Statement by the Hon. Margaret Wilson QC
Commissioner, Barrett Adolescent Centre Commission of Inquiry
18 July 2016

For about 30 years, the Barrett Adolescent Centre provided extended treatment and rehabilitation for adolescents with severe and complex mental illnesses. Its patients were young people who did not require admission to acute units and who were resistant to the less restrictive forms of care that were then available.

The Barrett Adolescent Centre was the only facility of its type in Queensland. It had capacity for 15 inpatients, 5 day patients and a small number of outpatients.

Broadly, the Commission of Inquiry's remit was to inquire into:

(a) the decision to close the BAC and how that decision was reached; and
(b) the transition of the patients to alternative care arrangements – the adequacy of the transition arrangements – the care, support and services provided to the patients and their families – the support provided to staff.

Tragically three young people who had been patients of the BAC died in 2014. The causes of their deaths were not within the remit of the Commission of Inquiry. They are matters for the Coroner to determine in investigations which were begun before the Commission of Inquiry was established, and adjourned pending completion of our task.

Several reasons were advanced for closing the BAC, the most prominent being:

(a) that caring for such young people in an institutional setting was not a contemporary model of care; and
(b) that the BAC's location at The Park Centre for Mental Health was inappropriate and fraught, as The Park provided mental health services to adults who were forensic patients or who otherwise needed to be in a secure unit.

Contemporary thinking clearly favours care of the mentally ill in the least restrictive environment possible. Care in the community, close to family and social supports, is desirable. Contemporary thinking acknowledges that there will always be some people who need inpatient care, whether at acute or sub-acute level, and for varying durations.

For some years there had been a plan to relocate the BAC, but its implementation was delayed by planning and environmental issues and the estimate of what it would cost had risen. That project was cancelled in mid–2012, and the funding was reallocated.

Significantly, before that was done, there was no analysis of the needs of the young people who accessed the Barrett Adolescent Centre, no express consideration of how those young people would be cared for, no consultation with specialist child and adolescent psychiatrists, and no community consultation.

Those who wanted to see the BAC closed pressed ahead. An expert clinical reference group was formed to consider models of care for adolescents with severe and persistent mental illness. The group was told there was no money available to build a new facility. Nevertheless, it advised that a design-specific, clinically staffed, bed-based service was essential for adolescents requiring medium-

term extended care and rehabilitation. It warned that if the BAC were closed before the establishment of such a facility, interim service provision would be associated with risk.

That advice was not heeded.

While there is a clear preference for and emphasis on community care, the preponderance of expert evidence before the Commission of Inquiry pointed to a number of conclusions:

- A small group of adolescents require care in an inpatient extended treatment and rehabilitation facility.
- There is a possibility, but it can be put no higher than that, that such a facility may not be needed if and when a full suite of community-based services is available.
- There is likely to be a need for such a facility even when the full suite of community-based services is available.
- In any event, the full suite of community-based services is not available more than two and a half years after the BAC was closed, and it is not imminent.

Accordingly the Commission has recommended the establishment of a bed-based extended treatment and rehabilitation unit for young people with severe and complex mental illness. This unit could form part of an adolescent non-acute mental health facility on, or adjacent to, the campus of a general hospital in south-east Queensland. (See Report chapter 31, paragraphs 11–24.)

There is no suggestion that the BAC should be replicated in a new location. It was geographically and clinically isolated. Some of its interventions and the lack of others have been criticised. Some patients remained there too long. It has been criticised for paying less than optimal attention to early discharge planning. Its accommodation was not purpose-built.

The Commission considers that there may be synergies from co-locating a new bed-based unit with other adolescent non-acute mental health services and with a general hospital, which may go some way towards offsetting set-up and operating costs. For example, co-location with other adolescent non-acute mental health services would allow full use to be made of the expertise and time of the various clinicians and provide opportunities for clinicians to learn from interaction with their professional peers. Co-location with a general hospital would counter clinical isolation and may provide opportunities for medical education, research and benefits for other patients.

Queensland would not be unique in having such a unit. There is already the Walker Unit in New South Wales, and Western Australia plans to re-scope an existing facility for this purpose.

The Commission was also required to consider the transition of the patients of the BAC to alternative care arrangements. This necessarily involved examination of individual case histories. There was understandable sensitivity associated with the receipt and use of this evidence. The Commission had to balance its obligation to conduct a full and careful inquiry in an open and independent manner with what were clearly legitimate claims to confidentiality and privacy. It examined the files of 41 young people who were former patients or on the waitlist or the list of those awaiting assessment for admission. It made contact with 34 families and took statements from 17 family members and five patients. There were some who did not wish to engage with the Commission: their concerns for the welfare of their young people and their wishes were respected.

Where appropriate in the interests of patient welfare, and patient and family privacy, the Commission's hearings were closed to the public and these hearings were not streamed online.

Those parts of the report which relate to individual patients will not be publicly available.

The patients' transition to alternative care arrangements had to be undertaken in the context of the closing down of an entire facility. This took place over about four months (from September 2013 to January 2014). There were limited alternative services available: although new community-based services were being planned, none was available by the time the BAC closed.

BAC clinical staff, led by Dr Anne Brennan, performed this task with unflagging commitment and professionalism. Overall, the transition arrangements were adequate, and in all the circumstances the care, support and services provided were adequate, although not always ideal.

One of the issues highlighted by the evidence is the non-alignment between adolescent and adult mental health services. The BAC cared for young people up to the age of 18 years. They were not necessarily discharged as soon as they reached 18, but allowing them to stay contributed to "bed block". There was always a waiting list for admission to the BAC.

Needless to say, a young person does not suddenly become an adult on turning 18. Sometimes, developmental age lags behind chronological age. However, adolescent and adult mental health facilities are based on different principles, and generally they care for markedly different cohorts.

The Commission received evidence of the lived experiences of several former BAC patients who had attended adult mental health facilities after turning 18. For some of them, their interactions with the adult mental health system and adult mental health patients were confronting and negative.

This lack of alignment is a systemic issue not confined to Queensland. The Commission has recommended that it be referred to COAG for possible development of a co-ordinated nationwide approach.

Another troubling area is the lack of services for dual diagnosis patients – that is, those who suffer both mental illness and intellectual disability. The few services that are available are spread across different government departments and agencies, and the level of co-operation and collaboration between departments and agencies is not high. This is a difficult area, in need of review and innovation.

In conclusion, I want to pay tribute to the wonderful team of lawyers, researchers and administrative officers without whose talents and commitment the Inquiry could not have been completed. Thank you, all.