[redacted]

BK: [?] like about Barrett.

AB: Yes.

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

AB: [redacted]

BK: Mm.

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

TS: Yeah.

AB: [redacted] Um who else is there.

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

AB: No.

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

AB: No.

BK: Um so okay. Mm.

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

BK: Mm.

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

TS: Yep.

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

BK: Yes.

AB: And put together a report

TS: [?] yes.

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

TS: Sorry when was that second report?

AB: Ah 3rd of March.

TS: 3rd of March right.

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

AB: There was no

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

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

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

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

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

TS: Yeah.

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

TS: So.

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

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

AB: Yes that's that. Yeah.

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

AB: This here.

BK: Yep.

AB: So this steering committee

BK: Mm.

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

BK: Yep.

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

BK: Right.

AB: Because it will take away my time

BK: Yep.

AB: From the clinical care of these kids.

BK: Yep.

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

BK: Right.

AB: And I would just do the clinical care

TS: The transition panel.

AB: Of the patients.

TS: Right.

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

TS: Okay.

AB: Cause it all goes together.

TS: Okay.

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

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BK: So you're on clinical

AB: I was in Wednesday morning.

BK: Night.

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

BK: And Wednesday morning was with Terry Steadman?

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

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

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

BK: Met once a week?

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

BK: Okay. Right.

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

BK: Yep.

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

BK: Right.

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

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

AB: That would be –

BK: Yeah.

AB: No, [?]

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

AB: Met twice weekly, on Tuesdays and Thursdays.

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

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

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

BK: Who's the chair of that meeting?

AB: Of the Transition Panel?

BK: Yeah.

AB: Me.

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

AB: Laura Johnson, the Project Officer.

BK: Right, okay.

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

BK: Yeah, yeah.

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

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

AB: With the parents?

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BK: Yes.

AB: It depended on each kid.

BK: No, that's alright.

AB: The dad is a

BK: I noticed you even organised

AB:

BK: And attend the meeting?

AB: Yes.

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

AB: We tried to, mm.

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

BK: [?].

AB: [?] I mean, looking back like

BK: Yes, yes.

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

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

AB:

BK: okay. Do you recall their names?

AB: Yes.

BK: yep.

AB:

BK: Yes, yes.

AB:

BK:

AB: Yes.

BK: Right, okay, yep.

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

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

TS:

AB: Nope.

TS:

AB:

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

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

BK:

AB:

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

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

[redacted]

BK: Okay.

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

BK: [redacted] we talked about.

AB: [redacted]

TS: [redacted]

AB: [redacted]

BK: Yeah, was there for about it looks like

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

BK:

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

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

AB: Yes.

BK: Okay, not just the residential.

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

BK: [?] be very flexible.

AB: Michael Taubman does AMYOS.

BK: What's AMYOS?

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

BK: Based on the original model?

AB: Yes.

BK: State-wide, is it?

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

BK: Did you have any more [?]?

AB: Yeah,

BK:

AB: He would have gone on.

BK: went on the – does that help you?

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

BK: So that [?] for about

AB:

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

BK: You can't do that.

AB:

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

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

BK: Yep.

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

BK: Mm.

AB: But I think this group is now defined as a group and the glue in many ways, well there's two, there's the Save the Barrett campaign and there's the school based at Yeronga is the kind of hub for them. And that, as far as I'm aware, has no mental health input. Liam Huxter, one of the nurses from Barrett, went as a school nurse there. When the school opened. He had no, that was a standalone position, he didn't belong within any mental health service or have structure to his job or career or supervision or anything like that, now in fact, he's left and gone to Japan. But, so he was there's to start with alone, but there's no mental health input and I must say, when I said to Stephen Stathis, someone's got to do something. So he did a ring around to make sure everybody was okay and being looked after. What concerned me was that the following day, another was talking to me about one of the kids and who they were seeing and what was happening in that therapy, and I thought, that's a bit odd. Because Stephen's just done this ring around and that kid is, in fact, seeing somebody else, and

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

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

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

BK: And who would that be?

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

BK: Have you raised that with anybody?

AB: Stephen.

BK: Mm. And did you get any feedback?

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

BK: Yeah.

AB:

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

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

BK: Yeah.

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

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

AB: Thank you. I hope [?]

BK: Very helpful [?]. Thanks.

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Queensland Health

Health Service Investigation - Barrett Adolescent Centre

1084936

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

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

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

SS: I am, yes.

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

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

BK: Okay.

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

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

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

BK: Okay, yep, yep.

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

BK: Great, no, that's fine.

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

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

BK: Yes, yep.

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

BK: Ahuh.

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

BK: Yeah.

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

BK: Ahuh.

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

BK: Right.

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

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

BK: Mmm. Yeah.

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

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

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

BK: Yeah

SS: For someone separate to have clinical oversights.

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

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

BK: Yep.

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

BK: Right, yep.

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

BK: Yeah.

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

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BK: Well.

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

BK: Yeah.

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

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

SS: Yeah.

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

SS: I don't recall doing that.

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

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

BK: That would be

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

BK: Yep.

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

BK: Ahuh.

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

BK: Ahuh.

SS: from memory. Those were the main ones.

BK: Okay. Okay. Can you.

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

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

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

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

SS: Yes, that was.

TS: Yeah.

BK: Yeah.

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

BK: Yeah.

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

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

SS: Oh gosh, [?].

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

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

TS: Right.

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

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

TS: Thanks, Stephen.

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

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

BK: Okay.

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

BK: Mmm.

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

BK: Yep.

SS: Beyond that, nothing that I can.

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

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

BK: No, thank you, Stephen.

TS: Thanks, Stephen.

SS: Thanks very much.

BK: Bye bye.

SS: See you.

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Queensland Health

Health Service Investigation - Barrett Adolescent Centre

1084936

Interview with Dr Trevor Sadler, 14 October 2014

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

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

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

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

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

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

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

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

DTS: So from the 6th of August …

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

DTS: ... when the announcement was made.

BK: Okay.

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

BK: Okay.

DTS: And then I stood aside.

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

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

BK: Right.

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

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

BK: What were your concerns about a workaround service?

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

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

DTS: I've got that.

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

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

BK: Thank you.

TS: Thank you.

BK: What's the ECRG?

DTS: The Expert Clinical Reference Group.

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

DTS: That's right.

BK: Okay.

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

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

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

BK: Right, okay.

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

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

BK: Right, okay.

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

BK: Right, yes, yep.

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

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

DTS: That's right.

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

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

BK: Mm-hm. Mm-hm.

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

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

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

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

DTS: Yes.

BK: Mhm. Hmm.

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

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

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

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

DTS: That was the State-wide cuts.

BK: Yep, yep, yep.

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

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

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

DTS: Yes.

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

DTS: Yes.

BK: Inpatients, day patients, outpatients?

DTS: Inpatients and day patients.

BK: Okay.

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

BK: Okay.

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

BK: Yep.

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

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BK: Mm-hm. Yes.

DTS:

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

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

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

DTS: Yes.

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

DTS: Yes.

BK: Okay. Yes?

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

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

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

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

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

BK: Okay.

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

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

DTS: No.

BK: No.

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

BK: [?]

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

BK: That would be after [?].

DTS: 2012.

BK: That would be after...

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

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

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

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

BK: Mm-hm.

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

BK: Mm-hm.

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

BK: Mm-hm.

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

BK: Mm-hm.

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

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

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

BK: Oh, okay, right.

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

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BK: Right, how's that going?

DTS: Good.

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

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

BK: Mm-hm.

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

BK: Right.

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

BK: Mmm, mmm.

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

BK: Mm-hm.

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

BK: Yeah.

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

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BK: How long had you been at Barrett?

DTS: Since 1986.

BK: Right, a very long time.

DTS: Yes.

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

DTS: No.

BK: So they transitioned [?].

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

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

DTS: Yes.

BK: There's been an investigation.

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

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

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

BK: Mm-hm.

DTS:

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

DTS: Mmm.

BK: Yeah.

DTS:

BK: Can we just clarify some details around

DTS: Mm-hm.

BK: Our understanding is that in fact

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DTS: Yes.

BK:

DTS:

BK: Mmm.

DTS:

BK: Mm-hm.

DTS:

BK: Mm-hm.

DTS:

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

DTS: Right.

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

DTS: Yes.

BK: ... for some

DTS: Yes I mean, no.

BK: And um [?] the program.

DTS:

BK: Yep.

DTS:

BK: Mm-hm.

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DTS: [redacted]

BK: Mm-hm.

DTS: [redacted]

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

DTS: Hmm.

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

DTS: Yes.

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

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

BK: Mm-hm.

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

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

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

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

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

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BK: Mm-hm.

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

455 BK: Mm-hm.

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

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

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

BK: Okay, okay. Thank you.

DTS: Thank you.

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Queensland Health

Health Service Investigation - Barrett Adolescent Centre

1084936

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

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

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

VY: Um...

BK: What we're doing and why.

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

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

VY: Yes.

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

VY: Um no.

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

VY: Yeah.

BK: Um so you were an RN at Barrett?

VY: Yes.

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

VY: Yes.

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

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

BK: Okay...

VY: ...on a contract.

BK: Okay.

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

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BK: Mhm...

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

BK: Right, right...

VY: ...leading up to closure.

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

VY: Yes about July.

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

VY: Yeah, it sort of started...

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

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

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

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

BK: Did you did you?

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

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

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

BK: Mhm

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

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

VY: Um I suppose informally, yes.

BK: Mhm

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

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BK: Mhm

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

BK: Mhm

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

BK: Yeah, yeah.

VY: Yep.

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

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

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

VY: High security and forensics.

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

VY: Yeah, very different.

BK: How are you finding that?

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

BK: Yeah...

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

BK: Yeah...

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

BK: Yes, yes...

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

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

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

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

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

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

BK: Yes...

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

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

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

BK: Yes...

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

BK: Mhm

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

BK: Yeah.

VY:

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

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

BK: Mhm

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

BK: Yes, yes...

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

BK: How was the role described?

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

BK: Mhm

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

BK: Yeah...

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

BK: Yeah, yeah...

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

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

VY:

BK: Mhm, mhm, she was transferred out to yeah.

VY:

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

VY: Um, in what way?

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

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

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

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

BK: Okay.

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

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

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

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BK: Right...

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

BK: Yeah, yeah...

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

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

VY: Um no.

BK: No, that's okay.

VY: No...

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

VY: Okay no worries.

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

VY: Oh sorry, yeah...

[**END OF TRANSCRIPTION**]

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Queensland Health

Health Service Investigation - Barrett Adolescent Centre

1084936

Interview with RN Susan Daniel - Care coordinator for 13 October 2014

Parties: Beth Kotze (BK), Tania Skippen (TS), RN Susan Daniel (SD)

BK: Okay. Okay. So I'm Beth Kotze. I'm Child & Adolescent Psychiatrist from New South Wales. Both Tania and I work for um Mental Health Children & Young People in New South Wales. So yes. A deep breath. And you've got some water there. Um and just take your time. Um so just to check up first of all, what's your understanding of the process that we're involved in while we're doing this?

SD: Um I understand you have some questions regarding the closure of the Unit and um the level of transition, care planning,

BK: Yep.

SD: Preparation and everything's taped and yeah.

BK: Yeah.

SD: That there were a few deaths upon the closure of the Unit.

BK: Mm. Now you've seen the Terms of Reference have you for the – um we've got an extra copy for you here if you don't have one with you but um have you got any questions about the Terms of Reference?

SD: Um you know, I can you more questions as we go.

BK: Yep absolutely. No please don't hesitate. Um so Susan your, you were employed in the, at the Barrett Unit up until its closure, is that right?

SD: No.

BK: Okay.

SD: I actually went on stress leave.

BK: Oh okay.

SD: In November.

BK: Right okay.

SD: I don't have the actual date

BK: Yep, yep. So you didn't actually return to the Barrett Centre after that? Okay. How long have you actually worked there for?

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SD: About 19 years.

BK: 19 years! Okay, okay. That's a long time.

SD: Yeah.

BK: Yeah, yeah. Where do you work now?

SD: Um I haven't gone back to work yet.

BK: Okay.

SD: Um I'm giving up nursing for a while.

BK: Mm.

SD: Just ah taking it easy for a little bit.

BK: Mm.

SD: Um yeah it was a very stressful couple of years towards the end. So I'm just going through a [?] process at the moment.

BK: Okay yeah. So you said the last couple of years were, were stressful. The closure announcement I think was made in August.

SD: Yes.

BK: So what, can you tell us about the sort of period before then, about. The last couple of years you've identified as stressful.

SD: A lot of it I've tried to forget.

BK: Sure, sure, yes.

SD: Um I have sort of managed to do that until I got the call to come but um I, we started to happen and we were aware that things would be winding down that the Unit would go to Redlands Hospital.

BK: Oh yes Trudy was talking about that before yeah.

SD: Yeah.

BK: There was a planning process.

SD: There was a lot of involvement by Barrett and the clients, the parents, um, architects, um and even I think we had Kings involvement in some of it.

BK: Mm.

SD: Regarding the architectural planning for the new unit.

BK: Mm.

SD: But we had difficulties with um some issues with the koalas and

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BK: Mm. Oh right. The old koala, what do they call the, the koala corridor?

SD: Corridor.

BK: Corridor. That's right. That's right. Yep, yep.

SD: I think there were other issues as well [?] other pressures for that site but anyway um I'm not clear on that.

BK: Mm. So when did that actually happen. Was that a year, two years.

SD: Actually many years before.

BK: Okay, yep.

SD: Um could have even been 2011.

BK: Mm.

SD: It just kept getting delayed.

BK: Mm.

SD: Um and extended um. Um so leading up to that and contributing to some of the stressors was the halt on recruitment.

BK: Mm.

SD: Um people had to think about their jobs, their futures, their careers. You know um what happens after we move. Um hard to sort of say when all this would happen because we never knew

BK: Yes.

SD: The dates kept changing. Um so we had people, some people exiting the Unit

BK: Mm.

SD: And you know we'd replace them with contract staff.

BK: Mm.

SD: Initially that was only one monthly contracts.

BK: Mm.

SD: Um and then we managed to get it three monthly. Um so continuity of care is a bit of a tricky balance to get. Um our Nurse Unit Manager

BK: Mm.

SD: Resigned.

BK: Mm.

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SD: Retired and I took his place for some of that period of time, so my stress levels went up.

BK: Yeah.

SD: Um there wasn't very many of the old more experienced staff um left to sort of take on that position or willing to take on that position, so I decided to help the Unit out, um gathered some more experience for myself um but yeah it was, it was very challenging.

BK: Mm.

SD: Especially towards the end.

BK: Mm. Mm.

SD: I um, I stopped that position in May.

BK: Yes.

SD: Um and someone else took over. Um and returned to my position as the Community Liaison

BK: Mm. Yes.

SD: It's a Monday to Friday position, you handle referrals, um transition of care, um and yeah the last six months were highly stressful

BK: Yes.

SD: Um September of 2012 we'd been informed that the budget had come out and um that Redlands Hospital plans was no longer going to happen.

BK: Mm.

SD: Um that Barrett was going to go through a review process, um to see if an alternative model of care without the residential

BK: Mm. Yep.

SD: Setting would happen. You know, was possible. Um the timeline on that review was as quickly as it could happen but, so it could have been two months to three months

BK: Mm.

SD: Initially they were hoping for that. But it went on for ah six to maybe eight months.

BK: And who was involved in that review or was that

SD: Um Dr Sadler initially.

BK: Yep.

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SD: Um various ah, I think there was a couple of psychiatrists

BK: Ahm.

SD: I can't tell you who.

BK: Okay. He was external as well

SD: It was very yeah.

BK: Right, yeah.

SD: Because it was a state-wide service so

BK: Mm.

SD: And there was parents involved in that meeting, that committee as well. Um Dr Sadler was also asked to step down

BK: Mm.

SD: Due to an investigation that was occurring. Um sorry it was a very confusing time because um we had the impression that maybe um we'd have an alternative service

BK: Mm.

SD: After this review process to go to. Um therefore as a state-wide service shouldn't we continue to accept referrals and um a lot of mixed agendas um mixed messages confusing from my perspective [?].

BK: Yeah.

SD: Um whose direction I follow for that. Um and then ah Dr Sadler had asked to be stepped down and um there seemed to be a, a separation between school and the health [?] group. Um the school felt quite isolated, um and kept out whereas before they were very much a collaborative input. Um a lot of the staff felt that they, they really didn't understand what was happening um, felt sort of not within the communication of things. Ah a lot of the happenings of where our Unit would, what was happening to the whole processes were occurring at a higher up level. Um Dr Brennan was part of that, um Vanessa Clayworth um the Acting Clinical Nurse Consultant which was a new position created in that last six months.

BK: Mm.

SD: Um she attended some of those but mostly it was Dr Brennan. And other executives um within the District. Um and I've forgotten all their names already. Ah Sharon Kelly, um, um mainly ah Will Brennan and Elizabeth Holland I think her name was. Um and she was our governing body um the Childrens Health

BK: Mm.

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SD: Queensland um. So yeah a lot of communication sort of feeling a little bit isolated and only pockets of information and um, um and a lot of pressure to get things happening and then we developed the transition team meeting.

BK: Yeah.

SD: Because we'd been given this ultimatum or this deadline that you know the Unit would close January.

BK: Mm.

SD: Um I think, I'm not sure when that actually happened. It was towards the end of the year, um it could have been, it may have occurred after Dr Sadler

BK: Mm.

SD: Um was stepped down um after September so yeah not much timeframe. Um but I mean we were always I think we were, we were trying to get kids out anyway. Um but there was more, more sort of prioritised at that point.

BK: So prior to the announcement of the closure and that kind of different formal transition um period, you'd be in the position of the um Community Liaison, um that, that position, Community Liaison position and so you'd been um, ah responsible for receiving referrals were you um and that sort of receiving referrals, coordinating assessments um screening interviews and um

SD: Yep, yep.

BK: Reports and

SD: Yep. Um managing the waiting list.

BK: Yes.

SD: Um working out which ones would suit the current mix and um yeah.

BK: And what was your involvement in discharge accounting processes in the CLP position.

SD: I guess after admission, I would start that transition more of handover to the case coordinator.

BK: Mm.

SD: [?] in terms of case workups review meetings um which occurred about two, two monthly to three monthly. And um we'd involve the Community Service that referred them

BK: Mm.

SD: Where possible. Um so that transition would also [?] but facilitate it better towards the end. Um then towards the end my role I guess was making sure that the different things were ticked off the list.

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BK: Mm.

SD: So checking with the registrar to stress summaries are done in time, um talking to case coordinators about um, um liaising with the outside referral, the outside mental health body that would be supporting the child. Um yeah mostly that and, and sort of making sure that they had um any copies of assessment reports that had been done.

BK: Mm.

SD: Um and a lot of those things were ticked off at the, in terms of case workups.

BK: Mm. So in terms of the kids during that um, that final period of transition before Barrett closed, which kids were you most involved with?

SD: Um when it was decided um that there was a closure date, um we decided to create a transition team

BK: Mm.

SD: And I suggested to Dr Brennan and Vanessa Clayworth um, um who I thought would be best

BK: Mm.

SD: Suited to the task um, basically a group of people with key skills that would be good with that transition stuff. So psychologists, OTs, um a representative from the school, Ann Brennan, Vanessa Clayworth, myself and I think that was it. Um we didn't involve the case coordinators at those meetings but just because of the, the deadlines, the short timeframe and the fact that it was also difficult to get part timer staff

BK: Mm.

SD: Um the existing transition team and shift work as well, um, um though some of the case coordinators would have liked to have been

BK: Mm.

SD: There for that but yeah

BK: Does that mean that you had um a kind of general overview role of all the kids that were being transitioned, rather than being particularly involved with individuals?

SD: I had through my experience I provided that, those suggestions

BK: Mm. Mm.

SD: But um I had people above me as well who made the decision to go with that process

BK: Mm.

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SD: Um but generally um well I guess it yeah the transition team, yeah as part of the transition team yeah I would have had a general overview.

BK: Can you tell us how the process was managed of um of looking at the various agencies that kids were going to be referred to, um and how that sort of process of actually understanding what the capacities of those agencies were to receive these particular kids.

SD: Um I wasn't involved with a lot of the decisions in, in regards to those. Um I know that it was a very difficult task. Um, ah I'd say Vanessa Clayworth and Megan, sorry no, the OT who was on our committee um came up with a lot of the accommodation places um and

BK: so the options, the suite of options

SD: Yes.

BK: And would actually go out to have a look at them?

SD: I know Vanessa had done one. I think she's gone to [redacted] or somewhere ah and she [redacted] out to another place um this is regarding yeah I won't say the names, one of the [redacted]

BK: Mm.

SD: Um I can't remember if, who did that for the others.

BK: Were you involved in any of the site visits, different agencies?

SD: No, no.

BK: Mm. So um in the period of time with business as usual um what was your role with discharge planning?

SD: Business as usual?.

BK: Yeah business as usual before the transition period, yeah, yeah.

SD: I guess um how I saw my role was um as a support person for others who um you know had placements and come to the Unit and don't really, may not remember what to do for this role, so I, I'm a prompt or a um ah a supportive co-worker [?] sort of okay this is the process for this you know um yeah so with the registrars. Um.

BK: So who would be nominated in terms of business as usual as the key contact person for an agency that Barrett was referring a kid too, who'd be the key contact person of that agency back at Barrett?

SD: I guess it depends on what type of information they require.

BK: Mm.

SD: Um but I would put them in touch with you know whatever they needed. I guess I am a bit of a triage person for a where they need category best tailor

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

BK: In the transition period, yeah.

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

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

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

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

SD: Yes.

BK: When were you the care coordinator for

SD:

BK: Mm.

SD:

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

SD: I'm not really sure.

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

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

BK: Right. Can you recall who that was?

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

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

SD: She was a

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

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

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

SD: About same time, it could have been

BK: It was all around the same time yeah.

SD: Yeah.

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

SD: Am I in trouble?

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

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

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

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

BK: Right. Yeah.

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

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

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

TS: Yeah.

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

BK: Yeah.

SD: And yeah it is really sad.

BK: Yes.

TS: Yeah. Mm.

BK: Well look thank you very much.

TS: Thank you very much.

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Queensland Health

Health Service Investigation - Barrett Adolescent Centre

1084936

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

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

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

RR: Nothing.

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

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

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

RR: Yes I have.

BK: Okay.

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

RR: I've got a copy.

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

RR: Okay.

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

RR: Yes, I was.

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

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

BK: Oh okay, is that busy?

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

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

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RR: Yeah. It's working out.

BK: How long did you work at Barrett for?

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

BK: Yep.

RR: Um, around August.

BK: And did you stay up until the close?

RR: The very end.

TS: You were there right to the end?

RR: Yes.

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

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

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

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

BK: Oh, right.

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

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

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

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BK: Yep, yep.

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

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

RR: Well it was maybe with that I had …

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

RR:

BK: Yes....

RR:

BK: Mmm hm.

RR:

BK: Okay.

RR:

BK: Mmm.

RR:

BK: Mmm.

RR:

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BK: Mhm

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

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

RR: Yes.

BK: Actively involved in negotiating with the school.

RR: And that's why...

BK: Yeah.

RR:

BK: Yes.

RR:

BK: Fantastic.

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

BK: Yeah.

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

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

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

BK: Mhm, yeah.

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

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

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

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

BK: Why's that? Why is that?

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

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

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

BK: Right.

RR: [redacted]

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

RR: [redacted]

BK: Yes.

RR: [redacted]

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BK: Mhm

RR:

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

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

BK: What lead to that happening then that

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

BK: Yeah, yeah.

RR:

BK: Yep.

RR:

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

RR:

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

BK: Yeah...

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

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

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

BK: yep.

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

BK: Yeah...

RR:

BK: Yeah.

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

BK: Yeah....

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

BK: Yeah, yeah...

RR:

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

RR: For

BK: Yeah yeah.

RR: [redacted]

BK: Transitional housing.

RR: Sorry?

BK: Accommodation?

RR: [redacted]

BK: Yeah....

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

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

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

BK: What did you make of that?

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

BK: Yeah, yeah...

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

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

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

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

BK: Yeah.

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

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

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

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

RR: Mhm

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

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

BK: Oh right, yeah.

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

BK: Did many staff go to the funeral?

RR: A few of us went.

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

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RR: Yeah, yep. It was.

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

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

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

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

BK: Okay.

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

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

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

BK: Yeah...

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

BK: A long, slow, horrible unwinding.

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

BK: Yeah.

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

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

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

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

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

BK: Mhm

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

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

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

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

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

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

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

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

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

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

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

RR: Okay. Thank you.

TS: Thank you.

[**END OF THIS TRANSCRIPTION**]

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Queensland Health

Health Service Investigation - Barrett Adolescent Centre

1084936

Interview with RN Peta-Louise Yorke - Care coordinator for [redacted] 13 October 2014

Parties: Beth Kotze (BK), Tania Skippen (TS), RN Peta-Louise Yorke (PLY)

BK: You okay?

PLY: Yeah.

BK: So Peta, can I just check out to start with your understanding of this process, and what we're doing?

PLY: Um, my understanding is that you're looking into the transition processes, into Barrett, prior to closure.

BK: Yep, yep, yep. And you've seen the terms of reference, have you?

PLY: Yes.

BK: Yes, and have you got any questions about them, or, if anything does occur to you, just um, let us know okay?

PLY: Yep.

BK: So Peta you were employed as an RN at Barrett, is that correct?

PLY: Yes.

BK: Were you in a care coordinator role there?

PLY: I was in a joint care coordinator role and I was an associate.

BK: Ok, yep. And where are you working at the moment?

PLY: Ah the Royal, at the Adolescent Unit there.

BK: Ok, how's that going?

PLY: Mm, good.

BK: Do you like it?

PLY: Yes.

BK: Do you find it very different from working at Barrett?

PLY: Um ... yes and no, just the turnover, 'cause the stays are a little bit shorter.

BK: Yeah, it's more an acute unit.

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PLY: Yeah, it is.

BK: Yeah. So how long did you work at Barrett for?

PLY: Um, it would have been roughly two years.

BK: And where did you work before Barrett?

PLY: Um, so I did nine months at Barrett, and my transition program.

BK: Yes, yep.

PLY: And then I got a permanent job in medium secure, um, where I was for a period and then I went back to Barrett in December of 2012 until closure.

BK: Ok, so you were there right up until um until closure.

PLY: Yep.

BK: Ok. And, at the point when there was a transition to closure, which of the kids were you involved with?

PLY: Um, I was an associate for And I was joint care coordinator for

BK: Ok. Would you like to tell us what your impressions, memories of the transition period are, or what you were involved in, any particular issues that came up for you?

PLY: Um, as a care coordinator I wasn't actually involved in the planning of it. There was a panel put together that dealt with it and we just assisted. Like our main job was to make sure that the kids were okay on a day-to-day basis.

BK: How was that communicated to you?

PLY: Um.

TS: That's what your role was during that period?

PLY: Um, just in the case conferences that were on each week, so um, they would just discuss what's happening, where they were in the transition process, whether they were looking at, and we were to support if they were needing to look at places and things like that, um, and just support that emotional um, the main thing, 'cause a lot of these young people were feeling abandoned, so we were just to support that feeling and help them process that.

BK: Do you recall any specific examples of the level of information that you had about what the decisions were that were being made about the kids? So what was communicated at the case conferences, was it sort of down to the nitty gritty of we're trying this place, or referring to that place or was it more general or ?

PLY: It was very general, like we're looking, um at different options, um ... there was ... mainly they were just, it was discussed individually with the adolescents and then it would just be brought through with what information that they, like they might looking at this place here ... um, or they might be going to have a look at another unit, but not a lot of information.

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BK: Did you have the opportunity to participate in the transition planning?

PLY: No.

BK: And in terms of the sort of difference from ah business as usual before the closure was announced, was there a difference in how you were involved in the discharge planning or transition planning?

PLY: Um, for me yes, because I was a student.

BK: Oh ok, yes.

PLY: and I came down to Barrett after the announcement of closure.

BK: Did you?

PLY: Yes.

BK: You decided that yourself, To go?

PLY: Yes, 'cause I want to specialise in child and OT. It doesn't matter, even if it was a short amount of time, I wanted to get that experience so I can move through.

BK: Yes, yes. What's, if you look back on it, what's your sort of sense of the experience?

PLY: Um, it was overwhelming.

BK: Yeah, yeah.

PLY: Um, it was nice to be able to support some of the kids, 'cause I was like, a couple of 'em, I did their actual transitions to their new places, so ...

BK: Because we had that sort of sense that it was pretty um overwhelming, at least at times.

PLY: Yeah, at times it was.

BK: Did you feel you were able to be effective?

PLY: Yes. Yep.

BK: Can you give us an example? Whatever comes to mind about being, having been able to be effective?

PLY: I know there was incidents where I was able to de-escalate young people where other people hadn't been able to and just, like in helping to develop skills that they were going to need in a short period of time for transition.

BK: Yep. And when you say there were some times when you were involved in um in transitioning young people, can you tell us about those times?

PLY: Um, I transitioned um, so I was the one who took so I actually did the transfer there. Um, so that was mainly just supporting her and just introducing and um doing a handover.

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BK: How did you feel that went?

PLY: [redacted]

BK: Do you recall during that period of time whether you had any particular concerns about any of the kids that you knew well, and where did you go to with those concerns?

PLY: Um, ... I think we worried about a lot of them, particularly the acute ones, um, I would have spoken to like the NUM# and Vanessa, um, about them, um ...

BK: Do you recall any specific examples?

PLY: It was more just the feeling that the kids were feeling that we were just dumping them, so a lot of them were told when they first came to Barrett, um that Barrett is the only place left for you, that they can't be managed at home, um and they can't let the acute, their stay needs to be longer than an acute stay um and so basically they were sold Barrett as this is your, the final step place, and then to be told that Barrett was closing, then they felt, where do we go, like this was meant to fix me. So ... and a lot of them are engaging in therapy and once that kind of um, the closure was announced, the therapy, they weren't as engaging in it. Um, because they couldn't see the point, that we were just going to dump them somewhere.

BK: During that time do you feel that, you know obviously there's a huge amount of skill in um holding kids in that kind of distress. Do you feel that you actually acquired any specific skills around different interventions, or ...?

PLY: Um, I use a lot of sensory modulation stuff, so I do a lot of sensory work, particularly with the girls. Um, also just did distraction, um, so like taking them out, doing different activities with them, and just validating what they were feeling and just listening to, listening to them.

BK: How did you acquire those skills? Was that part of the then ongoing skill development program, or, how did you know about those interventions?

PLY: I was, like Vanessa was quite a mentor to me, so I used to get a lot of that sort of stuff. She taught me a lot of that stuff, so and as, in the transition program, that I knew as a nurse, a lot of that was there so it's like it was just mainly stuff on the ward that you would see some of the senior nurses doing and they were teaching.

BK: Yep. So that was really valuable information about what works for which individual kid. What opportunities did you have to feed that into the transition process?

PLY: Me personally?

BK: Yeah, you personally, yep.

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PLY: I suppose just through the notes, like our note, like our case reviews. That would be stuff that you would mention that this was an intervention I did this week, it worked really well or it didn't work ... yeah. And like there was people from the transition panel in the case conference, so they would know that – and it was quite a small team so most of, everyone knew the kids and knew how they – what worked well for them.

BK: So the case conferencing process, was that a new and different process or it had been in place before the transition period?

PLY: No, it had been in place before, so...

BK: Yep, ok, so so the difference now was that the transition team was part of it, is that ...?

PLY: No.

BK: No? Ok.

PLY: Ok, so the transition team was made up of people who were already part of the team.

BK: Right.

PLY: I don't know who all the members were. I only knew who a couple were. And so it was like the nurse who was a non-CNC, Anne Brennan, Megan Hayes who was the OT. They're the three that I definitely know that were in it, so ... And they were all partly involved in care on a daily basis.

BK: Now you mentioned that you were involved with three of the kids and you mentioned that you were involved in the transfer of Can you just talk us through what your involvement with each of the kids was in the transition period?

PLY: So, what my main role was that, like with I was the one who actually with and did the handover to the new team.

BK: Yep.

PLY:

BK: Mhm, yes, yep.

PLY:

BK: That's like a is it?

PLY: Yes.

BK: And how soon before left with that?

PLY: No, that was so ...

BK: Okay, yeah.

PLY:

BK: Gosh it really upsets you. Why is that? Why do you think it makes you so upset?

PLY:

BK: Were you involved in those discussions or is that something you've heard about?

PLY: It's just something that I had heard so I wasn't actually involved in that but I was told that there was a number of and that they said they

BK: Do you know whether, what were made for in the

PLY:

BK: So what did you hear about what was happening to the kids after you, you know, said goodbye when they left? Did you hear about them from time to time or ...?

PLY: I saw some of the kids around, like – that would still, like I saw and things like that 'cause sometimes was with the and they would be who was in and I would hear like if with the school as well because I've got a friend who is a teacher at the school and so I knew who was going to school and things like that.

BK: During your time since you left Barrett have you looked back on what was happening to those kids and your involvement with them? Would you have done anything differently?

PLY: No, I don't think I could support them any more than I did. And it felt like decisions were much higher than I was able to control. That there was – yeah, I just ...

BK: And in your current role, plenty of challenge in that?

PLY: Yes, oh it's just learning a new board now because it's a little bit different. It's more eating disorders. And more of an acute presentation so that's just – getting to know that has been different.

BK: Do you find that you use different skills?

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PLY: Ah, yes. I use a lot more general than I did. It's more of a physical – like a medical model um, yeah.

BK: Have you had much opportunity to talk about that last shift that you did?

PLY: [inaudible]

BK: Do you have access to clinical supervision?

PLY: Yeah.

BK: Do you think you might be able to use that to perhaps reflect a bit on what happened?

PLY: I think so, yes. I'm just ... I do group supervision at the moment but I'm just looking for someone, to do individual work because I did ... yeah.

BK: Okay. Are there any question you'd like to ask?

PLY: No, no.

BK: Thanks. Is there anything that you think that we should know? Anything you'd like to reflect on, share with us, ask us questions about?

PLY: Um ... no, sorry.

BK: Okay, well that – we'll be here tomorrow as well and we're going to spend quite a lot of time with Judy [?]for two days, so if anything does occur to you, if you'd like to know anything or ask me questions just let Judy know and she can let us know.

PLY: Yeah, okay.

BK: Okay. All the best. Thanks.

PLY: Thank you.

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Queensland Health

Health Service Investigation - Barrett Adolescent Centre

1084936

Interview with RN Moira Macleod - Care coordinator for 13 October 2014

Parties: Beth Kotze (BK), Tania Skippen (TS), RN Moira Macleod (MM)

BK: First of all can I just check out with you what's your understanding of this process?

MM: I don't really have an understanding of the process.

BK: Okay. You're aware that we've been asked to investigate the transition …

MM: Yes.

BK: Yep, the transition process for young people leaving the Barrett Centre. Have you seen a copy of the terms of reference?

MM: Oh yes, I was sent that [?].

BK: Okay. Do you want a copy?

MM: [?].

<laughter>

BK: Just wondered if you had any questions about the terms of reference?

MM: No.

BK: Okay. And if something does occur to you, please just let us know. So Moira, you're an RN?

MM: Mm-hm.

BK: And where are you currently working?

MM: I'm now working in the Correctional Centre.

BK: Oh, right.

MM: At Wacol.

BK: That's quite a change.

MM: Quite a change.

BK: Yes. Is that a forensic mental health unit?

MM: No, no, I'm just working in the medical centre, broad clinic [?].

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BK: Right, right. And sorry I omitted to say that I'm a child adolescent psychiatrist and I work with Tania in the Children and Young People's Unit, the Mental Health Children and Young People Centre New South Wales, so that's a bit about our background and how we came to be involved in this process.

MM: It still is my passion, but …

BK: Yes, it's hard to leave it.

MM: Yes.

BK: Once you've, yeah.

MM: Yes, but my heart is sort of still there.

BK: Yeah.

MM: To a fair degree.

BK: So how long have you been working in that sort of correctional …

MM: Since February this year.

BK: Right, right. So when did you actually leave the Barrett Centre?

MM: The day it closed. Like, I was one of the very last ones to leave.

BK: Yeah. And how long had you been there?

MM: Seven and a half years.

BK: Mm-hm. How long have you been an RN for?

MM: About eight years.

BK: Okay.

MM: I entered that quite late in life.

BK: Mm-hm. And what sort of qualification did you do before you worked in child adolescent mental health?

MM: Did the transition program at [?] Park and I think the experience of working there with the kids, you know, and constantly researching and …

BK: Mm. What did you particularly value about that role?

MM: I like the thought of changing their lives perhaps, guiding them onto a different path and changing what the outcome might be. You know, I think the hope is still there when they're kids, when they're adolescents. Yeah, I guess that's what it was about for me, that you can actually make a difference.

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BK: So was your role described formally as a care coordinator?

MM: Initially not but then it progressed to being care coordinator not, I wasn't initially taken on as a care coordinator.

BK: No.

MM: That was something that I eventually went into.

BK: Okay. So what were the sort of different [?] in RN roles – you could be a care coordinator, but what otherwise, what were sort of the other different roles that RNs were employed in?

MM: Well we always, we all had very similar roles, but you just took on a particular client.

BK: Okay. It was a primary [?].

MM: Yeah, yeah, the primary care of that person. But we worked as a team, you know, it was, that was what it was all about. We all had the same goals basically.

BK: At the time of the closure of the Barrett Centre, which of the kids were you working closely with?

MM: I was Case Coordinator..

BK: Who was that sorry?

MM:

BK: Ah yes, okay. Um, okay, can you tell us about

MM:

BK: Yes, yes. We know the files.

MM:

BK: Mm-hm.

MM: I think I was going to say I don't think the transition program worked for in the way it should have done, but that's not really what you're asking about I had great hope for If things had not been snowballed and rushed,

BK: Mm.

MM: I tried to keep my emotional side of it, trying to be professional, but you know it has, the whole thing has affected us all quite greatly, you know.

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BK: Mm. So when did you first come to know

MM:

BK: Mm-hm.

MM: I can't tell you a date.

BK: Mm-hm. Were you involved in assessment for admission?

MM: No, no. We, actually as registered nurses we didn't have a lot to do with the assessment process. That was [?] responsibility…

BK: So was there ever a process of nursing assessment, to look at the …

MM: Oh, day to day, a day to day process, yes. Absolutely we were assessing them all the time, all of our interactions. In a way we ran adventure therapy groups and all sorts of stuff, but the whole, it was a constant.

BK: Mm-hm. What sort of improvements did you see?

MM:

BK: Mm-hm. Had you looked after or been involved with kids like before?

MM: No I hadn't.

BK: Okay, so it was pretty challenging …

MM: It has only been at the Barrett Centre that I've been involved in. I mean I've worked in disabilities and I've worked in different areas, but not actually areas with mental illness.

BK: Mm-hm. Kids like that can be incredibly challenging and get right under your skin.

MM: Absolutely, yes.

BK: What was the [?] like? Where did you go to for advice or discussion about how things were going?

MM: Well, colleagues, the CN's and so on and we had the psychologist on, we had support through the psychologists and, yeah.

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BK: Mm. So the closure was announced in I think it was about August. How did respond to that announcement?

MM:

BK: Mm-hm. So how did the transition process unfold for What was the planning? What was your involvement in it?

MM: Well I think everybody thought they were going to come up with some solution. They can't possibly just discharge them to, there was nothing out there that really suited that group of children. And I think we all just prayed for something, some miracle, that we were going to find some solution. And it didn't happen, you know. I feel sorry for, you know, the doctors that were involved in the transition program because it was an impossible task, an impossible task, 'cause there just aren't the facilities out there to, you know, to support somebody like Somebody like

BK: So what was your input into the process? How did you, I guess, feed in, the knowledge that you developed about how did you feed that into the process?

MM: I don't feel I was really involved a great deal in that because my role as care coordinator just continued on a week to week basis, you know.

BK: [?] worked closely with

MM: Very much so, very much so, yes. As I say, I think we all just thought that they were going to come up with a solution, they have to come up with a solution [?] kids and the kids that we had, it was just the tip of the iceberg. There were so many out there that were on the waiting list, waiting for help that never got it. So I mean as far as being part of the transition program, I mean all we were doing was trying to prepare these kids for whatever came. We didn't know, we didn't know, you know?

BK: Yes. So how did you deal with that with somebody like who had presented[?].

MM: So yeah, just trying to You know, maybe our other service was a bit outdated, you know? Maybe there would be something far better that was moving onto, that would get that support,

BK: So how do you imagine the transition process might have been different?

MM:

[redacted] We actually believed that there would still be a support element once [redacted] transitioned out from Barrett, that we would still be involved in that perhaps, being there for part of the days, you know, until [redacted] became more able to cope with the change of [redacted] circumstances then. That ended up not happening. We were kind of led to believe that would be the case and then we were just told that wouldn't be the case, [redacted] be going there and actually was led to believe that it was a bad thing to remain in touch with [redacted] was told that, that it was not therapeutically sound for [redacted] to remain in touch with us who were, who had been [redacted] support system.

BK: How different was that from your previous experience over the eight years or so working at Barrett?

MM: Well I think other kids that had transitioned out back to the community or whatever, you saw that process you saw that person becoming stronger and going out to something better than living in an institution type setting. But that, it just didn't feel right, it didn't feel right what was happening.

BK: mm-hm.

MM: You know having known [redacted] in particular for that length of time. Just you know we had no control over it. It was taken from us.

BK: mm-hm.

MM: That's all that does my feeling, I um. It just wasn't the right thing for [redacted] For [redacted] in particular. I don't know what else I can say other than that.

BK: Sure. In the, before the announcement of the closure in that sort of eight years or so working at Barrett how had transitions been it sounds like they might be managed in a more protracted type of way. They were over the longer terms is that right?

MM: Definitely yeah yeah.

BK: And was there contact with kids after they'd been discharged?

MM: I think some of still come in for a day programs and so on so the

BK: Right.

MM: So they went from being residential to spending more time at home.

BK: mm-hm.

MM: And it might start with one day a week that they go home and it would amount to two days eventually there would home more coming in for a day program.

BK: mm-hm.

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MM: So they'd be attending the school.

BK: mm-hm.

MM: Um so there was still that there wasn't that severed link you know it wasn't suddenly that's it. Suddenly you've gone from 24 hour care …

BK: mm-hm.

MM: And it felt that you were cared for to really not.

BK: mm-hm.

MM: You know. Yeah so I mean we have some successes over the years we haven't, we've had a few not so successful.

BK: Can you tell us about somebody that you regard as having been very successfully transitioned?

MM: Am I allowed to speak names? Am I allowed to say names? If you want to …

BK: First names are fine.

MM: Um let me think. There's a few one in particular I think about is a called

BK: Uh-hm.

MM: And ah the times we've sat in with when and you thought is and thriving and productive and has travelled overseas alone and done all the things

BK: Yeah yeah.

MM: And did. You know and still out there and communicates with us from time to time and yeah. Um there is a few others as well that are, quite a few that have were successful you know in that there are still alive. Some that we thought would never stay out of hospital and have actually that particular has not been admitted even once.

BK: Yeah. Yeah.

MM: You know it's a number of years since um left us. Left Barrett but ah she actually stayed with us till was But ah

BK: mm-hm. it's not at all um controversial keeping a kid in child and adolescence unit till there

MM: Certainly was but [?] the lack of 18 to 25 the great lack of support for because they're considered adult after 18 but ah no it was controversial and we did have another as well that stayed till that. Wasn't ideal.

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BK: mm-hm.

MM: You know we'd rather have had some other solution to me you know like some kind of step down [?]

BK: Yeah.

MM: Where they're still connected to you but they're learning to be individuals. They're learning to cope for themselves.

BK: mm-hm. mm-hm.

MM: Yes pretty much so.

BK: Okay.

MM: I mean professionally that's the way that you do it. But you know when you've um really been that persons support for all that time its very, very emotionally very difficult.

BK: mm-hm. Of course of course.

MM: There was a little bit of controversy with

BK: mm-hm.

MM:

BK: mm-hm.

MM: So there was a bit of friction there. Um can I say I don't know whether I am allowed to say that or not.

BK: That's fine that's fine.

MM:

BK: mm-hm.

MM: There would have to be something else.

BK: mm-hm.

MM:

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BK: mm-hm. mm-hm. I'm not questioning at all that, um it was environment fo but that idea of how did that work?

MM: Well it wasn't all the time it was you know …

BK: Right.

MM: It depended on how week had been.

BK: Yep.

MM:

BK: Yep.

MM:

BK: mm-hm.

MM:

BK: mm-hm.

MM: You know.

BK: mm-hm.

MM: I don't know if I'm going down the wrong track.

BK:

MM:

BK: Yeah yeah yeah. So how was that …

MM:

BK:

MM: Yes.

BK: For her whole admission?

MM: I'm not sure. I couldn't tell you for specifically.

BK: mm-hm.

MM:

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BK: Okay.

MM: No I could be wrong I could be wrong on that. I mean maybe towards the end the … the goal post might have been moved but I'm not aware of that. Because otherwise

BK: mm-hm. mm-hm. mm-hm. That's what I was asking yeah.

MM: No so there was still that certain amount of protection for

BK: mm-hm. In terms of um processes on the in patient unit um ah would you as care coordinator have attended the Magistrates Hearings or equivalent.

MM: Well [?]

BK: Queensland.

TS: The Mental Health Review.

BK: [?] New South Wales.

MM: [?] ah if I remember rightly. Um so it happened within the, within the park and sometimes was encouraged to attend when wanted to. And there would be myself or it would be one of the staff members that would go with You know. Yeah.

BK: mm-hm. Okay.

MM: Excuse me just have a little bit of water.

BK: Oh yes no please. Please. Um okay. Any questions for us.

[FEMALE] I'm also thinking about was transitioned to and can you tell us a little about how that happened you mentioned it before briefly but you can tell us a little bit about over what period and how that adjustment was made?

MM: I can't, I can't really remember the timeframe the whole process was quite stressful for all of us and some of that is a bit, times and so on.

BK: mm-hm.

MM: I just seems to me that we were lead to believe it would happen over a longer period of time and then suddenly it was .. cause we weren't really given an actual date of closing.

BK: mm-hm.

MM: You know it was basically we would keep going on until um everybody was transitioned to somewhere suitable. Now with when they eventually found this place which like it was a desperate situation there was nothing really suitable. We thought there would be a lot more support over there than there was. We thought we would still be involved.

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BK: mm-hm.

MM: For a longer period of time. Maybe I was delusional myself in that but in my heart I felt needed more than, that's what needed.

BK: mm-hm.

MM: You know. And I thought we, might be employed for a longer period of time.

BK: mm-hm.

MM:

BK: mm-hm.

MM: Um it just didn't feel right it just wasn't right at all.

BK: Did you actually get to visit

MM: I did yes.

BK: And what was your impression of it?

MM:

BK: mm-hm.

MM:

BK: mm-hm.

MM: To me it just wasn't the right place. But there didn't seem to be anywhere else.

BK: mm-hm. And did you have the opportunity to talk to the team who was going to be looking after in that setting.

MM: Only on that one day that I was over. You know and I believed at that time that we would still be involved.

BK: mm-hm.

MM:

BK: mm-hm.

MM: But it didn't. You know and I can remember I phoned them this was out with work and it might not have been terribly professional but you know I think morally the support that we felt we had to give these kids was nothing to do with professionalism.

BK: mm-hm.

MM: You know. And I phoned over to see after a few days you know would it be suitable to come and visit

BK: mm-hm.

MM: And they actually said no they thought that was going through a grieving process for Barrett and would be better to be left to settle.

BK: mm-hm. It seemed quite hard.

MM: It was yes.

BK: mm-hm.

MM: You know and you're trying to do the right thing I think.

BK: What were the levels of support at

MM:

BK: mm-hm.

MM:

BK: mm-hm.

MM: But it was a different you know, it was not our service it was something different.

BK: mm-hm. Had you worked with that service before?

MM: Not me personally no.

BK: Right okay.

MM: The staff seemed nice and everything but they, they said right from the start this is not the right place for They knew that as well. I don't know what the right place is, I'm not saying that I've got any ideas of any other solutions because there just doesn't seem to be that support.

BK: mm-hm. Do you know at all whether and family were at all involved in the decision making?

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MM: As to where went?

BK: uh-hm.

MM: [redacted]

BK: mm-hm.

MM: I mean my impression of it maybe is completely wrong I don't know.

BK: mm-hm.

MM: Maybe my emotions are over powering my clear thinking I don't know. But I just I felt you know and was discouraged from having contact with us which I thought was wrong but you know maybe from a professional point of view then that's maybe I am wrong in that I don't know.

BK: In the past when there's been transitions [?] there is often horses for courses and um um courses for horses or whatever the expression is, um but its not sort of uncommon in [?] to have different kinds of rituals or ceremonies around, around kids leaving um was that part of this transition process. Or had it been part of the culture before.

MM: Yes definitely. Yeah yeah.

BK: mm-hm.

MM: There had always been some sort of celebration of someone moving on and going out … um.

BK: Was there anything like that around these transitions that you were involved in?

MM: Not really that springs to mind. I think we had sort of a we had a party sort of thing and the kids painted the wall.

BK: mm-hm.

MM: In the dining room. We didn't know what was going to happen to the building we thought they were going to bulldoze it or something.

BK: mm-hm.

MM: But they painted a big mural on the wall and signed their names and all that. Yeah so yes that was all part of you know we were trying to you know we were trying to keep hope into these kids. You know we weren't all doom and gloom and all poor me what's going to happen to me. Because that had nothing to do with it.

BK: mm-hm.

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MM: It was personally I had absolutely no idea where I was going to work after that but that wasn't the issue you know.

BK: mm-hm.

MM: It was ...

BK: One of the issues often is that the kids form intense relationships between themselves as well. What was the sort of general approach to dealing with that because it can be quite an issue post discharge.

MM: They were quite supportive of each other but I think you know not knowing what was going to happen to them you know it was a very difficult time for them. You know it was like I think they kind of felt that they were kind of on the scrap heap a little bit that there was not a solution for this. They were all still very much in need of support and you know like just the year prior there had been the plans to build a new facility.

BK: Right.

MM: Oh it was the plan and the kids were involved in some of that as well. There were plans drawn up their input was very much, they had representatives that were on the committee and things like that and then suddenly to go from that, I know there was a change of government and so on but to go from that to suddenly saying well no you know. We don't really need a new facility that's it just transition back out to the community.

BK: mm-hm.

MM: Um its, it wasn't very easy to understand you know.

BK: mm-hm.

MM: Why that focus changed so radically sort of thing you know.

BK: mm-hm. Okay just thinking about the kind of holistic care that you were giving at Barrett so you had the young people involved in some kind of education or school or I think may have had still contact with the was it.

MM:

BK: mm-hm.

MM:

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sometimes. And I do, I do know it must have been difficult for the family but there were times many times that did not feel like going home.

BK: mm-hm.

MM: So often we were, we were made out to be the bad ones or not the bad ones but the ones that made the decision to say that When it was quite often it wasn't quite that. You know we were protecting I guess.

BK: mm-hm. mm-hm. So those other things like the or the education were they continued? Do you know whether the transition planning included those kind of activities as well?

MM: Well the could have done. I think still had some involvement there was people that met there that were very supportive of [?] our organisation nothing to do with Queensland Health that were part of the and um I can't remember the name … there was a time that had come and sleep overnight and things like that.

BK: mm-hm. mm-hm. What about education?

MM: Well that was within the Barretts we had a school there. And off and on sometimes was so preoccupied with whatever was going on. I mean I can only guess what was going on in mind but um but sometimes could attend. did quite a bit of [?] standard that we were able to do at there I'm not a teacher I don't know all the ins and outs of that. But

BK: So I understood that some of the young people that were transitioned continued they didn't come to the school but the Barrett school staff continued to visit them.

MM: Yes I find that quite difficult to even talk about it because sorry

BK: That's okay its okay. Do not think that actually a box of tissues in this cupboard Moira.

MM: Sorry.

BK: You're alright. Fridge.

MM: Sorry.

BK: No don't' apologise. That's fine.

MM: Because was considered

BK: mm-hm.

MM: couldn't be involved in further education with the school.

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BK: mm-hm.

MM: So that was some other thing that was excluded from.

BK: That was after transition? Or?

MM: Well the school, they continued but over at, Yeerongpilly is it?

BK: Yeerongpilly

MM: Yeerongpilly yeah. But the kids were all sort of assessed prior to us closing …

BK: mm-hm.

MM:

BK: mm-hm.

MM: And I don't know all the details of that but for

BK: Yeah. Was there something else to substitute for that?

MM: No. No. No. I'm sorry perhaps I'm, perhaps there were bits of the jigsaw that I don't know, that I don't understand.

BK: mm-hm.

MM: Um sorry.

BK: No you don't have to apologise. It's obviously still very upsetting for you. Is it just when you talk about it that it becomes upsetting or is it?

MM: Yes.

BK: Yeah.

MM: Just …

BK: Was there any ceremony for staff at the end?

MM: I think that party that we had that day with the kids um painted the walls and so on. We were all intending to get together and have a post Barrett party but that never sort of happened.

BK: mm-hm.

MM: It doesn't matter. Sorry to get upset at about it.

BK: You don't need to apologise at all. How was the um process managed from the staffs point of view?

MM: Well

BK: It sounds like often there wasn't much information but …

MM: No I mean I suppose you know we did go through like an interview process to try and find us other jobs out there within the Park or whatever. A few people left before the place closed um I guess a few of us kept thinking something will happen, something will come up that you know we're still going to be supporting some of these kids.

BK: mm-hm.

MM: And that really as far as where I was going to work personally really wasn't much of a focus for me until, you know at the end I was beginning the think, I've got to think about, well there was the chance of a, a voluntary redundancy which I really didn't want at my age at the time. But um There was always that to fall back on and as a nurse you know your always going to work. Maybe not fulltime work at the age of 56 you know. So. Um but that really only came into being afterwards.

BK: mm-hm.

MM: Yeah um can't remember what you asked me there sorry I got a bit sidetracked.

BK: I was wondering about the processes supporting staff in the transition period. After all the staff would have had time to soak up the anxiety of the kids.

MM: Yeah no I think it was very stressful for us all. A few of us got quite ill after the place closed for different reasons just you know the whole build up it had gone on for so long. You know and there was other issues that had happened earlier that our consultant psychiatrist was out of the picture then.

BK: mm-hm.

MM: He was you know he was very supportive of … we used to often turn to him for advice and whatever and then he was suddenly out of the picture because it was all this stuff going on.

BK: mm-hm.

MM: You know so that was another thing. That was very very um distressing for the kids as well. And then they started cutting down on staff. The you know we used to have two psychologists and one was sent elsewhere. Again had taken years to actually start opening up to the psychologist that had and then because we were coming towards restructuring or closing or whatever was going to happen that particular psychologist was sent elsewhere. So that was another person suddenly couldn't have any contact with.

BK: mm-hm.

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MM: That sounds like a terrible story there sounds awful sorry. Jumped around all over the place.

BK: No that's fine. Is there anything else that you would like to tell us if you think its important for us to know. Any reflections you want to offer or questions that you would like to ask?

MM: I'm not really sure how more[?] oh I don't know how it could have been done in a better fashion other than just over a longer period of time.

BK: Um its obviously very difficult predicament.

MM: Oh absolutely, absolutely. Because as I said we don't' have the facilities out there for that group. Um.

BK: mm-hm.

MM: I don't know.

BK: No no that's fine.

MM: [?]

BK: Thank you very much. Yeah. Okay thank you.

MM: Sorry for that.

BK: No you take water with you.

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Queensland Health

Health Service Investigation - Barrett Adolescent Centre

1084936

Interview with RN Matthew Beswick - Care coordinator for and 13 October 2014

Parties: Beth Kotze (BK), Tania Skippen (TS), RN Matthew Beswick (MB)

BK: So I'm a Child and Adolescent Psychiatrist from New South Wales and Tania I both work for Mental Health Children and Young People in New South Wales. So can we just check out first of all your understanding of this process, what it's about, why we're doing it?

MB: Well my understanding is that you'll be investigating the transition process and assessing my experience or what I have to say about the mental state of the kids in the lead up to that. That's my understanding, from talking to Kristen.

BK: That's great, great. And you've seen the terms of reference, we've got a copy here.

MB: I haven't read it recently but I read them initially, yeah, yeah.

BK: Yeah, do you have any questions or queries about the terms of reference?

MB: Not at present, I'll stop you if I've got a question. Speak up and ...

BK: Yep, if anything occurs to you, yep, no that's fine, that's great. So Matthew, you were employed as an RN at Barrett, yeah?

MB: Mhm.

BK: And where are you currently working?

MB: I'm working at the Ipswich Adult Acute Unit.

BK: Okay, okay. As an inpatient ...?

MB: Inpatient, adult acute mental health.

BK: Yeah good, how's that going?

MB: Yeah yeah, no, no worries um quite different but um I'm sharpening up my skill set and – well, just different, exercising different areas.

BK: Yeah, yeah. How long did you work at Barrett?

MB: I don't think – it's over 7 years; it's in the 8-9 year range because I was there for 18 months as quite a junior person, went away and came back and it's in that 7-10 – like I'm not sure exactly, I'd have to look it up.

BK: Yeah sure. And where did you work before Barrett?

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MB: Before Barrett? I was working, well, um ... I well, if we backtrack I did two years on Thursday Island doing general, which is basically everything else.

BK: Yeah.

MB: Accident and emergency and operating theatre.

BK: Wow. Yep.

MB: And community.

BK: Yep.

MB: And so that was a year of that mix and then the second year was general ward.

BK: Yeah.

MB: I didn't do maternity except for helping out when they call you in.

BK: [*Laughter*]

MB: Ah well you know when you're a [?] on night duty and they go can you give us a hand? Um, so I did that, then I did a year of agency because I wanted to ground myself in all the machines that go ping that you don't get to use on Thursday Island.

BK: Yeah.

MB: Um, and then I went to the Park which involved – now called the Park, it was Walson[?] Park.

BK: Yeah, yeah.

MB: So that involved um both before Barrett and during the two and a half years, involved Ipswich Adult, I did 18 months there um ... two and a half years in um, well in various levels of the high secure and a very brief stint in medium secure, like as in three months I think.

BK: Yeah.

MB: And – it might have been four months – and also a short stint, like four months, in rehab as in um sorry repatriation ...

BK: Okay.

MB: ... before they shut it down, so that was the veterans.

BK: Yeah.

MB: This is pre-Iraq type veterans. Yeah.

BK: Yeah.

MB: So a bit of a, some general [?] yeah my personal thing, I think everyone should get some general grounding before they get into mental health.

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BK: Yeah, yeah. So was the Barrett Centre your first experience of mental health inpatient care?

MB: Mm, first adolescent, but not first ...

BK: First adolescent sorry, yes first adolescent, ok, yeah, yeah and um and when did you finish at the Barrett Centre?

MB: When it shut.

BK: Okay. So you were there up until that day, up until it shut.

MB: Yep.

BK: Okay. So um you had a care coordinator role at the Barrett. How would you describe that role, perhaps you know compare it to some of the other mental health roles that you've been in?

MB: Well care coordinator was a subset of being an RN warder.

BK: Yeah.

MB: You weren't - you are going to have the job, you're a care coordinator. It was a lot of hats you wore on the ward um, so you were not the primary decision-maker, you just made sure that um all the boxes were being ticked so to speak with respect to um you didn't have to be personally doing it, so it could be all the way from you're driving everything and making sure everyone's doing it or to just sitting back and just making sure that it's all happening, so you have a lot of primary contact with the kids, you um make sure that you know what's going on with respect to individual therapy, family therapy, school-based stuff 'cause all the kids have – you can go and speak to anyone at the school but they also had a nominated teacher who was their teacher um, I already mentioned family and also whatever um, whatever's going on with respect to if they were doing um work experience or some sort of training program, you might have a role in seeing how they're going and a lot of – it's what needs to be done. You either do it or make sure someone else is doing it so you might be liaising with speech to make sure that they're, you know, what's their receptive understanding, what's their expressive, what's better written or, all this sort of stuff and making sure that that gets to the teachers if they hadn't already done it so it really is very varied. It's just making sure everything's done whether you're doing it yourself or just checking off the …

BK: What was the extent of the role of families?

MB: Um well it's, well it's just an extension of what I've already said.

BK: So it's more about communication and liaison with [?] family therapy sessions or ...

MB: Um well it would depend on the therapist because we had periods where we didn't have a family therapist but I always made a point of, it was appropriate, if a family was happy with it I would be in there with um – well our longest serving family therapist was named David, he was a social worker and a family therapist and I was always wanted to be there because it gave me better insight, as long as it wasn't impeding anything and it was welcomed by the family because they're only there

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9 to 5 Monday to Friday, if that. Sometimes it's less than a full time role so I would want to help support. You know, the parent might be ringing up saying oh he's on leave and something or other is happening and I can reflect back what's going on there. But in the broader context I'd be disappointed if anyone wasn't speaking to the family at least weekly, just to both hear what they think and also communicate what we think and also make it clear that they can ring at any time and if they don't get you they can speak to the and it'll get back to you when you come back on shift next.

BK: How would you compare it to the role that you're currently in?

MB: At Ipswich?

BK: Yeah, yeah.

MB: Oh wildly different.

[*Laughter*]

MB: But it sounds like I could fill up an hour, I'm not sure how, what sort of detail you mean, like we um I um well, we've recently changed to stream nursing.

BK: Yes.

MB: So there's a small increase in the amount of that sort of thing going on but …

BK: Yeah.

MB: Oh, it's wildly different.

BK: Yeah.

MB: It's much less nurse – not so much nurse directed but we're not co-ordinating as much.

BK: Yeah, yeah.

MB: Um doctors are largely making decisions based on seeing our notes and you get pleasantly surprised at the doctors that actually check in with the nurse prescribed, allocated to that patient.

BK: Mmm.

MB: Um it's, it's much less ...

BK: Very different. yeah.

MB: Very different, much less co-ordinated.

BK: Would you talk about um your role as a um a care coordinator in discharge processes and transition planning for kids at Barrett?

MB: For the transition that happened?

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BK: Yeah. Well no, just in general, as a general topic, sort of business as usual, before the closure.

MB: Yeah.

BK: Yeah.

MB: Um well, the broader decisions about moving towards discharging are more towards the end, was all, well, all of it was basically directed from both weekly case conference meetings …

BK: Mhm.

MB: Which were probably, any kid got anywhere from 5 to 20 minutes air time in those.

BK: Mhm, yep.

MB: But there was also 6 weekly um they'd change the names but there was, and intensive care work-up which was the larger directional decisions ...

BK: Yes, mhm.

MB: Um so the broad strokes are decided there and again, if it's transitioning to a school in the local area you're talking to the school. Sometimes I was involved in actually um being a support person at the school in the initial transition stages and being either in the classroom, out in the hallway or I'm in the office if you need me come and get me type stuff ...

BK: Yeah, yeah.

MB: ... and all sorts of levels or it could just be transport and um support and um I don't know, coaching or whatever they call it, in the car or driving them out there.

BK: Yeah.

MB: Um, seeing what is going to be going ongoing like you know CYMHS.

BK: Mmm.

MB: We would - you had less direct involvement with CYMHS.

BK: Mmm.

MB: You might touch base but we did have um a person whose role was more of the externalised stuff ...

BK: Hmm.

MB: ... like what ah what'd they call it – CLP - community liaison position.

BK: Okay, yeah.

MB: So they had, they were, they were involved with um intake and to a degree discharge as well.

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BK: Mhm.

MB: Because we wouldn't basically, the first time I'd know a patient's coming is, would be XYZ's showing up on Tuesday.

BK: Yeah.

MB: Read my brief, not involved in pre stuff but um with respect to discharge, so really it was as varied as the what's the child doing.

BK: Mmm.

MB: It could be um ... I've even travelled up to [redacted] once to help transition a boy back to his home.

BK: Fantastic yeah, yeah, mmm.

MB: That was once but it did happen.

BK: Yeah, yeah.

MB: Um and to share a lot of insight or teleconferencing with the local area, where they're going to.

BK: Mmm.

MB: Supports for mum and dad. Always offering them um helping it happen if they want to, which could be everything from [redacted] to just going in for support for themselves about the difficulty of having kids with mental illness.

BK: Mmm, mmm, mmm.

MB: Um I'm not sure I'm getting a bit nebulous but [?].

BK: Oh no no, that's okay, that's great. So um that was how thing were sort of business as usual.

MB: Mhm.

BK: Was it different during the transition to the closure?

MB: Totally.

BK: So okay …

MB: We got told overtly you are hands off from the discharge process um we're dealing with it, meaning that specific transition panel – I don't know what name they gave themselves.

BK: Right.

MB: Um the rationale that I was given was that the um by removing us from the decision making process and we're the primary supports for the kids as care coordinators,

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we're not therefore the bad guy if any decision making is – if it doesn't come from me I can whinge with the kid and say oh, you know, that's no good or you know, if they don't like it then I didn't make that decision so I'm not, you know, the bad guy or whatever.

BK: Mhm.

MB: That's shorthand. I could spend longer explaining what it's [?].

BK: Yep, oh no, no [?].

MB: So it stopped us being the bad guy. We'd just support them and um we were never asked: Well, [?] speak for me. I was never asked and my understanding was that no-one was asked directly we're thinking about doing this, what do you think?

BK: Hmm.

MB: That never happened to me and my understanding was that was consistent across everyone.

BK: Mhm, mhm. Okay.

MB: There was never any feedback sought um in fact I often heard about plans when the kid says 'you know they're thinking about doing this'. I'm going 'mmm okay, wow, well how do you feel about that?' And then you go and find out really is that what …

BK: How did you find that arrangement?

MB: I found it conflicting because I understood and liked the idea of not being the bad guy, not as in from a personal point of view but the kid could still – it's like I say kid but ...

BK: Yeah, no, we und ... what you mean, yeah.

MB: They could, they could talk to us and not feeling like I made that decision.

BK: Yeah.

MB: Like you don't get it, why did you pick that? So that was really positive.

BK: Mmm.

MB: But not having any feedback at all um you know like ...

BK: Mmm.

MB: ... we know these kids pretty well and never even we're thinking about this, do you have any input? Nope, I didn't like that.

BK: Yeah, yeah. In the lead up to the closure, which of the kids were you involved with?

MB: Well as – well you can there I was registered nurse, For the last two and a bit years I was acting clinical nurse ...

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BK: Okay. Yes.

MB: ... if that wasn't clear. I was – through that role you're involved to a moderate degree with absolutely everyone.

BK: Okay.

MB: Um ... I was primary care coordinator for um

BK: Mhm, yes.

MB: I was secondary coordinator/supervising coordinator for um

BK: Mhm, mhm.

MB: Um and I'm not sure exactly how far out before discharge but I was, I was a fill-in for

BK: Mhm.

MB: And um as the only CN um often gravitated to me as well. Yeah.

BK: Hmm. Can I just?

MB: [?]

BK: CN - is that …

MB: Clinical nurse.

BK: Like clinical nurse consultant?

MB: No, no.

BK: No it, in um Queensland we have um registered nurses ...

TS: Yes.

BK: ... then, you know, sort of a promotion to

TS: Clinical nurse?

BK: Clinical nurse specialist we call them.

TS: And then clinical nurse consultant.

BK: Yep, okay.

TS: And so there's a clinical nurse is still um you know, how would you ...they're clinically involved.

BK: Yeah.

TS: All clinically involved.

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BK: In our system the clinical nurse specialist is assigned to take on an additional portfolio...

MB: Well it's a bit like how you have um, I don't know if it's the same for you guys but um nursing manager and CMC …

BK: Yes.

MB: ... they're on the same level but have a different role.

BK: Yes.

MB: Clinical nurse is the um is not the specialising but like more in charge of the shift.

BK: Okay.

MB: Analog to a CNS.

BK: Yes.

MB: Well not analog, but on that same level, because CNSs do exist up here as well but they're less common.

BK: Okay, yes.

MB: Um you have far more clinical nurses than you have clinical specialists.

BK: Okay.

MB: Like they might be more in like your dialysis unit.

BK: Yes.

MB: They might not be in charge of the shift, like they're the whatever go to.

BK: Yep, yep, no I understand, thank you, thank you. So um can you talk to us a little bit about

MB: Yeah, what would you like to know about

BK: So when did you start working with

MB: Ah on

BK: been there for about is that correct?

MB: I was involved as soon as got there.

BK: Yep, yeah.

MB: Yeah.

BK: What were your impressions of

MB:

BK: Mhm.

MB: Um oh look, I'd have to go to [?] notes if you want, not much very specific but had you know

BK: Mhm.

MB:

BK: Mmm.

MB:

BK: Mhm.

MB: Um not directly but [?].

BK: Yeah, [?] so you were working with quite intensively? Um.

MB: Well I was never individual therapist.

BK: Okay.

MB: I was never anyone's individual therapist.

BK: Yes.

MB: But there's elements where you can become that by proxy but I want to make that really clear that there's still huge like okay that's stuff that you deal with.

BK: Yep, sure.

MB: So that's what I, my experience in a care coordination role is that you understand where they're at, directly speak with their OT.

BK: Mmm.

MB: You don't need to know the specifics but you have a relatively close understanding. You don't need to get into the details but it informs you that your understanding of what may be affecting them and triggers and helping them understand things and anticipating problems and stuff like that.

BK: Mmm. So during the period of time after it was announced that Barrett was closing um and I guess you know you're saying to us that um that um there was this decision that the care coordinators wouldn't be sort of involved in the process of transitioning um I mean, how could you manage that when you're working day to day intensively with somebody like this um you're not so involved in where they're headed for the future but you're kind of soaking up all the um ah the emotion that comes from that, I mean, what was that period like?

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MB: Well there was lots of challenges that included both and also the changing staffing environment. I don't know if that's something you want to get into.

BK: Yes please. can you tell us about that.

MB: Well we ah look, when professionals know that there's an expiry date they start looking for jobs so we had for want of a better word a brain drain going on.

BK: Mmm.

MB: Um we had increased acuity for children oh kids, adolescents, that have you know issues related to worry about their future, abandonment type issues.

BK: Yeah.

MB: Um as a whole of ward type experience we had more suicide attempts um, self-harm behaviours.

BK: Mmm.

MB: Um they were feeling elements of a loss of control based on the fact that people who'd been, you know, prominent were now also removed from their decision making process. There was also the experience of a long standing experience called the holiday program was actually removed from our control for the first time ever and put into the control of an external NGO.

BK: Mhm.

MB: Um and so even the kids going out to [?], usually a form of respite and also rehabilitation and so some of them quite frankly were saying like this is shit, this is nothing you know. You understand that's their language, they're like complaining about this, this is rubbish. What's going on? Why aren't you taking us? What, you're suddenly not authorised to take us to the movies or take us to Wet n' Wild and um.

BK: Mmm.

MB: My understanding, I don't understand why they chose to do, those other people to do it but I believe a factor was, 'cause a lot of thing were brought closer to the, to the unit that are related to acuity and concerns about what might happen so for example they'd bring a bus with, full of video machines, you know video arcade machines, on the unit to minimise going out so much. They did a lot more ward-based activities.

BK: Mmm.

MB: I believe it was related to concern about acuity of, you know, they know the place is closing.

BK: Mmm.

MB: Um let's keep 'em closer to the unit um that sort of thing um. I lost track of the question because [?].

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BK: No that's fine, that's fine, it's very helpful um and what about your relationship with the parents of the kids? I mean, you think about those kids that you've mentioned.

MB: Yes.

BK: During that transition period were there changes made to how you were relating to the families, to the parents?

MB: Well that's a, an hour's not enough. Um that's as varied as the kids.

BK: Yeah.

MB: I'll give you a broad one of each of them and then you can drill down to whatever you want.

BK: Yeah, no.

MB:

BK: Yeah.

MB: Through some form of I don't remember explicitly what it was.

BK: Yeah.

MB:

BK: Mhm, mhm.

MB:

BK: Yeah, yeah.

MB:

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BK: Mmm.

MB: So had a 'I know you're not behind this Matt but I don't like this, this and this'

BK: Yeah.

MB:

BK: Mmm, mmm.

MB:

BK: Mmm.

MB: So that's … ;

BK: [?] given that, it sounds like um you know you had an important role with at least ensuring the need for was done with the families in terms of

MB: What sorry, the ...

BK: The need for, whatever needed to be done.

MB: Yep.

BK: So kind of you know crossing the T's, dotting the I's, actually things happened.

MB: Mmm.

BK: So during this period when Barrett was moving towards um closure, you're still interacting with the families um but you're not involved in the decision making processes around the transition.

MB: Mhm.

BK: I mean, how did you manage that? Where were they getting their information from and …

MB: Well I'm not entirely sure. I assumed that they were having, getting input from the transition team or directly from the children, I don't know this for sure.

BK: Yeah, okay.

MB: There would be occasions, because I didn't actually get to

BK: Mmm.

MB:

BK: Mmm.

MB:

BK: Mmm, yeah.

MB: Like consistently.

BK: So if the decisions were being made by the transition team, was there a role for you in the transition, in the way you've described it in the business as usual period was happening and you might have gone out to the school to assist with integration or you know …

MB: Well that didn't happen in the shutting down transition.

BK: Yeah.

MB: Only because as a CN you're much less likely.

BK: Yes. Oh okay, so [?].

MB: So that was when I previously, when I was a C, was an RN.

BK: Yeah.

MB: I would be much more likely to do it because you're in charge of a shift, you'll need to coordinate the day.

BK: Yeah. okay.

MB: Um it would, I'd not, and also both of those were not going to be in the local area so the um they weren't going to schools and the age was not appropriate for school so but still, go on with what you were saying.

BK: Yeah. So did you have a specific role in the transition around any of those three kids?

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MB: I was never ascribed anything with respect to we're transitioning therefore we need you to adapt your role in any way or any new instructions.

BK: Mmm.

MB: It was just continue supporting, trying to get a handle on things, communicating between all the stakeholders um but that was removed completely from the transition process.

BK: Mhm. Were staff kept advised of the transition process? So how did you know sort of where [?]

MB: Well there was, well if you're talking about individual kids I wasn't. If you're talking about the fact that oh we're likely to be shutting at this point in time, we might hear about it on the radio or an email that, saying we just want you to know before it hits the news tonight um or um we had like an executive from West Morton also come out from time to time um, Laurence Springbrook came out once but we weren't in there. He was talking to parents and kids.

BK: Yeah.

MB: So I'm sure that we got emails of some sort of updates but it was, it was what do we call it? Like, you know, birds eye view type stuff not, well you know, well you know I can't think of the right analogy, you know, not the minutiae. Yeah, pretty remote stuff yeah.

BK: Yeah, yeah. Could I just ask a question about um Head Space in Queensland? What kind of services does Head Space here operate? I mean in New South Wales they're very much primary care um services, they don't do assertive outreach um they really do pretty much sort of short term um primary care sort of stuff. They wouldn't identify themselves necessarily as providing specialist mental health services. It seems like it might be a little bit different in Queensland?

MB: Um I think I'm barely qualified to answer that.

BK: Okay that's absolutely fine, that's absolutely fine.

MB: Yeah. I don't have any documents. Contrary to what you've just said ...

BK: Yeah.

MB: ... I don't have anything to say. I only know from just – I've never been directly out there.

BK: Yeah.

MB: But I've got a friend who works there and what she has described to me sounds very similar to your understanding, but that's not personal experience.

BK: Okay that's absolutely fine. So um prior to the transition to the closure of Barrett um are you aware of Head Space being used as a discharge resource generally or from time to time or unusually, was it …

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MB: I knew that Head Space existed.

BK: Yeah.

MB: I knew that it was certainly one of the things that um was to be considered.

BK: Yeah.

MB: I would hear the names thrown around, I didn't have much direct involvement and um with either making a decision to send someone there and I don't recall any of mine being sent to Head Space so therefore needing to go and do a lot more homework on that one.

BK: Yeah. No thank you, thank you.

MB: Tania, do you have you any questions you wanted to ask?

TS: No, I don't think so, thank you.

BK: Yeah, yeah, no thank you very much. Is there any questions you wanted to ask us?

MB: Um I don't know, what happens now?

BK: Well we've got two days of interviews.

MB: Mhm.

BK: Um and then um ah as you can see, a very large amount of paperwork that seems to grow every time we look at it.

MB: So once you've got all this information and you've had a look at, you have spoken to everyone and you've got these answers, what's?

BK: We have to sift through it and produce a report.

MB: Okay, so you then say we think that, I'm not asking to predict what you're saying but you're assessing the suitability of the transition process, is that what you're assessing?

BK: Looking at the, um, transition process in terms of its um effectiveness and appropriateness, that kind of thing.

MB: Yeah, okay.

BK: Well it was obviously an incredibly difficult time for everybody involved.

MB: Yeah, well you must be familiar with some of the outcomes as well.

BK: Mmm.

MB: Yeah.

BK: Indeed, yeah. But thank you very much.

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MB: No worries, no worries. I've got night duty again tonight.

BK: Oh no! [?]

MB: No but I have to stay up late to get, try and stay asleep. As it happens I woke up in time to come here and then I've got to try and get some more napping before …

BK: [?] But thank you very much.

MB: No worries, I hope it helps.

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Queensland Health

Health Service Investigation - Barrett Adolescent Centre

1084936

Interview with RN Mara Kochardy - Care coordinator for 13 October 2014

Parties: Beth Kotze (BK), Tania Skippen (TS), RN Mara Kochardy (MK)

BK: I think we are now recording. We also may take some notes as we go along just as prompts for us.

MK: Okay.

BK: So, as I said, my name's Beth Kotze, A Child and Adolescent Psychiatrist from New South Wales, and I work with Tanya. We're both from Mental Health Children and Young People Division in New South Wales. So, thank you very much for attending this morning. Can I just check out first of all what's your understanding of the process and what we're doing, and the investigation?

MK: My understanding is that, you know, you are investigating if the transition process was accurate.

BK: Yep.

MK: For the children's needs.

BK: Yep. Yep. The kids at the Barrett Centre. Have you actually been provided with a copy of the terms of reference?

MK: I have.

BK: Okay. Do you have any questions about the terms of reference, would you like to refresh your memory?

MK: At the moment, I haven't got any questions. No, I might ask questions as I go along.

BK: Please do. Please do. If anything's not at all clear, or you're wondering about anything, please do ask us. So, you're aware that we've been asked to look at the process of transition for the kids, once the closure of the Barrett Centre was announced. And you're aware of the circum …, the reasons for that?

MK: Not really.

BK: Ahuh. Okay, I understand there were some poor outcomes for some of the young people in the period subsequent to transition and closure of the Centre. So, that's sort of why we've been asked to do this. Okay, so look, I wonder if we could start with you're an RN, I understand?

MK: That's right.

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BK: And how long have you been an RN for?

MK: This will be my sixth year.

BK: Sixth year, okay, okay. And where are you working at the moment?

MK: At the moment I'm working at the adolescent ward at the Royal Brisbane.

BK: Okay. Is that a mental health unit?

MK: It's a mental health unit.

BK: Right, okay. And how are you finding that?

MK: I'm loving it yeah, love everything.

BK: So, you've been in, is it as an RN and mental health for six years? Or?

MK: Mm.

BK: Okay. And what did you do before that?

MK: I was a mum.

BK: Okay, yes, yes. Yeah, yeah. So, was the Barrett Centre your first RN position?

MK: When I finished my, when I graduated, I did a transition program at The Park, and I went all over The Park during that period. And then I did my Masters for two years.

BK: Oh, fantastic.

MK: After I did my Masters, I requested to enter the Barrett Centre.

BK: Yes.

MK: And so, yes, I did that for two years.

BK: Yeah, so you very much wanted to work with young people, is that right?

MK: Yes, I did.

BK: Yes, okay. And can you tell us how you generally found your duties at the Barrett Centre?

MK: I enjoyed it cause there was a lot of interaction with the kids, we got to know the patients very, very well. So, it was very, I found it very satisfying. Ah, yeah.

BK: Yeah. Is it, was it different or in contrast to your current position?

MK: I think it was in contrast cause these kids were long term patients, so, I mean, you got to know their families very well and you got to know the children

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very well. Whereas the place I'm at now, we share coordinators, so we don't get to know the patients as well, as we did at the Barrett.

BK: So, the model of nursing care is different in the inpatient unit that you are currently working in?

MK: It's more medically based.

BK: Okay, okay. Is it sort of a team model or is it a primary nurse model?

MK: It's a team model.

BK: Okay, okay. So, the, which is different to the Barrett Centre key coordination model. How did that actually work in practise?

MK: I think it worked quite well, because the nurses were with the patients for the majority of the time. And it was very good that we got to know them, cause we got to know what triggered any, we got to know them extremely well. But, at the same time, I think that we worked very well as a team there too, with the social workers and psychologists. I think we pulled together and worked well.

BK: What would you say were those sort of specific duties of care coordination?

MK: Mostly, it was to be an advocate for the child. To make sure that the family were involved, very important with you know nursing at the Centre, and to let the other members of the team know what was going on, so if they needed to see the psychologist or social worker, that we refer them to the people that they needed to see.

BK: Did the care coordinators have specific responsibility for specific interventions?

MK: Not really.

BK: Cause you mentioned that you got know the kids so well and, you know, perhaps in a good position to see what triggered certain things for them. Were there a suite of interventions then that the care coordinators were responsible for delivering, that tend to get handed over to RNs?

MK: [?] to get handed to other team members.

BK: Right. Okay. And in the usual kind of run of the mill, business as usual sort of situation, how did discharge planning work?

MK: You know, I was not really that much involved with discharge planning, that either was handled by the Allied Health or the, what do they call them, the clinical team.

BK: Okay.

MK: We didn't do admissions, and we didn't do discharges.

BK: Okay. So, how would an RN on the floor responsible for working for young persons get that sense of an understanding of the assessment, and then the discharge needs? How would you have been involved in the care planning processes?

MK: Each week there would be a meeting where we'd talk about the, what was needed for the children, so in that meeting, we would discuss everything that was happening with the child, what their needs were, and that's where we'd get some idea of what was happening [?].

BK: So, at the time that the Barrett Centre, the announcement was made that it was closing, how long had you been working there then?

MK: It'd be about 1.5 years, I guess.

BK: Okay, okay. Did the news come out of the blue or was there some anticipation?

MK: There was, I think there was some anticipation that it might happen, but we didn't know when.

BK: Right, right. Okay. At that time, do you recall the kids the you were actually dealing with at the time that you were involved with?

MK: Which ones I was involved with?

BK: Yes.

MK: Of course, I was involved with

BK: Yes.

MK: And

BK: Okay, okay. Could I just ask, sorry to interrupt, when you heard that Barrett was closing, it would have been around which date? Was the official date in August or was it prior to that?

MK: It wasn't prior to that, it certainly wasn't prior, it'd be, I think I went on leave too for a few weeks, so it would have been towards the end of August, I think.

BK: So, the beginning of the timeframe. Thank you. So, you were involved with and, I'm sorry, the other name, the other?

MK:

BK: And Okay, can you tell us about

MK:

BK: Okay.

MK:

BK: Mm

MK:

BK: So was suffering from

MK: Mm. Um, and also um also was a

BK: Mm huh.

MK:

BK: Mm

MK:

BK: was that a kind of a recurrent theme would do things like that ...

MK: ...always do things like this, always um, that was very habitual.. little episodes...

BK: How did the team come to understand that behaviour?

MK: Um, I don't really understand the question.

BK: Um so, presumably that behaviour was discussed in a team setting and people, you know, speculated on what it meant and on how to respond to it in, you know, presumably in such a sort of way to try and perhaps modify it over time. Do you recall what people thought with the, where it sort of fitted in to problems?

MK:

BK:

MK:

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BK: Yeah.

MK: And um, I know

BK:

MK:

BK: Yeah, yeah.

MK:

BK: Yeah.

MK:

BK: When you say in the time that you were involved, were you at Barrett up until the closure?

MK: I left in early January.

BK: Early January?

MK: To go to the [?].

BK:

MK:

BK: Yes, yes

MK:

BK: Yes. Can you tell us what your involvement was in the planning for transition?

MK:

BK: And what were the kind of things that you felt was important to advocate for?

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MK:

BK: Yep yes.

MK: You know, so wanted, but in particular, wanted to be

BK: Mmm. And did you feel that you were able to achieve, you know what you thought was important in that planning process, or in that transition process?

MK: It was very difficult with because um, it was my understanding that

BK: Yeah yeah.

MK:

BK:

MK: That's correct, yep.

BK: Yeah. Are there any um general comments or views that you would offer about the transition process the planning, from what you observed. I understand that you weren't um ...

MK: Um, I would have liked more time.

BK: Mmm.

MK: It was a bit rushed?

BK: Mmm hm. What bits of it were rushed?

MK: Um, it was just the, the (sigh), high acuity of the patients on the ward. It was difficult to get somewhere suitable for them to go.

So, I think um, yeah, I would like more time, to be able to find somewhere more suitable.

BK: How long do you think it would have taken, like how long do you imagine would have been … ?

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MK: I don't know. And to be, to be very honest, I don't know, I don't even know, of what places would be available, so you know, I'm not working on much information there.

BK: Yeah.

MK: Yeah.

BK: I was just wondering, um, you talked about the announcement back in August, and then what was the timeframe for when the transition started happening, um started happening. Was that kind of a thing that already started when the patients were admitted, that they were already being prepped for discharge all through their stay, or was it … ?

MK: No. I don't think that would be the case, no. Mmm.

BK: So when would the transition planning have started for

MK: (sghs), I can't give you answer to that either. I, I don't know.

BK: Mmm. What was the upper limit of age for admission to Barrett?

MK: Um, the age would be 18.

BK: Up to 18?

MK: 18, up to 18.

BK: 18 mmm.

MK: But, I know in some circumstances they did keep them longer if they felt it necessary. Mmm.

BK: Mmm ok. Can you tell us about

MK:

BK:

MK:

BK:

MK:

BK:

MK:

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BK:

MK:

BK:

MK: Yes.

BK: And um, ah…

MK: Sorry I was [?] got transferred.

BK: Right, can you talk about what it was like working with

MK:

BK: Mmm hm.

MK:

BK: Oh for

MK: Oh, yeah.

BK:

MK:

BK: Yep.

MK:

BK: Mmm.

MK: You know.

BK: Was how was managing um, ah the relationships and what it meant to, for the relationships in the transition, was that discussed at a team level, did the team talk about how that process of separating was, how was managing it?

MK: I, I don't know.

BK: Okay?

MK: Okay.

BK: So um, it doesn't sound like you were involved in the kind of practical arrangements of setting up appointments, um, and making referrals, you were there um, in advocacy role um during some of the, um some of the processes.

MK: Yes yes. Mmm.

BK: Okay. Would you know anything about the kind of communication that happened with around the decision making in the transition period?

MK: None at all.

BK: No no.

MK: As I say left in so, yeah, I had no [?] with

BK:

MK: Oh sorry. Often. Well not often but, on quite a few occasions and um, was invited into the meetings with um.

BK:

MK: Oh...

BK: I've tricked you now. (laughing) My fault.

MK:

BK: Mmm.

MK:

BK: Thank you. Is there anything you would like to ask us?

MK: No not really.

BK: Have you any reflections, or thoughts that you'd like to offer in relation to the ...

MK: No.

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BK: Okay okay, thank you so much.

MK: Thank you.

BK: Mara thank you for coming in today.

END OF TRANSCRIPTION

Queensland Health

Health Service Investigation - Barrett Adolescent Centre

1084936

Interview with RN Brenton Page - Care coordinator for [redacted] (by phone), 13 October 2014

Parties: Beth Kotze (BK), Tania Skippen (TS), RN Brenton Page (BP)

TS: Okay we have lift off so we're, we're recording it ah now and its, I'm Tania Skippen, I'm an Occupational Therapist who works in New South Wales for Mental Health Children and Young People for New South Wales Health. And with me is Associate Professor Beth Kotze who's a Child and Adolescent Psychiatrist.

BP: Yep.

TS: She also works for the same employer.

BP: Okay.

TS: Um we provided a terms of reference? For the review?

BP: Sorry.

TS: We've provided the terms of reference for the review?

BP: Um from the lawyer do you mean?

TS: Yeah.

BP: Yeah I've got email about a document with like points and stuff on it and I actually, I went into a, because I wasn't able to be ah in Brisbane when the actual interview date because I was actually in Europe um I had to go in earlier into the lawyer firm to have a look at ah one of the charts, two charts sorry.

TS: Yep. So you've, you familiarised yourself with the files for [redacted] and was it for [redacted]

BP: It was for [redacted] ahm to be honest, I didn't get um, because I only had an hour there and um I didn't like so obviously like [redacted] So I focused more on [redacted] because with [redacted] I wasn't, I didn't really have the KPL to deal with [redacted] but um I did have a look as much as I could at [redacted] but most of my time was trying to look through um just having a perusal over [redacted] stuff.

TS: Okay, so are you comfortable if we have a, have a bit of a chat about the kind of transition planning that was done for those two clients?

BP: Yeah sure. Um I, I'll try and, ah [redacted] I wasn't really involved in. I was more involved in [redacted] stuff [redacted] like I wasn't originally

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CC, um another nurse was. But she left the job so um I became CC then and with I only kind of became, on paper towards the end I was Associate but that was because there was no one out there and I had a good kind of face to face rapport with but I didn't, wasn't really involved in the transition ah process with That was that stuff but if I can remember about uestion I can remember I'll defiantly you know tell you it's just I wasn't really involved with stuff very much.

TS: Okey-doke. Would you be able to tell us a little bit firstly about your role as an RN at Barrett and how long you'd been there?

BP: Um at Barrett oh I was kind of, I was only casual, only causal at the time and so that means I kind of work all over the park. And I was on a contract at Barrett eventually but it was, its hard to say to how long I was there just because my, it was kind of split up um like cause I had a bit of time there, so my first contract was only supposed to be 3 weeks actually but it ended up being, ah man it could have been like 6 or 7 months or something. But then I went on tour again so I, obviously the contract ended and then when I got back from tour I restarted the contract up again which I think I was there until the closure of Barrett. So all up, maybe I was there for ah roughly a year and a half maybe. I couldn't be sure just because it was so, it was broken up.

TS: Uh-huh yep.

BP: Um but before then like I was, before the contract I was casual so, I did shifts at Barrett here and there but ah the rest at the hospital as well. Um so yeah and there, as an RN there, um my roles were pretty much like, I would give support to the kids, um dispense medication if you're on clinic. Because I only did, um I didn't do afternoons or nights I only did mornings. Monday to Thursday mornings because I was 0.8 I guess you, what we'd call it. I don't know if that's yeah, but part-time pretty much. So 0.8 and um so Monday to Thursday mornings so Monday, cause I do clinic on Thursdays, so clinic in the morning and eventually because I was casual I didn't have a case load for a while. And because I was contract and my contract was supposed to be ending you know in a certain time I didn't actually have any like kids, like I wasn't case coordinator for any kids for a part of start of it just because I was, you know supposed to be leaving so they, there's not much point having a load and then leaving it kind of thing. But when I say it was kind of say no I'll be staying for a while that's when I started um you know getting case, like being CC's to kids as well. So yeah.

TS: Okay so around what time would it have been and what was your role as the Care Coordinator? Say for

BP: Um when was I CC? Ah okay, I think, I think I was for, sorry um, I'm just trying to think when, original CC was a nurse called Moira. Um it was when Moira left that I became Case Coordinator I'm just not sure when she left or how long it was. It probably would have been,

[redacted]

TS: Mm-hm. Thank you.

BP: Yep that's alright.

TS: So was that a thing towards the end of just ah [redacted] or early of [redacted]

BP: The end of, ah the end of, oh in [redacted] Sorry.

TS: Would, would this period that you were doing that would that have been [redacted] So [redacted]

BP: Yeah, yeah that would have been happening yeah because the centre closed in [redacted]

TS: Hm.

BP: Yeah so but um cause I know I was told it was closing you know like the, just well I had been, it should have closed um you know we'd opened for a reason and the kids we had were you there for a reason but that was out our hands it was closing and that was it. So we did what we had to do, we did the best we could do. Some of the kids obviously have parents some don't. And the ones that do, some of them didn't want the kids back for example [redacted]

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[redacted] So yeah so then we had to find you know other places that we could in the time we had to put the kids.

TS: Can you tell me a little about um the relationship that [redacted] or the [redacted] had with [redacted] and how that overlapped with Barrett care?

BP: Yeah well because during the transition program the time because [redacted]

TS: Mm-hm. And it took a bit of doing?

BP: It did. [redacted]

TS: Mm-hm.

BP: [redacted]

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TS: Yep.

BP: Um, but their original name was I'm pretty sure.

TS: Yep.

BP: And um yeah they were kind of because in the last few days I had to leave because I had to go on tour again so, but no that's not right that's not right. I left on tour a few days after Barrett closed sorry. and then I left a few days after that's right.

TS: And that was, um that was around catering for living its for accommodation and kind of Australia or whatever their called.

BP: Yeah I do really feel that they had said yes.

TS: And what about mental health care?

BP:

TS: Mm-hm.

BP:

TS: Can you tell us a little bit and so we understand what does can you tell us a little bit about the kind of mental health services they provide please?

BP: Um yeah. in the community, you don't have there?

TS: um operate a bit differently.

BP: Okay yeah.

TS: And how thank you. How independent was

BP: Um, well ah how do you mean so like type thing do you mean or?

TS: Yeah I guess

BP: Yeah.

TS: Yeah

BP: Yep.

TS: Um and moving into um how was prepared I guess would have been receiving quite intensive support at Barrett?

BP: Yeah, yeah well see I was you know a good thing about Barrett we also had like a multidisciplinary team so a team worker cause you know

[redacted]

TS: Hm. So it sounds like there's been quite a bit of effort into functional transition are you able to tell us a little bit more about the mental health service transition?

BP: Yeah um what would you like to know, just like, like we did or what happened or?

TS: So perhaps the kind of interventions that ah was receiving at Barrett that, and the handover to

BP: [redacted]

Cause its all on Simmer I don't know if you guys have Simmer yet sorry yeah?

TS: We know what Simmer is we have something a little different but its your electronic record management system.

BP: Yeah, yeah, yeah pretty much. So …

TS: So …

BP:

TS: So, so how did Barrett then assist to become part of that trust network for

BP: Um now I think, I think that was, ah I think it was I don't quote me or, I think Mara it was Mara but um they had like so

TS: Was the other patient, um ah who was the other patient who you handed over do you recall? Was it or?

BP: No. Um I think … ah I think went to That's, ah his name sorry looks like but its

TS: Ah

BP: It's not but MA because it is spelled like that but it is

TS: Oh okay

BP: It spelt like that but its

TS: Okay

BP: I said

TS:

BP: Yeah.

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TS: Okey-doke. Um does provide or what level of kind of assertive follow up or what level of treatment do they provide. Are you aware of that Brenton?

BP: Um I couldn't tell you like ah how do you mean sorry?

TS:

BP: I think …

TS: Or …

BP:

TS: Do you know if followed up with because it looks like was …

BP: I, I don't know because I have no idea but um…

TS: Yeah, because involved with the child and youth friends yeah, yeah.

BP: Sorry?

TS: we have a list there that was involved with Um.

BP: Right. Oh was it and Or just

TS: Not sure.

TS: Yeah we're not sure.

TS: We'll follow that up.

TS: Yeah we'll follow that up. Yep.

BP: Maybe was just so maybe it was just I'm not sure sorry.

TS: That's alright.

BP: Yeah.

TS: Okay um. Sorry. Was there, was there anything else Brenton that in thinking, keeping

BP: Yep.

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TS:

BP:

TS: Mm-hm.

BP:

TS: Okay thanks, yep, thank you. So over um your time with in Barrett what would you say was the stand out success? For

BP: Stand out?

TS: Yeah what was a highlight for being in Barrett from your point of view in the time that you knew

BP:

[redacted]

TS: Did you see any evidence of that great deal of team and support and trust that was built um being kind of shared in the transition in any way for either [redacted] or [redacted] With the um receiving teams?

BP: Ah how do you mean like was the other team have the same thing or?

TS: How do you? How did Barrett help the other team develop the same thing?

BP: Oh build the same kind of rapport?

TS: Yeah.

BP: You mean?

TS: Yeah.

BP: [redacted]

TS: Mm-hm.

BP: At Barrett.

TS: Thanks Brenton. How long was…

BP: That's okay.

TS: How long was [redacted] involved?

BP: Oh ah, how long ago did um... sorry, sorry it was while ago so my that time at the end of it, um well when I got told we were closing, let me think. When did we, whoa, whenever we …

TS: August. August 2013 was that right?

BP:

TS: That's okay.

BP:

TS: Okay.

BP:

TS: Okay yep. Thank you. Is there anything else that you'd like. We are going to have to wrap up in a minute but is there anything that you'd particularly like to tell us about, any further about or about and your involvement in transition planning?

BP: Um I don't think so I mean unless you've got something else you'd like to know that I haven't answered already um. Like I was saying with

TS: Sure.

BP: But I had a good face to face relationship with

TS: Yeah.

BP: So yeah. So yeah that's sorry.

TS: No that's okay. Is there anything further that maybe you'd like to comment on or let us know about in regards to the transitions of clients from Barrett during that period?

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BP: Um I don't think so look I don't, I know obviously you guys are you know investigating the whole thing like I just, I think the team we had did the best we could with what we had. That's pretty much it.

TS: Mm-hm.

BP: Yep.

BK: Alrighty. Well thank you very much.

TS: Thank you for your time Brenton.

BP: No that's okay thanks for calling sorry I missed the first call I didn't hear my phone go off.

TS: That's okay all the best with the next part of the tour.

BP: Yeah thank you. Ah good luck with everything.

TS: Thank you. Bye bye.

BP: Bye

TS: Bye

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Queensland Health

Health Service Investigation - Barrett Adolescent Centre

1084936

Interview with Megan Hayes - OT, 14 October 2014

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

BK: Alright, thanks, Megan.

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

MH: Ahuh.

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

MH: Ahuh.

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

MH: No.

TS: Have any questions about it?

MH: No.

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

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

TS: Mm.

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

TS: Okay.

MH: Capacity

TS: Yeh,

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MH So, I had to shift.

TS: Ahuh.

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

TS: Yeah, sure.

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

TS: Mhm

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

TS: Mhm

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

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

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

TS: Mm.

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

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

MH: Yes.

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

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

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

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

TS: Right.

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

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

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

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

MH: Yes.

BK: Yes.

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

MH: Yes.

TS: Okay.

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

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

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

TS: Mm.

MH: What else we needed to follow up with.

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

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

TS: Mm.

MH: Yeah, they were main supports.

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

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

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

MH:

TS:

MH:

TS: Mm.

MH:

TS: And what did that involve to

MH:

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TS:

MH:

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

MH:

TS: Mm. Okay.

MH: Yep.

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

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

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

MH: Yes.

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

MH: Yes.

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

MH: Yes.

[*Phone ringing*]

TS: Excuse me while I, sorry.

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

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

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

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

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

MH: Yes.

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

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

BK: mm mm.

TS: Yes, sounds like it.

MH: Yeah.

TS: And are you working somewhere at the moment?

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

TS: [?]

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

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

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

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

MH: Mm.

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

MH: Um.

BK: And, and he's unusual.

TS: But..

MH: is that...

TS:

MH: Yeah.

TS: That's what Barrett Centre [?]

MH: I can't recall a particular child.

TS: Yep.

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MH: [redacted]

TS: Mm.

MH: [redacted]

TS: Yes.

MH: [redacted]

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

MH: Yeah,

TS: [redacted]

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

TS: Okay.

BK: Mm

MH: So, quite homeless.

TS: Mm.

MH: [redacted]

BK: Mm.

TS: Very, yes. Very tricky.

MH: [redacted]

BK: Mm.

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

MH: Yes.

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

MH: Yes.

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

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

TS: Mm.

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

TS: What was the risk of doing that?

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

BK: Where did that resistance come from?

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

TS: Sure.

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

TS: Mm.

BK: Mm.

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

TS: No ceremonies or a limited?

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

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

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

BK: What are the formal HR processes?

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MH: What were they?

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

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

BK: Mm.

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

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

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

TS: From HR or from Barrett closure?

MH: From HR.

TS: Right.

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

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

MH: Yes, with senior OT at the park.

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

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

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

MH: From a HR perspective or?

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

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

TS: That's alright.

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

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

BK: Yes.

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

BK: Mm.

TS. Mm.

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

MH: Personally?

BK: Yeah, personally.

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

BK: It helped, yes.

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

TS: Mm.

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

BK: Mm.

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

BK: Yeah.

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

BK: Mm.

MH: Okay.

TS: So we would be interested to hear where.

MH: Okay.

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

MH: Okay.

TS: Mm.

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

BK: Mm.

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

MH: Um, yeah, so we definitely.

TS: Or work experience.

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

TS: Mm.

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

TS: Okay.

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

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TS: Ahuh.

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

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

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

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

TS: Yes.

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

TS: Okay.

BK: So even some of the older kids?

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

BK: Okay.

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

TS: Yeah.

BK: Mm.

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

TS: Anything more that you...?

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

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

MH: No.

TS: Any questions for us?

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

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

MH: Okay.

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BK: Yeah, yeah.

MH: Okay. Thank you.

BK: We're getting a broad brush perspective.

MH: Yeah.

TS: Yeah. No, thank you very much.

BK: Thanks Megan.

MH: No worries. Thank you.

[End of recording]

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SKIPPEN, Tania

From: Kate Blatchly <Kate.Blatchly@minterellison.com> on behalf of Kristi Geddes <Kristi.Geddes@minterellison.com>
Sent: Wednesday, 29 October 2014 3:21 PM
To: KOTZE, Beth; SKIPPEN, Tania
Subject: FW: URGENT - Letter to Metro North Mental Health 27.10.2014 re Barrett Investigation [ME-ME.FID2743997]
Attachments: letter 29 10 M&E.pdf

Importance: High

Dear Beth and Tania,

Please see attached response from [redacted] Mental Health re the reason for the termination of additional supervision for [redacted]

Please let me know if you require any additional information and/or if you feel that this raises any issues that will prevent completion of the final report by this Friday's deadline.

Kind regards,
Kristi.

Kristi Geddes Senior Associate
[redacted]
Minter Ellison Lawyers Waterfront Place • 1 Eagle Street • Brisbane • QLD 4000
[redacted]

From: Keryn Fenton [redacted]
Sent: Wednesday 29 October 2014 11:28 am
To: Kristi Geddes
Subject: RE: URGENT - Letter to [redacted] Mental Health 27.10.2014 re Barrett Investigation [ME-ME.FID2743997]

Kristi

Please see attached response from the service regarding your enquiry

Kind regards

[redacted]

From: Kristi Geddes [redacted]
Sent: Monday, 27 October 2014 5:23 PM
To: Keryn Fenton
Subject: URGENT - Letter to [redacted] Mental Health 27.10.2014 re Barrett Investigation [ME-ME.FID2743997]
Importance: High

Dear [redacted],

Please see letter **enclosed**.

Kind regards,
Kristi.

Kristi Geddes Senior Associate
[redacted]
Minter Ellison Lawyers Waterfront Place • 1 Eagle Street • Brisbane • QLD 4000
[redacted]

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Unless stated otherwise, this email represents only the views of the sender and not the views of the Queensland Government.

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RJ ~~607~~

Queensland Government

[redacted] Hospital and Health Service

Reference number: Contact:
Position Title:
Directorate/Branch:
Phone:

Ms Kristi Geddes
Senior Associate Minter and Ellison lawyers
[redacted]

Reference Number SGE KXMM 1084936

Dear Ms Geddes

RE: Health Service Investigation – Barrett Adolescent Psychiatric Centre

[redacted]

[redacted]

Facsimile 3328 9988
www.health.qld.gov.au

Yours sincerely

28/ 10/ 2014

SDO Project 08/1613/117)

Transition from CAMHS to Adult Mental Health Services (TRACK): A Study of Service Organisation, Policies, Process and User and Carer Perspectives

Report for the National Institute for Health Research Service Delivery and Organisation programme

January 2010

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The Report

1 Introduction

Adolescence represents an inner emotional upheaval, a struggle between the eternal human wish to cling to the past and the equally powerful wish to get on with the future. Louise J. Kaplan, psychoanalyst and author

What I was really hanging around for, I was trying to feel some kind of a good-by. I mean I've left schools and places I didn't even know I was leaving them. I hate that. I don't care if it's a sad good-by or a bad good-by, but when I leave a place I like to know I'm leaving it. If you don't, you feel even worse. J.D. Salinger, *The Catcher in the Rye*

1.1 Background: review of literature

1.1.1 The importance of transition

There has been long standing concern about young people with mental health problems who fall between child and adolescent mental health services (CAMHS) and adult mental health service (AMHS) and may get 'lost' during their move from CAMHS to AMHS (hereby called transition) (Royal College of Paediatrics and Child Health, 2003; Lamb, Hall, Kelvin and Van Beinum, 2008, p6). Disruption of care during transition adversely affects the health, wellbeing and potential of this vulnerable group (American Academy of Pediatrics, American Academy of Family Physicians and American College of Physicians-American Society of Internal Medicine, 2002; Forbes, While, Ullman, Lewis, Mathes and Griffiths, 2002; While, Forbes, Ullman, Lewis, Mathes and Griffiths, 2004; Department of Health, 2006c; Kennedy, Sloman, Douglass and Sawyer, 2007; Department for Children Schools and Families and Department of Health, 2008; Lamb *et al*, 2008). Ideally, such a transition should be a planned, orderly and purposeful process of change from child-oriented to adult models of care (Blum, Garell, Hodgman, Jorissen, Okinow, Orr and Slap, 1993; McDonagh and Kelly, 2003).

Transition is distinct from transfer: the latter refers to termination of care by a children's health care provider which is re-established with an adult provider (Burke, Spoerri, Price, Cardosi and Flanagan, 2008). Transition is more than merely the means of an individual moving from one service to the next, but instead is 'a way to enable and support a young person to move towards and onto a new life stage' (Beresford, 2004, p584). It is a multidimensional, multidisciplinary, lengthy process continuing on into adult care, marked by joint responsibilities in multidisciplinary working (Royal College of Nursing, 2003; Royal College of Paediatrics and Child Health, 2003; HASCAS, 2006; McDonagh and Viner, 2006). It therefore needs to be 'co-ordinated, planned, efficient and smooth' (Conway, 1998, p210). As a 'dynamic process with a beginning, middle and end' (McDonagh, 2006, p3), optimal transition to adult health care should 'support each young person in attaining his or her maximum potential' (Rosen, 2004, p125).

Young people undergoing transition are also negotiating a developmental transition from childhood to adulthood, which generates needs beyond those which are illness-specific (Royal College of Paediatrics and Child Health, 2003; Royal College of Nursing, 2004). Needs related to such developmental transition may remain unmet if the process is seen simply as an administrative event between CAMHS and AMHS (Vostanis, 2005). Transitional care is becoming an important focus for both policy and practice with calls for generic, cross-specialty developments, since many problems which arise at the interface are not specialty- or disorder-specific, but embody common challenges for child and adult services across specialities (McDonagh and Viner, 2006).

In the USA, a survey of transition provision within 41 states found that a quarter of child mental health services and half of adult services offered no transition support (Davis, Geller and Hunt, 2006). Another US study (Davis and Sondheimer, 2005) found that continuity of care was hampered by separate child and adult mental health systems, marked by separate policies for access, lack of clarity in access procedures and lack of shared planning. A recent study from Australia found that many young people referred by CAMHS were not accepted by AMHS, despite having substantial mental health needs and functional impairment (Cosgrave, Yung, Killackey, Buckby, Godfrey, Stanford and McGorry, 2008). An Audit Commission (1999) report in the UK found that less than a quarter of national services have specific arrangements to support transition of care between CAMHS and AMHS.

In the UK, the *National Service Framework (NSF) for Children, Young People and Maternity Services* (Department of Health and Department for Education and Skills, 2004) has delineated several standards for mental health services. These emphasise access to age-appropriate services which are responsive to specific needs of all young people as they attain adulthood. For those with mental health problems, the NSF advocates access to local, multidisciplinary CAMHS teams that ensure effective assessment, treatment and family support. Transition in the NSF for Children and Maternity Services is envisaged as a planned and co-ordinated process around specific needs that aims to maximise health outcomes, life chances, opportunities and the ability to live independently. NSF recognises that providing such transition has implications for workforce capacity, capability and the inception of new roles and training. More recently, the HASCAS (2006) Tools for Transition report highlights the barriers to transition and makes recommendations for improvements to services. Such barriers include variable age boundaries, service configurations, and thresholds for access as well as differing professional cultures within CAMHS and adult services. HASCAS recommends having designated transition (or link) workers, the involvement of young people in the decision making process, focussing and building on young people's strengths, and improving continuity of care through case management, CPAs and enabling young people to make informed decisions through the provision of appropriate information.

Recent policy implementation to reform adult community services also emphasises the need for continuity of care. The NSF for Mental Health (Department of Health, 1999b) focuses on the need to integrate mental health and Social Services to combat fragmentation of services, poor interdisciplinary co-ordination, and user and carer distress arising from service discontinuities (Singh, 2000; Bosanquet and Kruger, 2003; Onyett, 2003). A further impetus to integrate health and social care has been through the formation of care trusts together with the development of care programme and care management approaches (Department of Health, 2000). Integrated, adult community mental health teams (CMHTs) are now considered intrinsic to delivering continuity of care (Department of Health, 2002b). More recent changes in community provision has resulted in

'generic' community mental health teams and specialist 'functional teams' such as early intervention services for first-episode psychosis, assertive outreach teams for difficult to engage users, and home treatment teams to avert hospitalisation and crisis management. Transition between these functional teams also needs to ensure continuity of care. This literature review focuses on transition between CAMHS and AMHS; transitions from one functional mental health team to another and between adult and older adult teams are not included.

1.1.2 The definitions of transition: adolescence to adulthood

The concept of transition in relation to young people can be viewed from three distinct perspectives. Firstly, from a developmental perspective, adolescence is a crucial stage of emotional, psychosocial, personal and physiological developments as young people embark on adult roles through tasks such as separating from family, deciding on a career path and defining self in a social context (Lee, 2001). Secondly, from a health care perspective, young people have to move from one service to another upon reaching certain age milestones. Thirdly, from a situational perspective, individuals experience changes as they move from one institutional environment to another. **In this study we use the term *transition* explicitly to mean health care transition defined as *a formal transfer of care from CAMHS to adult services***. However, to understand health care transition in the context of other transitions, we will briefly explore the literature around developmental and institutional transitions in adolescence.

Adolescence: stage or age?

Transition from childhood to adulthood involves crucial changes in social, sexual and identity development that occur over time (Eiser, 1993; Davis, 2003). Broadly speaking, it is a *process* starting with puberty and ending with the assumption of adult roles. There is wide variation between cultures and within cultures over time at the age at which a young person is considered to become an adult (McDonagh, 2006). Galatzer-Levy (2002) has argued against an 'essentialist' view of adolescence and instead suggested that the very existence of this period should be conceived as a social construct. The TRACK study addresses the health care transitions between child and adult models of care. The developmental transition between childhood and adulthood, while relevant, is not the primary focus of the study and will not be considered in this review.

Adolescence is a developmental stage, rather than something defined strictly by age. However, child and adult services are often demarcated by rigid age boundaries. Some authors (e.g. Davis, 2003) refer to the age group of 16-25 as the 'transition group'; in contrast, the Royal College of Paediatrics and Child Health (2003) names 10-20 year olds as adolescents. In its surveys on mental health, the National Office for Statistics groups 16- and 17-year-olds with adults and young people aged 15 and under as children, with no separate category for adolescents (Cooper and Bebbington, 2006) even though adolescents have been recognised as a

health service user group in their own right since the 1950's (Royal College of Paediatrics and Child Health, 2003).

In their study on socially disadvantaged young people, Webster *et al* (2004) state: 'the problems with youth transitions do not conclude at neat, age-specific points and, therefore, age-related policies ... do not "fit" harmoniously with the realities of the extended transitions that [their] sample members have undertaken' (p41). The Social Exclusion Unit (2005) notes that age boundaries that demarcate services 'can seem arbitrary, and often don't give any helpful flexibility to those whose lives aren't following a conventional pattern...' (p52). A consensus is now emerging that health services should consider the health and developmental needs of two groups: children under 12 years and young people aged between 12-24 years (Patel, Flisher, Hetrick and McGorry, 2007).

Why is adolescence a 'risk period'?

The journey into adult life is a time of profound psychological and social change for young people and their families. 'Adolescents' have greater propensity for risk-taking behaviours and the explanations for this range from biological (such as neuroendocrine influences and pubertal events), biopsychosocial (within which risk-taking is understood in relation to exploration, individuation and achieving autonomy) and psychological (e.g. related to establishing a locus of control) (Rolison and Scherman, 2002).

Adolescence is also a risk period for higher psychological morbidity. Overall rates of mental health problems in young people increase with age, problems become more complex, and the more serious disorders such as psychosis emerge (Petersen and Leffert, 1995; Lamb *et al*, 2008). Young people also fall between child and adult services, and have greater likelihood of disengagement from services (Lamb *et al*, 2008).

Young people with mental health problems have the highest rates of long-term morbidity and mortality (Royal College of Paediatrics and Child Health, 2003). A review of 52 studies of the prevalence of childhood and adolescent psychiatric disorders showed a median rate of 8% for preschoolers, 12% for primary school age children, 15% for adolescents and 18% in studies 'with a wider age range' (Roberts, Attkisson and Rosenblatt, 1998). A more recent UK survey found that 10% of 5- to 16-year-olds have a mental health disorder (Green, McGinnity, Meltzer, Ford and Goodman, 2005). In 11- to 16-year-olds the rate of mental health disorders is 12% (Green *et al*, 2005), while up to 20% of 16- to 24-year-olds have a mental health problem, most commonly anxiety and depression (Budd, Sharp and Mayhew, 2003). Attempts at suicide are made by 2-4% of adolescents, and 7.6 per 10,000 15- to 19-year-olds actually succeed. In addition, 2-8% of young people experience major depression; 1.9% have Obsessive Compulsive Disorder; 0.5-1% of 12- to 19-year-olds (predominantly females) have Anorexia Nervosa and a further 1% have Bulimia Nervosa (Department of Health, 1995). Taken together, at least one in four to five young people will suffer from at least one mental disorder in any given year (Patel *et al*, 2007).

Comorbidity is also common in adolescence, both in terms of psychiatric disorder and additional problems. Even in community samples, 20% of those with an impairing psychiatric disorder have more than one disorder, and comorbidity among those attending CAMHS is likely to be even higher (Ford, Goodman and Meltzer, 2003; Ford, Hamilton, Meltzer and Goodman, 2008). The *Breaking the Cycle* report (Social Exclusion Unit, 2004) found that 98% of young adults (16- to 25-year-olds) accessing services in the UK had more than one problem or need. Common comorbid problems included homelessness, problems associated with leaving care, lack of training/education opportunities, barriers to employment, crime, poor housing, drug and alcohol misuse and learning disability. In autumn 2004 there were approximately 5.5 million people aged between 16 and 24 in England; of these, around 750,000 were not in education, employment or training (Office for National Statistics, 2004) and thus more likely to be at risk of developing mental health problems (Mental Health Foundation, 1999; Smith and Leon, 2001; Myers, McCollam and Woodhouse, 2005).

The use and abuse of alcohol and drugs is a significant issue among adolescents: 29% of 13-year-olds report drinking alcohol once a week; 16% of 16-year-olds regularly use solvents or illegal drugs; while 17% of older teenagers use cannabis (Fonagy, Target, Cottrell, Phillips and Kurtz, 2000). Young people with chronic diseases are more likely to engage in risky behaviours, such as smoking, substance misuse and unprotected sexual activity, and to have psychiatric disorders (Green *et al*, 2005; Sawyer, Drew, Yeo and Britto, 2007). For young people receiving child mental health services, the rate of substance abuse or dependence increases dramatically, affecting nearly half of 21- to 25-year-olds (Greenbaum et al, 1991, cited in Davis and Vander Stoep, 1997).

These young people will be the next cohort of parents. A great deal of research now links poor and inconsistent parenting with child abuse, neglect, lower academic achievement, higher rates of offending, and conduct disorder (Farrington, 1994). Forty-seven percent of children assessed as having a mental health disorder have a parent with a mental health difficulty such as anxiety or depression. Having a parent with a mental illness increases the risk of children developing a mental illness themselves (Rutter, 1989; Green *et al*, 2005; Royal College of Psychiatrists, 2008). Young women with a psychiatric disorder are six times more likely to get pregnant between the ages of 18-21 than those without such a diagnosis (Wagner, 1995, cited in Davis *et al*, 2006). Teenage mothers also have an increased risk of mental disorder compared with mothers over 20 years of age (Lamb *et al*, 2008).

Mental health problems in adolescence also predict problems in adulthood (Silva, 1990; HASCAS, 2006; Lamb *et al*, 2008). The National Comorbidity Survey Replication in the USA found that 75% of people with a mental disorder had an age of onset younger than 24 years (Kessler, Chiu, Demler and Walters, 2005). Similarly, half of the adults with psychiatric disorder at age 26 in the Dunedin cohort had a psychiatric disorder before the age of 15, increasing to three quarters by age 18, and even further among adults who had contacted services in relation to their psychiatric disorder (Kim-

Cohen et al, 2003). Yet for many years this age group has only received inconsistent attention from services (Reder, McClure and Jolley, 2000; The Children's Commissioner for England, 2007). This group is also more likely to disengage from services, with younger age and comorbid drug use both predicting disengagement from care (Rossi, Amaddeo, Bisoffi, Ruggeri, Thornicroft and Tansella, 2002; Harpaz Rotem, Leslie and Rosenheck, 2004). Adult services deal with service users as individuals, while children's services treat them as part of a system (Social Exclusion Unit, 2004; Singh, Evans, Sireling and Stuart, 2005). With few arrangements in place for young people negotiating transition boundaries, some slip through the care net during transition only to present to adult services later on, by which time they may have developed severe and enduring mental health problems (Vostanis and Richards, 2002; Davis, 2003; Department of Health, 2003).

1.1.3 Transition in health care

Most studies on transitions in health care are from a non-UK perspective or address chronic illness, physical disability and learning disability, e.g. physical disability (Ko and McEnery, 2004); HIV (Miles, Edwards and Clapson, 2004); brain injury (Kent and Chamberlain, 2004); cystic fibrosis (Cowlard, 2003); learning disability (Cameron and Murphy, 2002). While *et al* (2004) carried out a systematic review to identify transition practices and good practice models. Of the 126 relevant articles identified and reviewed, only one addressed a mental health population, and that was within a US context. A comprehensive review of this literature is beyond the scope of this study; however, some of the main themes which emerge are outlined below. While evidence from physical health services or from outside the UK may not be generalisable to mental health services in the UK, there are certain lessons which can be learned from this research.

Advances in medical care over the last few decades have led to an increased life expectancy for many young people with chronic illness or physical disability (Department for Children Schools and Families and Department of Health, 2007; Sawyer *et al*, 2007). This in turn has led to higher numbers crossing over from paediatric to adult care. However, in a study examining transitions of young people with congenital heart defects, less than half were found to have made a successful transition to adult services (Reid, Irvine, McCrindle, Sananes, Ritvo, Siu and Webb, 2004). The report *Transition: Getting It Right for Young People* (Department of Health, 2006d) acknowledges the difficulties of such transition and its impact upon of young people under care. Many young people appear dissatisfied with transition arrangements, despite being satisfied with the treatment offered by both child and adult services (DARE Foundation, 2006, cited in Knapp, Perkins, Beecham, Dhanasiri and Rustin, 2008).

Findings from a postal survey of 40 health professionals illustrate the problems of transition in the learning disability and chronic illness fields (Por, Golberg, Lennox, Burr, Barrow and Dennard, 2004). Most respondents felt that 'mental maturity' was the key criterion for assessing a young person's readiness to transfer to adult services (21 out of 40). Other criteria cited included age (two-thirds of participants said children's services should

end at 17-18 years); willingness to be transferred; ability to care for self; level of support; and that the transfer time-point should depend upon the individual and not be prescriptive. Only 10% of participants believed that young people with chronic conditions were adequately prepared for transition. Some professionals, such as nurses from adult services, felt unprepared to take over care of adolescents. Some felt that the parents of service users were 'interfering'. Overall, clinicians wanted to be involved in transition care and decision making and meet young people prior to transfer. They also called for written transfer plans and information packs to be provided to families about the adult services. Similar findings have been reported in other surveys (Reiss and Gibson, 2002; Coleman and Berenson, 2004). Additional ideas proposed include electronic health information systems across child and adult services facilitating easy access to information on service users undergoing transition. Such a plan is apparently in development within the NHS (see www.connectingforhealth.nhs.uk).

Given the pervasive nature of the problems at the child and adult interface it is not surprising that more effective transition arrangements, increased joint working and closer liaison between child and adult services has been recommended in services for both learning disability (Department of Health, 2001) and chronic illness (Reiss and Gibson, 2002). Multi-agency working in health care transitions for young people is prescribed as a core standard in the NSF for Children, Young People and Maternity Services (Department of Health and Department for Education and Skills, 2004), particularly for those with chronic and serious medical conditions (see section 1.1.4 *Transition from CAMHS to AMHS: the policy imperatives*).

1.1.4 Transition from child and adolescent mental health services (CAMHS) to adult mental health services (AHMS)

Delineating service boundaries

CAMHS services are organised along four tiers denoting increasing specialism and case complexity as follows (Health Advisory Service, 1995):

Tier 1: Practitioners who are not mental health specialists, but who work with children in community settings such as general practice, schools, voluntary agencies.

Tier 2: CAMHS specialists who work alone in community and primary care settings and/or with children whose difficulties are milder and/or of recent onset, and/or who would be unlikely to reach traditional secondary level mental health care. These services support professionals working within Tier 1 and have a role in outreach and engagement.

Tier 3: CAMHS specialists who work in specialised multidisciplinary services in community mental health or child psychiatry outpatient settings.

Tier 4: CAMHS specialists who work in tertiary level services in day units, highly specialised outpatient teams, and inpatient unit settings (www.everychildmatters.gov.uk).

One key problem in the UK is a lack of consensus on where CAMHS ends and AMHS begins (Lamb *et al*, 2008). Some services use age cut-offs between 16 and 18 years while others consider CAMHS appropriate only for those in full-time education (Gillam, Crofts, Fadden and Corbett, 2003; Phimister, 2004; Singh *et al*, 2005; Treasure, Schmidt and Hugo, 2005). The Audit Commission (1999) reported that nationally 29% of health authorities commissioned CAMHS for young people up to their 16th birthday only, although adult services were not considered suitable for those under 17. The report highlighted the poor development of adolescent services and their inadequate links with other agencies, including adult mental health services. Indeed, transition boundaries drawn strictly by chronological age are driven by service capacity and limitations rather than what is best for young people.

Tantam (2005) suggests that increasing the age limit for CAMHS to 18 years will 'go some way towards the acknowledged transition problems' with adult services (p141). In contrast is a view that the cut-off when 'adulthood' is reached is difficult to define; hence instead of rigid age demarcations between services, it is better for services to be flexible and consider the developmental needs of individuals (Royal College of Paediatrics and Child Health, 2003; Singh *et al*, 2005; McDonagh and Viner, 2006; Department for Children Schools and Families and Department of Health, 2008; Lamb *et al*, 2008). McGorry (2007) has proposed a youth mental health model, arguing that 'public mental health services have followed a paediatric-adult split in service delivery, mirroring general and acute health care. The pattern of peak onset and the burden of mental disorders in young people means that the maximum weakness and discontinuity in the system occurs just when it should be at its strongest' (ps53).

Barriers at CAMHS-AMHS interface

Ideological, structural, functional and organisational differences between CAMHS and AMHS produce complex challenges for all those involved in negotiating the boundary, including service users, carers and clinicians (Kipps, Bahu, Ong, Ackland, Brown, Fox, Griffin, Knight, Mann, Neil, Simpson, Edge and Dunger, 2002; Singh *et al*, 2005; HASCAS, 2006). CAMHS and adult services differ in their theoretical and conceptual view of diagnostic categories and aetiological processes, in treatment focus, in service organisation, delivery and availability, and in professional training, all of which accentuate the problems at the interface (Reder *et al*, 2000; Singh *et al*, 2005). A Health Select Committee (2000) report identified several problems in transition including the failure of services to work together, the need for care management/planning led by a single practitioner who co-ordinates care across all relevant agencies, shortage of inpatient services for young people, the need for early intervention and poor liaison between various agencies.

Transition from CAMHS to AMHS: the policy imperatives

Following on from the NSF for Mental Health (Department of Health, 1999b), the Healthcare Commission (formerly the Commission for Health Improvement (CHI)) set a key performance indicator entitled: *Transition of Care between CAMHS and Adult Services (2002/2003)* (Commission for Health Improvement, 2003). This included recommendations of the Safeguarding Children's Review (November 2002) and the CHI Child Protection Audit (April 2003). The Emerging Findings of the Children's NSF (Department of Health, 2003) also demanded that CAMHS providers develop robust working protocols to ensure smooth transition of care from CAMHS to AMHS.

In 2002 the Priorities and Planning Framework (Department of Health, 2002a) set a target to 'improve life outcomes of adults and children with mental health difficulties through year on year improvements in access to crisis and CAMH services' and 'reduce the mortality rate from suicide and undetermined injury by at least 20% by 2010' (p11). The Green Paper *Every Child Matters* (Department for Education and Skills, 2004) promised increased investment to deliver a 10% increase in CAMHS each year for the next three years, so that all areas would have a comprehensive CAMHS by 2006, including the implementation of a transition protocol and greater provision of adolescent inpatient beds. The report *Getting the Right Start* (Department of Health, 2003) recommended that all children and adolescent services provide care up until the age of 18.

Subsequently, the National Service Framework for Children, Young People and Maternity Services (Department of Health and Department for Education and Skills, 2004) has recommended that CAMHS should be seeing all children up to their 18th birthday, rather than following arbitrarily drawn service boundaries. It also addresses young people's transitions to adult services within its Core Standard 4: 'Growing up into Adulthood'. This standard emphasises multi-agency transition planning, benefits of joint working between AMHS and CAMHS, involving young people and families in decision making, and improving service users' autonomy. Standard 9 of the Children's NSF ('The Mental Health and Psychological Well-being of Children and Young People') specifically targets services for 16- and 17 year-olds (Department of Health and Department for Education and Skills, 2004). Its priorities include extending CAMHS provision to the 18th birthday, while allowing for flexibility dependent on young people's development and choice, ensuring smooth transition of care and protocols to ensure a flexible but organised approach, staff training, ensuring the dignity and safety of young people admitted to adult mental health units, development of Early Intervention in Psychosis services, and the use of Care Programme Approach on discharge from inpatient care and on transition between CAMHS and AMHS.

Inpatient care for adolescents

Several national policy documents state that ideally no young person under 18 years should be admitted to an adult psychiatric unit, and that inpatient care should be in specialist, age appropriate facilities (The National

Assembly for Wales, 2001; Royal College of Psychiatrists, 2002; Scottish Executive, 2003; Department of Health and Department for Education and Skills, 2004; Scottish Executive, 2005, 2006). In England the NSF for Mental Health (Department of Health, 1999b) states that children and young people should only be admitted to adult psychiatric wards in exceptional circumstances, and requires measures to be in place to safeguard the interests of any young person admitted. A study for the Children's Commissioner for England (2007) highlights the problems associated with admitting young people to adult psychiatric wards and makes recommendations aimed both at preventing inappropriate admission and safeguarding young people admitted to adult wards. It also outlines the Human Rights issues regarding the treatment of children, under the United Nations' Convention on the Rights of the Child (United Nations, 1989).

Most recently, the Mental Health Act 2007 (England and Wales), which amends the 1983 Act, places a duty on hospital managers to ensure that from April 2010, any young person under the age of 18 years, whether detained or admitted voluntarily, is admitted to an environment suitable for their age and need (Department of Health, 2007). In Scotland the mental health delivery plan (Scottish Executive, 2006) has set, as one of its key performance targets, the halving of admissions of under-18-year-olds to adult beds. The Scottish Mental Health Act 2003 (Scottish Executive, 2003) stipulates that age-appropriate facilities, including access to education, must be provided to any young person under the age of 18 admitted under the Act.

Despite the plethora of policy documents and initiatives, there are still variations in service provision for young people with mental health problems, both between regions and within local areas in the UK, leading to inequalities of care provision (National CAMHS Review, 2008). The challenges at the interface between CAMHS and AMHS are not all the responsibility of CAMHS services. These require strategic collaboration between all agencies providing care for adults and children and range from specific local arrangements between CAMHS and AMHS for transition policies, the development of pathways to care and treatment protocols at the interface, to broader national initiatives to improve workforce capacity and training.

Transition and continuity of care

Continuity of care in mental health services is increasingly recognised as a key aspect of service provision (Crawford, de Jonge, Freeman and Weaver, 2004; Department of Health and Department for Education and Skills, 2004; Joyce, Wild, Adair, McDougall, Gordon, Costigan, Beckie, Kowalsky, Pasrheny and Barnes, 2004; While *et al*, 2004) including for those with mental illness (Adair, McDougall, Beckie, Joyce, Mitton, Wild, Gordon and Costigan, 2003; Adair, McDougall, Mitton, Joyce, Wild, Gordon, Costigan, Kowalsky, Pasmeny and Beckie, 2005; Laugharne and Priebe, 2006). While often discussed, continuity of care is not always clearly defined (Freeman, Shepperd, Robinson, Ehrich and Richards, 2000; Freeman, Weaver, Low, de Jonge and Crawford, 2002). Freeman and colleagues (2000) have

summarised the principal characteristics of continuity of care in a 'multi-axial definition' comprising: experienced, cross-boundary, flexible, information, relational and longitudinal continuity. In a subsequent study of continuity in mental health settings (Freeman *et al*, 2002), they added two further definitions, contextual and long-term (See Box 1, from Burns, Catty, Clement, Harvey, Jones, McLaren, Rose, White and Wykes, 2007, p4).

Box 1. Multi-axial definition of continuity of care

Generic (Freeman et al, 2000)

Experienced: experience of a co-ordinated and smooth progression of care from the user's point of view

Flexible: to be flexible and adjust to the needs of the individual over time

Cross-boundary: effective communication between professionals and services and with service users

Information: excellent information transfer following the service user

Longitudinal: care from as few professionals as possible, consistent with other needs

Relational: to provide one or more named individual professionals with whom the user can establish and maintain a therapeutic relationship

Mental health-specific (Freeman et al, 2002)

Long-term: uninterrupted care for as long as the service user requires it

Contextual: care which should sustain a person's preferred social and personal relationship in the community and enhance quality of life

Other definitions and components of continuity of care have also been suggested. Bindman *et al* (2000) consider continuity of service provision, breaks in service delivery, and regular contact with individual clinicians as measures of continuity. Fortney *et al* (2003) measure continuity through timeliness, intensity, comprehensiveness and co-ordination of service provision, relationship stability between the service user and provider as well as frequency, quantity and locational consistency of encounters, variety of services and case management.

Reviewing the literature, Haggerty *et al* (2003) concluded that continuity of care in mental health services differs from health care provision in its explicit and much greater emphasis on continued contact between service users and professionals. In another review, Joyce *et al* (2004) identified flexibility, access, availability, comprehensiveness of services, and 'longitudinality' as key attributes. Overall, the most important element of continuity of care appears to be service users' experience of continuity (Freeman *et al*, 2002).

In reviewing transition from child to adult services, While *et al* (2004) identified four models of continuity, based on the above definitions proposed by Freeman *et al* (2000; 2002). A *direct transitional model*, based on cross boundary and team continuity, emphasises communication and

information sharing across vertical levels (child to adult services) and horizontal levels (multiple services and agencies). Flexible and longitudinal continuity forms the basis of a *sequential transition model*, cognisant that the care needs of young people change and a period of preparation is needed to promote successful adjustment, requiring extension of child services or joint working between adult and child services. The *developmental transition model* actively focuses on personal growth and development and the support which young people need in order to experience adult care in a positive and effective way. Finally, a *professional transitional model* focuses on the need for professional expertise (child or adult) to respond to young people's needs, ensuring personal, relational and therapeutic continuity are maintained. These models are not mutually exclusive (While *et al*, 2004) and are meant to highlight the key elements of service delivery which can inform good practice and promote continuity of care during transition.

1.1.5 Barriers to optimal transition

McDonagh (2006) has identified several barriers to optimal transition (see Box 2). These include changes in established, long-term therapeutic relationships between young people and health professionals; differences between adult and child models of care; young people's level of maturity and understanding; differing perceptions of the adult care system; adolescent resistance to transfer; family stressors; inadequate education and training for adult care providers on adolescent disorders; and lack of organisational support (Lotstein, McPherson and Strickland, 2005; Burke *et al*, 2008).

Box 2. Barriers to optimal transition

Time

Training of professionals involved

Financial

Different perceptions of young person, parents, and providers (both CAMHS and AMHS)

Attitudinal

Discomfort of professionals involved

Lack of applicability

Difficulty accessing resources

Poor intra-agency co-ordination

Poor interagency co-ordination

Difficulties addressing parental issues

Adolescent resistance

Family resistance

Lack of institutional support
Lack of planning
Lack of appropriate adult specialists

Additional barriers to transition specific to mental health services include lack of local protocols and procedures to guide transition (Treasure *et al*, 2005), lack of collaboration between services, and ineffective interagency working.

Barriers for special groups

Neurodevelopmental disorders

For children with disabilities transition 'from childhood to adulthood is more complex, extremely problematic and, in many cases, highly unsatisfactory' (Beresford, 2004, p582). The situation for young people with a learning disability is particularly complex. They may not meet the eligibility criteria for either the Adult Learning Disability Service or the Adult Community Mental Health Team, yet require ongoing support and psychiatric intervention. This also occurs commonly with high-functioning young people with an autism spectrum disorder or Asperger syndrome, especially in the absence of clear-cut comorbid psychiatric disorder (Lamb *et al*, 2008). There is also growing recognition of inadequate services for young people with Attention Deficit Hyperactivity Disorder (ADHD)/Hyperkinetic Disorder, which is estimated to affect about 4% of the population (Nutt, Fone, Asherson, Bramble, Hill, Matthews, Morris, Santosh, Sonuga-Barke, Taylor, Weiss and Young, 2006). These problems with transition have also been identified in the Department for Children, Schools and Families and Department of Health (2007) transition guide for services for disabled young people.

Acute presentations

Many transitions are unplanned and result from acute, unanticipated and crisis presentations. These presentations can be at times (e.g. out of hours) or places (e.g. at emergency departments) where clinicians are unlikely to have an ongoing relationship with the service user. Alternately, transfers happen so quickly that formal procedures cannot be implemented in time (Coleman and Berenson, 2004).

Young people in special circumstances

Many young people in special circumstances (such as the Looked After or those leaving Local Authority care; the homeless) and from certain minority groups such as asylum seekers and those from a Traveller background may be particularly vulnerable to mental health problems. Pathways and access to mental health care are particularly problematic for people from Black and Minority Ethnic backgrounds (Singh and Grange, 2006; Singh, Greenwood, White and Churchill, 2007). Such groups may not access either CAMHS or AMHS (Richards and Vostanis, 2004). Others, such as those with a forensic history or with significant risk to others, have complex needs and yet may

not meet eligibility criteria of community services. These groups are particularly vulnerable to problems during transition (Lamb *et al*, 2008).

The effect of poor transition

The most disruptive outcome of poor transition is that young people with ongoing needs disengage from services during the transition process. Disengagement from mental health care is in many cases a major problem, with between 30%-60% of young people dropping out of treatment over time (Harpaz Rotem *et al*, 2004). Young, socially isolated males are most likely to disengage from services despite having the greatest need for services (Crawford *et al*, 2004). The most vulnerable therefore are at greatest risk of dropping out of care. Young people are also less likely to collaborate with clinicians about their treatment (Laugharne and Priebe, 2006), partly because many young people feel that they do not have an adequate 'say' in the care they receive (Barker et al, 1996, cited in Laugharne and Priebe, 2006). Poor transition simply adds to the risk of such disengagement.

In mental health care, young service users and their carers often have very different perspectives on treatment goals and outcomes from those of clinicians (Perkins, 2001; Garland, Lewczyk-Boxmeyer, Gabayan and Hawley, 2004). Additionally, when young people turn 18 mental health services are no longer obliged to involve their parents or carers in treatment due to the assumed autonomy of the 'adult' service user. Studies show that families feel left out of the treatment process following transition and involving families collaboratively reduces the risk of disengagement as well as carer distress (e.g. Dixon, Adams and Lucksted, 2000; Pitschel-Walz et al, 2001, cited in Mottaghipour, Woodland, Bickerton and Sara, 2006).

1.1.6 Transition from CAHMS to AMHS: gaps in the evidence base

Our review confirms the observation that transition is 'discussed frequently but studied rarely' (Reid *et al*, 2004, pe198). Recent reviews of continuity of care also comments upon the paucity of high quality research in this area (Forbes *et al*, 2002; HASCAS, 2006). While mental health service evaluation has improved greatly in its methodology and scope, understanding the relationships between service processes and user outcomes is still limited (Johnson, Prosser, Bindman and Szmukler, 1997). The exception is a recent study, ECHO, that evaluated organisational cultures, structures, processes and resources which influence continuity of care and outcomes for adult service users (Burns *et al*, 2007).

ECHO examined continuity of care in two cohorts – users with psychosis and without psychosis – with continuity measures generated by users and carers. These measures underwent rigorous psychometric assessment, making them the first of their kind, and reflected respondents' priorities. The study used these measures as well as medical records to assess experiences of continuity for both groups, totalling 288 service users. Data were also collected on 107 carers, followed by qualitative interviews with a

sub-sample of service users and carers. A comparative diagnostic analysis was conducted, based on questionnaires and interviews with professionals in NHS trusts, General Practices, and voluntary sector organisations. Findings revealed that barriers to informational, cross boundary, relational and long-term continuity were poor communication underpinned by lack of computing systems which impeded information transfer in joined up working; conflicts in cross boundary work resulting from problems in demarcation of professional role identities; lack of education and training opportunities for staff; use of medical decision-making models which did not maximise a range of professional inputs; staff shortages; inadequate accommodation for users and poor change management during service re-organisation (Burns *et al*, 2007; Belling, Whittock, McLaren, Burns, Catty, Rees Jones, Rose and Wykes, 2008).

Users participating in the ECHO study reported a range of positive and negative experiences in their engagement with the service, a notable barrier being that of 'depersonalised transition' (Burns *et al*, 2007). This occurred during transition between teams as services were re-structured, transition between teams during change of residence, and transition at discharge. Service users sometimes did not know who their key-worker was and felt that they were 'left dangling in unknown territory' with new teams and services that responded to crisis rather than providing preventive support (p195). The findings from ECHO provide important clues for conducting a study on transition from CAMHS to AMHS, since ECHO deals with interagency and cross boundary issues that influence continuity of care.

There are clearly significant gaps in our knowledge about the process, outcomes and experience of transition from CAMHS to AMHS in the UK. While such transition is widely accepted as a critical aspect of continuity of care, we do not know who makes such a transition, what are the predictors and outcomes of successful transition, and what organisational factors facilitate or impede successful transition. Significantly, we also do not know how the process of transition is experienced by clinicians, carers and, most importantly, young service users. Without such evidence, we cannot develop and evaluate specific service models that promote successful transition or plan future service development and training programmes. The TRACK study was designed to answer some of these questions in the UK context.

1.2 TRACK study: aims & objectives

The overall aims of the TRACK study are to:

(a) identify the organisational factors that facilitate or impede effective transition between Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services (AMHS) and;

(b) to make recommendations about the organisation and delivery of services that promote good continuity of care.

The specific objectives of the study were to:

(1) Conduct an audit of the policies and procedures relating to transition within six mental health trusts in London and the West Midlands (three trusts in each region) (Stage 1);

(2) evaluate the process of transition by a case note survey identifying all actual and potential referrals* from CAMHS to AMHS in the preceding year, 'track' their journey and outcomes in terms of referral and engagement with adult services, and determine the predictors of successful transition (Stage 2);

(3) conduct qualitative interviews across organisational boundaries and services within health and social care agencies to identify specific organisational factors which constitute barriers and facilitators to transition and continuity of care (Stage 3) and;

(4) explore the views of service users, carers and mental health professionals on the process of transition experience by a sample of service users (Stage 4).

*Potential referrals included those cases that are considered to need transition but are not transferred to adult services for lack of adequate service provision, or other reasons such as when young people with challenging behaviour are not considered to have a diagnosable (adult) mental disorder or for young people with learning disabilities.

2 Stage 1: Audit of Transition Protocols

'There is a transition protocol which is out of date and is being reviewed, so that might have been part of it. Sometimes you can't even get past the CMHT secretary if the young person isn't 18.' - Psychiatric Nurse, AMHS

2.1 Aims

The specific aims of Stage 1 of the TRACK study were to conduct a content analysis of the available transition policies in Greater London and the West Midlands; and to determine the annual transition rates from CAMHS to AMHS. The focus on protocols originated from The Emerging Findings of the Children's NSF (Department of Health, 2003), which demanded that CAMHS providers develop robust working protocols to ensure smooth transition of care from CAMHS to AMHS.

2.2 Methodology

2.2.1 Sample

We conducted an initial mapping exercise to identify transitions policies across the whole of Greater London. Mapping in this context involved compiling an inventory of transition protocols based upon protocol-sharing units; this was not a mapping of CAMHS provision in the region. The findings of that exercise have already been reported (Singh, Paul, Ford, Kramer and Weaver, 2008). Further mapping of protocols then occurred in the following areas of the West Midlands Region: Birmingham, Solihull, Coventry and Warwickshire. Here we summarize findings from all of Greater London and the West Midland sites. The original project funding did not cover mapping of the Birmingham & Solihull areas and data here were collected by two Specialist Registrars in Psychiatry.

2.2.2 Design

Developing the mapping tool

A literature review of transition from CAMHS to AMHS was undertaken through searches of Medline, EMBASE, CINAHL, PsychINFO, The Cochrane Library, International Bibliography of Social Sciences (IBSS), National Research Register, the HEA Database, and reports and publications from the Department of Health and charities such as YoungMinds and Rethink. Based on the review, a semi-structured study tool was developed which comprised of two parts: the first sought information on respondent structure and organisation (see details below). For the purposes of this study, a

respondent CAMHS was defined as a 'provider agency that provides CAMHS tier 2/3/4 services with shared transition protocols and procedures'. The questionnaire specified that 'if within your service some teams use different protocols or procedures for transition, please count each group of teams using a shared transition procedure/policy/protocol as a distinct service'. The second part collected information about local transition protocols, process and estimates of the average annual numbers of young people who were considered suitable for transfer to AMHS, were actually accepted by AMHS and who remained with CAMHS beyond the transition boundary.

The pilot questionnaire was discussed with two CAMHS consultants in London to help establish face and content validity. The tool collected data on:

- type of service (e.g. whether specialist Adolescent Mental Health Service or CAMHS caring for both children and adolescents)
- catchment area
- staff profile
- numbers of referrals received in the previous 12 months
- number of currently open cases
- the type of adult mental health services the service referred to
- number of adult mental health services the service referred to
- number of young people, on average, per year, who were kept within CAMHS care past the transition boundary
- whether there was a transition protocol in place (a copy of any transition protocol was requested)
- whether there was a protocol in place for the management of the interface between CAMHS and the AMHS (if separate to the transition protocol)
- whether there was a discharge protocol
- number of potential referrals to AMHS per year on average (i.e. those cases that are considered suitable for transition but are not transferred to adult services for lack of adequate service provision, or other reasons such as when young people with challenging behaviour are not considered to have a diagnosable (adult) mental disorder or for young people with neuropsychiatric disorders such as ADHD)
- number of actual referrals (i.e. the number of young people whose referrals were actually accepted by the AMHS)
- open question – 'Any further comments?'

The response from London services suggested that the original mapping tool needed revision to make it more user-friendly. An amended version, which

sought the same information as the original, was developed for use in the West Midland sites. This also sought additional information about all service users who had crossed the transition boundary in the preceding year, i.e. those who were or could have been transferred to adult services, were requested. This amended questionnaire was again reviewed by two CAMHS consultants, and a final semi-structured study tool agreed (see *Appendix 1* for the Mapping Tool).

2.2.3 Data collection

The task of mapping transition policies and procedures of CAMHS was complicated by the size, structure, levels of specialism of CAMHS and their relationship within health and social care trusts. The process of data collection therefore varied between sites; hence the London and West Midlands region processes are described separately.

Greater London sites

Between August and December 2004 a mailing list of CAMHS that potentially referred to AMHS was compiled using several sources of information including the National CAMHS Support Service (hosted by the DoH, London), CAMHS leads at London Development Centre for Mental Health and from consultant psychiatrists and service managers within various trusts. Data were collected from these CAMHS leads between January and April 2005 including data on actual and potential referrals in the preceding year (September 2003 - August 2004). The mapping tool was sent along with a letter explaining the study and asked to complete the questionnaire in consultation with the multidisciplinary team. A list of services included in the mapping was also sent and respondents asked to contribute to this list if they felt that any other relevant services had been missed. Any further services thus identified were also recruited into the study. Initially respondents were targeted at a trust level but it soon became necessary to target at an individual team level in order to increase the response rate; therefore, a second and then a third mail-shot were sent out. Follow-up phone-calls, emails and faxes helped to increase the response rate as well as consolidate links with teams. Some respondents attributed delays in response or reluctance to respond to the fact that many NHS staff frequently complete numerous questionnaires and/or audits as part of their duties. Two further reminder postal requests, supplemented by follow-up telephone calls, were conducted to improve recruitment rates

West Midland region sites

In the West Midlands region, Coventry and Warwickshire had been included in the original proposal and were part of the funded project. When the project began, it became clear that Birmingham and Solihull had particular problems in the interface between CAMHS and AMHS and the study team decided to extend the study to this area. A request for further funding request was denied so we decided to collect data from Birmingham and Solihull with the help of two specialist registrars, one from CAMHS (NF) and the other from AMHS (JD).

Coventry & Warwickshire region: A mailing list of CAMHS that potentially referred to AMHS was compiled from July to November 2006 using the CAMHS mapping exercise atlas (Department of Health, 2006b) which had been unavailable when the London site study was planned. In addition, advice was sought from consultant psychiatrists and service managers in regional trusts. The TRACK project was presented at CAMHS team meetings to inform clinicians about the study and garner support. Key professionals including team leaders and service managers were identified. As there were only three CAMHS in the study region, it was agreed with clinicians that responses should be sought at a service level rather than a team level. Data were collected on the mapping tool between November 2006 and October 2007 with data on actual and potential referrals for the 12 month period between January to December 2006

Birmingham and Solihull region: A mailing list of CAMHS teams that potentially referred to AMHS was compiled from September to November 2006 using advice from consultant psychiatrists and service managers in mental health and children's trusts. Nine relevant CAMHS were identified. The study was first presented in November 2006 at an educational meeting for CAMHS staff and received a favourable response. The Mapping Tool was distributed and sent out to the relevant lead clinicians within the nine CAMHS. No responses were received. A reminder was sent by post, supplemented by follow-up telephone calls. Again, no responses were received, so a second presentation was held in March 2007. Again the study received a favourable response from attending clinicians. It was suggested that the Mapping Tool be sent to 16 individual consultant psychiatrists and this was done. A reminder letter and supplementary telephone calls were made. However, only six questionnaires were returned, of which three questionnaires were significantly incomplete and none enclosed a transition protocol. After two further rounds of reminder letters but still no response, in November 2007 the TRACK steering group agreed that data collection from Birmingham and Solihull should be abandoned. Data from Birmingham and Solihull is therefore not presented in the results section. All Tier 4 services in the West Midlands region sub-sample were within Birmingham and Solihull and hence no data on Tier 4 services were available from the West Midlands.

2.3 Analysis

Protocols were subjected to content analysis. Key transition-related themes had initially been identified from a specific policy document (Department of Health, 2003); the transitions literature; sample transition protocols obtained from trusts outside London; and clinicians working in CAMHS in South West London & St. George's Mental Health Trust. Themes identified (e.g. transition boundary) were allocated to pertinent procedural concepts (e.g. transition criteria and service boundaries). Counts of protocols containing specific themes were thereby generated per procedural concept.

The survey questionnaire quantitative data were entered into SPSS. Summary statistics are presented as appropriate. Categorical variables are

presented as frequencies and percentages, continuous variables using means, standard deviations and minimum to maximum values.

2.4 Results

2.4.1 London sites

By April 2005, we had identified 65 CAMHS in Greater London, from which we received 42 (64.6%) completed questionnaires. Responses identified 15 protocols of which two were draft versions.

Respondents (n=42) were located in 11 health trusts, with each having at least five teams (range=5-41, mean=15.7) per CAMHS. Of the non-responding trusts, 78% CAMHS comprised of only one team. Respondents therefore came from most of the larger CAMHS. Respondents described themselves as 'CAMHS' (20), adolescent mental health services (12), specialist CAMHS (1), specialist adolescent mental health services (2), inpatient CAMHS (1), inpatient adolescent mental health service (1), national CAMHS (4) and national inpatient CAMHS (1), serving populations ranging from 60,000 to 4 million, having 1-37.5 whole-time equivalent staff (mean 10.9, SD 9.02, n=41) and having between 10 and 1500 currently open cases (mean 438.32, SD 469.56, n=31).

2.4.2 West Midland site (Coventry & Warwickshire only)

In the West Midlands Region, five mapping tools were completed on behalf of six CAMHS teams. Within the region there were three transition protocols, of which two were draft versions. Respondents (n=5) were located in three trusts, although the mental health services merged into one trust partway through the study. Each trust had two teams per CAMHS. Respondents described themselves as 'CAMHS' (3), Specialist CAMHS (1), and CAMHS/Looked After Children (one mapping tool was completed on behalf of both teams, i.e. the service) and therefore there was a 100% response rate. Respondents reported serving populations ranging from 250,000 to 533,000, having 1-42.6 whole-time equivalent staff (mean 18.18, SD 16.45, n=5) and having 1000 and 3000 open cases (mean 2000; n=2). None of the respondents identified service users who were considered suitable for transition (see section *3.5.1 Main Limitations*).

2.4.3 Structure of protocol-sharing units

London sites

We received 15 protocols of which two (protocols 5 and 12) were draft versions. They did not cover the whole of Greater London. In addition, we did not find that single CAMH services always generated a protocol each. We therefore use the term 'protocol-sharing unit' to refer to whatever CAMH unit (team, locality, service, trust) or combination of units shared one particular protocol. The protocol-sharing units varied greatly. Protocol 6 was shared by two trusts providing CAMHS, including generic, targeted and

inpatient teams. Protocols 1, 2, 7, 8, 9, 10 and 15 each covered teams within one trust. In relation to these protocols, responding teams within each protocol-sharing unit varied between being generic, locality teams (protocols 1, 9 and 15); generic teams at locality and wider than locality level (protocol 2); locality-based, adolescent teams targeting specific conditions (protocol 8); a generic team providing for 14- to 30-year-olds at wider than locality level (protocol 7); and generic and targeted locality teams alongside national targeted and tier 4 teams (protocol 10). Within another trust each of the four generic teams covering different localities had a protocol of their own (protocols 11, 12, 13, and 14). Within another trust three generic locality teams covering the same locality shared one protocol (3); an inpatient unit covering this locality and other areas used two protocols (3 and 5); and a specialist adolescent team covering one London borough used another protocol (protocol 4). Table 1 illustrates identified transition protocols in Greater London in the context of CAMHS teams, trusts and strategic health authorities. Figure 1 illustrates the distribution of these protocols between trusts identified in Table 1.

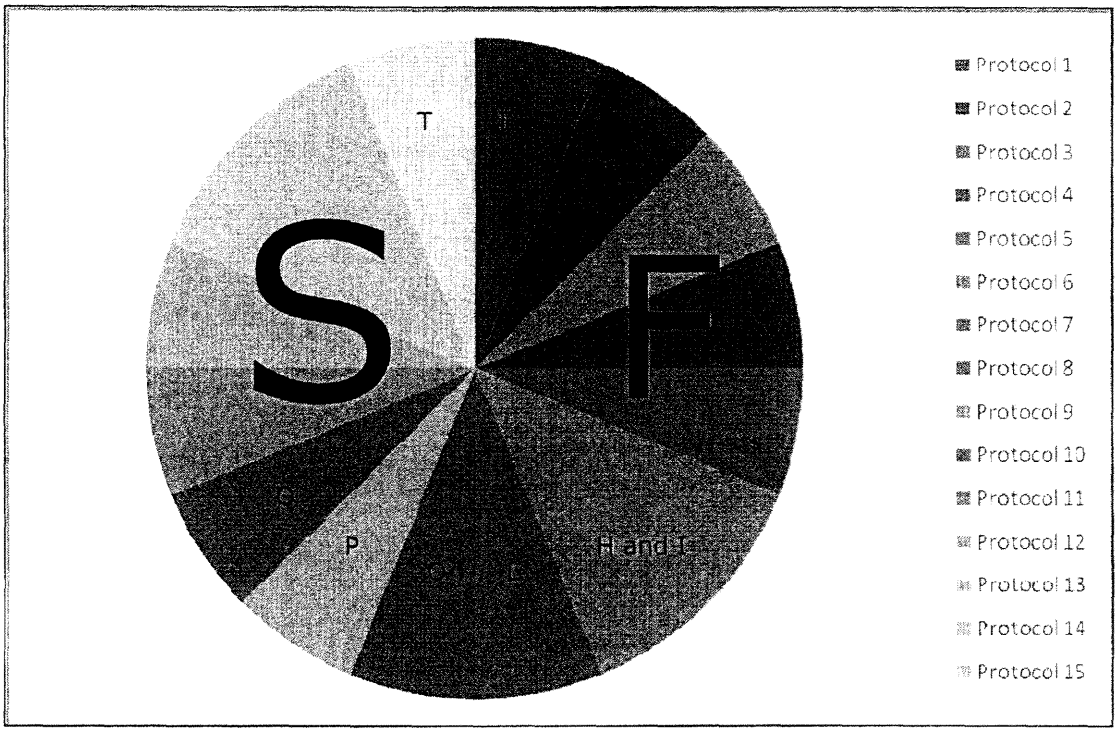
Table 1. Identified Transition Protocols in London in the Context of CAMHS Teams, Trusts and Strategic Health Authorities

STRATEGIC HEALTH AUTHORITY	NHS TRUST	CAMH SERVICES	CAMHS TEAMS P**	PRO-TOCOL	TRACK RESPONDING TEAM TYPE* / CATCHMENT AREA / SPECIFICALLY FOR YOUNG PEOPLE (ADOLESCENTS)*	NUMBER OF CMHTS REFERRED TO
1	A	1	3/10	2	• Generic MD/locality d/no	3
					• Generic MD/wider/no	
					• Tier 4 (inpatient unit 0-12yrs)/national/no	
	B	1	0/1			
	C	1	0/1			
	D	1	0/1			
	F	1	5/22	1	• Generic MD/locality a/no	
					• Generic MD/locality b/no	5
					• Generic MD/locality c/no	3
					• Generic MD/locality c/no	1
					• Generic MD/locality c/yes	3
2	F	1	6/25	3	• Generic MD/locality f/no	5
					• Generic MD/locality f/no	3
					• Generic MD/locality f/yes	8
				3+5	• Tier 4 (Inpatient unit)/locality e,f,g/yes	

				4	• Targeted (Education-based)/ locality e/yes	5
					• Targeted (Drug and alcohol)/locality ?/no	6
	G	1	0/6			
	H	1	1/5	6	• Targeted (condition-specific)/national/ no	2
	I	1	4/7	6	• Generic MD/locality h/no	1
					• Generic SD/locality h/no	
					• Tier 4 (outreach) /locality h/yes	4
					• Tier 4 (inpatient unit)/wider/yes	10
	J	1	0/1			
	K	1	0/2			
	L	1	1/14	7	• Generic MD/wider/yes (14-30 years)	
	M	1	0/1			
	N	1	0/1			
3	O	1	3/26	8	• Targeted (adolescent service) /locality i/yes	4
					• Targeted (complex mental health needs) /locality j/yes	4
					• Targeted (substance misuse) /locality I,j+/yes	
	P	1	1/15	9	• 1 Generic MD/locality k/no	
4	Q	1	10/27	10	• Generic MD/locality l/no	5

					• Generic MD/locality m/no	3
					• Generic MD/locality n/no	
					• Generic MD/locality o/no	3
					• Generic MD/locality p/no	3
					• Generic MD/locality n/yes	6
					• Targeted (children with moderate to severe learning disabilities)/locality j/m/n/o/p/no	
					• Targeted (for deaf children)/national/no	3
					• Tier 4 (inpatient unit)/locality j/m/n/o/p/yes	3
					• Tier 4 (inpatient eating disorder unit)/national/no	
5	R	1	0/1			
	S	1	4/45	[redacted]	[redacted]	[redacted]
				14	• Generic MD/locality q/yes	3
	T	1	4/10	15	• Generic MD/locality u/no	2
					• Generic MD/locality u/no	
					• Generic MD/locality v/no	1
					• Generic MD/locality w/no	3

Figure 1. Distribution of protocols between trusts in Greater London

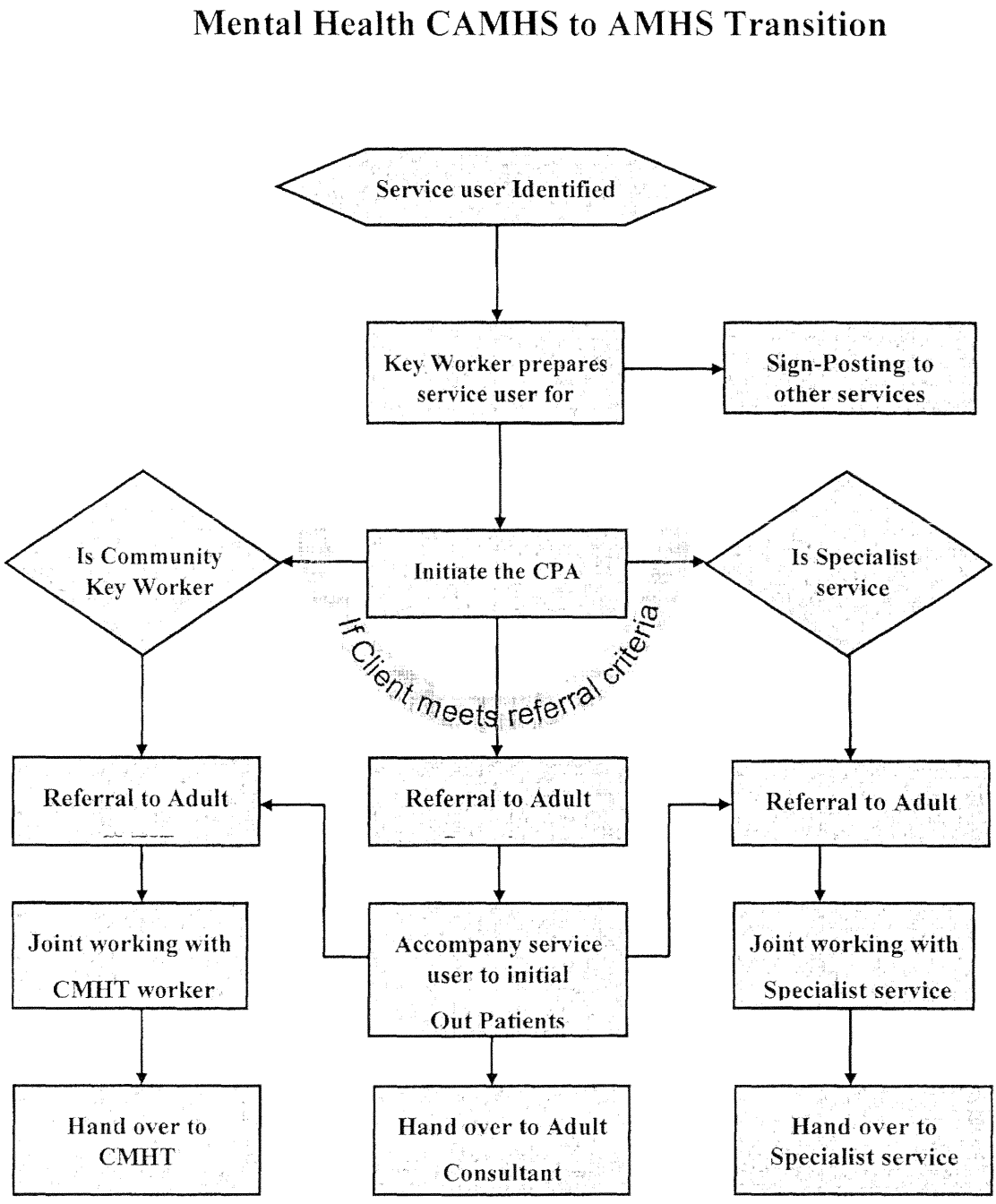


*Letters within the pie chart refer to the trusts as identified in Table 1.

West Midlands region sites

There was one operational protocol within use in West Midlands. There were two additional draft protocols, largely based on the neighbouring area's operational protocol. The three protocols covered the whole of Coventry and Warwickshire. A Transitional Steering Group, consisting of both CAMHS and AMHS members, had developed the operational protocol in December 2003. Figure 2 below, taken from the operational protocol, illustrates the agreed procedures.

Figure 2. CAMHS to AMHS referral: agreed procedures (from Coventry and Warwickshire protocol)



2.4.4 Transition boundary

London sites

The transition boundary between CAMHS and AMHS varied, with 18 years being the modal boundary (n=25). Among the other protocols, the transition boundary varied as follows: 16-years (n=2); 17-years (n=1); 16-years if not in full-time education (NIFTE) or else 18-years (n=5); 17 if NIFTE or else 18-years (n=2); 18-years, but up to 19 for young people with certain diagnoses (n=1); 19-years (n=2); 20-years (n=1); and over 21-years (n=1). One responding team provided a service for children and not for young people and therefore did not have an interface with AMHS.

The responding teams' estimates of their average annual number of cases considered suitable for transfer to AMHS ranged between 0 and 70 (mean 12.3, SD 14.5, n=37). Estimates of their average annual number of cases that actually made the transition ranged from 0 and 50 (mean 8.3, SD 9.5, n=33). Average numbers of service users who continued to be seen by the team beyond the transitional boundary varied from 0 to 64 (mean 7.6, SD 11.8, n=31).

West Midland region sites

The transition boundary between CAMHS and AMHS was variable and described mostly as 'depending on need': '17-18 dependant on need' (n=1); '17 in most cases' (n=1), and '19 in most cases' (n=1). One respondent provided a fixed boundary of 19 years of age (n=1). One respondent did not answer this question.

Only one respondent estimated their team's average annual number of cases considered suitable for transfer to AMHS each year, giving an average figure of 10, and the number of referrals accepted by adult services, giving an average figure of between 10 and 15 (we noted that the upper estimate is higher than the average number considered suitable for transfer to AMHS). Two teams reported the number of service users who continued to be seen by the team beyond the transitional boundary with one estimating 10 and the other as 'several based on need'.

2.4.5 Transition protocols

London sites

Only the 13 agreed protocols were subjected to content analysis – a research method used to find the frequency of terms or concepts in order to make inferences about their meanings and contexts. Draft protocols were excluded from content analysis since we wanted to capture information about ongoing practice. There were several broad similarities between the stated principles of the protocols. Most referred to the National Service Framework documents (Department of Health, 1999b, 2003; Department of Health and Department for Education and Skills, 2004) and identified the following factors as important in ensuring smooth transition between

services: consistency in service, continuity of care, a seamless transition, clarity about professional's roles and clinical responsibility, information sharing between agencies, aligning of assessment processes between services, resolution of eligibility and funding criteria, joint working preceding final transfer, co-operation & flexibility, user and carer involvement in decision making, care based on the principle of informed consent and consideration of the most appropriate care provision for a young person. All protocols considered an enduring mental health problem or the likelihood of mental health needs continuing into adulthood as important criteria for referral to AMHS. There was therefore very little variation in the stated principles underpinning the protocols. Table 2 summarises the key differences between protocols.

Table 2. Identified differences between transition protocols across Greater London

Protocol theme n=13	n (%)	Further details n (%)
Agencies involved in developing protocol	Not specified: 8(62%) specified: 5 (38%)	Where specified, between two (CAHMS and adult services) and six agencies (CAHMS, AMHS, PCT, Social Services, Information technology and Voluntary sector) had been involved in developing a protocol
CPA used as transition criterion	No: 10 (77%) Yes: 3 (23%)	Generally, service users on Enhanced CPA were considered appropriate for transfer to AMHS and those on Standard CPA would 'be considered'
Transition boundary: 18th birthday	Yes: 9 (69%) No: 4 (31%)	Transition boundary at: -16th birthday (n=2) or 17th (n=1) birthday if service user in full time education (FTE), - 18th birthday if in FTE -21st birthday: 1 (8%)
Transition boundary flexible	Yes: 10 (77%) No: 3 (23%)	
Specified duration of transition planning	No: 1 (8%) Yes: 12 (92%)	Specified duration of transition planning: -6 (46%) at least 6 months -2 (15%) at least 3 months -4 (31%) at CAMHS review prior to transition
Joint planning meeting	At least one: 11 (85%)	Only joint work mentioned in 2 (15%)
Formal transition plan to be drawn up	Not specified: 5 (38%) Specified: 8 (62%):	Where specified: -5 (38%) before first appointment with AMHS -2 (15%) following assessment by AMHS -1(8%) basic plan before and final plan after assessment by AMHS
Multi-agency involvement in transition planning	Not specified: 5 (38%) Specified: 8 (62%)	Where specified: -6 (46%) a general remark -2 (15%) specified inclusion in decision-making and information sharing
Joint working during transition	Not specified: 9 (69%) Specified: 4 (31%)	
Information to be transferred	Risk assessment and management plan: 6 (46%)	Other: -1 (8%) all case notes -1 (8%) specifically not individual session notes, except where directly relevant e.g. because of high risk levels -1 (8%) nothing specified -2 (15%) 'significant' reports, e.g. Occupational/ Speech & Language Therapy, Psychology -3 (23%) details of interventions & multi-agency working -2 (15%) Framework for the assessment of children in need and their families (DOH, 2000)
Procedures for service users not accepted by AMHS	Nothing mentioned: 10 (77%)	-2(15%) joint discussion between CAHMS and AMHS on further management -1 (8%) find 'alternate' AMHS

Protocols differed in terms of which services/agencies had been involved in developing the protocols; the transition boundary age and whether this was flexible; the procedure for service users not accepted by AMHS; what information should be transferred; and whether the individual's care level according to the Care Programme Approach (CPA) (Department of Health, 1999a) was a transition criterion. Protocols also differed in relation to specifications for the process of transition such as the duration of any transition-planning period and whether a formal transition plan was to be drawn up. Differences in terms of joint working included whether protocols specified a planning meeting between CAMHS and AMHS to help assess need for transition and agree a transition or discharge plan; the involvement of other agencies in this process and CAMHS input post-transition. Although most protocols (n=11, 85%) considered discussion with the service user as central to the transition process, none specified ways of preparing the service user for transition.

Two protocols specifically mentioned a transition liaison worker, one between CAMHS/AMHS and one between adolescent and adult inpatient units. Single protocols (8%) mentioned the local availability of a consultation-liaison service, through which CAHMS could request assessments and advice regarding ongoing care without the need for transition; and the need to conduct an assessment of the carers' needs.

Transition protocols: West Midland sites

Due to small numbers, all protocols in the West Midlands, including draft versions, were subject to content analysis. Two of the three protocols stated the importance of early transition planning and that the decision about which team to involve must be made based on the needs of the service user and the referral criteria of the relevant teams. All three protocols shared similarities with regard to CPA reviews, joint meetings and liaison, and the involvement of service users and their families. All protocols emphasised that transition can occur flexibly over a period of time dependent on individual needs; hence the transfer between the CAMHS and AMHS service should not be based simply on the service user's age (although the protocols all noted changes would be made in order to fall in line with the Children's NSF) and other factors should be taken into consideration, such as the level of maturity, and the nature of the identified need.

The key differences between protocols are summarized in Table 3 below.

Table 3. West Midlands Trust protocol differences

Protocol Theme	N (%)	Further Details
Number of protocols which recorded parties involved in development of the protocol	1 (33%)	A transition steering group was set up consisting of both CAMHS and AMHS members.

Review of transition plan	1 (33%)	1 protocol reviewed after 3 months; other not stated
Transfer of information – permission of service user sought	1 (33%)	Other protocols not stated

2.5 Discussion

In Greater London, in April 2005 there were at least 13 active and two draft transition protocols. In the West Midlands, in October 2007, Coventry and Warwickshire had one active transition protocol, and two others in development. Protocol-sharing CAMHS units varied, from being shared between two trusts, to one trust, several teams within a locality CAMHS and single teams. One CAMHS team had two protocols. Organisational variation therefore does not appear to be a barrier to establishing shared transition protocols. What this study did not and was not designed to answer is whether the variation in protocol-sharing units leaves gaps, i.e. CAMHS/AMHS interfaces that are not covered by agreed protocols, or whether the variation is a result of trying to cover the gaps. Later stages of TRACK will investigate whether the presence of such policies influenced transitions between CAMHS and AMHS and/or continuity of care.

Content analysis of protocols revealed little variation in their underpinning principles, which were based on the National Service Frameworks (Department of Health, 1999b, 2003; Department of Health and Department for Education and Skills, 2004). Protocols did differ on practical aspects of transition, ranging from who was involved with their development to transition boundaries and the process of transition planning, including variations in expected joint working. Three-quarters of the protocols had no provision for ensuring continuity of care for cases not accepted by AMHS. The discrepancy in estimates of numbers per annum thought suitable for transition (0-70) and the numbers that actually make the transition (0-50) raises questions about the outcomes of those who 'graduate' from CAMHS but are not accepted by AMHS, even though a proportion (0-64/several) continue to receive care from CAMHS beyond transition boundaries. The outcome of the rest should be a cause for concern for service providers and commissioners. While it is commendable that CAMHS offers some young people input beyond the transition boundary, this will inevitably have implications for CAMHS caseload, particularly as many CAMHS struggle with long waiting lists. In terms of structural issues (Forbes *et al*, 2002), protocols differed in terms of which services/agencies had been involved in developing the protocols, ranging between two and six, although 5/14 active protocols did not specify who had been involved in the process. General children and young people's policy documents (Department of Health and Department for Education and Skills, 2004; Department of Health, 2006d; Department for Children Schools and Families and

Department of Health, 2008; National CAMHS Review, 2008) and professional good practice guidance on transition and mental health (Lamb *et al*, 2008) advocate multi-agency transition planning and protocol development. Three protocols specifically mentioned a transition liaison worker, two between community CAMHS/AMHS and one between adolescent and adult inpatient units. A single protocol mentioned the local availability of a consultation-liaison service but none mentioned a transitional service, although 16 respondents described themselves as 'adolescent' teams/services.

All protocols considered an 'enduring mental health problem' as an important criterion for referral to AMHS. The term 'enduring mental health problem' seems to be a hybrid of the term 'severe and enduring mental illness', used by adult services, and 'mental health problems', a term used more in CAMHS. Stakeholders in the transition process may well hold differing conceptions of mental health, mental illness or disorder/problems (Sroufe, 1990; Gillett, 1999; Kendell and Jablensky, 2003). Young people with mental health problems as understood in a developmental or CAMHS context may not fulfil the disorder/illness criteria used by AMHS for prioritising and targeting mental health care. So, while individuals with psychosis or severe mood disorder may have their care suitably transferred, others with conduct disorder, ADHD, borderline learning disability, autism spectrum disorder, etc., may fall through the care net if not considered suitable for AMHS. Stage 2 of TRACK will address this issue further.

In terms of the policy imperatives that Care Programme Approach be used in making transition decisions (Department of Health, 1999a; Department of Health and Department for Education and Skills, 2004), only 3/13 (23%) of protocols in Greater London required use of the CPA. Within these protocols, CPA levels were used to distinguish between young people considered 'appropriate for AMHS' (service users on Enhanced CPA) and those who would 'be considered' appropriate for AMHS (on Standard CPA). It is possible that such a dichotomy allows AMHS to restrict its involvement to those with a 'severe and enduring mental illness' and to 'consider' those with an 'enduring mental illness'. In the West Midlands, by October 2007, all three protocols stipulated the use of CPA reviews at transition.

Most protocols identified the service user as central to the transition process. This is in keeping with policy documents such as the Department of Health document *Transition: getting it right for young people* (2006d), good practice guide (*Transition: moving on well*, Department for Children Schools and Families and Department of Health, 2008) and the Children's NSF Core Standard 4: 'Growing up into Adulthood' (Department of Health and Department for Education and Skills, 2004). All these policy documents stress the need to involve service users and carers in the transition process and decision making and prepare them for transition. However, none of the protocols included in this study specified ways of preparing service users or carers for transition. This suggests that protocols are being written more with policy than clinical practice in mind.

Protocols also differed in the process of transition such as the duration of any transition-planning period, whether there needed to be a joint planning meeting between CAMHS and AMHS, and whether a formal transition plan was to be drawn up or CAMHS involved post-transfer.

When should the mental health problems of a young person looked after by CAMHS become the responsibility of AMHS? Our data showed that age-based transition boundaries varied between 16 years to 21 years and over, with 18 being the mode. There is clearly no consensus on this issue although national policy will soon require comprehensive CAMHS to be provided for young people until the age of 18 years (Department of Health and Department for Education and Skills, 2004). Current boundaries are based on historical service development reasons rather than evidence or best practice. The variation in boundary definition depending upon educational or employment status is difficult to justify. If adult services are appropriate for unemployed 16-year-olds who are still living with their parents, why are adult services not appropriate for 17-year-olds who are about to leave the sixth form for university? The majority of protocols we collected did mention the need for flexibility when applying age-based transition criteria. However, there seems little consensus either on how such flexibility can be mutually agreed between services or operationalised in protocols. Mental health services for 16- and 17-year-olds are disproportionately expensive – so that comprehensive mental health services for individuals up to their 18th birthday may cost around twice as much as similar services that end at people's 16th birthday (Goodman, 2005). If cost is the reason behind a service gap for 16– to 18-year-olds, then the only way to bridge this gap is to resource services adequately.

Some argue that the best way forward is to develop specialist youth health services (Viner and Barker, 2005). YoungMinds have produced examples of good practice and guidance for commissioners in relation to services for 16-25 year olds (YoungMinds, 2006a, b). Our findings suggest that the complexity of service structures, arbitrary service boundaries, variation in protocols and possible policy-practice gap all contribute to such a discontinuity of mental health care for a significant number of young people who experience no or poor transition of care across services.

Main limitations

At the time of our data collection in Greater London, a comprehensive map of CAMHS services was unavailable. We identified services using information from several sources. Our aim was not to map CAMHS provision but to identify existing transition protocols. Responding teams in our study varied from generic to targeted and inpatient teams, and from locality-based to wider and national teams. While our study may not have captured responses from every relevant CAMHS and hence some selection bias is inevitable, the wide variation in responding teams suggests that the findings are representative of transition issues facing CAMHS in Greater London. Greater London is primarily urban and changes in service delivery are also frequently initiated in the capital. Both these factors may also limit the generalisability of our findings to other parts of the country. Nonetheless,

when including West Midlands sites, we utilised the appropriate CAMHS Mapping Atlases (Department of Health, 2006b) and covered a more diverse geographical area, including services covering rural, semi-rural and non-London urban areas.

Mapping data from London sites was already available at the beginning of the SDO-funded part of the project (Singh *et al*, 2008). However, completing Stage 1 in the West Midland sites was challenging, with several unexpected difficulties including procedural delays and poor participation from clinicians. Despite having site specific assessment (SSA) exemption and Multi-centre Research Ethics Committee (MREC) approval for the study, one local trust questioned the earlier decisions of the MREC and asked for repeated clarifications, both from the study team and the MREC. This led to considerable delay in commencing the study in West Midlands. Although all documentation was provided to the local R&D committee's satisfaction by August 2006, there was further delay in getting R&D approval due to trust reorganisation (mental health services within three participating trusts were reorganised under one trust). The approval, received in February 2007, was later retracted by the committee due to further concerns raised by the head of one of the CAMHS. The concerns were not shared by the MREC but final approval was delayed until March 2007. This procedural delay hindered Stage 1 significantly and resulted in lower recruitment, given the timeframe of the study.

At the time of data collection in Coventry and Warwickshire, there were three relevant trusts, whose mental health services have since amalgamated into one trust. Although this did not affect mapping process, it did have implications for later stages of TRACK. Additionally, despite stated enthusiasm for the study, Birmingham and Solihull clinician response rates were so poor and the quality of information in the few returns so incomplete that these sites had to be dropped from TRACK. This limited the richness and diversity of data collected from sites outside London.

Finally, the presence of a protocol does not necessarily ensure that actual practice adheres to stated policy. Stage 2 of the TRACK project aimed to identify any such policy-practice gaps.

3 Stage 2: Case note survey of transitions

'...I do feel a bit like when our young people hit eighteen we just have to say to them "that's it, that's your lot" because we just know that they're not going to meet the threshold for an adult service. And I have done that recently, I didn't bother to refer because I just knew she wouldn't qualify for the service.' – CAMHS key-worker

'...the problem with the adult transferral services is that we actually find it nearly impossible to transfer anything else except psychosis – it's complicated when you have anything combined with depression, it's really impossible to transfer...' – Psychiatrist, CAMHS

3.1 Aims

The aim of Stage 2 was to evaluate the process of transition using a case note survey, to identify all actual and potential referrals from CAMHS to adult services in the preceding year, to 'track' their progression through the service boundaries and evaluate their outcomes in terms of referral process and engagement with adult services, and thereby determine predictors of achieving transition. Throughout the section, the term 'cases,' rather than young people or service users, will be used. This is because we consulted case notes rather than the young people themselves; views of service users will be addressed in Stage 4 (section 5).

3.1.1 Definitions

We defined **actual referrals** as anyone who was referred to, and accepted by, an adult mental health service (AMHS) from a child and adolescent mental health service (CAMHS). **Potential referrals** included anyone who crossed the transition boundary during the study period but did not make a transition to adult care because

despite being considered to have an ongoing mental health need they were ***not referred*** to AMHS due to a lack of an appropriate service, the client refusing referral, etc.

they were ***still being seen*** by CAMHS.

they were ***not accepted by*** AMHS.

Transitions were also evaluated according to whether they were considered to be 'optimal' or 'suboptimal'. Freeman *et al*'s (2000) elements of continuity are given in brackets.

Optimal transition was defined as meeting the following criteria:

Continuity of care - either engaged with AMHS three months post-transition or appropriately discharged;

and the following three further variables (explored below in further detail):

Period of parallel care (relational continuity), i.e. a period of joint working where the service user is involved with both CAMHS and AMHS;

Transition planning meetings (cross-boundary and team continuity), i.e. at least one meeting discussing the transition from CAMHS to AMHS, involving the service user and/or carer and key professionals, prior to the handover of care from CAMHS to AMHS;

Optimal information transfer (information continuity), i.e. any or all of the following transferred from CAMHS to AMHS:

referral letter

summary of CAMHS contact

any or all CAMHS notes and a contemporary risk assessment

Suboptimal transitions were those that failed to meet one or more of the above criteria.

3.2 Method/design

A pilot survey of clinicians in South and East London had suggested that the rate of transition from CAMHS services to adult care is about 20 per million population per year, with another 10-15 per million per year being potential referrals. At this rate, within the study area, we expected 70-80 service users to make a transition each year (actual referrals) and 35-50 potential referrals.

For CAMHS teams to be included in the study, they had to meet the following criteria:

be defined as tier 2, tier 2-3 or tier 3 CAMHS;

manage young people up until the age of transition; and

refer cases to Adult Mental Health Services (AMHS).

CAMHS tier 4 inpatient units were included only if they managed young people up until the age of transition, while other highly specialised (tier 4 or tertiary) outpatient services were excluded because they dealt with extremely atypical populations of young people and accepted referrals from all over the country providing practical obstacles to tracking.

3.3 Data collection tools

3.3.1 Case ascertainment

In order to identify CAMHS teams that met the inclusion criteria the local collaborators for each site were asked to identify services and set up face to face meetings with the lead clinician for each, who, in turn, were also asked to identify suitable teams.

Within each included team, actual and potential referrals were identified from the preceding year using a two-stage process:

Phase 1: central databases searches

Phase 2: asking individual clinicians within teams to identify actual and potential referrals in the preceding year.

The exact dates for the preceding year differed for each trust due to data being collected at different time periods, but the data were collected from all sites for a 12 month period between 2005 and 2007. Data collection began in Trust L1 in April 2005, L2 in November 2006, L3 in December 2006, and the West Midlands Region Trusts in February 2007.

3.3.2 Phase 1: accessing databases

CAMHS databases

The central CAMHS databases for all trusts were accessed via IT teams using appropriate local data extraction procedures to obtain a list of:

- all young people whose cases were open when they reached aged X (where X is the last chronological year of age for which they should be seen by CAMHS as defined in the local transition arrangements), and to identify how many
  - were considered for transfer to adult services
  - were expected to have on-going needs
- any young people aged X+1 or older whose cases were open to CAMHS, in order to check how many were still being seen because of the lack of an adequate adult service

AMHS databases

The central AMHS databases for all trusts were similarly accessed to obtain a list of:

- all young people aged below the lower age cut-off on AMHS referral criteria, who had been referred to AMHS, and to identify
  - by whom,
  - whether they were accepted, and
  - why they were not referred to CAMHS (if the referrer was not CAMHS)
- all service users referred by CAMHS regardless of age
- all young people aged between the lower age cut-off on AMHS referral criteria and their 19th birthday, who were referred by non-CAMHS referrers, in order to cross-reference with CAMHS records to:
  - identify whether any of them had been open to CAMHS in the preceding year
  - check why CAMHS had not referred them

3.3.3 Phase 2: contacting clinicians

All CAMHS clinicians were asked for a list of all actual and potential referrals from their service to AMHS during the same year as in Phase 1 for that trust. Identified cases were cross-checked with the above database lists. Any discrepancies were raised with clinicians and/or heads of service and discussed to ascertain relevance to the project.

3.3.4 Developing the TRACKING tool

The TRACK questionnaires used to extract case note data were devised, piloted and reviewed by members of the TRACK team including CAMHS and AMHS psychiatrists. Separate questionnaires were used for actual (see *Appendix 2* for Actual Questionnaire) and potential referrals (see *Appendix 3* for Potential Questionnaire). Reviewed data were recorded in categorical, script and numerical form.

3.3.5 Data collection

The case notes of all cases thus identified as actual or potential referrals were subjected to a retrospective case note review. Researchers used the TRACK questionnaires to extract data from case notes at the relevant CAMHS team base. In the case of actual referrals, data were also extracted from the AMHS notes at the AMHS team base.

For actual referrals the following information was collected:

Clinical and socio-demographic details, including presenting problem at time of transition

Time from referral to assessment

Outcome of referral (accepted by adult services or not)

Time from referral to acceptance

Documented hand-over planning

Quality of information transfer (information continuity)

Nature and frequency of joint working during transition (therapeutic, relational and cross boundary continuity)

Any problems or difficulties documented during transition

Contact frequency, types of contacts and contact by whom

Admissions, discharges, referrals to other services

In order to access service users for Stage 4 interviews, researchers also collected information on last known address/phone number; last known GP details, and current case manager/key-worker (i.e. name, role, service contact details).

Due to the variation in case note descriptions of service users' presenting problems and diagnoses at the time of transition, it was deemed necessary to categorise presenting problems into distinct diagnostic groups for the purposes of data analysis. The following seven categories were agreed by CAMHS and AMHS clinicians in the study steering group:

Serious and enduring mental disorders: including schizophrenia, psychotic disorders, bipolar affective disorder, depression with psychosis

Emotional/neurotic disorders: including anxiety, depression (without psychosis), post-traumatic stress disorder, obsessive-compulsive disorder

Eating disorders: Anorexia Nervosa, Bulimia Nervosa, atypical eating disorder

Conduct disorders: including conduct disorder, behavioural disorder

Neurodevelopmental disorders: including Asperger syndrome, autism spectrum disorder, learning disabilities

Substance misuse disorders: alcohol and/or drug misuse

Emerging personality disorder

For potential referrals, additional information was collected on:

Current status (ongoing care by CAMHS, current management plan, discharged to GP, lost to follow up or other)

Factors accounting for the decision not to refer to adult services.

3.4 Statistical analysis

3.4.1 Reliability of data extraction

A reliability study was conducted by two researchers who independently collected data from five actual referrals from a site unrelated to the project using the study tools. These data were subjected to a data validation analysis by comparing the two resulting databases using validation software. For each of the five cases 491 non-text variables were completed and compared. Inconsistencies between databases were identified and where inconsistencies were related to coding of 'missing' or 'not applicable' variables or differences in number of decimal places used these were ignored. An error rate less than 2% resulted and was deemed to be satisfactory.

3.4.2 Transition pathways

Descriptive statistics and graphical presentation were used to examine transition pathways of all cases. Numbers and percentages of cases experiencing different pathways were determined and sub-analyses conducted by study region and included trusts.

3.4.3 Predictors of achieving transition

The modelling strategy used in this analysis uses an exploratory approach. Given the lack of evidence in the area it was not possible to construct hypotheses to test the effect of hypothesised predictor variables. A two stage analysis was therefore conducted. The first stage identified which

independent variables had at least a weak association ($p<0.1$) with the dependent variable. Variables found to have such a univariate association were then entered into logistic regression. Variables were entered simultaneously, without *a priori* assumptions about which variables were more influential than others. The results of the logistic regression were interpreted in terms of those independent variables found to be significant at the 5% level, $p < 0.05$.

The dependent variable in this analysis was whether referrals are 'actual' or 'potential'. The independent variables were drawn from four groups:

demographics: gender, age at first referral to CAMHS, ethnicity (i.e. Asian, Black, White, Mixed/Other, or not recorded), first language, accommodation (i.e. parents' home, on own, or other), highest education status reached, whether currently in education or employment, parental status (i.e. married or cohabiting, other, or not recorded), family history of mental health difficulties (i.e. any record in CAMHS or AMHS case notes of mental health difficulties in parents, siblings, uncles/aunts, grandparents or other family);

indicators of broader social risks while attending CAMHS: Looked After Child (LAC) at any point, special educational needs, Child Protection involvement, Youth offending Team (YOT) involvement, a refugee or asylum seeker;

service use: parental attendance at CAMHS (i.e. regularly – attending more than 50% of appointments, sometimes – attending less than 50% of appointments, or never – no evidence of ever attending any appointments), type of referral to CAMHS (i.e. routine or urgent), discipline of key-worker at time of transition;

clinical variables: any periods of mental health inpatient care, any MHA detentions under CAMHS, presenting problem, comorbidities (i.e. presenting problems at the time of leaving CAMHS fitting into more than one of the following categories: serious and enduring, emotional/neurotic, eating disorder, conduct disorder, neurodevelopmental disorder, substance misuse, or emerging personality disorder).

Reliability of data coding

Two CAMHS psychiatrists independently categorised presenting problems using the above definitions, and a third psychiatrist independently resolved any discrepancies arising in categorisations. There was a high level of agreement (95%) between the two independent psychiatrists, with only eight cases needing to be resolved by the third. Young people who

presented with problems that fell into more than one of the categories described above were allocated to more than one group and described as having a 'comorbid' presentation.

Tests for univariate association

Each variable was tested for univariate association with achieving 'actual' or potential' referral status (dependent variable) using Pearson $\chi 2$ tests (Fishers exact tests where necessary) for categorical variables and unpaired t-test for the continuous variables. Those variables found to be significantly associated at the 10% level (i.e. $p < 0.1$) with the dependent variable were taken into the second stage of analysis.

Tests for co-linearity of independent variables

In the second stage of analysis, variables found to have a univariate association with the dependent variable were to be entered in a logistic regression. Prior to the logistic regression, however, it was necessary to examine whether any of the independent variables were highly associated with each other (co-linear) at a 5% significance level (i.e. $p < 0.05$). Those independent variables found to be highly associated with each other were either recoded to create composite variables or one dropped (where it was felt one variable was more clinically relevant than another).

Logistic regression

Variables identified as relevant in the univariate analysis were entered into a logistic regression model to explore their relationship with the dependent variable. The 'Enter' selection method was used to enter independent variables into the logistic regression. The results of the logistic regression model are presented using odds ratios and 95% confidence intervals. Results of the logistic regression are interpreted by examination of those variables which are significant at the 5% level (i.e. $p < 0.05$).

3.4.4 Predictors of achieving an optimal transition

This analysis was carried out as in section 3.4.3 but the dependent variable in this case was whether a service user achieved continuity of care (definition: either engaged with AMHS at three months post-transition or appropriately discharged) or not. This analysis was only carried out on those who had made a transition to AMHS.

3.5 Results

3.5.1 Case ascertainment

Efforts to use databases to find cases were unsuccessful because of the poor quality of the datasets (see section 3.5.1 *Difficulties with Phase 1 Case Ascertainment* below). In London sites, a total of 113 cases and in the West Midlands sites a total of 42 cases were tracked completely, i.e. both CAMHS and AMHS notes were viewed for actual referrals and CAMHS notes were

viewed for potential referrals. Eleven cases (9 in London and 2 in the West Midlands) were partially tracked, i.e. these cases were actual referrals but only the CAMHS notes were viewed. Another 20 cases were identified as suitable for inclusion (18 in London and 2 in the West Midlands) but could not be included due to time restrictions. Table 4 details the number of cases tracked in each borough/locality for each site. Nine CAMHS Teams in London reported that they had no relevant cases.

Using this retrospective case note survey method, the rate of actual and potential referrals per 100,000 population (Office for National Statistics, 2002) in the London sites were 2.68 and 1.49 respectively, very close to the figures estimated in the initial pilot. The rate of actual and potential referrals per 100,000 population in the West Midlands sites were 2.23 and 2.97 respectively.

Table 4. Cases tracked by borough/locality

Borough/ Locality	**Complete: CAMHS and AMHS (where relevant) case notes tracked**			**Half-complete: (CAMHS notes tracked)**	**Not viewed (files identified as relevant but not viewed)**
	Actual	Potential	Totals	Actual	
L1	22	5	27	0	0
L2	27	23	50	0	10
L3	23	13	36	9	8
sub-totals	***72***	***41***	***113***	***9***	***18***
WM1	3	2	5	0	0
WM2	2	4	6	0	2
WM3	13	18	31	2	0
sub-totals	***18***	***24***	***42***	***2***	***2***
Totals	**90**	**65**	**155**	**11**	**20**

Difficulties with phase 1 case ascertainment

In the West Midlands Trusts included in the study, there were no inpatient (tier 4) units. Tier 4 provision is somewhat complex and, on behalf of 17 PCT's, the West Midlands Specialised Services Agency (WMSSA) is responsible for commissioning all CAMHS tier 4 services for children and young people under 18 years of age. Due to the unforeseen delay in receiving local R&D approval (see section 2.5 *Main Limitations*), it was decided that cases from the included West Midlands trusts who had been admitted to tier 4 units outside the participating trusts would not be included. Similarly, in L2 there were a number of tier 4 national and specialist services. Again due to the difficulties inherent in following up

national cases, such as getting R&D approvals from non-participating trusts, it was decided that these services would not be included in the study.

Difficulties were encountered when searching the central CAMHS databases in London. In London Trust 1, the list obtained was of no practical utility, being vast and including every person ever seen by CAMHS services from the appropriate year of birth. In London Trusts 2 and 3, the databases could not be searched according to the study criteria and reports were produced based on age and status criteria only. As these lists were of restricted usefulness, enquiries were made into searching databases at the borough level for London Trust 2. This proved futile as two out of the four boroughs had no suitable databases during the study period, and two had databases that could not be searched according to the study criteria.

In the West Midlands trusts there was no central database. However, one of the localities, WM3, did have a PAS database which was searched and a report was produced based on age only. The report identified all CAMHS cases who reached the transition boundary (i.e. 17+) between 01/01/2006 and 31/12/2006, which were either closed in 2006 or continued to be seen by CAMHS.

In order to search adult databases, the IT services in each trust were contacted. Useful lists were obtained in London Trusts 1 and 2 and WM locality 2. London Trust 3 and West Midlands localities 1 and 3 had no central database so individual team databases were searched, with some producing useful lists.

Overall we encountered several problems in case ascertainment via central datasets including lack of suitable databases; databases could not be searched according to proposed criteria; delays in gaining access to databases; and varying comprehensibility and accuracy in the reports produced by the databases. Thus, the database search was abandoned in favour of asking individual clinicians to identify cases (Phase 2).

Difficulties with phase 2 case ascertainment

In this phase we tried to ask individual clinicians within relevant teams to identify actual and potential referrals in the preceding year. Problems in Phase 2 included clinicians unwilling to meet study team because of busy clinical schedules and high staff turnover whereby relevant clinicians had left the service during the study period. Some clinicians commented that their high caseload would lead to a difficulty in remembering all relevant cases.

3.5.2 Transition pathways

Of the 155 cases tracked, 90 (58%) were accepted by AMHS (i.e. actual referrals). Sixty-four (42%) were potential referrals, i.e. those who crossed the transition boundary during the study period but did not make a transition to adult care. One case was excluded from subsequent analysis as it was found that this case was not referred on to an adult mental health service but a neurologist. Case notes of all actual and potential referrals

were tracked up to attendance at and/or discharges from AMHS (in the actual referral cases) or non-acceptance / reasons for non-referral (in the potential referral cases). Figure 3 illustrates this information. The subsequent analysis is on a total of 154 cases.

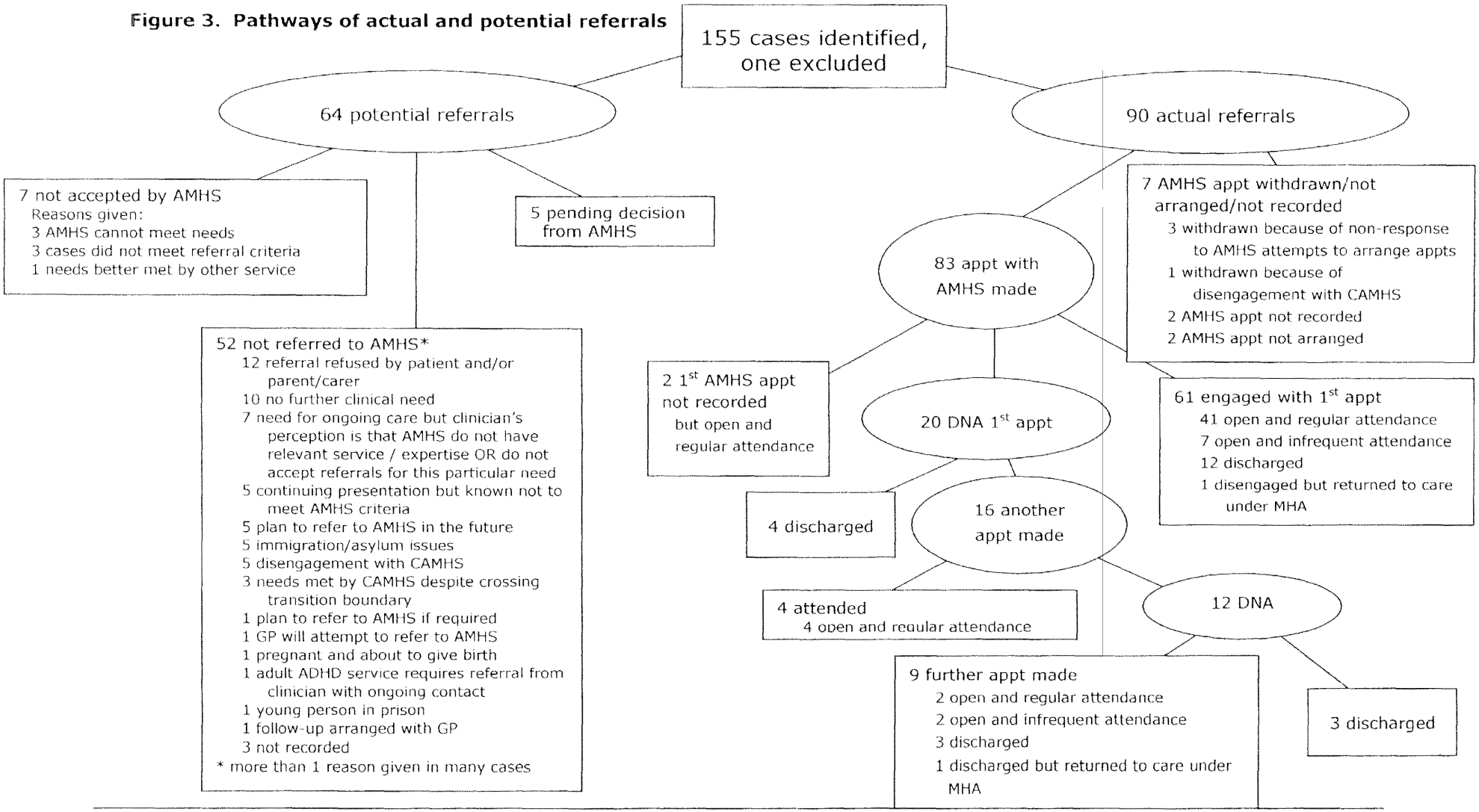
One hundred and thirty-one of the 154 (85.1%) young people reaching the transition boundary between CAMHS and AMHS were thought suitable for transition by CAMHS clinicians. Of the 131, in 12 (9.2%) cases the young person and/or a parent/carer refused referral to AMHS (1 refusal by parent/carer only, 2 by the young person and parent/carer and 9 by the young person only), in another 12 (9.2%) referrals had not been made because CAMHS thought AMHS would not accept the referral or because they did not think AMHS had appropriate services. In five cases (3.8%) referral to AMHS was planned but had not been made. Only 102/131 referrals to AMHS were made, i.e. 77.9% of those cases thought suitable for transition. Of these, 90 (88.2%) had been accepted by the end of data collection, with five (4.9%) still pending a decision by AMHS. Only seven (6.9%) had been refused by AMHS, either because they did not meet AMHS criteria (3/102, 2.9%) or because no suitable service was available (3/102, 2.9%) or because an alternative service was thought to be suitable (1/102, 0.9%).

Of the 90 cases referred to and accepted by AMHS, 58 (64%) remained open to follow up by AMHS. Twenty-six percent (23/90) were discharged following attendance at AMHS or following failed appointments. Twenty-four percent (20/83) of cases missed their first appointment. Seven cases (7.8%) were referred but had their first appointment withdrawn, had no appointment recorded or no appointment arranged.

Almost a quarter failed to attend the first appointment offered by AMHS (20/90), of whom four fifths were offered a second appointment, only a quarter of which were attended. All the rest were offered a second appointment, of which only a quarter were attended. All those who did not attend the second appointment nine (75%) were offered a third appointment, of which about half were attended. About a quarter were discharged following attendance at AMHS or following failed appointments. Only two thirds of the actual referrals remained open to AMHS when surveyed (64.4%). Sixteen cases (18%) were discharged without being seen.

The length of any wait to be seen by AMHS has not been recorded in the case note data so this information is not available. However, the number of appointments offered in the first three months has been recorded, and out of the 90 actual referrals, five cases (5.5%) did not have an appointment in the first 3 months. Seven cases (7.8%) had only one appointment.

Figure 3. Pathways of actual and potential referrals

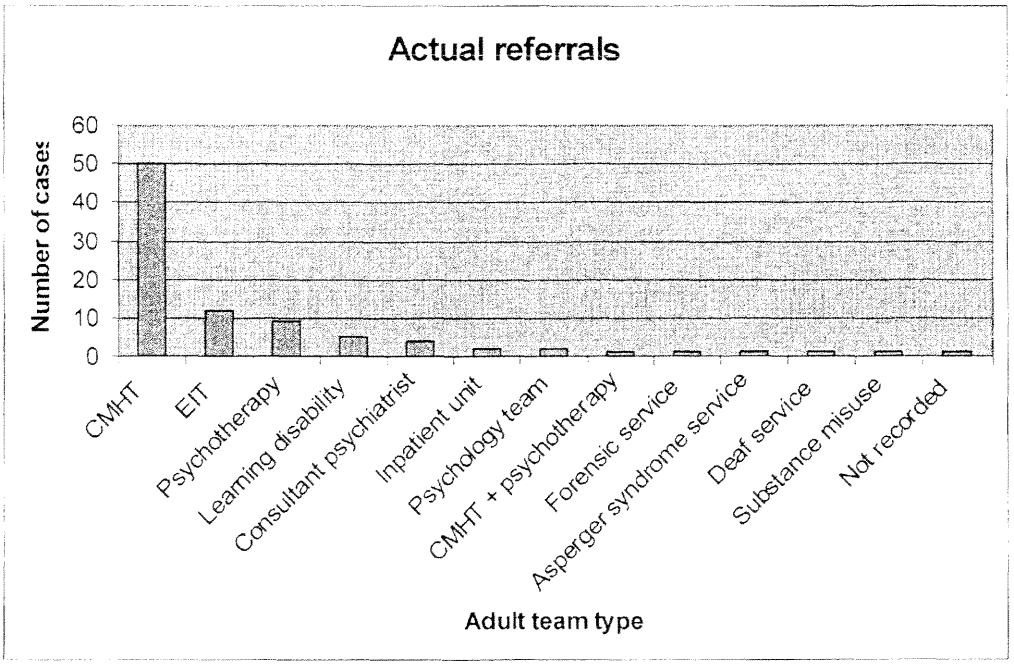


Transition pathways from different CAMHS to different adult teams

Of the 90 cases accepted by AMHS (i.e. actual referrals), 56 (36.4%) were from adolescent units (all in London). The transition boundaries for the adolescent teams were 18 years in all cases, with some flexibility in 5/6 units. The transition boundaries for the child and adolescent teams were 18 years for all London teams and 17 for all West Midlands site teams, although there was stated flexibility in the protocols.

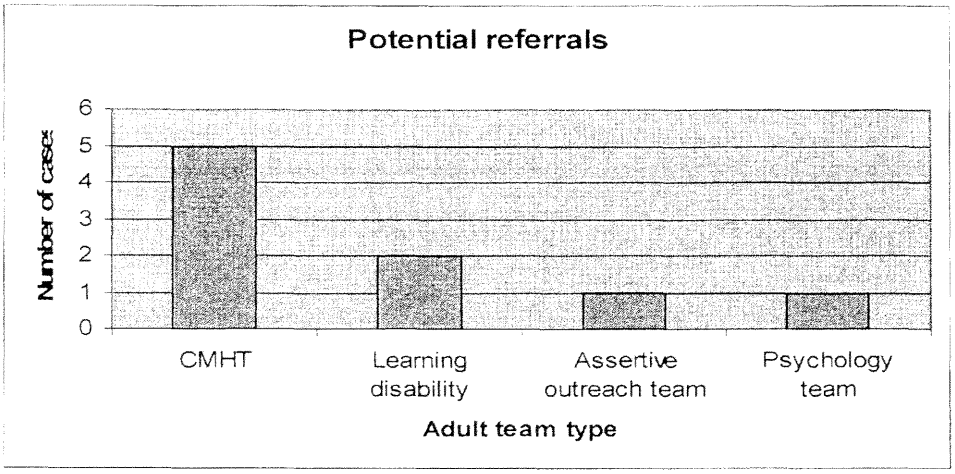
Of the 90 cases accepted by AMHS (i.e. actual referrals), CAMHS made referrals to the following: 50 referrals to Community Mental Health Teams (CMHTs), 12 to Early Intervention Teams (EITs), 9 to adult psychotherapy services, 5 to learning disability services, 4 to consultant psychiatrists, 2 to adult inpatient units, 2 to psychology teams and one each to a CMHT/adult psychotherapy service, forensic service, Asperger syndrome service, deaf service, and substance misuse team (Figure 4). One referral target was not recorded in the notes.

Figure 4. AMHS team destinations for CAMHS referrals accepted by AMHS



Stage 2 case notes indicated the following destinations for unsuccessful referrals from CAMHS to AMHS (potential cases): 5 to CMHTs, 2 to learning disability services and one each to an assertive outreach team and a psychology team (see Figure 5). No unsuccessful referrals were made to Early Intervention Teams. There was therefore no clear pattern suggesting that some specific adult service types did not accept CAMHS referrals although EI services appear to accept all referrals from CAMHS.

Figure 5. AMHS team destinations for CAMHS referrals not accepted by AMHS



Reasons why potential referrals were not actual referrals

The commonest reason for potential referrals not to be referred was that CAMHS clinicians did not expect the referral to be accepted by AMHS or that AMHS did not accept the referral (n=16) (see Figure 3). Other reasons included the referral being refused by the service user and, in some instances, the parent/carer (n=12) or there being no further clinical need (n=12). The characteristics of these three groups were examined further and some striking differences were revealed.

In the group where there was an ongoing clinical need but the service user was not referred on to AMHS because the clinician did not expect the referral to be accepted, or where AMHS did not accept the referral, the majority of service users were based in Trust L2 (n=11), with others in WM Trust (n=3), L1 (n=1), and L3 (n=1). The group consisted of nine females and seven males and ethnicity was White (n=8), Black (n=4), not recorded (n=2), Asian (n=1), and Mixed/Other (n=1). The mean age of first referral to CAMHS was 13.31 years. The majority of cases fell into either neurodevelopmental disorders (n=6, 37%) or emotional/neurotic disorders (n=5, 31%), and one case fell into both these categories. The other three cases were divided between serious and enduring mental illness (n=1), eating disorders (n=1) and substance misuse (n=1) categories. Four service users had at least one parent who attended CAMHS regularly, none had been admitted to hospital due to mental health problems, and seven were on medication at the time of crossing the transition boundary.

In the group where the referral was refused by the service user and/or carer, all of the cases were based in London, with L3 having half the cases (n=6) followed by L2 (n=4) and L1 (n=2). The group was divided evenly between males and females, and ethnicity was mixed between White (n=4), Black (n=3), Asian (n=2), not recorded (n=2) and Mixed/Other (n=1). The mean age at first referral to CAMHS was 14.42 years. A third fell into the emotional/neurotic diagnostic category (n=8), followed by

neurodevelopmental disorders (n=2), neurodevelopmental disorder and substance misuse (n=1), and serious and enduring mental illness (n=1). Three service users had at least one parent who attended CAMHS regularly, and nine service users were on medication at the time of crossing the transition boundary. Two service users had been admitted to hospital due to mental health problems, one of these under the MHA.

In the group that were not referred on to AMHS as there was no further clinical need, the vast majority of service users were based in WM Trust (n=11) and only one was based in London (Trust L2). The group was divided evenly between males and females, and ethnicity was not recorded in most cases; the others were White (n=3) and Black (n=1). The mean age at first referral to CAMHS was 14.58 years. Half of the cases fell into the emotional/neurotic diagnostic category at the time of crossing the transition boundary (n=6, 50%), followed by eating disorders (n=3, 25%), neurodevelopmental disorders (n=2, 16%) and conduct disorder (n=1, 8%). Five young people had at least one parent who attended CAMHS regularly, none had been admitted to hospital due to mental health problems at any time, and three were on medication at the time of crossing the transition boundary.

3.5.3 Sample description

The total sample (both actual and potential referrals) consisted of 78 (51%) males and 76 females, with a mean age of 18.12 (SD 0.824) at the time of data collection. The majority ethnic group was White (31%), followed by Black (23%), although no ethnicity was recorded for a large portion of the sample (27%). The majority (76%) spoke English as their first language. Most of the young people in the sample lived with their parents (71%) and were either in employment or education (60%).

Most young people's presenting problem at the time of transition fell into the diagnostic category of emotional/neurotic disorders (n=78. 51%), followed by neurodevelopmental disorders (n=38, 25%) and serious and enduring mental disorders (n=34, 22%). Much less frequently presenting problems fell into the categories of substance misuse (n=14, 9%), conduct disorders (n=6, 4%), eating disorders (n=6, 4%), and emerging personality disorder (n=4, 3%). In five cases (3%) the presenting problem was not recorded. Total percentages add up to more than 100% here as almost a fifth of young people (n=29, 18.8%) had more than one presenting problem at time of transition, i.e. they fitted into more than one diagnostic category.

Most of the co-morbid cases fitted into two categories (n=27). Of these, 21 were actual referrals and six were potential referrals. Two cases fitted into three categories (serious and enduring mental illness, neurodevelopment disorder and substance misuse; conduct disorder, neurodevelopmental disorder and substance misuse) and were both actual referrals, but only one had received ongoing care from AMHS. The most common comorbid categories were emotional/neurotic disorders and neurodevelopmental disorders (n=7), of which five were actual referrals and two received ongoing care. The next most common comorbid categories were serious and

enduring mental illness and substance misuse (n=6), of which all were actual referrals and four were receiving ongoing care from AMHS.

3.5.4 Predictors of achieving transition

Trusts

Table 5 below illustrates the number of actual and potential referrals by trust. Trust L2 had the highest number of actual referrals (n=26) and Trust WM had the lowest (n=18). Trust WM had the highest number of potential referrals (n=24) and Trust L1 the lowest (n=4).

Table 5. Actual and potential referrals by trust

Team Trust	Actual referrals (n=90)		Potential referrals (n=64)	
	n	%	n	%
L1	23	85%	4	15%
L2	26	53%	23	47%
L3	23	64%	13	36%
WM	18	43%	24	57%
Totals	90	58%	64	42%

The percentage of actual referrals differed significantly between the trusts (X2=13.175, p=0.004) with WM Trust having the lowest percentage of actual referrals to AMHS, only 43%, and L1 having the highest percentage at 85%. However, upon closer examination, it was found that Trust L1 had the highest percentage of cases with serious and enduring mental illnesses (37%), while WM Trust had the lowest (5%), X2=11.576, p=0.009.

Trust L1 had the highest ratio of actual to potential referrals (5.75:1) and Trust WM the least (0.75:1).

Table 6. Actual and potential referral ratios by trust

Team Trust	Actual referrals (n=90)		Potential referrals (n=64)		Actual: Potential ratio	Totals (n=154)	
	n	%	n	%	n	n	%
L1	23	25.6%	4	6.3%	5.75:1	27	17.5%
L2	26	28.9%	23	35.9%	1.14:1	49	31.8%
L3	23	25.6%	13	20.3%	1.77:1	36	23.4%
WM	18	20.0%	24	37.5%	0.75:1	42	27.3%

Teams

Referrals from CAMHS specifically for an adolescent age group (as opposed to CAMHS which managed both children and young people) were not more likely to achieve transition. On the AMHS side, referral to Early Intervention

in Psychosis Teams or CMHTs were significantly associated with achieving transition ($p < .0001$) although numbers referred to other types of AMHS were relatively low. In our sample, referral to an Early Intervention service always resulted in transition.

Demographic variables

There were no differences between the actual or potential referrals in terms of the following demographic variables; gender, age at first presentation to CAMHS, ethnicity, first language spoken, educational or employment history, parental status, having special educational needs, Youth Offending Team involvement, refugee or asylum seeker status. However, the actual referrals were significantly more likely to be living on their own, to have a family history of mental health difficulties, to have been a Looked After Child or to have had Child Protection involvement while attending CAMHS (using a 10% significance level). Only living on their own, Looked After Child status and evidence of Child Protection involvement were significant at a 5% level.

Table 7 illustrates demographic variable comparisons between actual and potential referrals.

Table 7. Demographic variables comparing actual and potential referrals

	Actual referrals n (%)	**Potential referrals n (%)**	**Total n (%)**	**Chi-Square**	***p* value**
Gender					
Male	49 (54.4)	29 (45.3)	78 (50.6)	1.248	0.26
Age at first referral to any CAMHS					
Mean	13.34 (n=88)	14.29 (n=63)	13.74 (n=151)	t=-1.696	0.09
Std Dev.	3.907	2.937	3.555		
Ethnicity					
Asian	8 (8.9)	5 (7.8)	13 (8.4)		
Black	23 (25.6)	13 (20.3)	36 (23.4)		
Mixed/Other	13 (14.4)	4 (6.3)	17 (11.0)		
White	26 (28.9)	21 (32.8)	47 (30.5)		
NR (not recorded)	20 (22.2)	21 (32.8)	41 (26.6)	4.531	0.34
Language					
English as first language / NR	82 (91.1)	54 (84.4)	136 (88.3)		
First language other	8 (8.9)	10 (15.6)	18 (11.7)	1.64	0.200
Accommodation					
Parent(s)' home	58 (64.4)	52 (81.3)	110 (71.4)	6.997	0.03

On own	13 (14.4)	2 (3.1)	15 (9.7)		
Other	19 (21.1)	10 (15.6)	29 (18.8)		
Highest education reached to date					
GCSEs and below	43 (47.8)	27 (42.2)	70 (45.5)		
above GCSEs	36 (40.0)	24 (37.5)	60 (39.0)		
NR	11 (12.2)	13 (20.3)	24 (15.6)	1.35	0.51
Evidence that young person is in education and/or employment					
Yes	58 (64.4)	35 (54.7)	93 (60.4)		
No/NR	32 (35.6)	29 (45.3)	61 (39.6)	1.489	0.22
Parental status					
Married/ cohabiting	25 (27.8)	22 (34.4)	47 (30.5)		
Separated/ divorced	44 (48.9)	31 (48.4)	75 (48.7)		
1 or 2 parents deceased	14 (15.6)	7 (10.9)	21 (13.6)		
Other/NR	7 (7.8)	4 (6.3)	11 (7.1)	1.242	0.74
Family history of mental health difficulties					
Yes	51 (56.7)	22 (34.4)	73 (47.4)		
No	15 (16.7)	15 (23.4)	30 (19.5)		
NR	24 (26.7)	27 (42.2)	51 (33.1)	3.644	0.06
Looked After Child at any point while attending CAMHS					
Yes	24 (26.7)	8 (12.5)	32 (20.8)		
No	66 (73.3)	56 (87.5)	122 (79.2)	4.56	0.03
Evidence of special educational needs while attending CAMHS					
Yes	19 (21.1)	10 (15.6)	29 (18.8)		
None/NR	71 (78.9)	54 (84.4)	125 (81.2)	0.736	0.39
Evidence of Child Protection involvement while attending CAMHS					
Yes	12 (13.3)	1 (1.6)	13 (8.4)		
None/NR	78 (86.7)	63 (98.4)	141 (91.6)	6.705	0.01
Evidence of Youth Offending Team involvement while attending CAMHS					
Yes	7 (7.8)	7 (10.9)	14 (9.1)		
None/NR	83 (92.2)	57 (89.1)	140 (90.9)	0.452	0.50
Refugee or asylum seeker while attending CAMHS					
Yes	10 (11.1)	9 (14.1)	19 (12.3)		
No	58 (64.4)	51 (79.7)	109 (70.8)		
NR	22 (24.4)	4 (6.3)	26 (16.9)	0.002	0.96
Any known broader social risks? (yes to any of above)					
Yes	45 (50.0)	23 (35.9)	68 (44.2)		
No	45 (50.0)	41 (64.1)	86 (55.8)	3.000	0.08

Clinical and service use variables

Actual and potential referrals differ significantly (at the 10% significance level) in terms of parental attendance, admission to hospital, detention under MHA, being on medication at time of transition, diagnostic categories of serious and enduring mental illness, eating disorders, substance misuse, emerging personality disorder, and significant comorbidity (Table 8). Actual referrals were significantly more likely (at the 5% significance level) to have attended CAMHS with their parents, been admitted to mental health hospital, to have been detained under the Mental Health Act and to have a serious and enduring mental disorder, substance misuse, an emerging personality disorder or more than one category of presenting problem (comorbidity); they were less likely to have an eating disorder.

Table 8. Clinical and service use variables comparing actual and potential referrals

	Actual referrals n (%)	**Potential referrals n (%)**	**Total n (%)**	**Chi-Square**	***p* value**
Parental attendance at CAMHS					
Yes	34 (37.8)	20 (31.3)	54 (35.1)		
No	33 (36.7)	39 (60.9)	72 (46.8)		
NR	23 (25.6)	5 (7.8)	28 (18.2)	11.643	0.003
Type of referral to CAMHS					
Routine	46 (51.1)	48 (75.0)	94 (61.0)		
Urgent	19 (21.1)	12 (18.8)	31 (20.1)		
not recorded	25 (27.8)	4 (6.3)	29 (18.8)	1.425	0.23
Discipline of key-worker at time of transition					
Psychiatrists	35 (38.9)	23 (35.9)	58 (37.7)		
Nurse (CPN/ Forensic/CNS/MHN)	16 (17.8)	8 (12.5)	24 (15.6)		
Psychologist	15 (16.7)	9 (14.1)	24 (15.6)		
Social worker, therapist, OT, psychotherapist, other	22 (24.4)	18 (28.1)	40 (26.0)		
NR	2 (2.2)	6 (9.4)	8 (5.2)	4.797	0.31
Evidence of admission to hospital for mental health problems while attending CAMHS					
Yes	31 (34.4)	3 (4.7)	34 (22.1)		
None/NR	59 (65.6)	61 (95.3)	120 (77.9)	19.251	<.0001
Detained under a section of the MHA at any point while attending CAMHS					
Yes	15 (16.7)	1 (1.6)	16 (10.4)		
No/NR	75 (83.3)	63 (98.4)	138 (89.6)	9.165	0.002
Presenting problem by category at time of transition (may be more than one)					

Serious and enduring mental disorder	Yes	32 (35.6)	2 (3.1)	34 (22.1)		
	No	58 (64.4)	62 (96.9)	120 (77.9)	22.866	<.0001
Emotional/neurotic disorder	Yes	43 (47.8)	35 (54.7)	78 (50.6)		
	No	47 (52.2)	29 (45.3)	76 (49.4)	0.714	0.40
Eating disorder	Yes	1 (1.1)	5 (7.8)	6 (3.9)		
	No	89 (98.9)	59 (92.2)	148 (96.1)	4.486	0.03
Conduct disorder	Yes	3 (3.3)	3 (4.7)	6 (3.9)		
	No	87 (96.7)	61 (95.3)	148 (96.1)	0.183	0.67
Neurodevelopmental disorder	Yes	19 (21.1)	19 (29.7)	38 (24.7)		
	No	71 (78.9)	45 (70.3)	116 (75.3)	1.48	0.22
Substance misuse	Yes	12 (13.3)	2 (3.1)	14 (9.1)		
	No	78 (86.7)	62 (96.9)	140 (90.9)	4.716	0.03
Emerging personality disorder	Yes	4 (4.4)	0 (0.0)	4 (2.6)		
	No	86 (95.6)	64 (100)	150 (97.4)	2.92	0.09
Comorbidity at time of transition						
0 or 1 category		67 (74.4)	58 (90.6)	125 (81.2)		
2 or more categories		23 (25.6)	6 (9.4)	29 (18.8)	6.41	0.01
Evidence of self-harm at time of transition						
Yes		5 (5.6)	7 (10.9)	12 (7.8)		
No/NR		85 (94.4)	57 (89.1)	142 (92.2)	1.508	0.22
On medication at time of transition						
Yes		69 (76.7)	29 (45.3)	98 (63.6)		
No/NR		21 (23.3)	35 (54.7)	56 (36.4)	15.89	<.0001

Summary of univariate analysis for the purposes of the logistic regression

The following variables were significantly associated with achieving transition with p-values less than 0.1: age, first language, accommodation, family history of mental health difficulties, Looked After Child, child protection involvement, parental attendance, admission, admitted under the Mental Health Act (MHA), serious and enduring mental illness, eating disorder, substance misuse, emerging personality disorder, on medication, and comorbidity.

Logistic regression

Composite and retained variables

Being a Looked After Child and on the child protection register were highly related, $X2=14.3$, $p<0.0001$. Therefore, a variable 'known broader social risks' was created which was equal to 1 if any of the following were present: Looked After Child, child protection involvement, Youth Offending Team

involvement, special educational needs, or refugee/asylum seeker. This new variable was marginally associated with achieving transition at the 10% level, X2=3.0, p=0.083. We examined this further by creating a scored variable for social risk (0 - 5) with 1 assigned to each of the previous five variables; thus the higher the score, the greater the number of social risks the service user had. A Mann Whitney U test indicated there was a weak relationship between the strength of the score and whether a case was an actual or potential referral (U=2449, p=0.078). This variable was therefore also entered into the logistic regression.

Being admitted to an inpatient mental health unit and being admitted under the MHA were also highly associated, X2=63.0, p<0.0001. Therefore, a composite variable was created with the three following categories: not admitted, admitted, admitted under the MHA. This variable was associated with achieving transition, X2=19.3, p<0.0001.

Accommodation type and parental attendance were highly associated, X2=21.2, p<0.0001. Parental attendance was, however, retained in the analysis as a separate variable. The reasoning was that, if found to be predictive of achieving transition, it is a potentially modifiable variable; i.e. children who do not have parents available to attend appointments could be provided with advocates.

Being on medication at the time of transition and having a serious and enduring mental disorder were highly associated, X2=14.3, p<0.0001. The research team felt that both these variables were independently important, so regression models were fitted with each variable to examine their respective association with outcome. Although there is weak evidence of an association between emerging personality disorder and achieving transition, this variable has not been included in the logistic regression as only four service users were allocated to this category and they all made the transition.

Logistic regression results including serious and enduring mental illness or medication variable

Tables 9 and 10 show the results of the logistic regression, including serious and enduring mental illness and medication variables, respectively.

Table 9. Results of logistic regression (including serious and enduring mental illness variable): factors predicting actual transition

Independent variable		OR	95% CI	p-value
Known broader social risk (score)		1.38	0.90, 2.10	0.14
English as first language	Yes	1	-	-
	No	0.76	0.25, 2.32	0.62
Parents attend CAMHS	Yes	1	-	-
	No	0.56	0.23, 1.33	0.19
	NR	1.57	0.42, 5.86	0.5
Admitted as psychiatric inpatient	No	1	-	-
	Admitted	5.05	0.95, 26.79	0.05
	Admitted under section	4.99	0.52, 48.34	0.16
Eating disorder	No	1	-	-
	Yes	0.24	0.02, 2.37	0.22
Substance misuse	No	1	-	-
	Yes	1.66	0.25, 10.99	0.59
Comorbidity	No	1	-	-
	Yes	2.82	0.85, 9.41	0.09
Serious and enduring illness	No	1	-	-
	Yes	7.85	1.63, 37.78	0.01

Table 10. Results of logistic regression including medication variable

Independent variables		OR	95% CI	p-value
Known broader social risk (score)	Yes	1.44	0.93, 2.21	0.09
English as first language	Yes	1	-	-
	No	0.60	0.19, 1.86	0.4
Parents attend CAMHS	Yes	1	-	-
	No	0.47	0.20, 1.08	0.08
	NR	1.28	0.36, 4.48	0.7
Admitted as psychiatric inpatient	No	1	-	-
	Admitted	4.97	1.00, 24.76	0.05
	Admitted under section	8.39	0.99, 70.87	0.05
Eating disorder	No	1	-	-
	Yes	0.32	0.03, 3.27	0.34
Substance misuse	No	1	-	-
	Yes	1.61	0.25, 10.39	0.62
Comorbidity	No	1	-	-
	Yes	2.95	0.87, 10.02	0.08
On medication	No	1	-	-
	Yes	2.36	1.05, 5.33	0.04

Summary of logistic regression analysis

When serious and enduring mental illness is entered into the logistic regression, young people admitted to an inpatient unit were five times more likely than those not admitted to be an 'actual' referral (95% CI: 0.95, 26.79, p=0.05). There is a similar odds ratio when comparing those who were detained under the MHA to those not admitted but this is non-significant, probably due to small numbers. People with serious and enduring illness are significantly more likely to be 'actual' referrals than those with other diagnoses, OR=7.85 (95% CI: 1.63, 37.78, p=0.01).

When being on medication at the time of transition is entered into the logistic regression, young people admitted to inpatient units were again almost five times more likely than those not admitted to be an 'actual' referral (95% CI: 1.00, 24.76, p=0.05). Young people who had been admitted under the MHA were 8.39 times more likely than those not admitted to be an 'actual' referral (95% CI: 0.99, 70.87, p=0.05). Young people on medication at the time of transition are significantly more likely to be 'actual' referrals than those not, OR=2.36 (95% CI: 1.05, 5.33, p=0.04).

Together these analyses suggest that severe and enduring mental illness, severe enough to require admission to hospital, whether or not under the

Mental Health Act, or to require medication, is the factor most likely to predict a transition to AMHS.

3.5.5 Optimal transitions: cases

Four criteria were used to define an optimal transition. These were:

- continuity of care (either engaged with AMHS three months post-transition or appropriately discharged); AND
- a period of parallel care (a period of joint working where the service user is involved with both CAMHS and AMHS); AND
- at least one transition planning meeting (meeting discussing the transition from CAMHS to AMHS, involving the service user and/or carer and key professionals, prior to the handover of care from CAMHS to AMHS); AND
- optimal information transfer (any or all of the following transferred from CAMHS to AMHS: referral letter, summary of CAMHS contact, any or all CAMHS notes and a contemporary risk assessment).

Based on these criteria only four of the 90 actual referrals experienced an optimal transition. They were 2 males and 2 females and were all from ethnic minority backgrounds. Three had a diagnosis of a serious and enduring mental disorder at the time of transition and had been admitted to hospital at some point while attending CAMHS (two under MHA). All four were on medication at the time of transition. All four cases were in two of the London Trusts: L2 (n=2) and L3 (n=2). Three cases (service users B, D and L) were referred from adolescent CAMHS teams, and all were referred onto CMHTs, although one case, service user G, is now with an Early Intervention (EI) team which was part of the CMHT to which he was referred. Service users B, D and L were all age 18 at the time of transition and service user G was age 19. These cases are described in Table 11 below.

Table 11. Cases with optimal transitions

ID	Diagnosis at time of transition	Admitted to hospital	On Meds?	Gender	Ethnicity	Trust
Service user L	Bipolar affective disorder	Yes (not on section MHA)	Yes	Female	Black	L2
Service user D*	Bipolar affective disorder	Yes (on section 2)	Yes	Female	Black	L3
Service user G*	Psychotic disorder	Yes (on section 3)	Yes	Male	Black	L3
Service user B*	Depression	No	Yes	Male	Asian	L2

* Interviewed in Stage 4

Suboptimal transitions: cases

Suboptimal transitions were defined as those cases that failed to meet one or more of the above criteria. The breakdown of the components of optimal transition, for the 90 actual referrals, are as follows (see Figure 6):

22/90 (24.4%) had a period of parallel care/joint working between CAMHS and AMHS, of whom 8 (8.9% of actual referrals) had a transition planning meeting (TPM), 6 (6.7%) had good information transfer and 18 (20.0%) had continuity of care;

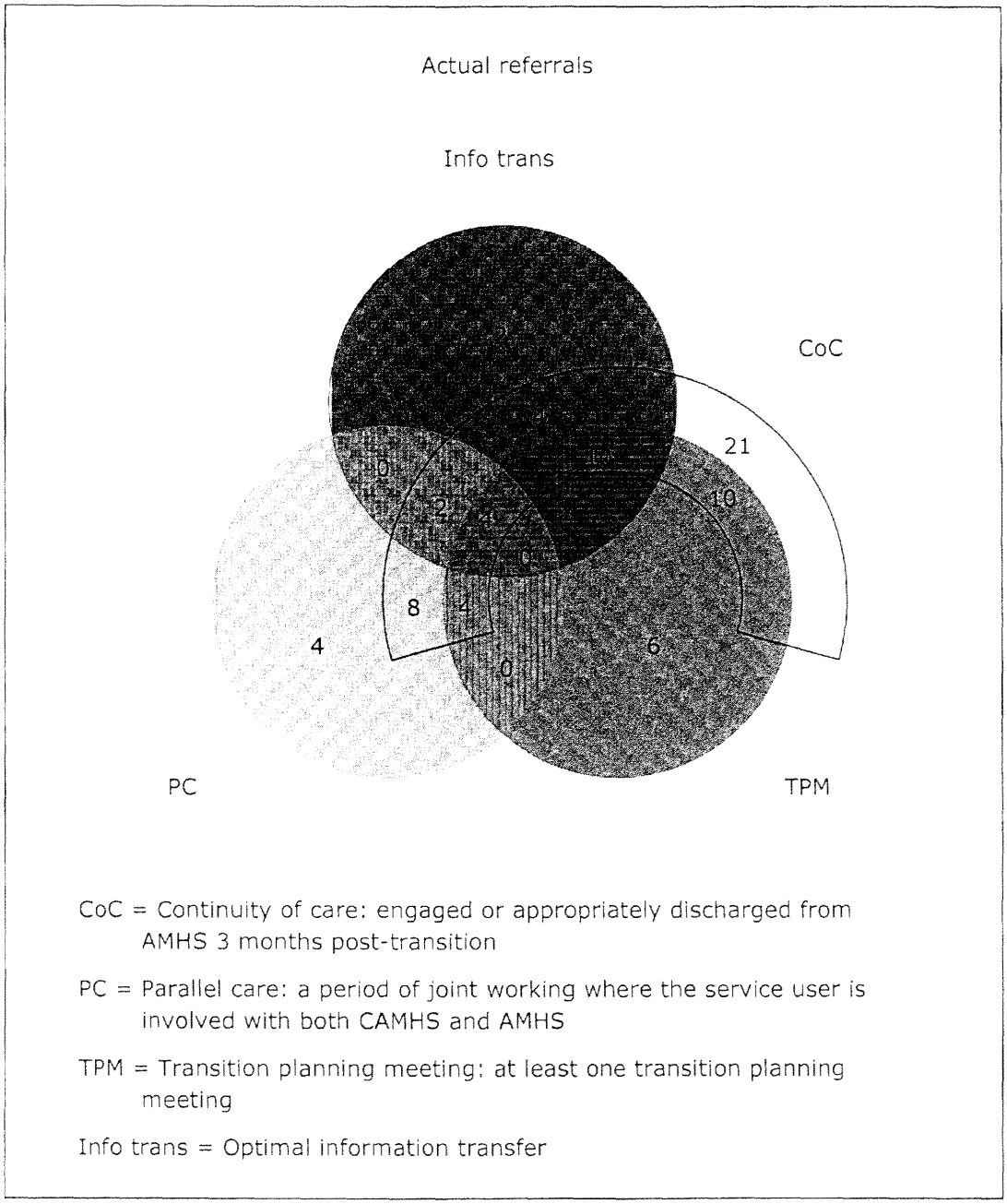
36/90 (40.0%) had at least one transition planning meeting, of whom 8 (8.9% of actual referrals) had a period of parallel care, 16 (17.8%) had good information transfer and 28 (31.1%) had continuity of care;

24/90 (26.7%) had good information transfer of whom 6 (6.7% of actual referrals) had a period of parallel care, 16 (17.8%) had at least one transition planning meeting and 20 (22.2%) had continuity of care; and

63/90 (70.0%) had continuity of care, of whom 18 (20.0% of actual referrals) had a period of parallel care, 28 (31.1%) had at least one transition planning meeting and 20 (22.2%) had good information transfer (see Figure 7).

Overall, actual referrals most often had continuity of care followed in decreasing order to also have had at least one transition planning meeting, good information transfer and a period of parallel care/joint working between CAMHS and AMHS. Thirteen out of the 90 actual referrals had none of the TRACK components of optimal transition (see Figure 8).

Figure 6. Numbers of cases meeting the constituent criteria for optimal transition



CoC = Continuity of care: engaged or appropriately discharged from AMHS 3 months post-transition

PC = Parallel care: a period of joint working where the service user is involved with both CAMHS and AMHS

TPM = Transition planning meeting: at least one transition planning meeting

Info trans = Optimal information transfer

Figure 7. Numbers of cases with continuity of care meeting the other constituent criteria for optimal transition

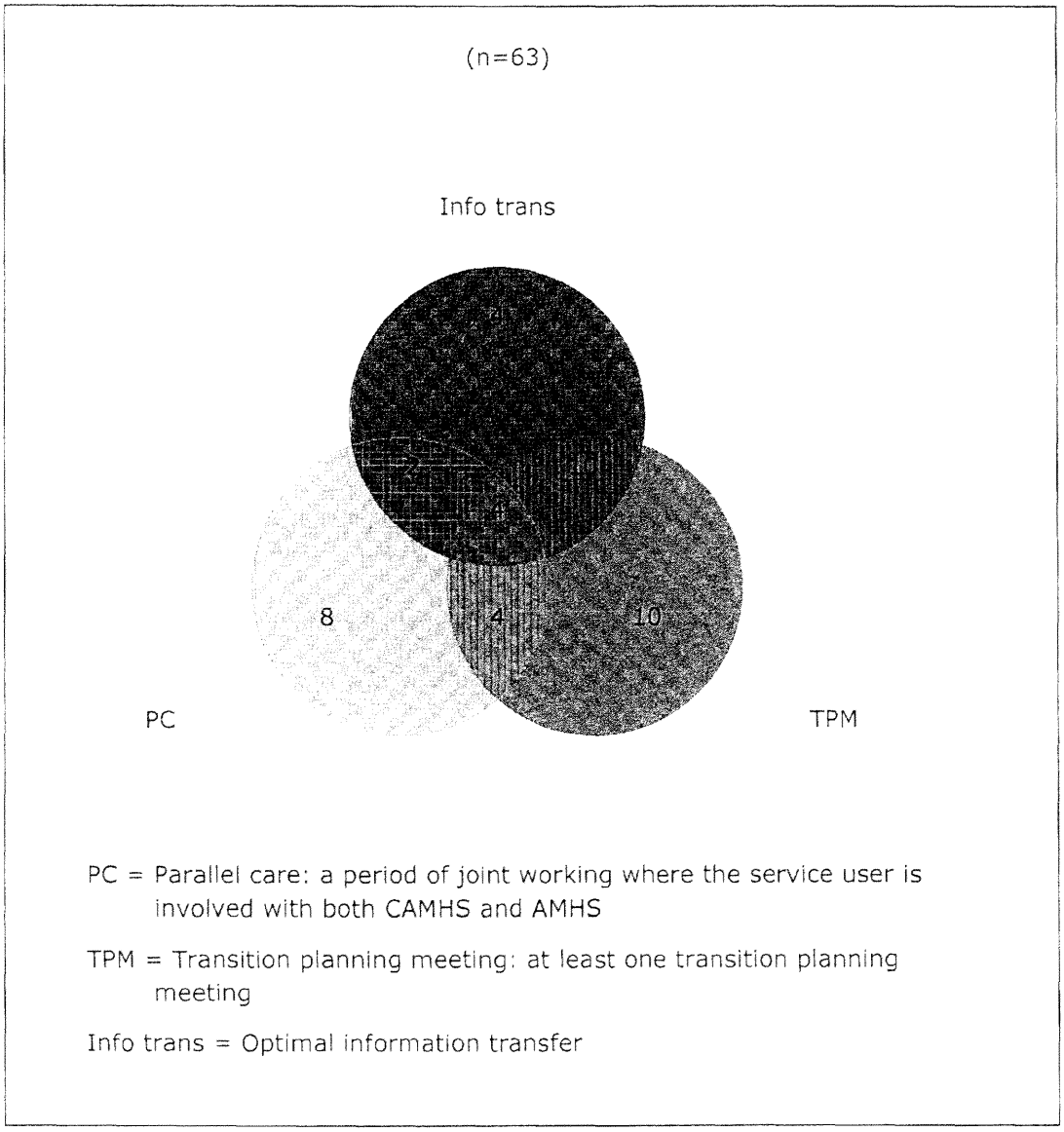
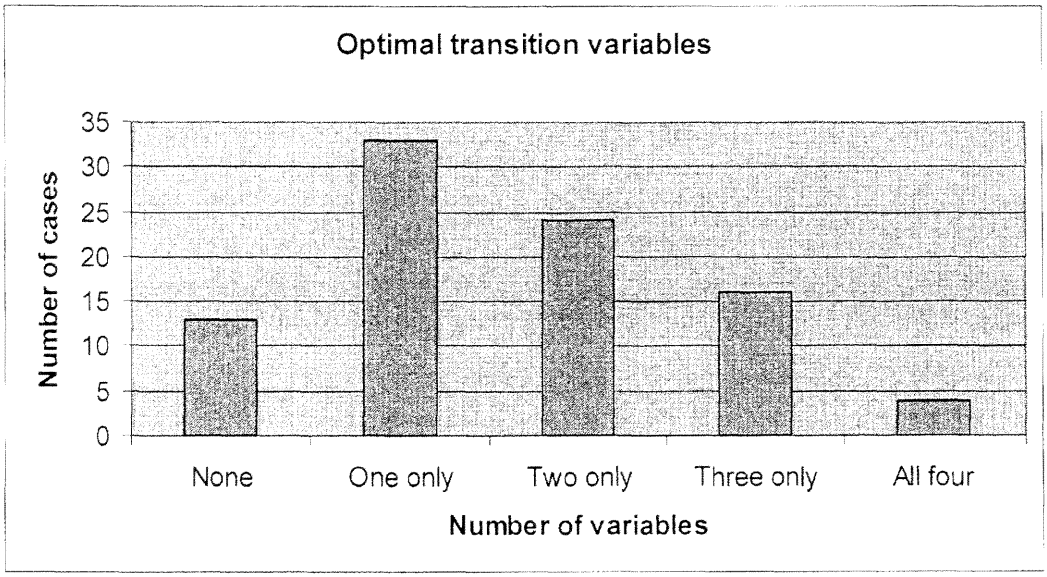


Figure 8. Cases with any or all of the optimal transition variables



3.5.6 Optimal transitions: predictors of experiencing continuity of care

The criteria agreed to define continuity of care were 'still engaged with AMHS or appropriately discharged 3-months post-transition'. Univariate analysis of actual referrals at the 10% level indicated that continuity of care was more likely for those cases where young people had married/cohabiting parents or a serious and enduring mental illness. Continuity of care was less likely for those with emotional/neurotic disorder or an emerging personality disorder. Only the latter two retain significance at the 5% level. The following tables provide details of the comparison of cases that did and those that did not experience such continuity of care in relation to demographic, social risk and service use / disorder variables, among all those cases that were referred to and accepted by AMHS (i.e. actual referrals).

Table 12. Association of demographic variables with continuity of care

	Actual referrals with continuity of care (COC)* n (%)	Actual referrals without COC n (%)	Chi-Square	*p* value
Male	35 (55.6)	14 (51.9)	0.105	0.746
Mean age at first referral to any CAMHS	13.56 (n=61)	12.85 (n=27)	t=.780	0.438
Std Dev.	3.823	4.12		
Ethnicity				
Asian	7 (11.1)	1 (3.7)	2.352	0.671
Black	16 (25.4)	7 (25.9)		
Mixed/Other	10 (15.9)	3 (11.1)		
White	16 (25.4)	10 (37.0)		
NR	14 (22.2)	6 (22.2)		
Language				
English as first language / NR	57 (90.5)	25 (92.6)	0.11	0.746
First language other	6 (9.5)	2 (7.4)		
Accommodation				
Parent(s)' home	42 (66.7)	16 (59.3)	1.783	0.410
On own	10 (15.9)	3 (11.1)		
Other	11 (17.5)	8 (29.6)		
Highest education reached to date				
GCSEs and below	31 (49.2)	11 (40.7)	0.544	0.762
above GCSEs	24 (38.1)	12 (44.4)		
NR	8 (12.7)	4 (14.8)		
Evidence that young person is in education and/or employment				
Yes	44 (69.8)	14 (51.9)	2.669	0.102
No/NR	19 (30.2)	13 (48.1)		
Parental status				
Married/cohabiting - 2 parents	22 (34.9)	3 (11.1)	7.175	0.067
Separated/divorced	28 (44.4)	16 (59.3)		
1 or 2 parents deceased	10 (15.9)	4 (14.8)		
Other/NR	3 (4.8)	4 (14.8)		
Family history of mental health difficulties				
Yes	36 (57.1)	15 (55.6)	0.518	0.472

No	12 (19.0)	3 (11.1)		
NR	15 (23.8)	9 (33.3)		

* Continuity of care: engaged with AMHS or appropriately discharged three months post-transition

Table 13. Association of broader social risks with continuity of care

	Actual referrals with COC n (%)	Actual referrals without COC n (%)	Chi-Square	*p* value
Looked After Child at any point while attending CAMHS				
Yes	15 (23.8)	9 (33.3)	0.877	0.349
No	48 (76.2)	18 (66.7)		
Evidence of special educational needs while attending CAMHS				
Yes	12 (19.0)	7 (25.9)	0.537	0.464
None/NR	51 (81.0)	20 (74.1)		
Evidence of Child Protection involvement while attending CAMHS				
Yes	8 (12.7)	4 (14.8)	0.073	0.787
None/NR	55 (87.3)	23 (85.2)		
Evidence of YOT involvement while attending CAMHS				
Yes	4 (6.3)	3 (11.1)	0.597	0.440
None/NR	59 (93.7)	24 (88.9)		
Was the YP a refugee or asylum seeker at any time while attending CAMHS?				
Yes	8 (12.7)	2 (7.4)	0.817	0.366
No	38 (60.3)	20 (74.1)		
NR	17 (27.0)	5 (18.5)		

Table 14. Service use / disorder variables for continuity of care

	Actual referrals with COC	Actual referrals without COC	Chi-Square	*p* value
Parental attendance at CAMHS				
Yes	26 (41.3)	8 (29.6)	3.851	0.146
No	19 (30.2)	14 (51.9)		
NR	18 (28.6)	5 (18.5)		
Type of referral to CAMHS				

Routine		29 (46.0)	17 (63.0)	0.680	0.410
Urgent		14 (22.2)	5 (18.5)		
not recorded		20 (31.7)	5 (18.5)		
Was the referring CAMHS an adolescent team?					
Yes		23 (36.5)	10 (37.0)	0.002	0.962
No		40 (63.5)	17 (63.0)		
Was the accepting AMHS an EI team?					
Yes		9 (14.3)	3 (11.1)	0.165	0.685
No		54 (85.7)	24 (88.9)		
Was the accepting AMHS a CMHT?					
Yes		35 (55.6)	16 (59.3)	0.494	0.781
No		27 (42.9)	11 (40.7)		
NR		1 (1.6)	0 (0.0)		
Discipline of key-worker at time of transition					
Psychiatrists		25 (39.7)	10 (37.0)	1.585	0.811
Nurse (CPN/Forensic/CNS/MHN)		12 (19.0)	4 (14.8)		
Psychologist		10 (15.9)	5 (18.5)		
Social worker, therapist, OT, psychotherapist, other		14 (22.2)	8 (29.6)		
NR		2 (3.2)	0 (0.0)		
Evidence of admission to hospital for mental health problems while attending CAMHS					
Yes		22 (34.9)	9 (33.3)	0.021	0.885
None/NR		41 (65.1)	18 (66.7)		
Detained under a section of the MHA at any point while attending CAMHS					
Yes		12 (19.0)	3 (11.1)	0.857	0.355
No/NR		51 (81.0)	24 (88.9)		
Presenting problem by category at time of transition (may be more than one)					
Serious and enduring mental d/o	Yes	26 (41.3)	6 (22.2)	2.993	0.084
Emotional/neurotic disorder	Yes	26 (41.3)	17 (63.0)	3.565	0.048
Eating disorder	Yes	1 (1.6)	0 (0.0)	0.433	0.510
Conduct disorder	Yes	3 (4.8)	0 (0.0)	1.330	0.249
Neurodevelopmental disorder	Yes	14 (22.2)	5 (18.5)	0.156	0.693
Substance misuse	Yes	8 (12.7)	4 (14.8)	0.073	0.787
Emerging personality disorder	Yes	1 (1.6)	3 (11.1)	4.037	0.045
Comorbidity at time of transition					
0 or 1 category		48 (76.2)	19 (70.4)	0.337	0.562

2 or more categories	15 (23.8)	8 (29.6)		
Evidence of self-harm at time of transition				
Yes	3 (4.8)	2 (7.4)	0.252	0.616
On medication at time of transition				
Yes	51 (81.0)	18 (66.7)		
No/NR	12 (19.0)	9 (33.3)	2.156	0.142

Summary of univariate analysis for the purposes of the logistic regression

At a univariate level, continuity of care was more likely for those cases where young people had married/cohabiting parents or a serious and enduring mental illness. Continuity of care was less likely for those with emotional/neurotic disorder or an emerging personality disorder.

Logistic regression

Composite and retained variables

Serious and enduring mental illness and emotional/neurotic disorder were highly negatively associated, $X2=34.3$, $p<0.0001$. This was because the two variables were virtually mutually exclusive with only 2 people having both disorders. The logistic regression was fitted twice, once with serious and enduring mental illness, parental status and emerging personality disorder and then with emotional/neurotic disorder, parental status and emerging personality disorder.

Logistic regression results

Tables 15 and 16 illustrate the results of logistic regressions predicting suboptimal continuity of care including emotional/neurotic disorder and serious and enduring mental illness variables.

Table 15. Results of logistic regression (including emotional/neurotic disorder variable): factors predicting suboptimal continuity of care

Independent variables		OR	95% CI	p-value
Parental status	Married/cohabiting	1	-	-
	Separated/divorced	0.23	0.06, 0.97	0.04
	1 or 2 parents deceased	0.32	0.06, 1.75	0.19
	Other/NR	0.13	0.02, 0.93	0.04
Emerging personality disorder	No	1	-	-
	Yes	0.12	0.01, 1.39	0.09
Emotional/neurotic disorder	No	1	-	-
	Yes	0.34	0.12, 0.96	0.04

Table 16. Results of logistic regression (including serious and enduring mental illness variable): factors predicting suboptimal continuity of care.

Independent variables		OR	95% CI	p-value
Parental status	Married/cohabiting	1	-	-
	Separated/divorced	0.27	0.07, 1.08	0.06
	1 or 2 parents deceased	0.32	0.06, 1.72	0.18
	Other/NR	0.11	0.02, 0.79	0.03
Emerging personality disorder	No	1	-	-
	Yes	0.21	0.02, 2.27	0.2
Serious and enduring illness	No	1	-	-
	Yes	2.08	0.70, 6.25	0.18

Individuals with emotional/neurotic disorder appear to be a third less likely to experience optimal continuity of care (95% CI: 0.12, 0.96, p=0.04), i.e. they are less likely to experience continuity of care than those with other conditions. Having parents who are married or cohabiting predicts optimal continuity of care in cases with both neurotic disorders and serious and enduring mental illnesses. Other categories identified by univariate analysis as significantly associated with continuity of care, were not supported as predictors of optimal continuity when assessed by the logistic regression. This included having a serious and enduring mental illness.

Transition process measures for cases with and without continuity of care

Table 17 shows comparison of cases that did and those that did not experience continuity of care. Of the actual referrals, 24% (n=22) had a period of parallel care and 31% (n=28) had a least one transition planning meeting. Twenty-seven percent (n=24) had optimal information transfer, but only 4% (n=4) had all of these measures.

Table 17. Association of transition process measures with continuity of care

	Actual referrals with COC n (%)	Actual referrals without COC n (%)	Chi-Square	*p* value
1) optimal parallel care	18 (29)	4 (15)	1.94	0.192
suboptimal parallel care	45 (71)	23 (85)		
2) optimal TPM*	28 (44)	8 (30)	1.73	0.189
suboptimal TPM	35 (56)	19 (70)		
3) optimal information transfer	20 (32)	4 (15)	2.77	0.096

suboptimal information transfer	43 (68)	23 (85)		

*TPM = at least one transition planning meeting.

Overall, none of the other components of optimal transition (period of parallel care, at least one transition planning meeting, and good information transfer) significantly predicted continuity of care, although the best indicator was good information transfer, for which there was weak association with continuity of care (p=0.09).

3.6 Discussion

3.6.1 Identifying actual and potential referrals

Case ascertainment

Stage 2 aimed to identify all actual and potential referrals from CAMHS to AMHS in the preceding year and track their transition and outcomes. Case ascertainment was conducted using a dual strategy of searching CAMHS and AMHS central databases and asking individual clinicians to identify actual and potential referrals within their caseloads in the preceding year. There were significant problems in case ascertainment in both strategies. Databases either did not exist or could not provide accurate and suitable information needed for the study. Some clinicians felt too busy to provide relevant information, some could not be contacted because of staff turnover, and some could not accurately recall appropriate cases because of high caseloads. While the study managed to recruit enough cases as per the original protocol, our rates of actual and potential referrals are likely to be underestimates.

If such extensive and prolonged research does not succeed in getting accurate information about transition from CAMHS to AMHS, then it is highly unlikely that service commissioners and providers have any information on which to develop, evaluate and improve services or understand the needs, outcomes and experiences of young people undergoing transition. The lack of central databases in mental health services and the poor quality of information available appear major impediments for both service evaluation and service development. TRACK is a good example of research making an important contribution to 'assessing the completeness and quality of data used for clinical care and health services' (UKCRC Advisory Group for Connecting for Health, 2007, p6).

There are several new initiatives in Information Technology developments with the NHS including Connecting for Health (www.connectingforhealth.nhs.uk). In conjunction with the UK Clinical Research Collaboration (UKCRC), its Research Capability Programme states that its '... primary objective is to enable research to achieve its full potential as a "core" activity for health care, alongside other uses of NHS data that lead to improvements in the quality and safety of care'. This has been reiterated by the Department of Health document *Best Research for Best Health - A New National Health Research Strategy* (Department of

Health, 2006a). The Department of Health has also commissioned the National Datasets Service of The NHS Information Centre for Health and Social Care to develop a CAMHS dataset (www.ic.nhs.uk/services/datasets/dataset-list/camhs) to support the implementation for the National Service Framework for Children, Young People and Maternity Services. It takes into account the CAMHS Outcome Research Consortium (CORC, http://www.corc.uk.net/) dataset and proposes to take into account the National Institute for Clinical Excellence (NICE) guidelines and related work. The current consultation version includes subsets on care planning including transition to AMHS (Information Centre for Health and Social Care, 2008). TRACK findings clearly illustrate the need for such improvements in central databases; whether these policy aspirations will be realised is a question for the future.

Data extraction from case notes

We encountered major difficulties in finding and searching case notes. CAMHS case notes were in different ways or different places depending on the team, and searching for closed cases required considerable time and effort by researchers, clinicians and administrative staff. For instance, files were sometimes located in damp, dark rooms in dusty boxes, in no particular order, or researchers found themselves climbing over filing cabinets in order to retrieve a file, only to find much of the information needed missing. On occasion, files appeared to be missing without any trace. For located files, data extraction was difficult since the way notes were organised varied between and sometimes even within each team, email and telephone contact was rarely recorded properly, and handwritten clinical notes were often difficult and sometimes impossible to read. This raised concerns about the accuracy of the data, especially about the nature and frequency of clinical contacts, types of interventions delivered, transition planning and discussions, discussions with users and carers, and the information transferred to AMHS. Accessing AMHS case notes to follow up actual referrals also posed challenges. Some teams demanded additional paperwork prior to allowing access despite R&D ethical approval, there was a lack of consistency between teams as to who should be contacted (e.g. consultant, team manager, care co-ordinator) and by what method (e.g. phone, letter, fax, or email), and service user being seen by an AMHS team different to the one specified in the CAMHS case notes. Overall, the accessibility, organisation and quality of case notes made this retrospective case note survey an extremely labour intensive task. Like the central databases, clinical information within medical notes appeared not conducive to research and analysis. In an era that demands both evidence-based practice and increased scrutiny of the quality of care provision, the TRACK experience suggests that major attitudinal and practical changes are needed in how clinical information is collected and recorded.

Tier 4 limitations

We could not include Tier 4 cases from any study site. No local inpatient adolescent units in our West Midlands site meant that all those requiring inpatient care were admitted elsewhere. Tracking cases from tier 4 national

and specialist services in our Greater London sites, where service users came from trusts across the region or the country would have entailed seeking data from trusts not participating in TRACK.

Tier 4 inpatient services may well have specific transition issues not picked up by TRACK. The National Inpatient Child and Adolescent Psychiatry Study (NICAPS) (O'Herlihy, Worrall, Banerjee, Jaffa, Hill, Mears, Brook, Scott, White, Nikoloaou and et al, 2001) undertook a census of inpatient units, in which 71 (89%) of the 80 identified CAMHS inpatient units returned information on 663 young people. The majority were aged 15-18 years and 21 inpatients were over the age of 18. The NICAPS study highlighted the scarcity of emergency provision, a main concern of community (tier 2/3) CAMHS. Shortage of emergency provision contributes to inappropriate admission to adult mental health units (Gowers, 2003). Over the next few years research will be needed to evaluate the development of age-appropriate service as required by the 2007 amendments to the Mental Health Act 1983.

Rates of actual and potential transitions

Our rates of actual and potential referrals per 100,000 population in the London sites were 2.68 and 1.49 respectively, the corresponding figures for the West Midlands sites were 2.23 and 2.97 respectively. For reasons discussed above, these figures are likely to be underestimates and should be used as the lower limit of the true range. Our methodology also cannot identify trends and variations in these rates and the potential reasons for such variations, such as local service organisation, case mix and variations due to the characteristics of the local population.

3.6.2 Sample description

Demographics

The total sample (both actual and potential referrals) consisted of 78 (51%) males and 76 females, with a mean age of 18.12 years (SD 0.824) at the time of data collection. The majority ethnic group was White (31%), followed by Black (23%), although no ethnicity was recorded for a large portion of the sample (27%). The total proportion of Black and Minority Ethnic (BME) cases was 66/154 (43%). The majority (76%) spoke English as their first language. Most of the young people in the sample lived with their parents (71%) and the majority (60%) were either in employment or education.

The relatively proportion of BME cases is not unexpected, given the geographical areas studied. CAMHS has traditionally thought to be poorly accessible to and used by BME families (Malek and Joughin, 2004). Young people from BME backgrounds have specific issues that impede access and use of services including concerns around discrimination, racism, confidentiality, family and community pressures, uncertainty about services and stigma of mental illness. Within CAMHS provision there is a relative lack

of services targeted to BME communities in particular and about cultural competence in general (Kurtz and Street, 2006).

Presenting problems

We found significant variation in how CAMHS clinicians recorded presenting problems and diagnoses at the time of transition. This possibly reflects ambivalence among some CAMHS clinicians about 'medicalising' children's problems. This was also noted in the national CAMHS Review (National CAMHS Review, 2008, s6.25, p66) which states: 'A specific example of this is the requirement within some health trusts to record diagnoses of all children and young people seen within CAMHS. This has met with concern from some professional disciplines, who see such an approach as "medicalising" children's problems. While accurate diagnosis remains important for some specific types of disorder, the eventual implementation of a CAMHS dataset (see paragraph 7.29), which incorporates a problem-focused approach, should help to address this issue'. In TRACK we were keen to use categories consistent with the way most child and adolescent clinicians reason as well as categories that might have relevance for transition and specialist adult services (e.g. Eating Disorder Services). The categories used were discussed and refined in an iterative way by the TRACK steering group. In relation to 'emerging personality disorder', there are no contemporaneous, widely accepted assessment schedules or adolescent-specific diagnostic criteria for adolescent Personality Disorder (PD). Indeed the American Psychiatric Association (2000) and World Health Organisation (1992) caution against using their PD criteria in under-18s (Chanen, Jackson, McCutcheon, Jovev, Dudgeon, Yuen, Germano, Nistico, McDougall and Weinstein, 2008). Some child and adolescent psychiatrists are reticent to diagnose PD in young people since personality development is as yet incomplete, the label of PD is stigmatising and a view that PD presentations can be explained using other Axis I constructs (Ma, 2005; Chanen *et al*, 2008). In addition, there remains debate about the classification of PDs, especially when adult PDs are discussed in terms of categories, dimensions and clusters (Tyrer, Coombs, Ibrahimi, Mathilakath, Bajaj, Ranger, Rao and Din, 2007), while adolescent PDs have been conceptualised using types (i.e. adult PD categories), prototypes (i.e. of adult PD categories) and traits (Westen, Dutra and Shedler, 2005). On the other hand, there is growing evidence, especially from the USA, that personality pathology is a significant form of psychopathology in young people (Westen *et al*, 2005). Research is starting to address the need for evidence-based interventions for young people with such conditions, especially because of the high morbidity, impaired functioning and high levels of concern about such young people (Chanen *et al*, 2008). Recent papers suggest long-term poor psychosocial adjustment predicted by presence of adolescent PD (Crawford, Cohen, First, Skodol, Johnson and Kasen, 2008). We found that emerging personality disorder and personality-related mental health issues were reasons for seeking referral to AMHS.

Learning Disability services have established procedures and policy-related toolkits and guidance for managing transition (Department for Education and Skills and Department of Health, 2006; Department for Children

Schools and Families and Department of Health, 2008). Young people with generalised learning disabilities not being managed by CAMHS were therefore not included in TRACK. Young people with specific learning difficulties, such as dyslexia without concomitant psychopathology also do not undergo transition to AMHS, hence were not included in TRACK. However, young people with generalised or specific learning difficulties who were attending CAMHS were included in the TRACK category 'neurodevelopmental disorders' along with those with pervasive developmental disorders and neurodevelopmental diagnoses such as Attention Deficit Hyperactivity Disorder.

About half the population that underwent transition fell into the diagnostic categories of emotional/neurotic disorders (51%), neurodevelopmental disorders (25%) and serious and enduring mental disorders (22%). Almost a fifth had more than one presenting problem at transition, most commonly comorbid emotional/neurotic disorders with neurodevelopmental disorders, and serious and enduring mental illness with substance misuse.

3.6.3 Transition pathways

Transfer of care

In TRACK Stage 1, the responding teams' estimated their average annual numbers suitable for transition as between 0 and 70 (mean 12.3, SD 14.5, n=37). Estimates of average annual number that actually made the transition ranged from 0 and 50 (mean 8.3, SD 9.5, n=33). Average numbers of service users who continued to be seen by CAMHS beyond the transitional boundary varied from 0 to 64 (mean 7.6, SD 11.8, n=31). The actual referral rates found in Stage 2 show that CAMHS professionals greatly underestimate the proportion of referrals that AMHS accept and overestimate the numbers CAMHS continue to see despite young people crossing the transition boundary.

As revealed by Stage 2 findings, four fifths of all cases who reached the transition boundary were thought by CAMHS clinicians to be suitable for transition. Of these, families refused referral in a tenth of cases and in another tenth, referrals were not made because CAMHS thought AMHS would either not accept referral or did have appropriate services. Almost four fifths of cases thought suitable for transition were referred to AMHS, and only 7% were not accepted by AMHS.

AMHS appear therefore to accept most referrals made by CAMHS, even though there is a widespread perception that they do not (Select Committee on Health, 2000; Singh *et al*, 2005; Lamb *et al*, 2008). Indeed, in TRACK fewer referrals were refused by AMHS than were not referred by CAMHS in the first place. TRACK is unable to confirm whether those cases not referred would, in reality, have been accepted by AMHS. In addition, clinicians who have adjusted to AMHS thresholds or assumed there is no adult service available will not be raising any unmet need. The concern should therefore not be about AMHS not accepting referrals from CAMHS, but about those who are never referred by CAMHS because of a perception that AMHS will

not accept these referrals or that appropriate services do not exist within AMHS. If CAMHS clinicians think that these young people have ongoing needs that should be met by AMHS, it is difficult to see why greater effort is not made, either by individuals from CAMHS contacting their counterparts in AMHS, or by discussion at a management level between CAMHS and AMHS managers about the unmet needs of these young people.

In summary TRACK reveals two very important findings: the perception that AMHS do not accept referrals is not factual, and that this misperception stops CAMHS clinicians from making appropriate referrals. One main message from this is that CAMHS clinicians should make referrals to AMHS, regardless of their perceptions about the unlikelihood of these referrals being accepted. If CAMHS perceive a service gap in AMHS, this should be raised at the management level, rather than leave young people with unmet need to fall through the CAMHS-AMHS gap.

There was regional variation in whether CAMHS provided services for young people up to the age of 18 years. Services in London did but the West Midlands Region sites did not. Thus, policy targets on extending CAMHS provision to the eighteenth birthday in Standard 9 of the Children's NSF (Department of Health and Department for Education and Skills, 2004) are only being met in some areas. The recent CAMHS review (National CAMHS Review, 2008) frames its recommendations on transitions in relation to young adults who are approaching 18 years of age and are seen at CAMHS, while acknowledging that many CAMHS struggle to effectively meet the needs of all young people until they reach eighteen.

Ongoing need: no transfer of care

The need for more AMHS or alternatives to AMHS?

In the 23.5% of cases where there was an ongoing clinical need but the service user was not referred on to AMHS or where AMHS did not accept the referral, the majority of cases had either the neurodevelopmental disorders or emotional/neurotic disorders categories. Almost half of potential referrals, whether not referred to AMHS, still with CAMHS or rejected by AMHS, were on medication. This raises major concerns about what happens to these young people and whether their medication is appropriately continued or monitored. Many adults with neurodevelopmental disorders like ADHD will continue to need treatment and have psychiatric comorbidity and complex problems (e.g. Young and Toone, 2000). Should AMHS extend its remit to care for this group or should there be an alternative provision? Lamb *et al* (2008) recommend that specific agreement should be reached between CAMHS and AMHS and protocols established for transition of young people with ADHD and autism spectrum disorders, among others. They also recommend that primary care, clinical psychology, Social Services and non-statutory organisations should work alongside mental health services to develop care pathways and transitional care for young adults with disorders other than psychotic or bipolar disorders. The Children's NSF (Department of Health and Department for Education and Skills, 2004) also recommends that arrangements for alternative provision should be made for those young

