clinical and academic input, and opportunities to rotate staff through a whole range of service delivery experiences.

Appropriate model of care for the BAC cohort

167. Much of the policy documentation relating to child and youth mental health has no direct impact on facilities such as the BAC. However, there are national and state principles that are clearly relevant. The most relevant, in my opinion, are the delivery of least restrictive care, access to services close to home, the overarching child and youth principle of developmentally appropriate services (that encourage normalisation rather than pathology), and a commitment to service evaluation.

168. There is also literature on facilities being more effective if they are more "homelike" and less clinical in appearance and structure.

169. Concerning least restrictive care, it is self-evident that day programs are less restrictive than inpatient facilities in that the former promotes the individual going to their home or to a homelike situation (foster-care or therapeutic residence) of an evening where they can put into practice therapy tasks and activities of the day. The BAC was restrictive by its nature as an inpatient unit, but also from its geographical isolation and placement on a large metal health campus.

170. The principle of access to care close to home is not in favour of a state-wide long stay inpatient unit such as the BAC, which at times had patients from far north Queensland, as well as central coast and other non-metropolitan areas. In part, the determination to invest in the Townsville CYMHS campus was to provide better access to care for Far North Queensland patients.

171. Developmental appropriateness concerns the concept that there should always be a strong emphasis on adolescents engaging in normal adolescent behaviour. The hallmark of this is attendance at a mainstream school or some other educational facility (for example, TAFE) and mixing with same age peers who do not have

[redacted]

Signed: Brett Michael Charles McDermott Taken by: Veronica Dubois, Commissioner for Declarations

psychopathology. For those with very severe mental health diagnoses and challenges it is unreasonable to think this group could experience a normal school week and school experience. Nevertheless, even the most troubled adolescent, with appropriate professional scaffolding, can attend school for some hours of each day. [redacted] Spending large periods of time, in some cases exclusively, with other adolescents who experience highly challenging behaviour runs the risk of learning and reinforcing dysfunctional ways of coping.

172. Finally, given the poor evidence base of many child and adolescent mental health treatment approaches, I am of the opinion that there is a clear imperative to respect patients, their families and the funding body (in this case the tax-payer) by proving the facility is a place that is more likely than not to produce good outcomes. This is consistent with national standards, the National Health and Medical Research Council ethos and the recent National Mental Health Commissions reform manifesto. If the BAC replacement is tendered out to a Non-Government Organisation, a robust generalisation is that such organisations have a limited track record for conducting outcome research.

Mental Health Expert Reference Group (ERG)

173. I was appointed by the federal government to the ERG in about 25 June 2015.

174. At the time of providing this affidavit, the ERG Report has not been publicly released nor has the federal government's response to the National Mental Health Commission's manifesto for reform.

175. Further, my work with the ERG group is subject to a signed confidentiality agreement with the federal government.

176. I do however, feel it is reasonable to reassure the Commission on this matter.

[redacted] ..... [redacted] .....

Signed: Brett Michael Charles McDermott Taken by: Veronica Dubois, Commissioner for Declarations

177. The National Mental Health Commission (NMHC) advocated strongly for a stepped-care model of service delivery. The base of such a model comprises promotion, prevention, followed by early intervention. At the apex of such a model is the provision of facilities that have low population reach (provide care for small number of individuals), but provides intensive interventions for individuals with very acute mental health needs.

178. The NMHC also strongly advocated that such undertakings should have a strong evidence base.

179. The ERG did not give any specific attention to adolescents with intense therapy needs in the NMHC's report.

Language

180. I am unaware of any process or policy at the BAC which formally proscribed whether adolescents who attended the facility should be called patients, clients, consumers, young persons or adolescents.

181. My personal observation is that medical practitioners exclusively use the term 'patient' during four to six years' medical school training, and then often up to seven years further study before becoming psychiatrists. Medical practitioners who are not psychiatrists still overwhelmingly use the word 'patient'. The term patient is generally associated with being treated by a doctor.

182. I have observed that in mental health services, psychologists and social workers often use the term 'client'.

183. There has been a strong move in the mental health field to define young people as a group worthy of their own service delivery ethos and therapeutic practices. If this group is considered by child and adolescent psychiatrist (looking at the

[redacted] .... [redacted] .....

Signed: Brett Michael Charles McDermott Taken by: Veronica Dubois, Commissioner for Declarations

individual's development after they traditionally treat them), they will often use the term 'adolescent'. If the group is considered by adult practitioners (looking at the individual's development before they traditionally treat them) they will often use the term 'youth' or 'young adult'.

Other

184. I do not believe that I have any additional information or knowledge relevant to the Commission's Terms of Reference.

185. All documents referred to in this affidavit have been annexed hereto.

Affirmed by Brett Michael Charles McDermott on 10 November 2015 at Townsville in the presence of:

[redacted]

Brett Michael Charles McDermott

[redacted]

Veronica Dubois,
Commissioner for Declarations

COMMISSIONER FOR DECLARATIONS
Reg. No. 1522
ATTORNEY-GENERALS DEPARTMENT

EXHIBIT 84

BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

CERTIFICATE OF EXHIBIT

Bound and marked "**BMCM-1**" to "**BMCM-15**" are the exhibits to the affidavit of Brett Michael Charles McDermott affirmed 10 November 2015.

[redacted]

Brett Michael Charles McDermott

[redacted]

Veronica Dubois,
Commissioner for Declarations

COMMISSIONER FOR DECLARATIONS
ATTORNEY-GENERALS DEPARTMENT
Reg. No. 1522

CERTIFICATE OF EXHIBITS

Filed on behalf of Prof. Brett McDermott

Name: MERIDIAN LAWYERS
Address: Level 8, 60 Edward Street
BRISBANE QLD 4000
Phone No:
Fax No:
Email: [redacted]
Our Ref: AGJ:DJD:2011113

EXHIBIT 84

INDEX TO EXHIBITS

EXHIBIT 84

BMCM-1

Curriculum Vitae

Brett McDermott
B.Med.Sci., MBBS., Cert.Child.Psych.,
MD., FRANZCP

Professor of Psychiatry, James Cook University and the Townsville Hospital and Health Service

Director, *BeyondBlue* the Australian National Depression Initiative.

By-Fellow, Churchill College Cambridge University

Adjunct Professor, Queensland University of Technology

Professorial Fellow, Mater Medical Research Institute

Queensland Health designation 'Pre-Eminent' Specialist SMO4.1

General and Personal data

DOB [redacted]
Nationality Australian
Correspondence address: [redacted]

Recent Appointments

- Executive Director Mater Child and Youth Mental Health Service (from March 2002-Dec 2014)
- Director responsible for the ADAWS: the Adolescent Drug and Alcohol Withdrawal Service (from June 2002-Dec 2014)
- By-Fellow Churchill College Cambridge University UK (ongoing)
- Director, BeyondBlue the National Depression Initiative (ongoing)
- Professorial Research Fellow: Mater Medical Research Institute (ongoing)
- Adjunct Professor of Child and Adolescent Psychiatry, Queensland University of Technology (ongoing)
- Member National Mental Health Working Group – Child and adolescent expert committee responding to natural disasters (ongoing)

- Chair: NHMRC-BeyondBlue Youth Depression Clinical Practice Guidelines Working Group
- Member: NHMRC PTSD Guideline Editorial and Advisory Committee
- For the Queensland Government
  Member CoAG mental health working group
  Member Child and Youth Mental Health network
  (2011-13) Chair of the child and adolescent response to the Queensland Floods and Cyclones.
- Member Rotary Mental Health Grant Committee (ongoing)
- At the Mater Children's Hospital:
  Member: Mater Children's Hospital Clinical Governance Committee
  Chairman 2008- 2011 Mater Children's Hospital Medical Advisory Committee
- National Health and Medical Research Council Psychiatry/Psychology Review panel 2007, 2008, 2009.
- Private Practitioner (Adult, Youth and Child Psychiatry) Teneriffe Family Doctors, 2004-current

Other (recent) appointments of note

- Convenor: Australasian Conference on Child Trauma (2012), Gold Coast, Australia.
- Chair, Queensland Health Child and Youth Mental Health Response to the 2010-2011 Natural Disasters
- Visiting Professor (2008) Universiti Kebangsaan Malaysia (UKM), Kuala Lumpa.
- Scientific Convenor 2006 World Congress of the International Association for Child and Adolescent Psychiatry and Allied Professionals.
- Chairman (2005-06) Child and Adolescent Mental Health National Outcome Measurement Experts Group

Medical Qualifications, Training, Courses

Educated in Sydney (NSW) and Hobart (Tasmania), Australia.
Graduated from the University of Tasmania with:
Bachelor of Medical Science (B.Med.Sci.), 1982.
Bachelor of Medicine (MB), 1984.
Bachelor of Surgery (BS), 1984.
Elected Fellow of the Royal Australian and New Zealand Colleague of Psychiatrists 1995.
Completion Child and Adolescent Psychiatry training (CertChildPsych.) 1995
Doctorate in Medicine (MD) 2005.
Recent Courses:

- European Education Program in Epidemiology – Residential Summer School (Florence 2006)
- Harvard-Karolinska Biostatistics Summer School: Modules: Advanced Categorical: Linear Regression (the Veneto, 2007).
- ACSPRI Winter School: Regression analysis (University of Queensland, 2009)
- ACSPRI Winter School: Structural Equation Modelling (University of Queensland, 2013)

Professional Record

1985	Intern, Launceston General Hospital
1986	Resident Medical Officer, Royal Canberra Hospital
1987	Surgeon Lieutenant Royal Australian Navy,
1988	Ship's Medical Officer, HMAS Jervis Bay
1989	Ship's Medical Officer RAN Flagship, HMAS Stalwart
1990 - 1991	Senior House Officer UK (Psychiatry)
1992	Psychiatry Registrar NSW

1993	Senior Registrar Mood Disorders Unit NSW
1993 - 1994	NSW Training Fellow in Child and Adolescent Psychiatry
1995	Staff Specialist: Child and Adolescent Psychiatry (Newcastle, NSW)
1995.	Senior Lecturer Child and Adolescent Psychiatry (UWA)
2000	Professor of Child and Adolescent Psychiatry (UWA)
2001	By-Fellow, Churchill College, Cambridge University, UK.
2002 -2009	Director Mater Child and Youth Mental Health Service (Brisbane, QLD)
2002	Associate Professor (University of Queensland)
2007	Director BeyondBlue
2009 - 2014	Executive Director Mater Child and Youth Mental Health Service (Brisbane, QLD)
2011	Chair of the child and adolescent response to the Queensland Floods and Cyclones
2011	Professorial Research Fellow; Mater Medical Research Institute
2013 - 2014	Director (0.4FTE) Mater Adolescent and Young Adult Centre (MAYAC)
2015	Private Consultant Child and Adolescent Psychiatrist - Locum Child and Adolescent Psychiatrist Fraser Coast (Queensland) Integrated Mental Health Service; Townsville Hospital and Health Service (Queensland) Mental Health Service; West Moreton Health Service.

Honours, Awards

1983	Kathleen Menzie Travelling Scholarship
1994	NSW Department of School Education Certificate of Commendation: "For meritorious services to New South Wales School Children after the 1994. January Bushfire Disaster."
1995	NSW Department of School Education: Assistant Director General's Award: "For providing outstanding support to students and school communities in Metropolitan East Region following the 1994 January Bushfires."
1998	"StateWest (Western Australia) Achievement Award; Group category. The Princess Margaret Hospital for Children Eating Disorders Team: Dr Brett McDermott Founding Director.
1999.	The Princess Margaret Hospital for Children "Service Excellence Award" to the PMH Eating Disorders Team: Dr B. McDermott Founding Director.
2003	Mercy Award: Child and Youth Mental Health Service
2003	Mercy Award: Kids in Mind Research: Mater Centre for Service Research in Mental Health
2006	Queensland Government, Queensland Health Certificate of Commendation "...contribution to the response to Cyclone Larry, North Queensland"
2006	Citation from International Association for Child and Adolescent Psychiatry and Allied Professionals: excellence in program development of 17th world congress.
2007	Australian Defence Service Medal
2007	"Mater Star" Award
2008.	Nomination for Queenslander of the Year award.
2011	Finalist and Joint Winner: 2011 Queensland Mental Health Achievement Award ("Natural disasters; personal achievement in service delivery")

Summary of Specialist Clinical Activities

1995.	Staff Specialist at a community Child and Adolescent Mental Health Clinic.
1996-2002	Clinical input, supervision and direction of a child and adolescent eating disorders clinic. Primary tasks include weekly assessments, individual

and family therapy and interaction with inpatient medical and nursing staff.

1996-2001 Child and Adolescent Mental Health Private Practice (0.2EFT)

1999.Specialist input to child and adolescent inpatient ward. Primary tasks include assessments, input to ward rounds, supervision of registrars and other staff, individual and family therapy.

1999-1999 Staff Specialist at a community Child and Adolescent mental health Clinic (part-time whilst on sabbatical).

1999-present Consultations from Paediatrician colleagues

2001-2002 "Second opinion" service to Perth and regional Child and Adolescent Mental Health Services

2014. Director Mater Child and Youth Mental Health Service (Clinical direction, primary and secondary consultations, staff inc. register supervision) inclusive of the Adolescent Drug and Alcohol Withdrawal Service (ADAWS)

2003-2015 Private Practice Clinic (with Teneriffe family Doctors) Youth and Adult Psychiatry

Research Activities:

Post-Disaster initiatives

- 1994-2000 Convenor and Director of the Sutherland Bushfire Trauma Project.
- 2003 Convenor Canberra Bushfire Project
- 2006 Convenor and Director Cyclone Larry child mental health response
- 2009 The Brisbane Storms Project
- 2009 Collaboration with ACPMH: Level III Victorian Bushfire intervention for children and adolescents
- 2011-13 Chair of the child and adolescent response to the Queensland Floods and Cyclones

The Sutherland Bushfire Trauma Project (SBTP) was the first such project in Australia, one of the first in the world. 4000 children and adolescents were proactively screened for post disaster emotional distress and depression. Clinical intervention was coordinated based on the results of screening. The project was the recipient of several awards and through media attention raised the profile of emotional issues following natural disasters. Analysis of SBTP data formed the cores of MD thesis.

Various aspects of this research have been presented at numerous conferences (see section "presentations"). A degree of academic prominence has been accorded this research and service provision endeavour as evidenced by the invitation to present at the American Psychological Associations annual meeting (Toronto, Canada, 1996) and the contribution of a chapter to the American Psychological Association publication "Helping Children Cope with Disasters: Integrating Research and Practice".

Two journal publications, one book and two book chapters have been published, numerous conference presentations undertaken and three research papers. The project Director (Dr McDermott) has received 2 awards (see "Awards" section) from the New

South Wales Department of School education for this endeavour, an unusual distinction for a Child and Adolescent Psychiatry intervention.

The Canberra bushfire trauma project was of smaller scale (one school) and built on the SBTP by using improved measures. The Cyclone Larry response (Category 5 Cyclone) involved the key service provision aspects of the SBTP: proactive school-based screening using psychometrically sound instruments followed by targeted interventions. New research aspects include the association of child post-traumatic psychopathology with family function, family resilience, social relatedness and parent economic pressure. With this initiative a new collaboration began with Dr Vanessa Cobham, this lead to a new trauma-focused CBT treatment resource. Four journal articles have reported new research from this project.

Post-disaster research and service provision has been a continuing theme with a response to the Brisbane 2009 Gap storms and leadership of the 2011-2012 Queensland flood and cyclone disasters. The latter has led to a more comprehensive stepped-care intervention and publication of a book on children and disasters.

1996 – 2002: Foundation Director of the Princess Margaret Hospital for Children - Eating Disorders Team.

Anorexia and Bulimia nervosa and related conditions in children and adolescents are a poorly understood and researched area. By establishing a unique, combined mental health and paediatric gastroenterology Eating disorders Team for children and adolescents the research aim of advancing the psychological, physical and nutritional understanding of this clinical population and their families is being advanced. Initial research endeavour has been the characterisation of this clinical population. This research phase has occupied the EDTeam for the first four years. Future research will consider aetiology from a developmental psychopathology perspective and treatment outcome. Lastly the EDTeam is a considerable research resource. As of August 2001 the database included 200 children and adolescents with Anorexia nervosa or limited symptom variants. 1 PhD candidates, 5 psychology masters students and 4 psychology honours students were completed research with the EDTeam.

1997 – 2002: Child Psychiatry Common Database Project.

The outcomes and efficacy of Child and Adolescent mental health treatment services are poorly researched. Despite the ubiquity of such services, the argument for service need in this area and the economic costs involved require substantiation. An interest in this area lead to data analysis and academic support to an existing project (evaluation of the Robinson Unit). Two publications (see "publications" section) have been published from this research.

To investigate this area in a more detailed way, in collaboration with Professor Bob McKelvey at the Princess Margaret Hospital for Children, a case register of consecutive attenders to any of the PMH psychological services was established. The database presently contains >2000 children and their families. Analysis of this data, as well as a 12 month follow-up of attenders, will inform about the differences between individuals with mental illness in the community and those that present at mental health services and

the decisions made by clinicians when providing one of several treatment options. Several conference presentations have been made based on this research, one research paper is in press and two further papers submitted for publication.

1997-1999 Children who experience Motor Vehicle Accidents.

Following on from work with children after natural disasters, a pilot project investigating the rate of Post Traumatic Stress Disorder and general psychopathology in children who experienced a Motor vehicle accident has been completed (see publications section: McDermott & Cvitanovich). More recently a treatment outcome study is being undertaken by a Doctor of Psychology candidate (Mr Michael Kemp). Dr McDermott is joint supervisor of this project.

2003 - Founding member Kids in Mind Research: The Mater Centre for Service Research in Mental Health

KIMResearch is a new Queensland initiative with a mission to provide high quality research support to child and adolescent mental health clinical activities. Initial activities include psychopharmacology usage in CYMHS clinics, See kidsinmind.org.au. for more detail.

2004 – Collaboration with the Mater-University Study of Pregnancy (MUSP)

Tasked to analyse and report of MUSP data that related to eating disorders and related constructs such as body dissatisfaction. Thus far there have been five publications from this collaboration.

2010- Mater F1-11 Seal-Reseal Research Group

PI Prof Frank Bowling: genetic, epigenetic, proteomic and toxicological investigation of F1-11 fuel and its implication on human cells and former serving members of the Australian Armed Forces.

2011 – MMRI Child Anxiety and Posttraumatic Mental Health Research Group

PIs Associate Professor Brett McDermott and DR Vanessa Cobham; the aims of the group are to investigate child and adolescent anxiety and posttraumatic mental health, encompassing population based approaches and, in collaboration, foundation science. This group has a special emphasis on service provision models in real-world situations such as natural disasters, including the application of empirically validated case identification and evidence-based treatments.

Postgraduate Research Supervision

(Primary or Co-supervisor Dr McDermott):

Candidate	Title	Completion date & level
L Smith	The Stroop paradigm in children & adolescents with anorexia nervosa.	passed 1998 (M.Psych)
S. Mitchell	The relationship between the EDI and EAT26 in a community adolescent sample.	passed 1998 (M.Psych)
C Harris	Cognitive functioning in adolescents with AN pre- and post nutritional resuscitation.	passed 1997 Psych(Hons)
B.Grey therapy	The Mirror within: identifying links between between	passed 1998 M.Art

	anorexia, object relations and the potential role of art therapy as the transitional object.	
G Casey	A study investigating the discriminant validity of the eating Disorders Examination in a Western Australian adolescent population.	passed 1996 Psych(Hons)
J Turner	Bone density in children and adolescents with Eating ongoing disorders. (NHMRC Research Fellow)	passed 2003 PhD
P Jennings.	Cross-Cultural Aspects of the Epidemiology of Eating Disorders and Eating Disorder Psychopathology: A Comparison Study between Caucasian and Asian Australian Adolescent Girls.	passed 2006. PhD
H D'Emden	Eating disorders psychopathology in adolescents with Type I Diabetes and relationship to metabolic control.	passed 2013 M.Phil
M Richardson	Chronic grief during childhood and adolescence.	passed 2013 PhD

Conference Presentations and abstracts

157. McDermott BM. (accepted abstract) Evidence based medicine under difficult circumstances: quantitative and qualitative evidence of the effectiveness of TF-CBT. RANZCP Child and Adolescent Psychiatry Conference, Vanuatu, (August 2015).
156. McDermott BM. Invited Keynote: Neuroscience and emotional trauma: recent advances that have significance for the Judiciary. Australian Judges Conference, Sunshine Coast, (Aug 2015).
155. McDermott BM. Invited talk/keynote: F1-11s, jet fuel and systems biology: does this inform a generational change in and adolescent child psychiatry. Faculty of Child and Adolescent Psychiatry, Gold Coast, (Oct 2014).
154. McDermott BM. Invited talk/keynote: Genes, parenting and regulation: Does the current genetic-biological revolution have any relevance to child protection?
Mater Child Protection Unit Conference, Brisbane, (September 2014).
153. McDermott BM. Invited talk/keynote: Approaches to managing and treating trauma. Bendigo Health Annual Forum, Bendigo, (September 2014).
152. McDermott BM. Invited talk/keynote: Psychiatry and the Law: a meeting of cultures or missed opportunities. Queensland Public Interest Law Clearing House; Public Interest Lecture, Brisbane, (August 2014).
151. McDermott BM. Invited talk/panellist: A Future Blueprint for Mental Health. Catholic Health, (August 2014).
150. McDermott BM. Invited talk/keynote: National Mental health Survey of Doctors and Medical Students. AMA Junior Doctors Conference, Brisbane, (June 2014).
149. McDermott BM. Invited talk/keynote: In the context of a changing workforce: the evidence for mental health interventions for work-related PTSD. Queensland Ambulance Service, Brisbane, (June 2014).
148. McDermott BM. A stepped-care post-disaster child and adolescent service response: attempting to address response reach and variations in Acuity. ISTSS 29th Annual Meeting. Philadelphia. (Nov 2013)
147. McDermott BM. Contemporary issues in child and youth mental health. Pontificio Consiglio Per Gli Operatori Sanitari. Vatican. (June 2013).
146. McDermott BM. Emotional trauma: essential lessons for teachers. H.E.L.P Conference. Gold Coast, (May 2013).
145. McDermott BM. Psychotropic medication for children. Annual Conference of the Australian and New Zealand Child Neurology Society, Sydney. (May 2013).
144. McDermott BM. Understanding type I and II trauma: implications for the residential care sector. National Therapeutic Residential Care Workshop, Brisbane (October 2012).
143. McDermott BM. The Australian child and adolescent early intervention program

"kidsmatter". Challenging frontiers in psychiatry, Seoul National Medical University, Seoul Korea (September 2012)

142. McDermott BM. Stepped-care model for delivery of post-traumatic mental health services for children and adolescents. Seoul National Medical University, Seoul Korea (September 2012).
141. McDermott BM. The impact of emotional trauma on childhood development: insights from the neurobiological revolution. Annual Conference of Australasian and Pacific Island Children's Court Judges. Brisbane. (August 2012)
140. McDermott BM. From Universal to intensive therapy: a post-disaster stepped care model. Australasian Conference of Child Trauma, Gold Coast (July) 2012.
139. McDermott BM. The Big Picture: Understanding Type I and II trauma. Australasian Conference of Child Trauma, Gold Coast (July) 2012.
138. McDermott BM, Cobham VE. Training Track: Tauma-focused CBT. Australasian Conference of Child Trauma, Gold Coast (July) 2012.
137. McDermott BM, Poulsen K, Cobham VE. Training Track: Parenting. Australasian Conference of Child Trauma, Gold Coast (July) 2012.
136. McDermott BM, Cobham VE. A stepped-care model for post-disaster service provision to children, adolescents and families. IACAPAP, Paris. (July 2012)
135. McDermott BM, Dwyer S, Bowers J, Berry H. The impact on community functioning and mental health of weather-related disasters. 3rd Rural and Remote Health Scientific Symposium. Glenelg, SA (June), 2012.
134. McDermott BM. From prevention to community based interventions: a stepped-care approach to post disaster child and youth mental health Earth, Fire and Rain The Australian and New Zealand Disaster and Emergency Management Conference. Brisbane (April 2012)
133. McDermott BM. Psychosis and Intellectual Disabilities. 11th Annual Meeting Society for the Study of Behavioural Phenotypes. Brisbane (October 2011).
132. McDermott BM Disaster Recovery: resources within an over-arching system of care. Australian Guidance and Counselling National Conference:- Challenging Practice: Focussing Futures. Brisbane. (September 2011).
131. McDermott BM. Disaster responses in the season of Sorrow. AGCA: Challenging Practice: Focussing Futures: QGCA 2011 Conference Brisbane (September 2011).
130. McDermott BM The Queensland response to the flood disaster: timely universal and targeted interventions for children & adolescents. 3rd Asian Psychiatry Conference. Melb, (Aug 2011)
129. McDermott BM Children as witnesses: neurobiology of memory and interviewing an at risk population, Queensland Magistrates Conference, Brisbane, (August, 2011)
128. McDermott BM Community based and individual approaches to children and families affected by the flood disaster. QCOSS 2011, (August, 2011)
127. McDermott BM and Cobham VE. Treating PTSD in Queensland children and adolescents following the 'summer of sorrow': taking an evidence-based approach to the community. Expert forum (ACPHM), Melbourne (August 2011).
126. McDermott BM. Early intervention for posttraumatic mental health presentations. Priority One Conference, Logan, Queensland (August 2011).
125. McDermott BM. Keynote address: Promotion Prevention Early Intervention Conference Logan, Queensland. (2011)
124. McDermott BM. NHMRC-Beyondblue Clinical Practice Guidelines for depression in adolescents and young people. RANZCP Congress, Darwin (May 2011)
123. McDermott BM. Disaster responses in the medium to long term with special reference to school communities. Catholic Education Queensland (Twin Waters, Queensland April 2011)
122. McDermott BM Disasters, adolescents and the Queensland emotional health response Australian College of Children & Young People's Nurses, Herston, Queensland (March, 2011)

121. McDermott BM. Working with teachers after natural disasters. ACOTS Annual Conference, Brisbane (September 2010)
120. McDermott BM (with Vanessa Cobham). Mini-masterclass: working with traumatised children. ACOTS Annual Conference, Brisbane (September 2010
119. McDermott BM. Eating disorders presenting in adolescents. 2010 Youth Mental Health Symposium, Brisbane (August 2010).
118. McDermott BM. Children and mental disorders with a focus on emotional trauma. Queensland Law Society and Family Law Practitioners' Association: 25th Annual Calabro SV Consulting Family Law Residential. Gold Coast (August 2010)
117. McDermott BM. Catholic presence in mental health in the next 10 years. Catholic Health Annual Conference, Adelaide (August 2010)
116. McDermott BM. A principal's guide to applying concepts from family therapy: systematic strategies to create change. Griffith University PDN Leaders Conference, GC (Aug 2010)
115. McDermott BM.NHMRC-Beyondblue Clinical practice guidelines in Depression, 1st International Youth Mental Health Conference Melbourne (July 2010).
114. McDermott BM, Cobham VE. World Congress of Cognitive behaviour Therapy, Boston US (June 2010).
113. McDermott BM. Children and disasters: empirical data from 3 Australian disasters. Australian Society for Psychiatric Research, Pre-Conference Workshop. Canberra (December 2009).
112. McDermott BM (Keynote) Rural and Remote Mental health Conference, Canberra (Nov 2009)
111. McDermott BM , Cobham VE. A public health approach to child PTSD: screening and treatment implication American Cognitive Behaviour Therapy, New York (November, 2009
110. McDermott BM. Children, adolescents and bushfire-related traumatic stress. North eastern (Vic) GP Annual conference (October 09).
109. McDermott BM (invited speaker). Helping children in the aftermath of the bushfire Conference Monash University, Melbourne, (October 2009).
108. McDermott BM. Symposium: International perspective on guideline development for the treatment of childhood and adolescent depression. RANZCP Child Faculty Conference, Queenstown, NZ (September 2009)
107. McDermott BM. (invited keynote) Eating disorders in children and adolescents: from fussy eaters to fad treatments. Australian and New Zealand Academy of Eating Disorders (ANZAED), Brisbane (August 2009).
106. McDermott BM. (invited speaker) Developments in mental health service provision for children and adolescents. 11th Johor Mental Health Convention, Johor Bahru Malaysia, (July 2009)
105. McDermott BM. (invited speaker) Children and disaster trauma: evidence and best practice. 11th Johor Mental Health Convention, Johor Bahru Malaysia, (July 2009)
104. McDermott BM. Children and trauma, evidence and best practice. General Practice Victoria – Australian GP Network Post-Bushfires Forum, Melbourne (April. 2009).
103. McDermott BM, Graetz B., Fraser L. Treatment of depression in children and youth: 2009 beyondblue-NHMRC Update of clinical practice guidelines, overview and consultation. Australian Guidance and Counselling Association Annual Conference, Hobart (April 2009).
102. McDermott BM. (invited keynote) Molecules and the mind: rendering redundant the nature-nurture debate. Australian Guidance and Counselling Association Annual Conference, Hobart (April 2009).
101. McDermott BM. Children's memory and giving evidence: invited panel. PACT Conference, Brisbane (Mar 2009).

100. McDermott BM, Mamun AA, Najman JM, Williams GM, O'Callaghan MJ, Bor W. Correlates of the persistence of irregular eating from 5 to 14 years of age. (Poster) RANZCP Child Faculty Conference, Port Douglas (October 2008).
99. McDermott BM, Cobham V, Berry H & Adam K. Child connectedness: a potential target for a pre-disaster resilience intervention that may modify PTSD in children. (Poster) RANZCP Child Faculty Conference, Port Douglas (October 2008).
98. McDermott BM. RANZCP Child Faculty Conference, Port Douglas (October 2008).
97. McDermott BM. Eating disorders treatment: a medical perspective. CRNC Conference. Brisbane (Oct 2008)
96. McDermott BM (invited keynote): The agony and ecstasy of research in the CYMHS clinical environment. RCH CYMHS Research Conference. (Brisbane, July 2008)
95. McDermott BM. Diagnosis, Management and Prevention of Childhood & Adolescent Obesity and Eating Disorders in General Practice. Woman's & Children's health Conference, Bris. (July 2008).
94. McDermott BM. Child and youth post-disaster emotional response. Psychological Response and Recovery Symposium. Brisbane, QLD (November 2007).
93. McDermott BM & Jaffa T. Child and youth eating disorders. Leeds UK. (Nov 2007)
92. McDermott BM. Multi-systemic therapy: challenges of service implementation in Queensland. Child and Youth Mental Health 'Mini-Conference', Brisbane (Oct 2007)
91. McDermott BM. Workshop: Eating disorders in children and adolescents. New Zealand Child and Adolescent Mental Health and Addictions Services Conference, Hamilton NZ (Sept 2007)
90. McDermott BM. Eating disorders across the children and adolescent developmental span. New Zealand Child and Adolescent Mental Health and Addictions Services Conference, Hamilton NZ (September 2007)
89. McDermott BM. Multi-systemic therapy in Queensland: A review of Progress. FRANZCP Child and Adolescent Faculty Meeting, Maroochydore, QLD (August, 2007).
88. McDermott BM. Child & Adolescent Response to Cyclone Larry: Exposure, Resilience & Targeted Intervention. Cell2Soul: RANZCP Congress, Gold Coast (May 2007).
87. McDermott BM. Impact of aggression on staff in a child and adolescent inpatient Unit. RANZCP Congress, Gold Coast (May 2007).
86. McDermott BM. Panic and the people: child post-disaster responses. Centaur Memorial Fund Annual Conference. Brisbane (November, 2006).
85. McDermott BM. Eating disorders and emotional trauma (workshop). 5th Annual Teenage Anorexia Conference, Cambridge, UK (November 2006).
84. McDermott BM. The Impact of Service Life on Children. Australian Defence Force Mental Health Conference. Canberra (October 2006).
83. McDermott BM. "Riding the Waves" - Opportunities and challenges of stakeholder participation in service research. 17th World Congress of the International Society of Child and Adolescent Psychiatry and Allied Professions. Melbourne (September 2006).
82. McDermott BM. MST-CAN in Queensland: initial results. 17th World Congress of the International Society of Child and Adolescent Psychiatry and Allied Professions. Melbourne (September 2006).
81. McDermott BM. Reducing the use of seclusion: targeting psychopathological and family factors. 17th World Congress of the International Society of Child and Adolescent Psychiatry and Allied Professions. Melbourne (September 2006).
80. McDermott BM. Eating disorders and adolescents: over-control versus negotiating developmental tasks. 17th World Congress of the International Society of Child and Adolescent Psychiatry and Allied Professions. Melbourne (September 2006).
79. McDermott BM. Disasters, child and family mental health and Cyclone Larry. 17th World Congress of the International Society of Child and Adolescent Psychiatry and Allied Professions. Melbourne (September 2006).

78. McDermott BM., Genetics and Mental Health (invited presentation). Connecting Minds Conference. Brisbane (August 2006).
77. McDermott BM., Children as witnesses: Considerations about memory, interviewing and the at risk population. Annual Conference of Queensland Magistrates. Brisbane. (June 2006)
76. McDermott BM, Invited lecture, PTSD in children: faith, political imperative or useful clinical syndrome. Royal Australian College Physicians Annual Conference, Cairns. (May 2006)
75. McDermott BM, Eatings disorders breakfast. Royal Australian College Physicians Annual Conference, Cairns. (May 2006)
74. McDermott BM, Multisystemic therapy. Royal Australian College Physicians Annual Conference, Cairns. (May 2006)
73. Menahem S & McDermott BM, Communication. Royal Australian College Physicians Annual Conference, Cairns. (May 2006)
72. McDermott BM, Psychological aspects of disasters. Queensland Disaster management Conference, Brisbane (May 2006)
71. McDermott BM., Keynote Address: How CYMHS practitioners think & act: from nosology to evidence-based practice. Blackboards and Bandaids: The Annual Conference of the Mater Children's Hospital Special School. (Apr. 2006)
70. McDermott BM. Outcome of child trauma & abuse on later functioning and the Queensland therapeutic response. Mandatory Reporting: Annual Conference of Queensland Paediatric and Community Nurses, Brisbane, QLD (Oct. 2005)
69. McDermott BM. Eating Disorders and the link to mental health. Mind Matters Conference, Brisbane, QLD (Oct 2005).
68. McDermott BM. Multi-systemic therapy for adolescents in foster-care with complex PTSD: utility of an evidence-based 24/7 model. ASTSS Annual Conference, Perth, WA (Sept. 2005).
67. McDermott BM, Mamun AA, Najman JM, Williams GM, O'Callaghan MJ, Bor W. 5-Year old children perceived by parents as irregular eaters: physical and psychosocial predictors from a birth cohort study. World Psychiatric Association Section on Epidemiology and public Health, Brisbane, QLD (July 2005)
66. McDermott BM, Rowland M., & Fedley H. Children, PTSD and Foster-care. 11th Annual Mater Child & Youth Mental Health Conference, Brisbane, QLD. (June, 2005)
65. McDermott BM, & Bor W. MST for abused children, matching treatment intensity to complexity of need. 11th Annual Mater Child and Youth Mental Health Conference, Brisbane, QLD. (June, 2005)
64. McDermott BM, Maddon S, Clarke S. Symposium: Nasogastric feeding and adolescent Anorexia nervosa: "the whys and wherefores". RANZCP Annual Congress, Sydney NSW. (May, 2005).
63. McDermott BM & Menzie K. Middle School and Mental health: holistic partnerships to promote adolescent development. Annual Middle School Association Conference, Broadbeach, QLD. (May, 2005).
62. McDermott BM. Responding to changing patient needs: multi-domain interventions across child and family focused agencies and sectors. Queensland Child Health Forum, Brisbane, QLD. (April 2005)
61. McDermott BM. Attention Deficit Hyperactivity Disorder: required knowledge to promote optimal care. Queensland SUPS Conference, Caloundra, QLD (April 2005).
60. McDermott BM. Emotional trauma in foster-children: identifying problems and pragmatic interventions. Queensland Foster-care Conference, Caloundra, (March 2005).
59. McDermott B M. Changing times, Changing Clients: are child and adolescent mental health interventions effective? Invited address: 5th Annual Grampians Mental health Conference, Ballart, Vic. (Feb 2005)
58. McDermott BM. What are the usual mental health problems of refugee children and how to best detect them. (October 2004). National Refugee Health Care Conference, Brisbane.

57. McDermott BM. Multisystemic Therapy for children with intellectual disability and severe challenging behaviour. National Disabilities Conference, Brisbane. (Oct, 2004).
56. McDermott BM. Management of ADHD: lessons from the MTA Study and consideration of new medications. Paed Society of QLD Annual Meeting, Couran Cove. (Oct 2004)
55. Low, E., O'Sullivan, J., McDermott, Dories, V., & Spears T. Kidzclub Brisbane Symposium: A sustainable early intervention response by Mater CYMHS where a parent or relative is living with a mental illness. (September 2004) 14th Annual TheMHS/5th AICAFMHA Conference, Gold Coast, QLD.
54. McDermott, BM, Lee E, Judd, M. & Vernberg E. (September 2004). Post-Disaster Intervention symposium. 14th Annual TheMHS/5th AICAFMHA Conference, GC, QLD.
53. McDermott, BM. (September 2004) Keynote address. Hope at the clinical coalface: Is intersectoral collaboration enough or do we need new child and adolescent service provision models? 14th Annual TheMHS/5th AICAFMHA Conference, Gold Coast, QLD.
52. McDermott, BM. (August 2004). Children and natural disasters: a selective preventive program utilising population-based screening. World Congress of the International Association for Child Psychiatry and Allied Health, Berlin
51. McDermott, BM. (May 2004). Children as witnesses: Considerations about memory and interviewing. National Judicial College of Australia annual meeting. Gold Coast, QLD.
50. Carwright M, McDermott BM (April 2004)Pitfalls and practicalities of developing a mental health website: www.kidsinmind.org.au Internet, Media and Mental health Conference, Brisbane, QLD.
49. Carwright M, McDermott BM (April 2004) Youth and parent attitudes towards the development of a child and youth mental health website: www.kidsinmind.org.au Internet, Media and Mental health Conference, Brisbane, QLD.
48. McDermott BM.(Nov 2003) Closing address: Concluding thoughts on Anorexia nervosa in Teenagers. 2Nd Cambridge Conference on Teenage Anorexia Nervosa., Cambridge, UK.
47. McDermott BM. Invited speaker: Society, Systems and Trauma: Do our public processes exacerbate emotional trauma in childhood? (Sept 2003) Trauma and Survival. 23rd Annual Conference Australian and New Zealand Association of Psychiatry, Psychology and Law. Fremantle, WA.
46. McDermott BN, Kohleis P, Daubiny M. (June 2003) Project Management Workshop. Partnerships in Recovery. Queensland Mental health Showcase Conference. Brisbane, QLD.
45. McDermott BM, Harris C, Harrigan K. (Apr 2003) Mainstream and Oddball Solutions to challenging child and adolescent eating disorders behaviours. London International Eating Disorders Conference, London UK.
44. McDermott B, Bor W . (2003) "Multisystemic Therapy". Youth Justice Conference. Making the Youth Justice System Work Better. 22 Feb . Brisbane .Australia.
43. McDermott BM. (Nov 2002). Keynote address, Treating Children with eating disorders in Western Australia. Asia Pacific Eating Disorders Congress, Melbourne.
42. McDermott BM. (Nov 2002). Eating disorder comorbidities in children: depression, OCD, personality disorders and trauma. Asia Pacific Eating Disorders Congress, Melbourne.
41. McDermott BM. (Oct 2002) Mater Child protection lecture series: Adolescence. aggro or the current effects of early child trauma. Mater Children's Hospital.
40. McDermott BM. (Oct 2002). Anorexia nervosa in Children. Paediatric Society of Queensland. Annual Paediatric Weekend, Noosa, Oct 2002
39. McDermott BM. (Oct 2002). Severe Disruptive behaviour disorders: A child psychiatrist's perspective. Paediatric Society of Queensland, Annual Paediatric Weekend, Noosa
38. McDermott BM. (Sep. 2002) Mater Child protection lecture series: Focusing on the mind in child protection. Mater Children's Hospital.

37. McDermott BM, McCormack J Chair: Tim Brewerton, Charleston). Children trauma: findings from a pediatric eating disorders team. American Academy of Child and Adolescent Psychiatry 49th Annual Conference, San Franscico.
36. McDermott BM. (Aug 2002) Mater Child protection lecture series: Infants, bonding and bathwater: parent-infant trauma and protection issues. Mater Children's Hospital.
35. Nicholls D, McDermott BM 'From collaboration to innovation: Catalysts and roadblocks in bringing multisystemic therapy to Western Australia' Third International Conference on Child & Adolescent Mental Health, 11-15 June 2002.
34. McDermott BM, McCormack J, (2001, October) American Academy of Child and Adolescent psychiatry Annual Conference, Honolulu, Hawaii. Child with Eating disorders and emotional trauma: Implications for psychological and physical care.
33. McDermott, BM. (October 2001). Recent Australian research on Anorexia nervosa in children and adolescents. Pacific Rim Conference: Eating Disorders Symposium. Melbourne.
32. McDermott, BM. (October 2001). Recent Australian research on Anorexia nervosa in children and adolescents. Pacific Rim Conference: Eating Disorders Symposium. Melbourne.
31. McCormack J, McDermott BM (2001, April) London International eating Disorders Conference, London UK. Child and Adolescent Eating Disorders and Trauma
30. Gibbon P, McDermott BM (2001, March) Australian Infant Child, Adolescent and Family Mental Health Conference, Brisbane. Consumer & Client Measurement Systems in the New Millennium: Fact, Fiction, Utility and Implementation
29. Potts J, Turner J, Fleming C, Gibbon P, McDermott BM (2001, March) Australian Infant Child, Adolescent and Family Mental Health Conference, Brisbane. A Client and staff satisfaction survey of an Eating Disorders Team.
28. McDermott BM, Turner J, Forbes F. (June 2000) 13th Annual Meeting, the RANZCP Faculty of Child & Adolescent Psychiatry, Auckland NZ. Physical Complications & Medical Emergencies in Children & Adolescents with Eating disorders
27. McDermott BM (2000, Jan) 2nd Getter Better Conference, Sydney Puberty, growth, bone formation and bone denisty in adolescent anorexia nervosa JM Turner, BMC McDermott, GC Byrne, DA Forbes, RL Prince
26. McDermott BM (1999, Oct) The relationship between Parent psychopathology, Child presentation and subsequent treatment setting: Results from a longitudinal case register. R. McKelvey, B. McDermott, L. Davies. 12th Annual Meeting, the RANZCP Faculty of Child & Adolescent Psychiatry, Brisbane
25. McDermott BM (1999, Oct) Indigenous youth in mainstream child and adolescent mental health services. B. McDermott. 12th Annual Meeting, the RANZCP Faculty of Child & Adolescent Psychiatry, Brisbane
24. McDermott BM (1999, Oct) Dissociation, PTSD and Eating Disorders 12th Annual Meeting, the RANZCP Faculty of Child & Adolescent Psychiatry, Brisbane.
23. McDermott BM (1999, Oct) Leader symposium: Focus on Eating disorders psychopathology in Children and Adolescents. Papers with Mary Batik:
    (1) Eating disorders psychopatholgy
    (2) General Psychopathology
    12th Annual Meeting, the RANZCP Faculty of Child & Adolescent Psychiatry, Brisbane.
22. McDermott BM (1999, May) (Invited lecture) "The Sequelae of Childhood Stress" Royal College of Physicians, Annual Meeting.
21. McDermott BM (1999, May) (Invited symposium member) "Models of care for Young People with Eating Disorders. Royal College of Physicians, Annual Meeting.
20. McDermott BM (1998, Nov) (Leader of symposium: "Specifically Children and eating Disorder". Papers:
    (1) Introduction to the PMH Eating Disorders Team
    (2) Integration of research and clinical practice

Eating Disorders Conference. Melbourne,

19. McDermott BM (1998, Oct) Interuterine Growth retardation and toxin exposure: Toddler Temperament as a proxy Measure for Affect regulation. 11th Annual Meeting, the RANZCP Faculty of Child & Adolescent Psychiatry.
18. McDermott BM (1997, Nov) Assessment of Psychiatric dysfunction during adolescence. Psychiatry in primary Care Conference, Joondalup, Perth.
17. McDermott BM (1997, Sept) Diagnostic difficulty in children and adolescents with eating disorders (Brett McDermott, Mary Batik, Cherry Martin, Julie Potts, David Forbes, Justine Turner). 14th World Congress on Psychosomatic Medicine
16. McDermott BM (1997, Sept) Non eating disorder psychopathology in children and adolescents with eating disorders. (Brett McDermott, Mary Batik, Cherry Martin, Julie Potts, David Forbes, Justine Turner.) 14th World Congress on Psychosomatic Medicine.
15. McDermott BM (1997, Sept) Diagnostic Difficulties in eating Disorders in children and adolescents. 10th Annual Meeting, the RANZCP Faculty of Child & Adolescent Psychiatry
14. McDermott BM (1996, Oct) Birth weight and mental health morbidity; the outcome of linked database research in WA Zubrick S, McDermott B, McKelvey B, Silburn S Princess Margaret Hospital Research & Advances Seminar.
13. McDermott BM (1996, Aug) (Invited symposia member) The Sutherland Bushfire Trauma Project: A randomised controlled treatment trial. The 104th Convention of the American Psychological Association. Toronto, Canada
12. McDermott BM (1996, Sept) An Eating Disorders Team for Adolescents in Western Australia. 9th Annual Meeting, the RANZCP Faculty of Child & Adolescent Psychiatry.
11. McDermott BM (1995, Sept) The Screen and the Black Box; Screening 4000 children for post bushfire emotional distress and their subsequent treatment with a guided workbook. The Australian Guidance and Counselling Association Annual Conference.
10. McDermott BM (1995, Sept) The organisational response after a plane ditching and a protocol of what should happen. The Australian Guidance and Counselling Association Annual Conference.
9. McDermott BM (1995, Sept) What's in the Black Box: An outline of a children's trauma workbook." RANZCP Child and Adolescent Faculty Annual Conference.
8. McDermott BM (1995, sept) Out of the Fire. Adolescent Group Therapy after a Natural Disaster. RANZCP Child and Adolescent Faculty Annual Conference
7. McDermott BM (1995, Mar) 4,000 Sutherland Children and other erect bipeds. The case for the human consequences of bushfires. Annual Linnean Society and ANZAAS Conference "Living in a fire prone environment" Sydney.
6. McDermott BM (1995, Feb) A Guided workbook for children traumatised by the 1994 NSW bushfire disaster. Storm V, McDermott B Inaugural National Conference on Child and Adolescent Mental Health. Adelaide.
5. McDermott BM (1994, Nov) The Child Psychiatrist in Children's Court Proceedings." College of Law, Continuing educational conferences. Repeated by request, April 1995
4. McDermott BM (1994, Oct) "The response of children following the 1994 NSW Bushfire Disaster: The Sutherland Bushfire Trauma Project." Southern Sydney Mental Health Conference "Innovation and Evaluation".
3. McDermott BM (1994, Oct) The Sutherland Bushfire Trauma Project: Methodology and Preliminary findings." Royal Australian and New Zealand College of Psychiatrists, Child and Adolescent Faculty annual conference.
2. McDermott BM (1993, Sept) Parenting Capacity Assessment. College of Law Continuing educational conferences.
1. McDermott BM (1993, Apr) The Effect of Parental Alcohol abuse upon Adolescent Offspring: A Review. Annual conference of the Australian Adolescent Psychiatry Society. Sydney

Publications

Referred Journals.

82. King S., Kildea S., Austin MP., Brunet A., Cobham VE., Dawson PA., Harris M., Hurrion EM., Laplante DP., McDermott BM., et al., QF2011: a protocol to study the effects of the Queensland flood on pregnant women, their pregnancies and their children's early development. BMC pregnancy 15(1): 109, 2015.
81. Akosile W, **McDermott B**. Use of Urine drug screen in Psychiatry emergency. Australasian Psychiatry, Feb 12, 2015, DOI:10.1177/1039856214568213.
80. March S, Kenardy JA, Cobham VE, Nixon RDV, **McDermott B**, DE Young A. Justin A. Feasibility of a Screening Program for At-Risk Children Following Accidental Injury. Journal of Traumatic Stress, 28(1), 34-40, 2015.
79. D'Emden H, Harris M, **McDermott BM**, Gibbon K. Choosing a screening tool to assess disordered eating in adolescents with diabetes Journal of Diabetes and Its Complications. Journal of Diabetes and Its Complications, 29(1), pp2-4, 2014.
78. Poulsen KM, **McDermott BM**, Wallis J, Cobham VE. School-based psychological screening in the aftermath of a disaster- are parents satisfied and do their children access treatment? Journal of Traumatic Stress, 28(1), 69-72, 2015.
77. Poulsen KM, Pachana N, **McDermott BM**. Health professional's detection of depression and anxiety in their patients with diabetes: The influence of the patient, illness and psychological factors. Journal of Health Psychology, http://dx.doi.org/10.1177/135, 2014.
76. **McDermott BM**, Cobham VE. A Stepped Care Model of Post-disaster Child and Adolescent Mental Health Service Provision. European Journal of Psychotraumatology. 5, 24294, http://dx.doi.org/10.3402/ejpt.v5.24294, 2014.
75. Hong SB, Youssef GJ, Song SH, Choi NH, Ryu J, **McDermott BM**, Cobham VEC, Park S, Kim JW, Shin MS, Yoo HJ, Cho SC, Kim BN. Different clinical courses of children exposed to a single incident of psychological trauma: a 30-month prospective follow-up study. DOI: 10.1111/jcpp.12241, 2014.
74. **McDermott BM**. Disasters, children and families: have we arrived at a comprehensive model of emotional health care? Australian Journal of Emergency Management 29(1) 2014.
73. Park S, Kim B, Choi N, Ryu J, **McDermott BM**, Cobham V, Song S, Kim J, Shin M, Yoo H, Cho S. The effect of persistent posttraumatic stress disorder symptoms on executive functions in preadolescent children witnessing a single incident of death. Anxiety Stress Coping 27(3):241-252, 2014.
72. Scheeringa M, Cobham VE, **McDermott BM**. Policy and Administrative Issues for Large-scale Interventions Following Disasters. Journal of Child and Adolescent Psychopharmacology, 2014, 24(1): 39-46.
71. Cobham VE, **McDermott BM.** Altered Parenting and Child Posttraumatic Stress Symptoms in the Aftermath of a Natural Disaster. Journal of Child and Adolescent Psychopharmacology 2014, 24(1): 18-23.
70. **McDermott BM**, Cobham VE, Berry H, Kim B. Correlates of persisting posttraumatic symptoms in children and adolescents 18 months after a cyclone disaster. Australian and New Zealand Journal of Psychiatry 2014, 48(1): 80-86.
69. McDermott BM. Contemporary issues in child and adolescent mental health in Australia. Dolentium hominum: revista del Pontificio Consejo para la Pastoral de la Salud, 83:165-167, 2013.
68. Bor W, Stallman H, Collerson E, Boyle C, Svenson C, **McDermott BM**, Lee E. Therapy implications of child abuse in multi-risk families. Australasian Psychiatry 2013 21(4): 389-392.
67. Clemens S, Berry H, **McDermott BM**, Harper C. Summer of sorrow: Trauma exposure and impacts using a brief screening instrument. Medical Journal of Australian 2013, 199(8): 552-555.

66. Cobham VE., **McDermott BM.**, Nixon R., Kenardy J. Involving parents in indicated early intervention for childhood PTSD following accidental injury: Two case reports. Clinical Child and Family Psychology Review 2012, 15(4):345-363.
65. Richardson M, Cobham VE, **McDermott BM**, Murray J. Youth Mental Illness and the Family: Parents' Loss and Grief. Journal of Child and Family Studies
64. D'emden H, Holden L, **McDermott BM**, Harris M, Gibbons, Liu, Gledhill, Cotterill. Concurrent validity of self-report measures of eating disorders in adolescents with type 1 diabetes. Acta Paediatrica, 2012, 101(9): 973-978.
63. **McDermott BM**, Berry H, Cobham VE. Family Functioning in the Aftermath of a Cyclone Disaster. BMC Psychiatry 2012, 12(1):55.
62. **McDermott BM**. Editorial: Patient aggression: a serious issue requiring a dedicated organisational response. Medical Journal of Australia. 2012, 20 Feb, 196(3).
61. D'Emden H, Holden L, **McDermott BM,** Harris M, Gibbons, Liu, Gledhill, Cotterill Disturbed eating behaviours and thoughts in Australian adolescents with type 1 diabetes Journal of Paediatrics and Child Health, 2013, 49(4), 17-23.
60. Song SH., Kim B., Choi NH, Ryu J., **McDermott BM.,** Cobham VE., Park S., Kim JW., Hong SB., Shin MS., Yoo HJ, Cho SC. A 30-Month Prospective Follow-Up Study of Psychological Symptoms, Psychiatric Diagnoses, and Their Effects on Quality of Life In Children Witnessing a Single Incident of Death at School. Journal of Clinical Psychiatry 2012, 73(5):e594-600.
59. Park C., **McDermott BM**, Loy J, Dean P. Patterns of adolescents admission to a general adult inpatient psychiatric hospital and implications for service provision. Australasian Psychiatry 2011, 19(4): 345-349.
58. **McDermott BM**, Berry H, Cobham VE. Social connectedness: A potential aetiological factor in the development of child post-traumatic stress disorder. Australian and New Zealand Journal of Psychiatry, 2012, 46:109-117.
57. Colleston, Stallman H, Bor W, Boyle, Swenson C, **McDermott BM**. New Directions in Treatment of Child Physical Abuse and Neglect in Australia: MST-CAN a case study. Advances in Mental Health 2010, 9:148-161.
56. Kenardy J, Cobham VE, Nixon RD, **McDermott BM**, March S. Protocol for a randomised controlled trial of risk screening and early intervention comparing child- and family-focused cognitive behaviour therapy for PTSD in children following an accidental injury. BMC Psychiatry 2010, 10:92
55. Dean A, Wragg J, Draper J, **McDermott BM**. Prediction of medication adherence in child and youth attending mental health services. Journal of Paediatrics and Child Health. 2011, 47:350-355.
54. Dean A, McBride M, Macdonald EM, Connolly Y, **McDermott BM**. Gender differences in adolescents attending a drug and alcohol withdrawal service. Drug and Alcohol Review 2010, 29(3), 278-285.
53. Richardson M, Cobham VE, Murray J, **McDermott BM**. Parent's grief in the context of child mental illness: a qualitative review. Clinical Child and Family Psychol Review 2011 14(1):28-43.
52. Heusler H, Lawton B, James R, **McDermott BM**, Bowling F. 22 q 11.2 deletion in a child previously identified with a mitochondrial disorder J of Intellectual Disability (in press)
51. Kemp M, Drummond P, **McDermott BM**. A wait list controlled study of Eye Movement Desensitization and Reprocessing (EMDR) for children with Posttraumatic Stress Disorder (PTSD) symptoms from motor vehicle accidents. Clinical Child Psychology & Psychiatry 2010;15(1):5-25
50. Heusler H, **McDermott BM**, Bowling F. PRODH in mental health Disorders and 22q11.2 deletion syndrome J of Intellectual Disability (in press)
49. **McDermott BM**, Cobham VE, Berry H, Stallman H. Vulnerability factors for post-disaster child Post Traumatic Stress Disorder: the case for low family resilience and previous mental illness. Australian and New Zealand Journal of Psychiatry 2010, 44(4):384-389.

48. Cobham VE, Dadds M, Spence S, **McDermott BM**. Parental anxiety in the treatment of childhood anxiety: a different story three years later. Journal of Clinical and Consulting Psychology 2010 May; 39(3):410-20.
47. Stallman H, **McDermott BM**, Beckman M, Adam K. Women who miscarriage: the effectiveness and utility of the K10 in identifying the symptoms of psychological distress. Australian and New Zealand Journal of Obstetrics and Gynaecology 2010; 50:70-76.
46. **McDermott BM**, Mamun A, Najman J. Williams, O'Callaghan M, Bor W. Longitudinal correlates of the persistence of irregular eating from age 5 to 14 years. Acta Paediatrica 2010; 99(1): 68-71.
45. Dean AJ, Gibbon P, **McDermott BM**, Davidson T, Scott J. Exposure to aggression and the impact on staff in a child and adolescent inpatient unit. Archives of Psychiatric Nursing 2010 24(1), 15-26.

44. Cartwright M., **McDermott BM**. Developing a child and youth mental health service website. Counselling, Psychotherapy and Health, 2009 5(1) Special issue, 148-170.
43. Dean A, Scott J., **McDermott BM**. Changing utilisation of PRN sedation in a child and adolescent psychiatric inpatient unit. Australian and New Zealand Journal of Psychiatry 2009 43(4):360-365.
42. Norris, Jones, Van Breda, Charles, Dean A, **McDermott BM**. Determination of Risperidone and 9-Hydroxyrisperidone using HPLC, in plasma of children and adolescents with emotional and behavioural disorders. Biomedical Chromatography 2009; 23(9): 929-934, epub april 7
41. Leong J., Cobham VE., De Groot J., **McDermott BM**. Comparing different modes of delivery: A pilot evaluation of a family-focused, cognitive-behavioural intervention for anxiety-disordered children. European Child & Adolescent Psychiatry 2009 42(6):536-543.
40. **McDermott BM**, Mamun AA, Najman JM, Williams GM, O'Callaghan MJ, Bor W. 5-Year old children perceived by parents as irregular eaters: physical and psychosocial predictors from a birth cohort study. Journal of Developmental and Behavioral Pediatrics, 2008, 29: 197-204.
39. Dean AJ., Duke S., Scott J., Bor W., George M., **McDermott BM**. Predictors of aggressive behaviour during admission to a child and adolescent inpatient unit and impact on clinical outcomes. Australian and New Zealand Journal of Psychiatry, 2008, 42(6): 536-543.
38. Al Mamun A, Cramb S, **McDermott BM**, O'Callaghan M, Najman JM, Williams GM. Adolescents' perceived weight associated with depression in young adulthood: a longitudinal study. Obesity, 2007, 15(12):3097-105.
37. de Groot J, Cobham VE, Leong, **McDermott BM**. Individual versus Group Administered Family-Focused CBT for Childhood Anxiety: A Pilot Randomized Controlled Trial. Australian and New Zealand Journal of Psychiatry, 2007, 41(12): 990
36. Mamun AA, **McDermott BM**, O'Callaghan MJ, Najman JM., Williams GM. Predictors of the maternal perceptions of their offspring weight status - evidence from a birth cohort study. International Journal of Obesity, 2007: 1-7.
35. Dean AJ., **McDermott BM**., Marshall R. PRN sedation – patterns of prescribing and administration in a child and adolescent mental health inpatient service. European Child & Adolescent Psychiatry 2006, 15:277-281.
34. Jennings PJ, Forbes D, **McDermott BM**, Hulse G. Acculturation and Eating Disorders in Asian and Caucasian Australian University Students. Eating Behaviours 2006, 7: 214-219.
33. **McDermott BM**, Forbes D, McCormack J, Gibbon P. Non eating disorders psychopathology in children & adolescents with eating disorders: Implications for malnutrition and symptom severity. Journal of Psychosomatic Research 2006, 60: 257-261.
32. Dean A., Marshall R, **McDermott BM**. Psychotropic medication utilisation in a child and adolescent mental health service. Journal of Child and Adolescent Psychopharmacology 2006, 16: 273-285.

31. Jennings P, Forbes D, **McDermott BM**, Hulse G. Eating Disorders Attitudes and Psychopathology in Caucasian Australian, Asian Australian and Thai University Students. Australian and New Zealand Journal of Psychiatry 2006, 40:143-149.
30. MacDonald E, Mohay H, Sorensen D, Alcorn N, **McDermott BM**, Lee E. Current delivery of infant mental health services: Are infant mental health needs being met? Australasian Psychiatry 2006, 13(4), 393-398.
29. **McDermott BM**, Jaffa T. Child and Adolescent eating Disorders: An Update. Current Opinion in Psychiatry 2005, 407-410.
28. **McDermott BM**, Lee E. Comment on Sourander: Mental health service use in 18 year old adolescent boys. Evidence-Based Mental Health, 2005, 8:56.
27. Cartwright M, **McDermott BM**, Bor W, Gibbon P. The use of e-mail in a child and adolescent: mental health service: are staff ready? Journal of Telemedicine and Telecare 2005, 11:199-204.
25. Dean AJ, Marshall RT **McDermott BM**. Pharmacological treatments in child and adolescent psychiatry: review and implications. International Journal of Neuropsychopharmacology, 2004; 7 (Suppl 1):S440
26. Jennings PS, Forbes D, **McDermott BM**, Juniper S, Hulse G. Acculturation and Eating Disorders in Asian and Caucasian Australian Adolescent Girls Journal of Psychiatry and Clinical Neurosciences, 2005, 59:56-61.
24. Frydrych AM, Davies GR, **McDermott BM**. Eating disorders and oral health: A review of literature. Australian Dental Journal, 2005, 50:6-15.
    Reprinted "Esstorungen and orale Gesundheit" in Ästhetische Zahnmedizin 2006
    Reprinted in Hygiene Today 2006
23. **McDermott BM**, Lee E, Judd M, Gibbon P. Post Traumatic Stress Disorder and General Psychopathology in Children and Adolescents Following a Wildfire Disaster. Canadian Journal of Psychiatry 2005, 137-143.
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21. Dean AJ, Marshall RT, **McDermott BM**. Pharmacological treatments in child and adolescent psychiatry: review and implications. International Journal of Neuropsychopharmacology, 2004; 7 (Suppl 1):S440
20. Beumont P, Hay P, Beumont D, Birmingham L, Derham H, Jordan A, Kohn M, **McDermott BM**, Marks P, Mitchell J, Paxton S, Surgenor L, Thornton C, Wakefield A, Weigall S; & Royal Australian And New Zealand College Of Psychiatrists Clinical Practice Guidelines Team For Anorexia Nervosa. Australian and New Zealand clinical practice guidelines for the treatment of anorexia nervosa. Australian & New Zealand Journal of Psychiatry. 2004 Sep;38(9):659-70
19. **McDermott BM**. Child and youth emotional trauma: an explanatory model of adverse outcomes. Psychiatry, Psychology and Law 2004, 11: 269-279.
18. Lee E, English A, Dorries V, Beech M, **McDermott BM**. Responding to complex serious youth mental health: The role of an Interagency Forum. Australasian Psychiatry 2004, 12:264-267.
17. **McDermott BM**, Palmer LJ. Post-disaster emotional distress, Depression and Event-related variables: findings across Child and Adolescent Developmental stages. Australian and New Zealand Journal of Psychiatry 2002, 36: 754-761.
16. Nicholls D, **McDermott BM**. Collaboration to Innovation: Development of Child and Adolescent Intensive treatment teams. Australasia Psychiatry 2002, 10: 139-143.
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(submitted) d'Emden, McDermott, Dover, Gibbons, O'Moore-Sullivan. The case for multidisciplinary input: psychosocial screening for young adults attending a multidisciplinary diabetes clinic.

(submitted) Akosile & McDermott. Chlamydia infection in youth who use drugs and alcohol: a missed opportunity for early intervention.

(submitted) Sohil, McDermott, Bor et al., Pharmacotherapy of Conduct Disorders in children and Adolescents: Systematic Review and recommendations.

(submitted) Coombe, Mackenzie, Munro, Hazell, Perkins, McDermott, Prasuna & Reddy. Teacher-mediated interventions in response to disaster: a review.

(submitted) Quek, White, Bor, McDermott, Lee, Tilse, Rushton, Christie, Connor. The risk and

resilience factors for injecting drug use in adolescents attending an alcohol and drug residential service.

(submitted) Bowling F., Heussler H., O'Brien G., Hyde R., Scott A., McDermott B. Lactic acidemia in 22q11.2: possible mitochondrial involvement.

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3. **McDermott BM.** Book review: From Neurons to Neighborhoods. Journal of the Royal Australian and New Zealand College of Psychiatrists 2001.
2. **McDermott BM.** Spring in Washington: Drs Carter and McDermott at the joint AACAP – RANZCP 2001 conference scientific advisory meeting. Bulletin of the Faculty of Child and Adolescent Psychiatry, September 2001.
1. **McDermott BM.** Psychiatry Training in the UK at junior Doctor level ; a trainee's experience. RANZCP News & Notes, May 1991

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- Stubbs Child and Family Mental Health Service: Future Directions in Service Delivery. McDermott BM, Wildsmith S. T.R.E.E. Oct 2000.
- Evaluation of the Youth Peoples Early Intervention Project. McDermott BM, Martin J. Kids in Mind Consulting, June 2003
- Member of Review Panel; Barrett Adolescent Centre, Walston Park, Queensland.
- Member KPMG review of NW Mental Health Melbourne, Victoria.
- Review of Eating Disorders Services, Women and Children's Hospital Adelaide, South Australia.
- Review of professional capacity for Waikato District Health Board, New Zealand.
- Review of Central Region (New Zealand) Eating Disorders Service.

Successful Grant Applications, Tenders and Project Management

1994	Funding Body; The Joint State-Commonwealth Disaster Relief Fund. $90,000-00 for the Sutherland Bushfire Trauma Project.
1996	Medicare incentive funding. $160,000-00 to establish an eating disorders team for adolescents and children in Western Australia (principals: B McDermott, D Forbes, K Gullick)
1997	Medicare incentive funding. $160,000-00 for the continuation of the eating disorders team for adolescents and children in Western Australia (principals: B McDermott, D Forbes, K Gullick)
1998	Small bequest research funds (biological research into mental disease): $10,000-00 Project Title: Quantification of genetically adjusted disease-environment relationships in Anorexia Nervosa: A Pilot Study
1998	WA Department of Health Quality Insurance Project: $28,000-00 (principals: R McKelvey, B McDermott, L Roberts)
1999	Core committee member RANZCP Clinical Practice Guidelines for Anorexia Nervosa. Chair of tender Professor Peter Beumont, University of Sydney.
2000/01	Intensive Psychiatric Treatment Teams Author; Denise Nicholls, Project Manager Brett McDermott Lead CAMHS Clinician: $34,000-00
2000/01	Mobile Youth Teams, Author Stephen Edwards, Project Manager Brett McDermott Lead CAMHS Clinician
2003	Evaluation of the Queensland Young People Early Intervention Program. $56,000-

2003	Evaluation of Aggression and Violence at the Barrett Adolescent Centre, Chair of Review Team. $8000-00
2003	Population pharmacokinetics of risperidone in children and adolescents - optimising treatment outcome. Marshall, Dean, McDermott. Bristol-Myers Squibb Clinical Pharmacy Research Grant $8000-00
2003	Evaluation of criteria for ascertainment of students with severe emotional disorders: Australian Independent Schools Association: Queensland $8000-00
2004	McDermott BM, Bor W, and Lee E. Department of Child Safety (QLD): "Multisystemic Therapy for children experiencing physical abuse, a randomised controlled trial", $1,800,000-00 over three years (2004/05/06).
2004	From Local Answers - Department of Family & Community Services, Commonwealth of Australia: "Interagency Infant Mental Health Network: Local answers for integrated care". Alcorn, N., Macdonald, E., & McDermott, B. (2004). $421,066 over 4 years.
2004	From ATODS, Queensland Health, $29,985."Outcome Evaluation of the Adolescent Drug and Alcohol Withdrawal Service [A.D.A.W.S.]". Kerr, M., Macdonald, E., & McDermott, B. (2004a).
2004	From ATODS, Queensland Health: "Parents as motivators for change". Kerr, M., Macdonald, E., & McDermott, B. (2004b). $110,070.
2004	Determining comorbidity in youth services: Prevalence of co-existing mental health and substance use disorders in adolescents receiving treatment in mental health settings and drug and alcohol settings MacDonald, E., Kerr, M., & McDermott, B. (2004). Mater Golden Casket Research Fund, $6,530.
2005	Dean AJ, Norris R, Charles B, McDermott BM. Mater Children's Hospital Golden Casket Funding "Population pharmacokinetics of risperidone in children and adolescents – optimising treatment outcome" Amount received: $13,393.60
2005	MacDonald E, McDermott BM. Patterns of service delivery in child and youth mental health: A 10-year review. Mater Children's Hospital Golden Casket Funding. Amount received: $10,000.00
2005	McDermott BM, MacDonald E, Dean A. Quantification of genetically adjusted disease-environment relationships in velocardiofacial syndrome: a longitudinal study. Amount received: $28, 148-00.
2006	Kurth R, McDermott BM. Creating expected recovery curves to monitor treatment progress for children in outpatient mental health clinics. MCH Golden Casket application, amount received: $41, 074
2008	Beckman M, Stallman H, Adam K & McDermott B. Evaluation Of The Effectiveness And Utility Of Kessler 10 As A Screening Instrument To Identify The Symptoms Of Psychological Distress In Women Who Present With Miscarriage In A Hospital Setting: $16,367.74.
2009	Cobham VE, Kenardy JA , Nixon RDV, McDermott BM. Treating children with PTSD following an accidental injury: A multi-site RCT. NHMRC no 569660 $346,425
2011	McDermott BM (as Chair) State-wide CYMHS Disaster Recovery and Resilience Team (Central Team and Metro Team): approx. $2,200,000
2011	Queensland Flood Pregnancy Study, Lead Prof Suzanne King. Canadian Institutes of Health Research (CIHR; King, Kildea and Austin co-principal investigators; MOP-1150067), startup funding from Mater Research Institute Mater Child Youth Mental Health Service and Mater and Australian Catholic University Midwifery Research Unit.
2012	A systems biology approach to potential genetic change from exposure to the F1-11 seal/reseal program. Lead P4r5of Frank Bowling. Department of Defence. $4,000,000.

2013 McDermott BM and Cobham VE. Tasmanian Child Disaster Response Program Beyondblue and Government of Tasmania, $620,000.

2013 McDermott BM, Bowling F, Waterhouse N. An investigation of the toxicity and mechanisms of cell death following exposure of cell lines to chemicals commonly abused by inhalation. Golden Casket Foundation $30,000.00

2014 McDermott BMN. Poulsen K. The burden of illness among adolescents and young adults with a chronic health condition. Golden Casket Foundation $140,000.00

Total grant and tender funding as of April 2010 $6,224,000-00 (approx)

Grand-Round Presentations, public consultations and other (non conference) presentations

Royal Hobart Hospital, Hobart Tas., 1998
Princess Margaret Hospital, Perth WA, 1999
Sir Charles Gardiner Hospital, Perth WA, 2000
Royal Perth Hospital, Perth, WA, 2000
Royal Brisbane Hospital, Brisbane, QLD. 2001, 2002, 2004
Mater Children's Hospital, Brisbane, QLD. 2002, 2003.
James Fletcher Hospital and Hunter Health Service, Newcastle, NSW. 2003.
Gold Coast Hospital, QLD. 2003.
University of Limerick, Ireland. 2003
Townsville region psychiatrists, 2004.
Adult Forensic Mental Health Service, Brisbane, QLD. 2004
Mater Campus Brisbane, QLD, 2005.
RANZCP Faculty of child psychiatry Grand Rounds, Aug 2005, May 2006.
RANZCP Tasmanian Faculty invited speaker Dec 2005
Joint RANZCP – AAPublic Health invited speaker Sept 2006
Cambridge University – Developmental Psychiatry Grand-Rounds, Nov 2006
RANZCP Faculty of child psychiatry Grand Rounds, May 2006.
Queensland Law Week Hypothetical Panel Member, Brisbane, May 2008.
Beyondblue-NHMRC Depression CPGs National consultation (Hobart, Launceston, Melbourne, Sydney, Coffs Harbour, Brisbane, Townsville, Perth) 2010
RANZCP Faculty of child psychiatry Grand Rounds, March 2011
Lockyer Valley Teachers 2011
Central District CYMHS 2011
Queensland Health MH Leadership 2011
Sunshine Coast Mental Health Network August 2011
Queensland Counselling association AGM Guest speaker Sept 2011
Queensland Clinical Psychology Association Guest Speaker, April 2012
Queensland Child Mental Health Network, Panel presenter, May 2012
Queensland Counselling association AGM Guest speaker Sept 2013
TTHS-CAYAS inservice (x2) April 2015. August 2015.
West Moreton CYMHS – inservice, May 2015
DHAS-Q AGM Guest Speaker, August 2015.

FRANZCP Tasmania Branch, CME Guest Speaker, August 2015

Workshops: 2002 onwards

- Mater Children's Hospital: 2002-2003 Child Protection series
- Mater CYMHS Research at the Coalface
- NZ Eating disorders (Apr 2003) Child and Adolescent Eating Disorders, at Whangrai, Auckland, Rotoroua, Nelson, Dunedin, Christchurch.
- Canberra bushfires (May 2003). Recent Bushfires: Children, Adolescents, their Families risk assessment and Therapy
- Newcastle Eating Disorders (2003)
- University of Limerick, Ireland. (Nov 2003) (1) Assessment and Management of Eating Disorders in children and adolescents., (2) PTSD and Emotional trauma in Children.
- Northern Child and Youth Forensic Team, Townsville. (Mar 2004). Overview of Multisystemic Therapy.
- Assessment and Management of Children with Emotional trauma, Brisbane (May 04). Queensland clinical section, The Australian Psychological Society.
- National College of Justice
  Gold Coast QLD (2005, 2006, 2008); Perth, WA Adelaide, SA (2005)
- Australian Society Traumatic Stress Perth, WA (2005)
- Centacare Cairns (April 2004) Emotional trauma in children and adolescents.
- Cyclone Larry Workshops

(a) Children and adolescents: post traumatic emotional sequelae (Innesfail, guidance officers and counsellors (May, 2006)

(b) Children and adolescents: post traumatic emotional sequelae (Atherton tablelands guidance officers and counsellors (May, 2006)

(c) Training of school screening staff (June 2006)

(d)Training with therapy manual (August 16th and September1st)

- Comprehensive management of child and adolescent Eating disorders. Pre-Congress workshop, International Association for Child and Adolescent Psychiatry and Allied Professionals, Melbourne, Sept. 2006.
- Royal College of Psychiatrist, Meet the Expert Series (Eating Disorders) with Tony Jaffa.Leeds (Nov 2007)
- Managing Challenging Behaviour (for Compass New Zealand or Compass Australia)

  September 2008

  Wellington; Napier; Rotorua; New Plymouth; Hamilton; Auckland (August 2009)

  Hobart; Melbourne (March/April 2011)
- BeyondBlue Early Childhood Experts Workshop. Co-Chair with Prof Bruce Tonge. (Melbourne Sept 2008)
- Victoria Level III Child and Adolescent TF-CBT intervention training (with Vanessa Cobham): Melbourne (2009, 2010); Launceston (2012); Townsville; Penrith (2014)

- Trauma-focused CBT (post diaster workshops)
  Brisbane; Lockyer valley; Townsville (2011); Ipswich; Rockhampton (2012); Hobart; Sydney (2013) Townsville; Penrith (2014)
- Understanding emotional trauma in children (Compass New Zealand)
  Wellington; Dunedin; Christchurch; Nelson (Aug 2011): Napier; Palmerston North New Plymouth ((March 2012)

(Approximately 65 workshops since 2002).

Teaching and University – Related Activities

University of Western Australia:
Coordinator of Child and Adolescent Mental Health curriculum (lectures and placements)
University of Western Australia
Chair Medical Student Entry Interview Development Committee.
University of Queensland:
UQ Medicine Year 1: deliver "Surviving child and youth psychiatry" introductory lecture
UQ Presenter Year 3: child and youth mental health tutorial sessions
UQ Year 3 : Examiner in psychiatry (co-ordinator Dr Jane Turner)

Nov-Dec 2008 Invited Visiting Professor, University of Malaysia, Kuala Lumpa.
Extensive teaching and lecturing in RANZCP psychiatry training scheme.

EXHIBIT 84

Kids in Mind

BARRETT ADOLESCENT CENTRE

CONSULTATION on AGGRESSION and VIOLENCE at the BAC

August 2003

Consult on Aggression & Violence 2003

McDermott
Gullick
Powell
Kyte

TES4005

Additional copies of the report can be obtained from:
Kids in Mind Consulting
Mater Child and Youth Mental Health Service
Raymond Terrace
SOUTH BRISBANE QLD 4101

Disclaimer
The opinions expressed in this report are those of the authors and are not necessarily those of any of the existing Barrett Adolescent Centre workers, CYMHS Team Leaders, or Queensland Health. Information in this report is from a combination of new data obtained from the Barrett Adolescent Centre and interviews with Queensland Health staff. The evaluation team are responsible for the methodology, data collection, analysis and conclusions drawn from this data. We thank the Barrett Adolescent Centre for their cooperation with this process, the many discussions around their endeavours and the data made available. Any similar process is fraught with omissions; events, forms, sheets, and questionnaires. We have attempted to minimise such loss, but note it will occur to some degree with this type of project.

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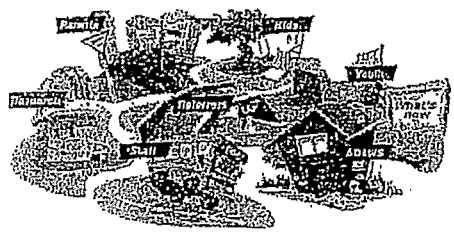

www.kidsinmind.org.au

Acknowledgements

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Mater Child & Adolescent Health Service

Kids in Mind

Mater Child and Youth Mental Health Service

CONTENTS

4

Executive Summary

The Barrett Adolescent Centre (BAC) has been providing medium to long term therapy for Queensland adolescents for 20 years. Of itself, this is a commendable record of continuous service provision to a group considered by many parents and professionals to be extremely challenging. In recent times it is likely the client group of the unit has changed with admission of more individuals with challenging, predominantly externalising behaviour, more individuals with broad internalising and externalising behaviour and more serious self harm. This brief review considered the impact of critical incidents at the BAC from a multi-domain perspective: the current risk on the BAC from the perspective of the BAC clientele, BAC management practices, staff, environment and systemic issues, as well as a review of BAC responses to critical incidents.

The review found that there is a significant burden of critical incidents at the BAC across issues dealing with aggression and assault, self harm and being away from the unit without permission. Less prominent incidents included property damage and injuries. The major critical incidents co-occurred in vulnerable individuals. This means that if a patient was involved in an assault they were more likely to be involved in both future assaults as well as self harm incidents. Additionally, it appears that girls were likely to be involved in aggressive behaviour at rates higher than the societal norms.

The review team identified areas for the BAC management to consider in a broad response to critical incidents. Recommendations include consideration of the group most likely to benefit from care at the BAC, more structured and clear admission criteria, greater inclusion of risk management assessment in the clinical care pathway, more scrutiny of the usefulness and application of the risk assessment tool and consideration of staff and environment issues. Changes should include consideration of the current relationship with other service units at The Park as well as BAC responses.

To invest in significant program revision, and policy and procedural change requires enthusiasm and motivation. The review team feel that this is impeded by the current uncertainty about the future of the BAC. In a broad sense, securing certainty about the BAC is an outcome that has a clear implication for improved risk management at the BAC.

RECOMMENDATIONS

The recommendations section is structured as:

(1) General recommendations relating to the BAC target group, clinical care pathway and interventions,

(2) Recommendations pertaining to specific risk management issues,

(3) Over arching recommendations that relate to the continuation of funding of the BAC and the motivation and enthusiasm of staff to implement change. The overarching recommendations should be seen as fundamental to, and equally important to 1 & 2.

(1) General recommendations relating to the BAC target group, clinical care pathway and interventions:

1. In the absence of other forms of outcome measurement, a qualitative and experiential review of the usual clientele admitted to the BAC should be undertaken with a specific objective of considering the ~~most suitable target group for the BAC~~.

2. The "have a go" ethos of admitting individuals to the BAC should be stopped and all potential referrals should be considered against strict and mutually accepted criteria.

3. BAC admission criteria should be more clearly operationalised.

4. Risk assessment should be specifically included in the BAC referral form and additional referral information obtained.

5. An inclusion of risk assessment should be made in the determination of whether an individual is accepted by the BAC. Issues around risk management should be included in information promulgated by the BAC about its program.

6. It should be more clearly annunciated to referrers, patients, families and staff whether there is a 2 week assessment period at the beginning of a BAC admission.

7. Analysis of risk assessment should be included in the determination of the effectiveness of the two week trial and whether the patient should remain at the BAC.

8. BAC staff should consider programming in the after school and early evening period as a risk management strategy.

9. The BAC should consider smaller groups size for therapeutic and recreational groups.

10. The BAC should consider a restructure of its program into smaller functional units including the possibility of having 2 home groups rather than a larger single cohort of adolescents on the unit.

(2) Recommendations pertaining to specific risk management issues

11. The BAC management should review the use of the risk assessment tool in the adolescence population: whether the tool is valid, the clinical use of the assessment tool findings in the BAC and the evaluation of the assessment tool over time.

12. There are policies related to risk management that have not been reviewed at the BAC for many years, the BAC management should review such policies.

13. The BAC management should instigate a critical and formal process of risk analysis following incidents where there was actual or potential significant morbidity or potential mortality.

14. The appropriateness of the A1-A7 system should be reviewed in light of contemporary changes in patient presentations at the BAC.

what's this?

8

15. Consideration of the appropriateness of the category red system in view of the new clientele should be reviewed.

16. All BAC staff should have regular inservice training about risk management.

17. Orientation of new staff should include risk management.

18. There should be clarity about the status of the unit in relation to it being an open (and therefore unlocked) unit; such changes to the status of the unit will have legal implications.

(3) Over arching recommendations that relate to the continuation of funding of the BAC and the motivation and enthusiasm of staff to implement change.

It is the opinion of the review team that a significant amount of money is required to be spent on the BAC environment. Further significant emotional investment in changes of policies and practices is required. Given this burden:

19. Senior BAC and Park management should, as a matter of some urgency; advance with Queensland Health the issue of the continued funding and support of the BAC. Whilst the current work environment of the BAC may be therapeutic to adolescents, the staff milieu is not promoting motivation and enthusiasm to review risk management and other procedures at the BAC.

20. With contemporary understanding of the burden of youth homelessness and school exclusion, the BAC provides an excellent opportunity for youth with mental health and challenging behaviour to live in a safe environment and receive high quality educational and psychological input. For these reasons the review team recommend advocacy for the BAC.

21. However the review team recommend further work in the delineation of the BAC in the continuum of care of adolescent mental health services in SE Queensland. Tasks include the current evidence base for adolescent inpatient care and whether the current broad admission brief should not be changed to focus on a more limited diagnostic range or alternatively to focus on particular challenging behaviours such as individuals with internalising conditions

and mild externalising behaviour or individuals with severe and ongoing suicidality and self harm.

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1. BACKGROUND

1.1 HISTORICAL CONTEXT OF THE BAC

The BAC was established in 1983. The unit was established with an overarching treatment ethos of milieu therapy and this has been a unifying treatment theme over the last 20 years. The last 5 years have seen a significant expansion in the number of inpatient child & youth mental health beds across south east Queensland. This includes the opening of inpatient units at The Royal Brisbane Hospital, Mater Children's Hospital, Logan, Gold Coast and Toowoomba, as well as a significant expansion in the community CYMHS clinics. It should be noted that for the new inpatient beds were conceptualised as acute beds, aimed at providing brief admissions around clarification of an individual's mental health diagnosis, the initiation of treatment and movement of the patient back to the community with follow-up by a CYMHS clinic or private practitioner. No other inpatient unit for adolescents has been established with a long stay brief. The Day Program of Mater CYMHS is potentially long stay (1 to 2 school terms) and includes the ability to attend the Mater Children's Hospital school, but has no residential capacity. ?

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With the increase in inpatient beds in south east Queensland the commitment to fund the Barrett Adolescent Centre has become less certain, and indeed at one point it was widely thought the BAC would close. Whilst this clearly did not happen it is true that there is significant ongoing apprehension amongst BAC staff about the continuing funding of the BAC. Further there is considerable discussion amongst staff about how, if it is to continue, the BAC will function within the current South East Queensland continuum of adolescent mental health care.

1.2 Terms of Reference of the current review

- To review the incident profile of the unit over the last four years and to consider the nature and extent of the risk associated with the profile
- To consider the relationship between risks and the current target population, associated diagnostic profile and service model
- To consider the organisational response to the incidents

- To consider the risk management approach in terms of individual risk identification and response efficacy
- To suggest strategies which may reduce the likelihood of further serious incidents.

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2. VIOLENCE AND AGGRESSION: DEFINITIONS, PREVALENCE, DETERMINING FACTORS AND IMPACT ON STAFF.

Definitions of Aggression: Multiple definitions for aggression have been suggested. Definitions include 'any threatening verbal or physical behaviour directed toward self or others,' (Owen, 1998), "an act whose goal-response is injury to another organism," (Dollar et al., 1989). Many authors have subdivided aggression type, including O'Leary-Kelly and colleagues. In a review of the literature, they found that terms such as hostile aggression, violent aggression, affective aggression, angry aggression, bullying, emotional and instrumental aggression, impulsive and reactive aggression, environmental aggression and enraged aggression or enraged violence dominate the literature (1996); the schema of Rippon states, "aggression can be physical or verbal, active or passive, and can be focused on the victim(s) directly or indirectly" (2000). Several authors have noted instrumental aggressive "does not have strong emotional basis and yet can be extremely violent" (Buss, 1961).

Definitions of Violence: Steinmetz (1986) defined violence as, 'an act carried out with the intention, or perceived as having the intention, of physically hurting another person". Steinmetz included a broad range of incidents from minor common assault to premeditated murder as violent acts. Others including Strasburg (1978) included legal concepts in a definition of violent behaviour, 'illegal use or threat of force against a person'. Strasborg included a range of crimes such as assault, robbery, sexual impositions and sexual assault, arson, threatening behaviour, kidnapping, burglary and murder. Rippon stated that "by definition, violence is synonymous with aggression", then went on to suggest a distinction by severity, "however, violence is reserved for those acts of aggression that are particularly intense, and are more heinous, infamous irreprehensible" (2000). The Department of Employment, Training and Industrial Relations, in its April 1999 brochure on 'Violence at Work' defined violence as 'the unwarranted or unjust use of force or power'.

In summary, the literature in this area is hampered by significant differences in the definitions of the core constructs. One useful theme is that violence is the act or the behaviour that often follows aggression, whereas aggression is the intent to commit a violent act or forms of behaviour. Examples of these include verbal abuse and physical intimidation that fall short of a physical act against another person.

The following discussion briefly considers violence and aggression prevalence, determining factors and impact on staff. The current literature in this area is predominantly derived from studies of adult mental health units. Generalising these findings to child and adolescent units requires caution.

Prevalence: Many studies have reported the prevalence of mental health staff being involved in acts of violence and aggression. The US Department of Justice statistics report (1992-1996) that 79.5 out of 1000 mental health workers have experienced nonfatal workplace violence. The British Columbia workers compensation board received 600 claims from nurses and health care workers for time lost from acts of violence or force, 10 times more than that from any other occupation. More than half of these are injuries suffered by nurses, care aides and other health care workers while working in long term care facilities, psychiatric hospitals, group homes and acute care hospitals. (Duxbury 2002).

Verbal aggression and threats of violence appear more prevalent than acts of violence, although research reports vary widely. Duxbury (2002) reported that incidents of patient aggression (an expression of hostility or intent to do harm) accounted for 70% of incidents (n= 157) and involved verbal abuse and verbal threats in total, whilst violence accounted for only 13.5% (n=30) of the incidents recorded. However, Nolan et al (1999) reported that 18% of staff had been threatened verbally and that 50% of psychiatric staff have been physically assaulted at some time during their careers. Similarly, Ruben et al., (1980) and Madden et al., (1976) concluded that approximately 50% of psychiatrists had been assaulted during the course of their work and in a multinational survey Poster (1996) found that 75% of mental health nurses had been physically assaulted at least once in their careers. The Poster report is in accordance with Whittington and Wykes (1994) who found 65% of nurses in their study had been violently assaulted by patients and led to their conclusion that there is overwhelming evidence that nurse are more likely to be physically

assaulted, threatened or verbally abused that any other health professional group. (Whittington et al 1996).

Clearly not all patients are violent, indeed, Weiser (1994) estimated that approximately 10% of psychiatric patients are violent towards staff. This includes perpetrating the most serious acts of violence with several documented cases of mental health clinicians being murdered in Australia by current or former patients. There is a poverty of research on aggression and violence by child and adolescent mental health clients, with most studies focusing on adults.

Determining Factors: Studies of adults with mental illness finds a range of illnesses associated with an increase in aggression and violence, including mania (Lion et al, 1981,) schizophrenia (Pearson et al., 1986), borderline personality disorder (Hansen, 1996) antisocial personality disorders and psychotic disorders (Whittington 1997). Other factors include male gender (Duxbury, 2002; Morrison et al,2002), age ranging from 15 to 30 (James et al; Noble and Rogers, 1989; West, 1974), a previous history of violence.(Flannery et al., 1994; Whittington, 1998; Owen et al., 1998 b) and patients who were on a high level of medications (Duxbury, 2002; Lion et al., 1981; Pearson et al., 1986; Finke 2001). Others report substance abuse (Lanza, 1988; Flannery et al 1994; Royal College of Psychiatrists, 1988) as a key indicator for potential for violence.

Length of stay has been reported as being an influential factor with long stay adult patients most likely to be violent (Morrison et al., 2002; Barber, Hundley, Kellogg, 1988). Studies on adolescents concur with these findings (Finke, 2001; Owen et al., 1998). Involuntary status under a mental health act was found to be a factor in patients most likely to be violent. Other precursors to violence and aggression were confusional states, non-compliance with medication (Whittington et al., 1996) and short hospital stays in overcrowded wards (Edwards and Reid).

Staff factors were seen to be important by Duxbury, "Factors including staff gender, experience, training and grade are also believed to have some impact upon the incidence of patient aggression and violence" (2002). Vanderslott found that male nursing staff were more commonly attacked than female staff, possibly because they are frequently involved in containing aggressive outbursts (1998). Hatch and colleagues postulated that, "female staff might also use non-aggressive strategies to de-escalate tension and aggression rather than the traditional male, "police-like"

techniques that could generate a power struggle instead of diffuse anger" (2002). This opinion has not been universally replicated with some studies suggesting that women are at higher risk (Binder, Ednie, Lanza and Wykes). However, in a general a review the consensus appears to be that women in mental health care settings are not at increased risk for patient assault.

A caveat may be the pregnant female staff member. Binder (1991) reviewed this literature and concluded that pregnancy remains a significant mental health work-related issue. The literature repeatedly reports instances of patients experiencing envy, abandonment, rejection maternal transference and aggression toward the therapist, including fantasies of hurting or killing both the therapist and the infant. Overall the literature in this area points to pregnancy as a significant risk factor for women, particularly in violence prone environments such as acute care wards, emergency rooms and forensic settings.

Research supporting the argument that staff grade may be correlated with the incidence of patient aggression or that less senior nursing staff are more commonly the victims of aggression and violence is inconclusive. Hodgkinson and colleagues 1985 found that student nurses were assaulted more often than trained or qualified staff (1985). Vanderslott reported that care assistants who are most at risk (1998). Other studies suggest students are at greater risk. In one study student nurses student nurses making up 19% of staff, but sustaining 24% of assault caused injury (doc 15). In another study physical assaults were higher among student nurses especially those with no training in conflict resolution (Grenade and Macdonald 1995). Nursing seniority may confer protection through experience and competent. Alternatively less senior staff may spend more time with patients and this in turn may make them more vulnerable to acts of violence and aggression. (Whittington and Wykes 1994b; Vanderslott 1998). With psychiatrists age and experience also appear to be linked with risk; younger clinicians with less experience were at a significantly greater risk for patient assault than older more experienced psychiatrists.

When: The literature is varied as to when violent and aggressive incidents occur. Results differ markedly with reports showing time periods for incidents are across the day (Cottrell, 1980; Whittington and Wykes, 1994b; Vanderslott 1998), with fewer incidences at lunch or after midnight. Low levels of staffing, such as when handovers occur (Carmel & Hunter 1993) and when staff are handing out medication and around meal times (Owen et al., 1998; Carmel & Hunter, 1993) are other predictive factors for increases in violence and aggression.

Where: Issues that have been examined include building deficits such as limited space or provisions for privacy, overcrowding, hospital shifts, the timing of assaults, raised temperature and additional poor environmental provisions (Nijman et al 1999). However, Blair and New argue that most studies in this area are inconclusive (1991). Recent guidelines by the royal college of psychiatrists (1998) recommend that hospital environments should be comfortable, safe, private, homely and free from noxious environmental factors as far as possible. Staff most commonly identified factors contributing to the development of patient aggression as problematic interactions and restrictive environments. The latter was deemed to cause over one-quarter of all incidents reported. High-risk areas, include bathrooms and bedrooms, ward corridors and dayrooms.

Why: Human resource issues are a common theme. Reduced numbers of staff, and an overuse of casual staff (Turnbull and Patterson 1999), inexperience, increased workload and low levels of training are probable factors. Management of the milieu has been implicated, mediated by numerous factors: the impact of varying staff, controlling styles, negative interactions, poor or limited communication and interaction with patients, authoritarian management approaches, and punitive management and interventions (Morrison, 2002; Anderson & Roper 1991; Garrison et al., 1990; Goren, Singh & Best, 1993).

The issue of negative staff interactional styles and limited communication skills is a cause for concern, particularly given the evidence of staff lack of awareness about the impact of these deficits. In one research project (staff) when surveyed did not view their interaction with patients to be problematic despite finding that almost one fifth of incidents of the incidents in practice (MSOAS) were reported to be the direct result of staff-patient interaction. Concomitant with poor staff insight may be lack of training in precursors to patient aggression such as self presentation and self awareness (Farrell and Gray 1992) to limited interaction with patients prior to incidents (Whittington and Wykes 1994a, 1994b.)

Impact on staff: There is an ever prevailing theme of a cultural acceptance of violence and aggression in mental health facilities. Most nurses believe that violence and assault are part of the job, and also that workplace violence has a normative effect, meaning that violent acts and aggression become accepted as a normal part of the workplace culture (Erikson & Williams Evans, 2000; Thomas, 1995; Scott, 1999). One reason for denial may be that mental health care

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provider's overestimate their ability to remain objective toward their patients in the face of personally disturbing incidence and deal with their assault at a cognitive rather than emotional level. (Wykes & Whittington 1998)

Workplace violence literature notes that the issues of cost to the organization remains of paramount concern (Wykes & Whittington 1998). Cost is typically conceptualized in terms of the individual worker (physical/physiological and mental/emotional issues) and the organization. At the individual level, physical cost refer to consequences of workplace violence such as disrupted sleep, cardiopulmonary problems, fatigue, hypertension, and susceptibility to illness, while emotional costs encompass issues such as depression, loss of self esteem, family conflict, cynicism, anger and impaired coping. At the organizational level, costs are associated with decreased worker productivity and morale, lost working days, legal liability costs, employee turnover and resources allocated to rehiring and retraining. (Barrett et al., 1997).

Wykes & Whittington (1998) found that of the psychiatric intensive care nurses who had reported being recently assaulted, 25% reported feeling jumpier, overly alert, and bothered by recurrent thoughts about the incident. One third of the assaulted nurses indicated they experienced significant psychological distress and anger following the incident. Assault victims see themselves as weak and often continue to fear the patient after the assault. Threats were reported to be as likely to cause psychological distress and disruption of service delivery in staff as were physical or sexual assaults (Flannery et al., 1995). There is evidence that increasing numbers of nursing and other health professionals are suffering the effects of PTSD (Rippon 2000), anxiety, impaired work performance (Robbins, 1997) and difficulties with sleep as a result of hostility and violence in the workplace (Fisher et al., 1995).

3. INTRODUCTION TO THIS CONSULTATION

The review team consisted of Melissa Kyte, consumer consultant at the Barrett Adolescent Centre, Ms Karen Gullick, Manager of The Hollywood Clinic, Hollywood Private Hospital in Perth, Western Australia and Dr Jacinta Powell from the Mental Health Unit, Queensland Health. Associate Professor McDermott, Director of the Mater Child and Youth Mental Health Service was the Chair of the Review Team. Context expertise in child and adolescent mental health was provided by members Gullick and McDermott. Ms Gullick has many years experience in various roles within child and adolescent mental health, and for 7 years managed an inpatient child and adolescent mental health unit. Dr Powell has extensive experience in reviews of risk management including recent reviews of adult mental health units. Melissa Kyte's consumer experience of child and adolescent mental health services included admission at the Barrett Adolescent Centre.

3.1 Staff and consumers consulted

The review team worked for three days at the BAC, and during this period, consultation time was offered to all staff members. Staff appeared very interested in the review and were open and helpful during the process. They were consulted individually and in small groups and whilst no staff member requested confidentiality per se, the review team consider it more appropriate to indicate the professional background of staff consulted rather than a list of individual staff members.

Table 3.1: Professions of staff consulted.

BAC Medical Director
BAC Nursing Practice Coordinator
Senior nursing practitioner (level 3) ?Nursing Unit Manager
Nursing staff (level 2)
Specific nurses involved in critical incidents
Community Liaison Officer
Adventure therapy coordinator
School teachers
Occupational Therapist
Consumers (specifically consulted by the consumer representative of the review team)
Police liaison officer
Social worker

The consultation included two meetings with the Executive Director and Clinical Director of The Park.

3.2 Access to documentation

Access to policy manuals, orientation information, standard forms and patient records was provided as requested by the review team.

The review team specifically considered the patient medical records of four critical incidents. These incidents were considered by staff to have conferred a high degree of risk to staff and/or patients of the BAC. Such charts were reviewed initially against BAC polices and procedures as given by existing BAC documentation and then against current best practice (as agreed by the review team). A number of charts randomly drawn from current BAC patients were also considered.

3.3 Access to Data

Summary data on critical incidents presented in graphical form was made available to the review team and is included in the appendices of this report.

The review team were interested in the whether the critical incident data was of sufficient quality for more detailed analysis. All critical incident forms completed at the BAC were obtained from 2000 until June 2003, entered and analysed. Details of this analysis are in section 4.1.b.

4. CURRENT STATUS OF RISK ON THE BAC

4.1. Client Profile of the BAC

The review team were informed that the current bed platform of the BAC was 15 beds with an additional 5 outpatient places. Occasionally there are more inpatients and indeed during the week of the consultation, there were 16 patients. A presentation from the Director of the BAC delineated the type of clientele seen at the BAC. Diagnoses of patients attending the BAC are listed below.

Table 4.1: Range of diagnostic groups admitted to the BAC

Psychosis,
Depressive disorders,
Avoidant anxious disorders,
OCD,
Tourette's Syndrome,
Eating disorders
Traumatic stress disorders,
Asperger's Syndrome.

From this presentation it was noted that the BAC accepted a wide range of individuals with a wide range of presentations and would generally give many individuals "a go" to see whether they could use the therapy offered at the BAC. This philosophy was stated by most senior clinicians, and they were clear that the admission criteria were quite open, i.e. from 13 to 17 years of age with a clear psychiatric illness, and suitable to be on an open unit and with evidence of client and family commitment. Individuals with substance abuse, with a diagnosis of only conduct disorder or who had moderate or severe intellectual handicap were excluded from the BAC.

There was a clear perception from all levels of clinical and management staff that the type of clients seen at BAC has changed over recent years. Many clinical staff noted there was a mismatch of recently referred adolescents with the original treatment philosophy at the unit, mainly manifest by an increase in the amount of disturbed behaviour including increased client histories of aggression and social problems. Some clinicians felt there were more patients with co-morbid drug and alcohol problems or adolescents from geographically remote locations, including Darwin. Some clinicians noted that the recent occurrence of finding several patients in possession of weapons was very unusual in the long history of the BAC. Lastly, many staff felt that the unit was under increasing pressure from external stakeholders to accept children whose presentations did not meet the admission criteria for the unit, and who in fact would previously have been excluded because of those presentations. Examples included adolescents on remand from the Brisbane Youth Detention Centre.

4.2 Risk Profile: Review of existing data analysis

The review team were provided with a powerpoint presentation of the incident profile of the BAC from January 2001 to March 2003. This information is found in Appendix 1, Figure A1 The Adolescent Incident Profile 2001-03, in which incidents have been aggregated into aggressive incidents, absent without leave (AWOL), self harm and 'other' incidents. In the 28 months graphically represented, 12 months have incidents from all 4 different categories recorded. Ten months have 3 different types of incidents, 6 months have only 2 types of incidents, no month has only one type of incident. There is no month at the BAC without a recorded incident. The range of incidents over this period is from 26 incidents occurring in June 02 and March 03 to a low of 3 incidents occurring in February 03. There is no significant seasonal variation with all types of incidents evenly spread across the reporting period. The most frequent type of incident by month was aggression and self harm. Both categories were represented in 24 of the 28 month reporting period, followed by 'other' (22 of 28 months) and AWOL (20 of 28 months).

Some analysis is provided in the BAC briefing material. The relationship between assault and aggression and absconding can be found also in Appendix 1 page 2. It is reported that 17 of 19 adolescents who absconded from the unit were also involved in aggression. Reasons for

absconding varied. Some absconding behaviour was driven by suicidal intent, peer pressure and a desire to obtain drugs. Six of 19 individuals used alcohol or substances when they absconded. Some comment is also included on page 3 of the relation to prior aggression stating that the group with the highest incidence of aggression prior to admission were a group who were reported as "violent at home", had perpetrated "physical attacks on parents" or demonstrated "excessive violence towards siblings". However, it was reported that only one of this group was involved in aggression at BAC. Nine of 34 adolescents involved in incidents of aggressive assault had antecedent conduct disturbance. The analysis does not mention the type of statistical test employed or the level of significance of the finding.

4.3 Risk profile: new data analysis

Critical incident reports were available on 93 patients. The mean patient age during the admission was 15.37 years (SD 1.25yrs), ages ranged from 13 to 18 years. There was a non significant over-representation of female patients (52.1% versus 47.9%). The majority of patients involved in critical incidents were Australian born (94.5%), all spoke English in the family home. No patient in this sample identified their ethnicity as Aboriginal or Torres Strait Islander.

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Table 4.1:

total number of incidents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00	42	45.2	45.7	45.7
	2.00	14	15.1	15.2	60.9
	3.00	5	5.4	5.4	66.3
	4.00	5	5.4	5.4	71.7
	5.00	4	4.3	4.3	76.1
	6.00	3	3.2	3.3	79.3
	7.00	2	2.2	2.2	81.5
	8.00	3	3.2	3.3	84.8
	9.00	1	1.1	1.1	85.9
	10.00	2	2.2	2.2	88.0
	11.00	2	2.2	2.2	90.2
	13.00	2	2.2	2.2	92.4
	16.00	2	2.2	2.2	94.6
	18.00	1	1.1	1.1	95.7
	19.00	1	1.1	1.1	96.7
	29.00	1	1.1	1.1	97.8
	37.00	1	1.1	1.1	98.9
	70.00	1	1.1	1.1	100.0
	Total	92	98.9	100.0	
Missing	System	1	1.1		
Total		93	100.0		

An important consideration about this analysis is that the results presented are indicative only. The analysis does not at present meet a research standard, given the need to further review and clean the data. Most variables have between 5-15% of missing data and this could be improved with further work. Further, most analyses were run without the results of one patient, an individual who was a significant statistical outlier. This person was responsible for 70 critical incidents whilst at the BAC, approximately 16 times the average incidents per patient in the CI sample.

Table 4.1 above highlights that out of 463 incidents 45.7 percent of patients accounted for only one incident, 60.9 percent account for 2 incidents. However, there is a substantial minority of patients would are involved in repetitive critical incidents, and indeed 12% of this sample were involved in 10 or more incidents.

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Figure 4.1: Relative frequency of Critical Incident Type

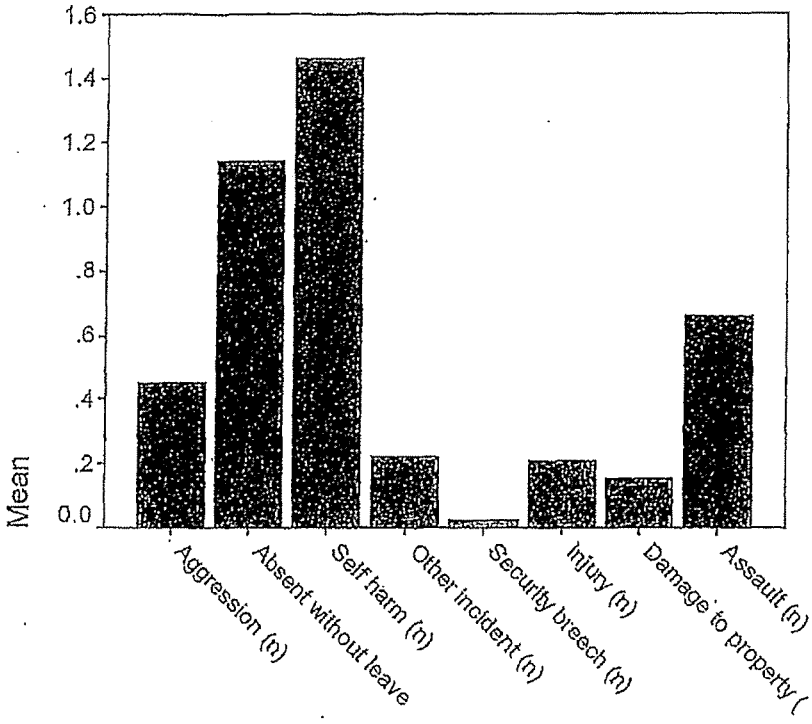

Figure 4.1 above depicts critical incident by incident type.

Self-harm was the most common critical incident occurring at the BAC. During this reporting period there were 134 incidents of self harm occurring in 33.7% of the critical incident patient sample. If self-harm occurred the patient was likely to do so on multiple occasions, given only 10.4% of the self harm group did so on only one occasion. In contrast approaching half of the sample (43.3%) of the self-harm group did so on 10 or more times. Self harm was significantly more likely to be perpetrated by female patients (female mean self harm = 2.703, male = 0.714, T_{70} =-2.232, p = .029). There was no correlation between patient age and number of self harming incidents. Self harm by gender is graphically represented in Figure 4.2.

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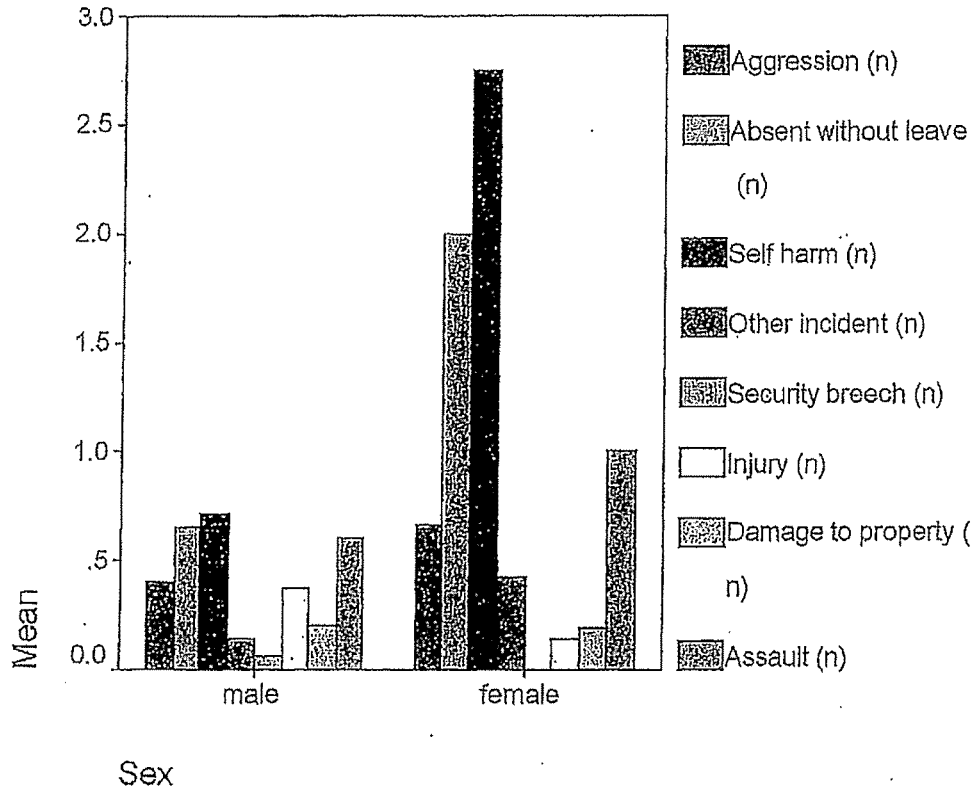
Figure 4.2 Critical Incident category by Gender



An **absent without leave (AWOL)** critical incident was recorded 104 times during the reporting period. 41 individuals were involved in one or more AWOL incidents, 22.2% of the CI sample had at least one AWOL incident. AWOL incidents were less likely to be multiple than self harm incidents: 54% of AWOL patients did so on only one occasion, 83% between 1 and 3 occasions and only 15% on more than 6 occasions. Significantly more female patients were involved in AWOL incidents (mean female AWOL = 2.000, male = 0.657, $T_{69} = -2.470$, $p = 0.016$). There was a trend ($p = .076$) for AWOL incidents to involve older patients.

An incident of **assault** was recorded 50 times during the reporting period. 33 individuals were involved in one or more assault incidents, 25.3% of the CI sample had at least one assault

incident. Similar to the AWOL data, multiple incidents of assault was uncommon, 69% of patients were involved in one assault incident rapidly declining to 12% involved in two assaults and 18% in more than 2 assaults. The data suggests some tolerance to an act of assault: 2 patients were involved in 4 assaults, 3 patients in 5 assaults, 1 patient in 6 assaults. There was no gender or age difference in patients involved in assault incidents.

An incident of **aggression** was recorded 41 times during the reporting period. 24 individuals were involved in one or more aggressive incidents, 17.4% of the CI sample had at least one assault incident. Similar to the AWOL and assault data, multiple incidents of aggression was uncommon, 67% of patients were involved in one aggressive incident declining to 21% involved in two assaults and 12% in more than 2 assaults. Three individuals accounted for 4, 5 and 6 aggressive incidents respectively. There was no gender or age difference in patients involved in assault incidents.

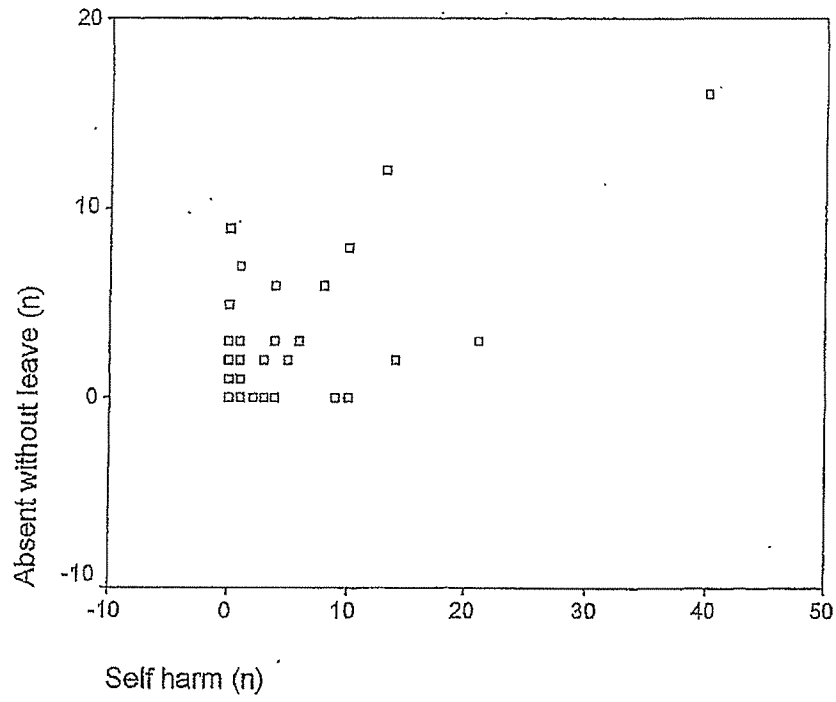
No separated analysis was performed on low prevalence incidents such as injury (n = 20, 4.3% of all incidents), 'other' (n = 20, 4.3% of all incidents), property damage (n = 19, 4.1% of all incidents) and security breach (n = 2, 0.4% of all incidents).

Table 4.2 below, highlights the significant relationship between the most common variables with significant bivariate correlations between incidents reported as aggression and assault, AWOL and self harm, assault and AWOL and self harm and AWOL. The example of self harm and AWOL is graphical depicted in Figure 4.3. Whilst a higher order factor such as gender may be found following multivariate analysis with a larger sample size these results suggest that multiple forms of critical incidents cluster in individuals. The clinical implication is that if a patient is involved in one form of critical incident, the clinical staff should be aware of the potential for further incidents in that as well as in other domains of critical incidents.

Table 4.2 Summary of Bivariate analyses (Pearson's correlation) of the four most common critical incidents

	Aggression	Assault	AWOL	Self harm
Aggression: p (2-tailed)		.000	.000	.000
Assault			.033	NS (.183)
AWOL				.000

Figure 4.3 Simple Scattergram of AWOL versus Self-harm incidents



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4.4 Current service delivery model

The BAC model was described to the review team as a milieu therapy model with adjunctive therapy mainly in the form of adventure therapy, individual therapy and psychopharmacology. The medical support to the BAC and hence the medication prescribers were the BAC Director and a psychiatry registrar. Individual therapy was provided formally primarily by allied health professionals. The form of individual therapy depended on the therapist: cognitive – behavioural and psychodynamic approaches were cited. It was not clear whether all adolescents were offered individual therapy, and on what grounds it was offered. The nursing case management role is also central to the therapeutic process, and during the course of an admission, would constitute a significant long term relationship for the adolescents admitted. Several staff members noted the current limited family therapy capacity due to an unfilled allied health position.

Certain aspects of the therapy programme seemed unclear to some staff. An example of this is the two week assessment period. Several staff were unsure about whether that still happened or not. In any case, there did not appear to be a formal review following the two week assessment, and nor was the outcome made overt to any of the relevant parties.

4.5 Current Admission Pathway

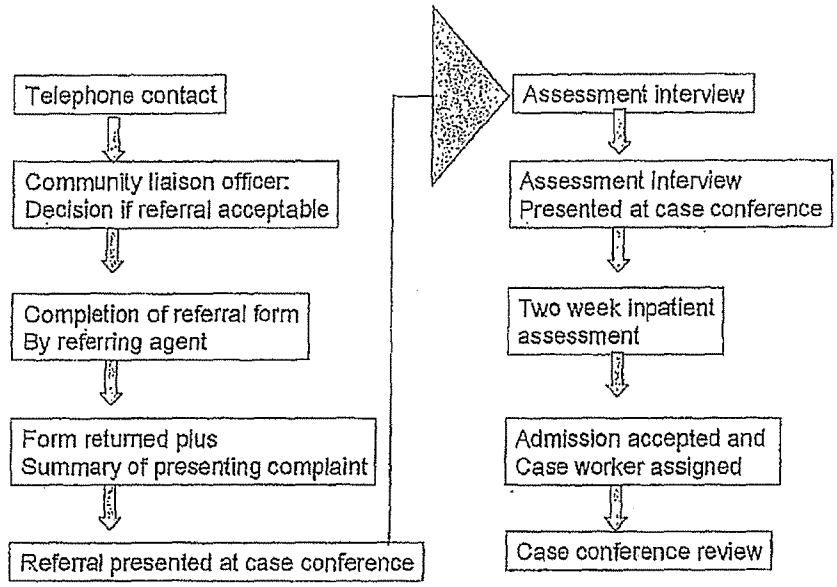
Figure 4.4 below, highlights the BAC clinical and administrative pathway from the first telephone contact with the BAC until a patient is accepted for an inpatient treatment stay.

Central to this process is the Community Liaison Officer's role. The role includes (1) Triaging telephone referrals, including the initial decision as to whether the patient seems acceptable, (2) presenting the case at the referral meeting, (3) completing the assessment interview with the registrar and (4) presenting the case at case the conference. The centrality of this worker clearly provides some consistency to the process, but may at some level not be appropriate. Issues include potential differences in the understanding of suitable referrals between the Community Liaison Officer and nursing staff or senior clinical staff.

Secondly, there is the potential for idiosyncratic practices or detailed understanding of systemic issues and processes residing in one individual and not generalising to the broader clinical team.

Another issue noted by several staff was that referrals were often considered at the end of the case conference. The identified problems arising from this process included staff having to

Figure 4.4: BAC Referral and Admission acceptance pathway



leave the meeting prior to discussing new referrals, time constraints on this item of discussion and fatigue at the end of an otherwise busy meeting. Given the importance of selecting appropriate adolescents for the milieu, it would appear that this process needs to be managed differently.

4.6 Treatment Model

Most staff stated that the BAC had an over-arching theme of working in a milieu therapy model with an adjunctive individual, group, family and adventure based therapy. A recent staff vacancy had diminished the availability family therapy. It was the opinion of the reviewing team that a more indepth understanding of the milieu model was not easily accessible either from staff or from the documentation provided. It was also apparent that whilst the senior and long serving

members of the team appeared to have a common understanding of the meaning of this model, newer staff felt that they hadn't been orientated to this, and felt that they were expected to learn on the job. Given the importance of staff roles in 'maintaining the milieu', this would need to be addressed.

4.7 Specific risk strategies

The **A1-A7 programs** are a series of behaviour management programs employed at the BAC. They are well documented, available to all staff as typed sheets and have been in use for many years. The review team noted the programs were developed before the current clientele with the more recent emphasis on externalising behaviour and consider the relevance of these programs to this client group is untested and there is no documented evidence that these programs change/effect behaviour. The programs could be seen to create a consistent response to behaviour, however, individual patients contexts differ, and a patient centred response that requires an adolescent to accept responsibility and participate in negotiating consequences may be useful. The review team felt that compliance with the 'A' program could be erroneously seen as the young person accepting responsibility.

Programs are a very 'public' response to behaviours. Some programs require restrictions to be in place for up to 48 hours. The review team were unsure that this fits with 'short, sharp and meaningful' consequences to behaviour. Further, the program would be 'monitored' by a number of staff over that period, leaving it open to interpretation. Indeed, some staff mentioned that they make modifications to the programmes when implementing them. Some consequences seem dissonant with the 'offence'; for instance a 48-hour response for a consistently untidy bedroom (A3).

More broad responses (other than A1-7) include '**suspension**' from BAC. Staff were of the opinion this was used more in the past, but homelessness and patients from geographically isolated areas make that impossible in some instances. Suspension was seen as a valuable response to some situations, as it allowed some "cooling off" and reflection on the part of the adolescent, and enabled a re-negotiation of expectations on return. The other advantage was that

family members were involved, and their support in the process had the potential to strengthen the relationship between them and the BAC.

4.8 Staff issues

An overarching staff issue was the concerns by BAC staff that the ongoing funding uncertainty hampered the capacity of the BAC to recruit and retain high quality staff. Many staff members felt that staff would preferentially move to or apply to units with a more certain future.

There were a range of staff issues that individual BAC staff members felt were related to critical incidents on the unit. Certainly there appears to be a growing lack of confidence in the BAC and Park's ability to respond in a timely and safe way to unexpected incidents, and this is affecting morale. There is a current position open for a family therapist, and staff felt that this position would not only increase the range of therapy available at the BAC but also the skills of a family therapist in thinking systemically were also valued. The position remains unfilled due to the need to fund the increased staff required when a category red is in place. Staff noted that the gym equipment available at the BAC was presently not able to be used because of the lack of a qualified trainer who could supervise the use of this equipment. Staff noted that this was a source of frustration for many patients who enjoyed using gym equipment and this form of exercise was a pro-social use of energy.

There review team also heard many positive comments about the internal peer support within the BAC. However, there was a sense of resignation to the continuation of the untenable position of being uncertain about the future.

4.9 Environmental issues

Maintaining a safe environment includes the need to ensure that all equipment (including furniture) is well maintained, especially in high-risk areas. This is fundamental modelling, in that it gives the adolescents a clear message about the importance of living in a clean and functional environment. It also impacts on staff morale.

The review team noted that whilst the main dining/ recreation areas appeared to be very clean, tidy and light, there did appear to be a lot of 'clutter' in other areas, including broken and unused equipment.

Added to this, the majority of staff cited concerns about the physical environment of the BAC. All staff stated that of the two accommodation corridors presented a considerable risk, especially the corridor furthest from the nursing station, which was not in line of sight of nurses. The other corridor was visible to nursing staff, however, the bedrooms at the far end of the corridor were still reasonably inaccessible. Staff also noted that the age of the building and the style of the building made for many small and out of the way spaces that were potential places for an individual to self harm or to hide belongings that were not allowed on the BAC and indeed this has been their experience.

The staff involved in the critical incident in which a chair was thrown through a glass window were very clear in their concerns about the extensive amount of glass in the unit. The likelihood is that this glass is not of a suitable strength to be in this type of unit, nor is it covered by a protective film that would stop the glass breaking into shards. It was of interest to note that the police liaison officer, who has some experience in matters related to physical safety of environments, has ongoing concerns about the safety of the environment at the BAC. It was the opinion of the review team that the building looked dated and that it would benefit from a process that established whether it could be improved by significant modifications or a new type of facility was required. A major advantage to the BAC was the space and parkland around the unit. However, this was not itself without problems in that the review team was told that the access to the oval had been recently restricted because of the oval being sold. In addition access to a nearby auditorium that had been fairly extensively used by BAC for badminton and other activities had also been stopped.

4.10 Systemic issues

The relationship between BAC and the Park: Staff cited considerable uncertainty about the ability and willingness of staff members from other Park areas to be of assistance to the BAC during critical incidents. Indeed several examples were given including one response by other staff members of The Park to a critical incident, where the response included a 'drive by' and the discovery that a serious incident was occurring only happened fortuitously. Some staff noted that The Park redevelopment and the creation of more discreet service entities, in their opinion, diminished the ability of units to cooperate on the campus. Other staff noted, in their opinion, a campus wide lack of appreciation of both the type of patients seen at the BAC and the potential for dangerousness of the BAC patient group.

The relationship between BAC and the other CAMHS units: this was difficult to assess given comments were only available from BAC staff. It was stated by staff that the BAC received referrals from CYMHS teams in all regions and that suitable working relationships existed with other CYMHS units.

Staff team relationships: Staff reported excellent communication between school and nursing and allied staff, and the teaching staff reported that they feel very well supported by nursing staff if there is a problem. Teachers reported 'useful' things as being: peer support from other teachers; nurses on duty in the school; they don't ever feel that people are critical; they have regular meetings to discuss issues; they have regular meetings with the nurses to handover info; the common understanding that 'we're all here to help the kids'.

The BAC and the Brisbane Youth Detention Centre (BYDC): there had been several individuals referred from the Brisbane Youth Detention Centre which is geographically close to the BAC. Whilst there was an overall ethos of the BAC of giving youth "a go" and seeing who could benefit from the program, given the types of offence that have led individuals to be in the Brisbane Youth Detention Centre it is likely that this group is at greater risk of creating critical incidents on the BAC. In-reach services would seem to be more appropriate, but this issue is outside the scope of this review.

Geographically isolated patients: It was the opinion of many staff that current patients were increasingly likely to be admitted from geographically very distant areas. Clear problems with such a regime included the decreased probability of visiting from friends and relatives, the diminished possibility of going on outings away from the unit with friends and relatives and the psychological implications of being dislocated from your local social network. In this regard there was some degree of double jeopardy: (a) you are going to a new residential environment which involves group living that the adolescent may have not experienced before and (b) this new residential experience is far from the normal place of abode and social networks. It was the opinion of staff that such individuals were more likely to be distressed through this process and this was a possible risk factor for critical incidents.

4.11 Risk Management Related Training

All Park staff attend compulsory training in manual handling, CPR, fire procedures and aggression management training (PART program, 3 days duration followed by refresher program). All staff spoken to believed that the PART program was both useful and relevant. Apart from the compulsory training, there does not appear to be any BAC unit based training.

4.12 Orientation of new staff

An orientation manual and checklist for new staff exists. This process covers all administrative requirements for new staff coming into the BAC, however there was some difficulty obtaining a copy of the manual, and it appears that the information needs updating in some areas. Several newer staff reported that they had not in fact been orientated to the unit.

5. CURRENT RESPONSES BY THE BAC

Current responses to escalating issues include the use of the various behaviour management plans, and include completing documented risk management ratings. The review team noted that there was little coherence between documented risk and management plans on occasion. It was difficult to establish what the management plan was apart from the typed multidisciplinary plan, which prescribed generic interventions. Documentation of management plans following case conferences varied greatly in the notes reviewed.

Recent events have left several staff feeling very unsupported, and indeed with unresolved stress related issues. Whilst all staff who spoke to the review team felt that there was very good internal and informal support following incidents, the lack of formal review process and subsequent changes to policy, practice or procedure left staff feeling that there was little between then and the next incident. Recently there has been use of an external facilitator on two occasions, however, their role appeared more debriefing than process analysis.

5.1 Review of case notes

Rather than provide outlines of individual cases and reported critical incidents, this section will details themes across the cases reviewed, including issues from case files and issues that arose when discussing cases with staff.

The review team found little evidence either documented or from staff report that a review of process related to critical incidents takes place. Risk management is not a theme that is easily found in case notes apart from the risk assessment forms. It was difficult to find specific and individualised plans that relate to self harm, aggression of AWOL incidents. This extended to the individual care plans, which were often not ungraded in general as well as specifically about

risk. From a review of some notes, the level of risk assessed did not appear to influence decision-making in some instances.

AWOL was specifically mentioned in case notes with case note information and Staff report suggesting that the "retrieval from AWOL rate" is very high. Verbal report indicates that staff, with the aid of security staff, pursue young people in the local area, and will use physical methods to return young person to the BAC. If this occurred with a voluntary patient, the review team were unsure of the legality of such a procedure. Clearly a negative of the physical environment is the amount of open space that can be used to abscond too. It seems that many patients undertake a 5-minute walk across parkland to train station.

5.2 Review of Policies and procedures

It is a BAC policy to complete risk assessment relating to absconding, self harm and aggression: (1) prior to admission by the referring agent, (2) on admission, (3) reviewed at case conference and (4) post-incident.

The review team identified several issues with the risk assessment protocols. The risk assessment tools did not clearly indicated how to score or interpret the results of the assessment, and staff reported that they were not trained in its use. There was no clear pathway between assessment and a proactive management plan with the exception of placing the patient on a CAT RED. There was no available evidence that the risk assessment tool was relevant to or had an evidence-base in the adolescent population

Some risk assessment and management polices and procedures appeared overly universal for instance searching bags and rooms, locking bedrooms during the day, searching day patient's bags. Whilst such activities may have uncovered prohibited weapons or substances there was no evidence of the efficacy of such activities, no obvious audit of this practice and in the opinion of the review team, it has the potential to create a culture of mistrust. "Living up" to this mistrust may increase\the overall risk in the unit.

Many staff demonstrated confusion between critical incident stress debriefing (CISD) and a risk review and management process. When CISD was mentioned the 'informal' nature of the debriefing was cited by some staff as useful.

A brief review of the adventure therapy programme manual was undertaken, as well as informal discussion with the coordinator. The standards set by several outside organisations in relation to adventure therapy, and the components of it, are adhered to in this programme. The low critical incident rate whilst adolescents (and indeed staff) are participating in the programme is testament to the adherence to those standards, and to the carefully planned and managed events. The philosophy of adventure therapy as explained to the review team and would appear to contribute to the risk management in this programme. The maintenance of equipment and emergency plans also contributes. Nevertheless, involving a group of adolescents presenting with psychiatric and behavioural problems does increase the risk factor. The fitness level of staff may present a risk at another level.

5.3 Review of Critical Incident process

The review team found little evidence that a review of processes related to critical incidents takes place in any consistent or meaningful way. Indeed many staff confused this question with the opportunity for staff support and debriefing following an incident, citing that an external facilitator has been used recently after a critical incident.

The review team are of the opinion the BAC needs to establish a process whereby incidents considered to have potentially major consequences are investigated.

The review team are of the opinion The Park needs to consider updating incident forums for the risk assessment to include looking at the

(1) actual outcome,

(2) potential outcome,

(3) likelihood of the event re-occurring and then

(4) looking in-depth at the responses. (A root cause analysis or similar process)

This process needs to become the basis for change in practice as it related to risk and critical incidents. Such an analysis would include what happened, why and how it happened, what opportunities are there to prevent further occurrence. A response should consider communication, training and experience, fatigue and rostering, environment and equipment, rules, policies and procedures, and other barriers that become the evident. It will assist the staff to identify deficits in policy, procedure, education and skills of staff etc.

For example a review of the incident when the window was broken by a thrown chair would have inevitably lead to an urgent need to ensure that all glass is replaced or protected in some way, as well as a change to the Park wide response process when a 'Code Black' is called. It may also have lead to changes in protocol related to outings and pro-active communication with others on the Park site prior to outings occurring. The failure to look at potential risk management issues resulting from service incidents could be seen as negligent.

5.4 Wider Park issues

It appears that issues related to budgetary processes are not necessarily transparent, and may not reflect the level of activity and risk profile of the BAC. Staff reported accruing extremely high numbers of TOIL hours, and felt they had little possibility of being able to take that time. Costs for provision of Category Red care need to be acknowledged, as there is an assumption that not filling staffing positions is to save money for cat reds. The belief is that the programme is compromised as a result of this. Capital works funding is an issue and is mentioned in the recommendation section.

5.5 Response to Codes

The review team noted an absence of an enforced protocol about who makes up the response team, and the timeliness and process of their response. Any review of critical incidents should include looking at whether this protocol was observed. There needs to be opportunities to practice this on a regular basis, and a process of review afterwards.

6. POSSIBLE IMMEDIATE ACTIONS

Possible immediate actions are also detailed in the report recommendations. Whilst specific actions will be discussed the overarching need for a secure future for the BAC is an important action with a direct relationship to risk management.

6.1 Clinical Issues

6.1.1 **More clear admission criteria.** The review team felt the BAC should undertake a purposeful process to determine which patients are most likely to receive benefit from the BAC program, and how this fits with the current continuum of client care across SE Queensland. The review team were surprised with both the range of potential diagnoses of individuals at the BAC and the often stated ethos by all levels of staff of "having a go" with most types of presenting problems. A review of the target group need not only be diagnosis driven. For example a role for individuals with severe, persisting self-harm (therefore problem based) may be equally as valuable.

6.1.2 **Regular program review.** The BAC should consider closing the program for 1-2 days twice a year to invest time in management, procedure and training issues. Other inpatient units have been able to schedule regular program reviews. The potential benefits of this would significantly outweigh the costs.

6.1.3 **Structure.** The review team were interested in the relative absence of critical incidents at the BAC school, and on the adventure therapy programme. Small group size and highly structured time seem important determinants. Based on this observation the BAC staff should consider more structure in the after school and evening time.

6.1.4 **Group size.** Following on from 6.1.3 above the therapy group size seems very large and division of the group should be considered.

6.1.5 **"Home groups" within the BAC.** To further impart structure, control and a sense of belonging, the BAC staff should consider two home groups within the BAC program rather than one larger group of adolescents.

6.1.6 **Drug and Alcohol detoxification.** Given greater numbers of youth with dual diagnosis, the BAC staff should consider developing a relationship with the Adolescent Drug & Alcohol Withdrawal Service to up-skill BAC staff in contemporary drug withdrawal management, as well as the possibilities of additions to the BAC therapeutic program on drug and alcohol issues.

6.2 Policies & Procedures

The review team identified a range of BAC policies that were several years over the documented time for review, or had been created more than 4 years ago and had not obvious review schedule. The BAC should invest in a quality activity to review and where appropriate update all policies. Policies should be written from a patient centred, risk management, point of view, and should be separate from procedures.

6.3 Risk Assessment Tool

The Park risk assessment tool does not clearly indicate how to score or interpret data. Further there is no available evidence that the risk assessment tool is relevant to the adolescent population. The review team feel that there should be greater scrutiny of the tool as it relates to the prediction of further critical incidents and the more general outcome of that individual at the BAC. Note that part of this increased scrutiny is the new data analysis included in this report. Other analysis is possible with the BAC collection of HoNOSCA and CBCL data.

6.4 Decisions following on from the risk management process

Some risk management strategies seem to be universal at the BAC, for example searching bags and rooms, locking bedrooms during the day and searching day patient's bags. The danger of

universal interventions is engendering a culture of "mistrust" in response to risk management, which in turn affects interactions and relationships between staff and patients. Policies such as these should be reviewed by the team.

Specific issues, highlighted by case note review, include the review team feeling that there should be increased clarity of the pathway between risk assessment and a pro-active management plan, including placing the patient on CAT RED. The review team feel a more formal process review should occur after significant incidents. Documented care plans do not appear to be updated during the adolescents stay in response to risk assessment outcomes. . The requirement to have a multidisciplinary care plan does not disallow a nursing care plan, or a behavioural management plan being written and updated on a regular basis.

If programmed responses such as the A1-7 and Cat Red processes to risk taking behaviour are to continue, the review team are of the opinion BAC staff need to:
(1) review current programs and update them in relation to current patients,
(2) Document patient compliance and responses to the program,
(3) Monitor usefulness overall of such programs in modifying behaviour and
(4) Give consideration to a process whereby the adolescent and staff member sit down together to discuss and agree on logical consequences following risk taking behaviours. Age and developmental maturity may influence the outcomes.

6.5 BAC Management issues relating to critical incidents

BAC staff need to establish a process whereby incidents considered to have potentially major consequences are investigated. Park needs to consider updating incident forms to include risk assessment of the incident looking at the actual and potential outcomes rather than as primarily a reporting tool. Simple categories could include; What happened, Why and how did it happen, What opportunities are there to prevent a further occurrence?

A broad BAC response would include better communication about risk and risk management, more focused training, consideration of fatigue and rostering issues, environment and equipment needs, reviewing relevant rules/policies/procedures and other barriers that become evident. This process needs to become the basis for changes in practice. For example a review of the 'chair through the window' incident would have inevitably led to the urgent need to ensure that BAC glass is replaced or in some other way the clients are protected. A failure to look at potential risk management issues resulting from serious incidents could be seen as negligent.

6.6 Training, Education and Orientation for all staff

Many staff stated there was no regular inservice program or training days programmed at the BAC or for BAC staff. The review team feel that regular and ongoing training for BAC staff, in risk management and other issues should be mandatory. Such training should be consistent with the severity of problems that BAC patients present and the issues around intense medium to long term admissions for adolescents. A special focus should be training and education for new staff on adolescent issues. This currently appears to be ad hoc, with some staff reporting they were not offered any training opportunities related to working with adolescents or developing their understanding of adolescence. It was clear that opportunities for personal clinical supervision should also be explored and incorporated into the BAC processes.

Example of potential risk management training would be regular participation in a program of local critical incident response training, which would include:

(1) Fire evacuation,

(2) Managing aggression,

(3) [redacted]

(4) Secluding a patient.

(5) CPR

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Orientation: the review team feel the orientation process and documentation should be improved, specifically:

(1) The manual needs to be updated, and several copies need to exist.

(2) All new staff need to be orientated including casual staff. Consideration be given to developing a competency based orientation programme, where staff need to be able to demonstrate skills and understanding of processes, developmental issues and therapies.

(3) Consider making up a 'cheat sheet' orientation for casual staff with the absolutely essential information to manage for a shift on it.

7. LONG TERM ISSUES THE CONTINUING ROLE OF THE BAC

This report has focused on critical incidents and risk management at the BAC. However, a pervasive theme amongst staff, and in the review teams opinion a significant barrier to change at the BAC is the uncertainty of the unit.

The review team encourage The Park and BAC management to activity pursue clarity of this issue. In doing so the review team note contemporary themes, not necessarily core to mental health but clearly related to adolescent mental health, that are reasons why the BAC offers a unique opportunity to severely troubled youth. Firstly most BAC clients have been serially suspended or excluded from the education system. Cessation of schooling confers a further and serious impairment to this client group. The BAC provides a unique educational opportunity for this group, with good evidence of major academic gains being made by clients during their BAC stay.

Secondly, youth homelessness is unacceptably high and the BAC clients are at the severe end of the spectrum of risk factors that lead to homelessness. Without the BAC many of this client group will become homeless and denied a place of safety, therapy and education. In brief without the BAC many of this group will still need accommodation somewhere, but alternative accommodation could not provide the possibility of restoration and rehabilitation which the BAC staff work so hard to provide to a very disenfranchised group of adolescents.

All services should change over time, and the BAC has this challenge. Precipitous action such as closure of the unit without a process of re-orientation with other SE Queensland service units could remove a part of the continuum of care that is extremely difficult to replace and simply transfers the burden to other areas of the wider system.

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Appendix I: Information provided by the BAC

Figure A1: Summary of Critical Incident by Incident Month.

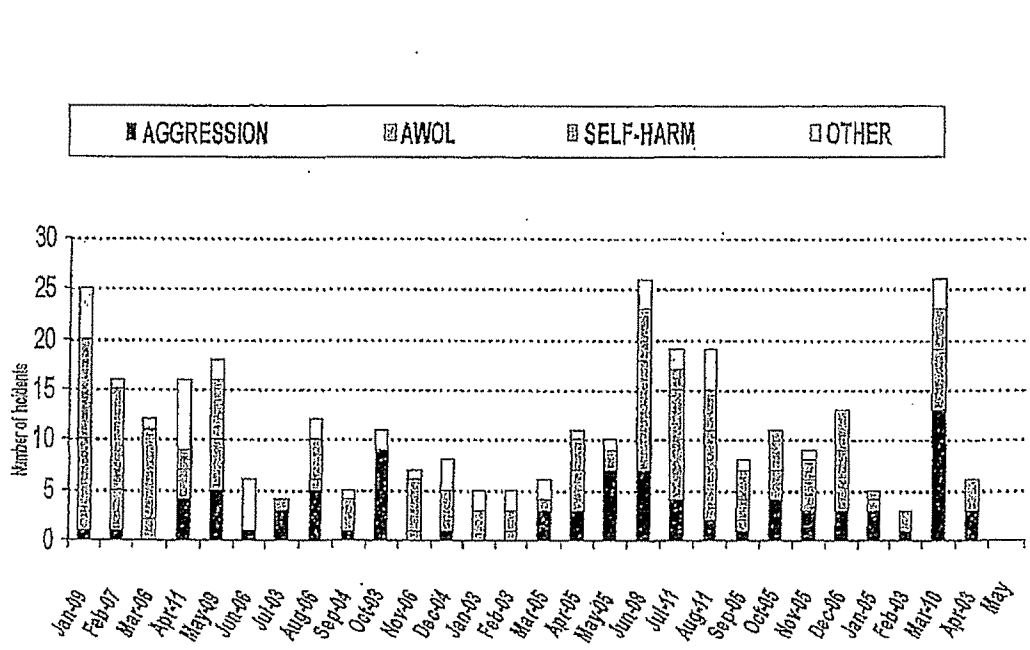

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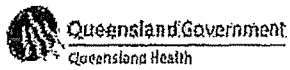
EXHIBIT 84

BMCM-3



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Report of the site evaluation subgroup

Site Options Paper for the redevelopment of the Barrett Adolescent Centre

October 2008

Queensland Government
Queensland Health

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October 2008

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Executive Summary

The Queensland Plan for Mental Health 2007-2017 provides significant funding to support mental health service improvement and reform. The plan includes investment in new and upgraded inpatient services.

This report of the Site Evaluation Subgroup includes an appraisal of the options explored for the redevelopment of the Barrett Adolescent Centre (BAC).

At the request of the Area General Managers of the former Southern and Central Area Health Services, the following sites were considered as options for the redevelopment of the BAC:

- Rogers Street Spring Hill;
- CAFTU- RBH;
- Land adjacent to Redland Hospital;
- Meakin Park – 3 km from Logan Hospital Site (precise land parcel unknown- assume bushland between Queens Rd and Beal St); and
- The Park Centre for Mental Health (3 site options on campus considered).

The report finds Redland and The Park as the only architecturally viable options if the service is to be redeveloped as currently envisaged.

It identifies redevelopment at Redland as the preferred option.

The report identifies the need for further consultation on this option with the current Barrett service providers, consumers, carers and the broader Child and Youth Mental Health Sector to inform a final decision.

The Barrett School is a critical component of the service and must be included in the redevelopment of the service at any site. Therefore, negotiation with the Department of Education, Training and the Arts is required in the process of deciding the preferred option.

A final decision for the service location will be made by the District CEOs of Metro South and Darling Downs West Moreton Health Service Districts. It is recommended that the District CEOs provide the Site Evaluation subgroup with the authority to consult these relevant stakeholders on the preferred option. Subject to approval consultation could consider the following identified issues:

- Review of transport options, including duration and cost of journeys. A comparison of the accessibility of the sites particularly for consumers accessing the day program and for consumers and carers travelling from rural, regional and remote areas who require the service.
- Consideration of the impact of the surrounding built environment at Redland. This should take account of the surrounding bushland and include some consideration of risk management strategies associated with bushfires, wildlife and proximity to other infrastructure including the sewage treatment plant.
- Further analysis of the impact of the built environment at The Park and associated risk management strategies. This may include consideration of the implications of having vacant buildings on the site. It could further identify the challenges and opportunities associated with the proximity of the service to the new Police Academy site.
- Further consideration of the cost and time implications should a staged redevelopment at the existing site be pursued.
- Consultation with police to establish whether Redland site may subject the unit to risk from 'undesirable persons' and consideration about how such a risk might be managed.
- Consideration of the implications of the implementation of the Clinical Services Capability Framework (CSCF) and the assignment of a level to the service. In particular, this may further clarify the specialised requirements of the unit including the need for specialist human resources and the advantages of being co-located with 24 hour medical care.

- Further clarification of plans for service expansion in the second half of the plan to provide 5 additional beds for the adolescent unit in the development of step down units and further consideration of accommodation options for family and carers.
- Clarifying the governance arrangements should the unit be located at Redland. In particular the service's reporting relationships to Metro South and/or the Queensland Children's Hospital.
- Further examination of the potential advantages of co-locating the service near the Brisbane Youth Detention Centre at Wacol, Child and Youth Forensic Outreach Service (CYFOS), Mental Health Alcohol Tobacco and Other Drugs Service (MHATODS) given the overlap of demographics and some characteristics of clients seen by each of these services. This requires some consultation with MHATODS and CYFOS to determine whether co-location of this kind is consistent with the service development intentions of these services.

It is proposed that the Site Evaluation Subgroup report on the outcome of this consultation to the District CEOs to support a final decision concerning the site for redevelopment of the Centre.

Dr Aaron Groves
Senior Director, Mental Health Branch
28/10/2008

Introduction

The purpose of this paper is to support decision making associated with the selection of a site for the replacement of the Barrett Adolescent Centre (BAC).

It considers the sites below, which were identified by Area Health Services as potentially suitable for replacement of the centre:

- Rogers Street Spring Hill
- CAFTU- RBH
- Redland Hospital
- Meakin Park – 3 km from Logan Hospital Site (precise land parcel unknown- assume bushland between Queens Rd and Beal St)
- The Park Centre for Mental Health (3 site options on campus considered)

The report includes:

- a brief description of the project;
- a summary of the model of service for BAC;
- a description of site requirements and;
- a site appraisal of the two architecturally viable sites- prepared by Project Services.

Appendix One includes the rationale for finding two of the three site options at The Park, CAFTU and Rogers Street to be architecturally unviable. Advice from Southside Health Service District subsequent to the site options tour indicated the option at Logan was no longer available or viable; therefore an appraisal of this site has not been undertaken.

Appendix Two is a collection of 'Site Tour Notes' providing a summary of some of the key issues considered by Site Evaluation subgroup during site visits by the subgroup on 5 August 2008.

The report identifies the need for further elaboration of some of the challenges and opportunities of the two architecturally viable sites to support a final decision concerning the redevelopment of the unit.

The report concludes that Redland appears to be the preferred option for the redevelopment of the service subject to further consultation with the sector.

1. Project Description

Replace Barrett Adolescent Centre with a new 15 bed adolescent extended treatment unit.

Background:

- Decision concerning the location for the redevelopment of the Adolescent unit is contentious
- Redevelopment at The Park is problematic because of the expansion of forensic services being undertaken on the site
- This expansion includes the development of a further 40 extended treatment forensic beds over the next 10 years
- Advantage of the current site is the existing service with highly skilled staff.
- No optimal location for the unit identified by Child and Youth clinicians
- "Site Evaluation Sub Group" established to assist in determining an appropriate site for the unit at the direction of the Area General Managers (participants identified below)
- Subgroup reviewed the site selection criteria and accommodation schedule produced by Project Services in collaboration with BAC staff
- Ranking of site selection criteria reviewed
- Scope for reducing footprint identified in accommodation schedule
- Alternate sites identified in discussion with Area Health Services
- Sub Group visited the following sites on 5 August 2008:

Rogers Street Spring Hill

CAFTU- RBH

Redland Hospital

Meakin Park – 3 km from Logan Hospital Site (precise land parcel unknown- assume bushland between Queens Rd and Beal St)

The Park Centre for Mental Health (3 site options on campus considered)

- Sub Group agreed to consider the site options on the basis that they may:
  - serve the clinical objectives of the service
  - satisfy the criteria nominated in the 'Site Selection Criteria'
  - meet the design requirements identified in the accommodation schedule

Participants:

Ms Denisse Best	Executive Director	Child & Youth Mental Health Service, Royal Children's Hospital & Health Services Districts, Chair Child & Youth Sub Group
Mr Kevin Fjeldsoe	Director	Mental Health Plan Implementation Team
Dr Trevor Sadler	Clinical Director	Barrett Adolescent Centre
Dr Brett McDermott	Director	Mater Child & Youth Mental Health Service
Ms Linda Ryan	Principal Project Officer	Southern Area Health Service
Ms Karen Ryan	Manager	Rural Service Planning Unit, Southern Area
Ms Erica Lee	Manager	Child and Youth Mental Health Service
Mr Paul Clare	Principal Project Officer	Mental Health Plan Implementation Team
Mr John Quinn	Manager	Mental Health Plan Implementation Team
Ms Jenny Stone	Assistant Director	(Southern) Program Coordination Unit LWAMB
Mr Chris Hollis	Network Coordinator	Mental Health - Central Area
Mr Mark Wheelehan	Area Team Leader	Central Area
Ms Elisabeth Roberts	Principal Project Officer	Southern Area

Additional invitees to site options tour:

Dr Terry Carter	Project Manager,	Mental Health Capital Works Program
Mr David Pagendam	Senior Architect	Project Services
Ms Karen Reidy	Architect	Project Services

Apologies for the site tour:

Dr Bill Kingswell	Director	Mental Health Services - Logan
Ms Karen Ryan	Manager	Rural Service Planning Unit, Southern Area
Mr Chris Hollis	Network Coordinator	Mental Health - Central Area
Mr Mark Wheelehan	Area Team Leader	Central Area
Ms Elisabeth Roberts	Principal Project Officer	Southern Area
Mr David Pagendam	Senior Architect	Project Services

2. Brief Summary of the Adolescent Extended Treatment Model of Service

Service integration

The Adolescent Extended Treatment and Rehabilitation Service is an integral part of Child and Youth Mental Health network of services in Queensland. Child and Youth Mental Health Services (CYMHS) include:

- community clinics throughout Queensland
- specialised therapeutic services to children and adolescents in the care of the Department of Child Safety (Evolve teams)
- acute inpatient services in Metro South, Metro North, Mater and Gold Coast Health Districts
- a day program at the Mater Children's Hospital, with proposals to develop further day programs at Townsville and the Sunshine Coast.
- a Child and Youth Forensic Outreach Service (CYFOS)
- a visiting service to the Brisbane Youth Detention Centre

An adolescent of high school age is referred to the Adolescent Extended Treatment and Rehabilitation Service if severe mental illness and impairment persist after extended treatments in one or more of these other settings. It is both a tertiary and quaternary referral service, depending on the severity and complexity of illness and range of settings for intervention prior to referral. Referrals are accepted from throughout Queensland. On occasions it is appropriate to accept referrals from northern New South Wales and the Northern Territory. Referrals may also be made by private child and adolescent psychiatrists or psychologists.

Adolescents usually will be placed on the waiting list, and managed by the referring service until admission is possible. Throughout the admission, ongoing linkages with the referrer will occur via videoconference and case management.

It is proposed that the Adolescent Extended Treatment and Rehabilitation Service be a Level 6 service in the Clinical Services Capability Framework being developed by the Mental Health Branch.

Target population:

Adolescents accepted for referral have severe, persistent, co-morbid mental illnesses associated with a range of impairments. Mental illnesses most commonly diagnosed include:

- depression
- eating disorders
- social and other anxiety disorders
- obsessive compulsive disorder
- dissociative disorders

- post traumatic stress disorder
- psychotic disorders
- organic disorders
- co-morbid disorders of development

The Health of the Nations Outcome Scale for Children and Adolescents (HoNOSCA) is an assessment tool used by mental health services across Australia to assess levels of symptom severity, impairment and family function. Compared with the national average of those admitted to acute adolescent inpatient units, those admitted to the Adolescent Extended Treatment and Rehabilitation Service show similarly high levels of symptoms and acuity (e.g. emotional distress, self harm, perceptual disturbances), but significantly higher levels of impairment (e.g. schooling, self care, peer relationships, impaired concentration) and family dysfunction.

Treatment of many disorders requires the active participation of the adolescent. Frequently they are not contemplating change, but continue with an illness seriously affecting health and their functioning. Both symptom severity and impairment are likely to persist for decades into adult life without adequate intervention.

Service description:

The core of the service is the provision of a wide range of intensive interventions for integrated treatment and rehabilitation. (Unlike many areas of physical medicine in which there is a definitive treatment followed by rehabilitation, effective outcomes in adolescent mental health require an integrated approach to treatment and rehabilitation over months.)

Core approaches to treatment and rehabilitation include:

- utilising standard biological mental health treatments (medication, ECT), although the effectiveness of these is limited
- utilising a wide range of psychological interventions for adolescents with often limited verbal skills and limited understanding of psychological issues
- utilising a wide range of life skill and activity based interventions to address developmental tasks in both treatment and rehabilitation
- providing of a range of comprehensive education and pre-vocational activities through the Department of Education, Training and the Arts
- continuing support of, liaison with and therapy for the family
- maintaining strong community linkages
- safely managing a range of life threatening behaviours
- effectively managing a range of dysfunctional behaviours
- maintaining a ward environment which promotes therapeutic interactions

Depending on levels of acuity and impairment, adolescents access this program at a number of levels:

- as inpatients (full or partial hospitalisation) for those with high to extreme levels of acuity and severe impairment. Up to 15 beds are available for this purpose.
- as day patients for those with severe impairment but lower acuity for those who can access the service.

A comprehensive extended treatment and rehabilitation program for a Statewide service would also include:

- a therapeutic residential unit for those who have severe levels of impairment, low to medium levels of acuity and cannot access the service as a day patient
- a transitional residential facility (step-down) service for those who have moved from high to lower levels of acuity, continue to have moderate to severe impairment, and cannot return to their family home.

- a family-stay residential facility to provide intensive family interventions or family interventions with adolescents with extreme acuity.

Legislative framework and Policy Directions:

In common with other Mental Health Services in Queensland,

- adolescents are admitted either as voluntary patients or under the Mental Health Act.
- consumer, and where possible, carer participation is essential to providing service.
- a Recovery framework is clearly articulated, although it differs in concept to adult mental health services.
- adolescents are managed in the least restrictive manner appropriate to safety. (This creates challenges on an open unit.)
- minimising seclusion and restraint is associated with better outcomes, but requires more intensive staffing.
- outcomes are routinely measured utilising a nationally standard suite of scales - the HoNOSCA, Children's Global Assessment Scale (CGAS) and Factors Influencing Health Scale (FIHS).

Pathways of service delivery once admitted

Transfer

- acute medical management at local general hospital occurs at regular intervals.
- rarely acute psychiatric care at referring acute unit may be required.

Discharge

- intensive discharge planning requires considerable integration with the local community of origin (including local schools)
- the adolescent often transitions from full inpatient admission to periods of partial hospitalisation prior to discharge.
- the lack of appropriately supervised accommodation in the NGO sector is a problem for adolescents who cannot return to their family of origin.
- remoteness of referring services makes follow up referral linkage sometimes difficult to sustain
- occasionally it is difficult to access support in adult mental health services if the adolescent requires further long term treatment.

Managing risk

Managing self harm, suicide attempts, absconding and aggression are major risk issues in patient safety in both adolescent and adult sectors. However, there are particular issues in the genesis and management of these risks in adolescents.

- adolescents do not often possess good verbal skills and their distress is manifest instead in a range of behaviours
- adolescents generally are fitter and have fewer problems with mobility (whether secondary to the type of illness or medications). This enables them to abscond.
- adolescents are more likely to encourage a peer to join them in absconding or to copy another with self harm – the so called "contagion effect".
- adolescents are more sensitive to adverse changes in the family environment. Although distant, this may be a potent effect on behaviours within the unit.
- adolescents are often more impulsive, especially in relation to negative life events to which they are more sensitive.
- adolescents have less experience at assessing safety in the community

- adolescents are more likely to react negatively to a perceived closed environment than an open one. There is a complex interaction between built environment and safety which will be described in the next section

Staffing structure and composition:

- Intensive levels of staffing required for intensive interventions and high levels of acuity
- Staff must have training and/or substantial experience in child and adolescent mental health
- Specialist skill sets in a range of psychological, activity based and life skills interventions required
- Clinical and educational multidisciplinary bio psycho social approach
- Maintenance of ongoing professional development and supervision of staff required
- Range of resources to support the necessary range of interventions

Performance, quality and safety:

- consumer and carer satisfaction
- ongoing workplace health and safety monitoring due to nature of service
- outcomes monitoring

3. Site Requirements

THE IMPACT OF BUILT ENVIRONMENT AND EXTENDED ADOLESCENT TREATMENT

1. The Rationale to Develop Guiding Principles for the Built Environment

Adolescents admitted to the Extended Treatment and Rehabilitation unit are likely to spend up to twelve months or more in hospital. (Hospital is acknowledged to be the most restrictive setting in mental health.) About half will at some stage be on an Involuntary Treatment Order. Initially most adolescents do not contemplate the need for change. Many adolescents believe they should be independent and exercising freedoms they see in their peers, These factors have the potential to actively work against the fact that most treatments require the active participation of the adolescent. There is considerable potential for adolescents them to react strongly against treatment, the staff and hospitalisation. This is manifest in two of the risk factors associated with the unit – absconding and aggression.

Clearly identifiable factors can minimise these tensions and their attendant risk factors. Broadly they can be divided into staff attitudes/skills and the impact of built environment. Guiding Principles 1 – 3 below have been extracted from surveys of adolescents who have been asked about the impact of the change of environment from the constricted environment of an acute inpatient setting to the more open environment of the extended treatment unit has had on their attitudes to being in treatment.

Built environment also has numerous other impacts:

- Adolescents on admission range widely in their fitness levels, co-ordination abilities and participation in physical activity. Providing for a range of physical activity addresses a number of impaired tasks of adolescent development. (Principles 2 and 3).
- Adolescents interact intensively with a limited range of peers over a long period. Adequate external and internal spaces achieve a balance between privacy and a range of peer interactions. (Principles 2,3 and 6)
- Adolescents can utilise external spaces to help them regulate emotional distress and aggressive impulses. (Principles 1 and 2)
- Many adolescents have had very limited interactions with peers or areas outside their home prior to admission. Time in acute inpatient units is in enclosed environments. It is initially helpful to spend time outside without the feeling of being on view to the public. (Principles 2 and 3)
- A number of adolescents often talk in therapy in an activity in the grounds. They are uncomfortable in a room with the expectation they should talk. (Principle 2)

The built environment must also be considered within the broader context of the neighbourhood in which it is located.

- An open unit offers more chances to abscond. Adolescents are at risk then of mishap from nefarious persons, or from themselves by [redacted]. (Principles 4,5)
- It is essential for rehabilitation that community public transport, sporting, community and recreational facilities are available within reasonable distance to prepare an adolescent for integration into their own communities. (Principle 6)
- Either sufficient recreational space and facilities are located within the grounds of the unit, or within close proximity (less than 1 minute) to afford opportunities for acutely unwell adolescents to access these in safety, or for staff return to attend to crises on the unit. (Principle 1, 2 and 6)

2. Guiding Principles

Six Principles can be derived from the above observations to guide the location and design of the Centre.

Principle 1.
Minimising visual restrictions in the environment enable adolescents to cope better with legislative and behavioural restrictions and the restrictions their illness imposes on them.

Principle 2.
The grounds surrounding the building must have sufficient room for multiple purpose activities – recreation, fitness, socialisation, private areas, areas for emotional regulation and areas to enhance therapies to be undertaken safely.

Principle 3.
Adolescents should not feel they are on display to the public, nor should the public have cause to stigmatise the unit.

Principle 4.
The chances of absconding successfully can be reduced by consideration of factors in the immediate neighbourhood of the Unit.

Principle 5.
The chances of an adverse event following an absconding can be reduced by attention to the immediate neighbourhood of the Unit.

Principle 6.
The neighbourhood in which the unit is located should afford opportunities to practice skills for rehabilitation and community integration which can be generalised to the community in which the adolescent lives.

3. Application of the Principals to Design

3.a Characteristics of the Site

3.a.i external views – desirable:

- Sky, trees, distant objects, grass, landscape, sports ovals. (Principles 1,2)
- Sense of distance, calmness more important than people, but distant views of people engaged in gentle activities is desirable. (Principle 1,2)
- Water views a bonus. (Principle 2)

3.a.ii External views – undesirable

- Anything that is too busy or intrusive; buildings. (Principles 1,2 and 5)

3.a.iii Access to natural environment

- Grass, trees, animals, water (as long as it is safe), gardens, getting back to nature. (Principles 1,2)

3.a.iv Access to outdoor activities

- Safe place for walking and riding (not on main roads), playing outdoor games and sports, and just "getting away". (Principles 2, 6)

3.a.v External buffer space and boundaries

- At least 50m away from houses is a minimum to reduce bad interactions with neighbours (both ways). (Principle 3)
- There needs to be clearly defined boundaries but boundaries should be as invisible and unoppressive as possible. (Principles 1,4)
- Good buffer spaces can reduce the need for fences. (Principles 1,4)

3.a.vi Topography

- An elevated site with long views and vistas into the distance is preferable, but the site of the facility must be reasonable level. (Principles 1,2)
- Slopes can be used to hide fences. (Principles 1,4)

3.a.vii Schools

- The facility will have an on-site school which contributes 60% of rehabilitation.

3.a.viii Privacy

- Privacy for the adolescent consumers is important, but the facility should not be too isolated. (Principles 3,6)
- It is desirable for consumers to have opportunities to see people outside, but adolescents should not be "on display". (Principle 3)
- Contact with the public and families needs to be controlled. (Principles 2,3,4 and 5)
- It is important that public thoroughfares do not happen through the facility site. (Principle 3)

3.a.ix Total site area

- 2 Ha preferred area. (Principles 1,2 and 3)
- 1.5 Ha minimum.

3.b. Characteristics of the Immediate Neighbourhood

3.b.i Surrounding built environment

Avoid:-

- High rise and high density buildings. (Principles 1,2 and 5)
- Sites that other buildings look down on. (Principle 3)
- Main roads, railways, and other noisy busy areas. (Principles 3,4 and 5)
- Intimidating or industrial general environment (Principles 2, 3)

3.b.ii Physical hazards

- Avoid bridges, high buildings, cliffs, multi-storey car parks, bridges, main roads, train lines. (Principles 4,5)

3.b.iii Absconding

- A buffer of open space around the facility is important to keep sight of an absconder (Principles 4,5)
- A buffer of 500m to public transport to deter rapid absconding. (Principles 4,5)
- Avoid potential hiding places. (Principle 4)

3.b.iv Schools

- The facility will have an on-site school which contributes 60% of rehabilitation.
- It is a Band-7 school (special education) but not all consumers attend this school, therefore access to other schools (particularly high schools) is necessary. (Principle 6)

- Need plenty of good schools within short driving distance including good ones with varying socio-economic levels. (Principles 3,6)
- Avoid areas where there are "tough" schools where there might be bullying. (Principle 3, 6)

3.b.v Recreational facilities in close proximity

- Recreational-size swimming pool. (Principles 1,2)
- Sports oval or park. (Principles 1,2)
- Adventure therapy components (Principles 1,2)

3.b.vi Undesirable persons

- Avoid opportunities for contact with undesirable persons. (Principle 2)
- Avoid close proximity to forensic units (Principle 2)

3.c. Characteristics of the Broader neighbourhood

3.c.i Sports locally off site

- Full-size swimming pool. (Principle 6)
- Sports oval or park. (Principle 6)
- Bike riding and recreational walking
- Water sports. (Principle 6)

3.c.ii Activities off site (remote)

- Reasonable access to adventure therapy activities. (Principle 6)

3.c.iii Public Transport

- Need access to good public transport. Trains are preferred as being more reliable in timetable and less intimidating. (Principle 6)

3.c.iv Shops

- Need access to a variety of shops via public transport. (Principle 6)
- There is graded use of shops in rehabilitation starting with smaller, less dense and closer shops and progressing on to large shopping malls. (Principle 6)
- Ideally there should be a corner store within walking distance, and a major shopping centre a train ride away. (Principle 6)

3.c.v Other facilities

- It is desirable to have other types of social activities available in the community such as:-
  - churches, (Principle 6)
  - youth groups, (Principle 6)
  - sporting groups, (Principle 6)
  - dancing classes etc. (Principle 6)
- (These are examples only – it is not important to have a particular type of community activity, group, club available).

4. Other General Considerations

4.i Staff access

- Staff recruitment and retention are important factors.
- Existing staff have a highly specialised background, and mostly live within easy reach of the Barrett Adolescent Centre.
- A location which is convenient to existing staff is important.
- Numbers and staff on the unit will be insufficient to meet every psychiatric and medical emergency which may arise.

4.ii Emergency Backup

- Access to help for 'code blacks' is critical. These incidents require back up from mental health trained nurses who have completed aggressive behaviour management training.
- A response is needed within 5 minutes; therefore the adolescent facility needs to be located within 500m of a hospital of other mental health facility where appropriate help is available.

4.iii Hospitals and Doctors

- Hospital emergency department within a 20 minute drive of the facility. (Principle 8)
- The existing Barrett Adolescent Centre has enjoyed good relationships with the Mater / Qld Children's Hospital to date, so proximity to there is desirable. (Principle 8)
- Proximity to an 'after hours' GP clinic is desirable. (Principle 8)

4.iv Access for families and visitors.

- Local external accommodation for families are desirable such as motels and hotels with good public transport access to the facility.
- On-site independent accommodation units (for family visits and for consumers preparing to leave).

4.v Police

- Police do not need to be close, but a relationship with a small local police station is good, more for consumer education and contact than to handle emergency situations.

4.vi. Climate / Aspect

- Good cooling breezes are desirable for personal comfort and to reduce the need for air-conditioning.
- Site must allow buildings to predominantly face north and south to maximise opportunities for natural cooling and light.

4.vii Public Perception, Politics

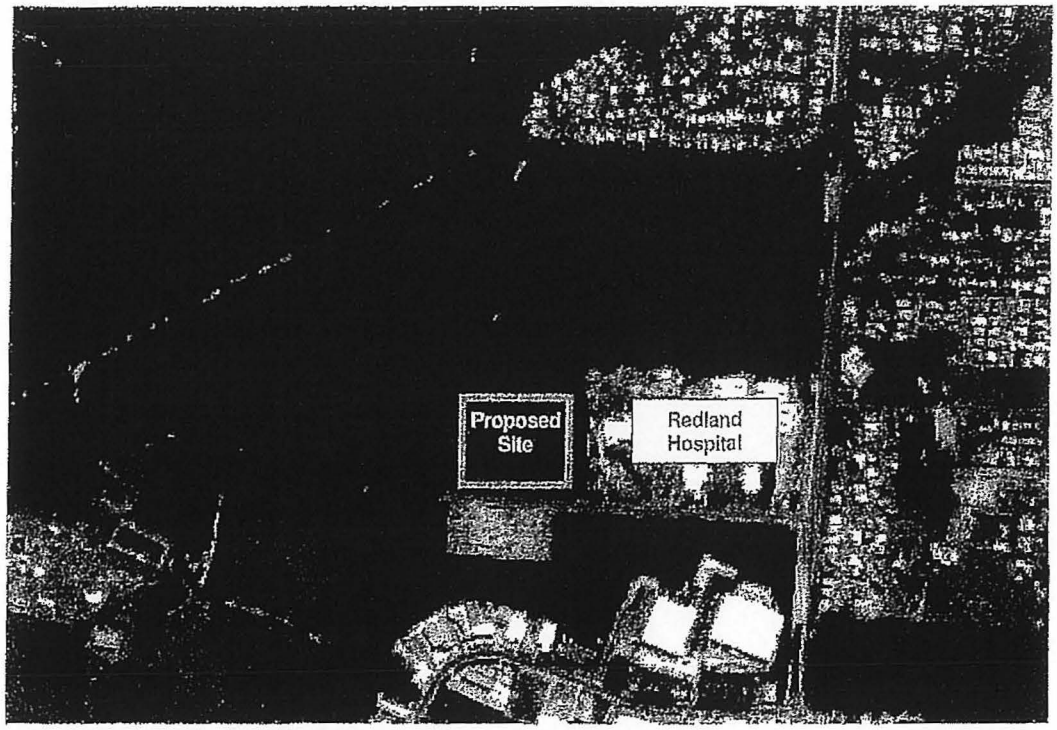
- Avoid close proximity to a high security adult mental health facility or prison.
- Avoid suburban areas where 'not in my backyard' syndrome may cause problems.

4.viii Site acquisition & Development

- Possible in reasonable cost and time
- Are there heritage, environmental, indigenous issues affecting the site.

4. Site Options Appraisal

Fig 1. Redland Hospital Site (Aerial View)



4.1 Specific Site Considerations for Site Next to Redland Hospital

- Site features
  - Potentially excellent bushland setting satisfactory for views, access to natural environment and access to outdoor activities.
  - No houses in vicinity or likely to be. Site is large enough to allow for adequate buffers. Site is surrounded by hospital, bush and industry.
  - Level site.
  - Distant views may be possible.
  - Sea breezes.
  - Site large enough to allow optimum orientation of buildings.
  - Surrounding built environment is potentially good, if it can be separated from the hospital.
  - Privacy is potentially good, if it can be separated from the hospital.
  - Reasonably close to existing mental health inpatient unit with possibility of closer location in future.
  - There are no physical hazards as per site considerations in the vicinity.
  - If site can be suitably separated from hospital and the public the propensity for interaction with undesirable persons will be limited.
  - 5 minutes walk to nearest bus stop, and being at the end of the bus and train line might make catching of absconders easier (there is only one way to get out of Cleveland)
  - Total site area of 5 Ha - 2 Ha preferred area.

- Local entertainment and sporting facilities
  - Aquatic centre (5 pools plus a spa) in Russell St Cleveland with skate park adjacent. Approx 3 km.
  - Chandler Aquatic Centre approx 10km.
  - Beaches, boating and creeks near.
  - Redland Youth Plaza, a large skateboard facility in Capalaba.
  - Social & community activities are catered for by Redland Shire Council – their web site lists numerous and varied organisations in the area.
- Public transport
  - Buses from Redland Hospital to Cleveland train station. 25 buses in each direction every day from 6 am to 11:30 pm. Veolia bus lines routes 258 and 272. Approx 10 minute ride.
  - 45 trains per day into Brisbane city and back.
- Shopping
  - Snack bar and kiosk in main hospital.
  - Small convenience shopping centre at corner of Bay Street and Wellington Road (approx 750 metres with one road to cross)
  - Good medium size shopping centre at Cleveland (10 minutes by bus)
  - Larger shopping centre at Capalaba (approx 8km)
  - Major shopping centre at Carindale (approx 15km)
  - Brisbane CBD shops accessible by train (approx 1 hour)
- Schools
  - Carmel College (Catholic High School) approx 5km
  - Faith Lutheran College (prep to year 12) approx 7 km
  - Redland District Special School and Thornlands Primary School approx 2 km.
  - Cleveland District High School approx 2km (on bus route)
  - Cleveland Primary approx 3 km
  - Ormiston Primary approx 4km
  - Ormiston College (private non-denominational prep to year 12 school) approx 5 km.
- Supplementary accommodation
  - As a tourist centre, Cleveland has a number of accommodation options for families from $70 per night.
  - The site is large enough to accommodate independent units.
- External services
  - Hospital emergency department is immediately adjacent.
  - Numerous medical practices in and around Cleveland, including Medeco Medical Centre which operates 24 hours out of central Cleveland and bulk bills children under 16.
  - Large police station in central Cleveland, close to train station.
- Staff
  - Existing staff can access the Redland site which is approximately 40km from the existing Barrett site.
  - The attractions of Redland area (particularly the coastal climate as compared with the Ipswich-Goodna area) might attract existing staff to move or new staff to join.
- Public perception

- Caters to Public perception and politics whereby there is no proximity to a high security adult mental health facility or prison - we are not aware of any such facility anywhere near.

Site acquisition.

- It is understood that the land is State Government owned and is available for purchase from Dept of Infrastructure.

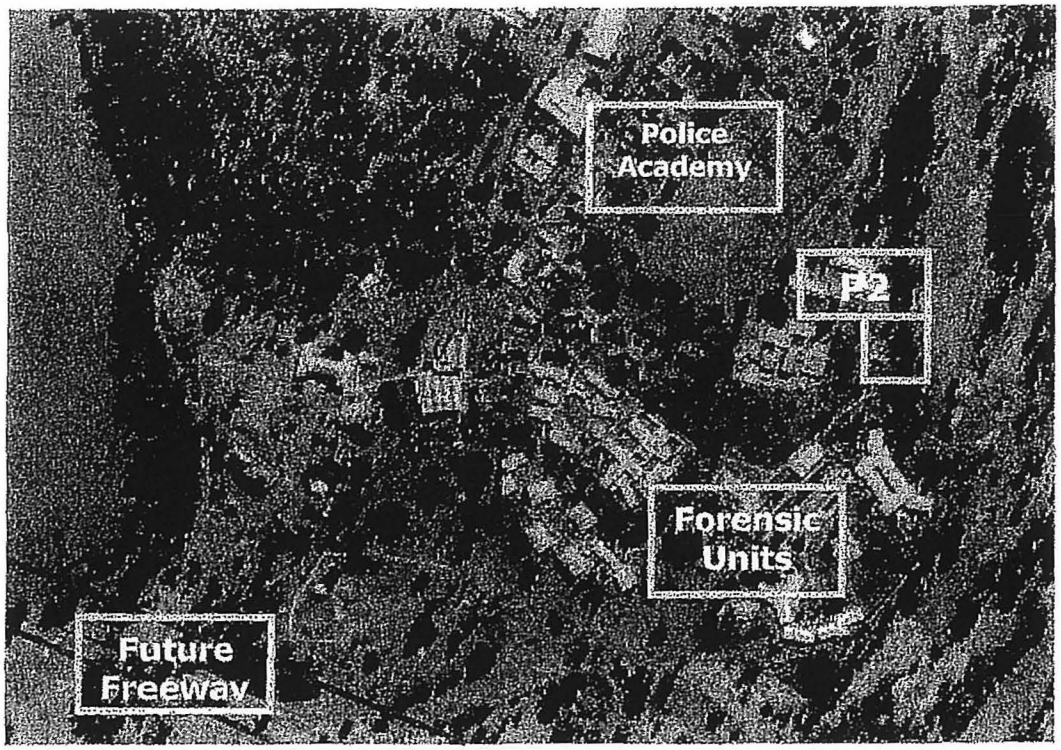
Koalas.

- The site is marked as an Urban Koala Area, which is the least onerous of the three types of Koala Habitat areas.
- It is adjacent to a large Koala Sustainability Area.
- Advice from Project Services Environmental section is that development on this site should not be a problem. It is just a matter of applying a Koala Management Plan, which will cover such items as retention and planting of suitable trees and appropriate fencing. The type of development proposed should be compatible with these requirements.
- Development on this site has not been costed, however, being a "green field" site should have some time and cost advantages.

Conclusion – Redland Site

The information currently at hand, indicates that this site would be suitable for the proposed Adolescent Unit.

Fig 2. P2- The Park Centre for Mental Health – (Aerial View)



4.2 Specific Site Considerations for P2 – The Park

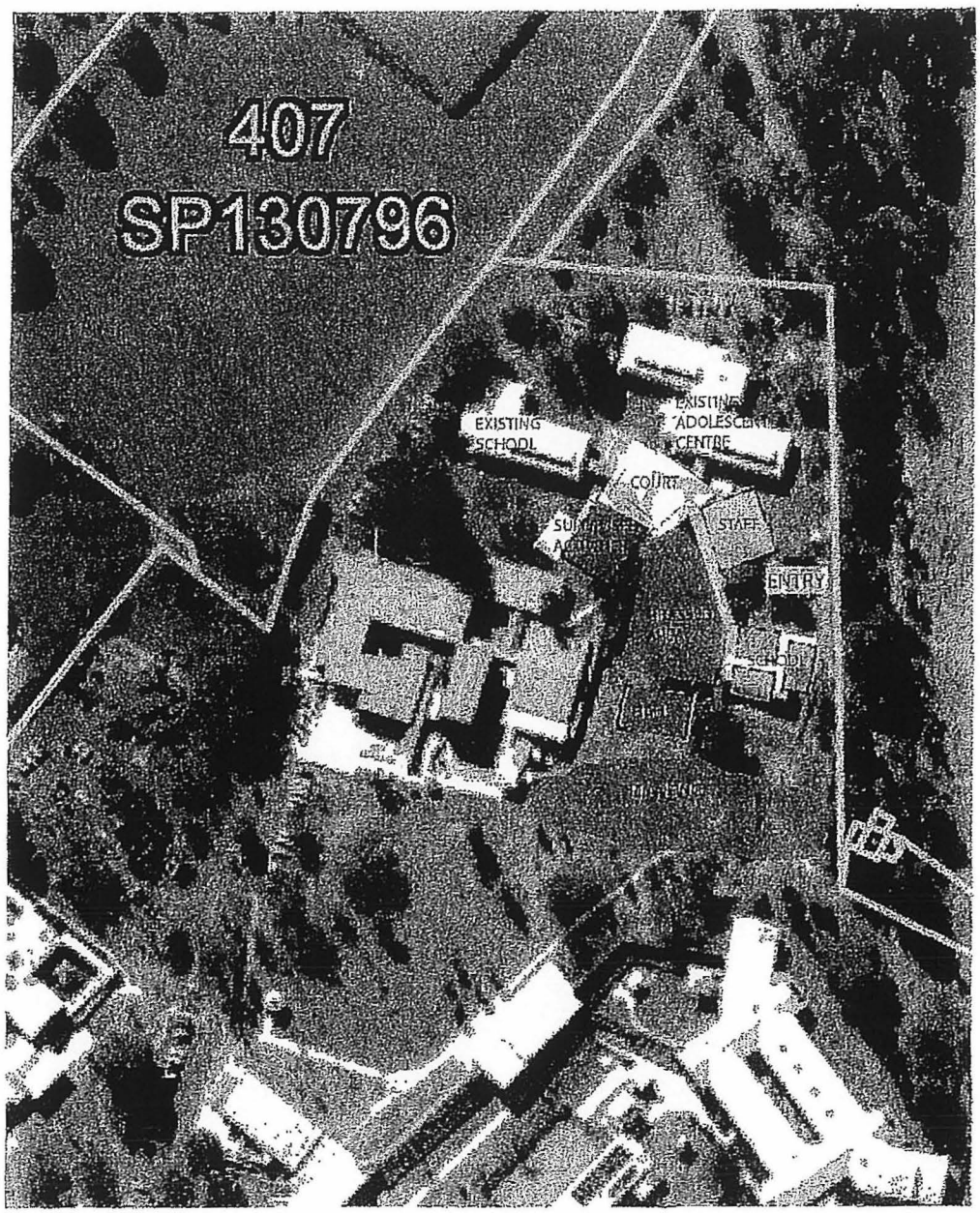
The existing location has been found to be satisfactory in many respects however the following issues need to be taken into consideration

- The Wacol location tends to be hotter in summer and colder in winter than sites closer to the coast.
- The close proximity of the high secure forensic unit could be a drawback.
- Undesirable persons - Open forensic unit nearby
- 2 Ha preferred area, 1.5 Ha minimum - About 1.5 Ha available.
- Existing oval may no longer be available once it is taken over by Police Academy.
- Access for families and visitors - No space available on site.
- Site development possible in stages while maintaining existing service is possible, but there may be a time and cost penalty in a staged development. Figures 3, 4 & 5 illustrate how such a staged development might be achieved while keeping the unit functioning.

Conclusion – P2 – The Park

If the continued proximity of the forensic unit and a compact site can be accepted, the site appears to be suitable for the re-development of the adolescent unit.

Fig 3. Site P2 Stage 1 (Existing Site Redeveloped in 3 Stages) (Aerial View)



SITE OPTION 1 ON EXISTING SITE AT THE PARK - STAGE 1

Project No: 5428
Project Title: 16 Bed Adol. ETU, Day Centre and School

Scale 1:1000 @ A3

Note: Options diagrams are based on draft accommodation schedule and spatial relationships workshops only and are not intended to be used as sketch designs.

Queensland Government
Project Services