the appropriateness of this exclusion.

d. Is Dr Sadler able to explain in more detail, his involvement in, and understanding of, the facility proposal, including details about the proposed facility and services and cost, and why the decision not to proceed with this proposal was made (and how he became aware of this).

*November 2012 onwards*

32. In paragraph 229 of the Statement, Dr Sadler states that he informed his child and adolescent psychiatrist colleagues that the BAC was closing. Please identify whom Dr Sadler informed, and how.

33. In paragraph 226 of the Statement, Dr Sadler states that on 2 November 2012, Ms Sharon Kelly advised him that BAC would close on 31 December 2012, and then in paragraph 231, he states that Ms Dwyer stated at a meeting in the MHAODD Branch around 20 November 2012, that the BAC would not close by 31 December 2012. Did Ms Kelly or Ms Dwyer provide Dr Sadler with any reasons for the planned closure and the subsequent delay? If so, please explain Dr Sadler's recollection of this conversation.

34. In paragraph 236-237 of the Statement, Dr Sadler refers to his concerns about 'wrap around services'.

    a. Please explain Dr Sadler's understanding of the 'wrap around' model of care proposed for the former BAC patients. How did this model differ from the services previously provided by the BAC?

    b. Please explain Dr Sadler's understanding of how the wraparound model of care was being used in Queensland for adult or adolescent mental health patients (if at all), distinguishing between the two.

35. In paragraph 237 of the Statement, Dr Sadler states that on 5 or 6 August 2013, Ms Dwyer informed him that the BAC would close in January or February 2014. Did Ms Dwyer provide Dr Sadler with any reasons in relation to why it was planned to close the BAC within that timeframe or any reasons why it was planned to close the BAC before the

development of alternative models of care? If so, please explain his recollection of this conversation.

*Impact of decision to close on staff and adolescents*

36. In paragraph 250 of the Statement, Dr Sadler states that "*I held particular concerns regarding the transitioning of some of the adolescents out of BAC*" and he details his concerns.

    a. The Commission understands from paragraph 257 of the Statement that Dr Sadler did not provide a formal handover to Dr Brennan because Ms Kelly had told him that he was to have "*no further input into the care of the adolescents at BAC and the staff were instructed to not have contact with*" him. However, does Dr Sadler recall any suggestion that he should prepare a written handover? Did Dr Sadler have access to his clinical notes once he was stood down? Does Dr Sadler recall whether he recorded his concerns about these adolescents in his clinical or other notes?

    b. To the best of his knowledge and understanding of the transition arrangements for the BAC adolescents, is Dr Sadler able to provide his clinical opinion in relation to whether the transition arrangements adequately addressed his concerns. If not, please explain in detail what he would have done differently. The investigation report provided by Professor Beth Kotzé and Tania Skippen is exhibited to the Statement of Beth Kotzé declared on 18 December 2015 which is available in the data room. The Statements of Ms Skippen and the health services investigator, Kristie Geddes is also available in the data room. Is Dr Sadler able to comment on the investigation carried out and its adequacy?

37. In paragraph 250 of the Statement, Dr Sadler refers to a number of adolescents. Please identify these adolescents.

***Exhibits***

38. In Exhibit H to the Statement, Dr Sadler states that each of the three young people who died within the first year of the BAC closing, complained, at times, of an absence of care either currently or during their childhoods. Please elaborate on the complaints made and the context in which they were made? Dr Sadler also refers to specific details about each of the deceased throughout Exhibit H. Please identify to whom Dr Sadler is referring to, and when?

39. In Exhibit I to the Statement, the Reply to the Draft Report on the Need for Child & Adolescents Secure Inpatient Services and the Re-development of Extended Treatment Adolescent Inpatient Services by the BAC Dr Sadler refers to a "*short lived experiment to admit acute inpatients in the early 1990s out of concern for the impact on adolescents of an acute adult inpatient admission*" which was "*abandoned because of the detrimental impact on longer stay patients*". Please elaborate on this so-called 'experiment', including the impetus for the experiment and reasons for its abandonment?

**Additional questions from our Legal Team**

40. Could Dr Sadler please provide his clinical opinion regarding whether there is a lack of alignment between adolescent and adult mental health services in that patients in the 18-25 year age group are not adequately dealt with by either adolescent or adult mental health services. If so, with particular focus on the cohort of patients at the BAC:

    a. Does this lack of alignment mean that patients in that age group commonly experience problems in their transition from adolescent to adult mental health services?

    b. Is there a need for mental health services directed to the 18 to 25 year age group, or a similar age group and if so, explain generally what services are needed?

41. Throughout his Statement, Dr Sadler refers to various demographic traits of the BAC cohort. Who was responsible for collating demographic data collected by the BAC, and where and how was this data stored? What is Dr Sadler's understanding of how this data was used in the service planning process?

42. In his response to the "show cause" letter from Lesley Dwyer dated 11 December 2013:

    a. Dr Sadler states on page 4, "*The Business Planning Framework was introduced in 2010 as a means of formalising the structure of the Clinical Business Units. Inherent within the documents from the different Clinical Business Units were significant changes to the role of the Nursing Director (ND) and the NUM*". How did the roles of the ND and NUM change? What effect did these changes have on the operations and management of the BAC?

    b. Dr Sadler also discussed changes to the Corporate Governance and Model of Service Delivery in April 2012 and states on page 4, "*It is clear that there was significant evolution away from the 2003 organisational structures of management processes and roles. In my submission, a fog descended on the role of the Clinical Director*". What changes to organisational structures and roles were implemented under the 2012 amendment to the Corporate Governance and Model of Service Delivery? What effect did these changes have on the operations and management of the BAC? Could Dr Sadler please explain what he means by "*a fog descended on the role of Clinical Director*"?

43. In his letter to the State Coroner dated 9 September 2014, Dr Sadler states that there did not appear to be a "contagion effect" in relation to the three deceased. In particular he states that "*[i]ndeed I am aware of an informal network of parents, supporters of Barrett and former staff (especially teaching staff) who provide support to the remaining adolescents who have been profoundly affected by deaths of their peers. I believe this network has prevented contagion*". Could Dr Sadler elaborate further on his views in relation to the issue of contagion?

44. The Commission understands that BAC staff were instructed to report incidents relating to patients to Child Youth Mental Health Services (**CYMHS**), rather than Dr Sadler, as

had occurred in the past. Please explain Dr Sadler's understanding of this "change" including when this occurred and the reasons for this "change".

45. The Expert Clinical Reference Group Feedback Register dated 23 April 2013 [QHD.001.003.441] contains records of feedback Dr Sadler provided to the ECRG on 22 April 2013.

    a. In the first entry, Dr Sadler refers to the 54 adolescents admitted to the BAC since 2008 and he estimates that "*80% of adolescents admitted in this period required the CSCF Level 6 inpatient facility*". Please identify the source/s Dr Sadler consulted and method/s he used to produce the statistics to which he refers, and provide any copies of any relevant documents in his possession. Dr Sadler also raises a number of concerns. Please explain whether these concerns were adequately addressed in the final ECRG report, and if so, how?

    b. In the second entry Dr Sadler states, in relation to former BAC patients, that "*our anecdotal evidence is that half will require only outpatient services, most of the other half will not need to access adult outpatient mental health services for their trauma, and only a couple have required recurrent admissions for some years*". Please explain how the BAC received and recorded this anecdotal evidence (if at all).

**Additional questions from our Research Team**

***Impact of significant reforms on Queensland Health in 2012***

46. What was the impact or proposed impact on the operation of the BAC of the following two key drivers of reform for Queensland Health in 2012 on the BAC:

    a. ***National Health Reform Agreement 2011*** to commence on 1 July 2012 which required, among other things, significant changes to governance, performance management and reporting and funding mechanisms. How did moving inpatient subacute mental health services from block funding to activity based funding (ABF) affect the care that was/could be provided at the BAC (if at all)?

    b. ***Change of Government in March 2012 (LNP) and implementation of new Government priorities*** of fiscal repair, outsourcing of mental health services to non-government organisations to save costs and improve efficiency and workforce downsizing. The Commission understands that in 2012, the then West Moreton Health Service District undertook an extensive financial analysis and service review. that the BAC was required to suspend recruitment of nursing positions and that the allocation of resources to the BAC was tied to bed occupancy levels, among other things. Please confirm and elaborate on Dr Sadler's recollection of the events at this time.

*Clinical Governance – Patient safety and quality of service*

47. The Commission understands that the Queensland Clinical Senate was established by Queensland Health in November 2008 to provide strategic advice and leadership on system-wide issues affecting quality, affordability and efficiency of patient care within the health system in Queensland. Is Dr Sadler aware of, or did he or to his knowledge, any other staff of the BAC, ever have involvement with, the Clinical Senate? If so, please explain the nature of involvement.

48. Is Dr Sadler aware of, or did he or to his knowledge, any other staff of the BAC, have any involvement with the State-wide Mental Health Clinical Network (or sub-specialty child and youth adolescent mental health state-wide network)? If so, please explain the nature of this involvement.

49. Was the State-wide Mental Health Clinical Network or any other group involved in approving the models of service for the BAC? If so, when did this occur?

50. What other clinical governance initiatives or assessments did the BAC adopt or submit to in order to ensure patient safety and appropriate service quality? For example:

    a. assessment against level 6 Clinical Capability Service Framework?

    b. assessment against National Mental Health Accreditation standards and other clinical standards?

51. The Commission understands that the Health Community Council for the previous West Moreton Health Service District was responsible for monitoring quality, safety and effectiveness of public health services in that District. Does Dr Sadler recall whether the Health Community Council ever reviewed the BAC? If so, please explain the outcome of that review.

52. What role (if any) did Dr Sadler have in the service planning process?

53. The Commission understands that the Queensland Mental Health Reform Committee was established to act as a peak cross sector, cross government body to drive Queensland's implementation of the Fourth National Mental Health Plan and associated initiatives under the National Mental Health Strategy in the 2010-2011 financial year. Is Dr Sadler aware of, or was he or to his knowledge any staff of the BAC, ever involved with this Committee, and if so, please explain the extent and nature of this involvement with this Committee.

*Models of care*

54. In paragraphs 20–21 of the Statement, Dr Sadler provides information and makes some comparisons between the programs at the BAC and the Rivendell and Walker Units in NSW. In the Statement of Professor Philip Hazell declared on 5 November 2015 (which is available in the data room), Professor Hazell describes the Rivendell and Walker units and their respective models of care. Please identify the similarities and differences between the BAC and Walker and Rivendell units in terms of the cohort of patients, operations and models of care, as Dr Sadler understands them, from the information

available to him. In doing so, please distinguish between the Rivendell and Walker units where possible.

55. In paragraphs 20, 28(e) and 136(d) of the Statement, Dr Sadler refers to aspects of family therapy.

    a. The Commission understands that family therapy is integral to the model of care for the Rivendell and Walker units (refer to paragraphs 23 and 34 of Professor Hazell's statement in relation to the Walker unit). Please explain how the BAC used family therapy (if at all).

    b. The Commission understands that the BAC was often understaffed during Dr Sadler's time as Clinical Director. Please explain the staffing that the BAC required in order to properly deliver family therapy, and how the BAC would have used family therapy if this level of staffing was provided.

56. In paragraph 28(b) of the Statement, in relation to Dr Sadler visits to inpatient units in the United Kingdom and Switzerland, Dr Sadler states that programs at these units were generally "*aimed at patients with shorter lengths of stay*".

    a. Please clarify whether this refers to an acute-type length of stay (1–4 weeks) or the UK average of three to four months, which Dr Sadler refers to in paragraph 199(b) of the Statement.

    b. Please explain how a program aimed at a 3–4 month stay would differ from a program aimed at a stay longer than six months, including both similarities and differences.

57. In paragraphs 34(e) and 179 of the Statement, Dr Sadler refers to the quarterly Care Planning Workshop/ quarterly Intensive Care Planning Workup. In particular he states in paragraph 34(e) that "*[w]e routinely sought input from the external agency as to whether they considered the adolescent could be adequately supported in the community...It also offered the opportunity for the external agency to understand the processes within BAC and offer feedback as to their relevance*" and in paragraph 179 "*[t]here was also the ability to review a longer term set of observations and to receive input from the various treatment providers as to their respective valuations of the progress and effectiveness of the various interventions*". The Commission understands that the Walker and Rivendell Units in NSW provide weekly progress reports to referring agencies/ providers.

    a. Did the BAC provide similar updates or reports to referring agencies (and if so, how often)?

    b. Did the BAC have any other mechanism for keeping referring agencies/ providers involved in the care of adolescents referred to the BAC?

58. In paragraph 40 of the Statement, Dr Sadler states that the BAC could treat 20 adolescents at any one time, including both day patients and inpatients, but that "*No data was kept regarding day patients even though they comprised a significant proportion of the adolescents we treated*".

a. Please identify, to the best of Dr Sadler's recollection, the average proportion of day patients at any one time.

b. Was there a change in the proportion of day patients over time and, if so, what factors contributed to any change that he observed?

59. In paragraph 44 of the Statement, Dr Sadler states that "*Diagnostic criteria alone did not distinguish the adolescent who was likely to benefit from admission to BAC. It was the combination of severe and complex mental illness, together with impairment, sometimes family factors, and the potential to benefit from multiple multi modal intensive interventions provided at BAC*". Please elaborate further on this statement, particularly:

a. the characteristics of the patients most likely to benefit from the interventions provided at the BAC, and why;

b. the characteristics of the patients less likely, or not likely, to benefit from the interventions provided at the BAC, and why;

c. why the cohort of patients most likely to benefit from the interventions provided at the BAC were not able to be successfully treated in the acute inpatient and community settings in which they had previously been treated.

60. In paragraph 44 of the Statement, Dr Sadler states that "*...the Chair of the ECRG defined three tiers of services*". The Commission is aware of the four-tiered system used in the United Kingdom and in Western Australia. Under this four-tiered system, the Commission considers that the BAC would be classified as a "Tier 4" facility. Please provide any information Dr Sadler may have that might assist the Commission to understand the three-tiered model used by the ECRG and why a BAC-type facility would be classified as a "Tier 3" facility within this model.

61. In paragraph 45 of the Statement, Dr Sadler summarises the predominant disorders with which young people presented to the BAC. The Commission understands that it is difficult to summarise the proportion of BAC patients within each category because of the "*complex array of co-morbidities*" to which Dr Sadler refers in the same paragraph. Despite this, please describe to the extent possible:

a. the proportion of BAC patients presenting with each disorder at any one time;

b. whether the proportion of patients presenting with each disorder changed over time, and if so, why that might have been so; and

c. the typical co-morbidities present.

62. In paragraph 71 of the Statement, Dr Sadler identifies the allied health positions at the BAC.

a. Please elaborate on the role of each position within the BAC treatment and rehabilitation model.

b. Please explain the nature of the allied health staff roster. For example, were staff typically rostered on weekday day shifts, or did their shifts extend into the evenings and over weekends?

63. In paragraph 72 of the Statement, Dr Sadler states that there was "*...a significant increase in acuity, complexity and severity of patients*".

a. Please explain the difference between acuity, complexity and severity, as Dr Sadler uses these terms.

b. Please elaborate on how the increase in acuity, complexity and severity of BAC patients manifested. For example, please provide examples to explain these differences.

64. In paragraph 95 of the Statement, Dr Sadler states that "*[t]he guidelines for admission to BAC were originally defined in 2003...*".

a. What was used to guide admission to the BAC before then?

b. In practice, what (if any) differences were there between the admission criteria used before 2003 and the admission criteria as defined in 2003?

65. In paragraph 96 of the Statement, Dr Sadler refers to the AETRC model of service delivery. Various versions of this document have been produced to the Commission. Copies of these various versions of the AETRC have been downloaded in the data room. Is Dr Sadler able to review these versions with a view to confirming (during the proposed meeting with Commission staff), the author(s) and context behind these various versions?

66. In paragraphs 108–109 of the Statement, Dr Sadler refers to the "*community of adolescents*" and the "*community environment*". Did the BAC incorporate any principles of "milieu therapy", and if so, how?

67. In paragraph 125 of the Statement, Dr Sadler states that "*BAC was at the forefront of using the sensory room as a form of intervention within The Park and CYMHS inpatient units in Brisbane*".

a. Please elaborate on the role of the sensory room and how it was used in treatment.

b. Please explain how the BAC was "at the forefront" in its use.

68. In paragraph 186 of the Statement, Dr Sadler states that the residential homes model in the USA is not an equivalent model to the BAC. Please explain the similarities and differences between the two models.

69. In paragraph 227(g) of the Statement, Dr Sadler states that "*The aim at BAC was to employ staff who possessed the particular skill set and experience to promote recovery for the sub-population of adolescents treated there*". Please elaborate on Dr Sadler's understanding of the similarities and differences in the skill set and experience of the staff he sought to employ at the BAC and those who were employed at adolescent acute

inpatient units and CYMHS community teams, distinguishing between acute inpatient units and CMYHS community teams where relevant.

70. In paragraph 227(l) of the Statement, Dr Sadler states that "*...acute inpatient units provide opportunities for stabilisation, but limited opportunities for therapies. Multiple therapeutic interventions were integral to the BAC program*". Similarly, in paragraph 262 of the Statement, Dr Sadler refers to "*[a]dolescents were often referred to BAC by community clinicians because they did not have access to the necessary range of interventions, or the number of interventions required were difficult to implement in the community or acute inpatient setting. Some services had only a component of the expertise necessary to provide optimal clinical services. This remains the case*". Please elaborate on the types of interventions that were available at the BAC, which are not available in CYMHS adolescent acute inpatient units and CYMHS community clinics, distinguishing between the two.

71. Could Dr Sadler please elaborate on the similarities and differences in the types and range of interventions used to stabilise a patient in an acute inpatient unit, and those provided as part of the treatment and rehabilitation program at the BAC.

72. In paragraph 253 of the Statement, Dr Sadler states that Dr Kingswell suggested Logan Hospital as a potential site for an interim BAC service, and that he, Dr Stathis, Mr Rodgers and Ms Clayworth concluded that that site (with some refurbishment) was a potential solution. Could Dr Sadler please elaborate on his knowledge of:

    a. any other options for an "interim solution" to the closure of the BAC; and

    b. the reasons that the Logan Hospital option (and any others identified) were not progressed.

73. In paragraph 254 of the Statement, Dr Sadler states that as at the 9 September 2013 meeting of the SWAETRI Strategy Steering Committee meeting, "*there remained no clear ideas of potential services to which adolescents would transition*". Please elaborate on this. Note that the minutes of all meetings of the SWAETRI and subsequent "Adolescent Mental Health Extended Treatment Initiative" (**"AMHETI"**) Steering Committee meetings are available at pages 50-194 of Exhibit K to the Statement of Judith Krause declared on 26 November 2015, which is available in the data room.

74. In paragraph 262 of the Statement, Dr Sadler states that "*There are some CYMHS acute inpatient services that have the capacity to address the above issues to a certain degree, through incorporating a range of interventions which include FBT for anorexia, music therapy, music therapy and a range of other therapies*".

    a. Could Dr Sadler please elaborate on this statement?

    b. Please specify the acute inpatient units to which Dr Sadler is referring.

75. In paragraph 265 of the Statement Dr Sadler states that, "*While BAC only treated and managed a small cohort of adolescents, it was those adolescents with serious and complex mental health issues who could not be stabilised in the community or acute*

*inpatient settings*". Could Dr Sadler please elaborate on the reasons why this cohort could not be stabilised in a community or acute inpatient setting.

76. Exhibit G to the Statement refers to the Children and Young Persons Inpatient Evaluation ("**CHYPIE**") study — footnote 2 of the paper. As yet, the Commission has been unable to source a copy of this paper. If Dr Sadler has access to this paper, could he please provide a copy?

77. The Commission is aware of a range of criticisms or concerns raised about the BAC and the model of care. These include:

    a. bed utilisation;

    b. problems with the building;

    c. proximity to adult forensic patients;

    d. the BAC model of care was not evidence-based and was no longer a contemporary model of care;

    e. the length of stay was too long, both on average and for some patients in particular;

    f. the average length of stay had increased; and

    g. the BAC was isolated from the broader CYMHS network, both clinically and in terms of governance.

    The Commission has been provided with information from different parties relating to the first three points (a–c). Dr Sadler has provided some information in relation to the fourth point (d). Please outline how Dr Sadler would respond to the last three criticisms (e–g).

78. **Attached** is a confidential working draft table which summarises the five elements of the replacement model, the AMHETI. Commission staff will provide Dr Sadler with a more detailed draft of the table at the proposed meeting with him. More detailed information about the relevant models of service mentioned in this table is available in the Exhibits to the Statement of Ingrid Adamson declared on 24 November 2015 ("**Statement of Ingrid Adamson**") available in the data room, in particular:

    a. the July 2014 AMHETI business case v 4.0 (pp. 8391–8495 of Exhibit ZK to the Statement of Ingrid Adamson);

    b. the draft model of service delivery for the state-wide subacute beds — Schedule D of the Agreement between Children's Health Queensland and Mater Health Services (pp. 761–766 of Exhibit T to the Statement of Ingrid Adamson);

    c. the model of service for an AMYOS team — Schedule B to the service agreements (see for example pp. 6334– 6351 of Exhibit ZJ to the Statement of Ingrid Adamson);

d. YPETRI House model of service (pp. 7836-7854 of Exhibit ZJ to the Statement of Ingrid Adamson).

Could Dr Sadler please provide his clinical opinion on whether the above AMHETI service elements, individually or as a continuum, provide adequate replacement services for the BAC cohort of patients? In doing so, could he please explain any concerns and distinguish between the various AMHETI service elements in comparison with the various elements of the BAC.

Your Ref: bandiv.wattd.7500016.00422
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By email to:

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Dear Mr Watt

**YOUR CLIENT DR TREVOR BRUCE SADLER – MEETING ON 9 FEBRUARY 2016**

I refer to the meeting between Counsel Assisting the Commission, Ms Muir, Commission staff, your Counsel, Ms Rosengren, your staff and your client, Dr Trevor Bruce Sadler yesterday. As discussed during this meeting, please find below the list of additional questions we discussed with Dr Sadler during this meeting.

**Additional matters discussed at our meeting**

1. At the time Dr Sadler was stood down, what (if any) steps did Dr Sadler take to transition patients out of the BAC (apart from Dr Sadler's usual process of progressively transitioning patients out when they were ready)? If Dr Sadler did not take any steps in this regard, why not?

2. Please explain Dr Sadler's knowledge of referrals to the subacute beds at Mater, then at Lady Cilento, including Dr Sadler's knowledge of any matters impacting referral decisions to these beds.

3. The Commission understands that Dr Sadler does not wish to respond to any adverse comments made in statements of former patients and family members of former

patients. However, can Dr Sadler please provide the Commission with any general comments in relation to these statements which would assist the Commission to understand the context in which some of these comments were made, to the extent that they are relevant to the Commission's Terms of Reference (for example, please explain the issue of consent to disclose clinical information to parents/ guardians when a patient turns 18 years old).

4. The Commission understands that an external review of BAC service delivery conducted by Professor Brett McDermott in 2003 identified concerns regarding admission criteria, risk assessment and management, BAC management practices and the Centre's response to critical incidents. Please explain what (if any) steps the BAC took in the subsequent years to implement the recommendations of this review, and when these steps were taken (for example, were these steps taken before the next review in 2009?).

5. Please elaborate on the reasoning behind delivering Dialectical Behavioural Therapy in a group context, rather than on an individual basis.

6. In one of the documents Dr Sadler produced to the Commission, entitled "One Page Service Summary of Major Achievements", you referred to an "Accommodation resource directory developed to enhance awareness of existing community-based options and include alternative accommodation options as part of care planning process" [Delium reference no.: DTZ.004.001.0066]. Please explain what this was, how it was accessed, and whether it was maintained?

7. The Commission understands that Dr Sadler has not yet had access to the statement of a which is currently being finalised. Once you have access to this statement, please explain in detail the circumstances surrounding Dr Sadler's standing down (in particular, Dr Sadler's knowledge of any steps taken to notify the police and Department of Communities, Child Safety and Disability Services and any subsequent action taken by these agencies).

8. As Dr Sadler may already know, one of the publicly stated reasons for the closure of the BAC was that it was not considered to be a "contemporary model of care" under the draft National Mental Health Services Planning Framework (**NMHSPF**). Extracts from the draft NMHSPF used by Children's Health Queensland Hospital and Health Service (**CHQHHS**) to inform the development of the new suite of services are exhibited at pages 4301–4332 of the Statement of Ingrid Adamson dated 24 November 2015, which is available in your data room. Service category 2.3.2 of the NMHSPF (pages 4322–4324 of the Statement of Ingrid Adamson) describes the service stream Sub-Acute Services (Residential and Hospital or Nursing Home based), and 2.3.2.5 of the NMHSPF (pages 4327–4328) describes the service element Sub-Acute Intensive Care Service (Hospital). Please arrange for Dr Sadler to examine the Extracts of the NMHSPF and comment on whether the BAC model of care is consistent with those described in the NMHSPF, including the reasons why or why not.

[1] The *Confidentiality Protocol* can be accessed via the Commission's website at: https://www.barrettinquiry.qld.gov.au/practice-guidelines. Please contact the Commission's Executive Director, Ashley Hill on ashley.hill@barrettinquiry.qld.gov.au for the details of transition client "AE":

9. As requested by your Counsel, Ms Rosengren, during the above meeting, Commission staff have drafted the following paragraphs to reflect their understanding of the timeline for the development of the BAC model of service delivery between 2008 and 2012 for Dr Sadler's review and confirmation. Note The matters requiring further clarification and further documents required to be produced to the Commission are highlighted in yellow.

> *A formal model of service delivery (**MOSD**) for the Adolescent Extended Treatment Centre (**AETC**) was developed in late 2008 [please confirm whether it was developed in 2008 or 2009 and who developed this first version] as part of a Mental Health, Alcohol and Other Drugs Branch ('the Branch') initiative requiring all health services to have a defined model of service in a consistent format. [Please provide Dr Sadler's copy of the first draft of the MOSD developed as part of this initiative]. After incorporating feedback from Dr Geppert, who was at that time the Manager, Projects, Mental Health Plan Implementation Team in the Mental Health Directorate, Dr Sadler emailed Dr Geppert a revised draft on 22 December 2009. [Please provide Dr Sadler's copy of that revised version of the MOSD]. Dr Sadler understands that this version of the draft MOSD was provided to the working group convened by Judi Krause, at Professor Crompton's request, to develop a MOSD for the planned Redlands facility, known as the Adolescent Extended Treatment and Rehabilitation Centre (**AETRC**).*
>
> [Adapted from current paragraph 88 in Dr Sadler's draft statement] *Members of the State-wide CYMHS Advisory Group reviewed the AETRC MOSD from March to May 2010. It was then endorsed [or was it only noted? If the MOSD was only "noted" by this group, then can Dr Sadler please explain his understanding of whether the MOSD was required to be endorsed, if so, who was responsible for endorsing the MOSD, and whether the MOSD was in fact endorsed, and if not, the effect of this?] by the SW CYMHS AG, and by the State-wide Mental Health Advisory Group and accepted by the Director of the MHAODD Directorate, Dr Aaron Groves. Dr Sadler does not have a copy of this version. Dr Sadler's recollection is that the admission criteria were similar or the same as the 2012 draft.*
>
> *Between January and May 2012, Dr Sadler was part of a working group formed to develop a MOSD for the BAC day program to support the establishment of similar day programs in Toowoomba and Townsville. The working group was convened an officer from the Branch named Mary Watt, and also included Emma Hart from Townsville CYMHS [is this correct, or was it Emma Foreman from the Branch?] and Dan O'Brien from Toowoomba CYMHS. This process prompted further refinement of the BAC MOSD. The resulting revised version of the MOSD was to be submitted to the SW CYMHS AG in June 2012 [for endorsement?], but that group was disbanded.*
>
> *Dr Sadler understands that it was this 2012 version of the BAC MOSD that was later provided to the ECRG, with one amendment requested by the Branch. The amendment was to include in the MOSD a specific process of case review by the BAC team and the referring team if the length of admission was to exceed*

*six months. [Please provide Dr Sadler's copy of the version of the MOSD that Dr Sadler provided to the Branch as part of this working group process and provide your clinical opinion in relation to the requested amendment].*

10. The Commission understands that Dr Sadler has not yet had access to a Discussion Paper about the subacute beds at Lady Cilento, which the Commission anticipates will be produced to the Commission and uploaded to your data room shortly. Once you have access to this document, please arrange for Dr Sadler to examine the context in which the 2003 Health of the Nation Outcome Scales for Children and Adolescents (**HoNOSCA**) paper Dr Sadler co-authored with Harnett et al. has been used in this Discussion Paper, and comment on the use of this data from the HoNOSCA paper in the Discussion Paper.

11. Please provide further information relating to BAC cohort including appropriate case examples to illustrate the key characteristics of this cohort (ie. what set this cohort apart from the cohort of patients that could successfully be treated in the community).

12. Today, Counsel Assisting will circulate to the parties a document identifying the key issues that Counsel Assisting the Commission are interested in. Included in that document will be a table that summarises the features of the five proposed extended treatment and rehabilitation service elements developed by CHQHHS, as Commission staff currently understand these proposed service elements. Please arrange for Dr Sadler to examine that table and make any comments on the adequacy of the proposed service elements. In particular, please explain whether the patients comprising the former BAC cohort could be adequately managed by any of these proposed service elements, including the reasons why or why not (distinguishing between the different types of patients comprising the former BAC cohort).

13. The Commission understands that adolescents with personality disorders and complex developmental trauma may not benefit from a prolonged hospital admission and may, in fact, disrupt the therapeutic milieu of an inpatient unit (see, for example, paragraphs 21–22 of the Statement of Dr Peter Parry dated 4 February 2016 and paragraph 37 of the Statement of Professor Philip Hazell dated 5 November 2015). Please provide your clinical opinion in relation to this matter, and describe how the BAC managed the admission and treatment of adolescents with personality disorders and complex developmental trauma.

14. Further to question 66 of our letter dated 22 January 2016, please provide your clinical opinion in relation to therapeutic value of a peer community, providing details or copies of any evidence-based research supporting your opinion (or if you are unable to provide such research, please explain why).

**Next steps**

As discussed at the above meeting, we would be grateful if you could arrange for Dr Sadler to formally address these questions in a further draft of his supplementary statement, along with the matters requiring further clarification in the current draft, which were also discussed during this meeting. Please contact Ms Muir if you require Commission staff to clarify or confirm any further matters discussed at the above meeting.

In the interests of making the statement available to the other parties prior to the commencement of the Commission's hearings on Monday 15 February 2016, Dr Sadler may need to answer question 7 and 10 (which relate to documents to which you do not yet have access) in a further supplementary statement, rather than in the supplementary statement you are currently preparing for production to the Commission. Apart from questions 7 and 10, could you please give us an indication of the likely timeframe for the completion of Dr Sadler's supplementary statement?

Yours sincerely

Ashley Hill
**Executive Director**
**Barrett Adolescent Centre Commission of Inquiry**
10/02/2016

**From:** Catherine Muir [mailto:
**Sent:** Thursday, 11 February 2016 9:56 AM
**To:** Jennifer Rosengren <
**Cc:** Stacey Parker
**Subject:** Commission of Inquiry

Jen

Further to question 3 of the letter we sent you yesterday, could you please ask Dr Sadler to comment on whether the BAC used "pain-compliance", which is mentioned in paragraph 9 of the Statement of including what circumstances in which "pain-compliance" was used, and why?

Regards
Cathy

Catherine Muir
Counsel Assisting
**Barrett Adolescent Centre Commission of Inquiry**
**Ph:**

CURRICULUM VITAE - Trevor Sadler

Contact details

Address Trevor Sadler

[redacted]

Email [redacted]

Phone

Current Position

| | |
|---|---|
| November 2014 – | Senior Visiting Psychiatrist, Mater Young Adult Health Centre/Adolescent Drug and Alcohol Withdrawal Services |
| 27 January 2014 - | Temporary Senior Staff Specialist, Royal Brisbane Women's Hospital Adolescent Inpatient Unit |

Other Positions

| | |
|---|---|
| 1998 – 28/11/2014 | Senior Visiting Psychiatrist – Child and Youth Mental Health Service, Mater Health Service |
| 1989 – 1998 | Visiting Psychiatrist – Child and Youth Mental Health Service, Mater Health Service |
| 1990 – 2013 | Director (variously Business Unit Director, Clinical Director) Barrett Adolescent Centre, Wolston Park Hospital (later The Park – Centre for Mental Health) |
| 2014 | Visiting Senior Psychiatrist, The Park – Centre for Mental Health |
| 1998 – 2013 | Visiting Senior Psychiatrist, Barrett Adolescent Centre, Wolston Park Hospital |
| 1988 – 1998 | Visiting Psychiatrist, Barrett Adolescent Centre, Wolston Park Hospital |
| 1986 – 1988 | Medical Officer, Barrett Adolescent Centre, Wolston Park Hospital |
| 1986 | Psychiatry Registrar, Royal Derwent Hospital, New Norfolk |
| 1984 – 1985 | Psychiatry Registrar, Royal Brisbane Hospital, Brisbane |
| 1979 – 1983 | Medical Officer, Division of Youth Welfare and Guidance, Redcliffe |
| 1978 – 1979 | Medical Officer, Division of Youth Welfare and Guidance, Wilson Youth Hospital, Brisbane |
| 1977 – 1978 | Medical Officer, Baillie Henderson Hospital, Toowoomba |
| 1975 – 1976 | Resident Medical Officer, Royal Brisbane Hospital, Brisbane |

Temporary Positions

| | |
|---|---|
| 30/6 – 28/11/2015 | Temporary Senior Staff Specialist, Senior Visiting Psychiatrist – Child and Youth Mental Health Service, Mater Health Service |
| 2/11 – 11/12/2015 | Temporary Senior Staff Specialist, Royal Brisbane Women's Hospital Adolescent Inpatient Unit |
| 15/9 – 30/10/2015 | Locum Psychiatrist, Metro South CYMHS (Community) |

Qualifications

| | |
|---|---|
| 1989 | Certificate of Child Psychiatry, Royal Australian and New Zealand College of Psychiatrists |
| 1988 | Fellowship Royal Australian and New Zealand College of Psychiatrists |

1974 Bachelor of Medicine, Bachelor of Surgery

Memberships of Committees and Professional Service

| | |
|---|---|
| June 2015 - | Co-chair, Adolescent Mental Health in Chronic Illness Working Group |
| 2010 - 2012 | Member, Child and Youth Mental Health Services Eating Disorders Working Group |
| 2009 - 2013 | Member, Steering Committee, State Wide Child and Youth Clinical Network |
| 2009 - 2010 | Member, State Wide Mental Health Services Advisory Group |
| 2008 - 2012 | Co-Clinical Lead, Tri- Clinical Network Collaboration on Adolescents with Chronic Illness |
| 2007 - 2012 | Clinical Chair, Child and Youth Mental Health Services Clinical Collaborative |
| 2007 - 2012 | Member, State Wide Child and Youth Mental Health Services Advisory Group (formerly Network) |
| 2007 - present | Clinical Senior Lecturer, Discipline of Psychiatry, University of Queensland |
| 1993 – 1996 | Chair, Queensland Branch and Member of National Executive, Faculty of Child and Adolescent Psychiatry, RANZCP |

Memberships of Committees and Professional Service

| | |
|---|---|
| 2013 | Member, Expert Clinical Reference Group, Adolescent Extended Treatment and Rehabilitation Services, Queensland Health |
| 2012 | Member, Working Party CYMHS Day Program Model of Service Delivery, Queensland Health |
| 2010 - 2012 | Member, Child and Youth Mental Health Services Eating Disorders Working Group |
| 2009 - 2013 | Member, Steering Committee, State Wide Child and Youth Clinical Network |
| 2009 - 2010 | Member, State Wide Mental Health Services Advisory Group |
| 2008 - 2012 | Co-Clinical Lead, Tri- Clinical Network Collaboration on Adolescents with Chronic Illness |
| 2007 - 2012 | Clinical Chair, Child and Youth Mental Health Services Clinical Collaborative |
| 2007 - 2012 | Member, State Wide Child and Youth Mental Health Services Advisory Group (formerly Network) |
| 2007 - 2014 | Clinical Senior Lecturer, Discipline of Psychiatry, University of Queensland (currently applying for renewal of appointment) |
| 2006 – 2007 | Member, Queensland CoAG Mental Health Group, Child, Youth and Education Sub Group |
| 2006 – 2011 | Member, Training Monitoring Subcommittee, Queensland Branch, RANZCP |
| 1994 – 1995 | Member, Reference Group, Child and Youth Mental Health Policy, Mental Health Branch |
| 1994 | Member, Steering Committee for the Review of Child Guidance Services, Mental Health Branch |
| 1993 – 1996 | Chair, Queensland Branch and Member of National Executive, Faculty of Child and Adolescent Psychiatry, RANZCP |
| 1990 – 2000 | Member of Council, Royal Queensland Bush Children's Health Scheme |
| 1990 – 1991 | Member, Suicide Prevention Strategies Group |
| 1990 | Member, Committee for Rotation and Placement of Psychiatrists in Training, Queensland Health |
| 1989 - | Member, Faculty of Child and Adolescent Psychiatry, RANZCP |
| 1988 - | Fellow, RANZCP |

Conference Presentations

Invited Presentations

May 2013 *Identifying Potential Psychosocial Barriers in Adolescents with Type 1 Diabetes* (co-presentation with J Pennisi, H D'Emden) Novo Diabetes Conference, Gold Coast

November 2011 *Psychosocial issues and Mental Illness in the Adolescent with Type 1 Diabetes* Diabetes Collaborative Project Forum, Brisbane

June 2011 *Using Chart Reviews to Ascertain Psychosocial Issues Affecting Diabetes Management* Australian Diabetes Educator Association Conference, Brisbane

October 2010 *A perspective on Adolescent Medicine,* RACP Division of Paediatrics and Child Health Queensland Branch Professional Development Conference, Gold Coast

December 2009 *Teenagers who Find it Difficult to go to School,* Mater Kids in Mind School Refusal Research Conference, Brisbane

August 2009 *A Framework to Analyse Needs of Young People in Care,* Presentation to Placement Directors, Department of Child Safety, Brisbane

February 2009 *Multiple Network Interventions for Adolescents with Chronic Illness*, Child and Youth Networks Forum, Brisbane

February 2008 *School Refusal and Social Anxiety*, State wide Grand Rounds in Child and Adolescent Psychiatry, Brisbane

November 2006 *The Role of Attachment in Treating Syndromes of Trauma*, State wide Grand Rounds in Child and Adolescent Psychiatry, Brisbane

September 2006 *The Role of Attachment in Professional Interactions with Traumatised Adolescents,* Royal Children's Health District Seminar on Trauma and Attachment, Brisbane

July 2006 *Adolescents, Trauma and Adolescence*, Toowoomba District Health Service/ University of Queensland Seminar on Adolescent Trauma, Toowoomba

March 2005 *Resilience vs Anxiety and Depression in Adolescents with Diabetes* Queensland Diabetes Conference, Brisbane

March 2004 *Borderline Personality Disorder in Adolescents*, Bi-National Grand Rounds in Child and Adolescent Psychiatry, Brisbane (with video-conference link)

October 1998 *Key Assumptions Behind Child & Youth Mental Health Policy: Dilemmas for Clinicians* 5th Annual Child & Youth Mental Health Conference, Brisbane

August 1997 *Research Questions in Adolescent Health*, AMAQ/Queensland Health Symposium on Adolescent Health, Brisbane

June 1995 *Issues in Adolescent Mental Health,* Queensland Association for Mental Health, Brisbane

Submitted Presentations

May 2011 *Concepts of Complexity in Child and Adolescent Mental Health,* CYMHS Collaborative Forum, Brisbane

June 2005 *The Meaning of Care in Child and Youth Mental Health Services* Mater Child and Youth Annual Conference

June 2003 *Outcome Scales for Children and Adolescents (HoNOSCA) in an Inpatient Unit,* Queensland Health Mental Health Research Conference, Brisbane

May 1995 *A Model for Delivering Mental Health Services to Children in Rural and Remote Areas*, Inaugural National Child and Adolescent Mental Health Conference, Adelaide

Workshops and Short Courses

May 2013 *A Recovery Model for an Adolescent Day Program* provided to Townsville Acute Inpatient and Day Program Clinicians, Townsville

August 2012 *Incorporating the Tasks of Adolescent Development into a Day Program Model* provided to Toowoomba Acute Inpatient and Day Program Clinicians, Toowoomba

April 2011 *A Framework for Providing Adolescent Mental Health Services*, A workshop provided to Cairns District Evolve Therapeutic Services and Child and Child and Youth Mental Health Services, Cairns

February 2009 *Workshop in Recovery in Adolescent Mental Health*, Queensland Health (Barrett Adolescent Centre), Mater Kids in Mind, University of Queensland

September 2008 *Trauma, Self Harm, Suicide and Risk Assessment*, Royal Children's Hospital CYMHS Skills Development Workshop

March 2007 *Trauma, Self Harm, Suicide and Risk Assessment* CYMHS Key Skills Development Workshop, Brisbane

October 2006 A *history of Mental Health Services to Children in Care,* Evolve Therapeutic Services Workshop

May 2005 *Recovery Workshop*, Queensland Health (Barrett Adolescent Centre), University of Queensland

1998 – 2003 *Seminars in Adolescence* Series, Barrett Adolescent Centre, Brisbane

Peer Reviewed Journal Publications

Harnett PH. Loxton NJ. Sadler T. Hides L. Baldwin A. (2005) *The Health of the Nation Outcome Scales for Children and Adolescents in an adolescent in-patient sample. Australian and New Zealand Journal of Psychiatry* 39(3):129-35

Young ES. Perros P. Price GW. Sadler T. (1995) *Acute challenge ERP as a prognostic of stimulant therapy outcome in attention-deficit hyperactivity disorder* Biological Psychiatry. 37(1):25-33, 1995 Jan 1

Teaching

2009 – 2010 *Self Harm and Suicide* Year 1 MB, BS Students, University of Queensland, Ipswich

2007 - *Assessing Depression and Self Harm*, Year 3 MB, BS Students, University of Queensland, Brisbane

2006 *Mental Health Issues in the ED Series*, Registrars and Residents, Mater Children's Hospital

1992 - *Adolescent Psychopathology*, Basic RANZCP Trainees, Brisbane

1994 - *Adolescent Therapy*, Advanced RANZCP Trainees in Child and Adolescent Psychiatry, Brisbane

2011 - *Leadership in Child and Adolescent Services*, Advanced RANZCP Trainees in Child and Adolescent Psychiatry, Brisbane

2010 - *Recovery and Rehabilitation in Child and Adolescent Services*, Advanced RANZCP Trainees in Child and Adolescent Psychiatry, Brisbane

2010 - *Spirituality in Child and Adolescent Psychiatry*, Advanced RANZCP Trainees in Child and Adolescent Psychiatry, Brisbane

# Development and Psychopathology

Trevor Sadler

# Characteristics of the Framework

- Trans-diagnostic
- Suited to a variety of therapeutic interventions
- Identifies strengths
- Identifies issues of concern
- Identifies moratoriums in progress
- Informs treatment decisions
- Informs decisions about settings for care
- Not evidence based treatment