In the matter of the *Commissions of Inquiry Act 1950*

Commissions of Inquiry Order (No.4) 2015

Barrett Adolescent Centre Commission of Inquiry

AFFIDAVIT

DR JOHN ALEXANDER ALLAN of c/- Crown Law, Chief Psychiatrist and Director of Mental Health, Queensland Health, solemnly and sincerely affirms and declares:

1. I have been provided with a Requirement to Give Information in a Written Statement dated 28 January 2016. **Exhibit A** to this affidavit is a copy of this notice.

Office of Chief Psychiatrist

2. Dr Jagmohan Gilhotra was my predecessor in the Office of Chief Psychiatrist. I defer to Dr Gilhotra in terms of the dates between which he held the position. To the best of my knowledge he would have held the position for around 5 to 7 years.

3. I list the key responsibilities of my role as Chief Psychiatrist at paragraph 28 of my affidavit affirmed 8 January 2016. The Office of Chief Psychiatrist is a departmental unit, by which I mean it is based in the Department of Health.

4. As mentioned at paragraphs 5 and 6 of my affidavit affirmed 8 January 2016, I also hold the role of Director of Mental Health. That role is a statutory role under the *Mental Health Act 2000*. I was appointed to that role by the Governor-in-Council.

COMMISSIONER FOR DECLARATIONS Reg.No.: DEPT. OF JUSTICE & ATTORNEY-GENERAL

Deponent A J.P., C.Dec., Solicitor

AFFIDAVIT

On behalf of the State of Queensland

Crown Solicitor
11th Floor, State Law Building
50 Ann Street
BRISBANE QLD 4000
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Document No: 6329941

5. My role as Director of Mental Health involves independent decisions for the purpose of the *Mental Health Act 2000*. However, in my role as Chief Psychiatrist, there are no independent final decision making powers. All decisions on policy or standards are escalated to the Director-General.

6. The responsibilities of the Office of Chief Psychiatrist include responsibilities in relation to child and adolescent mental health in a general sense because the *Mental Health Act 2000* covers children and adolescents as well as adults.

7. Further, as mentioned at paragraph 32 of my earlier affidavit, I am responsible for the quality and safety work of the mental health Clinical Governance Team in OCP. This includes responsibilities for such matters insofar as they relate to children and adolescents.

8. However, there is no separate child and adolescent team adviser role and, when it comes to policy for children and adolescents, most of the policy and implementation work is undertaken by Children's Health Queensland Hospital and Health Service. I am kept abreast of their work.

9. It is difficult to advise whether my predecessor would have made a substantive contribution toward the decision to close the BAC and/or transition arrangements for patients at the BAC at the time of closure given I was not in the role at the time and have no knowledge of the Department's expectations of the role at that time. I understand that the role was vacant for some time after Dr Gilhotra retired and before I was appointed.

Kotze and Skippen Report

10. The scope of the Kotze and Skippen Report was limited. The report:

(a) only examined one set of issues for a particular timeframe;

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(b) did not consider what happened to the patients after their transition;

(c) only considered the actions of the health services, not the view of the consumers or their carers or families.

11. The report would have been better had there been material from the consumers, their carers and/or families and the receiving services.

12. The scope was limited by the Terms of Reference for the report.

13. The conclusions in the report were reasonable given the material to which it made reference.

14. The investigators used a set of principles of '*best practice*' regarding transitional care for adolescents that was sourced from the international literature that they applied to the information that they had.

15. The investigators were, in my opinion, entitled to draw the conclusions that they did.

16. The investigators themselves acknowledged the limitations referred to above.

17. If the investigators had considered extra material, there is a prospect that they may have reached different conclusions.

18. The material considered by the investigators only included information up until January 2014. The conclusions expressed were supported by reasons that were open to be made by the investigators, given the material considered.

19. While the Terms of Reference limited the potential considerations, it may have been beneficial if they were wider and permitted the interview of the patients, their carers and families and the receiving services. To better understand the transition, it would

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have assisted to consider a longer timeframe as this would permit consideration of the outcomes post transition.

20. It is difficult to appreciate the quality of the transition plans unless you consider their implementation and the results. There were things that occurred after January 2014 that would have aided evaluation of the quality of the transition plans.

Mental health conditions

21. The most common conditions for adolescents are:

(a) anxiety disorders;

(b) mood (affective) disorders;

(c) some behaviour or conduct conditions; and

(d) substance abuse disorders.

22. Co-morbidity is common.

23. Other less common, but often treated, mental health conditions include eating disorders and attention deficit disorders.

24. It has been estimated that 75% of psychiatric disorders treated in adults arise during adolescence, so there can be considerable overlap in types of disorders and their treatment between adolescents and adults.

25. The key difference in these conditions in adolescents as compared to adults is in the way they present and the range of severity.

26. In adolescents, because of the differences in development, symptoms are less likely to be well formed, for example you are more likely to encounter hidden anxiety and

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hidden depression and these presentations are often considered "atypical" as they may not conform to the usual descriptions.

27. Because these psychiatric conditions are often seen in their early phases they may appear to be less severe but it is important to recognise and treat early so that the illness does not progress to a more severe form.

28. The way mental health conditions present in adolescents is modified by their developmental status and by their social, family and cultural circumstances.

29. In adolescents, their personalities are not fully formed and their brain is still maturing, making the usual diagnosis groupings less distinguishable, both making them harder to diagnose and diminishing the possibility of providing a single diagnosis. In adolescents it is common to diagnose more than one disorder i.e. comorbid disorders

30. Issues with family and peer relationships may play a very large part in the presentation of disorders for adolescents. This may be more prominent than is the case for adults.

31. Adolescents do get admitted for mental health issues, but such admissions should be for a particular purpose and a limited time.

32. Admissions tend to occur for mood disorders, psychotic illness and severe behavioural disturbances such as occur in personality disorder.

33. Crisis admission will occur if an adolescent is at risk of suicide and this cannot be contained in the community. Such admissions will generally be short in duration to allow the individual to settle and become re-engaged in the community, but may be longer if they have mood or psychotic disorders. The length of admission is usually days to weeks, but can go into months depending upon response to treatment.

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34. In adolescents, typically admissions for eating disorders are for the purpose of stabilisation and will last days to weeks.

35. There may be longer-term admissions for adolescents with forensic issues. This is driven by the danger that they pose to others if this cannot be contained by community treatment.

36. Where adolescents suffer a combination of ongoing anxiety, mood disorders, substance abuse, post-traumatic stress disorder and emergent personality disorders, there may be numerous short crisis admissions (with the occasional longer admission). However, there is generally little evidence of significant benefit to longer admissions for those types of symptoms.

37. In general, adults are admitted for affective (or mood) disorders and psychotic disorders. The majority of such admissions are in the order of days to weeks, although some can be admitted for longer when the illness is considered to be treatment resistant.

38. The important difference between adolescent and adult mental health issues relates to the developmental stage of the patient.

39. Adolescents, as they mature, are undertaking two essential developmental tasks, namely:

(a) growing their own identity, including their sexual identity and their work identity (which is informed by achievements at school and work) as a step to differentiating themselves from their parents and family; and

(b) beginning to form independent relationships, for example with girlfriends and boyfriends as a step towards adulthood. These relationships are usually more intense than the relationships they form as children.

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40. The setting for these developmental tasks is centred around schooling and later work, interaction with their peers and interaction with their family.

41. Adolescents may be less experienced and resourceful in these tasks than adults, so services provided to adolescents have to be mindful of this. The services need to be adapted to be 'youth friendly'. The services need to be dynamic because young people are open to change and want to be seen to be in-step with their peers.

42. There are similarities in treatment for adults and adolescents as there is overlap in the types of conditions treated.

43. The basic techniques (biological, psychological and social interventions or treatment tools), are similar but the content of those tools or the techniques deployed in using the tools are adapted to treat adolescents.

44. For example, with adolescents it is even more important that the treatment options are close to where they live, as the support of the family and school environment are of greater significance due to the development of their personality and independent relationships that is occurring at the same time.

45. It is best; therefore, to have interventions available in those settings for adolescents although it is also important for adults as well.

46. Adults are usually more independent and the treatment is more likely to be individual and less family-based.

47. Adolescent mental health services are usually best delivered by a multidisciplinary team. Although this is also true for adults, it is possible to deliver quality care for adults through solo practitioners. This is less so for adolescents.

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48. An example of the differences with a similar tool is the differences in use of cognitive behavioural therapy. For adults, this therapy may involve providing the adult with a workbook to complete, and leaving it with them for them to complete by themself. For adolescents, greater support is likely to be required in the completion of the workbook. Adolescents are also more likely to be open to completing a workbook online.

49. Another example is with a social intervention made by a mental health professional. With adolescents, a mental health professional may attend the adolescent's school and work with the teacher to look at the environment in which the adolescent is functioning whereas with an adult, the mental health professional would expect the adult patients to manage themselves and speak directly with the Human Resources section to manage the work environment themselves. Both still involve the provision of community support.

50. There are also differences in the sensitivity and safety of various medications depending on whether the patient is an adolescent or an adult. Many medications used for adults do not have recognised indications for younger patients. The efficacy, dosing and side effects may be different. Some medications used for adults may not be suitable for adolescents. Prescribing for adolescents can often be "off-label" and greater supervision is required to ensure safety and efficacy.

51. The age of 18 is an arbitrary age determined by law. In the mental health field, it does not take account of the developmental stage of the patient. A patient's biological, social and emotional maturity can progress at different rates. In the mental health field, it is more appropriate to consider an age range for adolescence and each person should be assessed on an individual basis.

52. There are differing opinions as to the appropriate age range. The World Health Organisation uses 10-19 to describe adolescents. In Queensland we have used a

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age range for adolescence of 16 to 21. Many Australian jurisdictions consider youth mental health services for 16-24 year olds. Obviously there can be quite large differences at the extremes of the age range. Thus no one age demarcation is appropriate and it is much better to have an age range, for treatment, than an arbitrary demarcation.

53. It is generally recognised that it is better to treat young people between 16 to 25 years of age away from an adult inpatient facility, particularly if they are having their first episode. In an adult facility, these young people are likely to be exposed to people with more severe conditions than their own and this is known to be disconcerting to them.

54. On a busy adult unit a vulnerable young person may not get all of the attention that they need. It is likely to result in them feeling exposed and as though they don't fit in.

55. In my view, there is a gap in services for this 18 to 25 year old age group.

56. Development of more appropriate services for that age group would include youth admission units, as well as support and treatment in community with strong links to primary health care and other supports and the avoidance of admission unless absolutely necessary.

57. I am fairly certain that I have not yet seen a State-wide Sub-Acute Beds Discussion Paper. I am aware that one is being finalised by Children's Health Queensland Hospital and Health Service and I have had discussions around the issues in general with the authors. I have had no specific input into the discussion paper.

58. I am aware that at the time of closure of the Barrett Adolescent Centre, there were sub-acute beds available at the Mater, which were later moved to the Lady Cilento Children's Hospital.

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59. I visited the Lady Cilento Children's Hospital as part of my general orientation when I commenced in my current role and I recall seeing an adolescent unit. I was aware that this was where the sub-acute beds would be available if required.

60. I am not aware of whether there were any admissions. This operational detail is not part of my role.

61. It is hard to provide a view about the adequacy of the beds for adolescents requiring extended inpatient admission without having seen the beds in action.

All the facts affirmed in this affidavit are true to my knowledge and belief except as stated otherwise.

Affirmed by JOHN ALEXANDER ALLAN)
on 3 February 2016 at Brisbane in the)
presence of:)

[redacted] C.Dec.

A Justice of the Peace, C.Dec., Solicitor

BRONWYN ELIZABETH REYNOLD

COMMISSIONER FOR DECLARATIONS
DEPT. OF JUSTICE & ATTORNEY-GENERAL
Reg.No.: 21636

In the matter of the *Commissions of Inquiry Act 1950*

Commissions of Inquiry Order (No.4) 2015

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CERTIFICATE OF EXHIBIT

Exhibit A to the Affidavit of JOHN ALEXANDER ALLAN sworn on 3 February 2016.

[redacted] [redacted] C. Dec.

Deponent A J.P., C.Dec./Solicitor

BRONWYN ELIZABETH REYNOLDS

COMMISSIONER FOR DECLARATIONS
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A

BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

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

REQUIREMENT TO GIVE INFORMATION IN A WRITTEN STATEMENT

To: Dr John Allan

Of: c/- Crown Law, by email to: cl-barrettinquiry@crownlaw.qld.gov.au

I, the Honourable MARGARET WILSON QC, Commissioner, appointed pursuant to *Commissions of Inquiry Order (No. 4) 2015* to inquire into certain matters pertaining to the Barrett Adolescent Centre ("the Commission") require you to give a written statement to the Commission pursuant to section 5(1)(d) of the *Commissions of Inquiry Act 1950* in regard to your knowledge of the matters set out in the Schedule annexed hereto.

YOU MUST COMPLY WITH THIS REQUIREMENT BY:

Giving a written statement prepared either in affidavit form or verified as a statutory declaration under the *Oaths Act 1867* to the Commission on or before **4.00pm, Friday 5 February 2016** by delivering it to the Commission at Level 10, 179 North Quay, Brisbane.

A copy of the written statement must also be provided electronically either by: email at mail@barrettinquiry.qld.gov.au (in the subject line please include "Requirement for Written Statement"); or via the Commission's website at www.barrettinquiry.qld.gov.au (confidential information should be provided via the Commission's secure website).

If you believe that you have a reasonable excuse for not complying with this notice, for the purposes of section 5(2)(b) of the *Commissions of Inquiry Act 1950* you will need to provide evidence to the Commission in that regard by the due date specified above.

DATED this 28th day of January 2016

The Hon Margaret Wilson QC
Commissioner
Barrett Adolescent Centre Commission of Inquiry

SCHEDULE

1. Who was your predecessor in the Office of Chief Psychiatrist, and to the best of your knowledge, between what dates did they hold that position?

2. What if any decision making powers rest with the Office of Chief Psychiatrist?

3. Do the responsibilities of the Office of Chief Psychiatrist include responsibilities in relation to child and adolescent mental health?

4. Would you have expected the Chief Psychiatrist to have made a substantive contribution toward the:

   a. decision to close the BAC; and/or

   b. transition arrangements for patients at the BAC at the time of closure?

5. Look at the Kotze and Skippen Report produced under the *Hospital and Health Boards Act 2011* (Qld) (**Report**). In relation to this Report, please outline and explain your view of:

   a. the scope of the investigation;

   b. whether in light of the scope of the investigation, you agree with the conclusions reached in the Report;

   c. whether the reasons stated in the Report form proper bases for the conclusions; and

   d. what (if any) other topics, or issues, you consider ought to have been addressed in the Report.

6. In your opinion, and based on your expertise and experience, what mental health conditions and issues do adolescents typically experience and how are these conditions and issues different from those suffered by adults?

7. What, if any, of these mental health conditions and issues are most likely to require inpatient admission (for both adults and adolescents) and for what purpose, period of time, and what type of inpatient facility is necessary?

8. What are the differences between adolescent and adult mental health issues and how are these issues typically reflected in the services provided to both adolescents and adults? In your opinion, how could any differences ideally be addressed, for example, by way of the types of services that ought to be available?

9. In many aspects of life, the end of childhood and adolescence is marked at the age of 18. Can you comment upon the appropriateness of this demarcation in the mental health field? Is a different age demarcation appropriate, and if not or if so, why?

10. What is your view in relation to the appropriateness of 18 to 25 year olds with severe or complex mental health issues being treated and admitted to adult mental health services and facilities? Is there, in your view, a gap in services for this age group and cohort of young people? If so, what if anything do you think needs to be done to address this gap?

11. The Commission understands that the Child and Youth Mental Health Service is in the process of finalising a State-wide Sub-Acute Beds Discussion Paper. Please detail your knowledge (if any) and contribution (if any) towards that discussion paper, or the issue more broadly. In particular, detail your knowledge and understanding of the sub-acute beds available at the Lady Cilento Hospital, and your view (if you are in a position to provide such a view) about the adequacy of these beds for adolescents requiring extended inpatient admission.

12. Explain any other information or knowledge (and the source of that knowledge) that you have relevant to the Commission's Terms of Reference.

13. Identify and exhibit all documents in your custody or control that are referred to in your witness statement.