BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

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

STATEMENT OF MYFANWY PITCHER

Name of Witness:	**Myfanwy Pitcher**
Date of birth:	**22/01/1973**
Current address:	
Occupation:	**Regional Manager**
Contact details (phone/email):	
Statement taken by:	**Jessi Whitby, Louise Norman and Helene Wells**

I, **MYFANWY PITCHER,** make oath and state as follows:

1. I am the Aftercare Regional Manager for Residential Services in Queensland. I have held this position since starting with Aftercare in October 2013.

2. As Regional Manager, I manage two Youth Residential Rehabilitation Units (YRRUs) in Greenslopes and Cairns, and one adult transitional service in Mackay, comprising of two residential houses and an outreach service. My role includes the operational, clinical and strategic management and oversight of all residential services.

3. Prior to this role at Aftercare, I worked for 13 years in child and youth, and adult public mental health services (both in inpatient and community services) as a social worker, senior social worker, family therapist and team leader at two community Child and Youth Mental Health Service (CYMHS) clinics. A copy of my curriculum vitae is attached and mark **"MP-1."**

Aftercare's experience in delivering community-based residential programs for young people

4. Aftercare operates two youth residential rehabilitation units (YRRUs) for Queensland Health. The YRRU at Greenslopes in south Brisbane commenced operations on 3 March 2014. The YRRU at Cairns commenced operations on 1 January 2015. The Cairns unit had previously operated under a different model — the Time Out House Initiative (TOHI) — with a different staffing profile and some different services.

5. The YRRUs provide a residential rehabilitation service for up to 12 months for young people aged between 16 and 21 years who have mental health concerns. The aim of the YRRU is to develop the skills necessary for each young person to live an independent and fulfilling life in the community. Clinical care is provided by Queensland Health Community Mental Health Services (either CYMHS or AMHS) as organised by the case manager. YRRU staff have contact with case managers as required.

6. Each YRRU can accommodate up to 5 young people. The Cairns residence has 5 single bedrooms, and the Greenslopes residence has three single rooms and one room shared by two residents. The shared rooms are not an ideal situation because young people need their own space, particularly to help support their coping strategies and contain their distress (when expressed).

7. Aftercare has also operated a youth residential facility, known as "Kurinda", in Sydney for 20 years. Kurinda is a different model to the Queensland YRRU model in a number of respects.

8. Firstly, Kurinda is a medium to long term facility, housing young people for up to 3 years. This compares with a maximum length of stay at the YRRU of 12 months. The longer length of stay at Kurinda is due to the step-down transitional nature of the service. Kurinda includes 2 high support beds, 6 semi-supported beds, and 2 independent living units at the rear of the property.

9. The age profile of the units also differs. Kurinda accepts young people aged between 14 and 26 years old, whereas the age range at the YRRUs is 16 to 21 years. This wider age range probably contributes to the more extended stays at Kurinda, because a 14 year old referred to Kurinda may not have alternative accommodation to be discharged to within shorter time frames.

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10. There are also differences between the YRRUs and Kurinda in terms of referral pathways and programs. Kurinda only accepts referrals from the Blacktown Mental Health Service because they are funded by the Western Sydney Local Health District (LHD). The YRRUs accept referrals from any Queensland Health inpatient unit or community Child and Youth Mental Health Services (CYMHS) or Adult Mental Health clinics. Kurinda does not have the same Living Skills program that is the core of our program in the YRRUs. Kurinda is now implementing some of the YRRU programs and guidelines, including the Living Skills program, medication management, risk management, and staffing guidelines.

11. The staffing profile of the two services is similar. At all Aftercare youth residential services there are two staff rostered on at all times during the day and night

12. The qualifications and experience of staff are also similar in nature, despite the fact that the YRRU service is not technically a clinical service. Rather the YRRU is an extended rehabilitation service. Clinical interventions — the treatment component of an extended treatment and rehabilitation service — are provided by Queensland Health case managers and clinicians.

The YRRU model

13. The YRRU model is strengths based. This is even reflected in our language. We do not have "patients", we have "residents" or "young people". Residents are not "admitted" or "discharged", they "enter" and "exit" the program.

14. We do things differently in that we do not isolate young people from the community. There is significant research that indicates that a person in hospital will take on a "sick" role or become more unwell.

15. Our role is to encourage and develop independence, rather than reliance, in our young people.

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The Living Skills program

17. The Living Skills program is the core of our rehabilitation program. This includes a range of individual and group activities based on the individual plans.

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24. Most young people exit the program to independent living in shared accommodation, student accommodation or a residence. We work with their Queensland Health case manager on the exit transition, and continue to link the young person with relevant community services as they are preparing to exit and after exiting.

Dealing with critical incidents

25. As I explain later in this statement, our staff are qualified and experienced workers, who are very capable in managing young people in a distressed state and in dealing with critical incidents, such as serious self-harm. Fortunately, critical incidents are relatively rare occurrences.

26. We have clear rules and procedures for dealing with residents who are distressed.

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30. Across the Cairns and Greenslopes units, An acute admission does not mean that the young person loses their place in the house. Once stabilised, they can return to the YRRU and continue their rehabilitation program. , although none have required admission.

Referral and entry process

31. The YRRUs accept referrals from Queensland Health mental health services, including community CYMHS clinics, adult mental health services, and acute inpatient units. The Greenslopes YRRU predominantly receives referrals from CYMHS, because the YRRU was established as part of the Adolescent Mental Health Extended Treatment Initiative (AMHETI).

32. In Cairns, most of the referrals come from adult mental health services. This is likely because the Cairns YRRU transitioned from the Time Out House Initiative (TOHI) model. TOHI was a respite accommodation unit that housed 18 to 25 year olds for up to three months. Due to the existence of TOHI, the adult services are familiar with making referrals to Aftercare. We are currently working on building our relationship with the Cairns CYMHS service to educate them about our service, and this appears to be reflected in a recent increase in referrals.

33. Referrals are considered by the Youth Resi Referral Panel, which meets monthly. The core panel members are:

    a. the Medical Director, CYMHS, Children's Health Queensland Hospital and Health Service (HHS) (Dr Stephen Stathis) — co-chair;

    b. the Deputy Chief Executive Officer, Aftercare (Ivan Frkovic) — co-chair;

    c. the Queensland Regional Manager, Residential Services (myself);

    d. the team leaders from the Cairns and Greenslopes YRRUs;

    e. the AMHETI project manager from Children's Health Queensland HHS;

    f. a mental health clinician from CYMHS, Children's Health Queensland HHS.

34. Other stakeholders, including the referring service providers, are invited to participate in consumer cases under review. Children's Health Queensland HHS performs the secretariat function. The referral panel protocol is attached and marked Exhibit **"MP-2"**.

35. The referring service provider (the "primary service provider") makes a referral via the Queensland Health Consumer Integrated Mental Health Application (CIMHA) system. The referral is emailed to the panel secretariat and then distributed to the YRRU panel members.

36. Panel meetings are held on the last Thursday of every month. The case managers are invited to dial in, so the panel can ask questions and discuss the referral. The panel determines if the young person meets the referral criteria to enter the program. If accepted, the next considerations are whether the house has a current vacancy or whether they will have to be waitlisted, their priority on the waitlist, and their fit with the current house milieu.

37. We can accept young people with complex psychosocial needs who are socially and functionally impaired. However, we do need to know that the young person is capable of improvement even if they have a significant impairment. We do not accept significantly intellectually impaired young people, young people who are acutely unwell either with physical or mental health issues, or young people who are withdrawing or detoxing from substance misuse, as we are not equipped to meet those quite specific needs.

38. The young person must be able to manage their basic self-care needs (showering, self-grooming and self-hygiene). The development of other life-skills such as cooking, using public transport, accessing an ATM, and enrolling in TAFE, is part of the purpose of the program.

39. Another requirement for entry is buy-in from the young person and a willingness to participate in the program, as it is entirely voluntary.

40. Dr Stathis notifies the Queensland Health case manager of the outcome. The house team leader organises entry.

41. Currently there are three people on the wait list for Greenslopes. There is one person on the waitlist for Cairns and two referrals to be discussed.

The process of accepting a referral — a case study

42. The following example demonstrates the referral and entry process.

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Outcome measures

46. On an individual level, we administer a range of standardised assessment instruments to monitor a resident's progress:

    a. the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS) rates the needs of the person over the preceding month on 22 different health and social domains;

    b. the Recovery Assessment Scale – Domains and Stages (RAS-DS) assesses aspects of recovery from the perspective of the young person across four domains — functional recovery, personal recovery, social recovery, and clinical recovery.

    c.

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47. the CANSAS and RAS-DS are mandated by Queensland Health, to be completed at least every 3 months.

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49. There is no expectation that Aftercare will follow up with exited residents and Aftercare is not in a position to undertake a longitudinal evaluation of its services.

50. On a program evaluation level, there is currently no long-term evaluation process. Children's Health Queensland HHS has indicated that it intends to conduct an evaluation, but there has been no progress as far as I am aware.

Staffing profile

51. There are shifts per day, with two staff are rostered on at all times:

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52. Staff are appointed at

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54. The only staffing profile requirements stipulated by Queensland Health are that each shift has two staff members. Consequently, Aftercare has established our own minimum standards for the recruitment of staff for each role.

55. This does place Aftercare at a commercial disadvantage when competing for tenders. The more qualified staffing profile we have mandated for ourselves increases our operating costs and makes it difficult for us to compete financially with other NGOs. However, we have made the decision that we do not want to assume the safety risks of operating the service with staff who do not have the skills and experience needed to manage the severity, complexity, and acuity of the young people we accept and support.

56. Aftercare requires In my role as Regional Manager, I am responsible for overseeing and working with the Team Leaders to recruit staff.

57. The current staffing profile at **Greenslopes** is as follows.

58. The current staffing profile at **Cairns** is as follows.

Resident profile

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66. Gender is not a factor for intake, unless there is a particular sensitivity that needs to be considered.

67. The **diagnostic profile** of our residents is young people with severe and complex mental health conditions, and complex psychosocial needs. Mental health disorders include a combination of the following: depression; anxiety; chronic self-harm; suicidal ideation; reactive attachment disorder; trauma; bipolar disorder; schizophrenia; eating disorders; Obsessive Compulsive Disorder; emerging personality disorders; and gender identity disorder.

68. **Acuity** refers to the current level of risk the young person presents to themselves and others. The mental health acuity of our residents would generally be considered as "moderate", although their diagnoses may be complex. For example, some residents have up to 10 diagnoses as well as a range of complex social and emotional needs.

69. We will not admit young person at a high level of acuity. For example, a young person who is suicidal with intent and a plan to carry it out, or continually self-harming. We are not set up to manage young people who enter in a state of high acuity. The same applies if a young person is actively psychotic or medically compromised by an eating disorder. These young people need an acute inpatient admission.

70. We will continue to manage a resident whose condition deteriorates to the point where they are self-harming on a regular basis, so long as we assess that we can keep them safe. If we assess that we cannot, we will liaise with their case manager and they will be admitted to an acute inpatient unit until they are stabilised. They can then return to the program.

Case examples

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A former Barrett Adolescent Centre patient

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Witness Signature: .... Justice of the Peace / ~~Commissioner for Declarations~~ / Lawyer

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Reflections on delivering the YRRU services

106. *I have been asked about any lessons we have learned in delivering the YRRU services over the past two years.* Relationships are crucial when living with a mental health issue. It does not matter if the relationships are with a family member, friend, or case manager — there has to be a strong, positive relationship. Our unit has a high staff to resident ratio, which means we are resourced to provide intensive, individualised care, and this allows us to build trusting and supportive relationships with our young people.

107. Open communication with staff and residents is also important. Everyone needs to know what is expected of them. I run a tight ship with my staff. My team leaders are on board with this and they run a tight ship in the two residences. This filters down across all levels. The staff know they need to be consistent in applying the rules and policies of the house.

108. These expectations extend to our residents. We talk a lot about choices and consequences with our young people. They are aware of the expectations of the program and the consequences if they break the rules. This is important as clear goals, structure and firm but consistent boundaries are important for young people.

109. While structure is important, our ability to be flexible with our processes is also critical, as each individual has different needs and a strict program may not always meet those needs.

110. The environment of the house is informal, in part because we have a small number of residents. This enables the staff to be proactive and vigilant in managing the individual care plans, and in ensuring that our young people are not idle.

111. All this means that the right staff are crucial. A competent team, with a high level of skill and expertise, is critical. I expect my staff to do their jobs well and have confidence that they will. An indicator of this is the fact that although I am on call at all times, staff have only escalated matters to me after hours 5–6 times in the two years we have been running the Greenslopes YRRU.

112. Unfortunately, attracting and retaining qualified staff is one the most significant challenges for NGOs. Even with the taxation benefits NGOs are able to offer employees through salary sacrificing, the discrepancy in remuneration (typically in the range of $20–40,000 per annum) makes it difficult for NGOs to be a competitive employer.

113. Furthermore, as I indicated previously, NGOs need to compete in a commercial marketplace for contracts to deliver services for government agencies. As staffing costs account for the majority of the cost of delivering a service, it is the staffing budget that is most under pressure.

114. I would like to see stronger linkages between the community CYMHS clinics and the YRRUs. Queensland Health and the NGO, as the service deliverer, need to work together to support the young person. I have been working hard to engage with community CYMHS clinics to educate the staff about our services.

115. One frustration has been information sharing. We do not have access to Queensland Health's CIMHA system, which is where Queensland Health staff record all the clinical information about consumers. This makes it difficult to integrate information about a young person's treatment, rehabilitation and progress. There are legal obligations and constraints about personal privacy and the sharing of information between agencies. However, as government services are increasingly contracted out, this is an area that needs reform to enable agencies who are working in partnership to deliver services to do so more effectively.

116. Despite repeatedly asking for the CIMHA Consumer Care Review summary that the Queensland Health case manager prepares at least quarterly we have never received one.

117. In my experience from working across both sectors, a key difference between NGO and Queensland Health delivery of residential bed-based services is that NGOs encourage young people to be a part of their community. NGOs do not lock young people in inpatient units for extended periods of time, isolating them from the community and social connections (though we do lock the front doors at night at Greenslopes and Cairns, as you would in your own family home). A key component of rehabilitation is being supported to strengthen relationships, and that is a big focus in our model of care.

Opinion — a statewide continuum of care for young people with severe and complex mental health issues

118. *I have been asked for my opinion on an appropriate continuum of services for young people with severe and complex mental illness and on extended inpatient treatment and rehabilitation models such as that provided by the Barrett Adolescent Centre.* Accessible and well-resourced community services, providing both clinical and non-clinical support, are critical to provide support to young people who are experiencing mental health issues and who are struggling to maintain their connections with family, peers, and the wider community. These types of services can be provided by both health departments and NGOs.

119. For those young people with complex, severe and persistent mental health issues, I think the following continuum of services is an effective model.

    a. Short hospital-based acute inpatient admissions of 5-7 days to stabilise a person in crisis.

    b. Sub-acute inpatient units for young people who are in distress and require admission to a hospital, but do not require acute care. This may also include young people who need monitoring, for medication for example. In my opinion, young people should not be hospitalised for more than four weeks. It is also not appropriate, in my opinion, to mix acute patients with subacute patients, for reasons I've elaborated on earlier in my statement, in relation to the "sick" role.

    c. Extended community-based treatment services are also needed for young people who cannot be effectively and safely managed by a community mental health clinic, such as the CYMHS clinics. This would be a clinical residential facility located in the community, that doesn't "look" like an inpatient facility. Clients would have daily appointments with clinicians, and may also attend a day program. The Victorian Youth Prevention and Recovery Care (YPARC) is a similar model, although it limits stays to 28 days. In my opinion, the maximum stay in such a facility would be around 3 months.

    d. Residential rehabilitation units, such as the YRRUs, are in my opinion a crucial component of an effective and integrated continuum of care. The primary focus of the YRRUs would be psychosocial rehabilitation and helping the young person to re-engage with their local community. I would recommend a maximum stay of 12 months.

120. We need many more YRRUs across Queensland, located according to service demand. For example, our referrals indicate that there is high demand in north Brisbane (Pine Rivers, Redcliffe, and Caboolture) and in West Moreton. As we focus on re-engage the young person with their community of origin, they must be easily accessible across the state.

121. I do not believe another Barret Adolescent Centre type facility is desirable. The BAC did not, in my opinion, provide an environment conducive to rehabilitation and recovery. The model required young people to be removed from their social connections, including schools and family. It was an unrealistic environment where everything was brought to them (including school). This is not real life and does not support normal developmental milestones such as independence, autonomy, and recovery. An environment like the Barret Adolescent Centre does not prepare young people for managing their mental health in the real world. Extended inpatient stays also make it easy for young people to compare ways to self-harm. The longer we keep young people in hospital, the more mentally unwell they become.

122. I believe that acute units are necessary at times and, for some young people, extended treatment of the type provided by YPARC facilities, will be required. But locking a young person away for two years does not help them to recover and develop independence to realise their full potential.

123. Based on my experience with the YRRUs, community CYMHS and the Barret Adolescent Centre, I do not believe there was a single young person in the Barret Adolescent Centre that could not be safely managed and more effectively supported in a YRRU. As I explained previously, we have clear and firm procedures for managing young people in distress, those with behavioural disturbance and those who are self-harming. Part of the success of the YRRU is that young people know they will be contained. We work through a young person's distress with them, and will do whatever it takes to keep them safe, including taking them to hospital for critical incidents.

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124. A YRRU-type service can effectively and safely support young people with mental health issues in most situations. I believe a YRRU-type service provides the psychosocial rehabilitation support required for the young people who resided at the Barrett Adolescent Centre, in combination with community MHS clinics and acute inpatient units as required. Those young people who were in Barret Adolescent Centre at its time of closure may have met the criteria for the YRRU, had it been open and fully operational at the time of the Barret Adolescent Centre closure.

OATHS ACT 1867 (DECLARATION)

I MYFANWY PITCHER do solemnly and sincerely declare that:

(1) This written statement by me dated 25 February 2016 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 Wadlongalba this 25 day of February 2016.

Taken By ..... [redacted]

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

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

INDEX OF ANNEXURES

Bound and marked "**MP-1**" are the annexures to the Statutory Declaration of MYFANWY PITCHER declared February 2016:

Annexure	Document	Date	Page
MP-1	Curriculum vitae	Current as at time of statement	~~20~~ 23

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MP-1

MYFANWY PITCHER

EDUCATION

2010 - 2013 James Cook University Townsville, QLD
Master of Social Work

2005 - 2007 Monash University Melbourne, VIC
Graduate Diploma in Family-Centered Practice

1998 - 1999 James Cook University Townsville, QLD
Bachelor of Social Work

1991 - 1997 University of South Australia Adelaide, SA
Bachelor of Social Work

RELEVANT PROFESSIONAL EXPERIENCE

June 2015 – current
Regional Manager, Queensland Residential Services, Aftercare

Dec 2013 – June 2015
Service Manager, Youth Residential Services - Qld, Aftercare

April 2013 – Dec 2013
Senior Social Worker, West Moreton CYMHS

June 2008 – March 2013
Team Leader, West Moreton CYMHS

June 2007 – May 2008
Senior Social Worker – Access Team, West Moreton CYMHS

Nov 2006 - April 2007
Social Worker, Paediatric Intensive Care Unit, Mater Children's Hospital

Feb - Oct 2006
Social Worker, Gold Coast CYMHS

Sept 2003 – Dec 2005
Team Leader, South Burnett Mental Health Services

Sept 2002 – Sept 2003
Social Worker, South Burnett CYMHS

PROFESSIONAL MEMBERSHIPS

Accredited Member of the Australian Association of Social Workers

Member of Australia & New Zealand Academy for Eating Disorders

Member of International Association of Eating Disorders Professionals

Associate Member of Australian Association of Family Therapy

SECURITY CLEARANCE

Positive Working with Children Check (Blue Card) #51192/8

Positive Police Check

REFERENCES

Mr Ivan Frkovic

Deputy CEO and National Operations Manager

Aftercare

Ms Kristi Isaeff

Senior Social Worker, Child & Youth Mental Health Service

West Moreton Hospital and Health Service