CONCERNS OF CONSUMERS, CARERS & COMMUNITY IN RESPONSE TO CLOSURE OF THE BARRETT ADOLESCENT CENTRE AND THE FUTURE OF ADOLESCENT MENTAL HEALTHCARE IN QUEENSLAND

Presented on the 11th September to

Dr Lesley van Schoubroeck, Queensland Mental Health Commissioner

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Since the possibility of closure of the Barrett Adolescent was raised in November 2012, the Queensland community has demonstrated **unprecedented public support** for this facility and for this model of care for young people suffering with severe mental health issues. These young people are at the critical end of a spectrum that includes depression, anxiety, schizophrenia, PTSD, OCD and more – and, as such, the need for a specific (and proven) model of care for this group **cannot be omitted from any future mental healthcare plan for Queensland**. Within the range of a medical field like 'respiratory illness', sufferers can be dealing with asthma, pneumonia, TB, cystic fibrosis, congenital pulmonary hypoplasia etc. While lung transplants are not considered for many children with respiratory illness, they MUST be available for the few who need it. The same applies to young people with SEVERE mental health issues. The Barrett Centre has been their only option for 30 years and it cannot be taken out of the overall mental health treatment plan.

There's no doubt that consumers, carers and the wider community embrace the concept of extended treatment options which would include greater access to regionally based options and community-based programs. But the **broad support for the retention of the Barrett Centre 'model' WITHIN whatever future plan is devised is irrefutable**. It is of significant concern that government officials have stated that "*the Barrett Adolescent Centre is no longer an appropriate model of care for these young people*" (Lesley Dwyer, West Moreton Hospital and Health Service Chief Executive) as it has been a vital resource that has positively affected so many lives and continues to do so every day that it remains open. The **Barrett Centre is not a prison-like institution** of the kind that warrants closure. Nor is it simply a hospital. It has been referred to by past and current patients as their "last chance" and, thankfully, that last chance is **a nurturing environment where specialised therapists, nursing staff and clinicians combine with dedicated educators and support staff to provide extensive, individually tooled programs combined with socialisation and learning opportunities that have PROVEN RESULTS**. The adolescents receive the kind of treatment that only long-term residential care can provide AND the access to on-site schooling which is a vital factor in not just transitioning them back to a world from which they have long withdrawn, but in preparing them to live independent adult lives. And though it is referred to as 'on-site schooling', it's important to note that the learning experiences don't just take place in the classroom but in the extended community. Beyond the group activities where specialised teachers have developed ingenious methods to incorporate learning into therapy and social/personal development activities, the patients attend cooking and self-defence classes, go on excursions and bushwalks and undertake work experience in the community.
The Barrett program is truly a bridge to a life in the 'real world' that will provide the strongest foundation for a stable future – making it a model of care that Queensland cannot afford to lose.

A PERCEIVED LACK OF CONSULTATION WITH KEY STAKEHOLDERS

There is a major concern that consumers, carers and the wider community haven't had the opportunity to provide the input that they should and need to have AND a feeling that their serious concerns will not be listened to nor their needs addressed. Even though the WMHHS's Governance Framework indicates a high priority on this (*Part E: Consumer and Community Engagement Strategy*), current patients and their families – and those on the waiting list for the Barrett Centre's services – are expressing not just devastation at the loss of such a vital and unique facility but a strong sense of being neglected and/or being seriously undervalued where their needs and input are concerned. They want their deeply challenging circumstances acknowledged and addressed and they need clarity and reassurance in the process as well as a clearly stated timeline that will reasonably meet the needs of this high risk group.

An example of this community sense of being overlooked is evidenced by the development and release of the Expert Clinical Reference Group's Recommendations. **The ECRG made clear recommendations for EXTENDED INPATIENT CARE WITH ON-SITE SCHOOLING**. The Planning Group then added 'considerations'. There are genuine community concerns about the expertise of this Planning Group – were there representatives with clinical backgrounds? Were there consumers and carers on Planning Group? If not, then the wider community is concerned that this Group's 'considerations' are being taken *over* the recommendations of the Expert Panel. Were current consumers/carers consulted about the ECRG's recommendations for their feedback or were they told just before the Minister made his announcement? If there was no consultation, how can the government reliably state that such vital stakeholders have been significant contributors to this process? And, how can they indicate that proper processes have been followed when Queensland Health's own Consumer, Carer and Family Participation Framework advocates *"adopting a consumer-driven, recovery-oriented, and carer and family inclusive mental health service model … enhancing consumer and carer participation at a local level."* As this links the Queensland Plan for Mental Health 2007–2017 to the National Standards for Mental Health Services (2010), surely in order to comply appropriately with government processes, a significantly greater input from the community should have occurred at many stages throughout the process that are already behind us?

The Health Minister has continually said that the change to a new model is <u>in response to community concerns</u> about more localised services but that community **doesn't want those AT THE EXPENSE of the BARRETT CENTRE** – it wants them as well. If there can be 3 or 4 Barrett-like facilities across the state, that will address the needs of the community. But if there is no Barrett type facility at all and just acute/community-based care options, then those community needs have not been met. The Community is looking for improvements, not the loss of care options and there are serious concerns about being referred to as having their needs met when, in reality, they are feeling overlooked. **The government would never consider closing a single, unique, specialist treatment facility for people with chronic, specific medical conditions associated with the heart, brain or cancer in favour of delivering a different model of care to these people closer to their home, *but a level of care that didn't and couldn't meet the level and complexity of care they require*.** It seems highly likely that none of the patients would choose this care as an option over travelling to Brisbane to give their loved ones the best chance at survival and leading a normal life. **But this is what the Government is proposing for young people with very specific mental health needs if Barrett is closed and not relocated**.

MAJOR CONCERNS ABOUT THE PROCESS, RECENT DEVELOPMENTS and DISPARATE PUBLIC INFORMATION

A process that doesn't seem to be in line with stated procedure and/or legislation

The new state Mental Health Commissioner, Dr Lesley van Schoubroeck, was appointed in July to oversee the Commission's remit to "prepare a whole-of-government strategic plan" for mental health service provision (*Queensland Mental Health Commission Act 2013 - Act No. 7 of 2013*). Yet when Mr Springborg announced the closure of the Barrett Centre on the 6th of August, it was unclear to the public how much input Dr van Schoubroeck actually had in this decision. To date, consumers, carers and the community are still unaware of whether Dr van Schoubroeck has seen more than just the Recommendations of the ECRG and what her views are, as the Mental Health Commissioner, on the role of the ECRG's findings in her review of services. It's assumed that there is more extensive documentation from the ECRG than the summary of recommendations. If so, **has Dr van Schoubroeck been supplied with the FULL REPORT from the ECRG? Would/does she accept this as a substantial/definitive document of the essential services for adolescents with the most severe, persisting disorders** in the context of the review of services her Commission has undertaken? (While services such as that offered by Y-PARC in Victoria are valuable in the treatment of the less severe end of youth mental health conditions, they do not cater to the needs of those who have been accessing treatment through the Barrett Centre.) Many Queenslanders – including those in extremely vulnerable circumstances – have waited through the months of the government-appointed Expert Clinical Reference Group's careful consideration of this specific area of need and feel that that unequivocal conclusions on the kinds of services required have now been presented. **So if the Commissioner accepts the ECRG's work as definitive and has/will have access to a full report, her expertise on assessing whether the proposition by the government – *that an equivalent service can be in place by January/February 2014* – is realistic would be invaluable.** It is of deep concern – particularly to the families of current patients and to the staff who have undertaken the care of these young people – that **compromises that cannot be withstood by deeply suffering young patients will be made to meet the proposed timeline. Young people at the severe end of the spectrum cannot be disadvantaged by the process in any way as the repercussions could be devastating.** The Commissioner's role in the future of Queensland's mental healthcare provision is a key one and the reassurance of her significant involvement and her openness to **recommending a delay to the closure to ensure that services to this group of adolescents can be consistently maintained throughout any change of model would provide the stability that has, unfortunately, been lacking in recent months**.

Another anomaly with the process that has been underway is that the Commission has also been tasked (*according to Act No. 7*) to form the *Queensland Mental Health and Drug Advisory Council* which is to work with the Commission to formulate the whole-of-government plan for mental health and drug and alcohol service delivery. Positions on that advisory council were only advertised on the 20th of August and applications will close on the 30th of September. As per the Act, the Commission must "*engage and consult with—(i.) people with mental health or substance misuse issues, and their families, carers and support persons*" as well as consulting with the Advisory Council on the whole-of-government strategic plan before it is given to the Minister. The Advisory Council must "*drive reform to improve the mental health and wellbeing of all Queenslanders and provide advice and guidance on mental health and substance misuse issues*" through wide consultation with the community (including parents, carers and 'consumers'). **So many are wondering how such a significant decision as the closure of the Barrett Centre can have been made – *without the wide consultation referred to in***

the legislation **– when the Advisory Council is yet to exist, let alone contribute to the whole of government plan.**

In recent weeks, we have heard that the Statewide Adolescent Extended Treatment & Rehabilitation Implementation Strategy Steering Committee is developing the alternative to the Barrett Adolescent Centre. **Is this Committee going to work within/alongside/ separate from the Mental Health Commission process?** With one carer and one consumer on this Committee, concerns have been raised directly with West Moreton HHS that this level of input does not fit the multiple tiers of community engagement outlined in WMHHS's Governance Framework. **It is hoped that, from now on, there will be greater opportunities for consumers, carers and others to provide input to the Committee so the support of the Queensland Mental Health Commissioner in ensuring that this commitment is met would be invaluable.**

On a National level, the National Mental Health Service Planning Framework (NMHSPF) Project, an initiative of the Fourth National Mental Health Plan, will provide its finalised Care Packages and Service Mapping by 30 September 2013. This is one part of a much larger process to develop national modelling for mental health services – involving consumers and community in the process – which will have implications for models of delivery and funding. The NMHSPF project is joint-led by the NSW Ministry of Health and Queensland Health. **What implications, if any, does this National process have for the whole-of-government plan to be developed by QMHC, and if a Care Package describing service models for 12-17 year olds has been designed, should Queensland wait to see what models are proposed before undertaking significant changes to youth mental health services, especially since funding will be tied to these models based on population demand for each service?**

In Western Australia, the WA Commission for Children and Young People commissioned an Inquiry into the Mental Health and Wellbeing of Children and Young People in Western Australia. The subsequent report (2011) specified that "*The Inquiry has recommended that the* ***Mental Health Commission*** *become the lead coordinating body for the improvement of service delivery for children and young people's mental health – by developing a comprehensive and strategic plan for the mental health and wellbeing of children and young people and leading a whole-of-government implementation process: Recommendation 10 – A whole-of-government collaboration to improve the mental health and wellbeing of children and young people across the State be led by the Mental Health Commission. (Page 63)".* Queenslanders see this as an appropriate process, and **singling out a specific service for closure WITHOUT such a thorough procedure is in complete contradiction to best practice**.

There are additional concerns that the Queensland restructure relates only to 'Adolescent Extended Treatment and Rehabilitation Services'. If so, what are the plans for these services to integrate into the other community based youth mental health and general youth services to allow for the 'seamless' transition to, and usage of, these services by youth from the Barrett model if the objective is to achieve recovery for these young people so they can transition back into the community. If the ***Mental Health Commission Act 2013*** states its 'Object' as achieved by

"(a) developing a whole-of-government strategic plan that—
(i) provides for coordinated action by relevant agencies involved in the delivery of relevant services; …
(iv) encourages integration of relevant services"

and its 'Guiding Principles' state that

"An effective mental health and substance misuse system is the shared responsibility of the government and non-government sectors and requires—
(a) a coordinated and integrated approach, including across the areas of health, housing, employment, education, justice and policing; and

(b) a commitment to communication and collaboration across public sector and publicly funded agencies, consumers and the community"

then surely the Queensland Mental Health Commission should be overseeing the decisions made on a treatment option that will *receive* adolescents from other services (acute care or community-based mental health care, education, even justice and other government services) and will *send* adolescents to other services (community-based, adult health care, government employment, housing services etc.)? It seems much less effective for a model to be developed in isolation and *later* integrated into a comprehensive plan than for all aspects of mental healthcare to be considered together and implementation of new service options to follow.

As well as the expectation that Queensland's Mental Health Commission oversees this restructure, there is also the feeling that, as these young people are a vulnerable and disadvantaged group, our Commission for Children and Young People and Child Guardian should contribute to this process at a high level. The Commission for Children "*promotes and protects the rights, interests and wellbeing of children and young people in Queensland*". Their vision is for *"a better life for Queensland children and young people, particularly our most vulnerable*"; their mission, *"to improve the safety and wellbeing of vulnerable children and young people in Queensland*". The Commission *"works collaboratively with both government and non-government agencies to resolve matters impacting on the best interests of children and young people … The Commissioner's operations and decisions must be independent of any Ministers, government departments or other agencies."* So surely **the involvement of the Mental Health Commission AND the Commission for Children is the appropriate way to ensure proper process and protect the rights and wellbeing of these young people**.

If this process continues to be separate from the whole-of-government plan, then **responsibility falls to WMHHS and/or CHQ to manage the issue of young people needing to transition to adult mental health services** (as this would affect most of the Barrett inpatients in 2014/15). Most of Barrett's consumers are socially, mentally and emotionally developmentally delayed to varying degrees due to their social isolation and subsequent loss of contact with peers and associated social engagement. To expect them to transition from Barrett to existing forms of adult services is unrealistic – it would be unrealistic for young people with *less* severe mental health needs to make the jump to adult services. Who will be ensuring the modifications to existing adult mental health services or the implementation of new mental health services will cater for these young people making the transition to adulthood? National and international research and consultation with consumers and community has informed evidence-based models of care that are now providing community based mental health services for a 16 – 25 year old age range e.g. Headspace (whose services cater for 12 – 25 year olds). This overlaps adolescence with adult ages **in recognition of the significant gap between adult and adolescent mental health services**, avoiding the 16 – 18 year old transition point and **improving the seamless transfer to adult services**. It would therefore seem **absolutely critical that the Barrett Centre – and youth mental health services in general – be considered in the QMHC's whole-of-government plan to facilitate this crossover from youth to adult mental health services**. Minister Springborg stated on 10 June, 2013 "*Most importantly, she* [the Mental Health Commissioner] *will be central to improving the system that supports people living with a mental illness or who misuse substances, as well as their families, carers and support networks*." Then on 28 June 2013 "*It* [the Mental Health Commission] *will also improve the coordination and transparency of clinical services and other human services and focus on outcomes, recovery, social inclusion and community wellbeing*." **This acknowledges the need for the Barrett Adolescent Centre to be considered in the process for the whole-of-government plan and infers, through the Health Minister's own words, that a closure announcement is premature before all the**

requirements of consultation have been met and all due consideration is given to future services and the best transition to those by young people who are already at risk.

No clear timeline – mixed messages and uncertainty

Initially, the Health Minister's announcement stated that "it is true that **some time in early 2014 that Centre will be closing** as we come up with a range of new options to deliver services closer to people in their own home or right in their own home town." Carers of current patients were given the news in phone conversations on the 6th of August, with some interpreting what they were told as "that early in 2014, it will relocate to another hospital … that the inpatient specific adolescent service will be retained" (*The World Today, ABC Radio, 7 August*). However in that same radio coverage, the Health Minister stated that "the final makeup of this will be known early next year". Only 2 weeks later, though, the Education Minister, when asked in parliament about the closure of the Barrett Centre School, said *"… Queensland Health advises that this model could take* ***up to three years to develop and implement****."* Just prior to this, in the same session of parliament, Mr Springborg had said "***no decision will be made to close that facility*** *until such time as we know that appropriate alternatives are in place, including alternatives which adequately ensure that young people with educational needs, as many of them are, can be supported in conjunction with Education Queensland."* **So – when will it close? When will new programs be up and running? And when will key stakeholders in the consumers, carers and the community be told?** Those who ***MOST*** need to know what will be happening are being given contradictory statements and vague explanations. They need to know the situation clearly and consistently. Many in the community are wondering … **Have there been rushed decisions and if so, why? Is the early 2014 deadline realistic? And again, importantly**, **is there an option for the 'early 2014' closure to be delayed to allow the best solution to be worked out or is that decision irreversible? And if it cannot be changed, how can adequate facilities be developed within the next 5 months?**

Repeatedly the **issue of failure in consultation and communication** arises. ***The consumers and community have had to rely on media reporting to stay informed and even that information – including quotes directly from the Ministers – changes from day to day.***

No clear process – mixed messages and uncertainty

The report of *the Inquiry into the Mental Health and Well-being of Children and Young People* in Western Australia by Commissioner for Children and Young People W.A. (April 2011) states **"***When serious problems with the status quo have been identified, as they have in mental health and specifically youth mental health, the onus is on governments and health departments to respond with better models, while* ***safeguarding the positive aspects of the original system****.***"** This warning highlights **the great risk that Queensland would be taking if the Barrett Adolescent Centre closures and its programs, services and personnel are not relocated as a complete entity**. The proposed reforms to youth mental healthcare in Queensland need to include an extended inpatient facility with on-site schooling – as this has proven to be uniquely successful over its 30 years in existence. So the system proposed by the minister as a potentially better model for general prevention and early intervention service delivery is welcomed but **as Barrett is clearly a positive aspect in the original system**, **it must be retained**.

Of particular concern now is Barrett's capacity to continue to implement the treatment plans of each inpatient and to prepare each patient for the proposed transition to other services/care in early 2014. Barrett has recently lost an Occupational Therapist – a crucial member of the treatment team, another OT is absent due to illness and is the centre is operating with reduced psychology and other services. As a result, therapy options and hence

'consumer' recovery is compromised. The absence of these important staff meant the holiday program for 'consumers' had to be cancelled. However due to the selfless dedication of Education staff, and their belief in the importance of this program, they have donated their time during their holidays by volunteering to run the program. So not only are treatment plans undermined because of staff losses, the pressure is now on for treatment plans to address the objective of preparing inpatients for a transition to a model of care about which the form/agencies etc. remain unknown. **If it wasn't enough for the young people to deal with their own illness, they now have to manage a monumental change in their life when, for most, they were starting develop a stable and manageable lifestyle. It should be an absolute priority to redress these staff losses/shortages to ensure treatment plan objectives are met.**

Treatment at Barrett is individualised. It would be completely unrealistic, given the varying times of entry to the centre and individual variations in progress with treatment, that every inpatient could be expected to be ready to transition out of the centre at the end of January 2014. **What plans do WMHHS have to address the situation that it may not be the right time to transition an inpatient? Has WMHHS already begun consulting with treatment teams to address this issue, and if not, when is that process to occur? Once transitioned, if a young person relapses, where are they to go – are they destined again for the 'in-and- out" of acute care that many have had define their lives before Barrett?** *(The mp3 of 'Molly' on the supplied flash drive indicates that this is a pattern than many young sufferers experience.)* CYMHS was able to refer young people to another level of care above community-based services. Once Barrett closes, that option will not exist and if there are other bed-based community services – what will happen if they are full? **And, in a not unrealistic situation, what duty of care does the WMHHS see itself having should a former Barrett inpatient suicide as a result of being transitioned to other care?**

One of the reasons that Barrett works so well is the **sense of community** and belonging that the inpatients develop which helps them to overcome their social isolation, develop confidence in their interactions and acquire skills to behave in a more functional way as well as manage their own condition. The relationships formed in the **micro-community** of the Barrett Centre between staff and adolescents are vital to the participation and engagement in – and effectiveness of – treatment and therapy. Such relationships and trust would take much longer to develop in community based models – if at all – as contact with workers would be more brief, variable and less predictable. The young person's inclination to engage could be severely reduced without those substantial relationships. **At Barrett, adolescents have opportunities to practice their social skills and observe those of others as well as have appropriate interactions in a range of situations supported and modeled by staff. This is one of the powerful tools that Barrett has in being able to address the social isolation of its inpatients**. With access to instant feedback and support in a variety of settings – inside Barrett, in the school and out in the community – 24 hours a day, this comprehensive approach couldn't be replicated beyond a Barrett-like environment. In addition, with staff able to make observations in a range of settings and situations, they are then better able to tailor interventions and therapy to assist each young person's development. The peer interaction (again, across settings) is also invaluable and has the added advantage of finally allowing a young person to not feel alone in their suffering. With peers going through similar issues in a safe and supportive environment, they can not only learn a range of ways to deal with shared issues and develop peer-to-peer social interaction skills but gain the invaluable insight of knowing that they are not as isolated as they have been feeling (often for years) in their own home environment. Treatment models within the community cannot provide the consistency and comprehensively supportive, understanding environments that facilitate this

kind of progress, leaving a young person at risk of withdrawing even further from social interactions and situations and becoming even more socially isolated over time.

As they progress and move to day-patient status, the young person still maintains the connection with Barrett as they try out their independence and self-management – but still with the support of the Barrett community. This process itself is a gradual one, starting with one day a week as a day patient if necessary. This way, the sense of belonging and support is maintained but progress is tested and consolidated. **The change from a supportive community to new services, processes, people – and potentially back to a social network that provides either no support or is unstable or dysfunctional – puts these young people at considerable risk**. It is absolutely crucial for Barrett to remain open as long as possible – to be part of the broader whole-of-government plan process of the QMHC – so that considerable deliberation and consultation can be undertaken so that if these young people *are* to be moved and Barrett is definitely not going to be a part of the new model of care, they are afforded **the respect and consideration of being transitioned to services that are in place and consolidated and properly integrated with other relevant services**. At this stage, five months out from closure, the committee has only just been formed to determine an alternative. If time to advertise for staff, find premises, establish protocols for operating and many other issues is factored in, ***how can services be ready by January 2014?*** It is also totally unjust to expect staff, inpatients and families, to be on a month by month proposition after January – wondering when these services would be up and running, particularly after 9 months of not knowing what was happening to the service. **In recognition of these factors, Barrett should be allowed to continue operating until the end of 2014 (as per the pre-existing Redlands Plan) or until the QMHC Plan is developed, whichever comes first.**

Recognition and Funding

Sam Mostyn, National Mental Health Commissioner states "*My aspiration for the National Mental Health Commission is that mental illness receives the same priority, focus and resources as any other part of our health system*." **Mental Health funding has always been the "poor relation" in the health system** according to Professor Patrick McGorry, attracting half the funding it should by proportion of the total health budget. However mental health and mental illness is a rapidly growing problem affecting a significant proportion of the community. The World Economic Forum states Mental Health is now equal to Cardio-vascular disease as the biggest health threat to the economy in the next 20 years. April 2013 figures estimate the cost to the Australian economy of $30 billion a year for care, treatment, welfare payments and hours of lost work. Within the mental health budget, ***youth*** **mental health** - the point at which the greatest impact could be made - **attracts an even smaller proportion of the mental health budget. Given that a significant proportion of mental illness appears in adolescence or is the result of childhood problems such as trauma it would make sense to distribute a larger share of funding to child and youth mental health, since National and State Mental Health priorities are the Promotion, Prevention and Early Intervention areas of the mental health strategy continuum.** Yet Queensland spent only **1.7% of the $983.3 million** on Promotion, Prevention and Early Intervention, Action Area 1 of the COAG National Action Plan on Mental Health 2006-2011 funding allocations *(Well meant or well spent? Accountability for the $8 billion of mental health reform, Rosenberg et al. 2012).* This would have massive implications for future spending on adult mental health - s**urely the goal of intervention in this area of the strategy continuum is to reduce the demand and adult services**.

Whilst the major focus is on these priority areas of the strategy continuum, the young people of Barrett have moved beyond this part of the continuum. They are in the Treatment part of the continuum – at the far end of treatment, for young people with severe and complex treatment

needs. One of the characteristics of the young people who attend Barrett is that they have become socially isolated – in most cases, completely disconnected from friends, family and community and education. Their functional impairment is so severe, and they are often developmentally behind because of such long periods of disengagement from the adolescent world, that a couple of months of inpatient care is not enough to rehabilitate or enable recovery. It is why this particular group of adolescents require such intensive inpatient treatment with expert, such individual multidisciplinary clinical and therapeutic treatment. The proportion of young people in this category may only constitute 1% of the adolescent population. But when considering the trajectory for these young people without such specialist support like that provided by Barrett, their future is particularly bleak, and their ongoing reliance on health and welfare services to function is inevitable. These young people have missed the opportunity for early intervention – either due to lack of early intervention services, or because methods of early intervention have failed. NO model of care, however effective, will ever meet every need of every person**. It is essential, therefore, that the particular specific, unique needs of this group of young people are recognized, catered and budgeted for in whatever model structure is developed by the Steering Committee. To ignore the statistics and the proven record of a treatment facility that has led many young sufferers to constructive adult lives is to ignore an effective approach for a specific cohort of the population with a great need for the best mental healthcare** – something that any government should take every step possible to avoid.

WILL THE NEW MODEL INCLUDE SOMETHING THAT RESEMBLES THE BARRETT ADOLESCENT CENTRE?

Again, ambiguous responses to queries about the future are causing great stress AND, significantly, disruption to the progress that current Barrett patients had been making. All those directly involved understand that this is a complex issue but there **needs to be more clarity in relation to the key features of the new model**. Those who use the Barrett service now and those who have been relying on it for the future **need to know** that the aspects listed by the Expert Clinical Reference Group as 'ESSENTIAL' will continue to be available.

Widespread support for the Barrett Model across consumers, carers, and the community

Those beyond the government have spoken with one voice on this issue. A petition on the CommunityRun website has garnered 4000+ signatories *(supplied on flash drive)* and a parliamentary petition was entered into records when it reached past 1000 signatories. Current patients and their carers – AND the families of young people on the waiting list to utilise the Barrett Centre's service – have given media interviews in support of the Centre *(mp3 files supplied on flash drive)* and, considering the hardships these people are already facing each day, to take the time and effort – *and* to expose their private lives so publicly – speaks to the depth of their need for a facility like the Barrett Centre.

Rarely have consumers been so effusive in their praise for a healthcare program. **Current and past patients' UNANIMOUS support** has reached pleading proportions. Young people – and especially troubled young people – are not known for their admiration for, or gratitude to, healthcare and/or educational facilities. But every single current patient is adamant about their need for Barrett and the need for Barrett to continue to exist for others like them. (*Sample Statements doc and mp3 interview files on the flash drive are evidence of this.)* **Of all the stakeholders and experts, this group's insights – whether we call them 'consumers', patients, students, adolescents or teenagers – should not only be acknowledged but prioritised. They are the people at the heart of this issue and if they are saying that**

nothing has worked for them like the Barrett Centre, then that endorsement should carry enough weight to ensure everything is done to continue to provide that uniquely successful program.

The Relocation option

If money is not an issue as the Health Minister and West Moreton HHS have clearly stated, why is a relocation of Barrett not automatically part of a program that also includes new community-based options? The ECRG has clearly emphasised the importance of a facility like Barrett so if the Queensland Health department has no concerns about financing whatever is required, many are wondering why the government is not demonstrating a comprehensive understanding of community needs by addressing the demand for more local, regional care options AND taking advantage of the financial and time investment already undertaken in the Redlands relocation strategy. Architectural plans exist for the new $10 million building that the previous government were to build adjacent to the Redlands Hospital so if there is at least $20 million available as the Health Minister has stated, is it only politics that is standing in the way of meeting adolescent healthcare needs fully and completely?

Under the previous Government, the new purpose built facility at Redlands would have been ready to move into sometime towards the end of 2014. It was obviously the intention of the then Government to have Barrett continue functioning on the existing site until that time. **What has changed, that Barrett now needs to be closed in early 2014? Safety concerns have been raised regarding the Forensic Mental Health facility at Wacol. What incidents have occurred in the past? What consultations have been held with staff to discuss these concerns – what strategies were developed and implemented to minimise potential harm? Has WMHHS spoken to inpatients and parents to ask if they were worried or sought recommendations about how it might be made safer?** There is a public cricket oval on the grounds of The Park. Every week families come to use the facility, people transit through the grounds exercising (bikes, walking) and the grounds are open to public access alongside the Gailes Golf Course with no fencing or boundaries. There are no signs warning of any danger to the public and nothing to keep the public out. If there are concerns for the inpatients of the Barrett Centre, then there should be some notice/s to warn the public as well. It is, then, difficult for many to accept that health and lives are being put at risk due to the closure/relocation of the centre based to a great extent (according to comments made by government officials) on a security risk which doesn't pose a threat to anyone on the grounds except those confined within the Barrett Centre's boundaries. Inpatients are likely at greater risk of harm during the transition from Barrett than any risk within the grounds of The Park at Wacol.

THE BENEFITS OF BARRETT

Only ACUTE or COMMUNITY-BASED OPTIONS aren't enough – there must be EXTENDED INPATIENT CARE WITH ON-SITE SCHOOLING

The Barrett model is the best opportunity for **progress to be made in cases where acute/community-based care options have failed** – the level of intensive, individually-tooled treatment plans can't be provided in any other setting. Extended inpatient treatment can provide a young sufferer with a full understanding of their condition, its influences and the ways to manage it through years of complex changes and the influences of life. And because the most appropriate and comprehensive care in adolescence can provide the strongest foundation for decades of adult living, the ongoing advantages of having a facility operating the unique way that Barrett does are clearly proven. In human terms, the benefits

are obvious but even in economic terms this means that these individuals are less likely to be a drain on the healthcare and welfare systems. They are more likely to become productive, tax-paying adults and those that have been their carers are more likely to be able to gain full-time employment and not be as vulnerable to stress related illnesses. In the long-term, a model which provides the required adolescent care options i.e. including access to extended patient care undertaken by a multidisciplinary team of specially trained and experienced clinicians, therapists, nursing staff and on-site educators is the **best for sufferers, families, communities AND the government purse**. Professor Patrick McGorry has stated " *youth mental health services would aim to provide an intensive, comprehensive and integrated service response to young people and their families, focused on symptom remission, social and vocational recovery, and relapse prevention*." This is precisely what Barrett provides.

In addition to its other advantages, an extended residential care option provides **respite for a family** whose lives have been severely compromised. This then ensures an environment more conducive to continued progress as the flexibility of the Barrett model leads to part-time inpatient treatment and ultimately only daily attendance. In addition, family members lead more well-adjusted, productive lives themselves.

A facility which houses 10+ patients allows the use of **an extensive multidisciplinary team over an extended period** (available all day every day if required). This not only means that the best progress will be made by patients because of the constant availability of specialised treatment and support, but in the case of Barrett, because of the approach of the team, this has led to the development of a **surrogate family atmosphere which enables young people to observe and form functional relationships**. **The trust on which these are based then provides a foundation for a young person to develop resilience and self-esteem. This environment is a major factor in overcoming** one of the predominating indicators of the severe mental illness that requires the Barrett model of treatment i.e. **long-term disengagement from society.** This occurs as a result of the initial manifestations of many cases of mental illness but evolves into becoming a significant issue in itself with feelings of isolation then exacerbating symptoms to the point that the sufferers feels as if his/her problems are totally unique and that they are beyond help. Acute/community based options rarely have the capacity to address this disengagement – so **severely withdrawn young people will not progress without a Barrett type program**.

Although there is clearly a need for additional local options, Barrett patients have cited that there can actually be advantages to a **NON-localised** facility i.e. **it can act as a circuit breaker for the young person to put an end to the cycle they have been stuck in – one of moving from acute facility to home back to acute facility etc.** In many circumstances, in an all too familiar environment, a young person is **destined to repeat destructive or stagnating patterns of behavior.** So moving to a totally new environment, neighbourhood and living space can not only give them a more conducive setting for understanding their condition and addressing their problems, but it can be a conscious trigger for them to acknowledge that they have NOT progressed in their previous situations and need to now apply themselves as fully as they can because their illness has reached a level that has warranted such a significant change *('Molly' interview on mp3 attests to this)*. In addition, in circumstances where abuse or neglect in the home environment has actually been a significant factor in the mental health issue that young person is suffering, **being away from unsupportive or, in some cases, an abusive home environment** is clearly a positive step and one that is vital if any progress is to be made at all. It should also be noted that the WA Report found that **it was unrealistic to expect specialist services to be available in all regional centres and that it was unavoidable that some specialist care would needed to be provided in major centres**. In fact the Fourth National Mental Health Plan acknowledges

"*it is not possible that uniform service provision exists in every area or across all age groups*" but the aim should be "***for equity of access and quality***."

The importance of the school

The community is unequivocal on the need for any future model to include an on-site school. The current education team are highly skilled and have the strongest commitment to remaining as a group to continue to offer their services as an integral part of the full treatment and rehabilitation program. This is further highlighted, as previously mentioned, by current teaching staff volunteering their time to run the holiday program for inpatients. Having *at least* one centralised facility in the state provides opportunities for the **acquisition of social and life skills as well the learning provided by every school's program and curriculum.** In addition, the school encourages **the adjustment to a more 'normalised' daily routine.** 'Patients' become 'students' away from the ward in an environment that leaves any medical/hospital atmosphere aside and allows interaction and the **development of peer relationships** – a key element of life but quite often something that **young sufferers of severe mental illness have never experienced**. Inpatients live with, attend school and socialise with their peers. In a safe and supportive environment where their peers are often going through similar issues, many young people experience friendship with people their own age for the first time in their lives. If there were only smaller regional facilities, this couldn't be replicated and the environment (with one or two patients and one or two therapists/educators) could *foster* feelings of isolation and difference rather than *engagement* with larger groups and the wider society. In these circumstances, young people would never progress through the socialisation and relationship experiences that shape healthy adult lives and, if they are to deal with severe mental health issues for the rest of their lives (as many of them might have to), those challenges alone are demanding enough. The support of ongoing relationships can be vital in living with mental illness and for young people to move beyond isolation, conflict and reliance on carers, they **MUST have the opportunity to develop peer relationships and the ability to have constructive and mature interactions with a range of people, and from within groups of people**. So the on-site school is essential in providing an environment to nurture the crucial skills for living in a society as well as living with a mental illness. In should noted too, that **for some of these young people, their attendance at school will cease if the new model does not maintain a co-located school** as they will not have attained a level of functioning that would allow them to attend other school options. So sustaining the on-site school in an extended inpatient facility will be vital.

At Barrett, teachers and support staff are experienced in mental health and **the education program is tailored for the needs of inpatients. It enables students to re-connect to and/or maintain their education – an area of their life that often suffers in young people with mental health issues**. Barrett recognises the importance of physical activity in mental health and **incorporates Physical Education in their school program as well as providing other physical activity opportunities when possible**. Access to a Department of Education Guidance Officer – as well as teachers experienced in vocational education – allows the young Barrett residents to explore options beyond school. These can include **further study and employment, engaging in work experience programs and career expos** – all activities which enhance the preparation for a return to the community beyond the Barrett Centre. **Far from being isolated from the general community/society, the young people at Barrett engage in general activities like going to the movies, shopping and other recreational excursions – simple things that many of us take for granted but which have often been absent from the lives of young people suffering with severe mental health issues**.

So Barrett is NOT a place that keeps young sufferers of mental illness from society but brings them back to it. And, in some cases, introduces them to the wider community for the first time in their lives.

IDEAS AND POSITIVES TO CONSIDER IN FUTURE PLANNING

The VALUE of the school economically

Funded and fully backed by Education Queensland (the Barrett Centre School had just passed their quadrennial school review with flying colours last year when the threat of closure become public) with EQ keen for the teaching staff to stay together as a team, this is a proven and funded asset INCLUDING equipment which includes computers and a car for transporting students to external learning opportunities, outside schooling and work experience. The staff are not only experienced in developing teaching opportunities as part of a total treatment program but, in practical terms, they are used to all the aspects of FLEXIBLE learning. The programs, materials and staff are all financed by Education Queensland and **fully supported to relocate as a complete unit to a new location**.

Utilising the Barrett Centre for RESEARCH … an added benefit of sustaining/expanding the Barrett model

The philosophy of 'Together…Toward Recovery' is a fundamental part of the Model of Service Delivery (MOSD) under which The Park at Wacol operates. The Barrett Adolescent Centre is, therefore, run like the The Park's other services – under the Guiding Principles for decision-making which include:

"Evidence based practice: *This refers to seeking to provide interventions that are supported by evidence. It also encompasses an expectation that we will seek to create evidence for our practice through evaluation and research;*

Outcome based services: *The services are committed to being able to demonstrate to individual consumers, service providers and to external agencies that the work undertaken contributes to better outcomes for the people who use the service."*

These two principles form the basis that would allow the expansion of Barrett to incorporate a research and education function. Furthermore, The Fourth National National Mental Health Plan states that "*services should be informed by the available evidence and look to innovative models as examples of service improvement*." Therefore, ***with 30 years of data and information that could be utilised for retrospective studies, Barrett is in a unique position to study a range of aspects of adolescent mental health and mental illness.*** That certainly fits with the guiding principle *'to create evidence for our practice through evaluation and research*' and is consistent with National mental health objectives. With its move to Children's Health Queensland, the research and education function of Barrett would fit well within Children's Health Queensland Strategic Plan, under Strategic Direction 6 i.e. "*excellence in paediatric health care through innovation, research, education and the application of evidence-based practice across daily processes and systems. We will embrace invention and innovation to continually improve the value of our service*."

Study areas could include self-harming, social anxiety (in particular its role in social isolation and exclusion) and benefits to recovery of the 'community' environment created at Barrett. Barrett could link with other institutions/research facilities to become part of larger studies or focus on research in the unique environment – where adolescents engage in a range of activities and environments (including Education) always supervised and observed by staff.

Information gathered from Barrett could be used to inform practice and treatment in many other areas. With such an emphasis on prevention and early intervention in National and State mental healthcare objectives, Barrett could make a valuable contribution by **analysing the circumstances under which adolescents find themselves admitted to Barrett and use this information to develop strategies and processes for prevention, early intervention and even identification of risk factors**. Barrett is also in the unique position of being able to observe **the effects of treatment on and the associated changes that take place in adolescents who transition from full-time inpatient to day patient**. Barrett can continue to monitor the progress of day patients and adjust treatment level and type accordingly. **Observations and knowledge gained from these observations is quite unique and could be applied to a range of treatment settings.**

Introducing promotion and early intervention strategies into schools and training school staff in the identification of students at risk of mental health problems is an avenue for reducing the stigma of mental health issues and increasing the opportunity for early intervention. The Education staff working in the Barrett School possess many years of experience working with adolescents in an education environment. One of the great tragedies, **should Barrett close, is that the collective knowledge and experience of the team will be lost**. With mental health issues so prevalent in adolescence, this expert education team are in a position to be able to document practices and strategies and share this information throughout the state education system – a valuable opportunity that should not be lost. In addition, the teaching group could **link with other organisations** to participate in studies and/or contribute to the community knowledge base of mental health issues in schools. Rivendell School in Concorde West, New South Wales, is jointly run and funded by the Department of Health and Department of Education and Communities. It offers both extended inpatient and day patient programs where clinical staff and educators work collaboratively for positive outcomes in both the mental health and education of the adolescents. The school develops an appropriate program related to the individual needs of the young person, including looking further to training options (e.g. TAFE) if school classes do not meet their needs. It essentially runs in the same way as Barrett – with strong connections between its school and treatment functions. Rivendell runs a mixture of programs, both for day patients and inpatients – in fact the inpatient accommodation is housed in one wing of the building, the school in the other. Like Barrett, there is a heavy focus on links with the community. Rivendell is well supported by both the NSW Health and Education departments.

The Queensland Health Minister, during interviews at the time he announced the closure of Barrett Adolescent Centre, repeatedly claimed Barrett had done a good job over the years. ***Why then, close it?*** **The wealth of knowledge and expertise at Barrett is extremely valuable and it has been a successful facility. Why not build on the important role it has played in treating a unique and specific group of adolescents, whose needs may not be adequately met by community-based models.** It is intended that the Mental Health Commission will "*promote greater use of research and evaluation in service development and delivery*." It is to develop a whole-of-government strategic plan that in part "*drives innovation and best practice through knowledge sharing, research and evidence-based policy and practice*." Barrett *with a research function* would certainly fit within the QMHC framework. Surely there is scope even for Barrett to link with University of Queensland and/or other Tertiary institutions and the Queensland Centre for Mental Health Research? Orygen Youth Health in Victoria very successfully combines a research function with a youth mental health service model and it attracts significant funding for its research into youth mental health issues and service delivery. There is no reason that the Barrett Centre could not be in the same position.

There is considerable research into community based/collaborative models of care and little research on Tier 3 service provision for severe levels of mental illness other than acute care – certainly no research on a unique facility such as Barrett that combines treatment and rehabilitation and education with community connection, from a 'recovery platform'. If Barrett is being closed because of a lack of evidence in contrast to that existing to support community based models of care, that is, in essence, a false premise, as there is **a general lack of any research and any evidence, supportive or otherwise. Can the government guarantee that the recovery and social inclusion for this cohort of youth with severe mental illness will be better under new models of care** – what measures did they use? Does the government know what the rates for re-engagement in education, training, employment and socially are for these young people – how did they measure those? Is the government certain that readmissions and relapses will be reduced under the new model – if so, how did they arrive at these figures? The argument for a new model to replace Barrett must be based on more than just being 'contemporary'. There must be some justification based on outcomes. There is **significant justification** for the existence of Barrett within the National Mental Health Framework and the Fourth National Mental Health Plan. Rather than close in favour of new options, the **government should be valuing the unique resource and knowledge base of Barrett and building on its significant foundations.**

We urge those undertaking the future planning for mental healthcare across Queensland to consider the opportunities that retention of the Barrett Centre affords – not simply in providing the ongoing successful treatment of young suffers of severe mental illness (there is no doubt that that is ample reason for the centre's existence), but as a vital tool in the research that could define future models beyond Queensland and even Australia. To neglect this valuable resource and the role it could play in the future not only ignores the needs of current adolescent suffers of mental illness, but those in the generations to come.

The consumers, carers and the extensive wider Queensland community that supports the incredibly successful work of the Barrett Adolescent Centre in assisting the most 'at-risk' young people in our society to gain an understanding of the mental illness that has reduced their lives to what can only be described as 'hell' are grateful for any opportunity to provide input into the future services that will be offered by the state government in this area. This document – outlining many of the concerns and suggestions of that community – is a representation of the commitment in, and knowledge of, the treatment and rehabilitation needs of that vulnerable group. It is hoped that the Queensland Mental Health Commission, along with the relevant Health Department divisions, the Steering Committees and Expert Panels that will be undertaking governance and future planning for adolescent mental healthcare across Queensland, will not only heed the reactions and ideas contained within this document but seek to explore ways to create an inclusive and collaborative process with all of those with a need for, or an interest in, the Barrett Centre and the future of adolescent mental healthcare in Queensland … with the sole objective of providing the best possible treatment and rehabilitation options for the young people of our state who suffer – along with their families and friends – under the blight of severe mental illness.

Thank you.