BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

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

STATEMENT OF DR CARY BREAKEY

Name of Witness:	**Dr Cary Breakey**
Date of birth:	[redacted]
Current address:	[redacted]
Occupation:	**Semi-retired/part-time consultant**
Contact details (phone/email):	[redacted]
Date and place of statement:	**14 January 2016 at Brisbane**
Statement taken by:	**Catherine Muir and Emily Vale**

I, **DR CARY BREAKEY**, make oath and state as follows:

1. On 21 December 2015, I was contacted by Commission staff for the purpose of arranging a second meeting to discuss matters arising out of, and in addition to, my statement sworn on 29 September 2015 (my first statement). I then attended the Commission of Inquiry Rooms situated at level 10, 179 North Quay, on the afternoon of Thursday 14 January 2016 to speak to Commission staff.

2. Since swearing my first statement, I was able to locate several further documents, including:

   (a) A letter from the Department of Health Under Secretary dated 8 January 1983 notifying me that Cabinet had approved the establishment of the Barrett Adolescent Centre (the BAC). This letter is attached as **Appendix A** to this statement.

   (b) A letter from Dr Mary Corbett dated 23 November 2012 in response to my letter to the Minister for Health, attached as Appendix E to my first statement (note that paragraph 32 of my first statement incorrectly states that I sent this letter on 9

November 2009, rather than 9 November 2012). Dr Corbett's letter is attached as **Appendix B** to this statement.

(c) A media relations protocol was distributed by the Barrett Adolescent Centre Planning Group. This is attached as **Appendix C** to this statement.

Current employment

3. While I am "retired", I continue to work intermittently as a locum if a particular Child and Youth Mental Health Services (CYMHS) unit is short-staffed. In the last few years, I have undertaken locum work in both Senior Consultant and Acting director roles for Rockhampton CYMHS, Logan CYMHS and Toowoomba CYMHS. At the latter, I helped set up the Toowoomba adolescent inpatient service.

4. I am no longer a Queensland Health employee. I contract to Queensland Health through my medical company.

5. Most of my locum work has been in the field of child, adolescent and family psychiatry. I have periodically worked in adult psychiatry, but I prefer working with children and adolescents, because the model is very different and I believe there is more potential for change.

6. One of the important differences between the models for treating children and adults is pragmatic. When treating children and adolescents, there is more opportunity to work with the environment around the child. Often the family is more willing to participate in the child's treatment, and it is possible to organise schooling around the child's needs. There is also more flexibility in getting children and adolescents involved in external activities, such as PCYCs and sports clubs as well as part-time jobs.

The BAC model

7. I never wrote a model of service delivery for the BAC. Formal "models of service delivery" did not exist in the 1980s. The focus was (and remained) on the best possible care for each individual adolescent. I am unable to comment on whether a model of service delivery was ever endorsed.

The BAC cohort

8. I am unsure whether there were any differences in practice for assessing admissions after guidelines for admission were defined in 2003. Even if the guidelines appear to have changed, this did not change the population group.

9. Community and acute inpatient units referred adolescents to the BAC. Almost all of the adolescents admitted to the BAC in the last five to ten years of my involvement (which was up to July 2013) had at least one admission to an acute inpatient facility, and most had had multiple contacts with community and acute services.

10. The BAC cohort of adolescents generally had comorbidities; that is, their psychiatric diagnosis was complicated by other factors. For instance, there was a high admission rate for adolescents with severe anorexia who had a propensity for losing weight rapidly. Many of these adolescents had family situations where the usual treatment, the Maudsley model, was not going to work and had already failed, as the family could not tolerate the emotional distress associated with it.

11. Other adolescents admitted to the BAC not only had a psychiatric disorder, such as bipolar disorder, but were also at high risk of developing personality disorders and also often had a background of family traumas.

12. The adolescents admitted to the BAC tended in my view to have more severe and complex mental health conditions than those who could be successfully treated by community or acute services. This was why they were referred to BAC. Those with suicidality had previously made serious suicide attempts. Those with a propensity to self-harm did so more often, and the harm was more life-threatening.

13. The concept of severity often focuses on the severity of illness, rather than the severity of disability. If an adolescent has a mental illness and is also in a really complicated situation, and has nobody from whom to learn resilience and other coping skills, the mental illness is going to escalate.

14. One of the difficulties with the BAC population was that it was very diverse. Each adolescent had their own disabling and disturbing condition. This made (and makes) it difficult to research the population as a group. It also means that individualisation of treatment is important.

The day program

15. I am unable to comment on the number of inpatients and day patients at the BAC at any point in time as I do not have access to these records. When Dr Shearer and I opened the BAC, our intention was for there to be places for 15 inpatients and 10 day patients. By the late 1990s, the BAC was admitting both inpatients and day patients with increased severity of conditions. With this increased severity, I would not be surprised if less day patients were being admitted. The capacity of the unit to manage the higher risk/acuity population safely was critical. Also the community services and other day-programs were developing; and the BAC Special School had developed strong relationships with other developing education services that patients could be integrated into. The day program still remained critically important to the successful treatment of the BAC population. The opportunity to assess the adolescent on the unit with the specialised education and clinical staff, and especially his peer interactions within the milieu was very valuable, and facilitated work with his family, either on the BAC campus or in the community. Successful integration into the Special School, and the milieu, was often very therapeutic apart from other interventions.

16. If there was not a bed available for an adolescent on the waiting list, sometimes arrangements could be made for that adolescent to start the day program, and then later get admitted as an inpatient when a bed became available.

17. Similarly, many adolescents were discharged through the day program. With the BAC Special School on board, it was possible to facilitate integration back to the adolescent's base school. The Education Staff at the BAC were often able to facilitate the adolescent's transition into local schools so they could have a grade 11 and 12 high school experience. Some adolescents would start out with two days a week at another school, then attend the day program on other days.

Therapeutic milieu

18. An important feature the BAC model was the therapeutic milieu. Essentially, The BAC connected a group of adolescents who could relate to each other. While I accept that this association sometimes caused contagion of self-harm, it, more frequently in my view, caused contagion of recovery. Adolescents who were getting better would set useful examples for the other. In addition, staff became role models that some of the adolescents had not experienced before. It is not possible to get this milieu effect in an acute unit and many BAC patients had been seen as disruptive and reacting negatively in admissions to acute units. When adolescent behaviour escalated to levels of self-

harm, BAC staff would stay calm rather than become angry or aggressive – the milieu effect was very powerful in helping management at these times.

Family Therapy

19. I consider Family Therapy to be an important aspect in the treatment of adolescents with severe and complex mental health issue. Formal Family Therapy was the BAC's least strong intervention, but it has also been the weakest intervention across all mental health services. Much critical and valuable "family work" was done by BAC staff in helping families cope with patients' emotions and behaviours (and often vice versa). Commonly, families or the patient would ring in during over-night/weekend leave and the BAC staff member most familiar with the patient would help them resolve their crisis.

20. BAC staff conceptualised each adolescent as part of a family and tried to have as much contact with families as possible. This would not necessarily be labelled as Family Therapy, which has developed as a separate formal discipline. Over the years quite a few staff undertook a considerable amount of very effective formal Family Therapy.

21. It was always a concern of mine that, mainly for obvious geographical reasons, staff at BAC were unable to do enough family work with families who lived at a distance (and often at a distance from regional CYMHS services). Tools such as video-link were used, as was facilitating connection of families to regional clinics.

Length of stay

22. A common criticism of the BAC was that adolescents were staying too long. This criticism focuses too much on the concept of institutionalisation, and ignores rehabilitation. When adolescents were admitted to the BAC, they were often 18 months to two years behind on milestones, academically, emotionally and socially. They had fallen "off the tram" so to speak. As well as getting the adolescent well, the BAC was tasked with the role of getting the adolescent "back on the next tram". By the time an adolescent had been admitted for a year, their peers had developed another year, so they were always playing catch up. The challenge at the BAC was moving adolescents who had been institutionalised in their home as mental health patients, to live in the community. Recently I attended a medical conference on Psycho-Social Rehabilitation in India and I gave a presentation titled "Towards Recovery – Maintenance of Developmental Trajectory Critical in Adolescent Mental Illness – Getting Back on the Tram". This presentation was based on my BAC experience. The PowerPoint presentation for this paper is **Appendix D** to this statement.

23. The BAC opened in the absence of any other adolescent inpatient units. I did not have a vision of the length of stay in 1983-1984, but aimed to admit the adolescents early, before they did too much damage to themselves. At that time, I would not have anticipated very long stays. However, by the late 1990s the severity of conditions of the BAC patients had increased. I think this reflected both increased severity across the increasing population, and community and acute CYMHS services dealing with all but the most severe – who then were referred to BAC.

24. With the services that were available around the time the BAC closed, it would not have been possible to limit length of stays to six months. I do not know whether this would still be the case now that new services have been introduced (many of which Dr Sadler and myself are on record as recommending over many years). For example, the opportunity for Youth Rehabilitation Residential Units and SubAcute Beds are a significant change in the right direction.

25. I am aware that the average length of stay increased in the last two or three years of the BAC's operation. One of the contributing factors to this increase, in my view, was issues with staffing. In later years, there were more agency nurses and the BAC gradually lost experienced senior staff who knew the adolescents and their families, and who had formed relationships of trust with them. Due to the uncertainty of the BAC closing, many staff for their own personal reasons had to move onto more certain jobs. Some staff were appointed on contract and did not know if they would be there the following month. These issues became more and more noticeable each time I did a locum. This is not a criticism of those staff, because all of these people were dedicated and working tirelessly in very difficult circumstances.

26. With adequately trained staff and appropriate step down facilities, a six month length of stay at the BAC would have been much more likely.

27. Referring services generally complained about the length of stay causing a bed block. In response, I would ask "whether the service was ready to handle the last adolescent they had referred to the BAC, back in the community". The plan at the BAC was always to get adolescents back to their families and the communities in the shortest time possible, if BAC had been better supported with other services, this could have been achieved faster.

Faculty of Child and Adolescent Psychiatry of the RANZCP Queensland

28. In November 2012, I requested to attend the Meeting of the Faculty of Child and Adolescent Psychiatry of the RANZCP Queensland to be held on 27 November 2012. I recall at this meeting that there was a lengthy discussion about the BAC, and my

impression was that there was generally support for the BAC service continuing in some form. This meeting was held after Dr McDermott had made his statement to the Child Protection Commissioner of Inquiry about potential closure of BAC. Attendances would have been recorded, but I cannot recall who attended.

Dr Sadler's suspension

29. After hearing an ABC radio report on a statement from the Minister of Health, in early September 2013, I discovered that Dr Sadler had been stood down [redacted] I was both concerned and surprised at this news and course of action. I was concerned because I knew that with the potential closing of the BAC it would be a very difficult time for the adolescents and they would need as much support as possible from people they were familiar with and trusted. I was surprised that Dr Sadler was stood down because in my 35+ years of working with Queensland Health, I have no recollection of a unit Director being stood-down in such a precipitous manner.

30. [redacted]

Transition

31. As discussed in paragraph 38 of my first statement, I emailed Sharon Kelly and offered to resume the role of Acting Director at the BAC after Dr Sadler was stood down. I considered that it might have been helpful for me to step into this role given that I had over the years stood in for Dr Sadler and I knew many of the patients and their families. I thought that it may assist in calming any anxiety surrounding the closure and Dr Sadler being stood down. My email is attached as **Appendix E** to this statement, and Ms Kelly's response is attached as **Appendix F.**

32. [redacted]
Struck Out by the Commissioner on 15 February 2016

[redacted]

Other services

33. I am aware that an Assertive Mobile Youth Outreach Service (AMYOS) has been established over the last two years. While I was undertaking locum work at Logan, the department was advertising positions for the Logan AMYOS team, but I do not think they received any applications. While I believe AMYOS is a valuable model, it is not useful as some sort of stop gap for the BAC.

34. I consider that the best use of assertive outreach is the Evolve model, developed by Dr Nigel Collings with QH and DoCS. As I currently understand it, Evolve has more flexibility than AMYOS, and lower patient/staff numbers.

35. I also consider that Headspace is not appropriate for most of the BAC cohort. While some Headspace units have very good and committed staff, the model is quite complicated and often rigid, and is more suited for patients that will recover within the 6-10 sessions that are funded. It can be a valuable service, just not to cope with the BAC patient group.

36. There has been a progressing tendency for government departments to contract out a range of their care responsibilities to NGOs. Whilst many fulfil their commitments admirably, unfortunately many do not. From my experience of working with Evolve teams relating to children in residential placements from DoCS, many services have difficulty maintaining staff with sufficient skills, experience, and emotional resilience to deal with their difficult population. These issues would make the management of a 24/7 model for adolescents of BAC complexity by an NGO very difficult from both care and governance aspects. BAC received regular referrals from NGOs and spent much (appropriate) time and energy supporting them for patients before, after and during admissions.

Alignment

37. There a significant gaps in the alignment of adolescent and adult mental health services in Queensland. Adult services primarily focus on psychosis, with some services for

alcohol and drug abuse. Issues relating to development, emotional control and resilience are not currently part of adult services and in my experience are referred out to private practitioners/NGOs with often limited resources/models. If a patient is 18 years old, adult services look at him as an 18 year old, not an adolescent perhaps functioning at the level of a 15 year old.

38. From a psychiatric point of view, the level of emotional maturity of 18 year olds vary considerably. Some 18 year olds behave like 22 or 23 year olds, while others behave like 15 year olds. Most of the BAC cohort were not socially functional 18 year olds, even upon discharge. The BAC assisted however in bringing them closer than they were, when they were admitted.

39. To improve alignment issues, services should be actively aware of these developmental issues. For instance, if a 19 year old is functioning emotionally at a 16 year old level, CBT aimed at an adult will not be a suitable treatment.

40. Ideally, I would like to see separate inpatient units treating 13 to 17 years, and 17 to 22 or 23 year olds separately. However this should be based on developmental levels rather than chronology.

OATHS ACT 1867 (DECLARATION)

I, DR CARY BREAKEY, do solemnly and sincerely declare that:

(1) **This written statement by me dated** 9.2.16 **and contained in pages numbered 1 to 9 is true to the best of my knowledge and belief: and**

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

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

.. [redacted] .....**Signature**

Taken and declared before me at BRISBANE **this** 9TH **day of** FEBRUARY **2016**

[redacted]

Taken By TARA BOSWORTH

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

BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

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

INDEX OF ANNEXURES

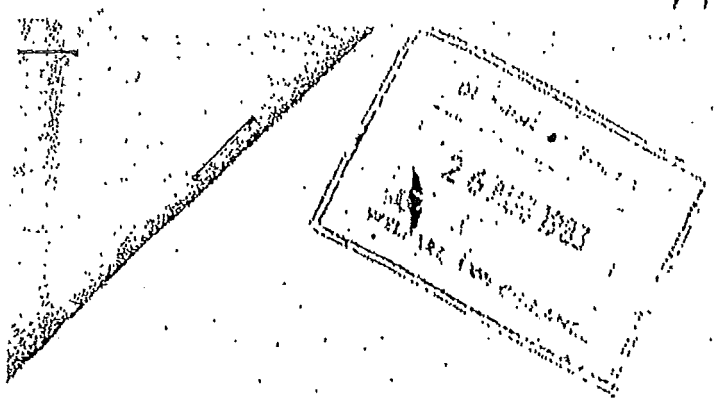
Bound and marked "**Appendix A**" to "**Appendix F**" are the annexures to the Statutory Declaration of **Dr Cary Breakey** declared 2016:

Appendix	Document	Date	Page
A	Letter to Dr Breakey from the Department of Health Under Secretary	8 Jan 1983	11
B	Letter to Dr Breakey from Dr Mary Corbett	23 Nov 2012	14
C	Media relations protocol distributed by the Barrett Adolescent Centre Planning Group	December 2012	15
D	PowerPoint slides of presentation entitled "Towards Recovery – Maintenance of Developmental Trajectory Critical in Adolescent Mental Illness – Getting Back on the Tram"	Undated	16
E	Email from Dr Breakey to Sharon Kelly re: BAC Consultant Cover	15 Sep 2013	29
F	Email from Sharon Kelly to Dr Breakey re: BAC Consultant Cover	16 Sep 2013	30

[redacted] .....
Witness Signature: /

[redacted] .....
~~Justice of the Peace~~ /
~~Commissioner for Declarations~~ /
Lawyer

'A'



8th January, 1983.

Dear Sir,

On the 20th December, 1982, Cabinet decided that approval be given for the establishment of an adolescent psychiatric service to be called the Barrett Adolescent Centre, Gailes. It also determined that the matter of additional staff be referred to the Public Service Board for consideration in the light of the approved 1982/83 Public Service staffing policy and administrative arrangements with respect thereto.

A copy of the proposal for the establishment of the unit which was attached to the Cabinet Submission is attached for your information.

It is proposed that the new specialised treatment service be established within the Division of Psychiatric Services. It is stressed that this unit will be an independent treatment unit. It will, however, have close professional links with the Division of Youth Welfare and Guidance and professional and practical links with Wolston Park Hospital, Wacol.

It is proposed that the staff establishment for the Barrett Adolescent Centre, Gailes, Division of Psychiatric Services, Department of Health, be -

1 Senior Psychiatrist
1 Medical Officer
1 Medical Officer (Psychiatry Registrar)
1 Social Worker
1 Occupational Therapist
5 Child Guidance Therapists
1 Nursing Supervisor
1 Charge Nurse
3 Deputy Charge Nurses
24 Nurses

All nursing positions are to be appointed under the Psychiatric Hospital Employees Award, and all other positions under the Public Service Award.

Additionally, five positions of Teacher are required for this service. The Director-General of Health and Medical Services is in correspondence with the Director-General of Education concerning whether these positions should be created within the Department of Health or the Department of Education. Further information will be furnished on this matter.

... 2.

Of the 40 positions required by the Department of Health, a ... of service requirements resulting from the establishment of this new unit indicates that eight positions from the Division of Youth Welfare and Guidance and 10 positions from the Division of Psychiatric Services can be made available to create this new service."

The current occupants of these positions are also suitable to work within the unit and it is therefore proposed to redesignate the positions and their occupants.

It is noted that all redesignations are at equal classification levels and the positions should therefore be considered as filled.

The Department of Health positions are listed in the attached Schedule.

In addition to these positions, the following 22 new positions should be created -

1 Medical Officer	Barrett Adolescent Centre, Division of Psychiatric Services	Gailes
19 Nurses	Barrett Adolescent Centre, Division of Psychiatric Services	Gailes
1 Social Worker	Division of Psychiatric Services	Gailes
1 Occupational Therapist	Division of Psychiatric Services	Gailes
22		

Your attention is drawn to the fact that the Internal Operational Audit Services is presently reviewing the organisational structure, finance utilisation, management and staffing of all established Institutions of the Department of Children's Services. The impact of the proposed service on the operations of the Wilson Youth Hospital is to be specifically considered in the review.

It is noted that there may be some qualified nursing staff supernumerary to the requirements of Wilson when these changes take place. Some of these staff may be suitable to work at the Barrett Adolescent Centre, Gailes and could be redesignated to the proposed new positions of Nurses. Such redesignation may require personal classification and specific union negotiations.

It is proposed that two specific conditions apply to the deployment of staff within the Barrett Adolescent Centre, Gailes.

Firstly, given the necessity of the closest professional links with the Division of Youth Welfare and Guidance, authority to transfer staff to and from the following positions to equivalent positions within the Division of Youth Welfare and Guidance be delegated from the Public Service Board to the Under Secretary, who will act on the advice of the Director of Youth Welfare and Guidance (and the Director-General of Health and Medical Services).

Positions which are able to be transferred by the Under Secretary to and from the Division of Youth Welfare and Guidance are -

Senior Psychiatrist
Medical Officer
Social Worker
Psychologist
Occupational Therapist
Child Guidance Therapists (5 positions)

It is stressed that this ability to transfer staff is necessary to provide a flexible, specialist child and youth psychiatric service.

Secondly, the practical links with the nursing services provided within the Wolston Park Hospital Complex should be recognised by allowing the staff to operate in a similar relationship to that of the Wacol Repatriation Pavilions to Wolston Park Hospital, i.e. there is a separate establishment but there is a combined coverage of some sick leave and absenteeism, student training and across centre promotional opportunities.

While generally the provisions of the Psychiatric Hospital Employees Award will apply and most agreements under the Award can be appropriately applied, there will need to be some specific negotiations with the nursing unions to emphasise special aspects of the operations of the service.

In particular, the fact that this unit will have a closed roster of specialised staff and there may be some (ex Wilson Youth Hospital) Nurses not having psychiatric nursing certificates initially employed, must be emphasised.

A draft letter from this Department to the unions is attached. Your agreement to this letter is sought.

It is noted that no additional contingency funds will be required to establish the service. Funds presently allocated to the Division of Psychiatric Services will be redeployed for this purpose.

During 1982/83, the service will be included within the expenditure of Wolston Park Hospital. From the 1st July, 1983, a separate Budget heading will be established.

Buildings will be ready for occupation and the service will be able to commence on the 31st March, 1983.

Your urgent attention is sought in this matter to enable the creation and filling of the staff positions to enable commencement of the service at that date.

Yours faithfully,

[redacted]

Under Secretary.

'B'

Queensland Government

Queensland **Health**

Enquiries to: Chief Executive
Telephone:
Facsimile: [redacted]
Our Ref: MI186231

Dr Cary Breakey
[redacted]

Dear Dr Breakey

Thank you for your emailed letter dated 11 November 2012 regarding the Barrett Adolescent Centre.

As you would be aware, the Office of the Minister for Health has forwarded your correspondence to me for direct response.

Please be assured that the West Moreton Hospital and Health Board is committed to ensuring Queensland's adolescents have access to the mental health treatment and care they need.

I understand that currently you are doing a locum at Barrett Adolescent Centre while Dr Sadler is on leave. During this time I understand you will be a part of the planning group that will work in collaboration with the expert clinical reference group.

As you are aware, the expert clinical reference group will develop a model of care that will be contemporary and evidence based. This model of care will be developed to meet the needs of adolescents in Queensland requiring longer term mental health treatment.

The Hospital and Health Service is committed to work together with the community, mental health consumers and families to ensure they and other stakeholders are kept up to date. A communication plan has been developed regarding the progress in the development of the model of care. Consultation will be broadly based prior to a decision being made.

Once again I thank you for your correspondence and in anticipation of your forthcoming contribution.

Yours sincerely

[redacted]

Dr Mary Corbett
Chair
West Moreton Hospital and Health Board

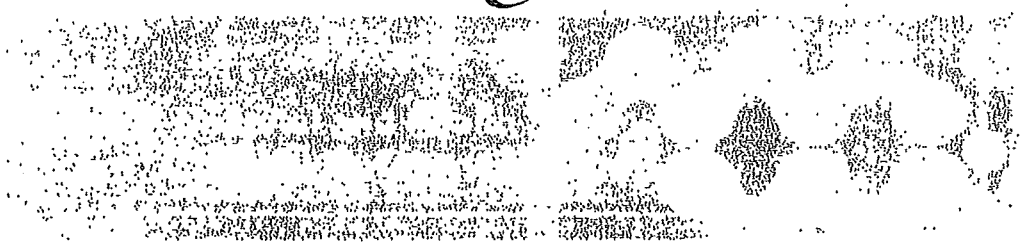
23/11/12

Office
Ipswich Hospital
Chelmsford Avenue
IPSWICH QLD 4305

Postal
PO Box 73
IPSWICH QLD 4305

Phone [redacted] *Fax*

(C)



This protocol applies to media relations in regards to the Barrett Adolescent Centre Expert Clinical Reference Group.

The protocol incorporates matters pertaining to media, inclusive of inquiries, alerts, releases, press conferences, liaison with the media, internal approvals, liaison with the Minister's office and associated approvals, procedural matters, parliamentary questions and other activities.

The purpose of this protocol is to establish clear guidelines for media management and liaison between West Moreton Hospital and Health Service (HHS), BAC Expert Clinical Reference Group, Queensland Health, the Minister's office and the media regarding the BAC.

Under the West Moreton Hospital and Health Board's direction, West Moreton will have direct control of operational media issues.

To ensure there are no competing messages being presented to media, the Chief Executive (CE) will ensure copies of all statements and responses are sent to corporate office and the Minister's office for their information.

The CE of West Moreton HHS or clinical delegate will be the spokesperson. Members of the Expert Clinical Reference Group will not participant in media unless requested to by the CE.

On matters requiring Ministerial approval, West Moreton HHS will defer to Queensland Health media unit. Media requiring Ministerial approval includes:-

- State Government policy
- potential to invoke political comment or contention
- significant funding or infrastructure delivery

If requests for media interviews on the topic of the BAC are received by panel members of their associated organisations, they should be forwarded to [redacted].

Queensland Government

EXHIBIT 172

towards recovery

Maintenance of Developmental Trajectory Critical in Adolescent Mental Illness

"Getting back on the tram"

Dr Cary Breakey
Child, Adolescent & Family Psychiatrist
www.ozemail.com.au/~breakey

Barrett Adolescent Centre

'D'

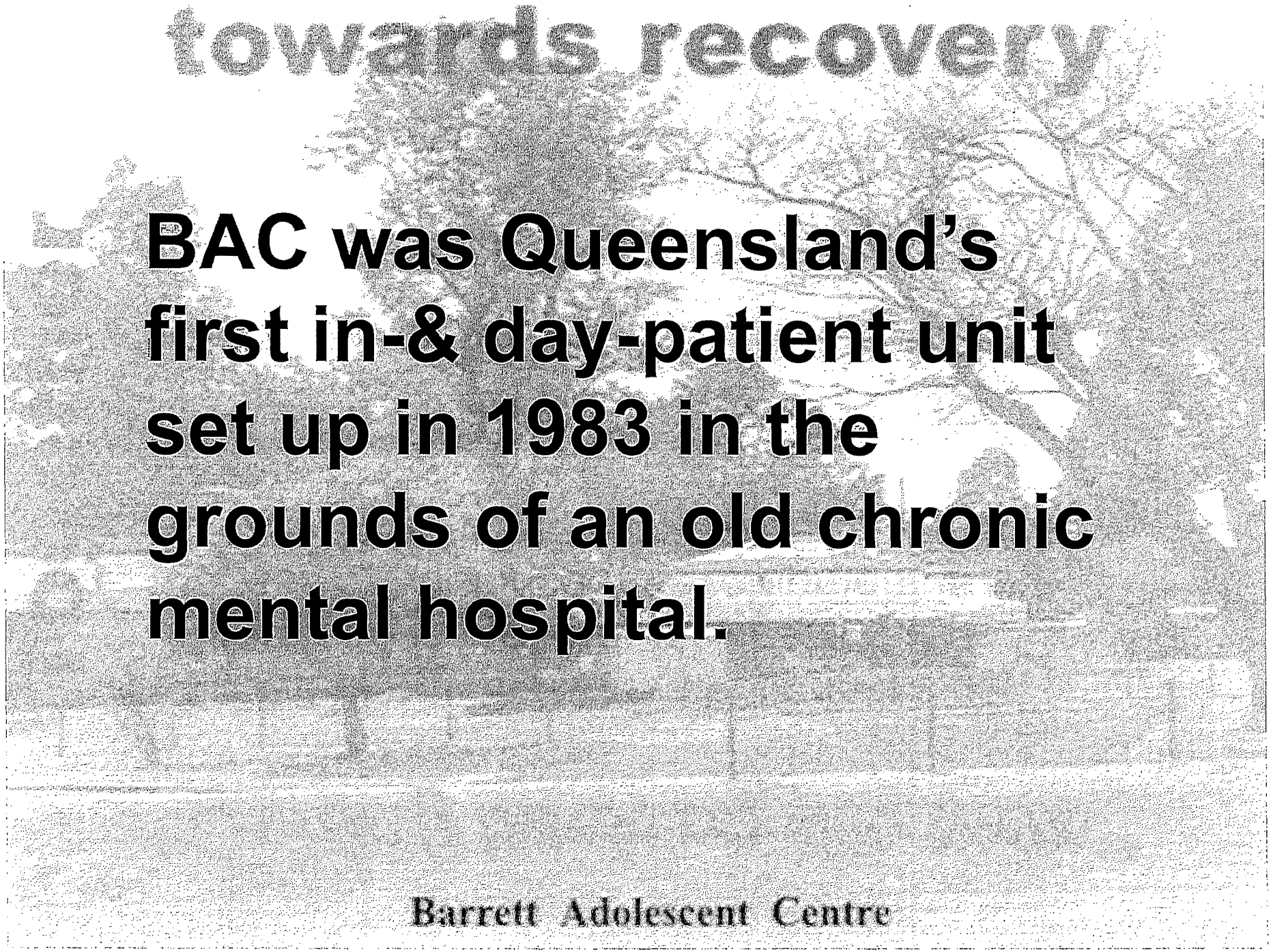
towards recovery

Acknowledgements:

Dr Trevor Sadler

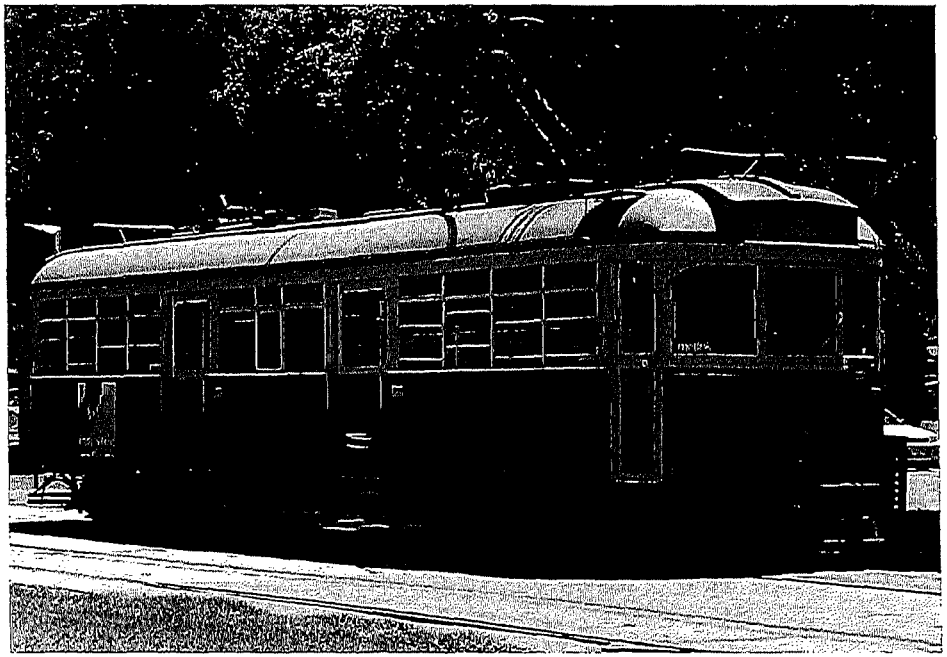
for these Barrett Adolescent Centre backgrounds, and some of my/his patient stories, as well as continuing on from me as Director of BAC for the last 25 years until its sad closure in 2013.

Barrett Adolescent Centre



"Getting back on the tram"

A useful analogy that kids and families can understand is that mental illness during the process of adolescent development is like "falling off the tram", and that their peers have continued on.



"Falling off the tram"

Regardless of diagnosis, all of the adolescents we had in the unit had significant degrees of impairment in often a few areas of adolescent development at the time of admission. Most commonly academic delays, but regularly social and emotional control deficits.

Initial Assessments

- **Problems with diagnostic specificity in adolescence**
- **Usually present with co-morbid diagnoses**
- **Often meaningless in the absence of a developmental history so this pre-morbid information is critical**

"Where's the tram gone!!"

Developmental tasks of Adolescence

- Cope with physical changes
- Develop cognitive maturity
- Develop emotional maturity
- Negotiate school and peer relationships
- Occupy leisure time
- Develop identity, establish boundaries
- Develop a sense of future - hope

"Can't catch a tram by myself" Will/Can the family help?

- Level of commitment
- Adequacy of nurturance
- Attachment/bonding styles
- Emotional containment
- Meeting protection & dependency needs
- Levels of consistency, supervision, monitoring, correction styles
- Communication of schemas, values
- Adequate boundaries

Critical Developmental tasks for Families of Adolescents

- Capacity to understand the new "becoming-adult"

- Capacity to facilitate transitions

As well what other resources?? Academic/vocational

- BAC had its own Education Dept Special School which was able to tailor approaches to where the each individual kid was at.
- Access to "graduate" kids to reintegrate either into their previous school or local to BAC

As well what other resources?? Academic/vocational/life

Many kids were helped to get part-time jobs which they would be supported to attend (Thank you Maccas!)

Finding areas of interest eg sport, drama, and matching kids to local community agencies for these was often a challenge

So

Yes, deal with the mental illness comprehensively, but focus beyond that for this adolescents life course will depend at least as much on help we can help he and the family progress these developmental steps

towards recovery
Remind him regularly he's a person – not just a patient.
Thank you for your attention.
Questions??
Barrett Adolescent Centre

From: Cary & Joan Breakey
Sent: 15 Sep 2013 20:23:43 +1000
To: Sharon Kelly;Terry Stedman
Subject: BAC consultant cover
Importance: Normal

Hi Terry and Sharon,

I have recently discovered that Dr Sadler is currently stood down from BAC, and Dr Anne Brennan is covering temporarily. Having known Dr Brennan well, even from her training days, I have implicit faith in her experience and expertise and am sure she will care for BAC and patients well. However I assume the BAC committment is in addition to her usual positions and may be particularly onerous for her at this particularly stressful time for the unit.

As you are aware, I have acted in Dr Sadler's position regularly over the years and quite recently, so I know most of the patients and regular staff. Currently I do not have any clinical commitments in the near future apart from two conferences, and would be available to cover the position if required.

Regards, Cary Breakey

From: Sharon Kelly
Sent: 16 Sep 2013 15:39:19 +1000
To: Breakey, Cary & Joan
Subject: Re: BAC consultant cover

Cary,

thank you for your email and offer of support. Currently we have made arrangements for the cover, but should this change I will ensure your offer is considered.

Regards
Sharon

Sharon Kelly
Executive Director
Mental Health and Specialised Services

West Moreton Hospital and Health Service
T: [redacted]
E: [redacted]

The Park - Centre for Mental Health
Administration Building, Cnr Ellerton Drive and Wolston Park Road, Wacol, Qld 4076
Locked Bag 500, Sumner Park BC, Qld 4074

www.health.qld.gov.au

>>> "Cary & Joan Breakey" [redacted] 15/09/2013 8:23 pm >>>
Hi Terry and Sharon,

I have recently discovered that Dr Sadler is currently stood down from BAC, and Dr Anne Brennan is covering temporarily. Having known Dr Brennan well, even from her training days, I have implicit faith in her experience and expertise and am sure she will care for BAC and patients well. However I assume the BAC committment is in addition to her usual positions and may be particularly onerous for her at this particularly stressful time for the unit.

As you are aware, I have acted in Dr Sadler's position regularly over the years and quite recently, so I know most of the patients and regular staff. Currently I do not have any clinical commitments in the near future apart from two conferences, and would be available to cover the position if required.

Regards, Cary Breakey