their needs. Um I'd say that Dr Brennan probably would have been key at that time as well as Dr [?]

BK: In the transition period, yeah.

SD: As well as Vanessa Clayworth. They carried a lot at that stage.

BK: Are there any observations or reflections that you would like to share with us about the transition committee?

SD: Um I think that Dr Brennan was under a lot of pressure. Um she did break down and cry and she worked a lot of late hours to try and get everything done. That was expected of her. Um she, she did seek um advice and support from her supervisors um but really it was just a, my impression of her account was that it was this has to be done you know, what're you worried about sort of thing. Um I don't know how she managed to do it. She was under a huge amount of stress. Um

BK: Are we right in thinking that you were um at one stage at least the care coordinator for [redacted] is that right?

SD: Yes.

BK: When were you the care coordinator for [redacted]

SD: [redacted]

BK: Mm.

SD: [redacted]

BK: That's fine. So do you recall, did you go off work at the beginning of November or the end of November or

SD: I'm not really sure.

BK: That's okay, that's okay. At the time that you went on leave, were you care coordinator for only [redacted] or did you have other care [?].

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SD: I did have another one and [redacted] was fairly newly admitted.

BK: Right. Can you recall who that was?

SD: No, I can't even remember [redacted] name.

BK: That's okay. So when did um Barrett actually stop admissions

315 SD: [redacted] was a [redacted]

BK: Oh okay. When did Barrett actually stop admitting?

SD: Um probably when they asked Dr Sadler to step down.

TS: Oh right okay. That was some months before that wasn't it. Was that, that was after that announcement of closure was it September or October or
320 something?

SD: About same time, it could have been

BK: It was all around the same time yeah.

SD: Yeah.

BK: Okay. Okay thank you very much. Do you have any questions for us?

325 SD: Am I in trouble?

BK: No, no, no. Thank you, I mean thank you you've been very helpful. You know we're very interested in people's perspective on what was happening and the process at the time and their involvement and observations, so thank you, you've been very helpful.

330 SD: Um I wish that there, we kind of expected there to be something towards the end of the closure to the transfer team but obviously that wasn't going to happen and there wasn't news about well is there going to be something later. So I don't know if there has been any news since.

TS: Were you very in touch with things after you um you know left the
335 workplace. Did you still stay in touch with people and or just

SD: Just one colleague. She's coming tomorrow.

BK: Right. Yeah.

SD: Um no I didn't even want to come to the Christmas breakup, school breakup, you know to say goodbye to the kids cause I just um when they decided my
340 position had ended and were going to put me onto the floor and work shift, shiftwork, I decided that was the last straw. I just, there was too many things that had happened. I was getting burnt out towards to the end too.

TS: So was that in November that the position was changed?

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SD: Yes. I decided then that I'd take stress leave. It was just the final straw and um I went and wanted to say goodbye to you know some of the kids because I didn't want them to worry about another staff member not, you know not being there for them and I just burst out into tears. I know that I made the right decision in stopping.

TS: Yeah.

SD: I could never [?] gone to work and worked with them without repeating that um. You know I'm really sorry about [redacted] um it's a [?]. I didn't know um the [redacted] as well but I know that [redacted] had mates and genuine um growth in [redacted] and trust and even connection with [redacted]

BK: Yeah.

SD: And yeah it is really sad.

BK: Yes.

TS: Yeah. Mm.

BK: Well look thank you very much.

TS: Thank you very much.

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KG-60

Queensland Health

Health Service Investigation - Barrett Adolescent Centre

1084936

Interview with Dr Anne Brennan, Clinical Director (from September 2013), 13 October 2014

Parties: Beth Kotze (BK), Tania Skippen (TS), Dr Anne Brennan (AB), Harry McCay - Avant (HMC)

Part 1 of 4

BK: [?] details.

HMC: I've got the original and a couple of copies.

BK: [?] that would be just great.

HMC: So, that's the originals and two copies.

BK: Thank you very much. Okay. So ah I'm a Child & Adolescent Psychiatrist from New South Wales. Tania and I work in Mental Health Children's and Young Peoples Unit in New South Wales. So, can we just start by confirming with you your understanding of this process?

AB: I understood that there's been an inquiry convened because there are three of the young people who are patients at Barrett last year have died since its closure, they decided to look at has something gone wrong, what needs to be done differently, and so forth.

BK: You've got a copy of the terms of reference?

AB: Yes.

BK: Do you have any questions about the terms of reference at all?

AB: No.

BK: No, okay. So, you're.

AB: Could I just interrupt?

BK: Yes, certainly.

AB: One question I had was what will happen to the report in that Is it [?]

BK: Look I don't know the answer to that, I know that we provide the report to Queensland Health, but we can certainly make sure that it is clear that any

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concerns about releasing the report broadly. There's nothing in the material that's been given to us that indicates what Queensland Health intend to do with it. But we will definitely make sure that, and if there's anything in particular that you would, you know, request that we keep in a separate file, refer to separately, we can certainly do that.

AB: Okay. Thanks.

BK: But we will clarify that [?]. And you're currently working for Children's Health Queensland?

AB: That's right.

BK: Where's that Unit based?

AB: Royal Children's Hospital.

BK: Okay, okay. So, in terms of just the organisational arrangements, were you seconded to?

AB: No.

BK: No, right.

AB: I had had a private practise which I closed, I was essentially retired, but that had only been a matter of weeks and I was actually doing, I'd suppose you'd call it almost volunteer work.

BK: Right.

AB: And I was also in negotiations with Headspace about maybe doing some work with them, and then I got a phone call from Peter Steel at Children's Health Queensland, saying could you do this. So, I wasn't working in public health. I refute that point.

BK: I had the impression that it was at very short notice and, is that correct?

AB: Less than 24 hours.

BK: Right.

AB: Yeah, it was can you start this tomorrow?

BK: Mmm.

AB: And told me the context in which it was happening and I didn't think that, I think my words were, those shoes are too big for me to fill. And then he was reassuring that no, he wanted me to do the job. And he said it would be overseen by Elizabeth [?] who was employed by Children's Health Queensland.

BK: Mm. So, we do have your statement and it's extremely helpful and comprehensive. But I wonder if you would perhaps start by [?] question telling us what you found when you started.

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AB: Um. That first day was quite overwhelming really. I spoke to Elizabeth on the phone the previous night, and then she picked me up at my house. We talked in the car going out to Wacol. Have you been to West Moreton?

BK: I haven't, no.

AB: So, it's quite a drive but anyway, we talked on the way out there, we went straight to the administration building, we had a meeting with the executive, we went from there down to the ward, and there was palpable hostility. We then convened a meeting of the kids in the hope, I am not being disrespectful calling them kids, they were kids.

BK: Look, I'd call them kids, yeah.

AB: So, we had a meeting with the kids. I was much more familiar with Barrett than Elizabeth because I'd worked there 20 years ago.

BK: Right.

AB: And, I guess, I would say I had a great affection for the place then and a lot of the staff were still exactly the same. So, there'd been this kind of warm embrace of me in some ways, but then because I didn't behave in the way the staff hoped I would, there was an immediate perception that I somehow had now become 'oh now you're a psychiatrist now', because I wasn't on a training program with [?] and then I went and joined it the following year and come back. And we then had a meeting of the kids and we just wanted to talk to the kids and that generated a lot of animosity from the get-go because we had a nurse standing at the door, because the kids were really, really distressed. But we didn't include the teachers. By not including the teaching staff, we had immediately broken one of the kind of traditions of the place and that really upset people. And so there were sort of battle lines almost drawn at that moment and as well as that, there was the distress of the kids over Trevor Sadler being stood down. And we finished that meeting and we said we would then go over and talk to the teachers. So between that meeting and going to the teachers, we had a brief chat with the nursing staff, Elizabeth had never been in the place, it was just a matter of just meeting who was who.

And then we were gong over to the school which is an adjacent building, they're attached, but by just a covered walkway. So, we were going over there and at that point, just as we walked into that building, the AO said it's in Parliament now and that was the announcement of about Trevor. So we immediately walked back into the ward because we thought, we knew the kids that will be there, they've all gathered around with radios on waiting. So, we went back And in doing that, we kept the teachers waiting an hour and a quarter and they were hostile after that and we had shown professional disrespect and so forth. So, that wasn't a good way to start. And with kids, it wasn't a good way to start because particularly

they were crying and very

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upset and they viewed us as evil and Elizabeth's communication style is, I suppose, she comes across as sort of more authoritarian I think than I did at that point. And so they were a bit more hostile towards her and then in the end, she decided I think two weeks down the track it was better for her not to be two [?]. So, better for her not to be seen and then she started only coming out irregularly and then once a week. But yeah, it was not a good way to start.

BK: So, how did you understand the task when you first started?

AB: I understood that Trevor had been stood down and I needed to look after, provide clinical care for those kids and that's all. Oh, and the closing, and I assumed that that was a process already in place and I would step in and continue it. But I found out by the end of that day, that it was clear there was no process in place, nothing was happening, and that I had to start it and then a meeting the next day with the executive again, it was clear I not only had to start it, I had to finish it. And it was a matter of then working out how we were going to do that.

TS: Okay, so how did you go about doing that?

AB: I wrote it in there, but I think the phrase, 'had to get to know them', that should have sort of gone for about 10 pages.

BK: Yeah, yeah.

AB: It was the trying to understand each child, there's nothing, you know, you can talk about the Barrett kids, but there wasn't a lot really that most of them had in common except that they'd had long admissions and a lot of family disadvantage and difficulties along the way. They were all very different to each other, they also had very different, obviously, different skill sets, different capacities for tolerating the thought of doing something different, etc. So, it was getting to know them while managing for a few of them [redacted] and just intense distress over the fact that it wasn't that they were moving on, at that point, it wasn't they were moving onto something good, it was they were being abandoned and they were having everything taken away from them. So, they were distressed and then they also needed to communicate their level of distress to me in case I didn't get it, I think. And to everybody else. So, the process was really, I thought, get to know them. Work out where they're at now, what their needs are, what can be done for them, what is out there for them, and then start moving them onto that. To do that, obviously, I had to also get to know their families and any other, you know, what had worked so far for them, what hadn't, who were their current service providers cause a lot of them did have other people involved.

BK: Can I just [?], how open was your access to resources? How, you know, what position were you in to pull together whatever you needed in terms of a team, just you were using only senior medical officers.

AB: There was a Registrar who was, I think, at best [?] for that first couple of weeks. He was very upset about what had happened to Trevor. He didn't

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cope well at all at the beginning. He then got anxious about his placement, Elizabeth stepped in to kind of take over looking after him, rather than me, like I was still supervising, but she had an hour with him each week, but she tried to define his training goals and so forth.

BK: Yep.

AB: She then organised a meeting with Darren Nealey who was the Acting Director of Clinical Services at the time, so he could go and have a meeting with him, and just clarify for him what that could provide and where he would go. So, that is in the medical person, as I say, Darren Nealey was Acting Director of Clinical Services who said to me, the clinical governance here has been terrible, if things happen, please let me know. So I would ring him from time to time and tell him there were what I thought was significant events. There was Elizabeth who I eventually I think got to the point where I would ring her every night almost. Often during the day as well, but at least every night. And then there were the executive meetings on a Wednesday morning where Darren Nealey was for the first few weeks and then Terry Steadman whose place he was filling came back and he was Director of Clinical Services so he would be at that meeting. But no other medical services or back up. In terms of resources, one of the OTs had just come back from maternity leave, the other OT was going off on sick leave. But the one who came back was all enthused because she'd gone away and worked in some other places as well, and I suspect I think you know who she is because she told me she was coming here this morning, but she was quite sort of enthusiastic about positive new things, and moving forward and so forth. So, she seemed to me like somebody who might be helpful. The Acting CNC, Vanessa, who I think is not going to come and talk to you, she was very motivated about helping kids get out of Barrett to somewhere new, there was almost nobody else who kind of was really supportive of the idea that Barrett should close or could close. So, within the staff, towards the end, some of them sort of came out of the woodwork and said, oh no, no, no, I think this is really good. But it certainly wasn't the majority. In terms of finding out what was in community I think it was within the first week it's written into, did we tender the Barrett register?

HMC: Which was the register?

AB: That's the, it's documented, there [?] little boxes, the themes that were, issues that were raised about difficulties, it's really badly constructed, it's just something Elizabeth had put together because nobody it seemed was minuting those executive meetings, but she would write some things down and kept it as a sort of register of ideas, and then right at the end, she'd finish it off and gave it to them, but it's not very detailed towards the end and it's not.

BK: This was about sort of managing the environment?

AB: Yeah.

BK: Within the unit it looks like, is that right?

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AB: It was about the issues that got brought up at the executive meetings on Wednesday mornings. So, I'm just going to look at the day when it got brought up where I said the resources we don't know what is out there, and we need help.

BK: Is that in your statement? Yes.

AB: To do this. So, and people said, well, you know Lifeline will have a database and somebody else will have this and, oh, what about Department of Health and what about, so I delegated people to try and find those things, they couldn't, so I tried, couldn't. We couldn't actually find anything. We did get some lists of accommodation services and so forth, and, you know, like we would have days where Megan and Vanessa would send out 32 emails and make between them 50 phone calls.

BK: What do you make of that, this Unit had open for a very long time, the kids, yes, they're a very mixed group, but all very complex with lots of sort of issues, many staying on til they're over 18 and even some we're hearing about, you know, for some years. So, this kind of needing to find resources in the community for this particular group, it wouldn't, it doesn't fit easily. It wouldn't have been a new issue. And yet, there wasn't, it doesn't sound like there was a body of knowledge. What do you make of that?

AB: It was very disappointing.

BK: Yes, [?]

AB: There was, they had a position within the staff called community and liaison, so Susan Daniel was the nurse doing that at this point. Before her, Vanessa had done that job, and I thought she would be somebody who would be ideally placed to do that sort of work. Part of the issue for her, though, was that she was so traumatised by Barrett closing, in the end she left and went on 500 hours sick leave. But she had worked there for 18 years, and her heart was just in Barrett. But she had I presume in the past been the person who would have linked kids into other services. I think part of the issue and I wondered a lot about this, particularly, like if you look at the three who are now dead, [?]. [redacted] But I wondered whether, had they stayed in Barrett for that long because they didn't have somewhere they could go back to. And so, is it about, like, where are the big holes in services? And I would argue that the first big hole State-wide is, if you are under 18 and you can't live at home.

BK: Yeah.

AB: You cannot access intensive mental health support unless you live in Brisbane and you are in the care of the Department. If you are outside of the care of the Department, you require supported accommodation. Where can you live, you can't. And if you've got significant mental health needs,

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there are no trained staff to support you. But if you're 19, you know, there's still nothing for young people in terms of supported residences within the mental health sort of framework and it looks to me like we're depending more and more on NGOs to provide that and what we know from doing this, is the NGOs are not trained up to do it. So, some of them say they can do mental health support, but when it came to the individual ones, you know, The next one I think is if you can provide them with accommodation, they then need some kind of intensive support and if it's a day program or whatever, that might be good but then case management and they need, you know, I guess, I started to think the last few days, should have used the word transfer in that what we're talking about transitional plans, they're really just transfer plans, that's just the last bit that you sign off on. The real issue is it was transition from day one, well, maybe day three, of me meeting and the first couple of days was just [?]. I think the term is poison chalice I think [?] from my colleagues and I [?] of three days, they were right. But I think it was, they needed to transition in their own minds about what was going to happen. They were transitioning from being children into being expected to be adults, you couldn't rehabilitate them, they hadn't be habilitated, you know, they hadn't learned developmental skills. I mean, what happened the first weekend, so I started I think on a Wednesday.

BK: What month was it? September?

AB: September 11. I remember the date.

BK: [?] yeah.

AB: And that first weekend I sat down and thought, right, what does an 18 year old need to be able to do? Came back with this great enthusiasm Monday morning and I said, right, for these ones, this is what they need, for these ones, this is what they need. Now, that wasn't about mental health services, it was: they need to be able to use a bank account, they have to be able to cook, or shop, or they needed, we need to clarify their educational aspirations, vocational skills, whatever. Every one of them who was over 15, must have a resume. It was the one job I gave to the school and said, I want them all to have a resume. I mean, I can't write my own resume [?] wasn't going to be able to beef up a 14 or 15 year old who hasn't done anything, but I knew school would be able to. But even that didn't get done. It was, yeah, so it was kind of frustrating that the things you knew they needed as a skill set for life, they couldn't or just weren't going to get. And then the next challenges were about who would be their mental health providers, who would be their accommodation providers, and so forth. And then it was almost they had to, for some of them, not all of them, some of them already had connections that they could continue, but they needed to work out how they were going to access that independently themselves, not

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everything be provided, what they'd kind of learned to do was to live at Barrett.

BK: Yes.

AB: They hadn't learned while at Barrett, you know, like can you imagine, this is being talked about around the edges by various people, but a lot of people have said, well, if Barrett had just stayed open, we could have got, for instance,

and there was for some of them, once you gave them a little bit of a taste of that outside world if you like, or a bit of responsibility or autonomy, it was amazing how they then sort of ran with it. And even

But, you know, I'm probably getting a bit off the track there.

TS:

AB:

TS: yeah.

AB: How was the risk communicated by us to them?

TS: Yes, yes.

AB:

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BK:

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AB: We'd have to make it.

BK:

AB: Yeah, no, no, you'd have to make a judgment of based on what had been going on at Barrett in some ways.

395 BK: Yes, mmm.

AB:

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BK: Yes.

AB:

415 But that was a sort of a subsequent proposal, that hadn't been started.

BK: Okay.

AB: And it was felt that needed to first.

BK: Right.

420 AB: So.

BK: Yeah.

AB:

So.

TS: We've heard from a couple of people that there might have been some talk

425 about nursing staff from Barrett actually staffing shifts at other places while the transition period was happening but that didn't eventuate.

AB: No.

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TS: Has that happened?

[Part 2 of 4]

AB:

BK: Yeah.

TS: So the original plan had been to try and get the kids out by the 13th of December.

AB: [?] here.

TS: Yep, is that why there, we've heard a hearing about an NGO was brought into run the Christmas program or something like that?

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AB: No, there's always been a holiday program at Barrett.

TS: Right yep.

AB: And in early December I'd been complaining a lot about, I thought it was becoming unsafe and I think that was the staff numbers were going down, the skills of the staff were reducing because they were from agency staff, and almost sort of paradoxically the number of kids was going down and I think that was making it less safe. While there's a sort of a critical body, there's at least some, you know, naughty stuff or fun happening at times, that sort of buoyed them along. So it was thought that they would bring in an NGO to provide a holiday program. Now again, and I don't think, I don't know that it's documented anywhere officially, I thought it was a ridiculous experiment myself, I probably shouldn't use such strong words but I thought this is not, it's a bit like the wisdom or otherwise of conducting a CMC enquiry into the director at the same time as you're closing somewhere. Like, that just is, defies belief, but for whatever reason they had to do it. Anyway, that, this was similar, they were bringing in, this is going to be a kind of a pilot model of new ways of doing things which was the partnership of NGOs and mainstream health services. Now that may be a legitimate thing in the future, but in such a traumatised community, that was so rejecting of new people and of change and had so much on their plate already, to bring in a new service to provide something was problematic, and then they came, it was Aftercare, was the organisation, you know within the first week they were making complaints about, you know, the sort of senior staff which were the sort of transition team people, and that was because we weren't spending enough time with them and we weren't welcoming enough of them and I'd have to sit them down and say, have any idea what we are dealing with at the moment? We have kids with nowhere to live in a month's time, with no mental health providers, with etc etc. Our priority is not you guys. We really don't care whether they're having a good time, just get on with it. There were almost no kids going to that program anyway,

TS: Is this Is that the name?

AB: No no, So in many ways, it felt like this program accommodated needs and also politically we could say we are providing the services. But the reality of what it provided was another hurdle for these kids to jump and some of them didn't bother coming, some who came, were a bit reluctant to get involved. When it was looking like this is not working very well at all, I then sat Aftercare down and said okay, let's use you guys to do something else. Could you work on skills acquisition individually for these few kids that you've got. And I went through each kid with them and said what I thought they needed to be able to do, could you do that, but it didn't, it really didn't work.

TS: So in that period of time then, obviously a huge amount of time was spent just trying to identify possible services and to undertake negotiations, it also would have been a very bad time of year to be trying to do that [?]

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AB: That's right, Christmas.

TS: Christmas. And it does sound like there was perhaps sort of internal disarray in terms of actually focusing on the kinds of skills etc. preparations that might have been helpful for the kids, that sort of issue though that these kids in a sense, they're misfits, and that difficulty in finding services that were able to, okay from even that example of short-term admission to an acute inpatient unit kind of doesn't quite sort of fit with that's how they see their role. We did pick it up also possibly in the example with [redacted] in some ways there were a number of service providers but the missing element seemed to be the mental health follow up and I think we noticed

AB: It was [redacted] case.

TS: [redacted]

AB: No, it's definitely not [redacted] went

TS: It was a. Do you remember that one?

BK: Would it have been [redacted] couldn't take [redacted] because of the [redacted]

TS: No, one of the [redacted] one that

AB: [redacted]

TS: [redacted]

AB: Yeah that's [redacted]

TS: [redacted] was it?

AB: Yeah. That was, and that was subsequent to closure but it was, [redacted]

TS: That's right.

AB: [redacted]

TS: And they took [redacted]

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AB: [redacted]

TS: In that process

AB: Sorry

TS: Was that a colleague-to-colleague negotiation or were there additional resources from the transitional process brought to bear by decision-makers or was it a colleague-to-colleague?

AB: Um the [?] from the executive, it was Moreton I think, got involved in that as well.

TS: Mm.

AB: It is after the closure but spoke to me and then I rang people. So it was colleague to colleague to convince them that yes please do it. And then also colleague to colleague [redacted] I spoke to about the families needs.

BK: There was this very small transition team really running as fast as you could with the number of kids and the amount of negotiating to be done. How did the next layer in the governance of the process articulate with the transition team, [?] more transition team, how did that sort of work together?

AB: Um, the next layer I guess would have been Elizabeth Holland and so there was, she was the Childrens Health Queensland arm and at West Moreton would have been Sharon Kelly and Leanne Geppert. And their Allied Health Senior, there were two of those, Michelle Giles and Lorraine Dowd. They were, they were supported but they weren't intimately involved, they were really involved, the allied health ones were involved in really kind of trying to sort out the HR distress and stuff about stuff, it wasn't about the kids. In terms of involvement about kids, Leanne Geppert was helpful, in escalating things. For instance, about [redacted] It wasn't always effective. Where it really fell down was, and it was identified quite early, that no one was documenting the transition panels that we were having and nobody was documenting executive meetings and so they then appointed a project officer, Laura Johnson, who was to document all of that. And I guess I would say from the day I spent, once this inquiry was going to happen, I was going to go out to West Moreton and sit down with them and the lawyers and so forth and look at the documentation and then I said well that's okay. Is it okay if I bring my lawyer along with me, and after that there was some kind of split in that they were doing things separately from me. Then they rang that night, and said *'well we can't find this, this and this, can you come and help us?'* So I went out there and helped them go through the files and find what they were looking for. And I guess what struck me

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then was, in the back of each file was a sort of a table which was a transition plan. They were clearly very not up-to-date because like on [redacted] So they didn't get updated. Laura did go on maternity leave before the closure, but they clearly were not being updated, so I don't know whether that's hers or whether she has got another file of documents that I have not seen that are somewhere that the executive has access to. But certainly, I don't think in those volumes that have been printed off from the electronic form that we've all got. And what happened then was, Holly was trying to put together something to give to you guys so she was then populating those tables with information. So, as well as the original one which is close to useless, it is the next one which is Holly the lawyer's attempt to put in information into there to give to you. But, again, that's not contemporaneous documentation of the transitional process or plans. And all through that information is contained within individual people's emails. So I think Leanne Geppert's are accessible. Megan Hayes, some of hers are in those charts because she had a day, maybe two days at the end [redacted] and she is trying to archive all her stuff because there was, you know, if anyone told you about this, there was a migration of emails from GroupWise to Outlook and it went from having a dash to a dot and I didn't archive mine. I was never going to work for QHealth again. So it didn't matter, and I got an email on Friday saying '*Any time now, they might be able to retrieve it for me*'. I [?] do it for this process. So there is a lot of information in emails but there is no central, as far as I could see, documentation. So if that's part, I don't know whether that's part of governance but to me that was a deficit.

BK: Yeah, yeah.

AB: There were times when at the next level of governance, and I know I was an Indian not a chief, but I felt like there were two things. One was, I've got a lot of responsibility here, where is the next person up in terms of medically or anything else. There didn't seem to be an expert you could turn to. Stephen Stathis, who was the director of Childrens Health Queensland and now my boss. He would ring me up and say '*What's going on with such and such?*' and I would tell him and he'd make some suggestions or, but he wasn't kind of in charge. He didn't have power…

BK: Was he a director or?

AB: No, there was Terry Steadman and then when we tried to [redacted] – as far as I understand – has no structure of command in mental health. I went to Terry Steadman. Terry Steadman discussed it with Leanne Geppert and Sharon Kelly but he went to Bill Kingswell as the director and said '*Can you get Brett Emerson as director of that service to do this, this and this*'. And it was up to Brett to decide whether he wanted it or not. And I thought, how does that work? But it just didn't seem to me that there was a central point of authority and maybe there isn't anywhere! But that's a hole

BK: [?] service. Who is the clinical director of the service?

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AB: Terry Steadman

BK: Okay. Okay. And that is a single point of accountability or is it director and a clinical director?

AB: He's the director of Clinical Services and then there is an executive director.

BK: Of mental health.

AB: Yeah, which is Sharon Kelly.

BK: Okay. Okay.

AB: And then the other thing we had was, I thought, interference from the Board. Now I know that the service is answerable to the Board, but when particularly

TS: So in the governance of the process, where did the Board fit in. Was this transitional process being reported to the Board? Did the Board own the decision for the service to be closed?

AB: I don't think they did.

TS: [?] Board right, okay.

AB: They owned the decision for it to be closed, they would give directives which Sharon Kelly would communicate, but they wouldn't, they wouldn't publicly own some of the decisions. For instance, we will no longer take, I think the 5th of October or 8th of October as the date, we will no longer take new referrals because there was well no that's not fair.

And we needed to say, '*We are not taking new patients*'. So, at the beginning, for the first couple of days of that, I could quite with full integrity say '*We can't possibly take a new patient at the moment because of the high acuity of the ward*'. We had that was just behavioural at that stage they're planning to burn the place down And there was just this going on. And so, and running away. So that was okay, but then when this decision was made that

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we wouldn't take new patients, there was well maybe we can't really say that though yet because we can't afford to scale down the number of beds and that was some political thing about however medical funding happens, I don't know. But so the Board was often trying to look like they're saying the right things and there was always this bit that would come up, Barrett will not close until there are lap around services available. Well, to my simple way of thinking, we are now more than 12 months on from when they said that they would be provided and that was the new services under SWAGR, their acronym for State Wide Adolescent Extended Treatment & Rehabilitation. So I guess you could say they were up and running! But the residential wasn't and still isn't.

TS: And what's the difference between their residential and what Barrett was providing?

AB: Their residential is not co-located.

TS: Right.

AB: Its not a one-stop shop. The idea is I think that you have more community-based care, that you live in a community and access other services. They are going to have wide park model care and step up and step down models. At this stage, they are not in existence. They've got the pilot residential at Greenslopes, but that's all.

TS: And what's the age range for that unit?

AB: It was 15 to 18. Now it's going to be 15 to 21. I think it's going to change because they also thought it was going to be six months max. I don't think they will leave within six months, unless somebody is focusing on, from the beginning, where's their next residence going to be and are they equipped to live independently. That is the aim that they give, but they also I didn't think had good psychiatric input. It was going to be point one of a psychiatrist and they asked me if I'd do it. I said no way, um I just thought it was an unsafe model. You know I think they just need to get it clear, are we going to continue to provide 24 hour supervised essentially subacute or long stay acute beds. Is that what we're really providing in these residentials for providing accommodation in the community.

BK: Yeah.

AB: For kids with mental health needs but their therapeutic results were and I'm not sure how.

BK: Whether they might.

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AB: They might have been thought through but I don't think it's been implemented.

BK: [redacted] If you think about all of the other kids, was there any other case where you felt there was um an unsatisfactory um even if it was interim it was unsatisfactory what was able to be achieved in transition.

AB: [redacted]

BK: Yeah.

AB: But I think if there's any kids who died some levels say well their needs haven't been met. Um and I think for all of them, so there's those particular ones and then, you know you could always say, well that's they're being missed or whatever but I think the other part of it is I didn't feel for any of them that they got adequate educational and vocational support.

BK: Mm.

AB: Or opportunities. They just didn't happen.

BK: How much did you think that was inherent in the Barrett model as opposed to part of the problem in the transition process?

AB: Well you're right it probably is within that model. So within the transition process, let me just think this through. [redacted]

BK: Right.

AB: [redacted]

TS: [redacted]

AB: [redacted]

TS: Yes.

AB: [redacted]

TS: Had you negotiated [redacted] would see [redacted] for a period of time?

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AB:

TS:

AB:

TS: I've got it down here that but I have written here was with a question mark, was

AB: No.

TS: She [?].

AB: She was

BK: She was a

AB: Sorry.

TS:

AB: Yes.

BK: Do you know why that didn't happen?

AB: I would be speculating but from bits I've heard I think it was. Look all I can tell you. I can tell you one piece of fact.

TS: Yeah.

AB:

TS: Do you know if there was any other um ah kind of platform in the transition plan that didn't eventuate? Apart from the staffing one

AB: Yeah that um when we

TS:

AB: For all of the kind of big ones. Um so that's about of them

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TS: Yep.

AB: Um we made recommendations what they required in terms of supervision and so [redacted] And each of those receiving services it was up to them I guess to decide really what they could or would provide and they deemed that not appropriate. [redacted]

[redacted]

TS: Yeah.

AB: And that was the other thing. There was no continuity. There seemed to be no thought that you would fund somebody to remain the person that might oversee you know at the transition had not occurred. Yes we got them to the end when the place closed but there was no, no one then monitoring what went on. For a while I stayed employed by the West Moreton [?]. I went to Ipswich CYMHS for a month. I would then just check when I could on [?] or ring people up and just see what was going on. To keep an eye on things as much as I could but once I left there, that role didn't exist.

BK: Just as a matter of interest, in the, any of the governance processes or the role of project officer, I don't know, um but was there ever any, ever any discussion of or reference to um the literature on transitioning kids out of [?] services into adult services?

AB: No.

BK: Um okay.

TS: Could we now talk about [redacted] um and um your reflections on the process with [redacted] Process of transition.

AB: [redacted]

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850

855

860

865

870

875

BK: Mm.

AB:

880

885

890

895

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[redacted]

BK: Yep.

AB: [redacted]

BK: Yep.

AB: [redacted]

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BK: Yeah.

AB:

BK: I need to understand they had been providing with, when they said they would take what was the range of services you thought

AB:

BK: Yes.

AB:

BK: Mm, mm.

AB:

BK: Yeah, yeah.

AB:

BK: That sort of that had, in the thinking, if it had been required, who would have provided with a kind of response, in terms of all the services.

AB: Who could have?

BK: Yeah, yeah. In terms of all the services that were to be involved or thought to be involved in ongoing care?

AB:

BK: Yeah, yeah.

AB:

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BK: Yeah, yep, yep.

AB:

TS: Can we now talk about your reflections on the process with

AB: what the books say within the hospital of who, when people go from being inpatient to day patient, isn't always accurate.

BK: Oh right, we've had.

TS: We were wondering about that.

BK: Some confusing information

AB: Yes.

BK: Particularly with actually.

AB: Well certainly by at least, I can't give you a date,

BK: In your report it says

AB: Yeah.

BK: But other reports said

AB: Yeah, see, the AO wouldn't process various things, so when I arrived they would give you a list of patients, or, sorry, you could get given if you asked for it, a list of patients and I looked at this list and I said that's not accurate, yes it is, and I said no it's not, and I said because

BK: Oh.

AB: Clearly that's not the case. So those things were not accurate.

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[redacted]

BK: Mm.

AB: [redacted]

BK: Sorry, was [redacted] or on a [redacted]

AB: I always thought [redacted] was [redacted]

BK: Okay, yeah, okay.

AB: I'm pretty sure. Gosh, I hope so, maybe you know something I don't know. [redacted]

BK: Mm!

AB: [redacted]

BK: Okay, yep, yeah.

AB: [redacted]

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BK: Yeah.

AB: [redacted]

BK: Yes.

TS: And that according to [redacted]

AB: Yeah. And so, and at [redacted]

BK: Mm.

AB: [redacted]

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BK: Mm.

AB: it's another Barrett kid who's just a bit of whinger, cause I think that was the perception, that these kids just live out there for a long, long time, but none of them have a mental health diagnosis.

BK: Yeah, yeah, I mean it certainly sounds like you had more than enough on your plate, but I'm just wondering, having found this, that there's

AB:

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BK: Yeah, yeah, yeah.

AB: [redacted]

BK: Traumas.

AB: [redacted]

BK: Yeah.

AB: There was another one, [redacted] was I think [redacted] by that stage.

BK: Yes, yes.

AB: [redacted]

BK: Yes, I saw that.

AB: [redacted]

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[redacted]

BK: [?] like about Barrett.

AB: Yes.

TS: In terms of being with the other kids that were there during that period of transition, any comments or reflections on their, on the process with them?

AB: [redacted]

BK: Mm.

AB: And [redacted] said do you know what I really don't need [redacted] but you know I'll still go just because you tell me I have to but I really don't need to.

TS: Yeah.

AB: [redacted] Um who else is there.

BK: Can I just ask, as part of the governance of the process, was it discussed whether there would be a process of follow up to ensure that um follow up arrangements will occur and [?] interface. Whether that was run by a

AB: No.

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BK: It could be run by a whole variety of people ah but that somebody was responsible for checking up in three months, six months

AB: No.

BK: Um so okay. Mm.

AB: No. There was um to be perfectly honest and it's a mistake now, um on the 26th of January I think it, or 29th of January it might have been, um I guess I was feeling good that. A whole lot of people had said they couldn't believe that we actually got to the end with them all alive.

BK: Mm.

AB: So that was the sort of major 'wow we've done it!'. Um and then there was going to [redacted] So just doing extra little bits but that was just me.

TS: Yep.

AB: And then I think it was the 29th of January, I've probably got it in here, I actually then did a ring around

BK: Yes.

AB: And put together a report

TS: [?] yes.

AB: Which I sent to the Board [?] identified but also the kids, the [redacted] big kids had written things on the whiteboards and that became the thing to do. Everything they did was always contagious but so and they were all beautiful quotes. Made the Board feel good um but they were and/or things like [redacted] so those got reported back to the Board but no, nobody was appointed to do that and as I say the next month I was at Ipswich CYMHS which belonged to West Moreton. So before I left there I did another ring around and then reported back on that and at that stage everything was good and some kids were doing much better than really I think anybody had ever guessed they might be.

TS: Sorry when was that second report?

AB: Ah 3rd of March.

TS: 3rd of March right.

BK: So was the transition panel concluded on a certain date or were they still

AB: There was no

BK: You don't [?] know that [?].

AB: No the transition panel was really just a panel of the staff within the Unit. There was no one from outside in that. Carol Hughes was part of it. She

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was a social worker, her contract ended well before it ended. She didn't get replaced. We didn't want her replaced. Um so she went. So there was really only this core left anyway um and Vanessa left She actually had some major things starting to happen for her and also seeking other employment but she knew that um so then she left. So that left Megan and I. There was nobody else. So it wasn't a matter of concluding a panel.

TS: What about the higher level governance um ah committee or panel, the one with Bill Kingswell.

AB: Bill Kingswell was never part. Bill Kingswell rang in on Wednesday morning for a couple of weeks until there was an incident, so it probably would have been about and it'll be in that risk register documented. Its code, it doesn't say Bill Kingswell. I can tell you exactly when it is though. Um and it was pointed out that these meetings are about the clinical needs of these kids, it isn't about politics or bigger issues. And so he was no longer part of it. Oh did I give you that risk register? Yeah I can

TS: Yeah.

AB: [?] find it um and that was because I think it was if I remember correctly it was that 25th of September and that's where Sharon Kelly put the phone on mute and said, is it really appropriate for Bill Kingswell to be part of these conversations and explained why it wasn't and then she told Bill, you will have to excuse yourself from these meetings from now on.

TS: So.

AB: So there was no, so the executive meetings that still happened, they continued until whatever the date of that register is, the 23rd or 24th I think of January and that was it.

BK: So um how does this all work and fit together [?] interpretation of how the governance model has been described to um to us, so ah we've got um an oversight committee in the um Department of Health, this must be

AB: Yes that's that. Yeah.

BK: So that's the um the development of the process happening in ah that you were referring to. The service operations implementation group for clinical care transition panel and the consumer consultation communication of strategies.

AB: This here.

BK: Yep.

AB: So this steering committee

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BK: Mm.

AB: In that risk register you'll see there'll be a date which is very early on, maybe the 16th of September.

BK: Yep.

AB: Which is I say I will have absolutely nothing to do with the development of new services.

BK: Right.

AB: Because it will take away my time

BK: Yep.

AB: From the clinical care of these kids.

BK: Yep.

AB: But also I thought it was possible there'll be conflicts of interest. I can't do it. Um so Elizabeth Holland was to do that.

BK: Right.

AB: And I would just do the clinical care

TS: The transition panel.

AB: Of the patients.

TS: Right.

AB: Whether that be day to day or transitioning them out.

TS: Okay.

AB: Cause it all goes together.

TS: Okay.

AB: But that – and Laura Johnson used to do an update which she would give to the Steering Committee on them but it was very, ah, bland, like not in detail and I think de-identified, so there was no. We had to be careful because the information from that Steering Committee would go then out on a fact sheet or to the public and so you couldn't say things like 'Well, Anne would really like to get them all out as soon as possible' because all of a sudden you'd have it in there, Barrett's closing on the 13th of December and they're all being put in acute units. So you had to, just what I was saying, you had to be careful what you sort of drip fed to people and how you framed things so there wasn't a direct report into them and there certainly wasn't, from my point of view, any sense that there was anybody providing governance of what was going on.

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BK: So you're on clinical

AB: I was in Wednesday morning.

BK: Night.

AB: Feedback to the executive where they'd say 'Okay, Anne, where's it at? How many have you got left? What's happening?'

BK: And Wednesday morning was with Terry Steadman?

AB: Terry Steadman, Director of Nursing was William Brennan. The other Director of Nursing for the Adolescent Services as part of Forensic Services was Pike McGrath. Michelle Giles as Director of Allied Health. That's all.

BK: So I'm sorry, can you just clarify the difference for me between the West Moreton Management Committee and the Clinical Care Transition Panel?

AB: I don't know who the West Moreton Management Committee is unless it's that Wednesday morning meeting which consisted

BK: Met once a week?

AB: That's the Executive Director, Sharon Kelly.

BK: Okay. Right.

AB: Leanne Geppert, Director of Transitional Services, I think is her title.

BK: Yep.

AB: But she would become Sharon when Sharon went away.

BK: Right.

AB: The Director, two Directors of Nursing but no nursing person from the Adolescent Unit and Vanessa Clay, sorry, Elizabeth Holland and myself.

BK: Okay. And the Clinical Care Transition Panel that met monthly.

AB: That would be –

BK: Yeah.

AB: No, [?]

BK: Right, okay, okay. How meet them?

AB: Met twice weekly, on Tuesdays and Thursdays.

BK: Yes, yes, that would make more sense, okay.

AB: And that was myself, Vanessa Clayworth, Megan Hayes, the OT, Carol Hughes, the social worker and Susan Daniel, the Community Liaison Nurse

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until she went on leave and a representative from Education Queensland which originally was Justine Oxenham until on her own admission, she was leaking information to the Minister's office which then was going to be public so she was then, there was a meeting of the Regional Director of Education and Sharon Kelly, myself and the Acting Principal of Barrett and she was never supposed to come to another meeting. I walked in on Tuesday and there she was again. And then eventually she stopped coming and the Acting Principal started coming instead. So that was. So they're the Transition Panel and Laura Johnson as the Project Officer to document it. And she drew up a timetable for those meetings but if you calculate the number of kids, give them all an 1½ hour, they get one show each because we had to also accommodate the waiting list at the end.

BK: Who's the chair of that meeting?

AB: Of the Transition Panel?

BK: Yeah.

AB: Me.

BK: Right, okay. And who timetabled the kids to be discussed?

AB: Laura Johnson, the Project Officer.

BK: Right, okay.

AB: But, look to be honest, that's really a tick box.

BK: Yeah, yeah.

AB: Which provided. The transition occurred starting at 8.00 o'clock each morning and went all day. You know, it was meetings in corridors, meetings in rooms. It wasn't. That Panel was the opportunity to formalise, if you like the documentation but also, like, it started off slightly differently, I mean it was different for each kid but for instance.

BK: Yes, yes. In some of the files we read that parents were normally invited or carers were invited to those meetings. I didn't know if clients were also invited to meetings and did you actually create those plans in consultation with those?

AB: With the parents?

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BK: Yes.

AB: It depended on each kid.

BK: No, that's alright.

AB:

I noticed you even organised

BK:

AB:

BK: And attend the meeting?

AB: Yes.

BK: So Barrett went to quite, or yourself went to quite a lot of effort to engage with the parents and that.

AB: We tried to, mm.

I mean there was some parents who I'd be in the first 48 hours I rang all but two and so some of them they said they hadn't had that involvement before. See, you were kind of meeting people for the first time and then you were having to transition a kid out of there so there was a lot that had to get done in a short period of time.

BK: [?].

AB: [?] I mean, looking back like

BK: Yes, yes.

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AB: So there are faults in it. There are ways you would have like to have done it better.

BK: How many of the kids at, at just a sense of the magnitude, how many of the kids were discharged under the *Mental Health Act* – transferred under the *Mental Health Act*?

AB:

BK: okay. Do you recall their names?

AB: Yes.

BK: yep.

AB:

BK: Yes, yes.

AB:

BK:

AB: Yes.

BK: Right, okay, yep.

AB: Very definitely. I think they're the only

BK: Any kids transfer to CTOs? [?] patient care. Okay. [?].

TS:

AB: Nope.

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1505

1510

1515

1520 TS:

AB:

1525

1530

BK: Are there any of the other kids that you would like to comment on?

AB: Who haven't we talked about? So there's only one specifically we've done. We've done

BK:

AB:

1540

BK: [?] for that long or medical treatment.

AB: No, but again and you know if you want to talk to the person who knows best, she's in the office of [?] at the moment, She's the Director of Medicine for the new services. She was the NUM at Logan and she was wonderful.

1545

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[redacted]

BK: Okay.

AB: That's [redacted] - they were the [redacted]

BK: [redacted] we talked about.

AB: [redacted]

TS: [redacted]

AB: [redacted]

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BK: Yeah, was there for about it looks like

AB: There were many of them like that. They weren't engaged in any therapy. The majority probably I would say.

BK:

AB: - this conflation of the care there and new services. Those new services still aren't there and that's what people keep saying they want. But even if there were new services really probably is not ideally suited to them anyway.

BK: Yes. The new services were part of a package of services that were being developed by the SWPP?

AB: Yes.

BK: Okay, not just the residential.

AB: Oh no, no. I think was identified as a priority then there's AMYOS – my current position is supposedly AMYOS so I don't work in – I was appointed to it and 12 hours later a movement form was done so I did consultation, liaison and [?].

BK: [?] be very flexible.

AB: Michael Taubman does AMYOS.

BK: What's AMYOS?

AB: Adolescent. No, Assertive Mobile Youth Outreach Service – so it's for the kids who are difficult to engage in CYMHS. High risk – State-wide and.

BK: Based on the original model?

AB: Yes.

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BK: State-wide, is it?

AB: And Michael listed those for models for – it's State wide and local so he's got six or seven teams that he's developing now and then the State wide bit was to appoint three positions – point two – positions, no point three. I should know it's my job. And so that was advertised – a point three position and nobody applied for it and I then applied on the last day and they appointed me to it but put me in these other jobs and it's not ready to roll out yet.

BK: Did you have any more [?]?

AB: Yeah

BK:

AB: He would have gone on.

BK: went on the - does that help you?

AB: Yes I was going to say the for Maybe the

BK: So that [?] for about

AB:

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happened on 4th of Feb. 4th of December, I think.

BK: You can't do that.

AB:

BK: Okay. Thank you, that's been incredibly helpful. Any questions for us or anything you think we need to know that we haven't covered?

AB: In some ways, like there was discussion at the National Conference over the last few days about and how to manage them.

BK: Yep.

AB: And I guess I'm still concerned, my magical thinking makes me think October is month.

BK: Mm.

AB:

But I think this group is now defined as a group and the glue in many ways, well there's two, there's the Save the Barrett campaign and there's the school based at Yeronga is the kind of hub for them. And that, as far as I'm aware, has no mental health input. Liam Huxter, one of the nurses from Barrett, went as a school nurse there. When the school opened. He had no, that was a standalone position, he didn't belong within any mental health service or have structure to his job or career or supervision or anything like that, now in fact, he's left and gone to Japan. But, so he was there's to start with alone, but there's no mental health input and I must say, when

I said to Stephen Stathis, someone's got to do something. So he did a ring around to make sure everybody was okay and being looked after. What concerned me was that the following day, another was talking to me about one of the kids and who they were seeing and what was happening in that therapy, and I thought, that's a bit odd. Because Stephen's just done this ring around and that kid is, in fact, seeing somebody else, and

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[redacted] So, how are they seeing that [redacted] that can't be right. But it was right. So, what really worried me was no-one really knows what's happening with them. And I know that's not my personal responsibility but I think that system wouldn't exist had Barrett not closed, had Barrett not existed, had those kids not been patients of Barrett. So, is there, should somebody be putting some effort into keeping an eye on what's going on there, and providing some either support or supervision of it. If, in fact, what you've got is something that's bringing kids together, [redacted]

[redacted]

BK: And in your reflections on this, what conclusion have you come to?

AB: That its not happening and, you know, that it should.

BK: And who would that be?

AB: An experienced psychiatrist who is not seen to be aligned with any political camp in terms of new services or closure of Barrett. It's got to be somebody that the school staff would trust.

BK: Have you raised that with anybody?

AB: Stephen.

BK: Mm. And did you get any feedback?

AB: Only that we're looking after it. And I get this sense, just from a comment in the corridor last week, that maybe something has been discussed because Michael Daubney who's doing the AMYOS stuff seemed to know a bit about the school's setting, and he previously wouldn't have, he's got no reason to, except that he is seeing, I think, he's supposed to be seeing [redacted] But also that school is facing an uncertain future because within the Children's Hospital coming online in November, there's the Royal Children's School going instead, there's the Mater School and what will be the role of what was previously called the Barrett School. And so those teachers are facing an uncertain job future and maybe of being separated and maybe their skills might be used but in a disbursed kind of way.

BK: Yeah.

AB: [redacted]

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BK: And you said the second thing was the campaign. Was that still something people were gathering around?

AB: Well, when this inquiry was just starting, I Googled online I think I wrote Barrett Adolescent Inquiry, just to see if there was, what was known and it came up with the petition that people were signing, about five of my close relatives have signed it, wanting an inquiry but, again, and I think they were, and I know they, and then you could write a comment when you signed it.

BK: Yeah.

AB: Now, in that, the preamble of that inquiry, it talks about or in somebody's comment right at the beginning, 'deliberate dereliction of duty, negligent care, you wouldn't want to get too worried about yourself and what you've done'. It was very critical, it didn't say names, but it was pretty targeted. And then there are people signing it, but there, I know from a couple of the relatives I've got who are in mental health who signed it, they are young people who are very committed and just feel like, oh, [redacted] So, of course, we want an inquiry and we want Barrett or something similar re-opened. So, I think that campaign is gathering and I think there's a lot of people wanting an inquiry into Barrett closing and also that Joanne Miller, the Opposition spokesman for Health, has come out and said, if Labour gets in next year, we will build a new Barrett in south-east Queensland and now Monday two weeks ago, three weeks ago, she said we will build one in Townsville. So, I think there's going, I might be wrong, I think there will be community activity around it, which I assume will be driven by that Save the Barrett campaign.

BK: Okay, well, on that note, thank you very much.

AB: Thank you. I hope [?]

BK: Very helpful [?]. Thanks.

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KG-61

Queensland Health

Health Service Investigation - Barrett Adolescent Centre

1084936

Interview with RN Rosangela Richardson - Care coordinator for and
14 October 2014

Parties: Beth Kotze (BK), Tania Skippen (TS), RN Rosangela Richardson (RR)

BK: Don't worry, don't worry, now you have got some water, do you want a tea or coffee?

RR: Nothing.

BK: No you are right? Okay. So I am Beth Kotze. I'm a Child Adolescent Psychiatrist from New South Wales, and both Tania and I work in the Mental Health Children and Young People's Unit in New South Wales. Can you start by just checking out what your understanding of the process is?

RR: My understanding is that it's an investigation on the closure of Barrett and how it closed and the process that it went through in closing.

BK: Pretty close. It's actually about the transitional planning process, about the care of the kids rather than the actual closure - that decision close or anything like that. Have you seen the terms of reference?

RR: Yes I have.

BK: Okay.

TS: We have actually got a copy here for you, if you would like to refresh your memory or if you would like to ask us anything about them.

RR: I've got a copy.

BK: Now if there is anything you would like to clarify or occurs to you during the …

RR: Okay.

BK: That would be great. So Rosangela you were employed as an RN at Barrett?

RR: Yes, I was.

BK: Okay, and what's your current employment?

RR: I'm working as an RN still in mental health with agencies, so I'm doing casual work at the moment.

BK: Oh okay, is that busy?

RR: I'm getting the shifts that I'm putting myself down for.

BK: Yeah, yeah, so it is working out for you?

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RR: Yeah. It's working out.

BK: How long did you work at Barrett for?

RR: Six and a half years. I started in 2007.

BK: Yep.

RR: Um, around August.

BK: And did you stay up until the close?

RR: The very end.

TS: You were there right to the end?

RR: Yes.

BK: Okay, so ah, during that time that you were at Barrett, the six and a half years, did your role change during that time?

RR: No, I remained as a Registered Nurse and doing care coordination for different kids as they came along.

BK: Okay and in the period leading up to the closure, I understand that you were care coordinator for [redacted] and [redacted] Is that right?

RR: Yep. [redacted] was mainly because all [redacted] care coordinators they just left.

BK: Oh, right.

RR: So it was only towards the end, so a bit prior to that, that I wasn't [redacted] care coordinator. So it was just because there was no one left.

BK: Yeah, yeah. I mean we've heard [inaudible] about the role of care coordinator at Barrett. It would be helpful just for us to hear from you what you saw as the components of the role.

RR: Well the way that I saw my role is to actually assist the kids to actually improve, you know, all the emotional problems that they had and because of the therapies that they were having. Some of them who were having therapy sometimes they, when they came back to the ward they sort of decompressed and that was my role to actually assist them with that process, you know, to think through what was happening and to help them with, you know, medication of course, you know, they needed medication and actually finding different ways of helping with the stress that they were going through and the de-stress from the therapies and all the uncertainties and all of those things that was happening with them. That was throughout, not just because of the closure, so it was because, depending on what their mental health concerns were at the time, so that was my role and also to help them through with reintegrating them back into, as much as I possibly could, you know, because there was, it was a team effort. It wasn't just a nursing role, because we had OT's and psychiatrists and registrars and you know it was a whole team process but me, as a nurse, that was assigned to those kids, I was actually an intermediary sort of thing …

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BK: Yep, yep.

RR: … between the kids and the team, you know.

BK: Before the whole issue of the closure of Barrett came up and that transitional process, can you think back to a pretty typical example of a reintegration or transitional process that you assisted with a kid, um before the whole closure issue.

RR: Well it was maybe with that I had …

BK: That was during the transition, prior to the closure?...

RR:

BK: Yes....

RR:

BK: Mmm hm.

RR:

BK: Okay.

RR:

BK: Mmm.

RR:

BK: Mmm.

RR:

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BK: Mhm

RR: ...from the school. So we did have enough time for that.

BK: Sounds like a very solid process that happened over time.

RR: Yes.

BK: Actively involved in negotiating with the school.

RR: And that's why...

BK: Yeah.

RR:

BK: Yes.

RR:

BK: Fantastic.

RR: You know, that was real... I was very pleased that that happened, that kept up with it.

BK: Yeah.

RR: You know so that's how...

BK: So, in case, would it fair to say then that in fact the transition plan was developed after this had been talked about, some components of it, and it was being implemented before the closure was ever on the cards?

RR: Yes, but that was because like some of the others were.

BK: Mhm, yeah.

RR: that's why by knowing the kids you apply different measures and different ways of dealing with them so that it suits the adolescent.

BK: And that general empathic support is incredibly important. Did you also see yourself as delivering some specific interventions to I don't know what the possibilities might be, what you know you have in your tool kit, but either

RR: Well what I was doing but she, never wanted but did, I was doing So I was doing that with a few of the kids as well when they wanted to do so we were doing that as well, and that seemed to help them a lot because I could see the difference between before we were doing and then

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during and then the days after the [redacted] You could actually see the changes that were happening. They were better able to tolerate stress and not decompensate as often so they were able to talk through more, so that's what I was, but [redacted]

BK: Why's that? Why is that?

RR: I think mainly because they were cha.... I don't know, I don't know why because they were leaving....

BK: The turnover of staff, right, yeah...

RR: Yeah, the turnover, but I don't know **why** it was actually happening, you know I don't know why that was happening, why there was such a quick turnover of staff, but it's just that with [redacted] and then it happened and some of the times they were using student, um, psychologists.

BK: Right.

RR: [redacted]

BK: How did you work through the termination phase with [redacted]

RR: [redacted]

BK: Yes.

RR: [redacted]

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BK: Mhm

RR:

BK: So if what was then the option? um...

RR: I don't think we had any other option.

BK: What lead to that happening then that

RR: It did. [*inaudible- coughing*] the problem with the is that if the...whoever you are referring to, if they don't attend appointments,

BK: Yeah, yeah.

RR:

BK: Yep.

RR:

BK: Yeah, it does, it does. It can be a very slow gradual, um, process and a few ups and downs....

RR:

So that would have happened. That's what we've done in the past for other kids that transitioned out.

BK: Yeah...

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RR: ...and we were there. So, even though they were discharged, they could ring us. So that's what was happening.

BK: When you stepped in with when – as care coordinator, can you talk already about that transition process. About involvement with that?

RR: The way that I remember is that I went on holidays

BK: yep.

RR: Came back and when I was on holidays I got a phone call to say if I wanted to be care coordinator and I said 'Yes, okay' but the thing is that there was nobody else that could be the care coordinator for and I, you know, had - we had a rapport because I've known from the

BK: Yeah...

RR:

BK: Yeah.

RR: So that's how it went with but I really had nothing to do with the transition for because nobody involved me in that way so all I was doing with was just doing my normal everyday nursing ...

BK: Yeah....

RR: I sort of had an idea because I was sort of told after. I mean there were places that was going to go and I never found out. was the one that was telling me.

BK: Yeah, yeah...

RR:

BK: During that period of time do you recall if you had any particular concerns about how things were going for about the process?

RR: For

BK: Yeah yeah.

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RR: [redacted]

BK: Transitional housing.

RR: Sorry?

BK: Accommodation?

RR: [redacted]

BK: Yeah....

RR: ...okay and there was always that risk of.. [redacted]

BK: It sounds like in terms of the care coordinator role, that there was quite a sort of abrupt change in model of what the care coordinator - what the relationship, the therapeutic relationship was about with the kids - is what I'm sort of interpreting from your, your um, the difference between the two processes that you're describing. I mean what sense did you make of that to the care coordinator relation...therapeutic relationship with the kids seemed to be so different in those two processes? Did you have any speculation or understanding of what was going on?

RR: The thing is that with the transition after August, September, October – something like that before the closure, we had no say. We had no say whatsoever where these kids were going to go. Nobody asked us, as the nursing staff.

BK: What did you make of that?

RR: I didn't make any sense...

BK: Yeah, yeah...

RR: ... well, well I didn't. I didn't understand why it was happening, I just didn't know but the thing is that the people that I knew were in the Transition Team, they knew the kids, okay. They knew them because they were there. They were in the ward and they were one-on-one with the kids as well. It's not as if they weren't in the ward, but that's only junior people. Who made the decisions, I don't know. You see what I mean but why we ... but

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even they found it - they struggled, they really struggled in finding appropriate places for these kids because...

BK: Yes, yes, it is a very difficult....

RR: .... it was so, and they were under so much stress to finding a place. Maybe that's the reason that we weren't involved because there was an extra person that you have to talk to when it didn't matter anyway because they have to find placements. So I don't know why, why it happened in that way. But I think I, I mean I stayed until the end because I was debating whether to look for another job before I went on holidays but then I thought these kids were... when I was going on holidays they'd say 'You're not coming back are you? You're not coming back' and I'd say 'Yeah, I'm coming back.' They were distressed that I was going on holidays and they all believed that I wasn't going to come back.

BK: Yeah.

RR: So I thought I can't do this so I mean you've left already and then but that's, you've got to think about yourself I've been told so, ok, I'm thinking about myself but what about these kids. You know, and that's why. But that's why I'm only doing agency from now on.

BK: Was there ever the opportunity to raise with anybody in discussion that, that there were aspects of the transitional process that you felt you could have had input into? Were you ever able to raise that with your team leader or ...?

RR: The only way that we ... I mean we were doing case conference notes but, towards the end, even that stopped. Not because it was - it wasn't case conferencing any more, it was transitional meetings and the cc's, the clinical coordinators, weren't involved, like with the case conference the - we used to write notes if we were unable to attend the actual case conference and we actually can discuss the adolescent in the team, you know, and then develop a plan from there but through the transition we weren't asked to attend any of those meetings. We weren't asked to write any notes for that meeting. So we would continue to write, you know, a weekly report but it wasn't to do – I don't know if they read it ... I mean a lot of the time it's, if I thought that I was writing so much, doing overtime after my shift was ended to do the notes, and then when I was there nobody even bothered to acknowledge what was being said, you know, so I don't know.

BK: So you've heard a bit on the grapevine about how [redacted] is doing?

RR: Mhm

BK: And so what was the last contact that you had with [redacted]

RR: Can I say? You know, the funeral, I saw, you know, at the funeral.

BK: Oh right, yeah.

RR: And that's when I saw [redacted] and saw a few of the other kids.

BK: Did many staff go to the funeral?

RR: A few of us went.

BK: It's really very tragic, very sad.

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RR: Yeah, yep. It was.

BK: And did you have a good connection with [redacted] at the funeral?

RR: Yeah, yeah. So that stayed, you know, it stayed and I saw a couple of others that went there that weren't at the park at the time of closure so they transitioned out, so there were a couple of them that came as well. How they found out I really don't know but they came and, you know, we sort of reconnected and things so, yep.

BK: It does sound like there's a group of kids that have stayed in touch...

RR: All the kids stay in touch through Facebook, so the majority of them keep up with things through Facebook.

BK: Okay.

RR: With each other, you know, so that's how they know when anything happens.

BK: That's right, that's right. Is there anything that happened after that that you think it's important for us to know?

RR: The only thing that I can say is the way that the wards were so unsettled because even for the staff – and the kids, even though we're tried not to show, the kids noticed it, you know, the kids that were left and that's why they were saying 'Oh you're going on holidays but you're not coming back.'...

BK: Yeah...

RR: ...because we changed unit manager so many times, you know, and I said why do they keep changing unit managers, you know, I mean in the last four, five months and I thought – and then towards the end we could never even find the unit manager when we needed them, you know, so it was so ... I don't know, it was so difficult, so difficult.

BK: A long, slow, horrible unwinding.

RR: Yep. It was difficult because we had to - the staff that was left - the kids that were left, they were decompensating, you know, and we were always on the lookout. We were, we were so highly strung because every time we're doing our rounds we're just making sure everything's okay, that everything - you know, the kids are okay, [redacted] so I think we became hyper-vigilant sort of thing and that's like, I don't know if that was an affect on the kids as well. I'm assuming it would have, you know so, but that's how it was and you know, the kids wanted to shoulder that. They even, some of them, their idea was: [redacted]

BK: Yeah.

RR: You know, that was their attitude at the time. I said 'Look, you can't do these things, you know, you've got to think about yourself. You know you're going to be put somewhere where you are going to be safe.' That's how we were trying to help them through but ...

BK: Were there any strategies put in place to help staff manage the stress?

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RR: We had no supervision. I mean we were talking to each and other but we had no professional supervision.

BK: Had there been professional supervision mechanisms in the past?

RR: We, it wasn't official but there was in the past we did have a social worker who was actually doing supervision with the nursing staff.

BK: Mhm

RR: ...and she was really good at it but then she left for her own personal career development I suppose and then she wasn't replaced and there was no-one else that we could go - officially go to. We always talked, you know, with each other and we talked with ... because we were all on friendly terms with the team, you know, the team members – the psychologists and social workers – the ones that were there left, so we were all there and talking but there was nothing official, you know, so....

BK: Okay, any questions that you'd like to ask, Tania?

TS: I was just wondering about um, with the young people that you knew – [redacted] - were they involved at all in their own care decisions that were being made about their own transitions and their own care?

RR: They were involved but um ... [redacted] I just don't know why that happened. All I know is that it happened from one day to the next. You know, so I just don't know.

TS: Okay, thank you very much, you've been very helpful.

RR: I don't know if I've said too much.

TS: No, you've been extremely helpful. Is there anything you'd like to ask us?

RR: Are we going to find out the outcome of this?

TS: We'll be providing a report. It will be up to the people receiving the report where it goes to.

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RR: And it's got nothing to do with us individually, sort of thing, like ...

TS: We're reviewing the process of the transition planning for the kids who were in Barrett at the time of the, of the closure so it's, you know, it's very much looking at that those planning processes, yeah.

RR: Okay. Thank you.

TS: Thank you.

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KG-62

Queensland Health

Health Service Investigation - Barrett Adolescent Centre

1084936

Interview with RN Victoria Young - Care coordinator for [redacted] 14 October 2014

Parties: Beth Kotze (BK), Tania Skippen (TS), RN Victoria Young (VY)

BK: So I'm Beth Kotze, Child Management Psychiatrist in New South Wales and Tania and I work in the Mental Health Children and Young Peoples Unit in New South Wales. Could we start by just checking out your understanding of this process?

VY: Um...

BK: What we're doing and why.

VY: Yes, yes, um just gathering information about the um appropriateness of the transition planning for the closure of the Barrett Centre.

BK: Yep, yep. You've seen the terms of reference?

VY: Yes.

BK: We've got a copy here if you want to refresh your memories. Anything you wanted to ask us about the terms of reference?

VY: Um no.

BK: Okay. So if anything does occur to you during the process of the interview just let us know. Yeah.

VY: Yeah.

BK: Um so you were an RN at Barrett?

VY: Yes.

BK: At the time of the closure, up until the closure?

VY: Yes.

BK: Yes. How long would you have worked there?

VY: Um I was there um for about six months.

BK: Okay...

VY: ...on a contract.

BK: Okay.

VY: Um I started out initially visiting Barrett a few times when I was in the casuals pool and then I was offered a three month contract.

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BK: Mhm...

VY: ...which was extended until closure which made it a six month total that I was there altogether.

BK: Right, right...

VY: ...leading up to closure.

BK: Okay so that would have been about July or something like that?

VY: Yes about July.

BK: Okay and the closure was announced in August, is that right?

VY: Yeah, it sort of started...

BK: Yeah, yeah. So you were there at a very difficult time.

VY: Mhm, it was fairly unstable. There was a lot of anxiety from all the staff, kids, their families. It was...yeah it was fair unsettled during that time.

BK: Mhm. What made it attractive to you to take the contract?

VY: Well I'd never worked in that area before and I just thought it would be a challenge and an opportunity to learn more and I certainly feel like I learned...

BK: Did you did you?

VY: ... for six months, that was...yeah.

BK: Yeah. And what do you think were some of the key learnings?

VY: Oh well I suppose it was more - even though it was a long stay, I think um a long stay unit. I'd previously only worked in more stepdown units in areas where is was just more caring for chronic mental illness.

BK: Mhm

VY: People with more chronic problems and I suppose it was a bit more of a volatile and could be more sort of acute and, yeah, just I suppose I'd never dealt with a lot of the things that I came across there and I found that really...as difficult as it was it was really interesting and just all the um eating disorders, self harm, PTSD. I hadn't really worked closely with people with those problems so, yeah…

BK: Did you find it um a supported environment? I mean it was a very difficult time but did you find it supported learning experience?

VY: Um I suppose informally, yes.

BK: Mhm

VY: The staff I forget the core staff but the ones who'd been there um for the longest were quite supportive of new staff. I always felt like I could talk to someone.

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BK: Mhm

VY: It wasn't sort of formal, I suppose, but, you know, there was definitely opportunities to just um yeah get input on how to manage certain things from... yeah, other nurses and certainly at...um the medical director at the end was fantastic. She spent a lot of time with the staff.

BK: Mhm

VY: And yeah gave us a lot of help and support and …

BK: Yeah, yeah.

VY: Yep.

BK: What sort of setting do you work in now?

VY: I'm in the high... I'm still at the Park. I'm in high secure um in the Franklin Unit which is a mixed ward. Um it's one of the - it's an admission ward for females um....

BK: Mhm. Is that high security...?

VY: High security and forensics.

BK: Oh okay sorry. So very different to this?

VY: Yeah, very different.

BK: How are you finding that?

VY: Um a bit quiet after Barrett but yeah I'm really enjoying it. It just comes with a whole new set of …

BK: Yeah...

VY: ...um I don't know the patients have just really different goals and…

BK: Yeah...

VY: ...A lot of them have been in the system for a long …

BK: Yes, yes...

VY: ...much longer time and it's just completely different but it's good. I am enjoying that.

BK: Yeah, yeah, okay. So you were the care coordinator for [redacted] is that right?

VY: Ah, yes. I was associate care coordinator.

BK: Associate care coordinator, okay. Can you talk to us about the process of transition planning for [redacted] from your point of view?

VY: Um well to be honest I wasn't really involved at all in that I wasn't really asked for any - to give input into what would be best for [redacted] I was kind of, at times, given updates of

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what had been planned. But my role with [redacted] was pretty much more just day to day management...

BK: Yes...

VY: ...and just compiling a weekly summary which was gathering everyone else's impressions of [redacted] during the week and that would be presented to the weekly meeting and then I suppose they would or wouldn't use that as to inform their transition planning. So I didn't really have much to do with that side of things. I was just trying to, kind of, I guess manage [redacted] and the other kids on day to day.

BK: Yep, yeah. Did you feel that you had information that might have been helpful to the transition planning process?

VY: Yes and I put that in the weekly summaries every week and I don't know whether that was sometimes noted or not or...

BK: Yes...

VY: But I took everything that I felt about [redacted] progress and wrote it up and entered it in Simmer and.....

BK: Mhm

VY: ...yep, I felt like I did my best to get - paint a picture of how [redacted] was travelling.

BK: Yeah.

VY: [redacted]

BK: Mhm, yeah. Given that you were quite new to that um sort of surface um setting, how did you um understand or how was it explained to you what the nursing role is within that kind of service?

VY: Um it wasn't really ever formally to be honest....formally ex...explained.

BK: Mhm

VY: I remember finding a role description in my last two weeks....

BK: Yes, yes...

VY: ...at Barrett and reading it thinking 'Oh wow! [?]'. Yeah, well I mean it was fortunately that I felt like I was doing most of those things by that point but I was never really given a formal description or much [?]...

BK: How was the role described?

VY: Um, to be honest it wasn't really. I just was invited to - I was just offered a contract for this period of time and um… it was very much just learn on the job really.

BK: Mhm

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VY: And because I'd been there a little bit, casually, just as part of a pool - I was there for a day here and there.

BK: Yeah...

VY: ...um I sort of was familiar with the kids by the time I got the contract and um I knew the routine, like what the average day was and so I kind of just pieced it all together myself over the time that I was there really...

BK: Yeah, yeah...

VY: ...after, when I needed it and....

BK: Do you recall at all how much notice you had of being transferred out?

VY:

BK: Mhm, mhm, to yeah.

VY:

BK: Mhm. Were you involved with any of the other kids at that time then?

VY: Um, in what way?

BK: Were you a care coordinator or executive coordinator, or....?

VY: Oh, I can't remember now. I think I might have been made assistant for one kid, just for a few weeks while Susan was away, or something like that, but not really. It was mainly just who I was...

BK: So once had been transferred out, what was your role on the unit?

VY: Well, just the same as all the other RN's, I suppose.

BK: Okay.

VY: Just day to day care and giving medication, assessing, monitoring mental states, making sure they were at school and just following the routine of the ward and...

BK: Okay. [?] ere you there until the very close? Or did you finish up earlier than the end of January?

VY: Um, I think I was there until about a week before, because we only the three kids at the end...

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BK: Right...

VY: ...we had too many staff and I think I was farmed off to other wards – farmed off to other wards at that point but...

BK: Yeah, yeah...

VY: ...because, yeah, they just couldn't justify having - they'd made the rosters previously but, yeah, I was there for about a week before closure.

BK: Okay, okay. Anything you'd like to ask us?

VY: Um no.

BK: No, that's okay.

VY: No...

BK: Look thank you that's been very helpful. Very helpful. Thank you.

VY: Okay no worries.

BK: I'll keep that one unless you really need it.

VY: Oh sorry, yeah...

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KG-63

Queensland Health

Health Service Investigation - Barrett Adolescent Centre

1084936

Interview with Dr Stephen Stathis, Clinical Director CYMHS, by telephone
14 October 2014

Parties: Beth Kotze (BK), Tania Skippen (TS), Dr Stephen Stathis (SS)

BK: As you know, I am a child psychia-, Child and Adolescent Psychiatrist from New South Wales, and Tania and I work in mental health children and young peoples unit there and you're familiar with the background to the investigation?

SS: I am, yes.

BK: So, you understand that we're looking at the transitional process to the kids at Barrett. Look, I guess some of the things that has emerged for us is trying to understand what was the role of the various parties in the transitional process. So, we've got a very good handle on the planning done within Barrett around the individual kids, but can you, are you able to fill us in on what the role of, what your role was, what the role of your service was, in the lead up to the closure of Barrett and then the, the subsequent transitional processes?

SS: Sure. Well, I guess, first of all, we, our role was really, there was no clinical role, so in the lead up, of course, Barrett was [?] so there was no clinical oversights there, and none of the clients in Barrett were, therefore, Children's' Health Queensland clients.

BK: Okay.

SS: And we made that very clear, and so we didn't access any case records, we weren't case managers, we had no clients under clinical care in terms of Children's Health Queensland. Over the transition process, Judy Crouch and I were co-chairs of the State-wide adolescent extended treatment and rehab implementation strategy.

BK: Okay, and that was really more about new services, was it not?

SS: Exactly, now look, by the way, because of the short notice, I haven't read any documents, so this is just of the top my head.

BK: Okay, yep, yep.

SS: So, I don't have anything in front of me, it's just from what my recollection.

BK: Great, no, that's fine.

SS: Absolutely, that steering committee was looking forward, not really looking at the transition process. Having said that, initially, under the terms of

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reference of that committee, we were going to establish and oversee three working groups which were associated with the transition process. However, it was then felt that rather than having working groups around that, the involvement was going to be really constrained to individual consumers considered by the transition panel which was chaired by Ann and, I'm sorry I just talked about that.

BK: Yes, yep.

SS: And that if a consumer was part of our HHS or, indeed, any HHS, that kid was going to be consulted directly for the consumer.

BK: Ahuh.

SS: Now, there was a clinical heir transition panel report, like a status report, about each of the consumers, but was tabled at the fortnightly steering committee. But that was just for noting.

BK: Yeah.

SS: And it was just so that we had some idea and I think, from memory, although we were meeting fortnightly for awhile, the status report was tabled monthly.

BK: Ahuh.

SS: And it was just so that we could quickly look down and have an idea who was being discharged, when, when the and where they were going to be discharged to. But it wasn't, we had no clinical oversight of that. It was just so that we would know how that process was unfolding.

BK: Right.

BK: So, once Barrett closed, when did you cease to receive those reports?

SS: Well, I guess, I do recall we had a report in January, and I can't recall, I'd have to look at whether we received any reports after January, because after the Barrett closed, this is the transition panel, I don't think we received any formal report. After it closed though, what we did do is I did informally speak with Ann, and we did, and I'm sure I could find the documentation around it, we did contact people. Certainly, we kept an eye on [redacted] and we did informally ask how things were going, then we were in a bit difficult position. We didn't want to feel like we were intruding into the clinical care of young people who had been managed by other hospital or health services.

BK: Mmm. Yeah.

SS: And, in addition of course, some young people were being managed by private therapists. So, it was a bit difficult ethically and clinically to ring in and say, well, how re those young people going?

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BK: Yeah, so, I guess, I mean that's really what we're struggling with I guess, is the sense that it's as if the transition process finished with the closure of Barrett, rather than the finishing of the transitional process, if you know what I mean. So, that with the closure of Barrett, it's not clear to us whether there was anybody who had oversight of the transitional processes for the kids, and I guess, you know, what you're saying, you know, perhaps sort of confirms our impression that there wasn't anybody formally responsible for oversighting the, you know, what happened during the transition processes. It just sort of finished with the closure of Barrett.

SS: Yeah, I mean, it was just very tricky because once a young person has been accepted into another hospital and health service.. As a client, it becomes difficult in terms of how the structure is.

BK: Yeah

SS: For someone separate to have clinical oversights.

BK: Yeah, yeah, oh look, yeah. We appreciate those [?] issues. We've done quite a lot of work trying to think through the issues of transitional care in New South Wales and that kind of sense of conceiving as the distinct process in the care, you know, in the general care processes, and it can be very difficult to manage when you've got two services involved. Well, it is, it's transition, isn't it?

SS: It is, I do certainly recall a number of occasions where we contacted private, either Ann or myself, contacted service, and we did this together in conjunction, we contacted other [?] and other private service providers, and from my recollection, everyone says that they were relatively stable and they didn't have any concerns. Particularly in relation to the [redacted] who were the most, shall we say, challenging to place.

BK: Yep.

SS: We also looked at the waiting lists. And those waiting to go on the waiting list. And because we were very concerned there was a very large waiting list for the Barrett clients.

BK: Right, yep.

SS: It was young people who were on the waiting list to get into Barrett, and there was then young people who were on the waiting list to be assessed to get onto the waiting list to get into Barrett. And so Ann and I spent a lot of time going through those, that list of young people as well, because we were very cognisant that there would be younger people out there who may not even be aware that the Barrett was closing.

BK: Yeah.

SS: Or who were waiting to get into the Barrett and some of these young people had been waiting for well over a year.

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BK: Well.

SS: And so we contacted all of those young, well as many, some had just disappeared.

BK: Yeah.

SS: But we contacted as many of the families as we could to ensure that we, that they were receiving some type of service, whether that was by a GP, or by a psychologist under say, an ANCAPS program, some would have been seen by their local community services. And Ann spent a lot of time chasing up those people and she even arranged the service providers individually.

BK: Yeah, yeah. Do you recall the very difficult kind of kids that were remaining at the Barrett at the end, I think that one of them was

SS: Yeah.

BK: Do you recall, you know, making phone calls in that sort of follow up period around

SS: I don't recall doing that.

BK: Okay, that's alright. Do you recall which kids that you would have made phone calls about?

SS: Yes, I do recall speaking to Ann and also ringing people, for instance,

BK: That would be

SS: I do recall speaking to about Shawn is Just to make sure that as okay.

BK: Yep.

SS: And I do have a recollection speaking to the who moved to

BK: Ahuh.

SS: To make sure that was settled, that was early on. I think over the month or so after. And I do recall speaking to the, see there was so many phone calls made. I didn't talk to anyone about

BK: Ahuh.

SS: from memory. Those were the main ones.

BK: Okay. Okay. Can you.

SS: And a number of conversations with because we were working out when

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package to support up in, initially, So, I had a number of conversations with around supporting

BK: Okay, okay. Tania, do you have any questions?

TS: Now, Stephen, the Children's Health Queensland were or weren't really involved at the stage of planning around the clinical governance and who might have been supporting the transition panel from a clinical perspective? You suggesting that would have been West Morton?

SS: Yes, that was.

TS: Yeah.

BK: Yeah.

SS: Because it was their young people and [?]

BK: Yeah.

SS: And all we did, well what we did in terms of the committee is, we were noting where the young people were in terms of their transition.

TS: And are you aware of any kind of package of resources that might have been offered following the decision to close Barrett?

SS: Oh gosh, [?].

TS: To assist with the, not for individual clients essentially, cause I think that they were, you know, funding was sought on an individual basis, but was there, after the decision was made, the political decision to close Barrett, was there any kind of resources offered to the clinical decision makers or the executives to carry out the closure, or to support the steps in the project.

BK: Well, in terms of the moving forward, there was the resources from the Barrett and money also, the extra money from the Redlands that we had pulled into our business case for the new services moving forward.

TS: Right.

SS: And so we were very cognisant of that money we used, in terms of our business case moving forward, we were looking at five, we did a lot of consultation, I know this is outside your terms of reference, but we did a lot of consultation in New South Wales and Victoria across the sector in Queensland with carers, consumers, care providers, we also spoke to different service providers in WA and South Australia about what services people would want for adolescents in Queensland. The very clear message was that there were gaps and the gaps were in terms of day programs, youth resi programs, and acute mobile youth outreach services, kind of like acute response teams. Which is what we modelled our youth services on. The other issue, of course, is we looked at what the ECRG recommended in terms of State-wide beds and we made sure that as part of our continuum of care, we recognised the importance of State-wide subacute beds in a

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decentralised State such as Queensland, and that was funded as part of our continuum of care, so indeed we do have two State-wide beds in the Mater and we will have four State-wide beds available in the latest [?] hospital when it opens next month for these subacute, for young people requiring subacute treatment and those beds have access to education on site. So, those, that was what was in keeping with the ECRG recommendations, and also what the Minister has stated would happen.

TS: Thanks, Stephen.

BK: Okay. Thank you, Stephen. Is there anything that you think that we, it would be useful for us to know that we haven't asked about?

SS: I don't think so. Off the top of my head.

BK: Okay.

SS: No. Not that I can think of off the, cause I'm not, you know, I'm not sure the questions you've asked Ann and the others.

BK: Mmm.

SS: I would have to say that when I was, I would be speaking to Ann in terms of peer support, we didn't talk about individual cases. But she has attended the peer support group that I am part of for many years, so I know her quite well. I mean, I thought that she was doing a very, an excellent job in a very difficult circumstance.

BK: Yep.

SS: Beyond that, nothing that I can.

BK: Okay. Look, thank you so much for your time.

SS: No worries, I'm more than happy to have helped where appropriate.

BK: No, thank you, Stephen.

TS: Thanks, Stephen.

SS: Thanks very much.

BK: Bye bye.

SS: See you.

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Queensland Health

Health Service Investigation - Barrett Adolescent Centre

1084936

Interview with Megan Hayes - OT, 14 October 2014

Parties: Beth Kotze (BK), Tania Skippen (TS), Megan Hayes (MH), Lisa Harris -Corrs (LH)

BK: Alright, thanks, Megan.

TS: Hi, my name's Tania Skippen and I am a child and adolescent psychiatrist, and we both work at Mental Health Children & Young People in New South Wales.

MH: Ahuh.

TS: And we've just been asked, as you know, to carry out this investigation. I did have some extra terms of reference here, in case you needed to see them. Did you receive the terms of reference for the?

MH: Ahuh.

TS: Yeah, great. Were there any questions? Here we go.

MH: No.

TS: Have any questions about it?

MH: No.

TS: Okay, great. So, would you be able to tell us a little bit about your role at Barrett, pre and post the announcement to close Barrett, and particularly your involvement in the transition planning of individual clients?

MH: Sure. So, initially, when I commenced at Barrett, I was in an OT specific role that focused on assessment and intervention around life skill development. Um, so, I was there for a period of approximately two and a half years, and then had some different periods of leave.

TS: Mm.

MH: And then came back, in around September last year where the role, I guess, shifted a little bit and became much more focused on the transitional panel involvement, rather than having a lot of time for OT specific focused work. Um, so I went from full-time, um, previously to a five day fortnight.

TS: Okay.

MH: Capacity

TS: Yeh,

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MH So, I had to shift.

TS: Ahuh.

MH: Um, did you want some more specifics around what they sort of looks like?

TS: Yeah, sure.

MH: ... in the role. Um, so, I guess, in terms of OT specific role, I was involved in doing lots of, um, comprehensive assessments for [?], ah lots of things around their vocational interests, um developmental, in terms of their activities of daily living and really looking at future planning, so how can we get these patients back into an appropriate day-to-day life. And very integrated with the school that was based there

TS: Mhm

MH: in terms of what that looked like. Compared to when I was back there more recently, um much more focused on assessing what their level of need might be

TS: Mhm

MH Currently, and having minimal time to actually, you know, intervene with some of those areas that might have needed some extra skill skilling up prior to discharge, it became much more focused on more: What is that area of my clinical need and how do we meet that from other services, post-discharge?

TS: And how did you go with finding other services?

MH: After that?...So, that took up a lot of my time. Um, I guess, when they gave the date for the closure, there wasn't um sort of an array of services that they said, 'here's all the options'. Um, so it had to be a lot of research for each individual patient as to what their actual need might be, what their family situation was, and how supportive they were from that perspective and what area they were going to be based in. Um, so, that definitely took a lot of research and understanding what they were eligible for.

TS: Mm.

MH: And what other services we could put in place that integrated nicely with the mental health supports that we felt were necessary. Yeah, so that was a very intensive process, I guess, ruling out lots of potential options and really securing what we thought might be a best fit at the time.

TS: So, how did that, you were part of a transition team and you had transition panels, is that right?

MH: Yes.

TS: So, how did the panels work and who were the teams?

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MH: Um, so, they scheduled them, um, each patient had a date that, I guess, they were scheduled for, on the panel. My understanding is we met fortnightly, um, initially and I guess, as the time went on, we had a lot more, um, many teams and many meetings that we had to engage in every day, pretty much. Um, so, in terms of the panel, there was a representative from, um a couple of representatives from Allied Health nursing, psychiatry and the school also were invited to be part of that. And there was also a project officer that came to document each of those panels.

TS: So, Allied Health nursing, project officer and the school, and medical?

MH: Yes and psychiatry, yeah I think that was all of us. And each of the case managers were included for each of those, like if they were relevant to that particular panel for that child. Which was nursing.

TS: Right.

MH: So, IC&C was always there, that's them. And an extra nurse might need to pop in...

TS: So, then their case manager, is that what's also called care co-ordinator?

MH: Yeah, sorry, yeah. And then the nursing team.

BK: Vanessa? Vanessa Turnworth was the CMC, is that right?

MH: Yes.

BK: Yes.

TS: Yes, okay. And so the care co-ordinators were also invited to the panel?

MH: Yes.

TS: Okay.

MH: Just the ones specific to the child that they were working with. Yeah.

TS: So, they had one meeting each, or they had a number of meetings for each young person?

MH: Um, there was one scheduled officially, but I think, um, the case reviews which were held weekly then also became very discharge-focused once we had the date and so all of our discussions, yes, were around how they were functioning this week and in terms of their mental status, but then also came: What's the plan, where are we up to with that? So, I guess, officially, there was this set scheduled transitional panels but all the additional meetings were happening around that on a regular basis for review where we're up to.

TS: Mm.

MH: What else we needed to follow up with.

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BK: And who provided support to the transition panel? And was there anyone above who provided support to you as a panel?

MH: Um. My understanding is that Dr Ann Brennan was very closely linked with the executive of West Moreton. But I wasn't directly linked in with them.

TS: Mm.

MH: Yeah, they were main supports.

TS: Yes. And were there any particular clients that, it sounds like you were across quite a few, were there any particular clients that you were particularly involved in the transition for?

MH: Um, I think I was more involved with, in terms of the organisational part of that. But yeah, each of them we discussed at length and supporting the process the whole way along.

BK: Yes. Can you tell us a little bit about transition?

MH:

TS:

MH:

TS: Mm.

MH:

TS: And what did that involve to

MH:

TS:

MH:

150 TS: So, your role was securing a first appointment for was it? Or...

MH:

155 TS: Mm. Okay.

MH: Yep.

TS: And was there anyone that you were particularly involved with?

MH: Um. Not like in a major role, I guess, so across all of them. Yeah.

TS: And so, was it easy to, I guess, there was some level of consumer and parent
160 communication with either the care co-ordinators or yourself on the transition panel?

MH: Yes.

TS: Yeah. And I guess some of them were easier because they had more supportive family than others

165 MH: Yes.

TS: I think from memory had a that was also involved?

MH: Yes.

[*Phone ringing*]

TS: Excuse me while I, sorry.

170 [*External telephone conversation takes place – wrong number.*]

MH:

So, they were both involved in the communication
175 around the plan and what might be possible. Yep.

TS: And are you aware of any kind of follow that happened after you left with the young people to see how well they transitioned, or?

MH: No, not from my area, I wasn't, um no longer working in West Moreton, once the closure occurred.

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TS: So, did you work there right up until close then?

MH: Yes.

TS: Yeah, okay. Was there any other comments that you have about, um, the transition process generally?

MH: No, it was a very difficult process, yeah.

BK: mm mm.

TS: Yes, sounds like it.

MH: Yeah.

TS: And are you working somewhere at the moment?

MH: Yeah, I work for Children's Health Queensland at the Childhood Family Therapy Unit which is an inpatient...

TS: [?]

MH: Yeah, can too. Yeah, it just connects my OT role there, the CR. So. [?]

TS: And is that different to how it was working at Barrett?

MH: Yeah, I guess it's a different, much, much shorter admission stays and, yeah, the age group, it's not [?]

BK: I know that this is a difficult question in some ways, but with [redacted]

MH: Mm.

BK: To your knowledge, had there been kids like [redacted] um, beforehand in Barrett and what had been their discharge plans? Do you know?

MH: Um.

BK: And, and [redacted]

TS: But..

MH: [redacted] is that...

TS: [redacted]

MH: Yeah.

TS: That's what Barrett Centre [?]

MH: I can't recall a particular child.

TS: Yep.

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MH: [redacted]

215 TS: Mm.

MH: [redacted]

TS: Yes.

220 MH: [redacted]

TS: Yes. so. was [?] that became clear during the process how [redacted] was able to be.

MH: Yeah,

225 TS: [redacted]

MH: Yes. Yeah, So, [redacted] Yeah.

TS: Okay.

BK: Mm

MH: So, quite [redacted]

230 TS: Mm.

MH: [redacted]

235

BK: Mm.

240 TS: Very, yes. Very tricky.

MH: [redacted]

BK: Mm.

TS: Where you aware, across the time that after the Barrett closure was announced, um so you came back in September which was the month after
245 the closure was announced?

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MH: Yes.

TS: Whether there was any, um, anything put in place around termination ceremonies or rituals for the young people of the staff members

MH: Yes.

TS: Or particular support for staff as they were having to say goodbye or?

MH: I think that there were some suggestions around having, um, like I think from the school's perspective.

TS: Mm.

MH: They raised having sort of um goodbye parties or, cause I guest there was a staggered nature to some of the discharges, um, and then were was quite a bit of resistance to that occurring, or they were I guess trying to be delicate with how we did that.

TS: What was the risk of doing that?

MH: Um, I guess, of bringing a lot of, like more emotion to what was already quite a difficult process for staff and young people.

BK: Where did that resistance come from?

MH: Um, I think it came, I think it came from executive, from my understanding, yeah. I guess I was limited in my part-time nature.

TS: Sure.

MH: To understand exactly where some of the processes were stalled, but there definitely was the consideration around how do we approach this.

TS: Mm.

BK: Mm.

MH: Delicately, but in a manner appropriately. So, I didn't really, it didn't occur.

TS: No ceremonies or a limited?

MH: Yeah. Not to my knowledge and big sort of parties and definitely from a staffing perspective, there was no support to have any sort of additional supports in place for staff members that I'm aware of.

TS: Quite a time of change for everybody as Barrett had been open for a long time?

MH: Yes, and I guess all the HR concerned staff were also dealing with on the side, made it quite difficult.

BK: What are the formal HR processes?

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MH: What were they?

BK: Yeah, the formal HR processes in terms of working through with people, what options they have in terms of employment and stuff like that?

MH: Um, so, we had representatives from HR come and talk to Allied Health, I know nursing had a different process, so I'm not sure exactly what there's was. So, they came and just let us know that the options would be obviously dependent on each particular person's situation.

BK: Mm.

MH: And then we had additional discussions individually with HR. Yeah.

TS: And was that early in the piece or later, do you recall?

MH: Er, I'm not sure if they had meetings prior to my coming back in September. But I guess we were given lots of different information so there was quite a lot of anxiety around what it would actually look like in the end and.

TS: From HR or from Barrett closure?

MH: From HR.

TS: Right.

MH: In terms of staffing opportunities post-Barrett. Yeah. So, yeah, the different information was quite tricky and I think people were quite anxious about getting it on paper and what that would actually look like for their individual situations. Yep. So, I think they, there was some containment that was attempted from professional, so line managers around supporting us through that process which was [?].

TS: How did you have professional supervision outside of Barrett with your clinical stream?

MH: Yes, with senior OT at the park.

TS: And was that like a routine thing or it offered for you...

MH: It was always routine when I was placed there, but, um, yeah so that just continued. Yep.

TS: Are you aware of anything that existed for the nursing staff or other staff?

MH: From a HR perspective or?

TS: Sorry, from a professional supervisional support or also a HR.

MH: I'm not sure what they had in place from their perspective, sorry, yeah.

TS: That's alright.

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BK: Were you involved in the Christmas program, the Christmas vocation program, the one that was run by the NGO of...?

MH: No, so the OT role previously had always been to run the holiday programs.

BK: Yes.

MH: So, when I came in September, there was already the September school holidays were scheduled, so I was linked in to support that process. Um, but we weren't very involved in the December one. That was sort of planned separately with the executive and the NGO and run by them with, I think, minimal nursing like our nurses would support. But it was mainly based at the ward during that time.

BK: Mm.

TS. Mm.

BK: Did you feel you maintained your morale during this time?

MH: Personally?

BK: Yeah, personally.

MH: I think being in a part-time capacity.

BK: It helped, yes.

MH: Was a supportive, preventative factor. And also being quite fresh coming back with, I think um, I hadn't had a chance.

TS: Mm.

MH: I don't think, to become um hostile towards the process or fighting that process, I came knowing it was closing and what needed to be done. And just trying to maintain that position from a clinical perspective.

BK: Mm.

MH: Rather than get, have discussions around the politics of it. Yeah.

BK: Yeah.

TS: Are you able to fill us in a little bit on the role and function of the school also through the transition, and then what might have happened for the school staff? We actually haven't heard a lot about the school \

BK: Mm.

MH: Okay.

TS: So we would be interested to hear where.

MH: Okay.

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TS: Where, cause we've [?] that there, that some of them were visited by school staff following or that some attended at Yeronga School or.

MH: Okay.

TS: Mm.

MH: Um, so, the school is based at Barrett, um run by Queensland, and they were always very integral in our day programs, so all our kids would always go to the school and we'd then engage with different individual therapy or they'd support our group programs. So, when I came back, there was minimal Allied Health support around lots of those group programs, because we were obviously focused a lot on the transition, so I think the school really allowed the day-to-day running of Barrett to continue. Like that was I guess a really good strength that they were able to try to operate as normal and they also had taken on a lot of the vocational aspects that the OT role previously had done, because we um had minimal OT support at that point. There was nearly two full-time equivalents and I think at the time that I came back, there had just been one OT in my role full-time, so she was quite stretched. So, the school were really good support, yeah, definitely and had good rapport with all of the kids and tried to keep engaging them in different appropriate activities, as well as their schooling focus on looking at what else they could get them, get completed for them to have on discharge. Um, in terms of the school, they were set up at Yeronga State High School as a, I think it was a trial for this year, and I haven't, I don't know what the process has been, I think they had quite a limited number of the Barrett kids that were really eligible to actually go there. So, I'm not sure how that's going and where things are at for them?

BK: Mm.

TS: So, did your transition planning um include how the young people would still access school or TAFE or?

MH: Um, yeah, so we definitely.

TS: Or work experience.

MH: We definitely considered that on each of their plans dependent on what they were able to sort of cope with at the time, I guess.

TS: Mm.

MH: We didn't specifically consider Yeronga, the Barrett School transition as a definite plan because, at that point, it was still quite unknown if that was really actually going ahead, they still didn't have all the plans in place from a higher level from Queensland.

TS: Okay.

MH: So, it was quite hard to really have it as a set plan and to transition them nicely to this particular school.

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TS: Ahuh.

BK: So, the young people who were leaving at that time, even though they might have ended up at Yeronga, later they wouldn't have known that they were going to have continuity at the school support, through that period...

MH: Yeah, we weren't 100% sure of that, so yeah, that was quite tricky.

TS: So, can I just check, so attendance at the school was mandatory to be an inpatient?

MH: Um, if they were well enough in terms of their acute mental state.

TS: Yes.

MH: They would attend the school and a different [?] alternative school program, obviously. So, that was decided so that on a day-by-day, session-by-session.

TS: Okay.

BK: So even some of the older kids?

MH: Yes, so they would have more of a vocational.

BK: Okay.

MH: Sort of role and lots of the activities at the school would do, would be around um, sort of building on that vocational aspect.

TS: Yeah.

BK: Mm.

MH: Just sort of more general skills that they would [?] and also different leisure based activities and these core activities that would keep them engaged. The social interactions. Yeah.

TS: Anything more that you...?

BK: No, no. That's really helpful.

TS: Mm. Was there any other comments that you would like to make?

MH: No.

TS: Any questions for us?

MH: Is this sort of all that will be required at this point or is?...

BK: Yes, yes. We are continuing interviews over these two days and then we'll be writing our report.

MH: Okay.

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BK: Yeah, yeah.

MH: Okay. Thank you.

BK: We're getting a broad brush perspective.

MH: Yeah.

TS: Yeah. No, thank you very much.

BK: Thanks Megan.

MH: No worries. Thank you.

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Health Service Investigation - Barrett Adolescent Centre

1084936

Interview with Dr Trevor Sadler, 14 October 2014

Parties: Beth Kotze (BK), Tania Skippen (TS), Dr Trevor Sadler (DTS), David Watt – K&L Gates (DEW)

BK: So as you know, I'm a Child & Adolescent Psychiatrist from New South Wales and both Tania and I work for Mental Health Children and Young People in New South Wales. So can I just check that you're familiar with the background, the cause and the process that we're conducting today?

DTS: Right, I mean I've read the terms of reference.

BK: Yes, good. Good, good, good.

DTS: And understood it was looking at the transition plans [?].

BK: Okay. And do you have any questions about the terms of reference?

DTS: Um, not at this stage. I mean I ... I had concerns about what went on beforehand, but I gather that's not part of the terms of reference, so some of the discussions...

BK: Yeah, yeah. So just so we can clarify – up to what point were you involved in the transition processes at Barrett?

DTS: So from the 6th of August …

BK: Okay, which was when the announcement was made?

DTS: ... when the announcement was made.

BK: Okay.

DTS: ... til the 10th of September.

BK: Okay.

DTS: And then I stood aside.

BK: Yep. So how did you find out about the closure? Was that communicated from the hospital? Or how did you find …

DTS: So that was from the Health Service. We went up the afternoon that the Minister made the announcement.

BK: Right.

DTS: And was told that we would be closing in late January, early February and that the, there would be a workaround service for the adolescents. Lesley Dwyer

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acknowledged my concerns about a workaround service - I'd been to them in Kingswood previously and, but she said things would be put into place.

BK: What were your concerns about a workaround service?

DTS: I felt that given, I mean, I do have the email to Bill that I wrote but I felt …

BK: Mm-hm. Have you got that with you?

DTS: I've got that.

BK: Would you mind us having a look at that. Thank you.

DTS: I've got them – there's copies for you.

BK: Thank you.

TS: Thank you.

BK: What's the ECRG?

DTS: The Expert Clinical Reference Group.

BK: Right. So when you talk about the planning group meeting – 'cause this is May 2013, so this is prior to the announcement?

DTS: That's right.

BK: Okay.

DTS: So the Expert Clinical Reference Group reported to the planning group and at that meeting we all objected to the planning group's recommendations for a Tier 3 facility, saying that it wasn't in accordance with the National Mental Health Service Planning Framework and but we'd look at a workaround service. He couldn't see why a workaround service wouldn't be suitable, so ...

BK: So this was, was this in the context of the talk there'd been about the move to Redlands, was it?

DTS: So, um, there was planning for a move to Redlands and I was, I had some reservations about that, but that's a separate issue. But then they ran out of money and I suggested, I was at the opening of the Toowoomba Child and Youth Mental Health Unit and the Minister asked me about Barrett and I thought, you know, if there's no money could we just refurbish the current buildings. But then, and I heard nothing then, but then in November 2012, I was informed that the unit would close and they would transition patients out by the 31st of December 2012.

BK: Right, okay.

DTS: They've had significant implications for the services because they were going to put people in acute in-patient beds, which were then full, largely, and so I wrote to my colleagues and said look, we need to think quickly how we're going to offer a service to them. And the, well Brett McDermott was asked at an enquiry about the closure

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of Barrett and so they instead of closing rapidly, they put in place the Expert Clinical Reference Group to review it.

BK: Right, okay.

DTS: And so Phillip Hazel[?] was on the …

BK: Right, yes, yep.

DTS: ... and various other people from South East Queensland and David Hartnell from North Queensland, there was a parent and another being a person who had been a patient at the unit, so that went through a process from January through til May and then in, and Phillip made the comment that, look we're not going to be able to get an inpatient limit, that's very clear. I wrote to them and then said 'here are the options for using a acute inpatient beds'. But anyhow the Expert Clinical Reference Group were insistent that we should be recommending a Tier 3 service, which was an inpatient service with, um, and then that was taken to the planning group, the oversight group from the District and the Director of, or Health Services Director at that time and at that stage Bill said 'well that's not in line with contemporary thinking and we need to institute this workaround'.

BK: Okay. So the announcement then in August of 2013 was around the closure of Barrett?

DTS: That's right.

BK: Okay. And at that point in time, as the director of the service, what were you tasked with doing?

DTS: We were tasked with transitioning patients, but we had no idea to what we were transitioning them. It was clear from the, from the media release that there were no, that the services were yet to be developed. One of the services that were recommended by the planning group, and I, sorry, I wasn't invited to any other planning group meetings after the 15th of May, so I didn't, I wasn't aware of what other discussions went on. But one of the things was a, looking at the Wyatt Park facilities in [?].

BK: Mm-hm. Mm-hm.

DTS: So we, Stephen Stathis and Judi Krause and I went down to Wyatt Park and I've submitted a report on that facility. In late August, I think it was about 30th of August, we then looked at inpatient beds in Logan to see if that was an alternative thing. So at that stage I thought perhaps beds are still an option, because, and so my, I was on, my task was that, was I felt that my task was to get adolescents as well as possible, but I thought some would be going to an inpatient unit because they were still really quite unwell and others would go to ... I didn't, I mean there were some who could go to the community but particularly with adolescents with severe social anxiety, unless there's strong supports around the rehabilitation process and keeping them integrated into the community, they quickly withdraw. So I saw, foresaw that as a difficulty, but I think by the time I left in ... 10th of September I was just trying to um, I mean we had a number of [redacted] at that stage, trying to deal with the clinical issues and sort out what options may be available for the future.

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BK: So in that sort of 4 to 5 weeks, how were you thinking about organising the transitional process? So I guess and that's quite a specific task and a pretty short timeframe, so in terms of the kind of processes you need to put in place, the team you might call together, or were you thinking of working through business as usual kind of mechanisms?

DTS: First of all I felt that we needed stability of staff and we had an occupational therapist within that stage which was a critical thing because they, we have had two occupational therapists and I mean the rehabilitation program was really integral to the whole process. And so that was a critical loss. We had a number of part-time staff who were, oh sorry casual staff, who were only extended on three month contracts and some of them had been terminated with only a week's notice before that. That was a disruptor to patients.

BK: That was prior to the announcement of any closure, right.

DTS: Yes.

BK: Mhm. Hmm.

DTS: And so that was disruptive to patients and they had to change then to, we had a psychologist suddenly leave because her contract was terminated and the OT who eventually left was just waiting always til the end of the contract before she'd learn if she was extended and she felt that she couldn't stay on any longer. There's no permanency. So I wrote a letter in July actually asking for permanency, just for stability, and certainly that was a recommendation of the Expert Clinical Reference Group that existing staffing be retained until the end of the period, so that we can um yeah, just to see the whole process through. There was money in the budget for that. I felt they could have at least have...

BK: ...Was that a change in how the staffing had been managed?

DTS: Yes. Um, a lot of ... um, I mean there were budget cuts at the beginning of, just generally to certain services, from the beginning of 20, by the end of 2013.

BK: That's the State-wide cuts, yes.

DTS: That was the State-wide cuts.

BK: Yep, yep, yep.

DTS: We were relatively untouched because we, our staffing levels had actually dropped since we actually began. We were, we were running under budget, so I thought that there was a good argument to keep the staffing level, levels stable, even though people were casual staff. And one of the major issues were permanency of nursing staff. We had a lot of difficulties with, and sometimes you'd have a shift of 5 or 6 nurses, only two of them would be permanent and that was a problem so, to me, the first thing was to get the staffing right so that we could then get the adolescents as right[?] as possible. But in terms of further transition plans, having no idea what we were going to transition to, I couldn't plan, or I didn't feel I could plan and I've been thinking about this since this, I got the letter about this investigation – about what I should have been doing, because I thought, really, it was just a matter of getting them as well as possible, because I, I just didn't know. No-one had any idea what service

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we were going to go to. When we saw the White Knight beds and then the fortnight later saw this inpatient unit at Logan, I thought well maybe, um, there may be further inpatient beds. But one of the problems between our service and Adult Services is that the number of adolescents whom we were seeing such as the ones with the severe anxiety disorders, the ones which, with the histories of strong abuse and trauma, they would often be seen, viewed as borderline personality disorders in the adult system and treated very differently. I mean I've got an overhead about our, just the transitions we'd notice if they worked through the abuse and we have seen young people with um, who, you know 19, 20, 21, were needing no further mental health care after quite a history of being, so, – could I just show you a folder of …

BK: Sure, certainly, certainly. Can I just clarify – were you the only senior medical practitioner on the unit?

DTS: Yes.

BK: Okay, okay. So you were responsible for all the kids?

DTS: Yes.

BK: Inpatients, day patients, outpatients?

DTS: Inpatients and day patients.

BK: Okay.

DTS: And we had occasional day patients but we didn't have a great number of those.

BK: Okay.

DTS: So this is a, sorry, it's in diagrammatic format, it's not got a lot of validity to what the, it's a process that we've noted and I've taken it from a thing that I would show to Child and Youth Mental Health Services. People would come in with histories of self harm, depression, the trauma, which is the black area, would be not known to them, and not recognised by them as being associated with the depression or anxiety. Then I think the relationships with staff, and I've got various qualities of relationships there – they went into this connection phase, we saw a lot more people use these symptoms.

BK: Yep.

DTS: And then some of them opted to numb out - I can't deal with this and we had DBT groups going and ... but some, and it was seemed to be when they said 'look, I want to get on with life' and they would start their developmental tasks and I've listed those developmental tasks there – that they would then start working on that but they'd say 'I've got to deal with these issues from the past' and during that stage there was a, um, because the um, post-traumatic symptoms were just so much worse, the be PTSD symptoms were worse, they were much more vulnerable and there's greater incidence of depression, but if they worked through that with trauma-focused therapy they would then - and we've got good evidence that they are in their 20s without needing further mental health care, and

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[redacted]

BK: Mm-hm. Yes.

DTS: [redacted]

BK: So in that initial phase of the transitional process, in that four weeks that you were involved with, what was the governance of the process at that time? Were you discussing these plans or issues with anybody outside the unit?

DTS: I, at that stage we really hadn't got too many meetings going so there was a, I think there was a transition planning group that both Judi Krause and Stephen Stathis were chair of, and from that there were going to be three working groups, and so at that stage we were just at the transition planning group and we hadn't established the group that would oversee these young people working through and that was to be established just as I left.

BK: Okay. So there would be, there, does that mean that there must, that there was some pretty quick discussion about how it was going to be organised? If the announcement was made the first week of August ...

DTS: Yes.

BK: ... there was some pretty quick discussion about what would be the governance structure?

DTS: Yes.

BK: Okay. Yes?

DTS: Yeah, sorry, Children's Health Queensland had owned the governance structure, and so Stephen Stathis and Judi Krause and so I would talk to Stephen about some of the clinical issues. I had more conversations with he than with Judi and I think Judi was away – she went away for a few a couple of, a weeks overseas, so, yeah.

BK: So that kind of um, was there discussion about the issue that you'd been given a deadline of January 2014 but you were thinking that in fact the kids needed longer, or some of the kids needed longer than that or how would that discussion have gone?

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DTS: Initially when Lesley Dwyer spoke she said it would be late January, early February but it'd be fixable, you know, whatever would fit me. When we were down visiting the Wyatt Park facility in Melbourne, Stephen just got off the phone to Bill Kingswell and said for some reason Bill wants to close it on Australia Day, and I'm not sure why that is. So that was the first I knew that it wasn't a flexible process, because I felt that Lesley Dwyer was more likely to take notice of Bill, in terms of process. So um, yes, I was, so I mean, the 30th of August we were discussing the implications of the beds at Logan, I thought well this is a real opportunity for a realistic transition plan to cope with some of these services and even if it was temporary, because they had another building that was newly built for those patients to go into and although they're not ideal in terms of observations or that, at least it would have been a building, you know, that we could have seen people through to the, what I thought was a satisfactory end of treatment. I had written previously to Lesley Dwyer raising the question that if we had shifted to Redlands, that shift wouldn't have occurred until the end of 2014 and I wasn't sure why there was urgency to close at the beginning of 2014. The money was there, the building, whilst not ideal, was adequate for the purpose, and just to close it in a measured state. But I mean, so, I raised it with Stephen that I had concerns about the speed of closure, but then this was when we went to Wyatt Park and he said what Bill had said, but then Bill had mentioned these beds at Logan and I thought well maybe they're being realistic, yeah.

BK: So at the time when you, up to the time when you left, how advanced was the planning for community options for the kids, or is that, was it still part of the round [?].

DTS: There was, there was no planning at all.

BK: Okay.

DTS: We really had no idea of what services they could transition to.

BK: At that point, are you saying that Redlands was still a live option?

DTS: No.

BK: No.

DTS: So it had been killed in, or they said no Redlands we've got, haven't got the funding for Redlands in um, um.

BK: [?]

DTS: No sorry, about September 2014 no 2013 or 2012.

BK: That would be after [?].

DTS: 2012.

BK: That would be after...

TS: Yep, yep, [?] sometime it was an option but Logan might have been an option.

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DTS: It might have been an [?], but when I said if Redlands had gone ahead, that was just on the Gantt plan]if it, you know, we're just looking at how long it would take to build it and open it and it was the end of 2014.

BK: Mm-hm. So um was your understanding um, in terms of options so, was your understanding that it was more a matter of waiting for options to be developed so at that stage it wasn't about actively seeking um existing options for each of the kids. Is that the sort of stance that …

DTS: Yes, I mean these were young people...

BK: Mm-hm.

DTS: ... who had already um you know, have trialled the community treatment ...

BK: Mm-hm.

DTS: ... and who had um struggled with community treatment, I mean I, it was only a very very small percentage of the young people who had ever came to Barrett but, um so just on that basis alone, some of them were well enough to transition.

BK: Mm-hm.

DTS: But on the basis that most had had quite extensive clinical attempts at community treatment and were still struggling and that we were working through issues that I knew weren't available in the community. Um I mean there were numbers of things that I'd asked for over the years. One was a step-down unit. Um there's no active rehabilitation programs for adolescents outside the day programs or that, so if you've got a young person for instance with severe social anxiety who, who has withdrawn to the bedroom, it's very difficult to get them out, initially outside of a residential setting. Um, but then it takes a lot to get them engaged both in schooling and vocational options and um, one of the difficulties becomes when um, like just ... there are a number of good community organisations that can take a young person who can connect and who's overcome their anxiety well enough to connect, they can continue on with that work but for the young people we have seen, there's quite a bit of work needs to be done to get up to that and I just couldn't see that happening [?] community [?] on [?] list but um I mean I understand that [?] he's gone to his bedroom and you know, very difficult to engage.

BK: Mm-hm.

DTS: Whereas the outcome for him I think we could have got him into some vocational setting.

BK: What kind of work are you doing do now?

DTS: I'm with the Mater. So I've been with, I've done consultation liaison with the Mater for 25 years.

BK: Oh, okay, right.

DTS: And also now I'm working in the acute inpatient unit.

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BK: Right, how's that going?

DTS: Good.

BK: Yes. So at the time then that the closure was announced and there was obviously the issue of transitioning of the kids, um what about um the whole issue of managing the staff um through the process. Was there discussion in that 4 weeks about um about the management of um the closure from the staff point of view, additional supports that might be required or additional processes, um …

DTS: No, look I'm, I was concerned about that and I think, thought that there was a lot of expertise amongst the staff.

BK: Mm-hm.

DTS: In May I had um written an options paper, um this was before the Expert Clinical Reference Group um ... delivered it to [?] but an options paper using acute inpatient beds because I thought that was probably the safest.

BK: Right.

DTS: But utilising the existing staff to, because they had the expertise and that, so there were no transition plans, there was no um ... I don't think any of the staff had felt supported by Seniors. Um I couldn't give any information about um staff processes or that or likely jobs that they may be able to transition to without services being developed. None of them knew what services that they could be employed at, I um I mean I, so I'd, I felt at a loss because I didn't have any information to give staff.

BK: Mmm, mmm.

DTS: I spoke to Judi Kraus about involving staff um because I felt that um just generally speaking, the Child and Youth Mental Health Services were very - as a community-focussed group, saw treatment as a main option but developing rehabilitation as part of the recovery program wasn't necessarily something that they were um as familiar with. I felt that um that that process was an [?off-site] day unit opening that they should try to retain the expertise of staff and that was part of the Expert Clinical Reference Group recommendations to try to retain that expertise. There had been a good um, um rapport developed with um the school and they had developed expertise in engaging young people um, looking at vocational options and they were an integral part of it. I felt that that expertise was being lost and in fact, if the school hadn't been involved in supporting some of the adolescents um I think,

BK: Mm-hm.

DTS: Um they had been invaluable but they had been, yeah so it, and Judi - he had just felt that look we can't guarantee any positions with Mater and Royal Children's moving into Lady Cilento ...

BK: Yeah.

DTS: ... very tight employment frameworks that we couldn't guarantee anything.

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BK: How long had you been at Barrett?

DTS: Since 1986.

BK: Right, a very long time.

DTS: Yes.

BK: So after you left then in early September, did you have any subsequent involvement with any of the kids?

DTS: No.

BK: So they transitioned [?].

DTS: You are aware of the circumstances in which I left?

BK: Ah we understand yes, that there was an incident and that you were stripped down.

DTS: Yes.

BK: There's been an investigation.

DTS: An investigation, so they asked me not to be involved in any planning so, yes.

BK: Did you have the chance to say goodbye to any of the kids?

DTS: No. I mean well, I was going to pack up my books and I was - this was Christmas/New Year ...

BK: Mm-hm.

DTS:

BK: It was very upsetting for you at the time.

DTS: Mmm.

BK: Yeah.

DTS:

BK: Can we just clarify some details around

DTS: Mm-hm.

BK: Our understanding is that in fact

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DTS: Yes.

BK: [redacted]

DTS: [redacted]

BK: Mmm.

DTS: [redacted]

BK: Mm-hm.

DTS: [redacted]

BK: Mm-hm.

DTS: [redacted]

BK: Mm-hm. There's a bit of disparity between the notes and the accounts that we have heard that ...

DTS: Right.

BK: ... the notes sort of suggest that what they um, the formal records suggest that [redacted]

DTS: Yes.

BK: ... for some [redacted]

DTS: Yes I mean, no.

BK: And um [?] the program.

DTS: [redacted]

BK: Yep.

DTS: [redacted]

BK: Mm-hm.

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DTS: [redacted]

BK: Mm-hm.

DTS: [redacted]

BK: I think um, do you want to ask any questions? I think given the specific focus of our enquiry into the transitional process, we've probably pretty much covered your involvement in that.

DTS: Hmm.

BK: You know, because this inquiry's pretty narrow ...

DTS: Yes.

BK: ... in its um, in its purpose. We've probably pretty much covered that. Is there anything that we haven't asked about that's relevant in terms of the transition process that we should know?

DTS: I'm not, I mean, I believe that I've supplied information on the degree of severity and needs for them.

BK: Mm-hm.

DTS: I believe that there were numbers of primary reports that were going in at the time.

BK: Mm-hm yes, yep there were incident reports.

DTS: Yeah and I feel that they were failed, you know there's a failure to consider just how unwell many of the adolescents were. Um I don't think there's anything more from the, from the 6th of August onwards.

BK: Mm-hm. Okay. When you say failure to consider how unwell they were, failure on the part of ...

DTS: Oh on the Health Service. I mean I'd, we had a number of [?] reports um relating to [redacted] during May after the psychologist was abruptly terminated, from people and we had a 30 years celebration for Barrett in June and Sharon Kelly came down and said oh, um you've had a lot of [?] reports lately and I thought, what ...

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BK: Mm-hm.

DTS: Yeah and so then I just, there seemed to be not a connecting between, these are quite

455 BK: Mm-hm.

DTS: Um and what are the impacts on what are the impacts on what are your staff doing um, is there anything else that we need to know about it? Those types of discussions just weren't occurring.

BK: Thank you. Okay, are there any questions you'd like to ask us?

460 DTS: I don't think so, no.

BK: Okay, okay. Thank you.

DTS: Thank you.

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KG-66

From: Wensley Bitton [
Sent: Thursday, 16 October 2014 04:11 pm
To: Kristi Geddes
Cc: Annette McMullan; Wensley Bitton
Subject: RE: Barrett - further request for information/documents [ME-ME.FID2743997]

Thank you for the update Kristi. I look forward to hearing of any changes that are likely to impact the deadline of 31 October 2014. Please continue to reinforce the importance of that deadline with the other investigators.

Kind regards
Wensley

From: Kate Blatchly [mailto: **On Behalf Of** Kristi Geddes
Sent: Tuesday, 14 October 2014 3:39 PM
To: Wensley Bitton
Subject: RE: Barrett - further request for information/documents [ME-ME.FID2743997]

Hi Wensley,

The investigators have both been in Brisbane yesterday and today completing all of the necessary interviews. They have both otherwise attended on separate occasions to undertake reviews of the material.

I was advised today that they will commence work on the report this Friday. At this stage, no specific issues requiring natural justice have been raised, but we will have a better idea about that following Friday. If any such issues are raised, it may give rise to a need for an extension, in order for us to properly provide the relevant person or entity with details of any allegations against them and provide them with a reasonable opportunity to respond.

I have also reiterated the timeframes for the report to the investigators, requesting a draft report be provided to us by next Friday, 24 October 2014, with a view to ensuring a final report is available for the Department by 31 October 2014. I am advised they will do their best, but again will have a better idea of the feasibility of that timeframe on Friday.

I will give you immediate notice if it appears likely that a further extension is required.

Kind regards,
Kristi.

Kristi Geddes Senior Associate
T:
Minter Ellison Lawyers
www.minterellison.com

From: Wensley Bitton [mailto:
Sent: Tuesday 14 October 2014 01:27 pm
To: Kristi Geddes
Cc: Annette McMullan
Subject: RE: Barrett - further request for information/documents [ME-ME.FID2743997] (14_821)

Hello Kristi

How is the investigation proceeding? Is all on track for delivery of the report on the due date of Friday 31 October 2014 please?

Regards
Wensley

From: Kristi Geddes [mailto:
Sent: Thursday, 11 September 2014 6:51 PM
To: Wensley Bitton
Subject: Re: Barrett - further request for information/documents [ME-ME.FID2743997]

Thanks Wensley.

Kristi Geddes
Senior Associate
Minter Ellison

On 11 Sep 2014, at 5:52 pm, "Wensley Bitton" <[redacted] wrote:

Thanks Kristi
I've sent them both out.
Records are to come directly to you.
Please let me know if you have not heard anything by the middle of next week.

Regards
Wensley

From: Kate Blatchly [mailto [redacted] **On Behalf Of** Kristi Geddes
Sent: Thursday, 11 September 2014 12:54 PM
To: Wensley Bitton
Subject: Barrett - further request for information/documents [ME-ME.FID2743997]

Dear Wensley

Please see **attached** correspondence.

Regards

Kristi Geddes Senior Associate
[redacted]
[redacted] www.minterellison.com

EXHIBIT 53

KGE.001.001.944

MinterEllison | LAWYERS

CLIENT

MATTER Barnett.

FILE NO

AUTHOR Kxnnn.

DATE 14/10/14.

TIME (start) am/pm

TIME (end) am/pm

PAGE OF

Circle activity

TO TI CW AT

With whom Measday Bitton [redacted]

1:42pm - AH msg.

A/I - flagged issue re: trafficname.

- may need ext, but may not.
- D-G will not be happy, must keep to think until 31 Oct.
- don't want to create names if may actually be issue.
- they are making a report Friday - shld know more then.
- pls respond to email requesting update, flagging T+T, that immediate notice will be given re any need for further ext

Reminders Who agreed to do what? By when? Without prejudice stipulated?

KG-67

From: Harry McCay
Sent: Wednesday, 15 October 2014 05:41 pm
To: Kristi Geddes
Subject: Part 9 Investigatioin into BAC transition process

Dear Kristi

Dr Brennan wishes to clarify a statement she made on Monday. After some consideration she believes she did not answer as accurately as she could. Although we cannot recall the exact wording of the question, we believe it was about whether services were resistant to changing their practices. Dr Brennan believes she said that she didn't feel they needed to change practices. However on reflection she would like to amend that to say that for there were additional requirements, particularly in terms of etc , which the services found it challenging to incorporate into their usual programs.

Harry McCay

Harry McCay
Queensland State Manager

Avant Mutual Group Limited
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Postal Address: GPO Box 5252, Brisbane Qld 4001

To find out more visit www.avant.org.au/risk/ig

FREECALL
FREEFAX

Please consider the environment before printing this email

From: SKIPPEN, Tania [
Sent: Thursday, 16 October 2014 08:36 am
To: Kristi Geddes
Cc: KOTZE, Beth
Subject: RE: Part 9 Investigatioin into BAC transition process

Thanks Kristi and the information below is noted.
Regards,
Tania

From: Kristi Geddes [mailto
Sent: Wednesday, 15 October 2014 9:04 PM
To: KOTZE, Beth; SKIPPEN, Tania
Subject: Fwd: Part 9 Investigatioin into BAC transition process

Hi Beth and Tania,

I've received the further information below in relation to Dr Brennan's evidence.

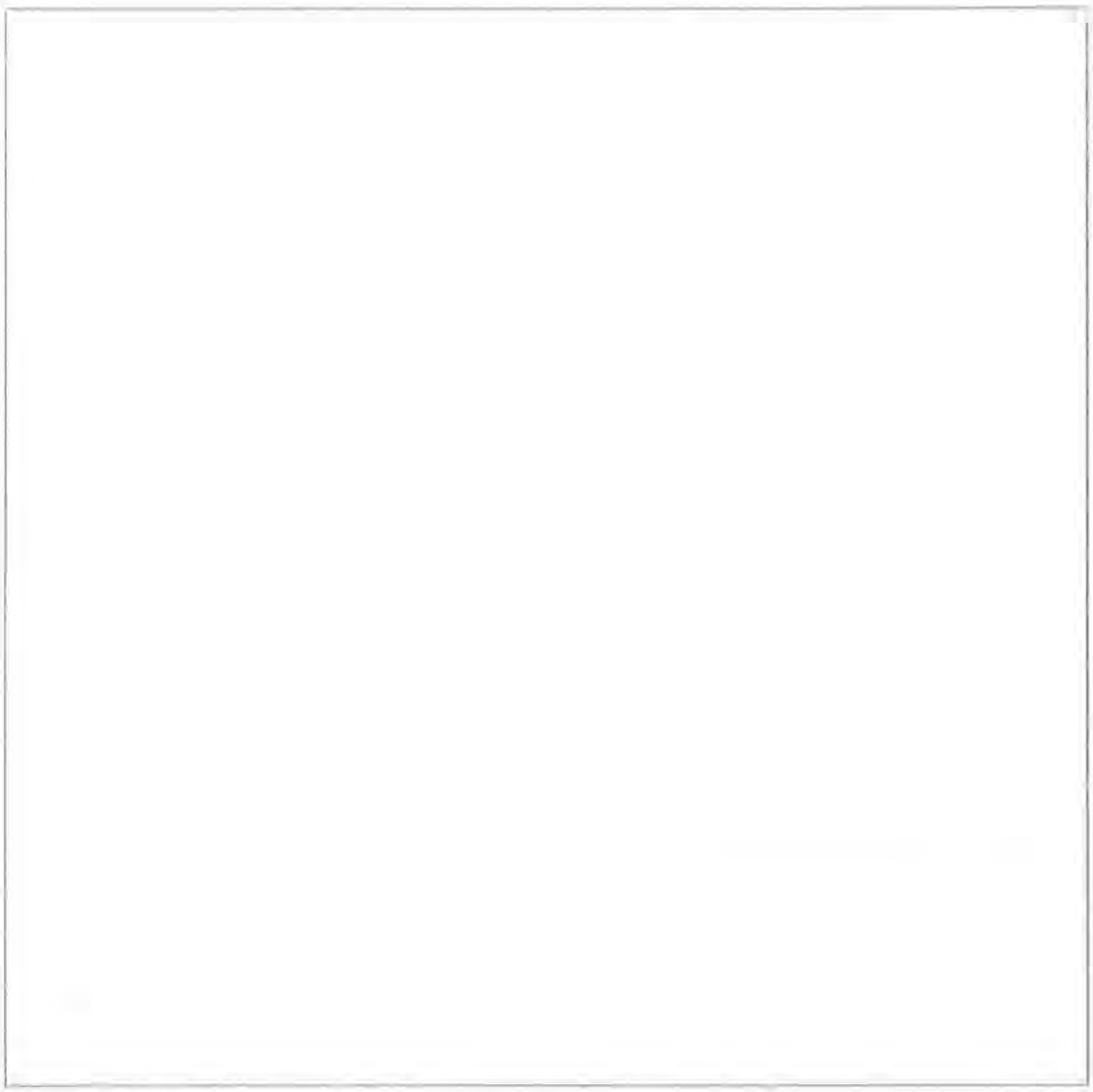
Our WP have also managed to finish all the transcripts today and Kate has sent them on overnight courier, so they should arrive tomorrow.

Kind regards,
Kristi.

Kristi Geddes
Senior Associate
Minter Ellison

Begin forwarded message:

> **From:** Harry McCay <
> **Date:** 15 October 2014 4:40:53 pm AEST
> **To:** Kristi Geddes <
> **Subject: Part 9 Investigatioin into BAC transition process**
>
> Dear Kristi
>
> Dr Brennan wishes to clarify a statement she made on Monday. After some consideration she believes she did not answer as accurately as she could. Although we cannot recall the exact wording of the question, we believe it was about whether services were resistant to changing their practices. Dr Brennan believes she said that she didn't feel they needed to change practices. However on reflection she would like to amend that to say that for there were additional requirements, particularly in terms of etc , which the services found it challenging to incorporate into their usual programs.
>
> Harry McCay
>
> Harry McCay
> Queensland State Manager
>
> **Avant Mutual Group Limited**
> Direct:
> Mobile:
> Email:
> Website: www.avant.org.au
>
> Postal Address: GPO Box 5252, Brisbane Qld 4001



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FREEFAX

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KG-68

From: KOTZE, Beth [
Sent: Tuesday, 21 October 2014 07:23 pm
To: Kristi Geddes
Cc: SKIPPEN, Tania
Subject: Re: Barrett Investigation [ME-ME.FID2743997]

Report on track
Adverse findings unlikely
Any feedback re issue arising from AB interview re records?

Sent from my iPad

On 21 Oct 2014, at 3:29 pm, Kristi Geddes < wrote:

> Hi Beth and Tania,
>
> Just following up on my email below.
>
> Please let me know if adverse findings seem likely, or if there is any other reason that an extension to the due date of 31 October 2014 may be required.
>
> I will be on leave between 5 and 17 November, so any extension request will need to take that into consideration.
>
> I look forward to hearing from you.
>
> Kind regards,
> Kristi.
>
> Kristi Geddes Senior Associate
>
> www.minterellison.com
>
> **From:** Kristi Geddes
> **Sent:** Monday 20 October 2014 08:47 am
> **To:** KOTZE, Beth; SKIPPEN, Tania
> **Subject:** Barrett Investigation [ME-ME.FID2743997]
>
> Dear Beth and Tania,
>
> Just touching base to see how the report came along on Friday and whether it looks like we're on track for the approved timeframes of having the draft report completed by this Friday and final report by next Friday, 31 October 2014. Also, whether it seems likely that any adverse findings will be made against an individual or organisation, that will need to be subject to a process of natural justice.
>
> If there are to be any further extensions required, I've been asked to provide the department with immediate notification. As discussed while we were in Brisbane, they have already indicated their reluctance to do so.
>
> I look forward to hearing from you.
>
> Kind regards,
> Kristi.
>
> Kristi Geddes Senior Associate
>
> www.minterellison.com

Please consider the environment before printing this email

KG-69

From: Kristi Geddes
Sent: Wednesday, 22 October 2014 08:40 am
To: Beth KOTZE; Tania SKIPPEN
Subject: Fwd: Belated response to question
Attachments: COMMUNITY TREATMENT OPTIONS IN TRANSITION PLANNING.docx; ATT00001.htm; SEEKING AN EVIDENCE BASE TO DETERMINE THE REQUIREMENTS FOR RESIDENTIAL CARE.docx; ATT00002.htm

Kristi Geddes
Senior Associate
Minter Ellison

Begin forwarded message:

From: Trevor Sadler <[redacted]>
Date: 22 October 2014 2:30:22 am AEST
To: 'Kristi Geddes' <[redacted]>
Subject: Belated response to question

Dear Ms Geddes,

At the recent interview regarding transition plans for patients who were in Barrett, A/Prof Kotze asked a question along the lines of whether I considered community treatments as part of my transition plan? (Perhaps the way I interpreted it at the time, and now recall in retrospect.)

I replied that I did not, and gave an inadequate answer as to why not. At the time, I can recall thinking of community treatment as seeing staff in a community CYMHS or seeing a private psychiatrist + private psychologist and perhaps some NGO support. She may have had in mind more than that. My mind went somewhat blank – in part because the answer is somewhat complex, and thinking of how to edit it, condense it and communicate it effectively was challenging.

I also went in to the interview with only a partial recall of my thinking with respect to the transition plans. Thinking through this question afterwards helped me gain a clearer recall into my line of thinking at the time.

The attached document both elaborates on my answer to this question, and my approach to early transition planning.

If it is permissible to pass this on, and not too late, could you please forward it to A/Prof Kotze and Ms Skippen? Thank you.

This may be somewhat incidental, but I have also attached a document I submitted to the Expert Clinical Reference Group and forwarded to Stephen Stathis. It describes the challenges of community based treatment for this sub-population of adolescents. This was written in March 2013, so the adolescents would have moved on in the 10 months from then until closure. However, there was a strong possibility some would have required an inpatient service.

Kind regards,

Trevor

Fwd: Belated response to question->ATT00001.htm

COMMUNITY TREATMENT OPTIONS IN TRANSITION PLANNING

I was asked a question along the lines of if I considered community treatments may or not be an appropriate option for an individual adolescent's treatment plan, or whether I could have been working towards that in the five weeks I was there after the announcement. I replied that I had not considered it was appropriate but did not adequately explained why.

However, the question jogged my memory. In the days since, I have greater clarity of recall of my thinking from the time of the announcement until I was stood aside.

I considered that the transition plans for most of the adolescents would necessitate

- access to rehabilitation programs including a specialised school component,
- tangible incorporation of key elements of recovery,
- continuing access to staff whom they had known to those working through issues of difficult parenting and continuation of the recovery elements as well as
- treatment and
- safe accommodation.

My primary tasks above my clinical role at that time were to

- support staff at a time of great uncertainty for themselves professionally to provide the best clinical care in the circumstances,
- have a very active input into the State-wide Adolescent Extended Treatment and Rehabilitaion Implementation Group (SAETRIG) and two of the working groups – the Patient Transition Working Group and the Services Options Working Group so that the transition plans would incorporate as far as possible the above key elements and
- support particularly vulnerable patients in their treatment so that they could survive a probable lower level of care than was provided during the preceding six months.

During the time that I was there transition plans were only considered in broad conceptual terms rather than in detailed planning.

<u>Anticipated Challenges</u>

I regarded the second task as being particularly challenging.

- Dr Bill Kingwell wrote in May to confirm that he was not an expert in child and adolescent psychiatry, yet his recommendations adopted by the Planning Group included the wraparound service and the Y-PARC model. The latter was fundamentally different to Barrett with no patients on an Involuntary Treatment Order and none who self harmed. As Director of Mental Health he had a key role in guiding the process but from my perspective had little understanding of the clinical issues of the Barrett young people.
- The SAETRIG was fundamentally different in composition from the Expert Clinical Reference Group (ECRG) which produced recommendations for alternative services to replace Barrett. Although from a

different Health District I had worked with Judi Krause on a number of committees and had known Stephen Stathis since he was a registrar. Both were the co-chairs of the SAETRIG. Unlike the ECRG, the SAETRIG had only two people with experience in longer term treatment and rehabilitation. (That was reduced to one when I left the SAETRIG.)

- The SAETRIG was not provided with a full copy of the recommendations of the ECRG by mid September, although the name implies its role was to implement the recommendations of the ECRG. There was no guidance as to what transition services may be possible, the exact nature of and the reasoning behind the ECRG recommendations was unclear, and pressure was being placed by high level sources to provide a model which was contrary to the ECRG recommendations.
- The Royal Children's Hospital CYMHS in which both Stephen and Judi worked provided only short term interventions. Neither had a good grasp of extended treatment and rehabilitation. They visited the AMYOS in Melbourne the day before we toured the Y-PARC facilities. They were impressed with this service, but did not appear to appreciate that it targeted a different sub-population of adolescents to those seen at Barrett.

This is not intended as a criticism of individuals. They are my perceptions of challenges in high level transition planning to ensure the transition plans incorporated the key elements listed above.

It was clear that there was no reduction in funding for the new services, and indeed funding would be enhanced. The Barrett budget would be transferred from WMHHS to CHQHHS.

I assumed (perhaps naively) that it would be a reasonable plan to utilise the existing Barrett staff in enabling the transition plans (in conjunction with a relocated school staffed by the Barrett teaching staff) and staff forming the core of new services to be developed. Not only would there be funding for this, retaining the expertise of staff was a recommendation of the full ECRG report. It would provide some continuity of care for the adolescents.

This arrangement could operate with adolescents in home, transitional accommodation or an acute hospital bed, but attending either a day program (there were possibly buildings at Prince Charles Hospital which could be available) or as a school based program with former Barrett clinical staff providing ongoing clinical care and facilitating transitional programs to adolescents in the community. By late August an inpatient unit at Logan Hospital also appeared to be a possibility if a significant number still required hospitalisation, or if new patients were to be admitted into the service.

In retrospect, my focus in those early weeks was trying to establish what I considered to be an adequate broad transitional framework, rather than specific transitional plans for individual adolescents.

I foresaw significant obstacles. I tried to get an Education Queensland representative appointed to the SAETRIG. They were identified in the original Work Plan of the WMHHS Planning Group as a key stakeholder, and had representation on both that Planning Group and the ECRG. It was apparent decisions were being made by Queensland Health with little reference to Education Queensland. A representative would be appointed to the Patient Transition Working Group.

I also anticipated difficulties in people on the various groups understanding what challenges the young people faced. Had I stayed on, I would have encouraged the Patient Transition Working Group to meet with the young people and their parent(s)/carers in separate groups. This involvement was a key policy of the Mental Health Directorate, the WMHHS and any recovery model ("lived experience").

I also intended to liaise regularly with Stephen Stathis and encourage him to also meet with both these groups. I reckoned that if he had a thorough appreciation of the clinical issues, he would be able to advocate for an appropriate service at the higher levels to which he had access. His advocacy would be particularly important, in my opinion to the SAETRIG, where he carried far more weight than I. This was a critical group, with potentially little appreciation of the clinical conditions.

Rationale for Service Elements

The literature lacks research which would provide guidance about the management of those who do not respond to certain treatment interventions. The following rationale is developed from more than two decades of observations about

- what interventions are useful in managing young people with severe and complex mental illness resulting in either profound risk to self, or profound impairment or both,
- the interrelationships between treatment, rehabilitation, developmental tasks, parenting styles, staff characteristics and relationships with staff and
- routes to recovery in this population.

In addition, we were informed by

- feedback from young people who were previous users of the service who spoke at the quadrennial school reviews,
- conversations with colleagues and researchers at national and international conferences (which afforded closer inquiry into aspects of service delivery than reading literature alone) and
- conversations with colleagues in units in the UK and Switzerland.

Rehabilitation Component

These adolescents were very impaired from their mental illness. Over the preceding 5 years, prior to admission,

- 98% had disengaged from school for > 6 months
- 90% had not had face to face contact with peers
- 83% had disengaged from community networks – shops, public transport
- 55% had adequate family supports. 12% had minimal contact with parents.

Notes and observations

Tasks of Adolescent Development

Cope with physical changes
Develop cognitive maturity
Negotiate school
Negotiate peer relationships
Develop emotional maturity
Care for the self
Develop moral maturity
Occupy leisure time
Establish boundaries
Develop competencies to become independent
Develop identity
Individuate
Develop life schemas
Develop a sense of future

- In the virtual absence of literature on adolescent rehabilitation in mental health, a program was developed around a construct of the developmental tasks of adolescence (see box). This allowed all activities – whether generated from the school, the health clinicians or both, to be conceptualised within a common framework. Strengths in development could be identified as well as deficits.
- We observed that the cognitions, behaviours and emotions of a mental illness often had a direct impact on developmental tasks. Conversely, the resultant moratoriums in developmental tasks often negatively reinforced the mental illness. In addition, developmental tasks were often fundamentally affected by biological developmental issues e.g. learning problems, ADHD, receptive-expressive language disorders, temperament, sensory motor problems.
- Rehabilitation activities were both generic and individualised.
- Rehabilitation activities were generated by the school (which ran a broad set of activities beyond offering formal academic tuition), health professionals, (particularly occupational therapists), in groups and individual activities, and more unstructured activities on the ward and with nursing staff. We observed a combination of group and individual rehabilitation interventions were more effective than either on their own.
- Unlike rehabilitation in physical medicine, where rehabilitation follows acute treatment, rehabilitation and treatment at times coincided. For example, a social anxious adolescent without peer contact for two years or more, was both desensitised to social contact simply by being admitted (treatment) while undertaking a rehabilitation activity by learning to re-establish peer contact and enhance social skills.
- In some cases, progress in rehabilitation preceded treatment, for example, the extremely socially anxious, alexithymic adolescent made many gains in developmental tasks attending school, participating with peers (even as an active participant), broadening their leisure interests, developing competencies to become independent (including washing, preparing meals) which altered their perception of themselves and facilitated capacity to talk.
- Progress in treatment often occurred in bursts which were interspersed with progress in rehabilitation and vice versa. The two seldom ran a linear course. At times they may be concurrent and interdependent.
- Although every effort was made to transition gains in rehabilitation to community services as early as possible (e.g. attendance at school, independently attending a community fitness centre or youth group), our observations were that typically adolescents required considerable facility based rehabilitation support and practice before they were ready.
- Treatment and rehabilitation activities were varied, intensive, complementary and coordinated. This intensity constantly reinforced the gains which were being made.

For all of these reasons, I anticipated that some/many of the adolescents by February would require an active rehabilitation component as part of their transition package. A treatment only transition (either with CYMHS or private providers), even with some NGO rehabilitation support in targeted areas would be insufficient because

- it would lack intensity – at most once a twice a week for an hour seeing the treating clinician
- lack integration between treatment and rehabilitation components
- outside the Mater Day Program which had a waiting list, alternative intensive rehabilitation programs were not available in the south east Queensland (where 70# of the adolescent population live)

- NGO's do not provide the intensity, coordination of programs, range of programs or mix of group and targeted individual programs
- the alternative to an integrated rehabilitation program was accessing multiple rehabilitation components in various settings which would prove challenging and often confusing.

Recovery Components

Multiple elements of what is now identified as components of recovery were identified as important elements in the progress of adolescents in the 1990's – before recovery was formally articulated as a process. It may seem at first counterintuitive that spending a long time in a mental health facility actually initiates and promotes recovery. I maintain this was so for this group. Their route to recovery was very different to what I observed in private or outpatient practice, and am now observing in adolescents in an acute inpatient setting.

The *National Mental Health Recovery Framework* was only released in November 2013, but I refer to it as it clearly articulates many of the elements which were essential to the adolescents' progress. As this is getting longer than I wanted it to be, I'll just refer to four elements.

Hope

This is common to all concepts of recovery. Most adolescents entered Barrett with hope of recovery after experiencing severe and incapacitating mental illness for a considerable period. This hope was maintained through the positive attitudes of regular staff (at least most of them); through learning new ways of coping; through participating in activities which enhanced skills and confidence and through engagement in therapies which offered significant amelioration of symptoms.

I considered that transition programs must incorporate elements which assisted, as much as possible, the continuation of hope. Hope became a very fragile commodity after the announcement. Patient [redacted] when considering the announcement of the closure said something like "[redacted]." The loss of hope was reflected in comments made by a patient on https://www.patientopinion.org.au/opinions/59116.

For those adolescents for whom community only services (referring to treatment appointments in the community) were not appropriate, I considered an environment of hope was an essential component. It was unthinkable in my mind to leave them to cope with anxiety, depression for much of the week, and only to be able to offer hope for an hour or two. That hope included access to staff who had assisted them to whatever point they were at, and who could facilitate further progress.

Looking back at the process post-closure, the prime embodiment of hope was the school, which Education Queensland had the foresight to support. Outcomes would be considerably worse, particularly with the suicides of three of their friends.

Connectedness

In my opinion, this was a critical component of the recovery process, but totally underrated in the research literature of inpatient units and treatment of individual disorders. Connectedness was both an individual and a

group dynamic. Connectedness to peers. Connectedness to staff who facilitated recovery, and through that connectedness to the larger community. Connectedness to people and programs at Barrett was the only passage to connectedness to the community.

By transition time, some adolescents would be ready to leave the Barrett connectedness to connect to the community. A tenuous connection to Barrett was often still important, though.

I considered the proposal I outlined previously to provide some vehicle for connectedness for those for whom some connectedness was important.

In retrospect, this has proved to be true for those who could access schooling run by the former Barrett school.

Empowerment

Some may consider the being in Barrett over an extended period the very antithesis of empowerment. I often heard comments that long term hospitalisation encouraged dependency. Undoubtedly it did. At times that was important therapeutically. But a long term environment which focussed on enhancing tasks of adolescent development ultimately resulted in adolescents being empowered sufficiently to want to move away, and stand on their own feet.

For many adolescents it was the beginning of the process of empowerment. Empowerment over the nightmares of past abuse; over emotions that threatened to take one's life, over social isolation. Empowerment that enabled an adolescent to resume school, commence vocational training, have conversations with peers, catch public transport, cook a meal.

Empowerment occurred in a combination of group and individual activities, through both treatment and rehabilitation. Empowerment was supported by hope and by and environment which encouraged progress rather than languish in inactivity.

I considered a continuing active rehabilitation program essential to continue the hope, the environment, the activities which promoted empowerment, perhaps in collaboration with external providers who supported the treatment. (Collaborating with external providers was already a model we utilised over the years.)

Identity

This is not only a challenging and variable process for many adolescents but adolescents who were admitted to Barrett often struggled with impairments to their identity because of the mental illness or assaults on identity from disruptive home environment. Some had core elements of identity on which to build while in others identity formation was very diffuse. Certainly constructing or reconstructing identity was an important task to begin while at Barrett and continued for years afterwards. Our observations were that progression in other developmental tasks and validation from staff as well as personal reflection were key elements in consolidating identity.

Whilst individual community based treatment could offer some validation as well as personal reflection it could not supplement identity formation with practical assistance in progression in developmental tasks nor in in vivo validation.

In summary many recovery elements inherent in the Barrett process could not be replicated by once or twice a week community treatments whether they were office based as in CYMHS or private providers or offered in the community such as by an Assertive Mobile Youth Outreach Service (AMYOS). In my view they needed to be supplemented by access to a day program with integrated schooling.

Unfortunately, I found that the West Moreton Mental Health Service at some level did not appreciate key aspects of recovery. Perhaps the release of the *National Mental Health Recovery Framework* would change this attitude. The lack of appreciation of recovery principles was a significant impediment to developing transition plans. I will outline three examples.

- Loss of hope after the announcement was described in the link below, but not actively enquired about at management level while I was there.
- My understanding of the Gant chart of the Work Plan of the WMHHS Planning Group indicated there would be a 3 week consultation period with key stakeholders prior to a decision being made. Consumers and carers were among the key stakeholders to be consulted. The communication strategy to both groups, the lack of consultation while I was there undermined any sense of empowerment.
- Some measure of risk can facilitate recovery. For years I took risks in the management of patients if it would facilitate an aspect of development which progressed both treatment and rehabilitation. For example, I sometimes authorised (after consultation with staff) an adolescent who was on continuous observations for suicidal behaviour to go on an outing in the car, or go on a high ropes course because I believed the evidence pointed to it being in the best interests of development. There was never an adverse incident from these decisions. They did indeed facilitate progress. However in the three months prior to the closure, and in the time I was there, edicts came defining progression from continuous observations. For example,

Continuing Access to Staff

The role of continued access to staff in promoting ongoing recovery was outlined above. Some degree of continuity of care could also help rehabilitation programs.

There was a more fundamental dynamic for a number of adolescents. These experienced a range of adverse parental environments – ranging from being a "poor fit" within a family with certain characteristics, emotional unavailability, enmeshment with a parent or poor supervision to

Tasks of Parenting

Level of commitment
Adequacy of nurturance
Attachment/bonding styles
Met dependency needs
Met protection needs
Levels of consistency, supervision, monitoring
Correction styles
Communication of schemas, values
Adequate boundaries
Emotional containment
Capacity to facilitate transitions
Capacity to understand

abandonment, physical, sexual or emotional abuse, or domestic violence.

We constructed a list of the Tasks of Parenting (see box) from longitudinal studies of parenting, with cross cultural validity and evident in literature spanning many centuries. (This has not been otherwise validated. It was developed before the concepts of attachment were better articulated. Its utility is that it can be fairly readily operationalised, was readily understood by clinical and teaching staff and was relatively free of jargon.

Our observations suggested that

- many of these qualities were applicable to staff qualities;
- the more qualities a staff member had the better they related to adolescents and comprehended the interactions;
- it provided an adequate explanatory model for many observations of the dynamics of the interactions between adolescents and staff;
- and being in an environment in which many of these characteristics predominated amongst the adults in the environment was a significant factor in working through important issues of their own home environment and in some important developmental tasks such as individuation and identity.

During the interview I supplied a diagrammatic representation of stages of change in adolescents who self harmed who experienced trauma. These tasks of parenting were inserted into the diagram between the pre-connection and connection phases. Our observations suggested that these were important staff qualities in both outpatient and inpatient settings in facilitating this transition between phases.

I considered a model which incorporated continuing contact with at least some key staff whom the adolescents knew well and who understood the issues of the adolescents were working through to be critical to assist adolescents individuating from an adverse environment to achieve independence. We also observed over the years that it was important for adolescents who needed to transition to independent living to have ad hoc continuing access to the unit for support although they would have their primary treatment within the community. The lack of parental support was significant in times of crisis even up until their early 20s.

Embedded is a letter I wrote on 14/10/2014 to Lorraine Dowell, senior OT at The Park advocating for the retention of staff.

Letter to Lorraine.rtf

Again some of these needs have been met by former Barrett teaching staff in the transition arrangements developed by the Department of Education.

Treatments

Typically adolescents received multiple, complimentary psychological therapies. For instance a DBT group was run regularly and elements of this would be incorporated into individual therapy is and in supportive counselling in the ward environment. An adolescent with social anxiety might examine cognitions with the psychologist

while undertaking graded exposure activities with the occupational therapist. Gains would be generalised in family therapy sessions. An adolescent with PTSD, while undergoing trauma focused therapy with the psychologist, would have expert counselling and support from select nursing staff if they were experiencing dissociative phenomena during the evening.

While it is possible to have a range of therapeutic approaches in community settings, in practice it is difficult to achieve the same level of coordination and intensity.

Safe Accommodation

I envisaged that adolescents would access a range of accommodation after discharge. If inpatient beds were available at Logan Hospital, there were some who may still need that level of accommodation. Some were already in transition away from the Centre and some could live in either home or residential accommodation and attend a day program is adequate transport arrangements were included as part of their transition package.

Issues for Individual Adolescents in Developing their Transition Plan

My early focus was on developing adequate transition systems and hopefully facilities into which adolescents could be optimally transitioned. I will briefly outline the transition processes I can remember for the adolescents at the time of the announcement to illustrate how these various components would be used in developing transition plans had I continued. The main intention is to illustrate the range of interventions necessary beyond community based treatments.

Adolescents are identified only by their initials and grouped into male and female. I may have missed one or two.

Males

Fwd: Belated response to question->COMMUNITY TREATMENT OPTIONS IN TRANSITION PLANNING.docx

Females

Fwd: Belated response to question->COMMUNITY TREATMENT OPTIONS IN TRANSITION PLANNING.docx

Fwd: Belated response to question->COMMUNITY TREATMENT OPTIONS IN TRANSITION PLANNING.docx

Fwd: Belated response to question->COMMUNITY TREATMENT OPTIONS IN TRANSITION PLANNING.docx

Fwd: Belated response to question->ATT00002.htm

SEEKING AN EVIDENCE BASE TO DETERMINE THE REQUIREMENTS FOR RESIDENTIAL CARE

(SHOULD INPATIENT CARE BE A COMPONENT OF THE NEW MODEL?)

SUMMARY

The literature on alternatives for adolescent inpatient admission is reviewed. The literature identifies a number of interventions appropriate to either adolescents presenting for acute admission, or young people who have different disorders to those admitted to Barrett or of a predominantly different age group. This literature describes a group of adolescents who do not respond to these interventions, or have a level of severity of presentation where the described intervention would not be appropriate. The literature does not describe alternative interventions for those with severe, persistent disorder.

The literature on length of stay is largely contextual, set against a background of changes in therapeutic approaches, third party influences necessitating change in the length of stay and changes in the disorders treated in inpatient units. Some patient and family variables related to length of stay are described. These are largely contextual to the cohort of adolescents admitted to that unit.

There is considerable evidence from observations over the past 25 years of the level of skills needed in staff to manage adolescents with the severity, persistence and complexity of those admitted to Barrett Adolescent Centre. These include:

- Levels of acuity in some adolescents requiring high levels of continuous and close observations
- Adolescents on an Involuntary Treatment Order requiring admission to an Authorised Mental Health Service
- In rare instances having the capacity to offer seclusion as a necessary intervention
- Observations to the therapeutic process from providing continuity of care vs breaks in continuity by transferring adolescents with high acuity to other units
- Observations from changes in the stability and permanency of staff
- Observations on the contributions of staff of various skill levels
- Observations on the necessary skills registered nurses bring to the unit which are required to manage adolescent of this level of complexity and severity. These skills include knowledge of mental illness, skills in assessing mental state, skills in assessing level of risk, knowledge of and capacity to generalise skills developed in specific therapeutic interventions, capacity to manage emotional dysregulation, capacity to manage behaviours, capacity to monitor and manage impaired medical states, capacity to provide therapeutic interventions as necessary across settings and across time, and capacity to provide care coordination.

It is concluded that substantial evidence exists to recommend that an inpatient service is a necessary component of care to manage adolescents with the severity, complexity and persistence of disorders of those currently admitted to the Barrett Adolescent Centre

THE LITERATURE

Medline and PsycInfo databases were searched for articles related to adolescent inpatient admission. Several papers were identified which consider the characteristics of innovations in inpatient admission and alternatives to admission, at times in randomised controlled trials of the alternative intervention vs inpatient admission. These can be grouped into interventions for general disorders, interventions for specific behaviours and interventions for specific disorders. In addition, several papers were identified that examined issues around length of stay.

Papers were examined for their relevance to the population of adolescents currently seen at Barrett in terms of age, the range of disorders treated, persistence of symptoms, and persistence of impairment. Some reviewers (Gowers & Rowlands, Inpatient services, 2005) noted differences in the range of acuity among the papers they surveyed. Examples of the criteria for admission are contained in the current Model of Service Delivery for the Adolescent Extended Treatment and Rehabilitation Service.

"Severe and complex mental illness in adolescents occurs in a number of disorders. Many adolescents present with a complex array of co-morbidities. AETRC typically treats adolescent that can be characterised as outlined below:

- *Adolescents with persistent depression. This is often in the context of childhood abuse. These individuals frequently have concomitant symptoms of trauma eg. PTSD, dissociation, recurrent self harm and dissociative hallucinoses.*
- *Adolescents diagnosed with a range of disorders associated with prolonged inability to attend school in spite of active community interventions. These disorders include Social Anxiety Disorder, Avoidant Disorder of Childhood, Separation Anxiety Disorder and Oppositional Defiant Disorder. It does not include individuals with truancy secondary to Conduct Disorder.*
- *Adolescents diagnosed with complex post traumatic stress disorder. These individuals can present with severe challenging behaviour including persistent deliberate self harm and suicidal behaviour resistant to treatment within other levels of the service system.*
- *Adolescents with persistent psychosis who have not responded to integrated clinical management (including community-based care) at a level 4/5 service.*
- *Adolescents with a persistent eating disorder such that they are unable to maintain weight for any period in the community. These typically have co-morbid Social Anxiety Disorder. Treatment will have included the input of practitioners with specialist eating disorders experience prior to acceptance at AETRC. Previous hospital admissions for treatment of the eating disorder may have occurred."*

Some papers were excluded from this review because they described interventions for young people with a behaviour disorder or young people who were 6 – 12 years of age.

Interventions for General Disorders

Two European studies (Mattejat, Hirt, Wilken, Schmidt, & Remschmidt, 2001; Schmidt, Lay, Gopel, Naab, & Blanz, 2006) conducted trials of allocation to inpatient treatment vs home treatment for children and adolescents aged 6 -17 years.

The mean age of the Mattejat et al trial was 11 years and 9 months at the time of the intervention, and 15 years and 6 months at follow up. Young people were randomly allocated to home treatment or inpatient interventions. Disorders treated at two centres included (in order of frequency) emotional disorders, conduct disorders, anorexia and other eating disorders, encopresis and enuresis, neuroses and ADHD. Because the early papers describing exclusion criteria (e.g. need for hospitalisation because of safety) were in German, it is difficult to gauge the numbers who may have needed hospitalisation and thus excluded from the randomised process. Because the follow up was an analysis of each group, they did not address the issue of varying trajectories within each group, including the need for subsequent admission.

The mean age of the Schmidt et al trial was 10.9 years in the home treatment group and 11.3 years in the inpatient group. This study excluded young people with cachetic anorexia, who were acutely psychotic or suicidal. Nearly 65% of the young people had a primary diagnosis of an externalising disorder, and 14% were admitted for a developmental disorder. Over 85% of young people in both groups had prior inpatient or outpatient treatments. 17% in the home treatment group and 13% in the inpatient group had subsequent inpatient admissions. Overall 17% in both groups declined in functioning.

A Community Intensive Treatment Team was developed in Firth, Scotland in response to the closure of the adolescent inpatient unit (Simpson, Cowie, Wilkinson, Lock, & Monteith, 2010). The age of young people described and the presenting disorders were more equivalent to the Barrett population. The HoNOSCA scores on admission were significantly elevated, characteristic of those admitted to acute inpatient units. Both the problems with family life and relationship and impairment subscales on the HoNOSCA were less than in Barrett on admission. This seems to be a population who were acutely unwell and who may be treated otherwise in an acute inpatient unit. As yet, impairment was not established. 3 of the 57 deteriorated over the time, and a further 6 required hospitalisation out of area.

The value of this study is its application to young people who may be otherwise admitted to an acute inpatient unit. The mean length of time in treatment was 23 weeks, substantially more than the average time in CYMHS outpatient treatment.

Multi-systemic Therapy (MST) is an intensive community based treatment introduced initially for delinquent youth. This was subsequently extended in a randomised trial comparing MST to hospitalisation to youth presenting to emergency departments with self harm or suicide intent, homicide ideation and psychosis. (Henggeler, et al., 1999). The average age of youth was 13 years, 85% had previous mental health care, 35% had previous hospitalisation. More than half had either Oppositional Defiant Disorder or Conduct Disorder and 25% had contact with the juvenile justice system. At one year follow up (Henggeler, et al., 2003), 49% of those in the MST required hospitalisation in the first four months, and 47% of both groups required out of home care. Periods of hospitalisation were brief (< 14 days). There were initial gains for those in the MST group in a number of measures, but these dissipated after a year. A subsequent paper (Halliday-Boykins, Henggeler, Rowland, & DeLucia, 2004) noted the heterogeneity of outcomes among the youth, with 17% showing marked deterioration. No

papers have been published for this group since 2005, in contrast to continuing research for MST for delinquent and substance abusing youth.

Three crisis interventions were trialled (Evans, Armstrong, Greenbaum, Brown, & Kuppinger, 2003) with young people from 5 – 17 years (mean age 12.9 years) who would otherwise have been hospitalised with a range of disorders and behaviours including disruptive, adjustment, mood, psychotic and anxiety disorders. 82% were maintained in the community. 5 – 10% were hospitalised because they were a danger to themselves.

Interventions for Specific Behaviours

Alternatives to inpatient admission for adolescents with self harm behaviours continue to be evaluated. A rapid response outpatient model for reducing inpatient admission is described (Greenfield, Larson, Hechtman, Rousseau, & Platt, 2002). This is a specific intervention evaluated in a controlled trial against routine evaluation in an emergency department. Rates of inpatient hospitalisation following attempted suicide or presentation with self harm were decreased using this intervention. Follow up was for 6 months. Some young people required readmission during that period.

Interventions for Specific Disorders

Treatment for anorexia was evaluated in a multi-centre trial of specialist community based eating disorder services vs generalist CAMHS vs inpatient treatment (Gowers S. G., et al., 2007; Gowers S. , et al., 2010). First line inpatient treatment showed no advantage over either specialist community treatment or generalist CAMHS treatment. The value of long term admission for those requiring subsequent hospitalisation for either community group was doubtful, although the lead author continues to consult at a longer term inpatient unit.

Literature on Length of Stay

Up until the 1980's, length of stay was often determined by the type of therapy, in particular psychoanalytically informed therapy (Nurcombe, 1989) which continues to be a factor in some European inpatient units (Hoger, et al., 2002). In the USA in particular, pressures from the health insurance industry necessitated dramatically curtailed lengths of stay (Nurcombe, 1989; Larson, Miller, Fleming, & Teich, 2007; Butts & Schwartz, 1991; Gifford & Foster, 2008; Case, Olfson, Marcus, & Siegel, 2007). Units changed practices in number of ways including the types disorders for which young people were admitted (Pottick, Barber, Hansell, & Coyne, 2001) and a shift from treatment to crisis intervention, short term stabilisation and transition to community treatment (Gold, Heller, & Ritorto, 1993). The UK has faced pressures to admit acute admissions in to what were previously longer stay wards, resulting in a mix of lengths of stay (Corrigall & Mitchell, 2002).

One study (Hoger, et al., 2002)noted that diagnosis is not an indicator of length of stay, although there is some evidence (Hanssen-Bauer, et al., 2011; Swadi & Bobier, 2005) that psychosis predicts a longer length of stay in acute inpatient units.

Factors described as being associated with longer lengths of stay include persistent aggression (Dean, et al., 2008), callous-unemotional traits (Stellwagen & Kerig, 2010), having a co-morbid disorder with an eating disorder (Lievers, et al., 2009), variation in the response rates in those with a depressive disorder (Subramaniam, Lewis, Stitzer, & Fishman, 2004) – although the causes of this variation is unclear - and active suicidal preoccupation without active preparation or attempt. (Lesaca, 1992). Because of the individual characteristics of these units, it is difficult to extrapolate many of these factors to an adolescent extended treatment unit.

Conclusions from the Literature

Numerous naturalistic and controlled studies have described alternatives to inpatient care. However, these are characterised by:

- predominantly being alternatives to acute admission for a cohort of adolescents with first or early presentations
- often being interventions for a younger age group to those at Barrett
- often being interventions for disorders which would not be a primary reason for admission to Barrett
- often excluding from the study a cohort who were severe enough to absolutely require admission
- often identifying a cohort who deteriorated from baseline after 4 – 6 months (on average) of the intervention under investigation
- not providing details of further interventions for this latter cohort.
- not adequately describing factors contributing to longer lengths of stay in a unit utilising multimodal interventions for a cohort of adolescents with severe, persistent disorders with severe impairment.
- did not consider residential treatment as an alternative to admission

Since adolescents admitted to Barrett are likely to be either those who were too unwell to participate in the interventions described in the literature, or deteriorated in spite of the intervention, the literature does not provide guidance regarding alternatives to admission.

Moreover, the literature provides little guidance regarding length of stay for adolescents with severe and persistent disorder with impairment.

ALTERNATIVE EVIDENCE TO CONSIDER FOR THE NEED FOR INPATIENT ADMISSION

Various observations from Barrett Adolescent Centre provide a range of evidences for the necessity for an appropriately staffed inpatient service.

1. Continuous Observations

Continuous observations are one measure of acuity. It is a carefully considered measure, because it is an expensive resource, is potentially aggravating to the young person at a time when they are already in considerable distress and is demanding on staff. It is an indication of a level of acuity which is not tolerated in units staffed by residential workers (e.g. ADAWS), and would necessitate transfer to an inpatient unit.

The decision to utilise continuous observations is made most often because of [redacted] whether in the context of profound depression or psychotic illness. This may be associated at times with extreme anxiety and agitation. Uncommonly adolescents who are nutritionally impaired due to a range of eating disorders may be placed on continuous observations for a period after meal times, or to support physical health. The decision is made with consideration to other measures available including locking the ward (it is normally an open unit where adolescents have free access to outside spaces).

Average hours of continuous observations per year for the following five year periods

1998 = 2002	4510 hours per year
2003 – 2007	4580 hours per year
2008 – 2012	5200 hours per year

In addition, to continuous observations, an equal number of hours may be spent in a state of "high acuity" – 5 minute observations, or restricted to an area of the ward where they are readily visible.

Changes in the permanency of staff in the unit during the period of uncertainty of relocation of the unit since 2008 allow conclusions to be drawn about staff who know an adolescent doing continuous observations vs those who may be contracted for a shift or for a series of shifts.

Skilled permanent staff

- continually monitor mental state for improvements (to enable lessening of the conditions of continuous observations) or deterioration. During periods of deteriorated mood, adolescents show considerable ingenuity in obtaining means for [redacted] if a staff member is unaware of their usual behaviours and early warning signs.
- have a thorough understanding of the history and course of the adolescent's illness
- develop judgment when to leave an adolescent, and when to attempt to engage them
- help to implement strategies to assist with distress tolerance or contain emotional dysregulation
- avoid attempts at rescue
- utilise relationships that have previously developed to engender trust and hope during periods of profound hopelessness and despair
- utilise relationships developed during periods of continuous observations to consolidate therapeutic relationships and enhance ongoing interventions once the crisis has eased and in future states of distress

2. Adolescents on an Involuntary Treatment Order (Inpatient Status)

The Model of Service Delivery states that *"The AETRC is gazetted as an authorised mental health service in accordance with Section 495 of the Mental Health Act 2000 [http://www.health.qld.gov.au/mha2000]"*

52% of adolescents admitted to Barrett from January 2008 – December 2012 were either admitted with, or at some point during their treatment placed on an involuntary treatment disorder. Two thirds were because of their

3. Seclusion

Seclusion is an intervention of the last resort. In the five years in which comparative data was collected by the Seclusion and Restraint Benchmarking Project, and later the CYMHS Clinical Collaborative, Barrett had the lowest rates of seclusion of the adolescent inpatient units in Queensland, although the adolescents often presented with sustained high acuity. Seclusion has most often been used for an adolescent who is not only at extreme risk to themselves, but also to staff. It is not used to manage aggressive behaviours per se, because of the availability of open spaces and other measures for de-escalation.

Under the *Mental Health Act 2000*, seclusion can only be used on an involuntary patient in an Authorised Mental Health Service.

4. Observations on Continuity of Care

Over the years, various interventions have been trialled with adolescents including managing high acuity in acute inpatient units e.g. highly suicidal behaviours or the need for nutritional restoration where the medical condition is such that it could be managed in an mental health unit rather than a medical unit.

There are perhaps five instances in the last 25 years where this has aided therapeutic progress. In most instances, it has proved to be a significant disruption to therapeutic alliances important for treatment and rehabilitation. This is particularly significant for those adolescents whose history of loss has contributed significantly to their current psychopathology.

Having skilled staff who can manage high levels of acuity is important.

5. Observations on Stability of Staff

A closed roster for nursing staff has 21 permanent staff on a fortnightly roster to cover the three shifts over seven days a week. Nursing numbers are reduced over the weekend because some adolescents are on leave.

Over the past two years we have had 14 permanent staff, with 3 or 4 graduate nurses on 4 month rotations, and other positions filled by contract and casual staff. Recently we have been able to secure the services of some excellent contract staff. However, for the 12 months from June 2010, we were only able to have staff on 6 week contracts. With holidays, sick leaves etc, and the demand for staff if

several adolescents were on continuous observations, there were some shifts that had only one or two permanent staff. In addition, there were two vacant Clinical Nurse positions, so clinical leadership on a shift was inconsistent.

These variations in staff stability and permanency allow observations about the importance of stable skilled workforce to the unit. Briefly, we observed:

- adolescents and their parents complained about inconsistencies in management. Adolescents complained about the lack of staff with whom they built trust and rapport
- therapeutic interventions (described below) did not occur
- the use of prn medication increased, because staff on a shift may have lacked skills for more appropriate interventions
- rates of seclusion increased a little
- adolescents were placed on continuous observations at a lower threshold, because staff lacked the experience of patients to recognise early warning signs
- graduate nurses did not benefit from their placement because of the lack of mentoring and staff cohesion

6. Observations on Skill Mix for the Inpatient Unit

The majority of staffing for the residential section has been Registered Nurses. The exceptions are

- two long term Enrolled Nurses have made an invaluable contribution
- 3 – 4 graduate nurses undertaking their mental health training have been a regular part of the nursing establishment for the past decade. Observations of the performance of this group of staff who have considerable training provide some evidence for staffing with residential workers.

Graduate nurses report the skills they develop on the unit include:

- learning to observe mental state and behaviours for early warning signs of distress
- learning the skills of therapeutic relationships including boundaries, promoting and monitoring developmental tasks, application of a range of interventions
- developing a range of behavioural interventions for specific behaviours

Some are observed to develop these skills from early in their rotation, but the majority are beginning to grasp the basic concepts by the end of a four month rotation. Those who return to the unit after they have finished their formal training continue to develop over the next twelve months. This is consistent with internships in other areas.

These observations that registered nurses offer the necessary skills for an inpatient unit compared to being staffed with a majority of pre-graduate residential workers is consistent with overseas experience (Greenfield, Larson, Hechtman, Rousseau, & Platt, 2002). In this study, the intervention was conducted utilising experienced mental health nurses or final year medical students, both supervised by a child and

adolescent psychiatrist. Improvements were greater on all measures with experienced mental health nurses.

7. Observations on Skills Utilised by Registered Nurses During 24 Hours of Care

Skills observed to be necessary in staff, and available through registered nurses include:

- Possessing knowledge of the presentations of mental illness. Often adolescents admitted to Barrett have complex presentations which makes diagnosis unclear. For example, some adolescents become elevated in mood and behaviour for a few days. Skilled observations of the range of behaviour and continuing assessment of mental state is necessary to determine whether this is a picture of an emerging bipolar illness or a transient elevation in mood.
- The unit is an open unit, with free access to outside areas. Careful observations of mental state are necessary to enable decisions to be made as to whether a potentially suicidal adolescent may require either closer monitoring, or is at risk of absconding. Conversely, some distressed adolescents will benefit from time out in the open spaces. A high capacity to assess risk is necessary to determine which interventions are the most appropriate.
- Generalisation of skills learnt in groups or individual therapy to the adolescent's day to day living situation. Skills include those that are part of Dialectical Behaviour Therapy, skills from Social Skills group or maintenance of graduated exposure through activities.
- Managing emotional dysregulation. This is a complex set of skills because staff need to be able to recognise the impact of their own emotional responses, know when to allow to ventilate, when to set limits, when to simply sit with an extremely sad adolescent, when to offer hope or simply contain an affect, when to offer specific interventions e.g the sensory room or the opportunity to do art and when to use the opportunity to process the current emotion. This is one of the most important therapeutic processes in adolescents who are very distressed. The relationships built up during these periods are a necessary function of furthering therapeutic interventions from both nursing staff and other professionals.
- Managing behaviours. Again, this requires a complex set of skills of observing antecedents, utilising an appropriate behavioural intervention and monitoring the outcome.
- Monitoring and managing compromised medical states. It is not unusual for adolescents with histories of complex trauma to have significant difficulties for periods of maintaining an adequate oral intake. The impact of this on nutritional status ranges from a barely adequate intake resulting in weight loss, but no changes in physical signs to severe dehydration to severe

malnourishment. Interventions are difficult. At the most basic level, staff must be able to monitor basic physical signs, and note changes indicative of deterioration. Skilled staff with an understanding of the impact of trauma can negotiate (in conjunction with advice from the dietitian) a basic level of intake to maintain homeostasis. At times, intravenous hydration or parenteral nutrition may be required. Although this may be initiated in a medical setting, it may need to be continued at Barrett if it continues for any length of time. The success of this intervention is dependent on a skill level to be able to manage intravenous or parenteral nutrition administered by staff with whom the adolescent has already developed a sound therapeutic relationship.

- Providing therapeutic interventions. For example, an adolescent with a severe Social Anxiety Disorder may be phobic eating with other adolescents. Skilled staff will be able to negotiate a process for eating meals with progressive gradual exposure to being able to tolerate eating with others. They must be able to recognise whether a reluctance to proceed to increased contact with others at meal times is simply entrenched avoidant behaviour, or whether the anxiety is still too high. Another example is managing symptoms of Post Traumatic Stress Disorder in adolescents with histories of severe and complex trauma. Frequently dissociation and flashbacks occur in the evening, and interrupt sleep if the adolescent is woken by nightmares. This requires a complex set of skills in staff from grounding, emotional containment, allowing appropriate exploration of the trauma if the adolescent needs to do that at that time and encouraging the adolescent to employ strategies and skills they have been developing.
- Provide Care Coordination. Relationships are built with adolescents and their families across shifts and in a variety of situations not available to other professions. This, together with the skills of nursing staff enables them to function in the complex role of Care Coordinator.

8. Observations on Referrals from the Mater Acute Inpatient Unit/Day Program

There have been occasions where adolescents have had extended inpatient care in the Mater CYMHS Acute Inpatient Unit and attended the Day Program. Although this has continued for a time, they have been referred to Barrett for further treatment and rehabilitation due to the unsuitability of being in an Acute Inpatient Service. Although this is an unusual pathway for referral, it does illustrate the limitations of acute inpatient care for this population.

In summary, multiple lines of evidence – high acuity, the need for an appropriate level of care as an Authorised Mental Health Service, the need for continuity of care and the requirements for the skills of registered nurses – together with lack of alternative models described in the literature for this population, suggests that inpatient care must be a component of the new service.

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Fwd: Belated response to question->SEEKING AN EVIDENCE BASE TO DETERMINE THE REQUIREMENTS FOR RESIDENTIAL CARE.docx

From: Kristi Geddes
Sent: Wednesday, 22 October 2014 11:26 am
To: Beth KOTZE; Tania SKIPPEN
Subject: Fwd: Amendment to this morning's email
Attachments: COMMUNITY TREATMENT OPTIONS IN TRANSITION PLANNING amended.docx; ATT00001.htm; Letter to Lorraine.rtf; ATT00002.htm

Further email from Dr Sadler.

Kind regards,
Kristi.

Kristi Geddes
Senior Associate
Minter Ellison

Begin forwarded message:

> **From:** Trevor Sadler <[redacted]>
> **Date:** 22 October 2014 9:39:50 am AEST
> **To:** 'Kristi Geddes' <[redacted]>
> **Subject: Amendment to this morning's email**
>
> Dear Ms Geddes,
>
> In the email I forwarded earlier this morning, I attached two files. I wish to amend a date in the file "COMMUNITY TREATMENT OPTIONS IN TRANSITION PLANNING". Half way down page 8 I embedded a file. The text above it said that this was a letter I wrote to Lorraine Dowell on 14/10/2014. It should have been 14/10/2013. (Actually, I wrote these letters in WordPerfect on 3/10, and converted this to file to rich text on 14/10.) I have attached an amended file and the embedded file separately.
>
> Obviously this letter was written during the time frame being examined by your investigation. Among other things, it expresses my concerns about potential outcomes for adolescents.
>
> Yours sincerely,
>
> Trevor

Fwd: Amendment to this morning's email->ATT00001.htm

COMMUNITY TREATMENT OPTIONS IN TRANSITION PLANNING

I was asked a question along the lines of if I considered community treatments may or not be an appropriate option for an individual adolescent's treatment plan, or whether I could have been working towards that in the five weeks I was there after the announcement. I replied that I had not considered it was appropriate but did not adequately explained why.

However, the question jogged my memory. In the days since, I have greater clarity of recall of my thinking from the time of the announcement until I was stood aside.

I considered that the transition plans for most of the adolescents would necessitate

- access to rehabilitation programs including a specialised school component,
- tangible incorporation of key elements of recovery,
- continuing access to staff whom they had known to those working through issues of difficult parenting and continuation of the recovery elements as well as
- treatment and
- safe accommodation.

My primary tasks above my clinical role at that time were to

- support staff at a time of great uncertainty for themselves professionally to provide the best clinical care in the circumstances,
- have a very active input into the State-wide Adolescent Extended Treatment and Rehabilitaion Implementation Group (SAETRIG) and two of the working groups – the Patient Transition Working Group and the Services Options Working Group so that the transition plans would incorporate as far as possible the above key elements and
- support particularly vulnerable patients in their treatment so that they could survive a probable lower level of care than was provided during the preceding six months.

During the time that I was there transition plans were only considered in broad conceptual terms rather than in detailed planning.

Anticipated Challenges

I regarded the second task as being particularly challenging.

- Dr Bill Kingwell wrote in May to confirm that he was not an expert in child and adolescent psychiatry, yet his recommendations adopted by the Planning Group included the wraparound service and the Y-PARC model. The latter was fundamentally different to Barrett with no patients on an Involuntary Treatment Order and none who self harmed. As Director of Mental Health he had a key role in guiding the process but from my perspective had little understanding of the clinical issues of the Barrett young people.
- The SAETRIG was fundamentally different in composition from the Expert Clinical Reference Group (ECRG) which produced recommendations for alternative services to replace Barrett. Although from a

different Health District I had worked with Judi Krause on a number of committees and had known Stephen Stathis since he was a registrar. Both were the co-chairs of the SAETRIG. Unlike the ECRG, the SAETRIG had only two people with experience in longer term treatment and rehabilitation. (That was reduced to one when I left the SAETRIG.)

- The SAETRIG was not provided with a full copy of the recommendations of the ECRG by mid September, although the name implies its role was to implement the recommendations of the ECRG. There was no guidance as to what transition services may be possible, the exact nature of and the reasoning behind the ECRG recommendations was unclear, and pressure was being placed by high level sources to provide a model which was contrary to the ECRG recommendations.
- The Royal Children's Hospital CYMHS in which both Stephen and Judi worked provided only short term interventions. Neither had a good grasp of extended treatment and rehabilitation. They visited the AMYOS in Melbourne the day before we toured the Y-PARC facilities. They were impressed with this service, but did not appear to appreciate that it targeted a different sub-population of adolescents to those seen at Barrett.

This is not intended as a criticism of individuals. They are my perceptions of challenges in high level transition planning to ensure the transition plans incorporated the key elements listed above.

It was clear that there was no reduction in funding for the new services, and indeed funding would be enhanced. The Barrett budget would be transferred from WMHHS to CHQHHS.

I assumed (perhaps naively) that it would be a reasonable plan to utilise the existing Barrett staff in enabling the transition plans (in conjunction with a relocated school staffed by the Barrett teaching staff) and staff forming the core of new services to be developed. Not only would there be funding for this, retaining the expertise of staff was a recommendation of the full ECRG report. It would provide some continuity of care for the adolescents.

This arrangement could operate with adolescents in home, transitional accommodation or an acute hospital bed, but attending either a day program (there were possibly buildings at Prince Charles Hospital which could be available) or as a school based program with former Barrett clinical staff providing ongoing clinical care and facilitating transitional programs to adolescents in the community. By late August an inpatient unit at Logan Hospital also appeared to be a possibility if a significant number still required hospitalisation, or if new patients were to be admitted into the service.

In retrospect, my focus in those early weeks was trying to establish what I considered to be an adequate broad transitional framework, rather than specific transitional plans for individual adolescents.

I foresaw significant obstacles. I tried to get an Education Queensland representative appointed to the SAETRIG. They were identified in the original Work Plan of the WMHHS Planning Group as a key stakeholder, and had representation on both that Planning Group and the ECRG. It was apparent decisions were being made by Queensland Health with little reference to Education Queensland. A representative would be appointed to the Patient Transition Working Group.

I also anticipated difficulties in people on the various groups understanding what challenges the young people faced. Had I stayed on, I would have encouraged the Patient Transition Working Group to meet with the young people and their parent(s)/carers in separate groups. This involvement was a key policy of the Mental Health Directorate, the WMHHS and any recovery model ("lived experience").

I also intended to liaise regularly with Stephen Stathis and encourage him to also meet with both these groups. I reckoned that if he had a thorough appreciation of the clinical issues, he would be able to advocate for an appropriate service at the higher levels to which he had access. His advocacy would be particularly important, in my opinion to the SAETRIG, where he carried far more weight than I. This was a critical group, with potentially little appreciation of the clinical conditions.

Rationale for Service Elements

The literature lacks research which would provide guidance about the management of those who do not respond to certain treatment interventions. The following rationale is developed from more than two decades of observations about

- what interventions are useful in managing young people with severe and complex mental illness resulting in either profound risk to self, or profound impairment or both,
- the interrelationships between treatment, rehabilitation, developmental tasks, parenting styles, staff characteristics and relationships with staff and
- routes to recovery in this population.

In addition, we were informed by

- feedback from young people who were previous users of the service who spoke at the quadrennial school reviews,
- conversations with colleagues and researchers at national and international conferences (which afforded closer inquiry into aspects of service delivery than reading literature alone) and
- conversations with colleagues in units in the UK and Switzerland.

Rehabilitation Component

These adolescents were very impaired from their mental illness. Over the preceding 5 years, prior to admission,

- 98% had disengaged from school for > 6 months
- 90% had not had face to face contact with peers
- 83% had disengaged from community networks – shops, public transport
- 55% had adequate family supports. 12% had minimal contact with parents.

Notes and observations

Tasks of Adolescent Development

Cope with physical changes
Develop cognitive maturity
Negotiate school
Negotiate peer relationships
Develop emotional maturity
Care for the self
Develop moral maturity
Occupy leisure time
Establish boundaries
Develop competencies to become independent
Develop identity
Individuate
Develop life schemas
Develop a sense of future

- In the virtual absence of literature on adolescent rehabilitation in mental health, a program was developed around a construct of the developmental tasks of adolescence (see box). This allowed all activities – whether generated from the school, the health clinicians or both, to be conceptualised within a common framework. Strengths in development could be identified as well as deficits.
- We observed that the cognitions, behaviours and emotions of a mental illness often had a direct impact on developmental tasks. Conversely, the resultant moratoriums in developmental tasks often negatively reinforced the mental illness. In addition, developmental tasks were often fundamentally affected by biological developmental issues e.g. learning problems, ADHD, receptive-expressive language disorders, temperament, sensory motor problems.
- Rehabilitation activities were both generic and individualised.
- Rehabilitation activities were generated by the school (which ran a broad set of activities beyond offering formal academic tuition), health professionals, (particularly occupational therapists), in groups and individual activities, and more unstructured activities on the ward and with nursing staff. We observed a combination of group and individual rehabilitation interventions were more effective than either on their own.
- Unlike rehabilitation in physical medicine, where rehabilitation follows acute treatment, rehabilitation and treatment at times coincided. For example, a social anxious adolescent without peer contact for two years or more, was both desensitised to social contact simply by being admitted (treatment) while undertaking a rehabilitation activity by learning to re-establish peer contact and enhance social skills.
- In some cases, progress in rehabilitation preceded treatment, for example, the extremely socially anxious, alexithymic adolescent made many gains in developmental tasks attending school, participating with peers (even as an active participant), broadening their leisure interests, developing competencies to become independent (including washing, preparing meals) which altered their perception of themselves and facilitated capacity to talk.
- Progress in treatment often occurred in bursts which were interspersed with progress in rehabilitation and vice versa. The two seldom ran a linear course. At times they may be concurrent and interdependent.
- Although every effort was made to transition gains in rehabilitation to community services as early as possible (e.g. attendance at school, independently attending a community fitness centre or youth group), our observations were that typically adolescents required considerable facility based rehabilitation support and practice before they were ready.
- Treatment and rehabilitation activities were varied, intensive, complementary and coordinated. This intensity constantly reinforced the gains which were being made.

For all of these reasons, I anticipated that some/many of the adolescents by February would require an active rehabilitation component as part of their transition package. A treatment only transition (either with CYMHS or private providers), even with some NGO rehabilitation support in targeted areas would be insufficient because

- it would lack intensity – at most once a twice a week for an hour seeing the treating clinician
- lack integration between treatment and rehabilitation components
- outside the Mater Day Program which had a waiting list, alternative intensive rehabilitation programs were not available in the south east Queensland (where 70# of the adolescent population live)

- NGO's do not provide the intensity, coordination of programs, range of programs or mix of group and targeted individual programs
- the alternative to an integrated rehabilitation program was accessing multiple rehabilitation components in various settings which would prove challenging and often confusing.

Recovery Components

Multiple elements of what is now identified as components of recovery were identified as important elements in the progress of adolescents in the 1990's – before recovery was formally articulated as a process. It may seem at first counterintuitive that spending a long time in a mental health facility actually initiates and promotes recovery. I maintain this was so for this group. Their route to recovery was very different to what I observed in private or outpatient practice, and am now observing in adolescents in an acute inpatient setting.

The *National Mental Health Recovery Framework* was only released in November 2013, but I refer to it as it clearly articulates many of the elements which were essential to the adolescents' progress. As this is getting longer than I wanted it to be, I'll just refer to four elements.

Hope

This is common to all concepts of recovery. Most adolescents entered Barrett with hope of recovery after experiencing severe and incapacitating mental illness for a considerable period. This hope was maintained through the positive attitudes of regular staff (at least most of them); through learning new ways of coping; through participating in activities which enhanced skills and confidence and through engagement in therapies which offered significant amelioration of symptoms.

I considered that transition programs must incorporate elements which assisted, as much as possible, the continuation of hope. Hope became a very fragile commodity after the announcement. Patient [redacted] when considering the announcement of the closure said something like '[redacted]' The loss of hope was reflected in comments made by a patient on https://www.patientopinion.org.au/opinions/59116.

For those adolescents for whom community only services (referring to treatment appointments in the community) were not appropriate, I considered an environment of hope was an essential component. It was unthinkable in my mind to leave them to cope with anxiety, depression for much of the week, and only to be able to offer hope for an hour or two. That hope included access to staff who had assisted them to whatever point they were at, and who could facilitate further progress.

Looking back at the process post-closure, the prime embodiment of hope was the school, which Education Queensland had the foresight to support. Outcomes would be considerably worse, particularly with the suicides of three of their friends.

Connectedness

In my opinion, this was a critical component of the recovery process, but totally underrated in the research literature of inpatient units and treatment of individual disorders. Connectedness was both an individual and a

group dynamic. Connectedness to peers. Connectedness to staff who facilitated recovery, and through that connectedness to the larger community. Connectedness to people and programs at Barrett was the only passage to connectedness to the community.

By transition time, some adolescents would be ready to leave the Barrett connectedness to connect to the community. A tenuous connection to Barrett was often still important, though.

I considered the proposal I outlined previously to provide some vehicle for connectedness for those for whom some connectedness was important.

In retrospect, this has proved to be true for those who could access schooling run by the former Barrett school.

Empowerment

Some may consider the being in Barrett over an extended period the very antithesis of empowerment. I often heard comments that long term hospitalisation encouraged dependency. Undoubtedly it did. At times that was important therapeutically. But a long term environment which focussed on enhancing tasks of adolescent development ultimately resulted in adolescents being empowered sufficiently to want to move away, and stand on their own feet.

For many adolescents it was the beginning of the process of empowerment. Empowerment over the nightmares of past abuse; over emotions that threatened to take one's life, over social isolation. Empowerment that enabled an adolescent to resume school, commence vocational training, have conversations with peers, catch public transport, cook a meal.

Empowerment occurred in a combination of group and individual activities, through both treatment and rehabilitation. Empowerment was supported by hope and by and environment which encouraged progress rather than languish in inactivity.

I considered a continuing active rehabilitation program essential to continue the hope, the environment, the activities which promoted empowerment, perhaps in collaboration with external providers who supported the treatment. (Collaborating with external providers was already a model we utilised over the years.)

Identity

This is not only a challenging and variable process for many adolescents but adolescents who were admitted to Barrett often struggled with impairments to their identity because of the mental illness or assaults on identity from disruptive home environment. Some had core elements of identity on which to build while in others identity formation was very diffuse. Certainly constructing or reconstructing identity was an important task to begin while at Barrett and continued for years afterwards. Our observations were that progression in other developmental tasks and validation from staff as well as personal reflection were key elements in consolidating identity.

Whilst individual community based treatment could offer some validation as well as personal reflection it could not supplement identity formation with practical assistance in progression in developmental tasks nor in in vivo validation.

In summary many recovery elements inherent in the Barrett process could not be replicated by once or twice a week community treatments whether they were office based as in CYMHS or private providers or offered in the community such as by an Assertive Mobile Youth Outreach Service (AMYOS). In my view they needed to be supplemented by access to a day program with integrated schooling.

Unfortunately, I found that the West Moreton Mental Health Service at some level did not appreciate key aspects of recovery. Perhaps the release of the *National Mental Health Recovery Framework* would change this attitude. The lack of appreciation of recovery principles was a significant impediment to developing transition plans. I will outline three examples.

- Loss of hope after the announcement was described in the link below, but not actively enquired about at management level while I was there.
- My understanding of the Gant chart of the Work Plan of the WMHHS Planning Group indicated there would be a 3 week consultation period with key stakeholders prior to a decision being made. Consumers and carers were among the key stakeholders to be consulted. The communication strategy to both groups, the lack of consultation while I was there undermined any sense of empowerment.
- Some measure of risk can facilitate recovery. For years I took risks in the management of patients if it would facilitate an aspect of development which progressed both treatment and rehabilitation. For example, I sometimes authorised (after consultation with staff) an adolescent who was on continuous observations for suicidal behaviour to go on an outing in the car, or go on a high ropes course because I believed the evidence pointed to it being in the best interests of development. There was never an adverse incident from these decisions. They did indeed facilitate progress. However in the three months prior to the closure, and in the time I was there, edicts came defining progression from continuous observations. For example,

Continuing Access to Staff

The role of continued access to staff in promoting ongoing recovery was outlined above. Some degree of continuity of care could also help rehabilitation programs.

There was a more fundamental dynamic for a number of adolescents. These experienced a range of adverse parental environments – ranging from being a "poor fit" within a family with certain characteristics, emotional unavailability, enmeshment with a parent or poor supervision to

Tasks of Parenting

Level of commitment
Adequacy of nurturance
Attachment/bonding styles
Met dependency needs
Met protection needs
Levels of consistency, supervision, monitoring
Correction styles
Communication of schemas, values
Adequate boundaries
Emotional containment
Capacity to facilitate transitions
Capacity to understand

abandonment, physical, sexual or emotional abuse, or domestic violence.

We constructed a list of the Tasks of Parenting (see box) from longitudinal studies of parenting, with cross cultural validity and evident in literature spanning many centuries. (This has not been otherwise validated. It was developed before the concepts of attachment were better articulated. Its utility is that it can be fairly readily operationalised, was readily understood by clinical and teaching staff and was relatively free of jargon.

Our observations suggested that

- many of these qualities were applicable to staff qualities;
- the more qualities a staff member had the better they related to adolescents and comprehended the interactions;
- it provided an adequate explanatory model for many observations of the dynamics of the interactions between adolescents and staff;
- and being in an environment in which many of these characteristics predominated amongst the adults in the environment was a significant factor in working through important issues of their own home environment and in some important developmental tasks such as individuation and identity.

During the interview I supplied a diagrammatic representation of stages of change in adolescents who self harmed who experienced trauma. These tasks of parenting were inserted into the diagram between the pre-connection and connection phases. Our observations suggested that these were important staff qualities in both outpatient and inpatient settings in facilitating this transition between phases.

I considered a model which incorporated continuing contact with at least some key staff whom the adolescents knew well and who understood the issues of the adolescents were working through to be critical to assist adolescents individuating from an adverse environment to achieve independence. We also observed over the years that it was important for adolescents who needed to transition to independent living to have ad hoc continuing access to the unit for support although they would have their primary treatment within the community. The lack of parental support was significant in times of crisis even up until their early 20s.

Embedded is a letter I wrote on 14/10/2013 to Lorraine Dowell, senior OT at The Park advocating for the retention of staff.

Letter to Lorraine.rtf

Again some of these needs have been met by former Barrett teaching staff in the transition arrangements developed by the Department of Education.

Treatments

Typically adolescents received multiple, complimentary psychological therapies. For instance a DBT group was run regularly and elements of this would be incorporated into individual therapy is and in supportive counselling in the ward environment. An adolescent with social anxiety might examine cognitions with the psychologist

while undertaking graded exposure activities with the occupational therapist. Gains would be generalised in family therapy sessions. An adolescent with PTSD, while undergoing trauma focused therapy with the psychologist, would have expert counselling and support from select nursing staff if they were experiencing dissociative phenomena during the evening.

While it is possible to have a range of therapeutic approaches in community settings, in practice it is difficult to achieve the same level of coordination and intensity.

Safe Accommodation

I envisaged that adolescents would access a range of accommodation after discharge. If inpatient beds were available at Logan Hospital, there were some who may still need that level of accommodation. Some were already in transition away from the Centre and some could live in either home or residential accommodation and attend a day program is adequate transport arrangements were included as part of their transition package.

Issues for Individual Adolescents in Developing their Transition Plan

My early focus was on developing adequate transition systems and hopefully facilities into which adolescents could be optimally transitioned. I will briefly outline the transition processes I can remember for the adolescents at the time of the announcement to illustrate how these various components would be used in developing transition plans had I continued. The main intention is to illustrate the range of interventions necessary beyond community based treatments.

Adolescents are identified only by their initials and grouped into male and female. I may have missed one or two.

Males

Fwd: Amendment to this morning's email->COMMUNITY TREATMENT OPTIONS IN TRANSITION PLANNING amended.docx

Females

Fwd: Amendment to this morning's email->COMMUNITY TREATMENT OPTIONS IN TRANSITION PLANNING amended.docx

Fwd: Amendment to this morning's email->COMMUNITY TREATMENT OPTIONS IN TRANSITION PLANNING amended.docx

Fwd: Amendment to this morning's email->COMMUNITY TREATMENT OPTIONS IN TRANSITION PLANNING amended.docx

Fwd: Amendment to this morning's email->ATT00002.htm

[redacted]

3rd October, 2013

Dear Lorraine,

I write because I heard that you were to be asked to be a member of the Working Group on Workforce and Finance. My being stood aside means that I cannot be involve d in patient care, but I do believe I can advocate for staff.

The ECRG, in its full report stated "Of concern to the ECRG is also the dissipation and loss of specialist staff skills and expertise in the area of adolescent extended care in Queensland if BAC closes and a Tier 3 is not established in a timely manner. This includes both clinical staff and education staff." This does not come across as strongly in the recommendations. Professor Philip Hazell, the interstate expert on the ECRG was adamant on this point. All other members agreed.

I have had the opportunity to do locums with other services, including Mater and Logan acute inpatient units. I interact with many community colleagues. I am absolutely convinced that there is a skill set among many permanent (and some temporary) Barrett clinicians which is not routinely found elsewhere. They incorporate a strong rehabilitation focus as well as strong expertise in managing trauma, self harm, disordered eating behaviours, and extreme social anxiety - often in the context of Aspergers and other developmental disorders.

From the rate of referrals from various Districts (compared to the number of young people they see annually), the average community CYMHS clinician or private child psychiatrist would only see a young person of Barrett level severity every 3 - 5 years. Clinicians in acute inpatient units may see them yearly. Since over half of CYMHS clinicians are there less than 5 years, many will not have seen even one. Yet this level of severity is our bread and butter. I know from doing workshops with the Townsville and Toowoomba day programs, that the level of severity which they see is not comparable to even our day program young person. The level of expertise at Barrett is generally what one would expect in a Clinical Services Framework Level 6 service.

Outside the ECRG, this expertise is really quite devalued. There was no recognition of this in the last Transition Steering Committee meeting I attended on 9/9/2013.

This email is to list a number of precedents which could be referred to.

1. The current approach in the Queensland Children's Hospital is to recognise expertise in the Royal Children's and Mater Children's staff. I forget if they refer to the various levels as Tiers or Divisions. The second Tier - Directors of various Departments was an open merit selection process. The third Tier (equivalent to Team Leader, NUM or CNC) is a closed contestable process. The fourth Tier - ordinary clinicians like myself - is people slotting into equivalent positions, if there is no duplication of position, in which

case there would be a closed merit selection process. Since Barrett is an add on service, which comes with its own funding, the same process could and should apply.

2. I would be interested to know what the process was when the Children's Cardiology service was transferred from Prince Charles to the Mater Children's. I cannot imagine that one would scrap expertise built up in children's cardiology, and the Mater (which is a private entity) bring in its own staff. That would devalue the whole service, and risk problems. Why should mental health be any different?
3. There was a smaller process when the gastroenterology department transferred from the Mater Children's to the Royal Children's. Apart from specialists, I don't know who else went across.
4. Finally I would be interested to know about the staffing of the Children's Emergency at Prince Charles. I am not sure if this comes under Metro North or Children's Health Queensland. If it is Metro North, were staff transferred from RCH (which would be the sensible first option), or did they employ totally new staff?

I am not writing out of self interest. Even if I was to be cleared of the allegations against me, the damage to my reputation is such that I doubt anyone in CHQ would be interested in having me. I am really concerned for two things.

1. Trying to maintain the best service for adolescents in whatever form that service takes. The time frames are incredibly short, and totally unrealistic. Adolescents were beginning to panic before I left because the future is so uncertain. Whatever service replaces Barrett, it will not be a CSCF Level 6 service. At best it will be between Levels 4 and 5. Some will be permanently impaired by their mental illness. The best hope of ameliorating the detrimental effects of this process is by maintaining the expertise of staff.
2. To maintain the expertise of staff. Through mentoring, selection of staff which show promise, and developing a strong team culture and ethos, as well as understanding of the processes of treatment and rehabilitation, I believe the team as a whole is unique. It is a total waste of experience to see that dissipated. Sure, it would be useful in community teams or acute inpatient units. Acute inpatient units have a very different focus, and will not utilise the skills at all. Community CYMHS functions as a team clinicians from individual disciplines, not as a multi-disciplinary team. Both of these settings will minimise the transfer of skills of our staff. Moreover, these skills will be totally underutilised because of the infreqeuncy of presentation of severe and longer term cases. They will therefore diminish with time. In addition, the significant feature of Barrett is that the contributions of every individual are integrated into the whole skill set of the team. This will not happen if they are dispersed.

I strongly implore you then to advocate for the retention of our staff into the new service(s), in the same way that the skills of staff from RCH and the Mater is recognised and will be incorporated into the new Queensland Children's Hospital.

I am also writing to Paul Clare and Padraig McGrath who I understand were to be invited on to the Working Group.

Kind regards,

Trevor Sadler

KG-70

From: Kristi Geddes [
Sent: Thursday, 23 October 2014 10:11 am
To: KOTZE, Beth
Cc: SKIPPEN, Tania
Subject: RE: Barrett Investigation [ME-ME.FID2743997]

Dear Beth and Tania,

Before sending off the letter to West Moreton HHS this morning, I note that their covering correspondence of 24 August 2014 specifically notes that *'to assist in providing the investigators with a snapshot of the transitional documents and actions that were taken by West Moreton and relevant stakeholders, we have updated a number of the transition guides for selected consumers, namely,* *and* I note these are the selected consumers under specific review in the investigation.

Given this explanation from the outset, I do not think it necessary to seek any further confirmation about when specific documents were prepared. However, if you have any questions about the process that remain unanswered or require further explanation, please let me know.

Kind regards,
Kristi.

Kristi Geddes Senior Associate
t
Minter Ellison Lawyers
www.minterellison.com

From: Kristi Geddes
Sent: Wednesday 22 October 2014 07:40 am
To: KOTZE, Beth
Cc: SKIPPEN, Tania
Subject: Re: Barrett Investigation [ME-ME.FID2743997]

Thanks.

No, not yet. I was waiting to see if there was anything else we needed to confirm with them, but as there doesn't seem to be anything, I'll send a request off today.

I've also received an email from Dr Sadler with further information to add to his interview responses, so I will forward that on.

Kind regards,
Kristi.

Kristi Geddes
Senior Associate
Minter Ellison

On 21 Oct 2014, at 6:23 pm, "KOTZE, Beth" < > wrote:

> Report on track
> Adverse findings unlikely
> Any feedback re issue arising from AB interview re records?
>
> Sent from my iPad
>
> On 21 Oct 2014, at 3:29 pm, Kristi Geddes < > wrote:
>
> > Hi Beth and Tania,
> >
> > Just following up on my email below.
> >
> > Please let me know if adverse findings seem likely, or if there is any other reason that an extension to the due date of 31 October 2014 may be required.
> >
> > I will be on leave between 5 and 17 November, so any extension request will need to take that into consideration.
> >
> > I look forward to hearing from you.
> >
> > Kind regards,
> > Kristi.
> >
> > **Kristi Geddes** Senior Associate
> > t f + m +
> > Minter Ellison Lawyers
> > www.minterellison.com
> >
> > **From:** Kristi Geddes
> > **Sent:** Monday 20 October 2014 08:47 am
> > **To:** KOTZE, Beth; SKIPPEN, Tania

Subject: Barrett Investigation [ME-ME.FID2743997]

Dear Beth and Tania,

Just touching base to see how the report came along on Friday and whether it looks like we're on track for the approved timeframes of having the draft report completed by this Friday and final report by next Friday, 31 October 2014. Also, whether it seems likely that any adverse findings will be made against an individual or organisation, that will need to be subject to a process of natural justice.

If there are to be any further extensions required, I've been asked to provide the department with immediate notification. As discussed while we were in Brisbane, they have already indicated their reluctance to do so.

I look forward to hearing from you.

Kind regards,
Kristi.

Kristi Geddes Senior Associate
Minter Ellison Lawyers
www.minterellison.com

EXHIBIT 53

KGE.001.001.1001

MinterEllison LAWYERS

KG-71

CLIENT

MATTER Barrett

FILE NO

AUTHOR Kxnum

DATE 23/10/14.

TIME (start) am/pm

TIME (end) am/pm

PAGE OF

Circle activity

TO (TI) CW AT

With whom Jacqui Keller [illegible] HHS.

Report due next week.

Will they get draft to respond?

Only ? potential adverse findings - no suggestion of any @ this stage.

If any - we will provide draft report to respond. Realistic this will blow out due date.

Will let he know imed if any.

Reminders Who agreed to do what? By when? Without prejudice stipulated?

From: Kristi Geddes [
Sent: Thursday, 23 October 2014 04:41 pm
To: Wensley Bitton
Cc: Annette McMullan
Subject: RE: Barrett - further request for information/documents [ME-ME.FID2743997]

Hi Wensley,

As far as I know, it is.

I will let you know immediately if and when I hear anything different.

Kind regards,
Kristi.

Kristi Geddes Senior Associate
t
www.minterellison.com

From: Wensley Bitton [mailto
Sent: Thursday 23 October 2014 03:31 pm
To: Kristi Geddes
Cc: Annette McMullan; Wensley Bitton
Subject: RE: Barrett - further request for information/documents [ME-ME.FID2743997]

Hi Kristi

Are we still on track?

Regards
Wensley

From: Wensley Bitton
Sent: Thursday, 16 October 2014 3:11 PM
To: Kristi Geddes
Cc: Annette McMullan; Wensley Bitton
Subject: RE: Barrett - further request for information/documents [ME-ME.FID2743997]

Thank you for the update Kristi. I look forward to hearing of any changes that are likely to impact the deadline of 31 October 2014. Please continue to reinforce the importance of that deadline with the other investigators.

Kind regards
Wensley

From: Kate Blatchly [mailto **On Behalf Of** Kristi Geddes
Sent: Tuesday, 14 October 2014 3:39 PM
To: Wensley Bitton
Subject: RE: Barrett - further request for information/documents [ME-ME.FID2743997]

Hi Wensley,

The investigators have both been in Brisbane yesterday and today completing all of the necessary interviews. They have both otherwise attended on separate occasions to undertake reviews of the material.

I was advised today that they will commence work on the report this Friday. At this stage, no specific issues requiring natural justice have been raised, but we will have a better idea about that following Friday. If any such issues are raised, it may give rise to a need for an extension, in order for us to properly provide the relevant person or entity with details of any allegations against them and provide them with a reasonable opportunity to respond.

I have also reiterated the timeframes for the report to the investigators, requesting a draft report be provided to us by next Friday, 24 October 2014, with a view to ensuring a final report is available for the Department by 31 October 2014. I am advised they will do their best, but again will have a better idea of the feasibility of that timeframe on Friday.

I will give you immediate notice if it appears likely that a further extension is required.

Kind regards,
Kristi.

Kristi Geddes Senior Associate
www.minterellison.com

From: Wensley Bitton [mailto:
Sent: Tuesday 14 October 2014 01:27 pm
To: Kristi Geddes
Cc: Annette McMullan
Subject: RE: Barrett - further request for information/documents [ME-ME.FID2743997] (14_821)

Hello Kristi

How is the investigation proceeding? Is all on track for delivery of the report on the due date of Friday 31 October 2014 please?

Regards
Wensley

From: Kristi Geddes [mailto:
Sent: Thursday, 11 September 2014 6:51 PM
To: Wensley Bitton
Subject: Re: Barrett - further request for information/documents [ME-ME.FID2743997]

Thanks Wensley.

Kristi Geddes
Senior Associate
Minter Ellison

On 11 Sep 2014, at 5:52 pm, "Wensley Bitton" < > wrote:

> Thanks Kristi
> I've sent them both out.
> Records are to come directly to you.
> Please let me know if you have not heard anything by the middle of next week.
>
> Regards
> Wensley
>
> **From:** Kate Blatchly [mailto **On Behalf Of** Kristi Geddes
> **Sent:** Thursday, 11 September 2014 12:54 PM
> **To:** Wensley Bitton
> **Subject:** Barrett - further request for information/documents [ME-ME.FID2743997]
>
> Dear Wensley
>
> Please see **attached** correspondence.
>
> Regards
>
> Kristi Geddes Senior Associate
> t +
> Minter Ellison Lawyers
> www.minterellison.com

KG-73

From: KOTZE, Beth [
Sent: Friday, 24 October 2014 11:53 am
To: Kristi Geddes
Cc: SKIPPEN, Tania
Subject: Report status

Dear Kristi
The first draft has been completed.
Unfortunately I am at home sick today and can't remotely access my documents folder (I intended to send it to you today from work) I will send on Monday morning Regards Beth

Sent from my iPad

EXHIBIT 53

KGE.001.001.1006

MinterEllison | LAWYERS

KG-74

CLIENT

MATTER Barnett

FILE NO

AUTHOR Kanum.

DATE 27/10/17

TIME (start) am/pm

TIME (end) 9:50 am/pm

PAGE OF

Circle activity

TO TI CW AT

With whom Beth Kotze.

In meeting - back to back meetings until about 5:30pm - will be for the rest of the week

T/O Tania.

On different site to Beth. Has seen my blocked out time. Will advise Barnett.

On the way one will let them be called.

Reminders Who agreed to do what? By when? Without prejudice stipulated?

From: Annette McMullan [
Sent: Monday, 27 October 2014 12:01 pm
To: Kristi Geddes; Wensley Bitton
Subject: RE: Barrett - further request for information/documents [ME-ME.FID2743997]

Hi Kristi – Ive just had another enquiry from our DG. I'm assuming we are still on track for Friday?

Regards
Annette

From: Kristi Geddes [mailto
Sent: Thursday, 23 October 2014 3:41 PM
To: Wensley Bitton
Cc: Annette McMullan
Subject: RE: Barrett - further request for information/documents [ME-ME.FID2743997]

Hi Wensley,

As far as I know, it is.

I will let you know immediately if and when I hear anything different.

Kind regards,
Kristi.

Kristi Geddes Senior Associate
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From: Wensley Bitton [mailto
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Cc: Annette McMullan; Wensley Bitton
Subject: RE: Barrett - further request for information/documents [ME-ME.FID2743997]

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I have also reiterated the timeframes for the report to the investigators, requesting a draft report be provided to us by next Friday, 24 October 2014, with a view to ensuring a final report is available for the Department by 31 October 2014. I am advised they will do their best, but again will have a better idea of the feasibility of that timeframe on Friday.

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Subject: RE: Barrett - further request for information/documents [ME-ME.FID2743997] (14_821)

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Wensley

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Senior Associate
Minter Ellison

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> Thanks Kristi
> I've sent them both out.
> Records are to come directly to you.
> Please let me know if you have not heard anything by the middle of next week.
>
> Regards
> Wensley
>
> **From:** Kate Blatchly [mailto **On Behalf Of** Kristi Geddes
> **Sent:** Thursday, 11 September 2014 12:54 PM
> **To:** Wensley Bitton
> **Subject:** Barrett - further request for information/documents [ME-ME.FID2743997]
>
> Dear Wensley
>
> Please see attached correspondence.
>
> Regards

Kristi Geddes Senior Associate
[redacted]
www.minterellison.com

Please consider the environment before printing this email

From: Kristi Geddes [
Sent: Monday, 27 October 2014 12:06 pm
To: Annette McMullan; Wensley Bitton
Subject: RE: Barrett - further request for information/documents [ME-ME.FID2743997]

Hi Annette,

I was advised by the other investigators last week that we were, and that a draft report would be completed by the end of the week. I was meant to receive it on Friday, but Beth Kotze was sick and could not send it from home. I've chased this morning, but am yet to receive it, so can't really say without seeing where it is actually at.

I am hoping to have it by this afternoon, so should have another update for you by the end of the day.

Kind regards,
Kristi.

Kristi Geddes Senior Associate
t +
Minter Ellison Lawyers
www.minterellison.com

From: Annette McMullan [mailto:
Sent: Monday 27 October 2014 11:01 am
To: Kristi Geddes; Wensley Bitton
Subject: RE: Barrett - further request for information/documents [ME-ME.FID2743997]

Hi Kristi – Ive just had another enquiry from our DG. I'm assuming we are still on track for Friday?

Regards
Annette

From: Kristi Geddes [mailto
Sent: Thursday, 23 October 2014 3:41 PM
To: Wensley Bitton
Cc: Annette McMullan
Subject: RE: Barrett - further request for information/documents [ME-ME.FID2743997]

Hi Wensley,

As far as I know, it is.

I will let you know immediately if and when I hear anything different.

Kind regards,
Kristi.

Kristi Geddes Senior Associate
t +
Minter Ellison Lawyers
www.minterellison.com

From: Wensley Bitton [mailto:
Sent: Thursday 23 October 2014 03:31 pm
To: Kristi Geddes
Cc: Annette McMullan; Wensley Bitton
Subject: RE: Barrett - further request for information/documents [ME-ME.FID2743997]

Hi Kristi

Are we still on track?

Regards
Wensley

From: Wensley Bitton
Sent: Thursday, 16 October 2014 3:11 PM
To: Kristi Geddes
Cc: Annette McMullan; Wensley Bitton
Subject: RE: Barrett - further request for information/documents [ME-ME.FID2743997]

Thank you for the update Kristi. I look forward to hearing of any changes that are likely to impact the deadline of 31 October 2014. Please continue to reinforce the importance of that deadline with the other investigators.

Kind regards
Wensley

From: Kate Blatchly [mailto **On Behalf Of** Kristi Geddes
Sent: Tuesday, 14 October 2014 3:39 PM
To: Wensley Bitton
Subject: RE: Barrett - further request for information/documents [ME-ME.FID2743997]

Hi Wensley,

The investigators have both been in Brisbane yesterday and today completing all of the necessary interviews. They have both otherwise attended on separate occasions to undertake reviews of the material.

I was advised today that they will commence work on the report this Friday. At this stage, no specific issues requiring natural justice have been raised, but we will have a better idea about that following Friday. If any such issues are raised, it may give rise to a need for an extension, in order for us to properly provide the relevant person or entity with details of any allegations against them and provide them with a reasonable opportunity to respond.

I have also reiterated the timeframes for the report to the investigators, requesting a draft report be provided to us by next Friday, 24 October 2014, with a view to ensuring a final report is available for the Department by 31 October 2014. I am advised they will do their best, but again will have a better idea of the feasibility of that timeframe on Friday.

I will give you immediate notice if it appears likely that a further extension is required.

Kind regards,
Kristi.

Kristi Geddes Senior Associate
www.minterellison.com

From: Wensley Bitton [mailto
Sent: Tuesday 14 October 2014 01:27 pm
To: Kristi Geddes
Cc: Annette McMullan
Subject: RE: Barrett - further request for information/documents [ME-ME.FID2743997] (14_821)

Hello Kristi

How is the investigation proceeding? Is all on track for delivery of the report on the due date of Friday 31 October 2014 please?

Regards
Wensley

From: Kristi Geddes [mailto
Sent: Thursday, 11 September 2014 6:51 PM
To: Wensley Bitton
Subject: Re: Barrett - further request for information/documents [ME-ME.FID2743997]

Thanks Wensley.

Kristi Geddes
Senior Associate
Minter Ellison

On 11 Sep 2014, at 5:52 pm, "Wensley Bitton" < > wrote:

Thanks Kristi
I've sent them both out.
Records are to come directly to you.
Please let me know if you have not heard anything by the middle of next week.

Regards
Wensley

From: Kate Blatchly [mailto: **On Behalf Of** Kristi Geddes
Sent: Thursday, 11 September 2014 12:54 PM
To: Wensley Bitton
Subject: Barrett - further request for information/documents [ME-ME.FID2743997]

Dear Wensley

Please see **attached** correspondence.

Regards

Kristi Geddes Senior Associate

www.minterellison.com

Please consider the environment before printing this email

From: Kristi Geddes [redacted]
Sent: Monday, 27 October 2014 01:37 pm
To: KOTZE, Beth; SKIPPEN, Tania
Subject: Barrett draft report [ME-ME.FID2743997]

Importance: High

Dear Beth and Tania,

Are you able to give me an indication of when I will receive the draft report?

I've been chased by the Department today to confirm that everything is on track from our end, as we were meant to receive the draft report on Friday.

Kind regards,
Kristi.

Kristi Geddes Senior Associate

[redacted]

www.minterellison.com

EXHIBIT 53

KGE.001.001.1015

MinterEllison | LAWYERS

CLIENT

MATTER Barnett

FILE NO

AUTHOR Kenn.

DATE 27/01/14.

TIME (start) am/pm

TIME (end) 2:44 am/pm

PAGE OF

Circle activity

TO TI CW AT

With whom Wendy Bitton

Still don't have report.

One to us last Friday. Beth emailed to say it was done but she was sick + could send from home so will send Mon am.

Have chased by email x 2 and phone x 2 - still nothing.

Essentially we've lost 2 days both ends.

Reminded re: Have a leave from Fri, me on leave next wk for 10 days.

Anything they can do to push along?

Pls send thru details + she will do. Agreed re having Michael call

Reminders Who agreed to do what? By when? Without prejudice stipulated?

From: Kristi Geddes [
Sent: Monday, 27 October 2014 03:36 pm
To: Wensley Bitton
Cc: Annette McMullan
Subject: Barrett [ME-ME.FID2743997]

Hi Wensley,

As discussed, Beth and Tania's contact details as per below:

Associate Professor Beth Kotze
MBBS FRANZCP FRACMA Cert Child Psychiatry MMed (Psychotherapy) MHA (UNSW)
Acting Associate Director, Health System Management
Mental Health and Drug and Alcohol Office
NSW Ministry of Health
Direct Dial: | **Mobile:** |**Fax:**
Address:
Email:

Tania Skippen
Associate Director, Specialist Programs | **MH-Children and Young People**
NSW Ministry of Health, LMB 961, North Sydney NSW 2059
Tel | Fax | Mob |

I will let you know when I receive the draft report and then give you an update on how on track we are after I've had a chance to review.

Kind regards,
Kristi.

Kristi Geddes Senior Associate
t f m
Minter Ellison Lawyers
www.minterellison.com