In the matter of the *Commissions of Inquiry Act 1950*

Commissions of Inquiry Order (No.4) 2015

Barrett Adolescent Centre Commission of Inquiry

AFFIDAVIT

Associate Professor Stephen Stathis C/- Crown Law, 50 Ann Street Brisbane, Medical Director, Child and Youth Mental Health Services solemnly and sincerely affirms and declares:

1. I have been issued with a requirement to produce a supplementary written statement by the Barrett Adolescent Centre Commission of Inquiry dated 22 December 2015. **Exhibit A** to this affidavit is a copy of this document.

2.

3.

4.

5.

Deponent A J.P., C.Dec., Solicitor

AFFIDAVIT

On behalf of the State of Queensland

Crown Solicitor
11th Floor, State Law Building
50 Ann Street
BRISBANE QLD 4000
Email:

Explain:

(a) Your clinical opinion of the desirability of an extended treatment and rehabilitation centre for adolescents with similar diagnostic profiles as the Barrett Adolescent Centre (BAC) cohort.

6. With reference to the diagnostic profiles of the Barrett Adolescent Centre (BAC) cohort, at the time of the announcement of its closure in August 2013, young people admitted to the BAC inpatient unit came from the following areas: [redacted] from Central Queensland; [redacted] from North Queensland; [redacted] from Sunshine Coast; [redacted] from Metro North; [redacted] from Metro South. The top three primary diagnoses amongst this group were Social Phobia, Post-Traumatic Stress Disorder and Mixed Anxiety Disorder. [redacted]

7. In my opinion, there is limited compelling evidence to support subacute in-patient extended treatment and rehabilitation for young people suffering mental health problems. There is, however, evidence to support extended treatment and rehabilitation for young people with mental health disorders in the community. The evidence to which I refer is contained in the discussion paper developed by Sophie Morson of Children's Health Queensland, currently in draft, which is expected to be published in January 2016. The final document will be provided to the Commission when it is available.

(b) Any concerns held by you in relation to the clinical governance at the BAC, providing details of the specific incidents giving rise to your concerns.

8. My concerns regarding clinical governance of the BAC are based upon past reviews I have been provided with. I do not recall how I came to receive this information. **Exhibit B** to this affidavit are copies of the reviews I have received.

9. I was concerned the average length of stay was 17 months (with some young people having up to 3 year stays) and I believe there was also a waiting list of approximately 18 months. I was also uncertain what management plans BAC had in place for patients and families on the waitlist who had been accepted by the BAC, but who may have disengaged from local mental health services.

10. I do not, however, have any specific incidents to reference as I did not work at the BAC.

(c) Any concerns held by you in relation to the currency of model of care at the BAC, providing details of evidence-based research supporting your concerns.

11. I have not seen any documents that articulate the Model of Care implemented by the BAC. A formal Model of Care should be underpinned by policies and procedures which are reflected by contemporary practice and demonstrate robust government structures.

12. Evidence supporting my concerns came from Barrett Review reports I have read contained in **Exhibit B** to this affidavit. This has been reiterated in the discussion paper developed by Sophie Morson. The discussion paper is due to be finalised by end of January 2016, and will be provide to the Commission upon completion. A relevant extract of this discussion paper is produced below:

> *"In 2003, an external review of BAC service delivery identified concerns regarding admission criteria, risk assessment and management, BAC management practices and the Centre's response to critical incidents (McDermott, 2003; cited in Walter, Baker & George, 2009). However, the resulting recommendations (including developing a model of care) do not seem to have been acted upon by the time of a second external review (Walter, Baker & George, 2009). It highlighted significant issues regarding governance structures; clinical leadership; sufficient handover between shifts; performance reviews of staff; limited clinical scope,*

professional development, leadership options or CYMHS experience amongst nurses; negligible evaluation of BAC treatments (including consistent completion of outcome measures or promotion of quality activities); no clear processes for managing complaints; and the young person's timely and seamless entry into and exit from the Centre. In particular, the reviewers noted an increasing average length of stay (including young people remaining past the age of 18 years), although the governance process through which this occurred was unclear. The reviewers made a number of recommendations regarding the patient journey, including that discharge planning should be held throughout the admission, and exploration for access to step-up/step-down facilities to assist the transition of young people back into the community.

Walter, Baker and George (2009) suggested that milieu therapy and adventure therapy, cited by staff as the main therapeutic interventions used, were not sufficient and, instead, strongly recommended developing a model of care using evidence-based interventions such as Dialectical Behaviour Therapy or the Maudsley model for eating disorders. They also recommended that individual treatment plans be developed using evidence-based treatments to meet the individual needs of young people, and that staff be trained and supervised in their delivery. Finally, the 2009 review noted that significant use of continuous observations (for monitoring the safety of young people) used up considerable staff time that could have been better devoted to delivering therapeutic interventions. They also raised ongoing concerns regarding the number of critical incidents (including "near misses") in the unit."

The Commission Understands that a user group established and chaired by Professor David Crompton developed a model of care, or at least a draft model of care, for a

proposed Adolescent Extended Treatment and Rehabilitation Centre at Redlands. Explain:

a) Your knowledge of that model of care or any subsequent drafts of that model of care.

13. The document attached to my requirement is entitled Draft Model of Service and is undated. I was not aware of that undated Draft Model of Service, but I was aware of the final version. I do not have a copy of the final version in my possession.

b) Whether you had any involvement in the development of that draft model of care and, if so, what involvement you had.

14. I had no involvement in the development of this Draft Model of Service.

c) Whether you had any involvement in the development of that draft model of care and, if so, what involvement you had.

15. I was not involved in the Draft Model of Service, developed in association with Professor David Crompton. I would state that the draft Model of Service may have been appropriate for its time (i.e. 5 – 6 years ago). In 2009 – 2010 there were fewer adolescent inpatient units in Queensland.

16. Some elements of the draft Model of Service are reflected in the current Model of Care for Statewide subacute beds, developed by Children's Health Queensland Hospital and Health Service.

17. These included elements are as follows:

- The inclusion of an independent subacute beds intake panel. The Professor Crompton draft Model of Service recommended this panel to review patients

every six months whereas the Children's Health Queensland (CHQ) Model of Care recommends independent panel review of patients every three months.

- The inclusion of discharge planning in treatment plans from the time of admission.

- The inclusion of family assessment as part of the treatment plan.

In paragraph 5 of your Statement affirmed on 30 October 2015 (your statement), you state that you have, at various times during your career, referred patients to the BAC. Provide details as to:

a) The number and types of patients you referred to the BAC (and when).

18. I cannot clearly recall how many patients I referred to the BAC. I believe that I may have made approximately 2 or 3 referrals over 10 years, all from the Brisbane Youth Detention Centre (BYDC) and therefore within the Youth Justice system. However, I am unable to recall names or individual circumstances of these referrals. I expect that the referrals reflected the limited availability of appropriate community services at the time of making them. The patients referred may have been under the care of the Department of Community Services/Child Safety. I am unsure whether any of these patients were actually accepted to the BAC. These patients would have experienced severe and complex mental health problems. Commonly the young people captured in the youth justice system experience limited access to appropriate accommodation, are itinerant, have disengaged from local community mental health services, and have comorbid substance abuse problems.

b) The reasons you determined that it was appropriate to refer each of those patients to the BAC (as opposed to some other service).

19. [redacted]

c) The service(s) to which you now refer those patients whom you would previously have referred to the BAC (alternative service).

20. [redacted]

21. Currently, apart from the lack of forensic beds for adolescent patients, there is a range of other services available to refer adolescent forensic patients to, including those services available from the Department of Child Safety. Referral to other adolescent mental health services such as adolescent inpatient units, Day Programs, Resi Services and AMYOS may be an option. As I recall there were very few patients who I referred to BAC.

d) The adequacy or otherwise of the alternative service, as compared to the services provided by the BAC.

22. Should I be required to refer an adolescent forensic patient to a service, it is my opinion that the suite of services currently available is adequate apart from those young people who require a dedicated mental health forensic facility, including secure beds. These

have never been available, and continue to be unavailable in Queensland. The BAC did not provide secure forensic services for young people with severe or complex mental health problems.

23. Based on the diagnostic profiles of past BAC patients I have been informed of, it is my clinical opinion that patients with similar diagnostic profiles are being treated by other mental health services including AMYOS, Day Programs, Community CYMHS, Youth Resis and acute inpatient units.

In paragraph 44 of your statement, you mention that as Medical Director, you were informed of the movements/status of a former BAC patient who was transferred to the North-West Child and Youth Mental Health Service. Identify this patient, and explain if you had any involvement in the care of this patient (for example, did you direct any of her movements?).

24. [redacted]

In paragraph 45(a) of your statement, you mention the Y-PARC model in Victoria. The Commission understands that the Y-PARC model informed the proposal for the Step Up, Step Down Unit (SUSDU). State whether this is correct, and if so, explain, to the best of your knowledge and understanding:

a) The elements of the Y-PARC model which have been adopted in the proposal for the SUSDU.

25. The SUSDU model is similar to the Y-PARC model but has been adapted to suit the needs of Queensland adolescent mental health services. **Exhibit D** to this affidavit is

the most recent draft of the Step Up Step Down Unit Model of Service. That draft model of service is yet to be endorsed.

26. The SUSDU broadly adopted the Y-PARC design plan, noting an external location from a hospital campus, and collaborative operational management in partnership with an NGO. **Exhibit E** to this affidavit is a copy of the Site Visit Report, prepared by Judi Krause and I, detailing how the Y-PARC model informed the SUSDU model.

b) The elements of the Y-PARC model which have been modified in the proposal for the SUSDU.

27. The differences between the Victorian Y-PARC model and the Queensland Step Up Step Down Unit model include:

- Timeframe – one month in Victoria; up to three months in a Queensland Step Up Step Down Unit.
- Geographic cover – In Victoria, the Y-PARC is encapsulated in a health service District. In Queensland, a Step Up Step Down Unit will transcend Hospital and Health Service boundaries.
- Schooling and Voc Ed. – in Victoria, Y-PARC patients are older and few attend schools. In the Queensland model, engagement with school or vocational education is actively encouraged or supported.
- Clinical governance – in Victoria, the consultant psychiatrist/s in Y-PARC also manage the local acute inpatient unit. This may not happen in Queensland as the Step Up Step Down Unit is not integrated into a single local Hospital and Health Service.

Deponent A J.P., C.Dec., Solicitor

c) What other models of care have influenced the proposal for the SUSDU.

28. The SUSDU model of service references the National Mental Health Service Planning Framework (NMHSPF) service category. I do not have a copy of this document as it is still in draft form. **Exhibit F** to this affidavit is an extract of that document. I am not aware of any other SUSDU models of service, and therefore adopted an adaptation of the Y-PARC model from Victoria, which is also referenced in the draft NMHSPF.

In paragraph 45(b) of your statement, you mention the Walker Unit and the Rivendell – Concorde Hospital. Explain, to the best of your knowledge and understanding:

a) Whether and how the model of care at the Walker Unit informed or has been incorporated in the AHMETI business case and if not, why not?

29. I attended the Walker Unit on 23 October 2013. Also in attendance were Ingrid Adamson and Judy Krause. The purpose of our visit was to view the Model of Service and operational management provided by the Walker Unit to inform the development of new services for Queensland. I asked for a copy of the Model of Service, however, I was advised that there was no articulated Model of Service for the Walker Unit.

30. The Walker Unit was built at a time when there were limited regional inpatient units in NSW. I believe it was built to consolidate expertise of child psychiatrists and to achieve economies of scale in treatment of challenging adolescent mental health patients. It appeared to me that at the time of opening the Walker Unit, NSW Health identified a need for subacute beds for children/young people with severe mental illnesses, though there is now an increased number of regional centres available and patients are usually first admitted to the regional inpatient units.

31. Our learnings from the visit to Walker informed the drafting of the subacute bed model of service, acknowledging the need for extended treatment for young people with severe psychosis.

b) Whether and how the model of care at the Rivendell informed or has been incorporated in the AHMETI business case and if not, why not?

32. Ingrid Adamson, Judi Krause and I visited the Rivendell Unit on 23 October 2013. Rivendell caters for a specific type of adolescent patient, being school refusal, anxiety or patients on the autistic spectrum. The Rivendell Unit provided a weekday program where patients returned home on the weekends. We considered this aligned closely with what is currently offered in Queensland's Day Programs, without the residential component. Information from our site visit confirmed that Rivendell accommodated young people, though not in a therapeutic sense. Rather, it provided week day residential accommodation for young people who otherwise would have had to travel long distances to attend the day program but could return to live with their family over the week end. It was not suitable for families living in regional areas of NSW who could not find or afford accommodation in Sydney on weekends. **Exhibit G** to this affidavit is a copy of the NSW Site Visit Report.

33. We did not consider that a week day only residential component to the existing Day Program model was an affordable option for families trying to access the services in such a decentralised state as Queensland. Rather, we included the establishment of a greater number of Day Programs across the state as our preferred option. Local Resi services could also be used for older adolescents who would benefit from a Day Program.

In paragraph 47 of your statement and Exhibit T to your statement, you refer to a meeting you attended with the Director-General, Ian Maynard, on 26 November 2013. Explain, to the best of your knowledge and understanding, how the views expressed by parents of former BAC patients in this meeting were considered and by whom, and how they were acted upon.

34. I refer to paragraph 47 of my previous Affidavit dated 5 November 2015. The date of the meeting I attended with Director-General Ian Maynard occurred on 26 November 2014, not as I previously stated 27 November 2013 or as this question now states as 26 November 2013.

35. I was requested to attend the meeting with parents by Ian Maynard in my capacity of Clinical Director for CYMHS, CHQ HHS with the view to assisting the Director-General with questions regarding AMHETI, as they arose. I did not take notes during this meeting and base my recollections on the notes provided to me, provided at **Exhibit T** of my previous affidavit.

36. I did not personally capture or act upon the views expressed by parents at this meeting.

37. Following the meeting, I received an email from Scott Davies on 4 December 2014. I was requested to prepare a letter back to the families covering 4 specific points. I believed that the content of these points I was being asked to comment on was above my level of authority/responsibility and was better directed to Dr Bill Kingswell. I provided an email response to Scott Davies and copied Dr Bill Kingswell in to that response, asking Dr Kingswell to comment further. **Exhibit H** to this affidavit is a copy of the email chain of my correspondence with Scott Davies.

Deponent A J.P., C.Dec., Solicitor

38. I recall Dr Bill Kingswell rang me and advised that he would draft a letter to send to the Director-General, which resulted in a letter to families of former BAC patients. Attached and marked **Exhibit I** is a copy of a letter sent to the families of former BAC patients.

In paragraph 48 of your statement, you state that '[t]he terms "Tier 1", "Tier 2a", "Tier 2b", and "Tier 3" used by the Expert Clinical Reference Group are not recognised definitions for adolescent mental health services in Australia.' Explain to the best of your knowledge and understanding:

a) The genesis of the Tier System.

39. I am unsure of the genesis of the tier system. I believe the terminology came from, and was adopted, by the Expert Clinical Reference Group.

b) The equivalent terms under Queensland's Clinical Services Capability Framework and Australia's draft National Mental Health Framework.

40. I am not aware of any equivalent terms to the 'tiers' or how they were derived.

c) How each of the AHMETI services fit into the above categories.

41. The AHMETI services were retrofitted to the Expert Clinical Reference Group tiered categories for purposes of communicating alignment, as follows:

- Tier 1 – Public Community Child and Youth Mental Health Services (existing) – correlates with existing CYMHS community services (outside the scope of the AMHETI).
- Tier 2a – Adolescent Day Program Services (existing and new) – correlates with AMHETI's Assertive Mobile Youth Outreach Service (AMYOS) and Day Programs.

- Tier 2b – Adolescent Community Residential Service/s (new) – correlates with AMHETI's Youth Residential Rehabilitation Units.
- Tier 3 – State-wide Adolescent Inpatient Extended Treatment and Rehabilitation – correlates with AMHETI's sub-acute beds.

42. We did refer to subacute beds being the equivalent of Tier 3 services, as contained in the ECRG recommendations, because there was a lot of energy around the terminology 'Tier 3' in the community and in the Department of Health and it was thought that consistency of terms was a useful communication strategy. This was done to emphasise that Tier 3 equivalent services were being incorporated into the new model of care.

43. The AHMETI Model of Care was drafted to comply with the draft National Mental Health Services Planning Framework.

In paragraph 58 of your statement, you state that the State-wide subacute beds are 'the "Tier 3" beds that the Expert Clinical Reference Group recommended. This involves extended treatment inpatient beds, with access to on-site schooling".

a) Provide your clinical opinion in relation to:

i. The necessity of a subacute bed-based service in the continuum of adolescent mental health services in Queensland.

44. To date, there has been low demand for adolescent subacute beds. There have only been 6 referrals in the past two years, of which only two patients have used the service. Two referrals were subsequently assessed as being better managed in an AMYOS team or Day Program, one referral declined the service, and the final referral is yet to be assessed.

45. Although this service forms part of the continuum of care, it is my opinion that there may be limited need for adolescent subacute beds if the whole of the continuum is endorsed and funded. I am not aware of any compelling evidence that supports adolescent subacute beds.

ii. Any difficulties with treating subacute patients in an acute inpatient ward, and how those risks have been mitigated in this model of care

46. A one size fits all approach is not suitable for treating adolescents with complex mental health issues. There are differing treatment needs depending on the stage the patient is at with their treatment and/or the mix of acutely unwell patients within the unit at the time of the subacute admission.

47. Patient treatment is assessed on a case by case basis depending on the diagnosis, treatment need and the individual presenting circumstances. Because there have been so few subacute inpatient admissions to date, any actual difficulties with treatment in the acute setting or how identified risks have been mitigated are unable to be provided at this time.

48. In general, consideration would be given to where the young person is from, whether or not a family assessment can be conducted, what kind of daily activities the young person needs and whether or not youth workers would be utilised to take the patient out or to their families on the weekends. There is onsite schooling facilities based at the Lady Cilento Hospital. Treatment is tailored to the needs of the patient regardless of their acute/subacute status.

49. Difficulties include differing milieu, differing clinical needs and treatment needs (i.e. short stay and long stay patients), differing skills base (community clinicians may have more family based treatment, clinicians may treat social skills, more family therapy treatment

available, etc.) and differing funding base. I am confident that we have access to skilled clinicians from all disciplines who have the ability to provide treatment in a subacute inpatient facility should the need arise in the future.

b) To the best of your knowledge and understanding, explain:

i. The reasoning behind delivering the "Tier 3" services recommended by the ECRG in this way;

50. There was limited evidence to support a "Tier 3" type of service, however, CHQ believed a small number of patients might require access to a subacute inpatient facility. Consequently, a small subacute bed service was included in the AMHETI continuum of care. Due to limited funds, the decision was taken to establish these beds as part of the Mater Children's Hospital, and subsequently the Lady Cilento Children's Hospital Adolescent Mental Health Unit. This also provided CHQ with an opportunity to test demand and seek further new funding should a larger or ongoing service be required.

ii. Any elements of the BAC model of care which have been adopted and any elements of BAC model of care which have been modified in the model of care for the subacute bed-based service and identify any other models of care that have influenced this model of care;

51. I am unclear whether the BAC had its own Model of Service or if the Draft Model of Service developed in association with Professor David Crompton was ever implemented. As abovementioned, some of the elements from the Draft Model of Service were incorporated into the new Model of Care as identified in paragraph 16 and 17 above.

iii. The difference between the treatment provided to patients occupying these subacute beds, compared to patients occupying the acute beds.

52. This is assessed on a case by case basis. In general, patients in an acute bed require immediate crisis management, including safety and containment, review of medication, and diagnostic clarification; whereas a subacute patient will receive a more comprehensive assessment, including family assessment, with tailored therapeutic treatment and a recovery-focused intervention plan. This may or may not require an extended stay.

c) Provide further details regarding:

i. The treatment (including any participation in day programs and/or therapy) actually provided to the patients who have used subacute beds so far;

53. I am unable to provide any information regarding the treatment of the two young people who used the subacute beds, as they were not under my direct clinical care. .

ii. Any other patients who have been referred to, or considered for, admission to these subacute beds and the outcome of any referrals or considerations.

54. There were two referrals in 2014 but these did not proceed to an admission as these patients were better cared for in AMYOS and the Day Program. There have been two more recent referrals, both from the Royal Brisbane and Women's Hospital. One referral did not eventuate as the family did not want to pursue the admission. The second referral was received just before Christmas and the panel is meeting in January 2016 to consider this referral.

55. An independent triage panel, chaired by Michael Daubney, Medical Director of Specialist Programs, as well as 3 senior psychiatrists – Donna Dowling (Northern Cluster), David Ward (Central Cluster), and Shannon March (Southern Cluster) assess the referrals. All panel members are Medical Directors of inpatient units. Janelle Bowra is a Nursing Director at Lady Cilento Children's Hospital. Janelle acts as a mediator between the triage panel and the inpatient units.

56. **Exhibit J** to this affidavit is the Statewide Subacute Bed Referral Panel Protocol and letters of invitation to some of the members of the panel.

In Exhibit I to your statement, the project plan for the State-Wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy (SWAETRIS) states that one of its objectives was to ensure "continuity of care for adolescents currently admitted to BAC, and on the wait list, through a supported discharge/transition process to the most appropriate care option/s that suit individual consumer needs, and that are located in (or as near to) their local community". However, one of the 'constraints' identified by this project plan was that "[a]lternative service options for BAC consumer must be available by early 2014". Explain, to the best of your knowledge and understanding, how the Adolescent Mental Health Extended Treatment Initiative (AHMETI) achieved this objective within the identified constraint, and provide details of the activities you undertook as part of the SWAETRIS/AHMETI Steering Committee to ensure the achievement of this objective within the identified constraint.

57. The responsibility for the AMHETI objectives was devolved to three Working Groups. It is well documented that Working Group 2 (the Clinical Care Transition Panels) would manage the transition process and continuity of care for BAC patients, and this was the responsibility of West Moreton Hospital and Health Service (WMHHS). Following consideration of each patient, on a case by case basis, it is my understanding WMHHS

identified the most appropriate service for the patient to ensure continuity of care. The Steering Committee were kept informed of this process by having the standing addenda item listed under 'clinical care transition panel update'.

58. Many of the BAC patients were approaching or over 18 years of age on transition. It is my understanding, therefore, that adult mental health services were considered by WMHSS as being more appropriate in these cases.

59. Another AMHETI objective was to develop service options within a Statewide mental health model of service for adolescent extended treatment and rehabilitation, within a defined timeline. The timeframe of 'early 2014' was announced by the then Minister for Health on 6 August 2013 and was therefore acknowledged as a constraint in the Project Plan. The Project Team (Judi Krause, Ingrid Adamson and myself) and Steering Committee met frequently to progress service development in order to expedite service establishment within these timeframes. The CHQ Executive and CHQ Board were very supportive and responsive to support service establishment activity.

60. Consideration was given to locating appropriate care options in, or as near to, the patients local community in accordance with the National Mental Health Plan and were considered to be best practice.

In Exhibit J to your statement:

a) Explain, to the best of your knowledge and understanding, what happened with these 'transition services' and how Children's Health Queensland Hospital and Health Service (CHQHHS) worked with West Moreton Hospital and Health Service (WMHHS) to ensure continuity of service delivery during this time.

61. In my previous affidavit, the document marked as **Exhibit J** is not the WMHHS Transition Services Options Plan. **Exhibit K** to this affidavit is a copy of the Transitional Services Options Overview.

62. The Transition Services Plan was a draft of services proposed by WMHHS. My understanding is that it was a very time limited plan that did not evolve or develop.

63. Continuity of service delivery was the responsibility of WMHHS. Children's Health Queensland (CHQ) only provided financial support for wrap around services, as requested by WMHHS and/or other Hospital and Health Services (HHSs) to provide continuity of care to BAC patients.

b) The Commission understands that the Cairns Step Up, Step Down Unit has not yet been built. State whether this is correct, and if so, to the best of your knowledge and understanding, explain why.

64. The Cairns Step Up/Step Down Unit has not yet been built. I am unclear why construction has not commenced and this question is best directed to the Cairns and Hinterland HHS or the Mental Health Alcohol and other Drugs Branch.

c) Explain, to the best of your knowledge and understanding:

i. How the elements in the Business Case were initially prioritised;

65. My understanding of service prioritisation is as documented in the AMHETI Business Case (Section 5.2). **Exhibit L** to this affidavit is a copy of the AHMETI Business Case.

ii. How and who from the Department of Health Policy and Planning Unit communicated this to CHQHHS, and who from CHQHHS received this communication;

Deponent A J.P., C.Dec., Solicitor

66. I cannot recall.

iii. How the Business Case was revised in response to the Department of Health notifying CHQ that there would be no new funding until 2015/16;

67. Ingrid Adamson held responsibility for the revision of the Business Case. I cannot recall the specific details of this revision.

iv. How any gaps in the service were addressed;

68. Existing services managed the needs of young people despite gaps in the planned service. Gaps are unable to be addressed without the availability of structured funding, however, we continue to liaise with government and request funds to stand up all planned further services.

v. When each service option included in the AHMETI Business Case was in fact established/is now projected to commence and explain any delays.

69. Below is the list of services, their projected commencement and actual operation date. Many of the delays in establishing AMYOS teams were the result of protracted recruitment processes in other HHSs. The delay in opening the Day Program occurred as a result of difficulties in finding a suitable site.

Service	Location	Projected Commencement	Operation Date
AMYOS teams	North Brisbane	From July 2014	July 2014
	South Brisbane	From July 2014	July 2014
	Redcliffe/Caboolture	From July 2014	July 2014

Deponent A J.P., C.Dec., Solicitor

	Toowoomba	From July 2014	December 2014
	Townsville	From July 2014	December 2014
	Logan	From July 2014	May 2015
	Gold Coast	From July 2014	November 2015
Adolescent Day Program	North Brisbane	From July 2014	January 2015
Youth Resi Unit	Greenslopes	From February 2014	February 2014
Sub-Acute Beds	Mater/LCCH	From February 2014	February 2014

d) The minutes of the Steering Committee meeting held on 1 September 2014 (chaired by you):

i. Refer to you visiting the "Time Out House Initiative (TOHI) in Cairns" run in collaboration with Aftercare and you having a separate meeting with Aftercare to discuss, amongst other things, modifying the TOHI "into a Resi". Explain the impetus for converting the TOHI into a Residential Rehabilitation Unit.

70. The decision to convert the TOHI was made by Dr Bill Kingswell, following our visit to the TOHI in August 2014. CHQ worked with the Mental Health Branch to compare the TOHI service with the Youth Resi model of service to determine the degree of change required.

ii. The minutes of the Steering Committee held on 1 September 2014 held that you were "confident that it will be found that the transition plans prior to the closure of the Barrett were as good as could be expected with the resources available at that time". Provide further details as to the basis for the opinion you expressed at this time.

71. The opinion I expressed was a personal opinion I formed at the time based on clinical updates I had been provided by Dr Anne Brennan and Dr Leanne Geppert. This position was subsequently validated by Beth Kotze's report into the transitional care arrangements for BAC patients. That report found that "transitional plans, without exception, were thorough and comprehensive".

In Exhibit M to your statement:

a) The minutes of the Oversight Committee held on 17 October 2013 (attended by you) state that:

i. "[I]t was noted that the future service model must be developed in line with the National Mental Health Framework; however a copy of this is not currently available." Explain, to the best of your knowledge and understanding, whether the Oversight Committee meeting received a copy of this framework, and how framework shaped the AHMETI.

72. It is my understanding that the Oversight Committee did not receive a copy of the draft framework although members on the Committee may have had access to it. I was given access to a draft copy of the document, by the Mental Health, Alcohol and Other Drugs Branch. During this review, Ingrid Adamson and I made a photocopy of the relevant parts of the framework for the planning of AHMETI. I understand that these photocopies have been provided to the Commission.

73. The NMHSPF service categories formed the basis for the service models we developed. These too have been provided to the Commission.

ii. "It was agreed that Logan is not a suitable solution for the interim needs for BAC consumers." Explain, to the best of your knowledge and understanding, why this decision was made.

74. I recall that Logan was decommissioning a ward following the commissioning of a new Adult Mental Health Ward. A decision was made that the decommissioned ward was not a suitable solution for BAC patients as it would not have been commissioned in time for the BAC closure. I also recall that there were safety concerns relating to caring for young people in the ward because it was located next to the adult wards, and significant work would need to be completed to separate the adolescents from the acutely unwell adult patients and to ensure the safety of adolescent patients. As I recall the ward would have required significant capital works to bring the facility up to a usable standard.

b) The minutes of the Oversight Committee meeting, held on 15 November 2013 (attended by you) state that "many young people are not the same development age and may require longer in an adolescent service. The model may need to extend the age group to cater for young people up to the age of 21 y.o." The Commission understands that a number of former BAC patients were transitioned into adult mental health services in anticipation of their 18th birthday, or once they had reached 18 years old. Explain your clinical opinion of the appropriateness of this approach.

75. For child and adolescent inpatient services in Queensland there is currently a cut-off age of the patient's 18th birthday. The current Queensland practice is to transition young people into adult mental health services after they have reached 18 years of age. It is my clinical opinion that there is a gap in services for young people over the age of 18 years of age, who do not meet the admission criteria for adult mental health services but who did meet admission criteria under Child and Youth Mental Health Services.

However, under the current approach, it is 'appropriate' to transition patients over 18 years of age into adult services.

76. The scope of the AMHETI was specifically to develop services for adolescents aged 13 to 18 years of age. It was not the scope of this initiative to develop services for young people over the age of 18 years of age, which included many of the young people who transitioned out from the BAC. Despite this scope constraint, CHQ considered flexibility in upper age ranges wherever possible.

In Exhibit T to your statement:

a) In a document titled "thoughts from meetings with Barrett families and DG, 26.11.2014 1800-2000", you state that "I gently questioned whether forming such a 'community' within BAC was therapeutic, or whether that would prevent reintegration back into the community. One of the parents stated this was a good example of why I 'don't understand'; they see the development of such a community as critical to their child's wellbeing." The Commission has received evidence from a number of parents of former BAC patients that the very reason that their adolescents were referred to and admitted to the BAC was because they were unable (for various reasons) to integrate within their own communities and so that this is why the BAC was so important to them – because it provided them with an alternative community, which equipped them with the skills to reintegrate into their own communities. Explain your clinical opinion in relation to the BAC 'community' was therapeutic or not, and explain how the new subacute services address any therapeutic deficiencies.

Deponent A J.P., C.Dec., Solicitor

77. In my clinical opinion, a key goal of treatment for these patients should include integration back into the community of origin, or if that is not possible, a more healthy or appropriate local community. By definition, the community within the BAC would be one characterised by adolescents who have severe and complex mental health problems. I was concerned how the development of such a small, isolated community within the BAC would be therapeutic particularly over an extended period of time (for some patients, over two years), and how it would impact on transition into the child's community of origin. This was a concern of mine and that is why I gently questioned the parents on this.

78. In child and adolescent psychiatry, a therapeutic process ideally includes a comprehensive, developmentally appropriate assessment and an evidence-based goal directed treatment plan. The therapeutic process should be frequently evaluated and reformed if necessary, as a patient's needs change over time. Broadly, the aim should be to integrate the patient back into their community in as timely a manner as possible. While I respect the views of BAC families, I am not aware of any compelling evidence to support the claim that the BAC community was therapeutic and assisted patients with integration back into their local community.

79. I was also conscious that the views expressed by the families present at the meeting may not have been representative of the entire former BAC patient and family cohort, and their perspective on whether there was a 'therapeutic' community and/or its importance to their child's recovery and transition back to their community of origin.

b) In an email from you to Scott Davies and Cathie Schnitzerling, copying in Bill Kingswell dated 26 November 2014, you state that "the [Statewide Mental Health, Alcohol and Other Drugs Clinical] network considered supporting a project to examine the transitional care of young people from the adolescent

to adult system." Explain, to the best of your knowledge and understanding, whether this project was ultimately endorsed by the Network and what happened to this project.

80. I believe the correct date of the email referred to above was 4 December 2014.

81. The Network undertook a project on transitional care of young people into adult services. The output from this project was a guideline that was recommended to the Network for approval at its meeting on 19 June 2015, and was subsequently approved for publishing by the Executive Director, MHAODB on 21 September 2015.

In Exhibit V to your statement:

a) In response to Dr Brennan [redacted] ***you state that "[w]e are unable to offer increased services at this time; they would need to be followed up at their local CYMHS or other appropriate local services". In contrast, the AHMETI business case states that it will "[e]nsure continuity of care for adolescents currently admitted to the BAC, and on the wait list, through a supported discharge/transition process to the most appropriate care option/s that suits individual consumer needs, and that are located in (or as near to) their local community" (see Exhibit I to your statement). Explain how the AHMETI achieved continuity of care for these consumers given that you are unable to offer increased services at this time.***

82. [redacted]

Deponent A J.P., C.Dec., Solicitor

increased services at this time", refers to CHQ. This was in direct relation to the fact that these consumers were not current patients of CHQ or living in CHQ's catchment. The use of "increased services" reflected the uncertainty I had about what type of services these young people might have been receiving in the private sector. That is why I made reference to follow up by their local CYMHS or other appropriate local services. Given that these were patients on the waitlist, and it was West Moreton HHS' responsibility to manage the waitlist, I requested that Dr Anne Brennan, as A/Clinical Director of BAC, offer re-assessment or broker engagement with their local CYMHS. Dr Anne Brennan did then actively follow up these patients.

83.

84.

Deponent A J.P., C.Dec., Solicitor

85. [redacted]

86. [redacted]

In Exhibit X to your statement, the AMHETI business case states:

a) In Section 1.5 (Scope), "[l]inkages to Adult Mental Health Services insofar as to ensure smooth transition from adolescent mental health services" were within the scope of the AHMETI. Explain, to the best of your knowledge and understanding, what linkages the AHMETI has established or proposed to establish and how these linkages are designed to improve the transition from adolescent to adult mental health services.

87. My understanding is that the BAC did not proactively plan discharge of patients on admission. A key feature of all new AMHETI services was the documentation discharge planning on admission, and continual review of plans over the treatment period. It is in discharge planning that any linkages to adult mental health services would be identified therefore allowing a smooth transition from the adolescent service to the adult mental health service. This was captured in all of the Models of Service developed under AMHETI.

b) In section 4 (issues):

i. ***"[w]hilst other services proposed would be able to service the same age range, it is not a supported mental health position in Queensland." Explain what the AHMETI business case means by this.***

88. As abovementioned in paragraphs 75 and 76, the current Queensland practice is to transition young people into adult mental health services after they have reached 18 years of age.

ii. ***"[i]t is important to note that the Queensland NGO market is relatively immature in the specialised field of adolescent mental health services. It is therefore acknowledged that NGOs will require time to build skills and capabilities to deliver services." Expand how the AHMETI proposed or proposes to address this issue.***

89. It was not in scope for AMHETI to raise the maturity of the Queensland NGO market in the specialised field of adolescent mental health services.

90. It should be noted that there are national NGO providers with specialised expertise in this area, which was CHQ's motivation for releasing a national procurement process for the Youth Resi services.

91. This procurement process has demonstrated that there is a national appetite to develop services in Queensland with a number of national NGOs applying.

92. For example, MIND Australia was the successful tender for two new Townsville Resi's. MIND Australia has significant experience across Australian child, youth and adult mental health services and is able to draw on its national resources.

93. To the extent that it is of a concern, the skills and capabilities to deliver services are captured by the service level agreement, and need to be demonstrated during the tender

process. This includes adequate staffing levels and skill mix which are contained in the contractual agreement and form part of the NGO's ongoing key performance indicators.

Provide your clinical opinion regarding whether there is a lack of alignment between adolescent and adult mental health services in that patients in the 18 – 25 age group are not adequately dealt with by either adolescent or adult mental health services. If so:

a) Does this lack of alignment mean that patients in that age group commonly experience problems in their transition from adolescent to adult mental health services?

94. A detailed analysis of services is required in order to determine if there is in fact a lack of alignment, and it is difficult to provide a considered clinical opinion until such analysis has occurred.

95. In regard to transition, I believe these issues are dealt with under the Queensland Health guideline approved by the Network in June 2015 and approved by the Executive Director, Mental Health, Alcohol and Other Drugs, in September 2015 for publication. **Exhibit O** to this affidavit is a copy of the Queensland Health guideline.

b) Is there a need for mental health services directed to the 18 – 25 age group or a similar age group and if so, explain what services are needed.

96. I believe that there likely is a need for specific mental health services for 18 – 25 year olds. However, before articulating what services may be needed, my strong recommendation would be as follows:

- a process mapping project be undertaken to:

    i. map current services for that cohort of patients;

ii. identify service needs specific to that age group;

iii. identify potential gaps in service delivery; and

iv. form an options paper for discussion between Mental Health, Alcohol and Other Drugs Branch, Office of the Chief Psychiatrist, Mental Health Commissioner, CYMHS and AMHS, and other interested stakeholders.

Identify and exhibit all documents in your custody or control that are referred to in your witness statement.

97. All relevant documents have been exhibited to my affidavit.

All the facts affirmed in this affidavit are true to my knowledge and belief except as stated otherwise.

Affirmed by Associate Professor Stephen)
Stathis on 15 January 2016)
at Brisbane in the presence of:)

[redacted]

[redacted]

~~A Justice of the Peace, C.Dec~~., Solicitor

In the matter of the *Commissions of Inquiry Act 1950*

Commissions of Inquiry Order (No.4) 2015

Barrett Adolescent Centre Commission of Inquiry

CERTIFICATE OF EXHIBIT

Exhibit A to O the Affidavit of Stephen Stathis affirmed on 15/1/16 .

[redacted] [redacted]

Deponent ~~A J.P., C.Dec.,~~ Solicitor

In the matter of the *Commissions of Inquiry Act 1950*

Commissions of Inquiry Order (No.4) 2015

Barrett Adolescent Centre Commission of Inquiry

INDEX TO EXHIBITS

Exhibit No	Exhibit description	Page numbers
A	Notice to Produce Written Statement	1 – 10
B	Barrett Adolescent Centre Review Reports	11 – 65
C	Reports in relation to Patient	66 – 73
D	Step Up Step Down Draft Model of Service	74 – 122
E	Victoria Site Visit Report	123 – 128
F	Extract of the Draft National Mental Health Service Planning Framework (NMHSPF) service category	129 – 130
G	New South Wales Site Visit Report	131 – 135
H	Email Chain of Correspondence with Scott Davies	136 – 137
I	Correspondence Sent to Former BAC families	138 – 139
J	Independent Panel Protocol and Invitations	140 – 154
K	Transitional Service Options Overview and Diagram	155 – 156

L	AHMETI Business Case	157 – 176
M	Email from Anne Brennan dated 20 February 2014	178 – 180
N	Email from Anne Brennan dated 25 February 2014	181
O	Queensland Health Transition Guideline	182 – 188

BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

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

REQUIREMENT TO GIVE INFORMATION IN A WRITTEN STATEMENT

To: Dr Stephen Stathis

Of: c/- Crown Solicitor, by email to [redacted]

I, the Honourable MARGARET WILSON QC, Commissioner, appointed pursuant to *Commissions of Inquiry Order (No. 4) 2015* to inquire into certain matters pertaining to the Barrett Adolescent Centre ("the Commission") require you to give a written statement to the Commission pursuant to section 5(1)(d) of the *Commissions of Inquiry Act 1950* in regard to your knowledge of the matters set out in the Schedule annexed hereto.

YOU MUST COMPLY WITH THIS REQUIREMENT BY:

Giving a written statement prepared either in affidavit form or verified as a statutory declaration under the *Oaths Act 1867* to the Commission on or before **4:00pm, Friday, 15 January 2016**, by delivering it to the Commission at Level 10, 179 North Quay, Brisbane.

A copy of the written statement must also be provided electronically either by: email at mail@barrettinquiry.qld.gov.au (in the subject line please include "Requirement for Written Statement"); or via the Commission's website at www.barrettinquiry.qld.gov.au (confidential information should be provided via the Commission's secure website).

If you believe that you have a reasonable excuse for not complying with this notice, for the purposes of section 5(2)(b) of the *Commissions of Inquiry Act 1950* you will need to provide evidence to the Commission in that regard by the due date specified above.

DATED this 22nd **day of** December **2015**

[redacted]

The Hon Margaret Wilson QC
Commissioner
Barrett Adolescent Centre Commission of Inquiry

SCHEDULE

1. Explain:

   a. your clinical opinion of the desirability of an extended treatment and rehabilitation centre for adolescents with similar diagnostic profiles as the Barrett Adolescent Centre (**BAC**) cohort;

   b. any concerns held by you in relation to the clinical governance at the BAC, providing details of the specific incidents giving rise to your concerns; and

   c. any concerns held by you in relation to the currency of model of care at the BAC, providing details of evidence-based research supporting your concerns.

2. The Commission understands that a user group established and chaired by Professor David Crompton developed a model of care, or at least a draft model of care, for a proposed Adolescent Extended Treatment and Rehabilitation Centre at Redlands. **Attached** is a copy of the most recent version of the draft model of care in the Commission's possession. Explain:

   a. your knowledge of that model of care or any subsequent drafts of that model of care;

   b. whether you had any involvement in the development of that draft model of care and, if so, what involvement you had;

   c. whether, in your clinical opinion, that draft model of care was appropriate for the BAC cohort, and your reasons for that opinion, including any recommended changes to that model.

3. In paragraph 5 of your Statement affirmed on 30 October 2015 (**your statement**), you state that you have, at various times during your career, referred patients to the BAC. Provide details as to:

   a. the number and types of patients you referred to the BAC (and when);

b. the reason(s) you determined that it was appropriate to refer each of those patients to the BAC (as opposed to some other service);

c. the service(s) to which you now refer those patients whom you would previously have referred to the BAC (**alternative service**); and

d. the adequacy or otherwise of the alternative service, as compared to the services provided by the BAC.

4. In paragraph 44 of your statement, you mention that as Medical Director, you were informed of the movements/ status of a former BAC patient who was transferred to the North-West Child and Youth Mental Health Service. Identify this patient, and explain if you had any involvement in the care of this patient (for example, did you *direct* any of her movements?).

5. In paragraph 45(a) of your statement, you mention the Y-PARC model in Victoria. The Commission understands that the Y-PARC model informed the proposal for the Step Up, Step Down Unit (**SUSDU**). State whether this is correct, and if so, explain, to the best of your knowledge and understanding:

a. the elements of the Y-PARC model which have been adopted in the proposal for the SUSDU;

b. the elements of the Y-PARC model which have been modified in the proposal for the SUSDU; and

c. what other models of care have influenced the proposal for the SUSDU.

6. In paragraph 45(b) of your statement, you mention the Walker Unit and Rivendell – Concorde Hospital. Explain, to the best of your knowledge and understanding:

a. whether and how the model of care at the Walker Unit informed or has been incorporated in the AHMETI business case and if not, why not?

b. whether and how the model of care at the Rivendell informed or has been incorporated in the AHMETI business case and if not, why not?

7. In paragraph 47 of your statement and Exhibit T to your statement, you refer to a meeting you attended with the Director-General, Ian Maynard, on 26 November 2013. Explain, to the best of your knowledge and understanding, how the views expressed by parents of former BAC patients in this meeting were considered and by whom, and how they were acted upon.

8. In paragraph 48 of your statement, you state that "[t]he terms "Tier 1", "Tier 2a", "Tier 2b", and "Tier 3" used by the Expert Clinical Reference Group are not recognised definitions for adolescent mental health services in Australia." Explain, to the best of your knowledge and understanding:

   a. the genesis of the Tier system;

   b. the equivalent terms under Queensland's Clinical Services Capability Framework and Australia's draft National Mental Health Framework; and

   c. how each of the AHMETI services fit into the above categories.

9. In paragraph 58 of your statement, you state that the State-wide subacute beds are "*the 'Tier 3' beds that the Expert Clinical Reference Group recommended. This involves extended treatment inpatient beds, with access to on-site schooling*".

   a. Provide your clinical opinion in relation to:

      i. the necessity of a subacute bed-based service in the continuum of adolescent mental health services in Queensland; and

      ii. any difficulties with treating subacute patients in an acute inpatient ward, and how these risks have been mitigated in this model of care.

   b. To the best of your knowledge and understanding, explain:

      i. the reasoning behind delivering the "Tier 3" services recommended by the ECRG in this way;

      ii. any elements of the BAC model of care which have been adopted and any elements of BAC model of care which have been modified in the model of

care for the subacute bed-based service and identify any other models of care that have influenced this model of care; and

iii. the difference between the treatment provided to patients occupying these subacute beds, compared to patients occupying the acute beds.

c. Provide further details regarding:

i. the treatment (including any participation in day programs and/or therapy) actually provided to the patients who have used the subacute beds so far; and

ii. any other patients who have been referred to, or considered for, admission to these subacute beds and the outcome of any referrals or considerations.

10. In Exhibit I to your statement, the project plan for the State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy (**SWAETRIS**) states that one of its objectives was to ensure "*continuity of care for adolescents currently admitted to BAC, and on the wait list, through a supported discharge/ transition process to the most appropriate care option/s that suit individual consumer needs, and a that are located in (or as near to) their local community*". However, one of the "constraints" identified by this project plan was that "*[a]lternative service options for BAC consumer must be available by early 2014*". Explain, to the best of your knowledge and understanding, how the Adolescent Mental Health Extended Treatment Initiative (**AMHETI**) achieved this objective within the identified constraint, and provide details of the activities you undertook as part of the SWAETRIS/ AHMETI Steering Committee to ensure the achievement of this objective within the identified constraint.

11. In Exhibit J to your statement:

a. the minutes of the Steering Committee meetings held on 18 November 2013 (co-chaired by you) and 2 December 2013 (chaired by you) refer to a "Transition Service Plan" developed by WMHHS. Explain, to the best of your knowledge and understanding, what happened with these "transition services", and how Children's Health Queensland Hospital and Health Service (**CHQHHS**) worked with West

Moreton Hospital and Health Service (**WMHHS**) to ensure continuity of service delivery during this time.

b. the minutes of the Steering Committee meeting held on 28 January 2014 (co-chaired by you) state that the "*Committee was informed of the Step Up/Step Down Unit being built in Cairns*". The Commission understands that this Unit has not yet been built. State whether this is correct, and if so, to the best of your knowledge and understanding, explain why.

c. the minutes of the Steering Committee meeting held on 10 March 2014 (co-chaired by you) states that "*AMHETI Business Case has been presented to the Department of Health Policy and Planning Unit. They have advised that there are no new funds for 2014/15...CHQ will provide a revised business case with new funding from 2015/16.*" Explain, to the best of your knowledge and understanding:

   i. how the elements in the Business Case were initially prioritised;

   ii. how and who from the Department of Health Policy and Planning Unit communicated this to CHQHHS, and who from CHQHHS received this communication;

   iii. how the Business Case was revised in response to the Department of Health notifying CHQ that there would be no new funding until 2015/16;

   iv. how any gaps in service were addressed; and

   v. when each service option included in the AMHETI Business Case was in fact established/ is now projected to commence and explain any delays.

d. the minutes of the Steering Committee meeting held on 1 September 2014 (chaired by you):

   i. refer to you visiting the "Time Out House Initiative (**TOHI**) in Cairns" run in collaboration with Aftercare and you having a separate meeting with Aftercare to discuss, among other things, modifying the TOHI "*into a Resi*".

Explain the impetus for converting the TOHI into a Residential Rehabilitation Unit; and

ii. the minutes of the Steering Committee meeting held on 1 September 2014 state that you were "*confident that it will be found that the transition plans prior to the closure of the Barrett were as good as could be expected with the resources available at that time*". Provide further details as to the basis for the opinion you expressed at this time.

12. In Exhibit M to your statement:

a. the minutes of the Oversight Committee meeting held on 17 October 2013 (attended by you) state that:

i. "*[i]t was noted that the future service model must be developed in line with the National Mental Health Framework; however a copy of this is not currently available.*" Explain, to the best of your knowledge and understanding, whether the Oversight Committee meeting received a copy of this framework, and how framework shaped the AHMETI; and

ii. "*It was agreed that Logan is not a suitable solution for the interim needs of BAC consumers.*" Explain, to the best of your knowledge and understanding, why this decision was made.

b. The minutes of the Oversight Committee meeting held on 15 November 2013 (attended by you) state that "*Many young people are not the same development age and may require longer in an adolescent service. The model may need to extend the age group to cater for young people up to the age of 21 y.o.*" The Commission understands that a number of former BAC patients were transitioned into adult mental health services in anticipation of their 18th birthday, or once they had reached 18 years old. Explain your clinical opinion of the appropriateness of this approach.

13. In Exhibit T to your statement:

a. in a document entitled "Thoughts from Meeting with Barrett Families and DG, 26.11.2014 1800-2000", you state that "*I gently questioned whether forming such a 'community' within BAC was therapeutic, or whether that would prevent re-integration back into the community. One of the parents stated this was a good example of why I 'don't understand'; they see the development of such a community as critical to their child's well-being.*" The Commission has received evidence from a number of parents of former BAC patients that the very reason that their adolescents were referred to and admitted to the BAC was because they were unable (for various reasons) to integrate with their own communities, and so that is why the BAC was so important to them – because it provided them with an alternative community, which equipped them with the skills to re-integrate into their own communities. Explain your clinical opinion in relation to whether the BAC "community" was therapeutic or not, and explain how the new subacute service addresses any therapeutic deficiencies; and

b. in an email from you to Scott Davies and Cathie Schnitzerling, copying in Bill Kingswell, dated 26 November 2014, you state that "*the [Statewide Mental Health Alcohol and Other Drugs Clinical] Network considered supporting a project to examine the transitional care of young people from the adolescent to adult system.*" Explain, to the best of your knowledge and understanding, whether this project was ultimately endorsed by the Network, and what happened with this project?

14.

15. In Exhibit X to your statement, the AMHETI business case states:

    a. in section 1.5 (Scope), "*[l]inkages to Adult Mental Health Services in so far as to ensure smooth transition from Adolescent Mental Health Services*" were within the scope of the AHMETI. Explain, to the best of your knowledge and understanding, what linkages the AMHETI has established or proposes to establish and how these linkages are designed to improve the transition from adolescent to adult mental health services.

    b. in section 4 (Issues):

        i. "*[w]hilst other services proposed would be able to service the same age range, it is not a supported mental health position in Queensland.*" Explain what the AHMETI business case means by this; and

        ii. "*[i]t is important to note that the Queensland NGO market is relatively immature in the specialised field of adolescent mental health services. It is therefore acknowledged that NGOs will require time to build skills and capabilities to deliver services.*" Explain how the AHMETI proposed or proposes to address this issue.

16. Provide your clinical opinion regarding whether there is a lack of alignment between adolescent and adult mental health services in that patients in the 18-25 year age group are not adequately dealt with by either adolescent or adult mental health services. If so:

[1] The *Confidentiality Protocol* can be accessed via the Commission' s website at: https://www.barrettinquiry.qld.gov.au/practice-guidelines. Please contact the Commission' s Executive Director, Ashley Hill on ashley.hill@barrettinquiry.qld.gov.au for the details of transition clients "T" and "AP".

a. Does this lack of alignment mean that patients in that age group commonly experience problems in their transition from adolescent to adult mental health services?

b. Is there a need for mental health services directed to the 18 to 25 year age group, or a similar age group and if so, explain generally what services are needed?

17. Identify and exhibit all documents in your custody or control that are referred to in your witness statement.

Child and Youth Mental Health Service

Adolescent Extended Treatment and Rehabilitation Centre

(Group changed name from Adolescent Integrated Treatment and Rehabilitation Centre to Adolescent Extended Treatment and Rehabilitation Centre AETRC as this better reflected where the service is positioned in the CYMHS continuum of care).

Model of Service

1. What does the Service intend to achieve?

Mental disorders are the most prevalent illnesses in adolescence and they have the potential to carry the greatest burden of illness into adult life.

The Child and Youth Mental Health Service (CYMHS) Adolescent Extended Treatment and Rehabilitation Centre (AETRC) is a statewide service providing specialist multidisciplinary assessment and integrated treatment and rehabilitation to adolescents between 13 and 17 years of age with severe, persistent mental illness/es. The majority of consumers present with severe psychosocial impairment as a result of their mental illness/es, and presentations are often complicated by developmental co-morbidities. Many also experience chronic family dysfunction, which serves to exacerbate the severity and persistence of the disorder and associated disabilities.

The AETRC is part of the Statewide CYMHS continuum of care that includes community based treatment teams, Adolescent Day Programs and Acute Child and Adolescent Inpatient units.

The key functions of the AETRC are to:

- build upon existing comprehensive assessment of the adolescent (obtaining a thorough treatment history from service providers and carers) with a view to assessing the likelihood of therapeutic gains by attending AETRC
- provide individually tailored evidence based treatment interventions to alleviate or treat distressing symptoms and promote recovery
- provide a range of interventions to assist progression in developmental tasks which may be arrested secondary to the mental illness
- provide a 6 month targeted and phased treatment program that will ultimately assist recovery and reintegration back into the community

Treatment programs undertaken by the AETRC will include an extensive range of therapeutic interventions and comprehensive activities to assist in the development and recovery of the consumer. The program will follow structured phases incorporating assessment, establishing a therapeutic alliance and developing realistic therapeutic goals, treatment, and assertive discharge planning to facilitate reintegration back to community based treatment.

Programs will include:

- phased treatment programs that are developed in partnership with adolescents and where appropriate their parents or carers
- targeted 6 month treatment incorporating a range of therapeutic interventions delivered by appropriately trained staff

- 24-hour inpatient care for adolescents with high acuity in a safe, structured, highly supervised and supportive environment to less intensive care.
- flexible and targeted programs that can be delivered in a range of contexts including individual, school, community, group and family.
- assertive discharge planning to integrate the adolescent back into their community and appropriate local treatment services.

Length of Admission:
- admissions will be individually planned
- in specific cases when the admission exceeds 6 months the case must be presented to the intake panel for review following the initial 6 month admission.

Level of Care:
The level of care is determined by:
- providing care in the least restrictive environment appropriate to the adolescent's developmental stage
- acuity of behaviours associated with the mental illness with respect to safety to self and others
- capacity of the adolescent to undertake daily self care activities
- care systems available for transition to the community
- access to AETRC

2. Who is the Service for?

The AETRC is available for Queensland adolescents;
- aged 13 – 17 years
- eligible to attend high school
- with severe and complex mental illness
- who have impaired development secondary to their mental illness
- who have persisting symptoms and functional impairment despite previous treatment delivered by other components of child and adolescent mental health services including CYMHS community clinics, Evolve, day programs and acute inpatient child and youth mental health services
- who will benefit from a range of clinical interventions
- who may have a range of co-morbidities including developmental delay and intellectual impairment

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

1. Adolescents with persistent depression, usually in the context of childhood abuse. These individuals frequently have concomitant symptoms of trauma eg. post traumatic stress disorder (PTSD), dissociation, recurrent self harm and dissociative hallucinoses.

2. Adolescents diagnosed with a range of disorders associated with prolonged inability to attend school in spite of active community interventions. These disorders include Social Anxiety Disorder, Avoidant Disorder of Childhood, Separation Anxiety Disorder and Oppositional Defiant Disorder. It does not include individuals with truancy secondary to Conduct Disorder.

3. Adolescents diagnosed with complex PTSD. These individuals can present with severe challenging behaviour including persistent deliberate self harm and suicidal behaviour resistant to treatment within other levels of the service system.

4. Adolescents with persistent psychosis who have not responded to integrated clinical management (including community-based care) at a level 4/5 service.

5. Adolescents with a persistent eating disorder such that they are unable to maintain weight for any period in the community. These typically have co-morbid Social Anxiety Disorder. Treatment will have included the input of practitioners with specialist eating disorders experience prior to acceptance at AITRC. Previous hospital admissions for treatment of the eating disorder may have occurred. Any admission to AETRC of an adolescent with an eating disorder will be linked into the Queensland Children's Hospital (QCH) for specialist medical treatment. Adolescents requiring nutritional resuscitation will be referred to QCH. For adolescents over 15 years of age specialist medical treatment may be met by an appropriate adult health facility.

Suitability for admission will be undertaken by an **intake panel** that will consist of:
- the AETRC director/delegated senior clinical staff
- referring specialist and/or Team Leader
- representative from Metro South CYMHS
- representative from the QCH CYMHS (interim arrangements may exist)
- representative from Education Queensland
- other identified key stakeholders (including local CYMHS as required)

In making a decision the panel will consider the:
- likelihood of the adolescent to experience a positive therapeutic outcome
- potential for treatment at AETRC to assist with developmental progression
- potential adverse impacts on the adolescent of being admitted to the unit (e.g. isolation from existing supports and/or cultural connection; possibility of escalation of self harm behaviour) posed by the adolescent to other inpatients and staff, this includes evidence of inappropriate sexualised behaviour
- potential adverse impacts on other adolescents if they were to be admitted
- possible safety issues

A comprehensive recovery and discharge management plan that includes community reintegration will be in place prior to admission for all adolescents.

Adolescents who reach their 18th birthday during admission will be assessed on a case by case basis by the panel. The panel will consider whether:

- continued admission is likely to produce the greatest clinical outcome in terms of symptom reduction and developmental progression
- admission will pose any risk to the safety of other adolescents in the AETRC

Admission Risks
Some young people may pose considerable risk to others. Admission to AETRC will be decided on an individual case basis by a multidisciplinary review panel.
Admission risks include but are not restricted to:
- substantiated forensic history of offences of a violent or sexual nature
- adolescents with Conduct Disorder
- ongoing significant substance abuse

When determining the admission of adolescents where recurrent absconding is a significant risk, the likelihood that the adolescent will experience a positive therapeutic outcome needs to be considered.

3. What does the Service do?

AETRC will provide a range of evidence based treatments tailored to meet the individual's mental health needs. Interventions will be delivered by appropriately skilled multidisciplinary staff that has access to professional development and clinical supervision.

The key components of AETRC are defined below:

Key Component	Key Elements	Comments
Working with other service providers	• the AETRC will develop and maintain strong partnerships with other components of the CYMHS network	• at an organisational level, this includes participation in the Statewide Child and Youth Mental Health Sub Network
	• shared-care with the referrer and the community CYMHS will be maintained	• in the provision of service this includes processes for regular communication with referrers in all phases of care of the adolescent in AETRC
	• the AETRC panel will develop and maintain partnerships with other relevant health services who interact with adolescents with severe and complex mental illness	• this includes formal agreements with Metro South facilities (paediatric and adult health services) and/or QCH to provide medical services for treating medical conditions which may arise e.g. medical management of overdoses; surgical management of severe lacerations or burns from self injury,
Working with other service providers		• Dietetic services to liaise with and advise on the management of eating disorders, adequate nutrition,

Key Component	Key Elements	Comments
		obesity, interactions with psychotropic medications etc • this may include developing conjoint programs for youth with developmental difficulties or somatisation disorders • this includes but is not limited to the Department of Communities (Child Safety), the Department of Communities (Disability Services) and the Department of Communities (Housing & Homelessness) and Education Queensland
	• mandatory child protection reporting of a reasonable suspicion of child abuse and neglect	• AETRC staff will comply with Queensland Health (QH) policy regarding mandatory reporting of a reasonable suspicion of child abuse and neglect
Referral, Access and Triage	• Statewide referrals are accepted for planned admissions	• this supports continuity of care for the adolescent
	• responsibility for the clinical care of the adolescent remains with the referring service until the adolescent is admitted to the AETRC	
	• all referrals are made to the Clinical Liaison, Clinical Nurse and processed through the panel	• a single point of referral intake ensures consistent collection of adequate referral data and immediate feedback on appropriateness • it expedites an appropriate assessment interview and liaison with the referrer if there is a period of time until the adolescent is admitted
	• the adolescent is assessed after referral either in person or via videoconference	• the pre-admission assessment enables the adolescent to meet some staff and negotiate their expectations of admission • this assessment enables further determination of the potential for therapeutic benefit from the admission, the impact on or of being with other adolescents and some assessment of acuity
		• this process monitors changes

Key Component	Key Elements	Comments
Referral, Access and Triage		in acuity and the need for admission to help determine priorities for admissions
	• if there is a waiting period prior to admission, the Clinical Liaison, Clinical Nurse will liaise with the referrer until the adolescent is admitted	• the Clinical Liaison, Clinical Nurse can also advise the referrer regarding the management of adolescents with severe and complex mental illness following consultation with the treating team
	• priorities for admission are determined on the basis of levels of acuity, the risk of deterioration, the current mix of adolescents on the unit, the potential impact for the adolescent and others of admission at that time, length of time on the waiting list and age at time of referral	
Key Component	**Key Elements**	**Comments**
Assessments	• the AETRC will obtain a detailed assessment of the nature of mental illness, their behavioural manifestations, impact on function and development and the course of the mental illness	assessment begins with the referral and continues throughout the admission
Mental Health Assessments	• the AETRC panel will obtain a detailed history of the interventions to date for the mental illness	• this is obtained by the time of admission
Family/Carers Assessments	• the AETRC will obtain a detailed history of family structure and dynamics, or history of care if the adolescent is in care	• this process begins with the referral and continues throughout the admission
	• parents/carers will have their needs assessed as indicated or requested	• parents or carers will be involved in the mental health care of the adolescent as much as possible • significant effort will be made to support the involvement of parents/carers
	• if parent/carer mental health needs are identified the AETRC will attempt to meet these needs and if necessary refer to an adult mental health service	

Key Component	Key Elements	Comments
Developmental Assessments	• the AETRC will obtain a comprehensive understanding of developmental disorders and their current impact	• this process begins with available information on referral and during the admission
	• the AETRC will obtain information on schooling as it is available	• this occurs upon admission
Assessments of Function	• the AETRC will obtain assessments on an adolescent's function in tasks appropriate to their stage of development	• this assessment occurs throughout the admission
Physical Health Assessments	• routine physical examination will occur on admission • physical health is to be monitored throughout the admission • appropriate physical investigations should be informed as necessary	
Risk Assessments	• a key function of the panel will be to assess risk prior to admission • risk assessments will be initially conducted on admission and ongoing risk assessments will occur at a frequency as recommended by the treating team and updated at case review	• all risk assessments will be recorded in the patient charts and electronic clinical record (CIMHA)
	• documentation of all past history of deliberate self harm will be included in assessment of current risk • will include a formalised suicide risk assessment	• risk assessment will be in accordance with the risk assessment contained in the statewide standardised clinical documentation
General Aspects of Assessment	• assessment timeframes	• routine assessments will be prompt and timely • initial assessments of mental health, development and family are to be completed within two weeks of admission
	• Communication	• the outcome of assessments will be promptly communicated to the adolescent, the parent or guardian and other stakeholders (if the adolescent consents)
	• Care Plans	• all assessment processes will be documented and integrated into the care plan

Key Component	Key Elements	Comments
	• *Mental Health Act 2000* assessments	• *Mental Health Act 2000* assessments will be conducted by Authorised Mental Health Practitioner and/or authorised doctor
	• drug and alcohol assessments	• assessments of alcohol and drug use will be conducted with the adolescent on admission and routinely throughout ongoing contact with the service
• **Information from the Mental Health, Family/Carer, Developmental and Functional assessments is integrated into a comprehensive formulation of the illness and impairments. Further information from continuing assessments is incorporated into developing and refining the original formulation at the Case Review Meetings**		
Recovery Planning	• an initial Recovery Plan is developed in consultation with the adolescent and their family/carers on admission	• during admission, adolescents have access to a range of least restrictive, therapeutic interventions determined by evidenced based practice and developmentally appropriate programs to optimise their rehabilitation and recovery • continual monitoring and review of the adolescent's progress towards their Recovery Planning is reviewed regularly through collaboration between the treating team, adolescents, the referrers and other relevant agencies
Clinical Interventions **<u>Psychotherapeutic</u>**	• Interventions will be individualised according to the adolescent's treatment needs • individual verbal therapeutic interventions utilising a predominant therapeutic framework (e.g. Cognitive Therapy)	• therapists will receive recognised, specific training in the mode of therapy identified • the therapy is modified according to the capacity of the adolescent to utilise the therapy, developmental considerations and stage of change in the illness • the therapist will have access to regular supervision • specific therapies will incorporate insights from other frameworks (e.g. Cognitive Therapy will incorporate

Key Component	Key Elements	Comments
Psychotherapeutic		understanding from Psychodynamic Therapies with respect to relationships) • supportive therapies will be integrated into the overall therapeutic approaches to the adolescent
	• individual non-verbal therapeutic interventions within established therapeutic framework (e.g. sand play, art, music therapies etc.)	
	• individual supportive verbal or non-verbal or behavioural therapeutic interventions utilising research from a number of specific therapeutic frameworks (e.g. Trauma Counselling, facilitation of art therapy)	• used at times when the adolescent is distressed or to generalise strategies to the day to day environment • staff undertaking supportive interventions will receive training in the limited use of specific modalities of therapy and have access to clinical supervision • supportive therapies will be integrated into the overall therapeutic approaches to the adolescent
	• psychotherapeutic group interventions utilising specific or modified Therapeutic Frameworks (e.g. Dialectical Behaviour Therapy)	• as for individual verbal interventions
Behavioural interventions	• individual specific behavioural intervention (e.g. desensitisation program for anxiety)	• behavioural program constructed under appropriate supervision • monitor evidence for effectiveness of intervention
	• individual general behavioural interventions to reduce specific behaviours (e.g. self harm)	• review effectiveness of behavioural program at individual and Centre level
	• group general or specific behavioural interventions	• monitor evidence for effectiveness of intervention
Psycho-education Interventions	• includes general specific or general psycho-education on mental illness	• available to adolescents and their parents/carers
Family Interventions	• family interventions to support the family/carer while the adolescent is in the AETRC	• supportive family interventions will, when possible be integrated into the overall therapeutic approaches to the adolescent • includes psycho-education for parents/carers

Key Component	Key Elements	Comments
Family Interventions	• family therapy as appropriate	• therapist will have recognised training in family therapytherapists will have access to continuing supervision • review evidence for effectiveness of the intervention • family therapy will be integrated into the overall therapeutic approaches to the adolescent
	• monitoring mental health of parent/carer	• support for parent/carer to access appropriate mental health care
	• monitor risk of abuse or neglect	• fulfil statutory obligations if child protection concerns are identified
	• promote qualities of care which enable reflection of qualities of home	• review of interactions with staff • support staff in reviewing interactions with and attitudes to adolescent
Interventions to Facilitate Tasks of Adolescent Development	• interventions to promote appropriate development in a safe and validating environment • school based interventions to promote learning, educational or vocational goals and life skills • individual based interventions to promote an aspect of adolescent development	
	• group based interventions to promote aspects of adolescent development which may include adventure based and recreational activities	• individualised according to adolescents in the group • goals to be defined • under the clinical direction of a nominated clinician
Pharmacological Interventions	• administration of psychotropic medications under the direction of the consultant psychiatrist	• education given to the adolescent and parent(s)/carer about medication and potential adverse effects • regular administration and supervision of psychotropic medications • regular monitoring for efficacy and adverse effects of

Key Component	Key Elements	Comments
		psychotropic medications
	• administration of non-psychotropic medications under medical supervision	• includes medications for general physical health
Other Interventions	• sensory modulation	• utilised under the supervision of trained staff • monitor evidence of effects
	• electroconvulsive therapy	• a rarely used intervention, subject to a specific policy compliance with Australian clinical practice guidelines • administered in accord with the *Mental Health Act 2000*
Care Coordination **Clinical care coordination and review**	• prior to admission a Care Coordinator will be appointed to each adolescent The Care coordinator will be responsible for: • providing centre orientation to the adolescent and their parent(s)/carer(s) • monitoring the adolescent's mental state and level of function in developmental tasks • assisting the adolescent to identify and implement goals for their care plan • acting as the primary liaison person for the parent(s)/carer and external agencies during the period of admission and during the discharge process • assisting the adolescent in implementing strategies from individual and group interventions in daily living	• the Care Coordinator can be a member of the treating team and is appointed by the AITRC director • an orientation information pack will be available to adolescents and their parent(s)/carer(s)
Care Monitoring	• providing a detailed report of the adolescent's progress for the care planning meeting	• the frequency of monitoring will depend on the levels of acuity • monitoring will integrate information from individual and group interventions and observations
	• adolescents at high risk and require higher levels of observations will be reviewed daily	• this includes daily reviews by the registrar, and twice weekly reviews by the consultant

Key Component	Key Elements	Comments
		psychiatrist
Case Review	• the case review meeting formally reviews the Care Plans which will be updated at intervals of not more than two months	• the Community Liaison Clinical Nurse is responsible to ensure adolescents are regularly reviewed • the adolescent, referring agencies and other key stakeholders will participate in the Case Review process
	• all members of the clinical team who provide interventions for the adolescent will have input into the case review	• the consultant psychiatrist will chair the case review meeting • documented details to include date, clinical issues raised, care plan, contributing team members, and those responsible for actions
	• ad hoc case review meetings may be held at other times if clinically indicated	• these will be initiated after discussion at the case conference or at the request of the adolescent
	• progress and outcomes will be monitored at the case review meeting	• where possible this will include consumers and carers • appropriate structured assessments will be utilised • the process will include objective measures • annual audits will ensure that reviews are being conducted
Case Conference	• a weekly case conference will be held to integrate information from and about the adolescent , interventions that have occurred, and to review progress within the context of the case plan	• a consultant psychiatrist should be in attendance at every case conference
	• risk assessments will be updated as necessary in the case conference	• the frequency of review of risk assessments will vary according to the levels of acuity for the various risk behaviours being reviewed • risk will be reviewed weekly or more frequently if required
Record Keeping	• all contacts, clinical processes and care planning will be documented in the adolescent's clinical record	• progress notes will be consecutive within the clinical record according to date
	• clinical records will be kept legible and up to date, with clearly	• personal and demographic details of the adolescent, their

Key Component	Key Elements	Comments
	documented dates, author/s (name and title) and clinical progress notes	parent/carer(s) and other health service providers will be up to date
	• there will be a single written clinical record for each adolescent	• the written record will align with any electronic record
Record Keeping	• all case reviews will be documented in the adolescent's clinical record	• actions will be agreed to and changes in treatment discussed by the whole team and recorded
Discharge Planning	• discharge planning should begin at time of admission with key stakeholders being actively involved.	• the adolescent and key stakeholders are actively involved in discharge planning • discharge planning should address potential significant obstacles e.g. accommodation, engagement with another mental health service
	• discharge planning will involve multiple processes at different times that attend to therapeutic needs, developmental tasks and reintegration into the family	• the AETRC School will be primarily responsible for and support school reintegration
	• discharge letters outlining current treatments and interventions need to be sent to any ongoing key health service providers within one week of discharge	• the Registrar and Care Coordinator will prepare this letter • it should identify relapse patterns and risk assessment/ management information • follow-up telephone with any ongoing key health service providers will occur as well as the discharge letter
	• a further comprehensive Discharge Summary outlining the nature of interventions and progress during admission will be sent at full transfer from the AETRC	• this will be prepared by the clinicians involved in direct Interventions
	• if events necessitate an unplanned discharge, the AETRC will ensure the adolescent's risk assessments were reviewed and they are discharged or transferred in accord	

Key Component	Key Elements	Comments
	with their risk assessments • in the event of discharge the AETRC will ensure they have appropriate accommodation, and that external services will follow up in a timely fashion	
Transfer	• depending on individual needs and acuity some adolescents may require transfer to another child or adolescent inpatient unit • transfer to an adult inpatient unit may be required for adolescents who reach their 18th birthday and the AETRC is no longer able to meet their needs	
Continuity of Care	• referrers and significant stake holders in the adolescent's life will be included in the development of Care Planning throughout the admission	• referrers and significant stake holders are invited to participate in the Case Review meetings • the Care Coordinator will liaise more frequently with others as necessary
Team Approach	• specifically defined joint therapeutic interventions between the AETRC and the Referrer can be negotiated either when the adolescent is attending the Centre or on periods of extended leave	• joint interventions can only occur if clear communication between the AETRC and external clinician can be established
	• responsibility for emergency contact will be clearly defined when an adolescent is on extended leave	• this will be negotiated between the AETRC and the local CYMHS
	• case loads should be managed to ensure effective use of resources and to support staff	
	• staff employed by the Department of Education and Training will be regarded as part of the team	

4. Service and operational procedures

The AETRC will function best when:

- there is an adequate skill mix, with senior level expertise and knowledge being demonstrated by the majority of staff
- strong internal and external partnerships are established and maintained
- clear and strong clinical and operational leadership roles are provided
- team members are provided with regular supervision
- AETRC is seen by all CYMHS staff as integral and integrated with the CYMHS continuum of service

Caseload

Caseload sizes need to consider a range of factors, including complexity of need, current staff resources within the team, and the available skill mix of the team.

Under normal circumstances, care coordination will not be provided by students or staff appointed less than 0.5 FTE. Typically Care Coordinators are nursing staff.

Staffing

The staffing profile will incorporate the child and adolescent expertise and skills of psychiatry, nursing, psychology, social work, occupational therapy, speech pathology and other specialist CYMHS staff. While there is a typical staff establishment, this may be altered according to levels of acuity and the need for specific therapeutic skills.

Administrative support is essential for the efficient operation of the AETRC.

All permanently appointed medical and senior nursing staff be appointed (or working towards becoming) authorised mental health practitioners.

Hours of Operation

- access to the full multidisciplinary team will be provided weekdays during business hours and after hours by negotiation with individual staff
- nursing staff are rostered to cover shifts 24 hours, 7 days a week
- an on-call consultant child and adolescent psychiatrist will be available 24 hours, 7 days per week
- 24 hours, 7 days a week telephone crisis support will be available to adolescents on leave is available. A mobile response will not be available
- routine assessments and interventions will be scheduled during business hours (9am - 5pm) 7 days a week

Referrals

Referrals are made as in Section 3 above.

Risk Assessment

- written, up to date policies will outline procedures for managing different levels of risk (e.g. joint visiting)
- staff safety will be explicitly outlined in risk assessment policy

- risk assessments will be initially conducted on admission and ongoing risk assessments will occur at a frequency as recommended by the treating team

Staff Training

Consumers and carers will help inform the delivery of staff training where appropriate.

Staff from the AETRC will engage in CYMHS training. On occasion AETRC will deliver training to other components of the CYMHS where appropriate.
Training will include:

- Queensland Health mandatory training requirements (fire safety, etc)
- AETRC orientation training
- CYMHS Key Skills training
- clinical and operational skills/knowledge development;
- team work;
- principles of the service (including cultural awareness and training, safety, etc.)
- principles and practice of other CYMHS entities; community clinics, inpatient and day programs
- medication management
- understanding and use of the *MHA 2000*
- engaging and interacting with other service providers and
- risk and suicide risk assessment and management.

Where specific therapies are being delivered staff will be trained in the particular modality of the therapy e.g. family therapy, cognitive behaviour therapy.

5. Clinical and corporate governance

The AETRC will operate as part of the CYMHS continuum of care model.

Clinical decision making and clinical accountability will be the ultimate responsibility of the appointed Consultant Psychiatrist - Director. At a local level, the centre is managed by a core team including the Nurse Unit Manager, Senior Health Professional, the Consultant Psychiatrist, an Adolescent Advocate, a Parent Representative and the School Principal. This team will meet regularly in meetings chaired by the Consultant Psychiatrist.

The Centre will be directly responsible to the corporate governance of the Metro South Health Service District. Operationalisation of this corporate governance will occur through the AETRC director reporting directly to the Director, Child and Adolescent Mental Health Services, Metro South Health Service District. Interim line management arrangements may be required.

- maintain strong operational and strategic links to the CYMHS network
- establish effective, collaborative partnerships with general health services, in particular Child and Youth Health Services and services to support young people e.g. Child Safety Services

- provide education and training to health professionals within CYMHS on the provision of comprehensive mental health care to adolescents with severe and complex disorder;
- develop the capacity for research into effective interventions for young people with severe and complex disorder who present to an intensive and longer term facility such as AETRC.

6. Where are the Services and what do they look like?

The Adolescent Integrated Treatment and Rehabilitation Centre is currently located at Wacol (the Barrett Adolescent Centre). It is anticipated it will move to Redlands Hospital in 2011.

7. How do Services relate to each other?

- formalised partnerships
- Memorandum of Understandings between government departments
- guidelines
- statewide model of CYMHS
- the AETRC is part of the CYMHS network of services in Queensland as described in Section 3

8. How do consumers and carers improve our Service?

Consumers and carers will contribute to continued practice improvement through the following mechanisms:

- consumer and carer participation in collaborative treatment planning
- consumer and carer feedback tools (e.g. surveys, suggestion boxes)
- consumers and carers will inform staff training

Consumer and carer involvement will be compliant with the National Mental Health Standards.

9. What ensures a safe, high quality Service?

- adherence to the Australian Council of Health Care Standards (ACHS), current accreditation standards and National Standards for Mental Health Services
- appropriate clinical governance structures
- skilled and appropriately qualified staff
- professional supervision and education available for staff
- evidence based treatment modalities
- staff professional development
- clear policy and procedures
- clinical practice guidelines, including safe medication practices

The following guidelines, benchmarks, quality and safety standards will be adhered to:

- Child and Youth Health Practice Manual for Child Health Nurses and Indigenous Child Health Workers: http://health.qld.gov.au/health_professionals/childrens_health/child_youth_health
- Strategic Policy Framework for Children's and Young People's Health 2002-2007: http://health.qld.gov.au/health_professionals/childrens_health/framework.asp.
- Australian and New Zealand College of Anaesthetists (interim review 2008) Recommendation of Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations T1: http://anzca.edu.au/resources/professional-documents/technical/t1.html
- Guidelines for the administration of electroconvulsive therapy (ECT): http://qheps.health.qld.gov.au/mentalhealth/docs/ect_guidelines_31960.pdf.
- Royal Australian and New Zealand College of Psychiatrists, Clinical memorandum #12 Electro-Convulsive Therapy, Guidelines on the Administration of Electro-Convulsive Therapy, April 1999: http://health.gov.au/internet/main/publishing.nsf/Content/health-privatehealth-providers-circulars02-03-799_528.htm/$FILE/799_528a.pdf.

Legislative Framework:

The Adolescent Extended Treatment Centre is gazetted as an authorised mental health service in accordance with Section 495 of the *Mental Health Act 2000.*

10. Key resources and further reading

- Queensland Plan for Mental Health 2007-2017
- Clinical Services Capability Framework - Mental Health Services Module
- Building guidelines for Queensland Mental Health Services – Acute mental health inpatient unit for children and acute mental health inpatient unit for youth
- Queensland Capital Works Plan
- Queensland Mental Health Benchmarking Unit
- Australian Council of Health Care Standards
- National Standards for Mental Health Services 1997
- Queensland Mental Health Patient Safety Plan 2008 – 2013
- Queensland Health Mental Health Case Management Policy Framework: Positive partnerships to build capacity and enable recovery
- *Mental Health Act 2000*
- *Health Services Regulation 2002*
- *Child Protection Act (1999)*
- State-wide Standardised Suite of Clinical Documentation for Child and Youth Mental Health Services.
- Mental Health Visual Observations Clinical Practice Guidelines 2008
- Council of Australian Governments (CoAG) National Action Plan on Mental Health 2006-2011
- Policy statement on reducing and where possible eliminating restraint and seclusion in Queensland mental health services
- Disability Services Queensland – Mental Health Program

- Principles and Actions for Services and People Working with Children of Parents with a Mental Illness 2004
- Future Directions for Child and Youth Mental Health Services Queensland Mental Health Policy Statement (1996)
- Guiding Principles for Admission to Queensland Child and Youth Mental Health Acute Hospital Inpatient Units: 2006
- The Queensland Health Child and Youth Mental Health Plan 2006-2011
- National Child and Youth Mental Health Benchmarking Project
- Consumer, Carer and Family Participation Framework

{ FILENAME \p }

2009 REVIEW OF BARRETT ADOLESCENT CENTRE

(Final Report)

Reviewers: Garry Walter, Martin Baker, Michelle George

Psychiatrist Director MH Rivendell

Psychologist Rivendell

Nurse Unit Manager.

BACKGROUND

For a considerable period of time, concern has been expressed about the role, function and capacity of the Barrett Adolescent Centre (BAC) to provide an appropriate, effective and safe service for its client group. Most recently, the ACHS indicated concerns about the capacity of BAC to provide safe care. The local governing body has decided that environmental changes (including relocation) are necessary. These have been agreed to and are underway.

The present review has been commissioned in the knowledge that the proposed environmental/geographical shift will take place. The reviewers were asked to focus upon the philosophy and clinical practices of the unit, with a view to assessing whether the unit is safely meeting the needs of the consumer group, and to make recommendations for change and improvement.

PREVIOUS REVIEWS AND REPORTS

ACHS Review

In a recent accreditation survey by the ACHS, BAC received a "High Priority Recommendation" from the ACHS to ensure that immediate modifications are made to improve patient and staff safety. In making this and other recommendations, the ACHS observed:

- Patients admitted to BAC have severe and complex clinical pictures;
- BAC has limited choice over which patients it accepts;
- In the Park Hospital redevelopment, BAC has lost access to facilities;
- There are aspects of BAC's configuration and related building issues that are dangerous;

- There has been an increase in critical incidents;
- There has been an increased use of "Continuous Observation".

The ACHS made a number of other recommendations around staffing and infrastructure needs.

DOH Brief

A brief to the Director General of Health in Queensland noted that the profile of consumers treated in BAC had changed since the opening of the new Acute Child and Youth Mental Health Beds in Queensland and that BAC was now treating more complex and impaired cases. Apparently, the Acute Units are now referring to the BAC if there are no obvious community placement options. This has resulted in more complex cases in BAC and even less "referral out" options. In support of this contention is the fact that Average Length of Stay in BAC has risen from four months in 1994 to ten months in 2006.

McDermott Review

This review considered: the impact of critical incidents on BAC; current risks at BAC; BAC management practices, staff, environment and systemic issues; and, BAC responses to critical incidents. The recommendations included:

- Admission criteria and a more clearly defined target group;
- Better Risk Assessment in the admission process;
- Improvement of the risk monitoring process, especially the "Risk Assessment Tool";
- Improving the relationship with other parts of Park Hospital;
- Providing more certainty about the future of BAC.

Also included were recommendations about staff training, whether the unit is open or locked, the material fabric of the Unit, and the role of BAC within Queensland Mental Health Planning.

Community Visitors Report

This report noted that:

- BAC was over Census;
- BAC had clients in it who were over age;
- "The Unit is not of a standard to safely house medium to long term residents";
- "Not all the young people participate in all of the programs. The young people are encouraged to choose the groups they are comfortable with on a voluntary basis".

Queensland Nurses Union

The Union had written a letter of concern, specifically around the injuries sustained by a nurse trying to apprehend a client who had run away.

CRITICAL INCIDENTS

In addition to the above reports, the present reviewers were provided with three incidents to consider. The local governing body believed these to be emblematic of the difficult issues BAC faces and expressed a desire for the reviewers to examine these incidents within the broad purpose of the review. These reports related to three young women who had been inpatients at BAC for some time. The reviewers found that the incidents that occurred were characterised by the following elements:

- All the patients were female;
- All were near or over the age of 18 years;
- All exhibited severe and complex self-harming behaviours;
- All had been given diagnoses that did not seem to adequately reflect the chronicity, severity and complexity of the behaviours;

- Referral on to Adult Mental Health Services or other more appropriate services did not appear to be an option that had been realistically considered for any of the patients.

The reviewers conducted an incident and file review of the cases and have incorporated considerations around the incidents into the broader observations and recommendations of the report.

On the basis of the above materials, meetings with stakeholders and key staff on 26 and 27 February 2009, and attendance at a staff/stakeholder ongoing education meeting, we offer the following observations and recommendations:

OBSRVATIONS AND *RECOMMENDATIONS*

Governance

In terms of both corporate and clinical governance, a number of the usual mechanisms, processes and systems for ensuring proper governance did not appear to be in place at BAC. Specifically, there did ***not*** appear to be:

1. Clear lines of responsibility and accountability to senior levels within Queensland Health for the overall quality of clinical care;
2. Clear local policies that are integrated with wider policies aimed at managing risks;
3. Procedures for all professional groups to identify and remedy poor performance;
4. Much in the way of Quality Improvement activities. A comprehensive approach would include consideration and use of
    - Clinical guidelines/Evidence-based practice;
    - Continuing Professional Development;
    - Clinical Audits;
    - The effective monitoring of clinical care deficiencies;

- Research and development;
- "Caldicott principles" to manage the collection and use of patient information;

To elaborate, the role of BAC in the hospital and State plan remains unclear. BAC does not feature in the hospital organisational charts, nor is its role articulated in a State-wide plan for child and adolescent mental health services. While patient safety was certainly a priority at BAC, there was a focus on physical environmental issues and less emphasis on a systematic approach that included formal reporting and documenting in the medical record for all incidents, including "near misses", and a process for reviewing incidents to inform staff and to effect change in client management to improve patient safety.

To support the above process and address other clinical documentation issues, regular reviews of medical records (file audits) are often used in other centres; this did not seem to be the practice at BAC.

Policies and procedures sighted had been in place a long time with little evidence of a review of their continued appropriateness.

There did not appear to be a system in place to manage, respond to or analyse complaints either from within the client population in the unit or from the broader community.

While we did not specifically ask about this issue, it is feasible that Performance Reviews are not a regular part of professional practice at BAC and, if they are, they do not appear to be targeted at assisting clinicians to maintain best practice and improve patient care.

BAC does not appear to have a framework which aligns with State legislation, Queensland Health policy directives, and local protocols governing the credentialing and defining the scope of clinical practice of medical, nursing and allied health practitioners working in the unit. In the absence of this framework, aspects of

recruitment, the capacity to adopt particular clinical models and a coherent approach to professional development and clinical supervision are all compromised. For example, it was evident that clinical practice at the unit was established on principles that had been developed some time ago. Apart from the external reviews of the unit, there was little evidence that BAC had recently reviewed and audited its clinical model against current accepted best practice and evidence based care.

Communication around continuity of care of clients in the unit, but particularly between nursing staff on each shift and between shifts, is poor and poorly documented.

Recommendations:

1. *That generally accepted mechanisms of clinical and corporate governance are introduced or enhanced within BAC. These would include:*
2. *The State and hospital should give a clear determination of the role and function of BAC.*
3. *This information (about role and function) needs to be disseminated in written form to all stakeholders.*
4. *The role and function should be operationalized and a reporting framework developed such that the unit is shown to be fulfilling its function.*
5. *That a procedure is developed to provide a framework governing the credentialing and defining the scope of clinical practice of practitioners at BAC.*
6. *That an integrated risk management approach is introduced into all aspects of BAC functioning, ensuring it is evidence based and aligned with a broader Hospital, Area and State Risk Management approach.*
7. *All incidents (including "near miss" events) should be reported and documented and regularly reviewed in a broad staff forum to identify problems and improve client safety.*
8. *Regular file audits be undertaken to ensure the medical record is capturing all appropriate patient centred data and to identify areas and indicators for improvement.*

9. *All policies should be reviewed as to their appropriateness and rewritten or updated to reflect desired practice.*
10. *That a system for managing, responding to and analysing complaints be introduced to improve community and client satisfaction with BAC.*
11. *That Performance Review processes are established or enhanced to assist clinicians maintain best practice and improve patient care.*
12. *That audits of clinical practice are carried out and, where necessary, strategies for improving practice are implemented.*
13. *Clinical handover should be refined and implemented; its nature will be dependent on the integrated model of care adopted, but it should involve all relevant clinical staff and provide nursing staff, in particular, with the opportunity to comment on consumers that they have had direct care responsibilities for on a particular shift.*

Clinical Model

Noting that the clinical population serviced by BAC has changed in recent years (with a greater proportion of more severely ill clients, extensive comorbidity etc), one of the major problems is the apparent lack of evidence-based treatments employed by the unit.

The reviewers had a number of interventions described to them; however, Milieu Therapy and Adventure Therapy were the two overriding interventions highlighted as encapsulating the clinical approach of the programme.

Typically, **Milieu Therapy** is a form of psychotherapy that involves the use of therapeutic communities. It has been used as a viable treatment modality for children for over fifty years in residential and inpatient settings. Milieu Therapy is potentially a powerful therapeutic tool when individual dynamics and the social system can be combined in a planned and meaningful way to manage and change behaviour and relationships in settings such as BAC.

There was little evidence presented to the reviewers that Milieu Therapy at BAC is a planned intervention in which everyday events and interactions are therapeutically designed for the purpose of enhancing social skills and building confidence. Rather, the evidence and the finding of the reviewers was that afternoons and evenings are unstructured times with no program and that the BAC nursing staff are not engaged in this type of therapy, partly because they are not trained in it and partly because they spend much time in the continuous observation of clients.

Adventure Therapy is the creation of opportunities to explore the unknown in a safe environment through team based adventure activities. This therapeutic approach has the capacity to engage adolescents and young people. There is a small body of literature about the intervention and, while the data about effectiveness from that literature is equivocal, its use at BAC is not contraindicated. Its drawbacks, however, are that it is not an activity that can be intensively introduced into the day to day running of the unit and that as a stand-alone intervention its outcomes are poor.

It is noted that the loss (as reported in early reviews) of positions and facilities will have compromised the capacity of BAC to successfully implement structured out of hours activity and the Adventure Therapy Programme.

The A1-A7 programs are behaviour management programs employed to manage difficult and challenging behaviours. It has been previously noted that they have been used for many years without documented evidence that they are effective or that they have been systematically reviewed.

A previous review conducted in 2003 recommended the BAC close the programs for several days each year to invest time in program review, management, procedural and training issues. There is no evidence that this recommendation has been acted upon.

The recommendation made previously (2003) to close the program for several days to undertake review and development activities is considered to remain integral to the successful functioning of BAC.

Behaviour management plans continue to have a place within the clinical model in managing difficult behaviours; however, these plans may benefit from being individualised more, and eliminating their availability in pre-typed form that serves to inhibit consumer and staff creative problem-solving skills.

Time and effort could be directed at identifying interventions, other than continuous observation, that are suitable for maintaining the safety of consumers and others when consumers present with severe behavioural disturbance. Pursuing the idea of a high dependency unit may prove to be the most judicious use of human and financial resources.

Recommendations about unstructured periods of the day made here are reiterated from those made in the previous review (McDermott et al, August 2003, p 40) that the risk of critical incidents occurring could be reduced by ensuring small group sizes and structuring time outside of school hours with therapeutic group activities. The therapeutic milieu and adventure therapy style interventions may be utilised - the important aspect here is that they are planned and integrated into a holistic therapeutic approach

It is worth emphasising that while it may be argued that the various types or aspects of treatment – Milieu Therapy, Adventure Therapy - described above have a role, these should not be the cornerstone of a contemporary treatment program, nor the optimal "model of care". For example, patients with eating disorders may benefit from using the "Maudsley Eating Disorders Model", those with challenging personalities may warrant Dialectical Behaviour Therapy (DBT), etc.

Finally a previous review noted that "not all the young people participate in all of the programs. The young people are encouraged to choose the groups they are comfortable with on a voluntary basis" While appreciating that attainment of autonomy is an important task of adolescence, the reviewers believe a more directive approach about treatment in agreement with the client will be more productive.

Recommendations:

1. *A model of care should be formulated, based on the currently available evidence and the nature of clients presenting to the service.*
2. *The recommendation made previously (2003) to close the program for several days to undertake a review and development of a model of care is reiterated.*
3. *That the increase in risk associated with unstructured time is noted and that structured interventions are considered for these periods.*
4. *If BAC is seen as a Therapeutic Community utilising a Milieu approach, that this approach is formalised, key activities identified and documented, and appropriate training and supervision for staff provided.*
5. *That Adventure Therapy may continue but, if so, this should be seen as a component part of an overall therapeutic approach.*
6. *That interventions other than continuous observation be introduced, that are suitable for maintaining the safety of consumers and others when consumers present with severe behavioural disturbance.*
7. *The different presentations to the service and variety of disorders encountered will require a range of tailored treatments and, consequently, individual treatment plans should be developed and documented in the medical record and an appropriate range of evidence based interventions should be utilised to meet the individual needs of an increasingly complex group of clients.*
8. *Staff require adequate training and clinical supervision to ensure the new treatments are delivered optimally and that they are modified as new evidence becomes available.*
9. *Individual treatment contracts should be developed with patients and parents/carers. The contract should stipulate the expectation of participation in BAC programmes by clients/parents/carers and the consequences for non participation.*

Nursing Model of Care

It is unclear which model of care the nursing staff at BAC are presently utilising. However, it appears that the Functional or Task Allocation model may be closest to

reflecting how the team are functioning. In this model, the nurse is allocated tasks to complete, rather than patients to care for. The particular tasks that may be allocated to a nurse working at BAC include continuous observation, medication and escort.

The *Queensland Health Nursing Model of Care – Toolkit for Nurses* (2003) notes that while this model may useful in situations where there is a staffing crisis or that it may be more efficient for certain care, its weaknesses include depersonalised care, ritualised and repetitive tasks, and reduced job satisfaction.

During the visit, some nursing staff identified that it was particularly stressful being allocated to escort duty, during which time the nurse is required to be a continuous escort for consumers attending appointments usually outside BAC. Nurses reported feeling anxious and unsupported having to remain alone with consumers in what is usually an unfamiliar environment.

Recommendations:

1. *Consideration should be given to changing to a Patient Allocation Model or a Team Nursing Model, or a combination of both (the Combination Patient Allocation & Team Model). The strengths of each model are outlined in Queensland Health Nursing Model of Care – Toolkit for Nurses (2003, pp6-7).*

   [Patient allocation sees an individual nurse allocated to a group of patients and undertaking total patient care for that group. It has the advantages of providing personalised and holistic care while increasing the sense of autonomy and accountability and allowing more opportunities for communication with other health professionals. Team nursing involves dividing work between a group of nurses who are allocated to care for a number of patients. The Team Nursing Model strengths are identified as improving collaboration, flexibility and time efficiency as well as having a supportive/teaching function. The Combination Patient Allocation & Team Model combines the strengths of team nursing with patient allocation.]

Patient Journey

The "Report of the Site Options paper for the Development of the Barrett Adolescent Centre" identified a number of issues related to the patient journey of clients admitted to BAC. These included:

- The need for acute medical management at a local general hospital at regular intervals;
- Occasional need for more intensive acute psychiatric care;
- The need for intensive discharge planning at point of referral;
- Integration of BAC with services at the local community of origin;
- Partial hospitalisation as a method of transition from BAC to community management;
- The remoteness of referring services, making the above patients difficult to manage;
- Out of home care for increasingly older adolescents and young people who cannot return to their family of origin;
- Transitioning to suitable adult mental health services if the adolescent requires long term treatment and has reached an age where this transition is necessary.

The management or the difficulties in managing these issues has created some significant problems for BAC. The reviewers were advised that:

- Admissions to BAC are increasingly severe and complex;
- There is a perception that BAC has a limited choice over whom it accepts;
- There are referrals on from the CAMHS Acute Units if there is no obvious community placement option and that BAC becomes a treatment option of "last resort";
- A number of clients who are accepted are homeless;
- A number of clients are referred from very remote parts of Queensland – often by NGOs with little local CAMHS type support.

The concept of continuity of care is based around the notion of seamless transitions between treatment episodes, and this does not appear to be the case at BAC.

While some of these issues will be addressed when the unit is relocated to a site adjacent to an acute hospital, there appear to be significant problems with all of: referral to the unit, waiting time to admission for accepted patients, length of stay, and discharge planning and discharge placement.

The BAC has 15 inpatient beds gazetted for use of adolescents with challenging mental health problems requiring medium to long term treatment. At the time of the visit, there were inpatients. The nursing staff on duty were unable to clarify how the remaining beds were being utilised. [One of the clinical nurses performs the role of Clinical Liaison Officer, coordinating the intake activities of the service. The clinical liaison nurse informed the reviewing team that BAC has developed exclusion criteria that include: conduct disorder, predatory behaviour, criminal behaviour, aggression, substance misuse and moderate-severe intellectual impairment.]

An obvious indicator of this constellation of problems is the increasing age of the clients. At the time of the review, one third of the inpatients were over the age of 18 years. Those individuals had admission dates of , meaning length of stay for them was approaching 2, 3 and 4 years respectively.

Thus, consumers are not necessarily discharged at 18 years of age and there appears to be a lack of clearly understood or communicated process to transition these young people to adult services.

An assertively managed approach to admission and discharge will need to be adopted by BAC wherever it is located. The following recommendations can define the parameters of this approach.

Recommendations:

1. *That advice be provided to referring agencies about the nature of the services offered by BAC.*
2. *That clear inclusion and exclusion criteria be formulated.*
3. *That referral forms for referring agencies be updated.*
4. *That service level agreements, Memoranda of Understanding or shared protocols be used as the basis of agreement for the transfer or sharing of care between BAC and other units. These would include but not be restricted to:*
5. *Agreements with local Acute Hospitals for assistance in the management of the physical sequelae of self harm.*
6. *Agreements with local Acute Hospitals for assistance in the management of the physical complications of eating disorders.*
7. *Agreements with local Acute Mental Health Facilities for assistance in the management of acute and extreme behavioural disturbances.*
8. *Agreements with local Acute Mental Health Facilities with regard to the transition of older adolescents from care at BAC to care in Adult Mental Health Services.*
9. *That responsibility for accepting admissions and managing discharges be clearly articulated in the Unit policies and that this include the position(s) responsible for the decision making.*
10. *That the length of admission, and planned discharge date, for prospective admissions, be agreed upon by referrer and BAC staff prior to admission.*
11. *That there is firm agreement, prior to admission, about which service will have an ongoing role in the patient's management upon discharge (failure to agree on this will result in the patient not being admitted to BAC).*
12. *That homelessness in the absence of an identified and agreed upon strategy for accommodation at discharge be an exclusion criteria for admission to BAC.*
13. *That the concept of step up/step down facilities and halfway houses, possibly managed by NGOs, be explored as methods of transitioning clients back to the community, especially those clients who will require out of home care.*
14. *That a target for Length of Stay be set for BAC – this can be aspirational, but should be no more than 12 months. Any client that exceeds this target on*

clinical grounds should be identified and intensively managed to find alternative clinical placement including, for older clients, placement with Adult Mental Health Services.

15. *That planning towards and documentation regarding a patient's discharge should be undertaken throughout the admission.*
16. *That regular (eg twice yearly) meetings of BAC staff with key referring agencies occur to improve the referral, treatment and discharge processes.*
17. *That data regarding referrals, wait times, lengths of admission etc be reviewed regularly and in different forums (eg at meetings of senior BAC staff and Park Hospital and Old Mental Health)*

Treatment evaluation

There appears to have been negligible evaluation of treatments delivered by BAC.

Recommendations:

1. *Routine use of standardised outcome measures.*
2. *Additional (specific) measures be used for the specific disorders managed by the unit (eg depression rating scales for those patients with depression etc).*
3. *Regular use of patient and parent/carer satisfaction surveys.*
4. *Affiliation with an academic unit to facilitate treatment evaluation.*
5. *Introduction of a regular meeting to specifically address the process of outcome measurement at BAC and the (outcome) results obtained for patients.*

Clinical leadership

One of the major problems of BAC relates to leadership and leadership structure. While several staff (e.g. psychiatrist, NUM, liaison nurse, senior allied staff) have considerable experience, there does not appear to be a clear Executive structure nor forum for the Executive to meet. In relation to nursing, while nursing staff reported

that they weer all were very supportive of the relatively newly appointed Nurse Unit Manager, it was apparent that the Clinical Nurses were underutilised in their potential capacity as clinical leaders. It was not clear if regular nursing staff meetings were conducted, and the reporting lines were vague.

Similarly, it was unclear whether the Nurse Unit Manager and the Director attended regular meetings in their roles as providing the leadership group at BAC.

Recommendations:

1. *Appointment of an Executive whose members have clear roles and responsibilities*
2. *Clear delegation and succession planning (for example, when the Director, NUM, liaison nurse etc go on leave, others are appointed to act in these roles – this also provides career development opportunities for various staff).*
3. *The Director should implement professional development seminars for all the staff and these should reflect the practice of other service providers. Examples of new and innovative therapies, presented by people external to BAC, should be included.*
4. *BAC should provide a regular (eg quarterly) report to Park Hospital and State mental health about its programs and use of both tested and innovative approaches.*
5. *The Nurse Unit Manager may benefit from adopting strategies to encourage the Clinical Nurse group to take on more leadership roles and functions. This would firmly establish reporting lines and support the Nurse Unit Manager in the everyday functioning of BAC.*

Staffing profiles (nursing)

BAC consists of a large multidisciplinary team; as with most inpatient services, the nursing establishment make up the bulk of this team. BAC currently maintains a nursing establishment of 23.9 FTE. Six nurses are rostered on each shift on

weekdays. The nurses work continuously in 8 hour shifts. The nursing team is led by the Nurse Unit Manager and 4 Clinical Nurses, one of which holds an Intake/Community Liaison position.

As in all nursing teams, there are varying levels of clinical skill and experience amongst the individuals. At BAC, there are a number of staff who have been working there for many years and some staff who are relatively new to Child and Youth Mental Health (CYMH). Consultations with nursing staff present on the day of the visit suggested that there were no nurses who had experience with another CYMH service outside BAC. This indicates the team may be disadvantaged by a lack of current exposure to contemporary nursing practice within the CYMH speciality.

While all nursing staff reported being very supportive of the relatively newly appointed Nurse Unit Manager, it was apparent that the Clinical Nurses were underutilised in their potential capacity as clinical leaders. It was not clear if regular nursing staff meetings were conducted and the reporting lines were vague.

Recommendations:

1. *More robust interactions between nursing staff of BAC and other CYMH services should be facilitated; one way to address this may be found in secondment activity negotiated between services.*
2. *The Nurse Unit Manager may benefit from adopting strategies to encourage the Clinical Nurse group to take on more leadership roles and functions. This would firmly establish reporting lines and support the Nurse Unit Manager in the everyday functioning of BAC.*

Nursing Staff Training and Education

Individual consultations with nursing staff during the visit identified a general desire for more educational/training opportunities, specifically in adolescent mental health.

There appeared to some issue with the budget limiting nursing staff access to their professional development funds to pay for development activities.

The previous BAC review conducted by McDermott et al in 2003 recommended more training and education for staff on adolescent issues. It is clear from discussions with nursing staff that this education is still somewhat haphazard and limited.

Clinical supervision structures are problematic. The whole team attends group supervision with a specialist clinical supervisor, who is also a member of the team. Additionally, nursing staff identified a need for more clinical supervision.

Recommendations:

1. *The use of professional development funds by nursing staff should not be compromised by budgetary constraints. The provision of the money to undertake development activities is an award condition.*
2. *Nursing staff would benefit from regular and relevant in-service, and a program or calendar of such in-service could be developed and then facilitated through rostering. There appears to be generous blocks of time that could be regularly quarantined for staff development during the time the young people are attending school.*
3. *Structures for group clinical supervision should be reviewed and strengthened by sourcing a clinical supervisor not currently working at BAC.*

Finally, while staff may understandably be unsettled by the prospect of significant changes as recommended in this report, the proposed rebuilding of the facility at a new location constitutes an unprecedented opportunity to reflect on BAC's purpose, mission, systems and work practices. With a motivated leadership team employing good change management skills, BAC and key stakeholders can seize this chance to review the service and maintain BAC's commendably long record of service provision to young people in Queensland.

REPORT ON THE NEED

FOR

CHILD & ADOLESCENT SECURE INPATIENT SERVICES

AND

THE RE-DEVELOPMENT OF EXTENDED TREATMENT ADOLESCENT IN-PATIENT SERVICES.

Mental Health Unit
Queensland Health
October 2002

Contents