BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

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

STATEMENT OF TREVOR BRUCE SADLER

Name of Witness:	**Trevor Bruce Sadler**
Date of birth:	
Current address:	
Occupation:	**Psychiatrist**
Contact details (phone/email):	
Date and place of statement:	**11 December 2015 and Brisbane**
Statement taken by:	**K & L Gates**

I **Trevor Bruce Sadler** make oath and state as follows:

1. I am employed as a psychiatrist at Mater Health Services. I have occupied this position since 9 April 1989. Since 2 November 2015, I have also been employed as a temporary psychiatrist at the Royal Brisbane and Women's Hospital Adolescent Mental Health Inpatient Unit (**RBWH AMHIU**).

2. In my current role at Mater Health Services, I work approximately 13 hours per week and perform the following duties:

   (a) I provide psychiatric assessments and treatment to adolescents and young adults with long standing medical illness as a member of the Young Adult Support Unit.

   (b) I provide psychiatric consultations on the management of young people receiving services from the Adolescent Drug and Alcohol Withdrawal Service.

3. In my current temporary role at the RBWH AMHIU I work approximately 24 hours per week and I am responsible for the management of inpatient adolescents in my care.

4. In early July 2015 I became aware through a report on the ABC news of an inquiry into the closure of the Barrett Adolescent Centre (**BAC**) and related matters. I subsequently obtained a copy of the Inquiry's Terms of Reference and in late September 2015, I

contacted the Commission staff to advise that I had information relevant to the Terms of Reference.

5. On 29 September 2015, I met with three Commission staff for approximately three hours with my solicitor Mr David Watt. I provided a general overview of my relevant involvement with BAC. In preparation for this meeting I made available to the Commission a number of documents that I had prepared or had in my possession. These documents are referred to further below.

6. The Commission prepared an initial draft statement for me which included a request for me to address numerous further issues and answer a number of questions. I have not had access to much documentation for the purposes of preparing this statement.

Qualifications

7. In 1974, I graduated from the University of Queensland with the degrees of Bachelor of Medicine and Bachelor of Surgery.

8. Since 15 October 1988, I have been a Fellow of the Royal Australian and New Zealand College of Psychiatrists.

9. Since 28 October 1988, I have been registered with the Medical Board of Queensland and subsequently the Medical Board of Australia to practise as a specialist in psychiatry.

10. On 3 June 1989, I obtained a Certificate of Advanced Training in Child Psychiatry from the Faculty of Child and Adolescent Psychiatry of the Royal Australian and New Zealand College of Psychiatrists (**RANZCP**).

11. Exhibited and marked '**A**' to this statement is a copy of my curriculum vitae.

Specialist knowledge

12. I have in excess of 33 years of experience in working with adolescents with mental health issues. My experience has included assessing, treating and managing such adolescents. I have also acted in a consulting capacity, which has involved providing psychiatric input in the management of patients under the care of another clinician.

13. The following is a list of the facilities and capacities in which I have provided psychiatric care to adolescents with mental health issues:

    (a) Between October 1978 and December 1983 I was a Medical Officer with the Division of Youth Welfare and Guidance.

    (b) Between October 1978 and October 1979 I managed adolescents who were offenders at the Lesley Wilson Youth Hospital.

    (c) Between October 1979 and December 1983 I assessed and treated adolescents at the Redcliffe Child Guidance Clinic.

(d) After a period of training in adult psychiatry, I resumed providing psychiatric care to adolescents as a registrar and then as a consultant psychiatrist at the BAC from December 1986 until September 2013.

(e) Between November 1988 and 2005 I also worked in private practice with adolescents with mental health issues. My rooms were at Scarborough and Manly. I saw on average approximately 180 children and adolescents per year.

(f) Between April 1989 and March 2015 (when the Mater Young Adult Health Centre opened) I also worked as a psychiatrist consulting and assessing inpatient and outpatient adolescents at the Mater Children's Hospital. From 2005 a significant part of my consulting was to the adolescent clinic of the Queensland Diabetes Centre.

(g) Between July and November 2014, I worked as a locum psychiatrist in the Mater Acute Mental Health Inpatient Unit. Most of my work over this five month period involved providing psychiatric care to adolescents.

(h) For seven weeks from mid-September 2015 I was a locum psychiatrist providing consultation on the management of adolescents at community Child & Youth Mental Health Service (**CYMHS**) clinics in the Metro South Health and Hospital Service.

(i) In my roles with the Mater Health Services and the RBWH AMHIU as detailed in paragraphs 2 and 3 above.

14. I estimate that as at September 2013 when I left BAC, I had assessed and treated approximately 1000 adolescents in various outpatient settings (community clinics, private practice, hospital-based outpatient services). The skills and experience I gained from this work greatly assisted me while working at BAC. This is because it enabled me to develop a detailed understanding of what mental health conditions could be best managed in the community.

15. I have been and continue to be passionate about providing the most appropriate service for adolescents at the severe end of the spectrum disorder.

16. A list of my publications relevant to adolescent psychiatry is contained in Exhibit A to this statement.

17. I have maintained relevancy of knowledge in adolescent psychiatry. For more than a decade, one of the two foci of my professional development has been researching and understanding interventions for adolescents with severe and complex mental illness with consequent impairment. I have participated in the Continuing Professional Development Program of the RANZCP.

18. Further, I have been the coordinator of a Peer Supervision Group registered with RANZCP since February 2011, and as a member of that group since 2000. This group meets monthly. The group comprises child and adolescent psychiatrists working in private practice, community public sector clinics and acute inpatient units. Usually we discuss two

clinically complex cases each meeting. The vast majority of these cases are adolescents. Prior to the closure of BAC some of the cases discussed would be adolescents who were at BAC. These discussions provided opportunities to better understand therapeutic interventions within the community and also those being used in acute inpatient units and to compare them with those which were being used at BAC.

19. I continue to read widely and regularly review literature relevant to adolescent mental health. This has included systematic searches of the Medline and PyscINFO databases, which are search engines which search a wide range of peer review journals for topics such as inpatient care and social anxiety disorder.

20. Over many years, I have also been a regular attendee at conferences, the details of which are listed as an appendage to Exhibit A to this statement. In particular, in 2012 I attended the conference of the Faculty of Child and Adolescent Psychiatrists in Sydney. At this conference I had the opportunity to speak with Dr Jean Starling, full-time psychiatrist in the Walker Unit in Sydney. This is also a long-term inpatient treatment facility for high-risk young people aged between 12 and 18 who have complex mental illness. It is part of the Concord Centre for Mental Health, located in the grounds of Concord Hospital. We discussed clinical presentations, staffing and outcomes for adolescents. It was my impression at that time that the Walker Unit had stable staff and was better resourced. For example, there was a dedicated art therapist and family therapist, as well as more psychiatrist time. At this conference I also spoke with Dr Robert Adler, a prominent Victorian psychiatrist, who was formerly a Professor of Child and Adolescent Psychiatry at the University of Melbourne. It was my impression that the model he envisaged for Victoria was similar to the model and approaches that were in place at BAC.

21. Invitations were extended for psychiatrists from other longer-term inpatient facilities to visit BAC. I can recall that in 2006, a psychiatrist attended from Rivendell Child, Adolescent and Family Mental Health Service. It is also part of the Concord Centre for Mental Health, located in the grounds of Concord Hospital. This is a long-term inpatient unit in Sydney for adolescents with anxiety disorders and who have been unable to attend school. Until 2009, Rivendell had been the only other longer term inpatient facility in Australia. This psychiatrist was sceptical regarding the benefits of inpatient treatment for the sub-group of patients who were treated at Rivendell. However, one advantage that BAC had over Rivendell was that Rivendell was not open on weekends, meaning that the adolescents at Rivendell had to be transferred on weekends to other inpatient units or on occasions, to an acute adult unit. In my experience, this could be quite disruptive to the therapeutic process. Further, the program offered at Rivendell was limited to a six month period, which meant that some adolescents were being discharged in circumstances where they were not ready to be re-integrated into the community.

22. We also had a visit in 2008 from Dr Patrick Hammerle, a psychiatrist from an inpatient unit in Fribourg, Switzerland. He is a past President of the European Society for Child and Adolescent Psychiatry. He endorsed the BAC model of care.

23. In 2012, we had a visit from the administrator of Child and Adolescent Mental Health Services in Edmonton, Calgary. She had previously worked in Rockhampton and was

interested in extended treatment inpatient adolescent units. She considered the BAC model of care had valuable insights and invited me to provide training in Edmonton to child and adolescent mental health clinicians as I was intending to visit Canada at the end of 2012. However I was unable to accommodate this request on account of other commitments.

24. In about 2008 or 2009, I gained access to the online forum of the Quality Network of Inpatient Child and Adolescent Mental Health Services (**QNIC**), a quality initiative of the Royal College of Psychiatrists in the UK. The other participants are clinicians from multiple disciplines working in other inpatient Child and Adolescent Mental Health Services (**CAMHS**) units. This provided a valuable opportunity to exchange information regarding operational matters relevant to inpatient adolescent units. I regularly collated email threads from my involvement in this forum, and circulate them to staff for discussion. The QNIC also provided a set of standards relevant to adolescent inpatient units, against which we could review BAC. Where BAC fell short we could advocate for improved systems.

25. I have maintained a keen interest in educating myself as to other inpatient adolescent mental health units worldwide.

26. Professor Barry Nurcombe reported on his experiences in the USA. I also read articles from surveys of United Kingdom inpatient units in 2003/2004 and learned that there were several inpatient units in the United Kingdom which managed a very similar cohort as we did.

27. In 2010 and 2011, I visited at my own expense a number of inpatient units in the United Kingdom and Switzerland with features and characteristics similar to BAC. This provided an opportunity for me to discuss with senior colleagues in these various inpatient units the range of existing services for adolescents with severe and complex difficulties. Exhibited and marked **'B'** to this statement is a summary I have prepared as to the inpatient units I visited.

28. My key learnings and observations from my visits to these other inpatient units were:

    (a) There was generally an unsatisfactory mix of patients in general adolescent inpatient units, with a combination of acute and longer stay adolescents.

    (b) Most units had one and often several adolescents where the length of stay was for longer than six months. This was the sub-population accommodated at BAC. All units found it difficult to provide adequate models of care for such adolescents. Adolescents requiring stays of six months or more did not have access in most cases to an intensive integrated treatment and rehabilitation program such as was provided at BAC, because the program was aimed at those with shorter lengths of stay.

    (c) The clinical profiles of the adolescents in general adolescent inpatient units reflected the profiles of those who are likely to present to emergency departments. These included those with psychosis, eating disorders, and serious self-harm or suicide attempts. Although all of these had serious disorders, there was another sub-group,

those with severe anxiety disorders, who suffered equally, had severe impairments, but were likely to be confined to home rather than present to their emergency department.

(d) Due to the increasing incidence of self-harm and eating disorders since the 1970s, it seemed the sub-population of adolescents with severe anxiety and persistent school refusal had been displaced from the inpatient adolescent units.

(e) Most units had therapists trained in non-verbal therapies (e.g. art, music, sandplay or animal assisted therapies) and had specifically designated family therapy positions.

(f) Although many general adolescent units had similar components of rehabilitation programs to those found at BAC, only a couple of the units had as well defined models of rehabilitation.

(g) BAC had a clear model of the conceptualising changes experienced by adolescents with complex trauma as they progressed through treatment. None of the other units I visited had a clear model in this regard.

(h) The adequacy of community adolescent mental health services varied considerably. This appeared to be a function of the priorities of individual Health Trusts and whether in a given area, community services were in the same Trust as inpatient services. I formed the impression that Queensland has a much more integrated system of CYMHS.

(i) The private sector in the United Kingdom offered a similar level of service to NHS funded inpatient units. Some private sector units offered well run specialist programs.

29. Each inpatient unit that I visited was a stand-alone unit with adequate space. I estimate that the footprints of each of the units varied between one and four hectares. While some units were two stories, the vast majority were single-storey buildings. There was a strong connection with external spaces in many of the units. All had exercise equipment which a number of adolescents find useful to help them regulate their mood.

30. On account of my experience in treating adolescents external to BAC and my close liaison with the mental health clinicians at the Mater Children's Emergency Department, I gained valuable insights into adolescents requiring acute inpatient admission but not within the realms of BAC.

Employment with BAC

31. It was while I was working as a medical officer in the Division of Youth Welfare and Guidance that the BAC was established. I worked there as a medical officer between December 1986 until November 1988. Then, from 1989 to 1998, I was employed as a visiting psychiatrist to BAC for 24 hours per week. In 1998, I applied for, and was appointed as a senior visiting psychiatrist at BAC.

32. During the time I was at BAC, I was given a number of other titles. I was the Acting Medical Director between 1986 and 1995. As Acting Medical Director, I was a member of the Business Unit Management Committee (**BUMC**). I attended the Administration Meetings, the Management Committee Meetings, and monthly meetings with the Hospital Executive with other members of the BUMC.

33. I was the Business Unit Director from 1995 until the latter 2000s. I was then referred to as either Medical Director or Clinical Director. My role as Business Unit Director was the only role that was defined. My role as Clinical Director was not one of single point of accountability for the operations of BAC. Governance through the BUMC is outlined below.

34. In the absence of a clear job description, I conceptualised my role as Clinical Director as providing clinical leadership. My simple focus of clinical leadership was to provide better outcomes for the adolescents and to help them maximise their recovery. This is consistent with the broadest understanding of the role of a psychiatrist. The following are the multiple facets of my roles as both a senior psychiatrist and the Clinical Director at BAC:

    (a) I had the ultimate responsibility for clinical decision making and was accountable for these decisions with input from each discipline responsible for the interventions they administered.

    (b) I had the responsibility for the decision to discharge each adolescent, in consultation with the multidisciplinary team assigned to the adolescent.

    (c) As well as assessing, reviewing and providing treatments directly, I collaborated with other clinicians and the teaching staff in developing a comprehensive range of treatment and rehabilitation interventions for the adolescents.

    (d) I oversaw clinical decision making within the BAC for the adolescents through chairing the weekly Case Conference, which discussed every adolescent. This was a multidisciplinary team meeting which reviewed the particular adolescent's response to interventions and participation in activities. The adolescent could and sometimes would be present for part of the meeting to raise issues they wanted addressed. The team identified challenges and assessed progress to date. Part of my input was to synthesise all the available information from observations of the adolescent's functioning in various contexts to conceptualising how they were progressing in pathways to recovery. This meeting also reviewed risks, status under the Mental Health Act 2000 and leave and participation in groups. Plans for the participation of the adolescent in the various programs and interventions were outlined.

    (e) I oversaw the Care Planning Workshop held every two to three months. This meeting received information from the adolescent and the parent or carer, either by interview before the meeting or in person. We endeavoured to link with the referring agency, whether it was a private psychiatrist, private psychologist, or clinicians from a community CYMHS. If the adolescent was close to discharge and the referrer would not be following them up, we would ask the service or clinician who would be

following them up (the external agency), to join the meeting. I regarded this input as a critical part of the Care Planning Workshop. The external agency would typically join the meeting in person, by video conference or by teleconference. The purpose of the meeting was to review assessments over the previous two to three months, progress in recovery, participation in interventions and future goals. It was a collaborative process with the adolescent and with the external agency. We routinely sought input from the external agency as to whether they considered the adolescent could be adequately supported in the community. My role was to synthesise the information from all the observations and negotiate a plan for the future, both with the adolescent and with the external agency. This meeting developed the broad steps for transition planning. It also offered the opportunity for the external agency to understand the processes within BAC and offer feedback as to their relevance.

(f) I helped to identify and develop emerging skills in the clinicians at BAC which would be of benefit to adolescents at BAC.

(g) I developed a model which proved to be effective in predicting whether an adolescent required community, day patient, acute inpatient or extended treatment and rehabilitation services. This was used by staff at BAC to conceptualise the various processes of treatment and rehabilitation for an adolescent, and readiness to transition. I presented it to a number of forums.

(h) I also developed and articulated pathways of recovery for adolescents who had experienced complex trauma. I subsequently presented these to clinicians external to BAC for review. This not only allowed for feedback, but also provided these clinicians with a better understanding of the suitability of referring adolescents to BAC.

(i) I chaired the BUMC which was comprised of adolescent representatives, senior nursing staff, the school principal and a member of the allied health staff (usually an occupational therapist because their programs required the greatest coordination across disciplines). Although the meetings were intended to be monthly, at times there was not a quorum, or clinical demands on the unit necessitated cancelling a meeting. Minutes of these meetings were taken.

(j) From the early 1990s, I was permanently on call for BAC unless I was on leave. Before that a call roster was established of psychiatrists within the Division of Youth Welfare and Guidance. Being the only psychiatrist on call offered the opportunity for better integration of care across the entire week, as well as support for staff. This was critical in later years with instability in the complement of nursing staff.

35. On 10 September 2013, I was suspended from duty as Clinical Director of BAC following

[redacted]

(a)

(b)

(c)

36. Ultimately on 12 May 2014, I was formally reprimanded By this time, BAC had closed and I did not return to employment with West Moreton HHS.

BAC in the CYMHS setting

37. BAC was established in 1982 in buildings of the Wolston Park Hospital. It was part of the Division of Youth Welfare and Guidance. The Division at that time was also responsible for about 13 community clinics which were primarily in the Greater Brisbane area, Toowoomba, Gold Coast and Townsville. These community clinics were to become local CYMHS clinics. The Senior Medical Director of the Division reported directly to the Director General and the Minister. BAC was a clearly defined component within the organisational structure of the Division. The Child and Family Therapy Unit, which opened in 1980, was part of the Royal Children's Hospital.

38. Until 1990, BAC was integrated with Child Guidance Clinics (later CYMHS) throughout Queensland. The organisational structure became less certain once the Division of Youth Welfare and Guidance was disbanded in 1991 and the clinics became part of Health Regions. Priority was given to developing services specific to the Health Region. The future of BAC was tenuous from the release of the *Future Directions for Child and Youth Mental Health Services in Queensland* in December 1996, until the allocation of monies to rebuild BAC was made in the 2007 State budget. The history of this period is detailed further below.

39. When BAC closed in 2014, there were more than 30 community clinics; eight community based specialist services for children in the care of the Department of Child Safety – the Evolve Therapeutic Service (Gold Coast, Logan, Toowoomba, Ipswich, Mt Gravatt, North West, Sunshine Coast, Townsville and Cairns); eCYMHS and visiting child psychiatry services to towns in the Outback (e.g. Longreach, Charleville); six acute adolescent inpatient units (Robina, Toowoomba, Townsville, RBWH, Logan and Mater) and three other day programs (Mater, Toowoomba and Townsville).

40. BAC could treat 20 adolescents at any one time. This included both day patients and inpatients. When BAC initially opened, there were 16 inpatient beds but there were15 such beds since the 1990s. No data was kept regarding day patients even though they comprised a significant proportion of the adolescents we treated. I believe the reasoning behind this was that day patients were defined to be under the care of ambulatory services, and The Park – Centre for Mental Health did not provide ambulatory services.

41. The average bed occupancy rate was recorded as approximately 40%. However, this percentage does not reflect numerous aspects of the treatment and services provided by BAC. It does not include the day patients. An inpatient was encouraged to take weekend leave if it was readily arranged, and they were clinically stable, to enable them to keep in contact with family and develop skills to reintegrate with the community. Further, if an inpatient adolescent was in the transitioning phase of treatment and as part of that transition was spending more than two nights at home, this bed was recorded as being unoccupied for those nights the adolescent was not in the unit even though the bed could not be allocated to another patient. The adolescent, however, continued to access the day program. If an adolescent accessed longer leave during school holidays, the bed would be vacant, but the adolescent would return. We aimed to manage 20 adolescents in the combination of inpatient and day patient settings. This depended on the mix and acuity of adolescents.

42. From at least 2006, there were always adolescents on waiting lists for admission to BAC. As at September 2013, I recall that there were around 10 adolescents on the waiting list for admission to BAC.

43. BAC provided a state-wide service available to Queensland adolescents aged 13 – 17 years at time of admission, with severe and complex mental illness who:

    (a) had previously received a range of less restrictive interventions with specialist services in adolescent mental health, but still had persisting symptoms of their mental illness and consequent functional and developmental impairments;

    (b) were likely to benefit from the range of clinical interventions offered at BAC; and

    (c) required extended and intensive clinical interventions ranging from day patient admission to an inpatient admission.

44. Diagnostic criteria alone did not distinguish the adolescent who was likely to benefit from admission to BAC. It was the combination of severe and complex mental illness, together with impairment, sometimes family factors, and the potential to benefit from multiple multi modal intensive interventions provided at BAC.

45. Severe and complex mental illness in adolescents tends to occur in a number of disorders. Many present with a complex array of co-morbidities. The predominant disorders with which young people presented to BAC were severe and persistent:

(a) depression with dissociated self-harm and depression;

(b) anxiety, especially social anxiety disorder;

(c) Post -Traumatic Stress Disorder (**PTSD**);

(d) eating disorders, both anorexia nervosa and bulimia nervosa; and

(e) severe psychotic disorders.

46. I undertook a review in November 2012. Exhibited and marked '**C**' to this statement is a copy of the review. The review shows that of the adolescents admitted to BAC from 2007 to 2012:

(a) 98% had disengaged from their educational networks for at least six months prior to admission. Those adolescents who had not disengaged, were either able to be admitted as partial day patients and participate in the educational programs, or the educational setting was a continuing stressor which adversely affected their mental health.

(b) 90% had no face to face contact with peers. Some had even disengaged from online networks.

(c) 83% had disengaged from community networks. They either did not or rarely went to shops or caught public transport.

(d) 12% had been abandoned or removed by family networks and 35% had tenuous family networks. For instance, the adolescent resided in the family home but the parents were disengaged, neglectful or abusive. 55% had adequate family networks. These families however described tremendous strain from needing to support an adolescent with severe mental illness, including sleepless nights, giving up jobs, sometimes severe family conflicts, sometimes fear of the adolescent dying and younger siblings witnessing incidents of self-harm.

47. In approximately May 2013 the Expert Clinical Reference Group (**ECRG**) released recommendations in relation the proposed service models. In response to this, the Chair of the ECRG defined three tiers of services. Tier 1 was for community clinics, Tier 2 was for day program services and Tier 3 was for inpatient extended treatment and rehabilitation services, such as BAC. The final report of the ECRG aligned the Tier 2 and Tier 3 services to the relevant sections of the Clinical Services Capability Framework (**CSCF**).

48. The process of tiered levels of treatment is appropriate and commonly found in physical medicine. For example, a person with mild chronic kidney failure may be managed by their general practitioner. Some with more severe disease will be monitored by a renal physician. A small proportion of these will require renal dialysis, which is available in regional centres throughout Queensland. Finally, in the most extreme cases some will require renal transplantation which is usually available in only one centre in the State. Another example is that burns victims require treatments which range from simple

dressings, a smaller number may need a small skin graft in a hospital in a regional city, some could require transfer to a larger regional city e.g. from north Queensland to Townsville, but those with very severe burns will require transfer to the specialist burns unit at RBWH. This is analogous to the various levels of treatment which were available in CYMHS.

49. The importance of an AETRC in an organisational context was clearly outlined in Queensland Health's CSCF for public and licensed private health facilities published in recent years.

50. The CSCF is a suite of documents describing clinical and support services by service capability levels. BAC was a level 6 service within the CSCF because it:

    (a) was State-wide;

    (b) provided a service to adolescents with the most severe and complex illness;

    (c) provided a range of specialist services not available elsewhere;

    (d) provided intensive treatment not available elsewhere; and

    (e) assisted in training clinicians throughout the State.

51. In the 2010/11 financial year, Community CYMHS across Queensland opened 15,043 children and adolescent cases. Of these, only about 40 cases were referred to BAC, and less than 20 cases were accepted for admission.

52. While at first glance, these figures may suggest that an insignificant proportion of adolescents with mental illness received inpatient treatment at BAC, there are a few important caveats. I estimate that only about half of the cases were adolescents. Of this half, the majority of the cases were closed in less than 10 weeks, and only one in eight had more than six face to face sessions. Approximately 2000 to 3000 adolescents, with more severe mental illnesses, presented to public and private sector mental health services each year. The majority of these were well treated within the community or acute inpatient settings. BAC was a specialised service that treated the sup-population of adolescents with severe and complex mental illness with consequent impairment, who had the potential to carry the greatest burden of illness into adult life.

Organisational structure within BAC and The Park – Centre for Mental Health

53. In 1991 the Wolston Park Hospital Executive issued a statement making the management committee of each unit responsible for the development, coordination and monitoring of clinical programs in that particular unit. This structure continued until September 2013.

54. BAC's management committee comprised the BUMC and the Hospital Executive. From about 2002 onwards, a representative of the adolescents and on occasions, a parent representative was on the management committee. From about 2010, the Nursing Director was also expected to attend management committee meetings, which were minuted by the

administration officer. These minutes were made available to staff and forwarded to senior management.

55. Medical Registrars were assigned to BAC by the Director of Training for Child and Adolescent Psychiatry. This director was external to BAC and allocated registrar positions to inpatient, outpatient and community adolescent mental health facilities throughout Queensland. The registrars reported to the consultant psychiatrists, who reported to the Director of Clinical Services who reported to the Executive Director of Mental Health Services (**EDMHS**).

56. Registered nurses reported to the clinical nurse for each shift, who reported to the nurse unit manager (**NUM**), who reported to the Nursing Director, who reported to the Director of Nursing who reported to the EDMHS.

57. BAC employed psychologists, social workers, occupational therapists and speech and language pathologists. A Director of Allied Health position was created in 2012. Prior to this time I am unsure whether the senior psychologist, senior social worker and occupational therapist reported directly to the EDMHS or to the Director of Clinical Services. After the Director of Allied Health was appointed, allied health staff reported to their discipline seniors, who reported to the Director of Allied Health, who reported to the EDMHS.

58. At the time I commenced in 1986 at BAC, there were 28 nursing staff, six allied health staff and three medical staff (psychiatrist, medical officer and registrar) employed. In addition, two to three student or intern nurses (or equivalent classifications but with different names), were attached to the unit in supernumerary positions. All nursing staff were permanent.

59. By October 2012, BAC had 20.9 nursing staff, five allied health staff and 1.8 medical staff. Most of the reduction in staff occurred in the early 1990s with the introduction of Regional Health Services.

60. While some reduction in staff was necessary, BAC faced difficulties from the early 2000s with the level of nursing staff.

61. In the 1990s, the senior nurse on the ward performed the role of the Clinical Nurse Consultant and reported to an external NUM. When the position of the external NUM was abolished, the Clinical Nurse Consultant became responsible for fulfilling those duties previously the responsibility of the external NUM. These duties included the rostering of nursing staff and performing performance reviews of the nursing staff. The Clinical Nurse Co-ordinator was also required to attend facility wide meetings. These meetings rarely included items on their agenda relevant to BAC. This was less than ideal for BAC because the Clinical Nurse Co-ordinator's time was taken away from staff training, development and supervision, all of which are critically important in the complex clinical environment that existed at BAC.

62. Nursing staff at BAC were originally in a closed roster. This means that there were no temporary or casual staff as part of the core roster. This ensured that nursing staff knew the adolescents well, they managed the adolescents consistently, they were able to generalise interventions from groups and individual therapy to the residential lives of the adolescents and they could provide supportive counselling to a distressed adolescent. Knowing an individual BAC adolescent well, built rapport and trust and enabled nursing staff to recognise early warning signs of distress.

63. Adolescents at BAC were often anxious or distressed, whatever their stage of transition. Consistent staffing enabled an anxious or distressed adolescent to approach a number of staff with whom they felt comfortable. This was particularly important when other adolescents were in a time of crisis and required more intensive nursing interventions.

64. The 20.9 nursing staff referred to in the paragraph above included three Transition Nursing Educational Placements (**TNEP**) nurses. The TNEP is similar to a nursing intern program. They were placed at the unit usually for three months, but it could be extended for up to six months. Therefore there were only 17.9 permanent nursing staff, one of whom was the NUM, which was a non-clinical position. This was an inadequate number of nursing staff to care for up to 20 adolescents who were presenting with issues of increasing complexity and severity.

65. From the time of the announcement of the redevelopment at Redlands in approximately 2008 there was a reluctance to fill vacant BAC nursing positions with permanent staff. On occasions staff who performed poorly in other areas of the hospital were placed in BAC. Further, up until July 2012, nursing positions for BAC were only advertised with generic nursing positions at The Park. This did not ensure either a suitable pool of applicants or people suited to work in the ward.

66. Apart from the permanency and numbers of nursing staff, another significant issue was nursing leadership. The permanent NUM resigned in June 2012. He had worked in this position at BAC for approximately 3 years. After this time I worked with three nurses in the Acting NUM position. Whilst I held each of them in high regard and considered them to be professionally competent, it created significant challenges for the nursing staff reporting to them. The instability of the Clinical Nurse (**CN**) positions was another issue. There were typically three or four permanent Clinical Nurses and their roles were to lead the shift, allocate adolescents and duties to nursing staff and to prevent and then manage any incidents that may arise. The role required experience, good clinical skills and the respect of other registered nurses. My recollection is that two or perhaps even three of the CN positions were vacant by May 2013. This meant that there was often no CN rostered on for shifts and registered nurses would act up in these positions.

67. In 2012 Mr Will Brennan, Director of Nursing at The Park recognised the staffing issue was serious and agreed to advertise for three permanent nursing staff. Interviews were held in July and August 2012 but appointments were not made until September to December 2012. Two of the staff to whom positions were offered did not accept. Another two who would have been suitable were only offered contracts of 3 to 6 months.

68. During the last quarter of 2012, 61 different nursing staff worked at BAC. Essentially there were 38 non-regular nurses during that quarter who did not know the individual adolescents. In the first quarter of 2013, there were 55 nursing staff. The percentage of non-regular nursing staff in that quarter ranged from 19% to 39% on a fortnightly basis. The QNIC Standards 2011 (a quality initiative of the Royal College of Psychiatrists) recommended that agency staff were only to be used in exceptional circumstances and an inpatient unit should not use more than 15% of agency staff during a week. BAC was unable to comply with this recommendation.

69. In the decade prior to October 2012, the allied health staff tended to be stable. They usually only left to go on maternity leave. During the second half of 2012, the permanent social worker was encountering personal problems which necessitated extended periods of leave. He resigned in January 2013. He was employed in a PO5 position. I met with and subsequently wrote to the senior social worker for West Moreton HHS to discuss a replacement. I believed we did not require a replacement of a person of this classification as it would take too long to recruit a suitable person. I thought we needed someone with family therapy skills for 0.5 full time equivalent (**FTE**) at a PO3 level to assist adolescents engage with their families. A replacement social worker was not appointed until May 2013.

70. During the latter part of 2012 and into early 2013, one permanent occupational therapist took periods of leave with a severe medical illness. No replacement occupational therapist was provided.

71. The five allied health staff were comprised of one FTE psychologist, one FTE social worker, two FTE occupational therapists 0.5 FTE speech and language pathologist and 0.5 FTE Specialist Clinical Supervisor.

72. Corresponding with the reduction in staff was a significant increase in acuity, complexity and severity of patients.

Impact of restructure of health services; Government priorities

73. I do not have detailed knowledge of funding models. Having said this, in 2012, I became aware that there were new funding arrangements with the Australian Government which were likely to be disadvantageous to BAC, which had previously received block funding for services. This was to be replaced by activity based funding. I was aware that acute inpatient units restricted overnight leave on weekends because of the impacts of activity based funding. This posed considerable challenges for BAC because overnight leave, partial hospitalisation (as adolescents were transitioning) and attendance as day patients, were an integral part of our program. Use of Occupied Bed Days (**OBDs**) as a measure of activity based funding was always disadvantageous to BAC. Certainly for medical and allied health staff, each adolescent in the centre could be considered a part of their case load. I knew from my time with the CYMHS Clinical Collaborative, the case load of our clinicians was at least equivalent to that of clinicians in community CYMHS, but our frequency of interventions was likely to be higher. Activity of nursing staff was not as easy

to measure, but face to face contact with adolescents was at least equivalent to their counterparts in community CYMHS. I considered a hybrid model of a measure of these types of activities, as well as OBDs was likely to provide a more accurate reflection of activity. There were no forums to advance these proposals.

74. At a service level there were significant changes with the election of a new Government in 2012. The Statewide CYMHS Advisory Group (**SW CYMHS AG**) was disbanded. As a result there was no formal conduit of advice from Child and Youth Mental Health into the MHAODD Branch. I knew of only two people in the MHAODD who had child and youth mental health experience.

75. Prior to the budget cuts to mental health which began in October 2012, BAC was operating below budget. Subsequent to this time, there were continuing moves to reduce staffing and cut positions. Budget cuts not only created uncertainty amongst clinicians, but also had the effect of making middle level managers reluctant to advocate for adequate staffing in services.

76. The establishment of Queensland Hospital and Health Services (**HHS**) in July 2012 meant that the West Moreton HHS had a new Board, most of whom had limited experience with health service management. There was also a new Chief Executive and subsequently a new EDMHS.

77. The new Chief Executive and EDMHS had worked in South Australia for significant parts of their career. Further, the background of the EDMHS was not in mental health services. Her background was in obstetrics and health administration. The extent of changes at senior level meant a significant loss of corporate history and knowledge, as well as a ready access to clinical networks for information.

78. The priorities of the Chief Executive were to establish a corporate governance structure with clear levels of management responsibility and accountability. The strong hierarchical approach to management, without face to face contact between our service and the EDMHS, caused difficulties in effectively being able to communicate information to the EDMHS about operational matters of BAC.

79. I was unsure of the role of the MHAODD Branch. I knew the West Moreton HHS had signed a contract with Queensland Health to provide services including BAC. I also knew that the MHAODD Branch was now the System Manager, but was unsure what that meant in practice to our service.

80. The contract refers to the BAC as a level 6 service under the CSCF (subsection 1.3), which outlines the services to be provided at BAC.

Physical Environment of BAC

81. BAC was located in the grounds of The Park – Centre for Mental Health. It was set on approximately 1.5 hectares of land surrounded by open spaces with a golf course on one side, a cricket oval on another, vacant land on the third and the Forensic High Secure unit on the fourth, which although visible, was unobtrusive.

82. There were two buildings on the BAC site, a residential building and a school building with offices for allied health and medical staff. These buildings were connected with a walkway so that adolescents had the feeling of getting up and going to school.

83. I became aware of the importance of the physical environment after a visit to the unit by Professor Robert Kosky in the 1990s. He explained that the unit they had in South Australia was two stories with security to prevent adolescents jumping off the upper story. BAC had the substantial benefit of being a ground floor unit, where doors to the outside were unlocked most of the time. An open ground floor environment gave a sense of external freedom and was likely to promote more cooperation between the staff and the adolescents. As explained above, these features are evident in most of the inpatient units I visited in the United Kingdom and Switzerland and were key in the selection criteria for an alternative site.

84. Beside the school and office building, an extensive kitchen garden had been cultivated and money was provided to build a garden kitchen and dining area. Apart from being utilised in school programs and rehabilitation activities, it often supplied some of the produce for the cooking groups. Some adolescents found it quite calming to walk in the garden when they were agitated.

85. The school involved adolescents in an active landscaping program, which for some was a rehabilitation activity. The adolescents built outdoor gardens, benches and tables. Another outdoor space incorporated a pergola, and had room for a trampoline and outdoor seating. Adolescents frequently used these outdoor areas to regulate their mood.

86. At the end of the ward and on the other side of the school, was a grassed area. This accommodated school physical education lessons as well as outdoor activities for the adolescents in the evening e.g. games of soccer.

87. The residential building consisted of two wings containing the bedrooms and other rooms. These wings were connected to a central community area which contained the kitchen, dining area and recreational spaces. One wing had two four-bed dormitory bedrooms, two single rooms, a communal bathroom, an office, a quiet room, and a small high dependency area with an ensuite. It could sleep up to 10 adolescents of one gender. The second wing had one four-bed dormitory bedroom, two single bedrooms, a communal bathroom, an art room, a meetings room, an art therapy space, and a sensory room. It could sleep up to 6 adolescents of one gender. Sleeping arrangements were such that the genders were separated by the communal area. Which wing would accommodate which gender would depend on the relative number of admissions of each gender.

88. BAC was not a purpose built building. In spite of this, there were some aspects to it which worked well. These included the facts that it was a single storey construction with open access to the outside; open spaces surrounding the building; grounds available for recreational purposes and exercise, and there were multiple communal spaces where adolescents could mix. For adolescents who were socially isolated prior to admission, this environment gave the opportunity for those adolescents to connect with other adolescents

in a safe closed environment. This enabled them to learn skills to connect socially with the broader community again.

89. Having said this, there were multiple problems with the building. These were identified in reports from Queensland Health. Throughout the 2000s surveyors of the Australian Council of Healthcare Standards (**ACHS**) reported not only on remedial deficits such as hanging points or glass which could be smashed, but generally on the poor state of the buildings.

90. I considered two aspects of the building were particularly detrimental to the progress of the adolescents. These were the four-bed dormitories and the communal bathrooms.

91. Issues for adolescents in the four-bed dormitories included a lack of privacy, an inability to secure personal belongings such as diaries, being subjected to bullying by other adolescents who were accommodated in the same dormitory, an inability to accommodate individual sleeping patterns and being disturbed at night by other adolescents in the dormitory who may have been experiencing nightmares or flashbacks. At times these issues could become so difficult that they impeded therapeutic progress for several months.

92. The issues for the adolescents with the communal bathrooms included a lack of privacy, being distressed poor hygienic practices of other adolescents or the smell of vomit of an adolescent with bulimia with whom that were sharing the bathroom. These difficulties could escalate peer tensions and impede the progress of particular adolescents in the unit.

93. Further, the location of BAC within the grounds of Wolston Park, which was later known as The Park - Centre for Mental Health, was never ideal. There were always adult patients on site with a forensic history, although no adverse interactions with adolescents occurred.

Referral and admission

94. Throughout the period from 1983 until 2013 all adolescents were assessed prior to admission to BAC. Only planned and not emergency admissions were accepted. Admission occurred only after all community treatment had been exhausted

95. The guidelines for admission to BAC were originally defined in 2003, consequential upon a recommendation in a review of BAC led by Associate Professor Brett McDermott. After discussion and review by interested parties, those guidelines were accepted in 2004.

96. The admission criteria was developed to reflect both current practice and a determination of what could be managed in the community and in other settings. They were incorporated as admission criteria into a 2010 version of the ATERC Model of Service Delivery (**AETRC MOSD**). This document was endorsed by the SW CYMHS AG and by the Statewide Mental Health Advisory Group and accepted by the Director of the MHAODD Directorate. The reason for revision of the AETRC MOSD document was that the wording of the Child and Adolescent Day Program MOSD needed to be revised to reflect clinical practice and this was the opportunity for consistent wording across both MOSD documents in circumstances where there were strong similarities in the programs. The revision of the

ATERC MOSD was undertaken in consultation with senior staff of day treatment programs in the State and also with staff of the MHAODD Branch. The plan was that the 2010 version of the AETRC MOSD would be submitted to the SW CYMHS AG in June 2012. However that advisory group was disbanded prior to this time.

97. BAC accepted referrals from clinicians in the community, acute inpatient and day program CYMHS, after consultation with a psychiatrist and from child and adolescent psychiatrists in private practice. Referrals from other sources were not accepted, nor were referrals where the adolescent was outside the 13 -17 years age bracket.

98. Referrals were initially made to the Community Liaison Clinical Nurse (**CLCN**). This nurse was responsible for obtaining detailed information from the referrer regarding the particular adolescent. The CLCN then discussed the referral with me to determine the suitability of the referral. If it was considered that the referral may have been suitable, the relevant information was then taken to a meeting of the multidisciplinary team, which was usually the Case Conference. If potential suitability was unclear, either the CLCN or I would review any further information in detail.

99. If suitability of the referral was confirmed at the multidisciplinary team meeting, the parents or carers of the adolescent were contacted. A time was made to meet with them and the adolescent. For those from regional areas, this initial meeting was via video conference. If the referral appeared to be straightforward, the CLCN and one of the allied health staff or the medical registrar would conduct the interview. For more complex cases, I would be present at the initial meeting in the place of the allied health staff. The purposes of this meeting were to obtain a more detailed in person assessment with a view to gauging how an adolescent might adapt or affect a particular mix of adolescents and to enable the adolescents and carers to meet staff and to ask questions. This meeting also facilitated an assessment as to an adolescent's willingness to be admitted. The approach was to work collaboratively with the adolescent from the start.

100. At this initial meeting, we usually met with the adolescent initially to ascertain how they perceived their challenges. We asked questions directed at gaining an understanding of their lifestyle, including school, social and community networks. We then met with the parents or carers, followed by a joint meeting with the parents/carers and the adolescent to discuss a plan and the potential benefits of being admitted to BAC, as well as some of the potential challenges. If they were visiting in person, they were also given an opportunity to look over the centre.

101. When adolescents were interviewed via video conference, they were often accompanied by the referring clinician. I found this helped to make the adolescent feel more comfortable. The clinician may or may not have been in the room when the parent was interviewed. For some adolescents with severe social anxiety who could not come to the unit for an interview, the process included six to eight weeks of progressive exposure to desensitise them to the community outside their house, until they could travel to BAC.

102. There were occasions when an adolescent or their parents/carers declined the services of BAC. In these cases the referring service would continue to manage them in the

community, but emphasise the limitations of the community based service. If it was not possible to engage an adolescent in this initial meeting but a community CYMHS was concerned about the severity of an adolescent's mental illness, there was the potential option for the adolescent to be regulated under an Involuntary Treatment Order pursuant to the *Mental Health Act 2000* (Qld). This was uncommon.

103. Adolescents with histories of recurrent suicide attempts and self-harm, often in the context of complex trauma, usually regarded admission to BAC as their "last hope". Adolescents with an eating disorder usually accepted that treatment at BAC was an alternate program to the acute inpatient units, but were often resistant to changing their eating behaviours. Adolescents with severe anxiety disorders, were either reluctant to or resisted admission, but realised they had a limited future in the absence of such assistance.

104. After the initial multi-disciplinary meeting and the meeting with the parents/carers and adolescents, the case would then be discussed by the intake panel which consisted of:

(a) the CLCN who was aware of all referring details;

(b) the NUM who was aware of the mix of nursing experience over the coming months if the adolescent's behaviour posed any particular challenges which may need to be taken into account;

(c) an allied health member who was familiar with the current demands on allied health capacity;

(d) the principal of the School who could gather any further educational information if consent had been obtained, and could assess the capacity of the school to manage and accommodate the adolescent; and

(e) myself as the psychiatrist as I had overall responsibility for clinical decision making.

105. In making the decision as to whether to accept the admission of an adolescent, the intake panel took the following matters into account:

(a) the adequacy and availability of community treatment with a view to assessing the likelihood of therapeutic gains by attending BAC;

(b) the likelihood of the adolescent experiencing a positive therapeutic outcome;

(c) the potential for treatment at BAC to assist with developmental progression;

(d) the potential adverse impacts on the adolescent being admitted to the BAC;

(e) the potential adverse impacts posed by the admission of the adolescent on other inpatients and staff;

(f) the potential adverse interactions with other adolescents; and

(g) the possible safety issues.

106. If the decision of the intake panel was to accept an adolescent, a determination then had to be made as to whether the adolescent should be admitted as an inpatient or a day patient. Suitability for admission as a day patient required considerations of whether the adolescent would be safe at home in the evenings, whether attendance at the day program was in the adolescent's best interests, where the adolescent was residing including access to regular transport to BAC and the likely motivation of the adolescent in attending BAC on a daily basis.

107. Some adolescents were only admitted to BAC as day patients while others became day patients after a period of inpatient admission, providing that their mental health was sufficiently stable and the abovementioned considerations lent themselves to day patient attendance.

Model of interventions, treatment and rehabilitation at BAC

108. BAC was a community of adolescents where treatment and rehabilitation was provided in this context. This community environment was one of the strengths of the program. It provided an environment of a small group of adolescents who had in common, difficulties with some type of mental illness. It allowed the anxious adolescent to desensitise to peers, it facilitated interactions between adolescents, it fostered cooperation and learning experiences and it provided exposure to a range of experiences for the adolescents to promote their development and wellness.

109. Addressing the individual issues of the adolescents within this community environment enabled the adolescents to learn a set of skills about peer relationships, including respect for others, acceptable styles of communication, consideration for others and setting boundaries in their interactions with others. These skills were transferrable to the school and the residential environments. During the day, both inpatients and day patients interacted together, and depending on the level of social integration they required, day patients were sometimes offered the opportunity to remain at BAC until after dinner. However they were not allowed in the inpatient sleeping areas. The adolescents were generally allowed visitors when designated programs were not running. For younger adolescents, visitors were approved by parents/carers. With older adolescents, approval for visitors outside of family, sometimes involved a negotiation process between the adolescent and the parent/carer to protect the interests of the safety and well-being of the adolescent.

110. As part of their daily routine, the adolescent was required to tidy their area, assist with the breakfast tidying up and prepare themselves for school. The expectation was that they would attend school and other programs that were running unless they were involved in the transition program, or there was some other particular reason why they could not attend, for example if attendance at school could place their safety at risk. The school program was individually tailored to minimise anxiety for any particular adolescent.

Attendance at school was effective in reducing anxiety induced avoidance behaviours. In addition to school, various groups and programs ran throughout the day and sometimes into the evening. One such program was the cooking group which attended a restaurant each term to familiarise the adolescents with eating out. Afternoon activities after school were often unstructured, because this is typical of adolescent leisure time. These activities ranged from listening to or playing music, playing Xbox, relaxing on the trampoline, watching television, playing table tennis or pool or simply talking with other adolescents or with staff. There were occasions where nursing staff organised a more structured leisure activity, such as a game of soccer to reduce the risk of adverse incidents which were more likely to occur during unstructured times.

111. There were rules at BAC. Some of these were absolute, such as no smoking as it was a Queensland Health property. Other rules were framed within the broad principles of "respect yourself, respect others, respect your property, and respect other people's property". Because of the four-bed dormitories, there was a rule about lights out, but we endeavoured to provide some flexibility if a distressed adolescent had a single room and needed to occupy themselves prior to going to sleep. Other adolescents came in with an established pattern of sleep reversal – they were awake at night and slept during the day. This rule enabled them to accept a normalised sleep pattern.

112. Many adolescents at BAC were at risk of self-harming or attempting suicide. Other adolescents could be exposed to such behaviours either through a Code Black being called during an incident, . Further, adolescents identified to be at an increased risk were placed on increased and sometimes continuous observations. This not only reduced the opportunities to self-harm, but also afforded the opportunity for the adolescent to talk about their distress to nursing staff rather than to act on it. Following an incident of self-harm, there were a range of interventions available. One such intervention was encouraging the adolescent to complete a questionnaire, which often provided some insight as to the reasons for the self-harm behaviours. In periods of crisis, other adolescents were offered support and the opportunity to debrief. Incidents of self-harm were more likely to occur when there were increased numbers of non-permanent nursing staff, or significant staff changes to BAC.

113. There is little literature and research based evidence on models of intervention, treatment and rehabilitation for this sub-population of adolescents. Key principles of recovery in adult mental health have been enunciated particularly during the last decade. I maintained a literature search on the topic of recovery in mental illness from approximately 2002.

114. At BAC we synthesised available evidence from the literature and conferences we attended with what we were observing about recovery and feedback from former and current adolescents. These observations helped us to develop both a treatment and rehabilitation program and to guide the transition process.

115. On admission to BAC, adolescents were given a comprehensive range of assessments (if they had not been given them recently prior to admission). Each discipline had a range of

assessment and observational skills and conducted an initial interview as an integral part of the assessment, before commencing discipline specific assessments. These assessments were used to enable a complete formulation and identification of the issues and to develop a management plan. A list of the evaluations and interventions is exhibited and marked '**D**' to this statement

116. There were essentially the following three categories of interventions provided at BAC:

    (a) Interventions Specific to a Disorder;

    (b) Treatment Interventions across Disorders; and

    (c) Rehabilitation Interventions to Address Impairments across Disorders

117. Treatment involved using direct applications, adaptations and modifications of recognised pharmacological, family and psychological interventions which included both verbal and non-verbal therapies.

118. Based on our observations of the applications of evidence based treatments (where they existed), adaptations and modifications were often necessary for a number of reasons. In a research setting of a single disorder, treatment continues in a linear and uninterrupted fashion until there is significant symptom resolution. While the research literature reports on people who dropped out of treatment completely, it rarely reports on the number of missed sessions. Our observations of breaks in therapy probably equated to missed sessions in the community. The adaptations necessary with the adolescents who were at BAC included:

    (a) treating one of the co-morbid disorders to a certain stage before treatment of another disorder could commence;

    (b) allowing progress in a developmental task to be consolidated before individual treatment could continue;

    (c) timing individual therapy and family therapy according to the issues raised and the adolescent's capacity to participate in family therapy; and

    (d) interrupting more formal therapy for a particular disorder to explore the current emotions around the dynamics of BAC.

119. One example of a modification of an evidence based treatment intervention for adolescents at BAC related to the use of Dialectical Behaviour Therapy (**DBT**) to treat Borderline Personality Disorder (**BPD**). DBT provides a range of skills which could be useful in a number of disorders. However the psychologist at BAC observed that adolescents rarely tolerated the evidence based approach for DBT. For this reason, the essential components of DBT were delivered by a group program to all adolescents and the application of these was then reinforced in discussion and individual therapy and by nursing staff on the ward.

120. Another example of the need to modify evidence based treatment intervention for adolescents at BAC related to the use of Family Based Therapy (**FBT**) to treat anorexia

nervosa. Parents of adolescents with anorexia nervosa in the community provide feedback as to how stressful this approach can be. It was identified that adolescents who were referred to BAC for treatment of persisting anorexia nervosa, typically had lower ideal body weights than those receiving treatment using FBT in community or acute inpatient settings. For a variety of reasons, FBT proved not to be successful in treating these adolescents at BAC with this condition. Instead a ward based approach was implemented at BAC where nursing staff rather than parents encouraged an adolescent to eat.

121. A rehabilitation model was integral to BAC from its establishment. Rehabilitation of adolescents with severe and complex mental illness is complex. While I was working at BAC there was unfortunately little literature on this topic. For this reason I researched and used literature relevant to paediatric rehabilitation to guide me in developing a rehabilitation model for adolescents. This model refined the original rehabilitation concepts and associated interventions. The interventions in this model were also based on observations over the years of what appeared to be effective, together with feedback from adolescents after they left BAC as to what they had found useful in their recovery.

122. The rehabilitation interventions included adapting the school program, supporting transition into an external school and participating in group activities such as community access, the cooking group and the social skills group. The unstructured activities during the evenings and on weekends also provided opportunities to develop peer relationships and explore a range of activities to occupy leisure time and to facilitate appropriate social interactions.

123. Once I had developed this rehabilitation model, I presented a number of papers on it at a range of events. These included at local conferences and the quarterly Ground Rounds of child and adolescent psychiatrists. I also presented it at two workshops in 2005 and 2009 to CYMHS clinicians, at a two day workshops in Townsville attended by day program clinicians, at a workshop in Cairns to Evolve Therapeutic Services clinicians, and at a one day workshop in Toowoomba to day program clinicians. The feedback from external sources about the model was generally positive.

124. The occupational therapists at BAC and teachers of the BAC School were pivotal in assessing individual adolescents and developing specific rehabilitation plans for implementation by all staff. They provided individualised rehabilitation activities which could be used by other staff, as well as identifying and implementing multiple transitional activities to reintegrate an adolescent within a community. Both the occupational therapists and the teaching staff developed programs to enhance the skills of the adolescents, developed physical activity programs (recently recognised as an essential intervention in young people with serious mental illness).

125. The occupational therapist also developed the sensory room, and trained staff in its use. BAC was at the forefront of using the sensory room as a form of intervention within The Park and CYMHS inpatient units in Brisbane. The occupational therapists developed, organised and facilitated the adventure therapy intervention program. Through feedback, adolescents identified all of these as key experiences in their recovery.

126. Two of the concepts that the adult literature in rehabilitation or recovery does not adequately capture, are "regaining identity" and "empowerment". These concepts are extremely important in the recovery of an adolescent with serious mental health issues. Regaining identity is a key developmental task of adolescence and empowerment is part of the process of adolescent emancipation.

127. Interventions which may help to consolidate identity which were used at BAC ranged from individual therapy, to the re-evaluation of their perception of family relationships, through to activities which helped the adolescent engage with the broader community including peers, and facilitating progress in educational and developmental goals.

128. Admission to the BAC had complex effects on empowerment. On the one hand, there were increasing restrictions due to communal living. On the other hand, there were processes to ensure the adolescents had a say in their environment. For example, a member of the Business Unit Management represented the adolescents and would present their concerns to the leadership group of BAC at the meetings.

129. Other processes facilitating empowerment included progress in education, financial planning and management, developing skills for independent living and being engaged in a range of activities within the community. Initially this was part of the directions of the rehabilitation program and involved BAC staff. However, with time and the implementation of the Care Planning Workup, we liaised with external clinicians and agencies to determine if some of these tasks facilitating empowerment, with their assistance, could be extended into the community.

130. Obviously empowerment was integral to the process for transition. However it was such a continuing process from the time of admission that it merged imperceptibly into transition, again making identification of a point of transition difficult. At times transition would occur at a relatively rapid pace (e.g. over a month) whereas at other times it would take several months.

131. In some cases, a more nurturing and personal type of care was required. Some adolescents complained of a lack of care because of no or minimal visits from a parent during their admission. Other adolescents reported that their needs had not been met in childhood because of an issue such as substance abuse. Whilst this more personal style of care facilitated both treatment and rehabilitation, there was a need to guard against the adolescent becoming dependent on such care. Ultimately the adolescent would either be discharged back to the care of the family or to semi-independent or independent living.

132. The way in which BAC sought to transition adolescents from therapeutic levels of care to being able to tolerate semi-independence, was analogous to the "Circle of Security" program used in toddlers. Whilst this has a medium level of evidence base in toddlers, its application to adolescents has not been substantiated. However I attended a workshop by Dr Simon Wilkinson of Oslo, Norway at the Cambridge Faculty of Child and Adolescent Psychiatrists conference in 2011. He ran an inpatient unit there and observed the role of attachment in staff-adolescent interactions within the unit. Whilst not referring specifically to the Circle of Security program his observations were similar. This program encourages

parents to encourage their child to appropriately explore the environment while providing a secure base to which the child could return.

133. The effectiveness of the treatments provided to adolescents at BAC depended on staff resources and the experience and permanency of the staff. The loss of the second occupational therapist in July or August 2013 compromised all rehabilitation and transition interventions. There were also periods of time in the previous two years when one of the occupational therapists was on extended leave and there was no replacement.

134. Further, the ratio of nursing staff to adolescents, varied over the 10 years prior to closure. BAC required six nursing staff on day and evening shifts during the week – an equivalent ratio to the Walker Unit in Sydney.

135. Another issue affecting the efficiency of treatment was the rostering of sufficient skilled nursing staff that knew the adolescents well and could provide consistency in the management of the adolescents. Knowing the adolescents well enabled nursing staff to recognise early warning signs of distress and to build rapport with the adolescents, which was essential for effective treatment. This practice is consistent with the standard for inpatient units published by QNIC. While the QNIC Standards are neither recognised in Queensland, nor are they part of the National Mental Health Standards, they are the only standards of which I am aware that apply specifically to child and adolescent inpatient units.

136. Up until 2011, the average length of stay for adolescents at BAC was about nine months. The optimal time for an adolescent in an inpatient unit such as BAC is difficult to say, as there are many variables. Having said this, I believe that the length of stays for adolescents at BAC had the potential to be protracted for the following reasons:

    (a) Staffing stability (particularly nursing staff) was a significant issue which contributed to increased length of stays. Non-permanent or unsuitable staff could not provide adequate therapeutic counselling to distressed adolescents, they often applied more restrictive practices (e.g. seclusion), and would place adolescents on behavioural programs which could aggravate them. They were also often not skilled in monitoring and managing peer interactions. With stability in the team and a focus solely on treatment and rehabilitation, more focus could be given to tailoring interventions and integrating the adolescents.

    (b) Accommodating adolescents in a four-bed dormitory contributed to poor peer relationships. Periods of managing negative peer interactions generally resulted in a moratorium of the therapeutic and rehabilitation benefits of other interventions.

    (c) The lack of step-down accommodation contributed to increased length of stay for those adolescents who were unable to return to their home.

    (d) Family therapy was perhaps our weakest intervention for a variety of reasons. These include difficulties in engaging some families in therapy and resistance of an adolescent to engage in family therapy. The benefits of more active family therapy

interventions around the time of discharge would have resulted in more therapeutic assistance, rather than simply maintaining contact with the family and the local community.

(e) The BAC had a lack of consistent staff with skills in art, music, sandplay and family therapy. When this skill set was available and integrated into the program at BAC, positive gains were made.

137. One of the questions raised in the draft statement prepared by Commission staff is whether pressure was applied by administrators for BAC to be more efficient or to deliver better outcomes. I cannot recall this occurring. On occasions I wrote letters or emails to administrators raising concerns about staffing levels but I usually received no response. The school at BAC obtained funding in about 2011 to cover the cost of a modular home, which could have been a step-down unit for the adolescents. The importance of having this in reducing length of stay was discussed with the relevant administrators at the time. However this proposal was ultimately not accepted. Another of the questions raised in the draft statement prepared by Commission staff is whether the West Moreton HHS applied key performance indicators to demonstrate that services at BAC were efficient. I am not aware of this having occurred, apart from with respect to the rates of seclusion. This task would have been difficult given that there was no known equivalent unit with which to benchmark the services of BAC as against.

138. In November 2013, the Federal Government released a publication entitled *National Framework for Recovery Oriented Mental Health Services*. Although it was released after I had finished at BAC, I refer to it because it encapsulates key principles which we had identified as being important to the service over the previous decade.

Transitioning back into the community

139. Transition is the time leading up to discharge. From the time of admission, the objective was to transition BAC adolescents back into the community if possible. There was and could be no set time frame for this transition. Such a course needed to be considered in the context of the individual needs and the circumstance of each BAC adolescent.

140. Since at least 2002, adolescents who turned 18 years of age while they were receiving mental health treatment at BAC, were permitted to continue receiving the treatment and were not automatically transitioned to an Adult Mental Health Service (**AMHS**). This was formally recognised in both the 2010 and 2012 AETRC MOSD. The criteria for the adolescent remaining at BAC was that continued admission was likely to produce the greatest clinical outcome, in terms of symptom reduction and developmental progression and that continued admission did not pose a risk to the safety of other adolescents.

141. While the National Mental Health Standards 2010 and the QNIC standards have criteria for discharge, they do not have criteria for transition. From my review of the literature in relation to child and adolescent inpatient units and residential facilities, the references to transition are limited to the context of residential facilities, which generally accommodate

young people in the care of the State without the same level of severity or complexity of mental illness as seen in the adolescents at BAC.

142. Although there was no formal documentation about the transition process at BAC, the processes involved:

(a) being satisfied that the adolescent was ready to transfer a skill from BAC into the community e.g. going to school, going to part-time work;

(b) exploring practical details of how this may be accomplished;

(c) ascertaining the level of support that the adolescent would need to accomplish this phase of the transition;

(d) monitoring the progress of the transition;

(e) monitoring safety and impacts on the mental health and developmental tasks of the adolescent;

(f) monitoring any unanticipated obstacles to the transition;

(g) providing opportunities for the adolescent to explore difficulties, with either the care coordinator or in individual therapy; and

(h) exploring further transitional activities.

143. Transition could involve multiple processes – integration into a school; integration into a TAFE or other educational setting; finding part-time or full-time work; accessing either school or work independently; establishing more independent routines within the family home if they could return home; finding alternative accommodation if they were unable to return home; developing skills to live independently; linking with social or sporting groups in the community or other organisations; linking to an external clinician for ongoing care and negotiating care arrangements with local service providers. Throughout this process there continued to be ongoing involvement with BAC – either at the school, with therapists or partial hospitalisation. There was no set order to this transition process. Once the adolescent appeared capable of functioning in an area of their life, and arrangements could be made, BAC would then transition them into that particular activity.

144. The planning and implementation phases of transition were often interlinked processes which were initiated and monitored in the Case Conference and/or the Care Planning Workup. My role as chair of these meetings and as the consultant psychiatrist was to ensure that all available information about the adolescent's mental state and progress was integrated into the decision making for the next phase of transition. This required a long term perspective of any previous difficulties the adolescent may have faced and the likelihood of these difficulties being repeated in further transition arrangements.

145. The relevant transition principles are documented in the AETRC Draft MOSD under section 3.4 – Clinical Review. Section 3.4.1 was relevant to Case Conferences and Section 3.4.3 was relevant to the Care Planning Workup. Elements of transition planning are also

incorporated in Section 3.5.1 – 3.5.5, Section 3.9 – Transfer/transition of care and Section 3.10 – Discharge/external transition of care. These sections obviously do not capture the nuances of clinical decision making.

146. Linkage with the external agencies was absolutely vital to the Care Planning Workup. With the permission of the adolescent, BAC linked not only with the Community CYMHS or private psychiatrist and/or psychologist (whom I will refer to collectively as the local mental health provider) who would provide for their care in the community, but it also linked with other relevant agencies, such as the Department of Communities, Child Safety and Disability Services. Further, staff from BAC School liaised directly with a local school which may be involved in the transition and would provide this information to the Care Planning Workup. The local mental health provider and other agencies knew the services that were available in the local area where the adolescent was to be transitioned to and BAC sought their advice as to what local services could manage in assisting the adolescent to transition at any stage. If a local service was unable to meet the needs of the adolescent at any stage in the transition process, BAC would resume providing the service while the situation was rectified or an alternative service provider was arranged.

147. If an adolescent in BAC had turned 18 years of age, had shown minimal improvements following the treatment received at BAC and were likely to experience long term mental health problems, transitions was made to an appropriate AMHS. This would be explained to the adolescent and a clinician from the appropriate AHMS would be invited to the Care Planning Workup so that arrangements could be made for the transition to occur. If the adolescent was to be transferred to a community service of the AMHS, the phase of crossover engagement with the AMHS was usually over a period of two months or more. In the meantime BAC continued other phases of supporting the adolescent transitioning to the community.

148. On two occasions I recall that adolescents were required to transition to an Adult Community Care Unit (**CCU**). This was a much more lengthy process because of the demands on beds in a CCU. There could be some process of limited leave to the CCU prior to discharge.

149. Discharge from BAC could occur in a number of ways. Some adolescents would be discharged as a full or partial inpatient to that of a day patient, but this was more often regarded as a transition, particularly if the adolescents were accessing all other levels of the service. Most commonly, the adolescents were discharged when they could access community services without support from BAC and their ongoing clinical care was transferred to another service provider. On very rare occasions, an adolescent could be discharged as either an inpatient or a day patient, but continue as an outpatient at BAC.

150. Transition to the community was only considered if there appeared to be sufficient stability in the acuity and severity of presenting symptoms for management in the community without either danger to life or repeated acute hospital presentations. However the mental state of some adolescents appeared stable for a time while they were given partial leave to transition, but then subsequently deteriorated.

151. Rehabilitation programs laid a foundation for transition. For each adolescent, rehabilitation programs were integral to future transition.

152. From a rehabilitation perspective, transition was a process which had its foundations in many activities which prepared an adolescent for the community. It was a continual monitoring of stages of treatment, stability of symptoms, and progress in developmental tasks. In a similar way the point at which BAC ceased to have contact with the young person was quite variable.

153. The inpatient adolescent who required supported accommodation on discharge was often complex to transition because they would be living without family and there were often difficulties in finding adequate supported accommodation. BAC facilitated the transition for each adolescent individually. The aim was to gradually build independence. Throughout this process, each adolescent was supported in their integration into the community and the linking with other service providers who were already involved through the Care Planning Workup. The process would start by providing the adolescent with longer periods of leave, then reducing their inpatient treatment to partial hospitalisation, until the adolescent could be confidently accommodated in the day program attendance. Some adolescents would transition to outpatient care, to ultimately only having contact with BAC by telephoning or dropping in whenever necessary.

154. The capacity of BAC to affect the timing and quality of transition depended on staffing availability and stability, peer relationships on the unit and the level of acuity among adolescents, including those who required high levels of care.

155. There was no formal follow-up of adolescents once they were discharged from BAC. There were simply inadequate resources for this to occur. However, BAC staff did have ad hoc contact with many adolescents subsequent to discharge. This occurred when the adolescent contacted the staff member to let them know how they were going, or when the adolescent rang BAC to seek advice about further treatment options, or if the adolescent had social contact with another adolescent who was still receiving treatment at BAC. Further, on occasions, referrers provided feedback about particular adolescents who had been at BAC.

Evidence based practice – the concept

156. The dominant use of the term Evidence Based Practice (**EBP**) refers to the applications of Evidence Based Treatments (**EBT**) in practice where a treatment intervention is applied to a number of individuals. Evidence Based Treatments are rated as to whether they were conducted as an open trial without a control group – (the lowest level of evidence) or a randomised control trial (**RCT**) – the highest level of evidence. While some authors use the terms interchangeably to imply that EBT can always be translated into practice, they cannot. Further information in relation to this complex issue can be provided if required.

157. Since 2010, authors who in the previous decade assumed that EBT equated to EBP have begun to examine the complexity of translation of EBT into practice. A comprehensive review article and a clinical trial of EBT in a clinical rather than in a research population

has now been published (a copy of which is exhibited and marked '**E**' to this statement). The review found that the effect size for an EBT in a clinical population was insignificant (research includes young people with a sub-clinical disorder) and therapies that originated in the USA lost some of their effect size when translated to Europe or Australia. The second paper exhibited and marked '**F**' to this statement documents the implementation of an EBT to a clinical setting. In this setting, the evidenced based interventions showed a non-significant effect.

158. There is ongoing research into why the inter-relationship between EBT and EBP may be more complex than originally assumed. A range factors which affect translation of EBT into practice have been identified, including co-morbidity in the adolescent, a range of family factors and clinician judgment.

159. A smaller body of research literature describes a planned intervention for an individual – case studies, single-subject research designs and the n equals 1 randomised trial. This relates to the concept of single case study design. The literature relevant to rehabilitation is more likely to incorporate this approach. It is also a useful approach to those individuals who have not responded to the interventions described in EBTs.

160. Both large EBTs and single case study design are from the clinician's perspective. The Recovery movement, which is explained further below, also incorporates evidence from consumers and carers. It is not clear as to how evidence from these sources is incorporated into EBP. I shall provide examples of how we incorporated evidence from adolescents into programs at BAC.

161. Elements of evidence consistent with the recovery perspective are in an emerging literature. They involve the need to continuously monitor feedback from a young person in therapy as to the issues that are affecting them. This literature is driven by strong proponents of EBT derived from RCTs. Professor Len Bickman, who visited BAC in 2010, and whose comments I shall refer to later, developed and evaluated an intervention of Continuous Feedback Monitoring. This involves adolescents providing feedback on the value of a therapy session.

162. The strands of practice which need to be incorporated into EBP are consistent with the Sicily Statement on Evidenced Based Practice. This primarily considered EBP in physical medicine. The term "evidence based medicine" first arose in the 1990s, and was taken up by other areas of health in various ways. A conference of medical educators met in Sicily in 2003 to define the concept to incorporate it into medical education.

163. The Sicily Statement on Evidence Based Practice supports the following five step process for evidence based practice:

    (a) translation of uncertainty to an answerable question (i.e., making a clinical observation about a patient's progress, and defining a term by which that observation may be researched);

(b) systematic retrieval of the best available evidence; (i.e. doing literature searches, or a search of the Cochrane database for useful interventions applicable to this observation);

(c) critical appraisal of evidence for its validity, clinical relevance and applicability; (e.g. checking the age range of the population, whether it is discussing the same sub-population one is seeing in terms of severity, whether there are exclusion criteria in the EBT which may affect results in the population one is seeing);

(d) application of the results in practice (practical limitations e.g. therapist training, usefulness to the population, adaptations which need to be made);

(e) evaluation of performance (the outcomes of the intervention for single or multiple adolescents – what worked and what did not).

Evidence based practice – application at BAC

164. There were multiple factors to consider when critically appraising research and other evidence based tools for their validity, clinical relevance and applicability to the sub-population of BAC adolescents. This is in circumstances where these adolescents who presented with persistent, severe and complex disorders (in terms of co-morbidities and family functioning) with impairment, had already not responded to the more straight forward evidence based treatments. Adolescents required the tools to be adapted to their individual needs.

165. I was committed to educating myself regarding the best evidence based approaches as they could be applied to BAC adolescents. Research in this area is an ongoing process. Other staff at BAC, particularly allied health were also very committed to maintaining currency with trends in the treatment of various disorders. External supervision by professionals external to BAC provided valuable opportunities to seek input when difficulties arose with the implementation of an EBT as it related to a particular adolescent. Long established nursing staff at BAC were trained within the hospital. This generated an emphasis on practical nursing procedures. Some sought specific ongoing education in particular areas. More recent nurses graduated from university, some were enrolled in Masters courses. This brought a greater focus on research and seeking an evidence base for practice. Examples of dissemination of such information were the provision of formal feedback following attendance at a conference and the sharing of information at Case Conferences or the Care Planning Workups. These forums provided an opportunity for the presenter's critical evaluation of the intervention, and for discussion of potential application and relevance to BAC adolescents. Further, my literature searches were made available to staff online.

166. One of the principal limitations in the application of EBTs to BAC is that EBTs are based in community settings. The inpatient and day patient settings at BAC had the three following important and valuable distinctions and advantages insofar as the development of EBP:

(a) they provided for comprehensive observations of the adolescent's functioning across a number of settings throughout the week, including the effectiveness of various interventions being implemented;

(b) there was often first-hand knowledge of events which may be highly significant to the adolescent which may have been impacting on their mood, their behaviours or the effectiveness of the treatment; and

(c) there were opportunities for multiple and regular ideally integrated interventions.

167. The abovementioned distinct advantages informed BAC's approach to implementing EBP as follows:

(a) elements of an EBT which may have been applicable to adolescents with a range of disorders were incorporated into various aspects of both the rehabilitation program and treatment regime;

(b) elements of an EBT which may have been of benefit to other disorders were incorporated into the treatment program, with the effectiveness being evaluated over time;

(c) elements common to several EBTs could be extracted and incorporated into treatment or programs;

(d) staff could work with the adolescent on those issues which were of highest priority to them;

(e) the nature of the setting at BAC permitted the development of hypotheses as to when a certain EBT may be becoming limited, versus when the adolescent may experience a moratorium in one area of treatment or rehabilitation, but progress in other areas;

(f) multiple elements of a range of EBTs could occur in a week in an individualised manner; and

(g) therapists could be flexible to the responses of the adolescent with respect to the delivery of an intervention.

168. The above demonstrates that EBP in the BAC environment was complex with multiple interventions and modifications of interventions for therapeutic progress. There are many examples which illustrate how EBTs would be adapted at BAC in an endeavour to achieve the best outcome for the adolescent. Below are but a few examples.

169. Anxiety was common to many adolescents at BAC, whether as a formal diagnosis, or present at sub-clinical levels. The interventions with greatest efficacy for anxiety are exposure, relaxation, cognitive therapy, modelling, psycho education and therapist praise and rewards (this analysis includes interventions for both children and adolescents).

170. An adolescent with severe social anxiety began exposure immediately on entering BAC. For the first time in 12 months the adolescent may have face to face contact with another

adolescent. Many reported that this initial exposure, whilst difficult, was tolerable because they knew the other adolescents had problems and got to know them over time. Exposure was repeated time and again in the various situations within BAC – sitting in a small classroom, sitting at the dining table, sitting on a couch watching television. The adolescents were taken on group community outings. For example an adolescent who did not have the confidence to buy a meal was encouraged over time to ask for what they wanted. This is an example of the multiple applications of an EBT approach in practice. The literature does not describe the intensity of interventions necessary for change, but there are no modifications in this instance to the treatment.

171. EBP for anxiety at the BAC comprised multiple medium to high level evidence based treatments in a range of targeted interventions. These were then generalised into the everyday activities at BAC.

172. DBT is a treatment for BPD with a medium level of evidence base for that disorder. Its use has been extended to a wider range of conditions. Among its elements, it utilises a variety of standard psychological interventions which have been developed since the 1970s. One of the locum psychologists at the BAC was trained in DBT. She encountered difficulties in utilising DBT with the sub-population of adolescents at the BAC, especially those with Complex PTSD. Through a process of trials of adapting the elements of various EBTs in a number of ways outside those in the DBT manual, the psychologist and her colleagues implemented a program specifically tailored to BAC adolescents. Some adolescents were able to utilise the strategies immediately, others were at a certain point in recovery before they utilised them. Issues raised by the adolescent in a group environment could be discussed later in an individual therapy session, and the principles generalised to day to day experiences with the assistance of BAC staff.

173. In a similar way, EBTs for trauma focussed Cognitive Behavioural Therapy (**CBT**), involve working through a number of stages to resolution of the trauma, and then consolidating other gains. The psychologists at BAC who also worked in the private setting, found this was effective for the private patients but did not provide a clear, sequential process for adolescents at BAC. For example, one or two sessions focussing on trauma may then have been interrupted by a session around difficulties in the family or with peers, which was considered necessary in light of the adolescent's current circumstances. There would be other occasions where trauma focussed sessions would be interrupted to explore other issues which were impacting on the willingness or ability of the adolescent to address the trauma related issue, particularly where it was intensely distressing. Ongoing treatment of the adolescent would be guided by feedback from the multiple and ongoing observations of the adolescent.

174. There were no clear guidelines with respect to EBP for adolescents with severe and persisting anorexia nervosa. BAC incorporated RANZCP guidelines for the management of anorexia nervosa but these had their limitations in the applicability to the sub-population of such adolescents treated for this condition at BAC. For example, for over a decade inpatient admission in acute adolescents units for anorexia in Brisbane relied heavily on

nasogastric feeding. Experience at BAC taught us that many of the adolescents appeared to respond negatively to this and it entrenched the anorexia.

175. Maudsley Family Based Therapy was the treatment therapy with the strongest evidence base for adolescent anorexia. It was most effective for adolescents who were stabilised at 85% of ideal body weight and for whom anorexia was of shorter duration. This was not the sub-population of adolescents with anorexia being treated at BAC. They generally had persistently low body weights, of longer duration, and did not tolerate this family based therapy. BAC was able to adapt some of the Maudsley strategies of supporting eating, in the context of additional and alternative interventions. For example, one strategy implemented at BAC was to challenge thinking around eating. Another example relates to the rehabilitation phase for these adolescents. BAC staff observed over time that most adolescents at BAC with a persisting eating disorder had concomitant social anxiety. These adolescents were delayed in many milestones of social development because of their focus on restricting weight, together with the avoidance of many social interactions. Therefore, interventions were not only focussed on restoring weight, but also on facilitating progress in the lacking aspects of their social development. This approach of integrating a rehabilitation component for people with persisting anorexia was validated in subsequent conferences I attended.

Evaluation of BAC interventions

176. Evaluation of interventions is a critical aspect of EBP. This is complex in an environment with multiple interventions. Evaluation of BAC's interventions occurred in multiple domains.

177. One mode of evaluation occurred at the discipline level and involved reviewing the progress of the adolescents. Psychologists performed formal assessments and repeated these after several months of interventions. Occupational therapists reviewed living skills. Teachers performed semester appraisals. Doctors reviewed the mental state. These reviews gave some indication of the success of the various interventions being utilised.

178. The weekly Case Conference provided another opportunity to evaluate the success or otherwise of the various interventions being used in individual cases. It was a multi-disciplinary approach. Sometimes it would be apparent when evaluating an adolescent's responses to an intervention in this environment, that while an adolescent may have appeared well engaged in an aspect of therapy, the skills being taught were not being used in other domains of their day to day life at BAC. This process of evaluation also enabled the team to identify those adolescents who needed to progress in one domain before therapy would be successful in engaging them in other domains. This was critically important in ensuring an intervention was not abandoned prematurely because the short term evidence indicated it may not have been effective.

179. The quarterly Intensive Care Planning Workup was also another avenue for evaluating the effectiveness of interventions used at BAC. Importantly, during this process feedback from the adolescent and often their parents/carers would be sought as to the progress being made and what they saw as helpful or potentially counter-productive. There was also the

ability to review a longer term set of observations and to receive input from the various treatment providers as to their respective valuations of the progress and effectiveness of the various interventions. The external mental health provider was routinely present for these meetings and could provide valuable input from their perspective. For those adolescents who were progressing towards transitioning or discharge to the community, their progress would be evaluated along with the potential interventions available in the community which were available to replace those at BAC.

180. At the conclusion of the Intensive Care Planning Workup, the treating team completed the Outcome Measures. There were four such measures, namely:

    (a) the diagnosis;

    (b) ranking the adolescent on the Children's Global Assessment Scale (**CGAS**), which ranked their overall level of functioning with a number from 1 to 100;

    (c) ranking the adolescent on the Health of the Nations Outcome Scale for Children and Adolescents (**HoNOSCA**) where there were 13 domains of function which were rated from 0 to 4, with two parenting domains; and

    (d) completing the Factors Influencing Health Status (**FIHS**), which was a yes/no rating of the presence of prejudicial psychosocial factors.

181. It was recognised that team rating may have reduced inter-rater reliability, but its main value was to provide a common assessment of the overall function of the adolescent. The adolescent, one or both parents/carers and the team as a whole (based on the collective observations of the adolescent), completed respectively the Young Person, Parent and Teacher versions of the Strengths and Difficulties Questionnaire (**SDQ**) – a questionnaire assessing function in five different domains, the level of difficulty experienced or caused, and the impact this had on their functioning. Adolescents and parents/carers completed their questionnaires prior to the intensive Care Planning Workup. The team completed the Teacher's version without access to the questionnaires completed by the adolescents and their parents/carers. Points of similarities and difficulties were identified and discussed. The referrer was also present for this part of the evaluation.

182. Often comparisons were made with previous measures to evaluate effectiveness and progress, mindful of the limitations of each measure. For example, often initial ratings were made on limited information on clinician rated scales. As more information was gathered, HoNOSCA scores were rated higher while CGAS scores were rated lower. Further, initial scores on admission were more likely to be rated by a single-rater, with subsequent variation in inter-rater variability. These were likely to complicate comparisons of admissions vs discharge scores. Comparisons of admission and discharge SDQ scores could also need to be qualified e.g. inter-rater comparisons between parent and adolescent could be difficult to interpret and the adolescent's insight may have developed, rating the impact higher.

183. The BAC 2005 paper on the use of the HoNOSCA in an adolescent inpatient unit describes a less severe population to that seen a decade later. One of the insights from the data on which that paper was presented, is the variation in sequential HoNOSCA scores between adolescents with shorter vs longer lengths of stay. Those with shorter stays often had anxiety disorders. Their HoNOSCA scores followed a linear trend of improvement. Those with longer stays often had Complex PTSD. The HoNOSCA scores fluctuated more around a mean improvement trend. This led to recognition of stages of change over time in adolescents with Complex PTSD. The hypotheses of these stages of change were built on observations of adolescents until about 2005. Since then, these hypotheses appear to generalise to later adolescents admitted to BAC, and to those seen in other settings. This has potential implications for some of those with complex PTSD, and also for the timing of transition of adolescents at BAC, who at the time of closure were working through the issues of Complex PTSD.

184. On multiple occasions I took the opportunity to present to a range of professionals the conceptual model and range of interventions utilised at BAC. These are listed in Exhibit A to this statement. These included Grand Rounds, conferences and workshops. Clinicians provided valuable feedback. This was a form of external appraisal and a form of evaluation of the interventions being used at BAC. In addition, there were two reviews of BAC. The first review was in 2003 and was led by Associate Professor Brett McDermott. The second was in 2009 and was led by Dr Gary Walters. Although I did not agree with some aspects of this more recent review, it provided a useful process for reflection for me and other BAC staff.

185. A further key element of evaluation of BAC evidence base intervention was feedback from young people after they had transitioned and been discharged from BAC. This feedback was formalised in a collaborative process between health and education sectors of BAC in a quadrennial review from which individual elements of the program were refined.

186. In 2010, Professor Len Bickman, Professor Emeritus, Research Professor, Department of Psychology and Human Development, Vanderbilt University visited Brisbane as guest scholar of the Mater Kids in Mind Research Centre. He is a strong advocate for the use of EBT, but has recently developed the Continuous Feedback Monitoring system about providing feedback to clinicians as to the value of an intervention. He is a strong critic of the lack of evaluation of residential homes for youth with serious emotional disturbance in the USA. (These are not equivalent to BAC.) I spent several days with Professor Bickman when he visited BAC. I outlined the model of care and our approach to incorporating EBP for the adolescents at BAC, as well of the model of care. He provided positive feedback, together with outlining the challenges for future directions. I found this to be very useful.

187. Despite the numerous and varied avenues of evaluation which were used by BAC, difficulties were experienced in evaluating the efficiency of BAC and the optimal length of time spent in BAC. There is no doubt there was room for improvement in efficiencies, including stable staffing and adequately trained staff etc.

188. From time to time, the Australian Council of Healthcare Standards (**AHCS**) reviewed the facilities and services provided by BAC. Its performance was thus reviewed against initially the EQuIP standards, but these were then incorporated into the National Mental Health Standards. Reviews occurred:

(a) in the 1990's, of Wolston Park, until a periodic (interim) review of The Park – Centre for Mental Health in 2004;

(b) in 2006, when a full review of West Moreton Mental Health Services (of which The Park was the major service) was undertaken;

(c) in 2008, when there was an organisational wide survey of the West Moreton South Burnett Health Services District, of which The Park was a much smaller component;

(d) in 2011, when a survey of Mental Health Services in Darling Downs – West Moreton Health Services District was undertaken;

(e) in 2012, when a survey of the West Moreton HHS was undertaken. BAC provided substantial documentation to the surveyors. However, as the ACHS surveys grew to cover larger organisations, the amount of face to face contact with the surveyor visiting BAC decreased from 2 -3 hours in the initial visits to 40 minutes in the last visit. This curtailed the amount of constructive feedback that could be provided.

Relevant policies and plans and their impact on the development of the model of care provided at BAC

189. Over the years there have been a number of National and State mental health policies, plans and frameworks that governed the delivery of such services.

190. *The National Mental Health Policy* 2008 (**2008 NMH Policy**) and the *Fourth National Mental Health Plan* (**Fourth Plan**) provided a whole of government framework for mental health reform. The 2008 NMH Policy and the Fourth Plan outlined:

(a) the history of the development of the National Mental Policy and Plan;

(b) the aspirational statements for 'consumer focussed services'. These statements were goals for clinicians working with consumers to optimise their treatment and promote recovery;

(c) principles on which services were planned to promote optimal treatment and comprehensive recovery; and

(d) principles on developing a culture of 'consumer' focused, recovery oriented services.

191. I read each of the National Mental Health Plans to understand the national priorities in mental health, to reflect on how those priorities could be translated in practice for the particular group of adolescents we saw at BAC and to examine our role in meeting these priorities for these adolescents. The plans were also relevant to seeking an understanding of the role of BAC as an essential service that enabled the State to meet its obligations to

these adolescents under the National Mental Health Plan. As far as I can recall, the SW CYMHS AG did not formally review the range of CYMHS against the Fourth National Mental Health Plan. I can recall a one day workshop in about 1998 or 1999 arranged by the MHU to examine CYMHS against the Second National Mental Health Plan.

The National Mental Health Services Planning Framework (**NMHSPF**)

192. The requirement and rationale for establishing the NMHSPF is outlined in the Fourth Plan.

193. Of note, the NMHSPF does not:

(a) identify who was on the Executive, on the various Modelling Groups or on the various expert reference groups;

(b) identify with whom it consulted;

(c) provide access to submissions that may have been made;

(d) identify how many child and adolescent mental health professionals were involved, nor their background;

(e) identify if any "consumers" or "carers" who had experience with child and adolescent mental health services were representatives; or

(f) identify if any representatives were present on all three Expert Working Groups (**EWG**), being the Primary Care/Community/Non Hospital Working Group, the Psychiatric Disability Support, Rehabilitation and Recovery Working Group and the Inpatient/Hospital Based Service Expert Working Group.

194. These issues make it difficult for the NMHSPF to bridge the potential gaps noted in the previous section between what clinicians, adolescents and their parents or carers identify as necessary for the aspirations of the Policy and Plan for optimal services, and what service planners and administrators envisage in the mix of services given the specific needs of the sub-population that received treatment at BAC.

195. The third Communique of the NMHSPF states "Using evidence based practice and epidemiological data, the National Mental Health Service Planning Framework (NMHSPF) Project aims to estimate the range and quantity of mental health care required by our population and the resources required to provide it." I believe that determining the need for a unit like BAC could not have been done by using epidemiological data because the sub-population of adolescents at BAC is not identified in any epidemiologic studies of which I am aware. Further, if evidence based practice was used in the terms of the Sicily Statement of Evidence Based Practice, neither I nor Professor Philip Hazell were contacted. As explained above, there is scant literature on adolescent impairment, rehabilitation or recovery. The lack of an evidence base in the literature on these issues and the fact that neither myself nor Professor Hazell were consulted, would have limited the appropriateness of any recommendation about adolescent service by the Psychiatric

Disability Support/Rehabilitation and Recovery EWG. I have not been able to find out any information about the work of the NMHSPF, despite my attempts in this regard.

196. Despite the abovementioned short comings, extraordinary reliance was placed on this process. From the first announcement of the intention to close BAC in November 2012, through to comments from the Planning Group in July 2013, statements were made that BAC was no longer a contemporary model within the NMHSPF.

197. Between May and July 2012 I communicated with Professor Philip Hazell either by phone or by email. He was on the Expert Clinical Reference Group. He had also published widely and would present and attend Australian child psychiatry conferences. At the time he was the Director of the Service in which the Walker Unit and the Rivendell Centre are located. He said that although he was having difficulties with the necessary data for these services with activity based funding, he was unaware of any intention to close the Walker Unit or Rivendell Canter due to decisions from the NMHSPF. I was aware Professor Hazell reported to Associate Professor Beth Kotze. Associate Professor Kotze was on the NMHSPF, but I am unsure of her role.

198. I do not understand the basis for the statement from November 2012 that BAC was no longer a contemporary model within NMHSPF. The Communiqués 3 (issued in September 2012) and 4 (issued in June 2013), were unclear that the process was at any stage of completion and it does not appear that a decision had been made that a service such as BAC would no longer fit within NMHSPF.

199. A media report on the Queensland Health website dated 18 November 2014 stated that "Internationally throughout the past 10 years there has been a move to de-institutionalise young people, as reduced lengths of stay decrease the risk of secondary disability as a consequence of institutionalisation, developmental arrest and, disconnection from families and communities. These considerations meant the BAC model was outdated and in its current form was not supported by other Queensland and Australian mental health experts, who had actually warned against keeping it open." This statement is difficult to understand for a number of reasons:

    (a) I am not aware of any moves during the previous 10 years to de-institutionalise young people as the overwhelming majority of young people in Australia, New Zealand and United States of America do not experience lengthy stays in hospital. This had been the position in the USA for the previous 25 years.

    (b) The average length of stay in the United Kingdom was three to four months, but this situation is changing as there was a distinct lack of dedicated acute inpatient beds. A number had a considerably longer length of stay. A position paper by QNIC in 2013 exhibited and marked '**G**' to this statement states their position in relation to beds in the United Kingdom. It says inpatient admission is an essential part of the care pathway and evidence of effectiveness has been demonstrated.

    (c) It implies that adolescents admitted to BAC had normal developmental trajectories prior to admission. It does not acknowledge that, in fact, the opposite was true – that

they were experiencing a moratorium on their developmental trajectory in multiple domains.

(d) It ignores the content of the AETRC MOSD, to the effect that a key purpose of BAC was to facilitate developmental tasks.

(e) It ignores evidence that I presented to senior members of Queensland Health in November 2012 that adolescents in BAC were already significantly disconnected from their peers, schools and communities (Exhibit C).

200. The use of the term "institutionalisation" contains a pejorative element which had the effect of attracting negative connotations. BAC had many elements that were not likely to be found in stereotypical institution. For example, via the morning meetings and representation on the BUM, adolescents had a say in their environment, negotiated some rules, and had the opportunity to demand accountability from staff. There was also frequent contact with the external community which was maintained through a number of planned activities, meaning that the adolescents were not confined to BAC. Further, the adolescents, depending on the severity of their conditions, went on leave, travelled with their families or travelled independently on airlines. They were actively engaged in tasks to facilitate their development.

*The National Framework for Recovery Oriented Mental Health Services (**NFROMHS**)*

201. Recovery orientated principles in mental health services have been developing since 2000. Rehabilitation programs laid a foundation for transition. It was against this background that the NFROMHS was released in November 2013.

202. The recovery concept arose out of the period of deinstitutionalisation. Simple stabilisation of severe mental disorder with medications was not enough. Mental illness may be associated with impairments in social, educational, vocational and housing settings. Deinstitutionalisation required community supports to be built around former patients to enable them to function in the community. Recovery involves developing a new meaning and purpose in life after mental illness, in the same way as a person who experiences paraplegia learns to live a new way of life. Encouraging services to adopt a recovery focus helped clinicians treating people with psychotic disorders (schizophrenia and bipolar illness) to consider a range of issues besides symptom stabilisation and compliance with medication. Recovery used in this way is different to recovery from pneumonia where there is not only an absence of symptoms, but a restoration to health.

203. Emerging as a concept from the era of deinstitutionalisation, the recovery literature focuses on a group of illnesses for which people were likely to be hospitalised. The key recovery principles are incorporating the evidence from "consumers" and "carers" about their experiences in terms of what has worked for them and what has not. For the individual - hope, connectedness, empowerment and identity are integral to optimising recovery. Exhibited and marked '**H**' to this statement is a document that I prepared for the Coroner. It is a discussion of the conceptual framework of treatment, rehabilitation and transitions. It attempts to describe observations which have been made of the important elements

which promote recovery in an adolescent with extreme mental illness. It observed that the progress of such adolescents appeared to be more than a combination of evidence based (and sometimes modified) treatment, plus rehabilitation interventions. Relationships with staff seemed to be crucial, as were factors identified in the recovery literature.

204. The recovery orientated principles were incorporated into the framework of treatment and rehabilitation of BAC adolescents. This was an evolving process. The Park – Centre for Mental Health, in its transition from Wolston Park Hospital in 2000, developed a vision of "Together towards recovery". The National Mental Health Standards contained a number of elements related to recovery. Recovery as a concept continued to emerge, and BAC recognised its application to the adolescents.

205. One of the common concepts of recovery is 'Hope'. Most adolescents entered BAC with the hope of recovery, after experiencing severe and incapacitating mental illness for a considerable period. At BAC, hope was maintained through:

    (a) the positive attitudes of regular staff;

    (b) learning new ways of coping;

    (c) participation in activities which enhanced skills and confidence; and

    (d) engagement in therapies which offered significant amelioration of symptoms.

206. 'Connectedness' was both an individual and a group dynamic. Connectedness had multiple forms including:

    (a) connectedness to peers;

    (b) connectedness to staff who facilitated recovery; and

    (c) through recovery, connectedness to the larger community.

207. A sense of connectedness to people and programs at BAC was viewed as the passage to connectedness to the community. By transition time, some adolescents were completely ready to leave connectedness to BAC people and programs and to connect with the community. For others, a graduation from connection to BAC people and programs was important.

208. Admissions to BAC had complex effects on 'empowerment'. Long term admissions could encourage dependency. However, 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 become independent. Interventions which facilitated empowerment included encouraging school education, commencing vocational training, obtaining part time work, having conversations with peers, joining external social or sporting clubs or voluntary organisations, catching public transport, shopping for and cooking a meal; and obtaining a driver licence.

209. Establishing 'identity' was a challenging and variable process for adolescents. Many adolescents admitted to BAC often struggled with impairments to their identity because of the mental illness or assaults on identity from disruptive home environments. The literature is scant on the facilitation of identity, particularly during adolescents. Our observations were that identity is constructed by the adolescent, based on a core inner sense of self, the sense of how they are similar or dissimilar to their families, their achievements and competencies, their standing with peers and acknowledgement of strengths and difficulties, while at the same time minimising negative self-evaluation.

210. In practice, developing an identity at BAC occurred in a number of different ways.

    (a) Often adolescents have a core moral identity, such as they are essentially a kind or prosocial person who is both honest and fair. For an adolescent who had been abused, this identity does not sit well with their shame about the abuse. One intangible benefit for an adolescent's identity at BAC, was continued validation by staff, whose opinions the adolescent trusted, that the adolescent was regarded as a person consistent with their core moral identity.

    (b) For some adolescents at BAC, gaining competencies in day to day living and facing and conquering new challenges gave them a new and positive perspective of themselves.

    (c) Other adolescents had to learn to not accept responsibility for everything that went wrong, and this was facilitated through the day to day interactions on the unit. This contributed to creating a more positive identity for the adolescent.

    (d) The identity of some adolescents was bound up in a family identity which they did not value. Having said this, they were reluctant to envisage an independent identity out of loyalty to the family, or a desire to please a parent. Some of the programs and interventions at BAC were aimed at addressing these issues.

    (e) Adolescents at BAC routinely completed the SDQ. Many of the responses reflected issues which correlated with some aspect of identity. The care coordinator frequently discussed the adolescent's self-concept as shown on this questionnaire and the implications for the adolescent. This enabled the adolescent to reflect on their identity and potential positive change.

211. The aim of BAC was to provide the adolescents with a high level of professional care. They tended to respond over time to a more personal, nurturing but professional style of care from staff. It was a significant feature in facilitating recovery. It is encapsulated in the concept of "authoritative parenting". It is based on cross sectional, longitudinal and cross cultural studies, and is evident in literature spanning centuries.

212. The ability of BAC to provide this style of care was at times compromised by the staffing and other resourcing issues as explained above. Many of the adolescents had not experienced this style of care in their families. It was hoped that by staff exhibiting this style of care, the adolescents would be exposed to fairness, consistency, commitment,

approachability and a capacity to understand. The style of care, when appropriately implemented, involved the staff member speaking calming when setting limits, seeking clarification from the adolescent if required, acting consistently and responding in a way that was appropriate to that situation. It was thought that the adolescents were more likely to talk to, confide in and seek support from these staff when distressed. This style of care was particularly important with the nursing staff because the interactions with other staff were more likely to be more structured.

213. It was recognised that there was a risk of some particularly vulnerable adolescents becoming dependent on BAC, particularly those who required long periods of inpatient treatment. BAC sought to minimise this risk through an active program which both addressed development delays and maintained exposure to the community. Examples of facets of this program included opportunities for interactions with peers, re-engagement with school (first at BAC School and then often at a community school or external education provider), undertaking everyday tasks such as washing, planning and preparing meals, planning activities and outings, catching public transport and developing budgets and timetables. BAC also encouraged the adolescents to engage in youth groups or sporting activities within their own community or an external local community if they lived in regional Queensland. The ways in which BAC encouraged exposure to the community, included going on weekend or other leave when safe and it could be arranged; going to community swimming pools, gymnasiums, movie theatres and a range of shopping centres and visiting recreation areas such as Southbank or the beach. These both assisted recovery and addressed some of the issues of dependency on BAC.

214. In general, the initiatives of the National Mental Health Strategy e.g. the National Mental Health Plans and the National Mental Health Standards have been very positive in both conceptualising and validating a framework for interventions at BAC within the context of State-wide CYMHS.

215. I am aware of submissions made to the Independent Health Pricing Authority regarding mental health and definitions of acute, subacute and non-acute care. It was suggested that the definitions could be used to determine the level of funding provided to CYHMS inpatient services. This was an initial discussion point for the ECRG in relation length of stay and the appropriate definition for BAC.

Other Organisational Context

216. From my perspective, the establishment of the Mental Health Commission in mid-2013 did not have any impact on the management of adolescents at BAC. I had no contact with the Commissioner prior to leaving BAC in September 2013. I am not aware of any request from the Commissioner's office to meet with other BAC staff, adolescents, parents or carers.

Prior considerations regarding closing or relocating BAC

217. Between 1994 and 1995 I was a member of the Reference Group of the Child and Youth Mental Health Policy. This reference group was organised by the Mental Health Branch. I

became aware through my participation in this group that BAC was not to be included in the *Future Directions for Child and Youth Mental Health Services in Queensland.* This decision had been made even though the Queensland Branch of the Faculty of Child and Adolescent Psychiatrists, RANZCP had advocated for BAC to remain open. I was the chair of the Queensland Branch of the Faculty of Child and Adolescent Psychiatrists, RANZCP at the time. In that capacity I wrote to the then Health Minister, Mike Horan on a range of issues. In particular, I brought to his attention the previous documents which had been produced by the Faculty highlighting the need for BAC to remain open. I also met with Minister Horan and the Director of the Mental Health Branch, Dr Peggy Brown. It is my recollection that Dr Brown explained during the course of that meeting that the priorities of Queensland Health were to provide community services and acute inpatient services.

218. In 1997 it was announced that BAC was to close. Some parents who had adolescents at BAC wrote to and met with the Minister and wrote to the newspapers. A journalist took up the story for the Courier Mail. Dr Brown, Professor Nurcombe, Professor of Child and Adolescent Psychiatry at the University of Queensland and Director of the Royal Children's Health District CYHMS and Mr Kevin Fjeldsoe, in a managerial role within then Mental Health Branch met with the parents and listened to their concerns.

219. Minister Horan opened the Royal Brisbane Acute Adolescent Inpatient Unit in approximately 1997. Shortly thereafter, he visited BAC to learn more about the adolescents receiving treatment there and the range of services and interventions provided to those adolescents. The buildings were in a dilapidated state by that time. It is my recollection that it was following his visit to BAC that Minister Horan directed that BAC remain open. I have no documentation from this time. Despite this direction the *Future Directions for Child and Youth Mental Health Services in Queensland* was not changed to reflect this.

220. In 2002, *Draft Report on the Need for Child and Adolescent Secure Services Inpatient Services and the Redevelopment of Extended Treatment Adolescent Inpatient Services* was released and again raised the issue of closing BAC. I provided a submission to the Director of the Mental Health Branch, Dr Peggy Brown outlining what I considered were incorrect assumptions within the paper. Exhibited and marked '**I**' to this statement is a copy of my letter to Dr Brown.

221. The CYMHS plan 2006-2011 included a recommendation that BAC be rebuilt but on a different site. Therefore by 2006 BAC was considered by both West Moreton Health Services District and the Mental Health Directorate to be an integral part of the future CYMHS.

222. The Queensland Plan for Mental Health Services 2007 – 2017 was released in 2007. Even though there was no mention of adolescent mental health in this plan, BAC had a future within the broad organisational structure of Queensland Health Mental Health Services because there was the allocation of funding in the 2007 budget to rebuild it.

223. Five potential sites were identified for the rebuild of BAC. One was the site it was already on and another was at Redlands, next to Redlands Hospital. Visits to all sites were undertaken in 2008. I attended these site visits. From there a decision was made to rebuild at Redlands. There were continuing discussions and meetings held around a design and the plan generally. I was present for some of these meetings. In April 2012 I wrote to Dr Kingswell as I was aware that significant environmental concerns in relation to the Redlands' site were being raised. I enquired of Dr Kingswell, Executive Director MHAODD as to whether there was a back-up plan in the event that the rebuild at Redlands did not go ahead. He indicated that there was no such plan as Redlands was the only option.

November 2012 onwards

224. I have prepared a timetable for the closure of BAC. It is exhibit and marked **'J'** to this statement.

225. In July and August 2012, interviews were undertaken with the view to employing more nursing staff. At that stage I understood that BAC would still be relocating to Redlands. I can recall in September 2012 that Ms Dwyer (Chief Executive of the West Moreton Health and Hospital Board), Dr Bill Kingswell, Dr Michael Cleary (Deputy Director General) and others visited BAC. I had thought the purpose of the visit was to better understand the services provided by BAC. At the time of this visit there was no discussion regarding the future of BAC. In particular, I was not advised of an intention to close it. Shortly before this, it was announced that the rebuild of BAC at Redlands was no longer going ahead. I then emailed Ms Dwyer to advocate for either basic refurbishment of BAC, or to consider rebuilding the accommodation section on the existing site given that it had been one of the five potential sites which had been identified for the rebuild. Ms Dwyer responded that Ms Kelly would meet with me regarding future developments.

226. On 2 November 2012, I was verbally advised by Ms Sharon Kelly, Executive Director of West Moreton HSS in the presence of Dr Terry Stedman, Director Clinical Services WMMHS that BAC would close on 31 December 2012. The information of the planned closure came as a surprise to me. I can recall Ms Kelly telling me that this was not a decision of West Moreton HHS, but had come from MHAODD Branch. As part of this discussion, I was told by Ms Kelly that the closure was not to be disclosed to BAC staff, adolescents or their families at that time. I was advised by Ms Kelly that a group of experts would advise on alternative programs. Given that BAC was going to be closed in less than two months, I considered this advice process was likely to be a perfunctory. Ms Kelly suggested that BAC accept no further adolescents. I do not recall being informed of any transition plans for the adolescents. They were simply to be relocated to acute inpatient units.

227. I had many concerns about the proposal to place adolescents in acute adolescent inpatient units:

    (a) The vast majority of patients in acute adolescent inpatient units were admitted and discharged within weeks or less. This created a sense of hopelessness and lack of