



Barrett Adolescent Centre Commission of Inquiry Report

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Barrett Adolescent Centre Commission of Inquiry

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The Honourable Anastacia Palaszcuk MP
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Dear Premier

In accordance with *Commissions of Inquiry Order (No. 4) 2015*, as amended, I present the report of the Barrett Adolescent Centre Commission of Inquiry.

The report is in two volumes.

The first volume addresses matters relating to the decision to close the Barrett Adolescent Centre and systemic issues affecting patients.

My conclusions and recommendations appear in the first volume.

The second volume contains sensitive material relating to patients and waitlist patients, and their medical histories.

To accord proper respect to the legitimate privacy concerns of those adolescents and their families, and to avoid compromising their welfare, I recommend that access to the second volume be strictly limited and controlled.

Yours sincerely

[original signed]

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

Barrett Adolescent Centre Commission of Inquiry

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1 Introduction and context

Introduction

The Barrett Adolescent Centre (BAC) was a public mental health facility which operated between 1983 and January 2014 on the campus of The Park – Centre for Mental Health at Wacol. It provided extended inpatient treatment for adolescents with severe and complex mental illnesses. It had capacity for 15 inpatients, as well as five day patients and a small number of outpatients. There was also a waiting list for admission as inpatients or day patients.

The clinical director of the BAC, a psychiatrist, led a multi-disciplinary team of medical, nursing and allied health staff.

There was an on-site school, the Barrett Adolescent Centre Special School (BACSS) from 1985, operated by the Department of Education.

On 6 August 2013, the then Minister for Health announced that the BAC would close.

Two processes were set in place. The first was to identify appropriate alternative services for the then patients and the second was to develop a new suite of services intended to cater for adolescents with extended treatment needs including for those who might otherwise have been admitted to the BAC. The first process was undertaken by West Moreton Hospital and Health Service (HHS). The second process was led by Children's Health Queensland HHS (CHQ). The extent to which these two processes overlapped (or were thought to overlap) is considered in chapter 26.

This Commission's terms of reference focus on the closure decision and questions relating to the "transition" of the existing patients.

Tragically three young people who had been patients of the BAC at the time of the closure announcement died in 2014 – one in April, one in June and one in August. The Coroner has begun an inquest into the causes of their deaths, which are not within this Commission's remit.

On 14 August 2014, the then Director-General of the Department of Health, Ian Maynard, appointed psychiatrist Beth Kotzé, occupational therapist Tania Skippen and lawyer Kristi Geddes as health services investigators to investigate and report on (among other things) the healthcare transition plans developed for inpatients and day patients of the BAC between 6 August 2013 and its closure in January 2014.¹ The investigators delivered a report entitled 'Transitional Care for Adolescent Patients of the Barrett Adolescent Centre' to the Department of Health on 30 October 2014.

Because of the sensitive and confidential nature of much of the evidence received by the Barrett Adolescent Centre Commission of Inquiry, this report is presented in two volumes. The first concerns matters relating to the closure decision and systemic issues affecting patients. The second relates to matters which cannot be properly addressed without identifying patients and their medical histories, and the Commission recommends that access to that volume be strictly limited and controlled.

Clinical context

The BAC commenced as an adolescent day program in 1983, and admitted its first inpatients about a year later. For more than a decade, it was the only exclusively adolescent mental health facility in Queensland.

When the BAC opened, the only inpatient services then available for children and adolescents were at the Royal Children's Hospital (RCH) and the Mater Children's Hospital. At the RCH, the Courier Ward was opened in 1976. It had six inpatient beds and also outpatient facilities, all catering for persons up to 14 years of age. It was replaced by the Child and Family Therapy Unit (CAFTU) which opened in 1983. It had 12 inpatient beds as well as outpatient and day hospital services for persons up to 14 years of age. The Mater Children's Hospital provided child psychiatry services for persons up to 13 or 14 years from 1966, but these were not in a dedicated unit until the 1990s. The beds at both the RCH and the Mater Children's Hospital were intended for short-term admissions. According to Cary Breakey (the first clinical director of the BAC), adolescents did not fit into these paediatric services; nor was it appropriate that they be treated through adult services.²

A dedicated child and adolescent day program was established at the Mater Children's Hospital in 1989.

The Child and Youth Mental Health Service (CYMHS) was established by Queensland Health in 1996. It provided integrated care across community and hospital settings. A case manager would be appointed for a patient who would then be managed by a multi-disciplinary team. There were various aspects of CYMHS – acute adolescent inpatient units, day programs, and community clinics.

The first acute adolescent inpatient unit was established at Royal Brisbane Hospital in 1996. Units were subsequently established at Logan, Robina/Gold Coast, the Mater Children's Hospital and Toowoomba.³

A day program was started in Toowoomba in 2012, followed by one in Townsville in 2013.

CYMHS established community clinics across Queensland, an e-CYMHS telepsychiatry and clinical outreach service for those in remote parts of the state, and the Maudsley Clinic for adolescents with anorexia nervosa.

The highly regarded Evolve Therapeutic Services were established in 2007 to provide intensive, medium- to long-term mental health support for children and young people in the care of Child Safety Services. These involve a collaborative inter-departmental response by the Department of Communities, Child Safety and Disability Services, Queensland Health and the Department of Education and Training.

The BAC continued to provide day program and inpatient and outpatient services until it closed in 2014.

The National Youth Mental Health Foundation, known as 'headspace', was initiated by the Australian Government in 2006. It provides early intervention mental health services to young people aged 12–25 years, through a network of nearly 100 Headspace centres across Australia, in addition to the eHeadspace online service, a youth psychosis program and the Headspace school support program. These focus on four core streams of: mental health and wellbeing; general health; alcohol and other drug services; and work, school and study services.⁴ Referrals are from a variety of sources, the majority being self-referrals or referrals from family members, general practitioners or schools.⁵

Headspace relies on a number of Australian government funding streams and in-kind contributions by partner organisations.⁶ It contracts agencies to run Headspace centres locally, with lead agencies using a consortium of organisations and professionals including psychologists, psychiatrists, general practitioners, social workers and occupational therapists.⁷ For example, Aftercare, which is the lead agency for four Headspace centres in Queensland (Nundah, Ipswich, Woolloongabba and Meadowbrook), is contracted to manage and deliver services, including human resources, on behalf of Headspace.⁸

The Barrett cohort

The BAC treated an estimated 800 or more young people while Trevor Sadler was its clinical director (1989–2013).⁹ Time and resources did not allow a detailed analysis of the medical records of them all.

From 1996–1997 until the closure, a total of 575 young people were admitted, as shown in Figure 1A. From 2005–06, 178 were admitted, two-thirds of whom were readmitted (Figure 1B).

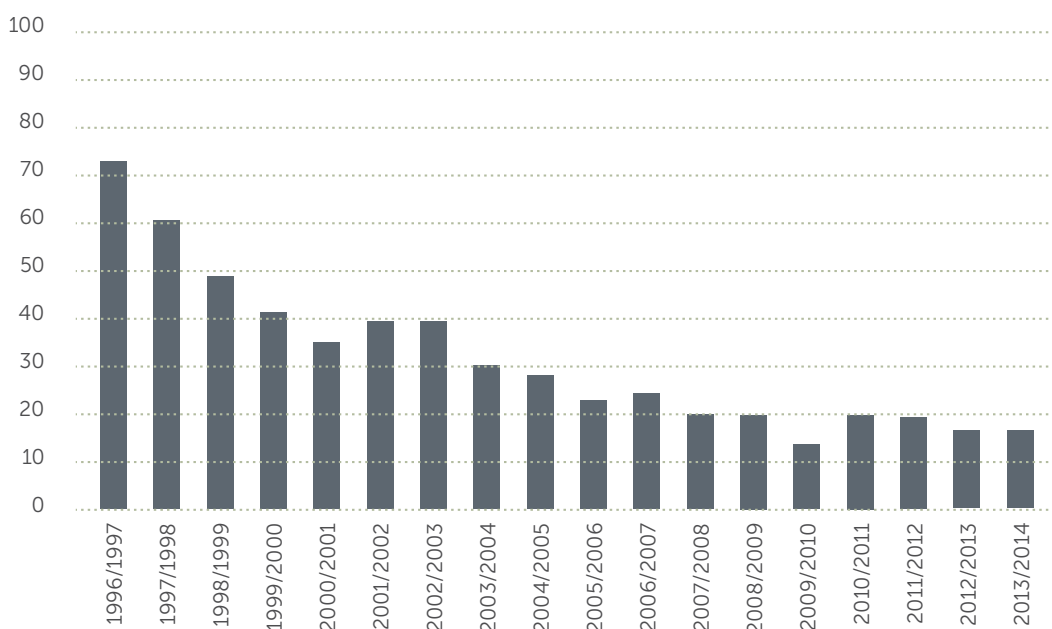


Figure 1A: The number of young people admitted to the BAC (1996–1997 – 2013–2014)

Source: Queensland Hospital Admitted Patient Data Collection (QHAPDC)

Note: These data are inclusive of all same day and overnight separations.



Figure 1B: The number of young people readmitted to the BAC (2005–2006 – 2013–2014)

Source: Queensland Hospital Admitted Patient Data Collection (QHAPDC)

Note: These data are inclusive of all same day and overnight separations.

Sadler's evidence was that the predominant disorders with which young people presented to BAC were severe and persistent:

- a. depression with dissociated self-harm and depression;
- b. anxiety, especially social anxiety disorder;
- c. Post-Traumatic Stress Disorder (PTSD);
- d. eating disorders, both anorexia nervosa and bulimia nervosa; and
- e. severe psychotic disorders.¹⁰

As other services such as acute adolescent inpatient units and community services became available, the BAC experienced a change in its patient cohort. Young people requiring acute admissions were directed to the new acute inpatient units,¹¹ and those at the less severe end of the spectrum were treated in the community, while the BAC admitted young people with increasingly severe and complex mental illnesses who could not otherwise be effectively treated and developed expertise concerning their treatment.¹²

West Moreton HHS and the State of Queensland provided the Commission with a list of the names of **41** young people who were admitted to the BAC as inpatients, outpatients and day patients between 31 October 2012 and January 2014, as well as those who had either been successfully placed on a waiting list or were yet to be placed on the waiting list over that period.¹³ Commission staff reviewed the files of all **41** patients on this list – 14 males and 27 females ranging from 15 years to 19 years old at the time of their discharge. Twenty-six of the 41 were admitted to the BAC – 18 as inpatients, five as day patients and three as outpatients. Of the 15 who were not admitted, eight were assessed but never admitted (including two were refused treatment), and seven were referred but were never assessed for admission.

Counsel Assisting identified 16 patients (some of them admitted before 31 October 2012) as potential *transition clients* within the Terms of Reference (a seventeenth patient was subsequently added to the list of transition clients – see chapter 21) and considered their mental histories prior to their admission.¹⁴ Without taking co-morbidities into account, the following diagnoses were identified from the medical records:

- three cases of [redacted]
- seven cases of [redacted]
- one case of [redacted]
- two cases of [redacted]
- one case of [redacted]
- one case of [redacted]
- one case possibly of [redacted]
- one case of [redacted]
- one case of [redacted]

Prior to their admission to the BAC, these young people had been resistant to treatment at less restrictive levels of care. They included young people who had had multiple admissions to acute mental health units (paediatric, adolescent and adult) and young people who had attended community clinics and other CYMHS services. They had highly individualised combinations of morbidity, co-morbidity, acuity, severity and complexity. They were affected by various combinations of physical ill-health, mental illness, delayed educational development, social incapacity and poor future occupational adaptation. Most had chronic and recurrent high acuity, by virtue of suicidality, self-injury, explosive aggressive behaviour, or incapacity to cope with the vicissitudes of life. Their symptomatology was mostly severe. Their symptoms were sufficiently frequent or intense to cause them severe distress and to cause serious disruption to their families and communities.

In November 2012, Sadler conducted a review of the young people who were admitted to the BAC from 2007 to 2012,¹⁵ which showed that prior to their admission:

- 98 per cent had disengaged from their education networks for at least six months
- 90 per cent had no face-to-face contact with peers, and some had disengaged from their online networks
- 83 per cent had disengaged from community networks – they either did not or rarely went to shops or caught public transport
- 35 per cent had only tenuous family networks – for instance, although the adolescent lived at home, the parents were disengaged, abusive or neglectful
- 12 per cent had been abandoned or removed by family networks
- 55 per cent had adequate family networks – however these families described being under “tremendous strain from needing to support an adolescent with severe mental illness, including sleepless nights, giving up jobs, sometimes severe family conflicts, sometimes fear of the adolescent dying and younger siblings witnessing incidents of self-harm.”¹⁶

Michelle Fryer, the chair of the Queensland Branch of the Faculty of Child and Adolescent Psychiatry within the Royal Australian and New Zealand College of Psychiatrists, described the characteristics of patients who were admitted to the BAC as including severe symptoms that were treatment resistant and associated with severe functional impairment and/or a high level of risk to themselves (and sometimes to others).¹⁷

Statistical context

It is difficult to place the Barrett cohort in statistical context both because limited data is available and because it was such a small and variable cohort.

The estimated resident population of Queensland was 4,651,912 in 2013 and 4,722,447 in 2014. The estimated resident population by age and sex (12–17 years and 18–25 years) was as follows:¹⁸

Year	Male 12–17	Female 12–17	Male 18–25	Female 18–25
2013	185,632	176,780	266,352	258,895
2014	186,600	177,738	269,725	261,352

The second national survey of the mental health and wellbeing of Australian children and adolescents was conducted between 30 May 2013 and 12 April 2014, and published in August 2015.¹⁹ The diagnostic modules from the *Diagnostic Interview Schedule for Children Version IV* (DISC-IV) were used to assess the prevalence of the seven most common and disabling mental disorders in children and young people according to DSM-IV:

- major depressive disorder
- attention deficit/hyperactivity disorder (ADHD)
- conduct disorder
- the four most common anxiety disorders (social phobia, separation anxiety, generalised anxiety and obsessive compulsive disorder), reported as a class.²⁰

The survey did not assess the prevalence of conditions such as post-traumatic stress disorder (PTSD), eating disorders, and psychosis.

Because the survey assessed the prevalence of only seven disorders, its findings:

- underestimate the overall prevalence of mental disorders among children and adolescents (although the underestimation is considered to be small in relation to the overall prevalence)
- underestimate the comorbidity of disorders because some young people who participated may have had other mental disorders not covered in the survey.²¹

The survey used a number of age ranges in reporting its results. The results for those aged 12–17 are mentioned where they are available. The upper and lower limits of the 95% confidence intervals were reported (meaning that there is a 95% probability that a value lies within that range).

The national survey estimated that 14.4% ([12.9, 15.9]) of adolescents aged 12–17 had experienced at least one mental disorder in the 12 months prior to the survey, with comorbidity across conditions. Male adolescents aged 12–17 were more likely than their female counterparts to have experienced mental disorders in the 12 months prior to the survey (15.9% [13.8, 18.1] and 12.8% [10.8, 14.7] respectively).

The table below (Figure 1C) shows the disorders the survey found most commonly suffered by people aged 12–17 years in the previous 12 months.

Disorder	Males 12–17 years (%)	Females 12–17 years (%)	Persons 12–17 years (%)
Anxiety disorders	6.3	7.7	7.0
Major depressive disorder	4.3	5.8	5.0
ADHD	9.8	2.7	6.3
Conduct disorder	2.6	1.6	2.1
Any mental disorder	15.9	12.8	14.4

Figure 1C: Disorders most commonly suffered by 12–17 years in the previous 12 months²²

In comparison with an earlier national survey in 1998,²³ “overall prevalence ha[d] remained relatively stable, with modest declines in prevalence of ADHD and conduct disorder and a modest increase in the prevalence of major depressive disorder”.²⁴

Almost one third (30.0% or 4.2% of all 4–17 year-olds) of children and adolescents with a mental disorder had two or more mental disorders at some time in the 12 months prior to the second national survey.²⁵ A small proportion of children and adolescents (0.4%) experienced three classes of mental disorder (anxiety disorders or major depressive disorder, ADHD and conduct disorder) in the 12 months prior to the survey.²⁶

The report of the second national survey included an estimate of the severity of the impact of the adolescents’ mental disorder symptoms on their functioning across a range of domains,²⁷ including functioning at school, with family and friends, and the personal distress symptoms caused.

The overall severity of the impact on functioning was estimated and a graded response model was used to create a composite impact on function score. This score was standardised with a range from -3.0 to +3.0 where higher scores represent increasing severity of impact on functioning. Those adolescents surveyed were classified into three levels of impact on functioning by applying the National Mental Health Service Planning Standard ratio of severity for mental disorders to the standardised score (1:2:4 for severe, moderate and mild cases). In addition suicide plans or attempts in the past 12 months were considered. The three levels are:

- *Severe*: A positive diagnosis plus an impact score greater than or equal to 1.75 and/or a history of suicide attempt in the 12 months prior to interview
- *Moderate*: A positive diagnosis plus an impact score greater than or equal to 0.95 or a history of suicide plans in the 12 months prior to interview
- *Mild*: All other cases with a positive diagnosis.²⁸

The severity ratings of mental disorders among 12-17 year-olds were as follows: mild (44.1%); moderate (32.8%); severe (23.1%).²⁹ As a proportion of the general population, the same figures for 12-17 year-olds are: mild (6.4%); moderate (4.7%); severe (3.3%). The prevalence of the severity rating varied according to the type of disorder(s) suffered by the young person. Major depressive disorder had a greater impact on functioning than did the other disorders surveyed.

Fryer considered that the BAC patients should not to be equated with the “severe” group in the national survey:³⁰ they were a small sub-group, which she thought likely to be less than 1 per cent of the “severe group” in the national survey.³¹

The BAC model

While it had a number of draft model of service documents, the BAC did not have a formally endorsed model of service.³²

Trevor Sadler, the Clinical Director of BAC between 1989 and 2013, described the model as follows:

BAC provided multiple interventions, engaging the adolescent in the community wherever possible (similar to elements of a community wrap around service), while at the same time providing opportunities for social contact, intensive, integrated therapeutic interventions delivered in conjunction with a rehabilitation program. BAC offered a mix of “in house” interventions, plus exposure to outsourced providers such as going with the group to an outside gym or swimming pool, plus outsourced interventions such as going to an external school.³³

The BAC model of service attracted both praise and criticism. Examples of the praise include:

- The BAC provided a “total ... package”,³⁴ including therapy, counselling, medication, safe accommodation, acute containment when required and education.³⁵
- The staff were able to build long-term therapeutic relationships with the adolescents.³⁶
- The BAC accommodated those adolescents who did not easily fit within other service models.³⁷ It was considered to be the “last resort”.³⁸
- The BAC provided a high degree of staff supervision, making it a relatively safe environment for distressed young people with complex mental health needs.³⁹

Examples of the criticism include:

- The BAC was an institutional style setting that did not provide a contemporary model of care (that is, one close to family, carer and support networks).⁴⁰
- The average length of stay (estimated to be 13 months) was too long.⁴¹
- The BAC was isolated in clinical governance and needed to sit as part of a continuum of care within the broader CYMHS system.⁴²
- The building was old and not purpose built.⁴³
- Treatment and discharge planning and processes were not clearly defined.⁴⁴

Ultimately, the merits (or lack thereof) of the BAC model are beyond the scope of this Inquiry. However, the differing views on the model are relevant in illustrating, among other things, that although the BAC was certainly valued by many patients, families and carers, and staff, it also had its critics. This will be discussed in the sections of the report that deal with the decision to close the BAC, the effect of that decision and the subsequent transition arrangements.

The staff

The clinical director

Cary Breakey was the Medical Director of the BAC from its opening in 1983 until 1989. For the next 25 years (from 1989 until 2013), the Clinical Director was Trevor Sadler, a psychiatrist. Sadler was stood down from this position approximately one month after the closure announcement.

Anne Brennan was the acting Clinical Director of the facility from 11 September 2013 until it closed in January 2014. She oversaw the transition of the patients to alternative care arrangements and the BAC closure.

Allied health and nursing staff

In 1986 the BAC employed 28 nursing staff, six allied health staff and three medical staff.⁴⁵ By October 2012, these numbers had dropped to 20.9 nursing staff, five allied health staff and 1.8 medical staff.⁴⁶ The allied health staff included one full-time equivalent psychologist, one full-time social worker, two full-time occupational therapists, a part-time speech and language pathologist, and a part-time specialist clinical supervisor.⁴⁷

Referral and admission to the BAC

The BAC accepted patients aged 13–17 years at the time of admission. However, patients were permitted to remain after their 18th birthday if their continued admission was likely to produce the best clinical outcome in terms of symptom reduction and developmental progression, and they did not present any risks to the safety of other adolescents in the centre.⁴⁸ Between 2004 and 2009 the mean age of BAC patients was 15.62 years.⁴⁹

Because it was gazetted as an authorised mental health facility, the BAC was able to treat patients on an involuntary basis. Between 2004 and 2009, 39.3 per cent of patients were subject to involuntary treatment orders at some point during their treatment at the BAC.⁵⁰

admitted to the

⁵¹

Referral pathways

The BAC accepted only planned admissions, and not emergency admissions. Referrals were accepted from CYMHS facilities and programs, after consultation with a psychiatrist, and from private child and adolescent psychiatrists.⁵²

Assessing a referral

Sadler's evidence is that there were several stages of assessment for each referral:

1. BAC receipt of referral
2. Initial assessment
3. Review by the BAC multidisciplinary team
4. Interview
5. Intake panel assessment.

The interview stage had two main purposes. First, it allowed detailed clinical assessment of the adolescent with a view to gauging their perceived challenges, level of engagement, how they might adapt to the BAC and how they might affect the particular mix of patients in the

unit. Second, the BAC program and the potential benefits and challenges of the program were explained to the adolescent and their parents/carers who also had the opportunity to ask questions.

Factors considered in assessing a referral

The intake panel considered seven factors in assessing a referral:

1. the adequacy and availability of community treatment with a view to assessing the likelihood of therapeutic gains by admission to the BAC
2. the likelihood of the adolescent experiencing a positive therapeutic outcome
3. the potential for treatment at the BAC to assist with developmental progression
4. the potential adverse impacts on the adolescent being admitted to the BAC
5. the potential adverse impacts posed by the admission of the adolescent on other inpatients and staff
6. the potential adverse interactions with other adolescents
7. the possible safety issues.⁵³

Priority for admission was determined by level of acuity, risk of deterioration, the mix of adolescents within the unit, the potential impact of admission at that time on the adolescent and other patients, length of time on the BAC waiting list, and age at the time of referral.⁵⁴

A core admission criterion was that an adolescent had exhausted community treatment options before being referred to the BAC.⁵⁵ Sadler noted that all BAC patients had received intensive treatment, in community and acute inpatient settings, for 1–4 years prior to admission.⁵⁶

No specific exclusion criteria were identified in the BAC model of service delivery. A draft document Sadler sent to Leanne Geppert⁵⁷ on 16 December 2009 noted that the BAC was not available to adolescents whose primary problems were associated with conduct disorders, substance abuse, intellectual impairment or homelessness, or to adolescents with a history of sexually assaultive behaviour or severe aggression who might pose a danger to others.⁵⁸ This is consistent with Sadler's written evidence that these groups, along with adolescents with a history of frequent absconding or refusal to engage with a therapist, were less likely to benefit from the interventions provided at the BAC.⁵⁹ Finally, Sadler's evidence was that adolescents with "well documented evidence of borderline personality disorder" were not admitted to the BAC.⁶⁰ Sadler's evidence was that:

Diagnostic criteria alone did not distinguish the adolescent who was likely to benefit from admission to BAC. It was the combination of severe and complex mental illness, together with impairment, sometimes family factors, and the potential to benefit from multiple multi modal intensive interventions provided at BAC.⁶¹

Admission

Once the intake panel decided to accept an adolescent, it then decided whether to admit the adolescent to the BAC as an inpatient or a day patient. Suitability for admission as a day patient required consideration of where the adolescent was residing, whether they would be safe at home in the evenings and whether they would likely be motivated to attend the BAC on a daily basis. In addition, a day patient needed access to regular transport to the BAC.⁶² Some adolescents were only admitted as day patients, while others became day patients once they were sufficiently stabilised after a period of inpatient admission.⁶³

Prior to admission, each BAC patient was appointed a care coordinator, typically a member of the nursing staff. The care coordinator would help the adolescent identify and implement goals in their care plan, monitor the adolescent's mental state and level of function, provide detailed reporting to care planning meetings on the adolescent's progress, and eventually facilitate the adolescent's transition and discharge.⁶⁴

The BAC treatment and rehabilitation program

The following description of the BAC program is structured around three broad phases: assessment, treatment and rehabilitation, and planning for discharge and reintegration.

Phase 1: Assessment

The initial phase of treatment involved assessing the nature and course of the adolescent's mental illness, its behavioural manifestations, and its impact on function and development to inform the development of an individualised treatment and rehabilitation "care plan".

The following domains were assessed using a range of standardised and non-standardised assessments within the psychological, occupational therapy, speech therapy and dietetic streams:

- mental illness — nature and course, behavioural manifestations and impact on function and development
- family and carers — family structure and dynamics or, if the adolescent was in care, a history of that care
- development and function — development disorders and their impact, educational and schooling status, function in tasks appropriate to stage of development
- physical health including oral health
- risk screening
- alcohol and drug use.⁶⁵

Some standardised assessments were performed in respect of abilities and characteristics that were unlikely to change, but that had to be accommodated in a rehabilitation program — for example, intelligence and sensory profile. Other standardised assessments allowed for testing at intervals or on discharge to evaluate treatment and rehabilitation. Non-standardised or unstructured assessments included observations of family, parents/carers, peer interactions and general behaviour.⁶⁶

Phase 2: Treatment and rehabilitation

The BAC aimed to stabilise and treat the symptoms of mental illness using "direct applications, adaptations and modifications of recognised pharmacological, family and psychological interventions".⁶⁷ It also aimed to promote developmental progress through a range of psychosocial, education and vocational rehabilitation programs.

There were five broad types of interventions used at the BAC; these could be delivered at the individual, family or group level:

- pharmacological
- psychological
- family therapy
- rehabilitation interventions targeting tasks of adolescent development
- other interventions such as sensory modulation.

Pharmacological interventions

Pharmacological interventions included psychotropic medications prescribed by the consultant psychiatrist and administered by nursing staff consistent with Queensland Health policies and guidelines. Non-psychotropic medications, including medications for general health, were administered under medical supervision.

Psychological interventions

There were three categories of psychological interventions: psychotherapeutic, behavioural and psycho-educational. According to Sadler, evidence-based psychological interventions sometimes had to be modified or adapted for BAC patients, including:

- treating one of the co-morbid disorders to a certain stage before treatment of another disorder could commence
- allowing progress in a developmental task to be consolidated before individual treatment could continue
- timing individual therapy and family therapy according to the issues raised and the adolescent's capacity to participate in family therapy
- interrupting more formal therapy for a particular disorder to explore the current emotions around the dynamics of BAC.⁶⁸

Family interventions

Family therapy is designed to provide support to the family/carer and to improve family functioning. According to Sadler, Breakey originally "established BAC with family therapy as an integral part of the process".⁶⁹ However, Sadler and Breakey acknowledged family interventions as an area of weakness, with the BAC not having a dedicated family therapist position.⁷⁰ Family therapy was typically provided by David Ward, the BAC's social worker, along with the case coordinator and sometimes the psychiatric registrar. Sadler's evidence is that providing family therapy at the BAC became a significant challenge after Ward left the BAC in 2013.⁷¹

Rehabilitation interventions targeting tasks of adolescent development

Sadler's evidence is that a rehabilitation model – one that focused on psychosocial, educational and vocational programs to promote appropriate adolescent development – was integral to the BAC from its establishment.⁷² Most BAC patients presented with severe psychosocial impairment as a result of their mental illnesses, often complicated by developmental co-morbidities.⁷³

Rehabilitation interventions included a range of school, individual and group interventions designed to address developmental delays and moratoriums, and to facilitate tasks of adolescent development, including skills for independent living. There was a range of structured interventions such as the school program, cooking and social skills groups, and planned physical activities including group activities. Unstructured activities during the evenings and on weekends provided opportunities for patients to develop peer relationships, interact socially and explore ways to occupy leisure time.⁷⁴

The on-site BAC school was integral to the rehabilitation model providing education, vocational preparation and peer group experiences. Personal educational plans were tailored for all BAC patients. According to Deborah Rankin (acting principal of the on-site school from 21 October 2013 to 3 December 2013), plans were "developed for each student, informed by observation and interactions with the student, and intended to enable the student to engage in learning".⁷⁵ The BAC school is discussed in more detail in chapter 29.

Other interventions

Other interventions were used as and when required.

The BAC had a multisensory room containing different lighting, aromas and tactile experiences (for example, bean bags and cushions). This was used by patients to “modulate distress” if, for example, they “felt themselves about to dissociate” or wanting to self-harm.⁷⁶

A de-escalation suite, also known the ‘blue room or the high dependency unit’ provided BAC patients a safe place to be if they were experiencing emotional dis-regulation.⁷⁷ Sadler explained in his written evidence that it “offered a quieter, safer area” when needed.⁷⁸

Individualised treatment and rehabilitation plans

The available treatment and rehabilitation interventions were tailored according to individual need. Some interventions were specific to particular disorders and patients while others were relevant across disorders and were delivered in group format. All BAC patients attended the BAC school, participated in a weekly dialectical behavioural therapy group, and participated in structured group activities such as community access, cooking group, social skills group, a landscaping program and health and physical activity classes.

According to Sadler, there was also provision for a range of unstructured activities after school, “because this is typical adolescent leisure time”.⁷⁹ These included watching television, playing music, playing table tennis or other games, going for a walk, or talking with other adolescents or staff. Day patients were sometimes allowed to stay at the BAC until after dinner, but they were not allowed in the inpatient sleeping areas.⁸⁰

Sadler described a range of “generic” interventions associated with day-to-day living or attendance at the BAC that were integral to the treatment and rehabilitation program. Patients were required to tidy their room space daily, assist with the breakfast tidying up and ready themselves for school. There were also rules that all patients were required to observe, some absolute and some “framed within the broad principles of ‘respect yourself, respect others, respect your property, and respect other people’s property’”.⁸¹ Shared dormitory accommodation had significant therapeutic disadvantages, but also required adolescents to consider and respect others and set boundaries in their interactions with others.

Sadler’s evidence is that the BAC community environment was one of the strengths of the program:

It provided an environment of a small group of adolescents who had in common, difficulties with some type of mental illness. It allowed the anxious adolescent to desensitise to peers, it facilitated interactions between adolescents, it fostered cooperation and learning experiences and it provided exposure to a range of experiences for the adolescents to promote their development and wellness.⁸²

In summary, Figure 1D provides an overview of the individual, group and generic interventions used at the BAC.

INDIVIDUALISED INTERVENTIONS

- Psychological verbal therapies, such as cognitive therapy, dialectical behaviour therapy (DBT) and trauma counselling
- Psychological non-verbal therapies, such sandplay, art and music therapies
- Pharmacotherapy
- Family therapy and education
- Behavioural programs (including restraint and seclusion; time-out and quiet rooms)
- Maintaining safety and wellbeing consistent with least restrictive practice, including visual observations where necessary
- Other biological interventions, such as ECT and surgery.

INTERVENTIONS DELIVERED IN GROUPS

- Individual education plans delivered by the BAC school
- Predominantly activity-based group programs tailored to the group, including health and fitness exercise, cooking group, healthy living, community access and socialisation group, adventure therapy camps and psycho-education programs.

GROUP INTERVENTIONS

- Maintaining a milieu with professional staff reflecting qualities consistent with longitudinal studies of optimal parenting
- Forming strong positive therapeutic alliances with the majority of staff
- Providing opportunities for activities of daily living, leisure, social interaction and personal privacy.

Figure 1D: Summary of interventions used at the BAC

Phase 3: Planning for discharge and reintegration

According to Sadler, from the time of admission, the objective was to move patients back into the community if possible. Transition could involve multiple processes, and its planning and implementation were often interlinked processes initiated and monitored in case conferences and/or care planning workups. There was no formal documentation about transition at the

BAC, and the time it took varied from patient to patient according to individual needs and circumstances. Most commonly, patients were discharged when they could access community services without support from the BAC, and their ongoing clinical care was transferred to another service provider. In the course of transition some patients changed from being inpatients to being day patients. In very rare cases, patients were discharged as inpatients or day patients, but continued as outpatients at the BAC.⁸³

Criticisms of the BAC model of care

The BAC was criticised for not operating a contemporary model of care.⁸⁴ Inquiry witnesses described a contemporary model of care as one that conforms and takes into account statewide, national and international planning frameworks,⁸⁵ links to other services,⁸⁶ is “wholly and comprehensively integrated with the rest of the continuum of care,”⁸⁷ “modern” and in keeping with “currently understood standards and evidence”.⁸⁸ Some of the criticisms about BAC not operating a contemporary model of care include the following:

- Service evaluations and research were not regularly undertaken.
- Evidence-based treatments and therapies were not employed.
- The clinical model did not align with recognised policies and frameworks.
- The service was not integrated with other mental health services.
- The length of stay for BAC patients was increasing over time.
- BAC patients were at risk of institutionalisation and dislocation.
- The BAC facilities were not purpose built and were outdated.
- There had been an erosion of permanent and experienced BAC staff.

Service evaluations and research were not regularly undertaken

The BAC was criticised for not routinely conducting service evaluations or research about its treatment outcomes and effectiveness of its model of care.⁸⁹ Criticism was levied, too, at the quality of the research that was undertaken.⁹⁰ Despite Sadler’s saying there was an expectation of “ongoing research or outcome evaluations”,⁹¹ the BAC’s “capacity to do research was really quite limited”⁹² due to limited funding and staffing issues.⁹³ Brett McDermott⁹⁴ told the Commission that Queensland and more broadly Australia has “an extremely poor record in effective evaluation”.⁹⁵ The lack of service evaluation is a complex issue, not specific to the BAC, but affecting the wider mental health service community.⁹⁶ Given the complexity of the BAC cohort, it is “difficult to research the population as a group”.⁹⁷ Kotzé agreed that despite the BAC “collecting the so-called mandatory outcome measures”, she was unaware whether it was “systematically ... analysing and reviewing those”.⁹⁸ However, she pointed out that this was “to be expected for an inpatient unit” and “they were not evaluating outcomes over time once the young person had been discharged, and that’s the common situation for acute or inpatient units”.⁹⁹

Evidence-based treatment and therapies were not used

One of the criticisms of the BAC model was that it did not use contemporary evidence-based treatment and therapy approaches. Scott Harden¹⁰⁰ opined that “the BAC model of care and treatment was an appropriate one when the unit was opened” but that it had “ceased being consistent with best practice approaches to such treatment probably two decades ago”.¹⁰¹

There was criticism of the lack of family therapy at the BAC.¹⁰² This weakness has been discussed above under *Phase 2: Treatment and rehabilitation*.

Other therapies were also criticised. For example, concerns about the BAC's use of milieu therapy and adventure therapy were raised in the '2016 Statewide Sub-Acute Beds Discussion paper'¹⁰³ despite Sadler's having already addressed those criticisms.¹⁰⁴ Many evidence-based interventions needed to be tailored or modified for individual BAC patients.¹⁰⁵

The model did not align with recognised policies and frameworks

The BAC model of care was criticised for not being in alignment with national policies and frameworks.¹⁰⁶ Kotzé considered the BAC model not contemporary because it did not align with the *National Mental Health Service Planning Framework* (NMHPSF).¹⁰⁷ While arguing that "[m]uch of the policy documentation relating to child and youth mental health has no direct impact on facilities such as the BAC",¹⁰⁸ McDermott gave evidence that there were national and state principles relevant to an appropriate model of care for the BAC cohort:

The most relevant, in my opinion, are the delivery of least restrictive care, access to services close to home, the overarching child and youth principle of developmentally appropriate services (that encourage normalisation rather than pathology), and a commitment to service evaluation.¹⁰⁹

The service was not integrated with other mental health services

Some witnesses argued that multiagency disconnection and lack of integration with other mental health services contributed to a young person's protracted length of stay at the BAC.¹¹⁰ It was criticised for not integrating with local services and broader Child and Youth Mental Health Services.¹¹¹ Breakey argued that had the BAC been better supported from a systemic point of view (for example, better support from other services), young people may have been able to have shorter lengths of stay.¹¹² Sadler argued that the "lack of accommodation or step down facilities" for BAC patients was a barrier to service delivery.¹¹³

Increasing length of stay

Length of stay had "been a criticism for a quite a few years".¹¹⁴ Some witnesses were critical of BAC patients "staying too long"¹¹⁵ and were concerned that the average (mean) time period had risen over the years.¹¹⁶ Various length of stay figures are quoted, some conflicting. For example, the '2009 Review of the Barrett Adolescent Centre report, stated the average length of stay at the BAC "has risen from four months in 1994 to ten months in 2006".¹¹⁷ In response to that report, Sadler stated the 2006 figure as being eight months, not ten months.¹¹⁸ From an examination of the oral evidence and written submissions, it does not appear that anyone refuted that the length of stay had increased over the years.

An adolescent's diagnosis and the type of therapy required were argued to be a strong indicator of increasing lengths of stay (for example, young people with emerging personality disorders, complex and severe diagnoses, entrenched pathology or in need of having their medications stabilised).¹¹⁹

Length of stay was also influenced by systemic factors such as staffing stability, lack of family therapy and problems in finding appropriate alternative care and accommodation for young people.¹²⁰ Patrick McGorry suggested that although people may have been “critical ... about the lengths of stay but you just look at what else would’ve been possible for them and [it was] very little”.¹²¹

BAC patients were at risk of institutionalisation and dislocation

Risk of institutionalisation was another criticism of the BAC model of care.¹²² As Fryer said, “longer lengths of stay carry risks of institutionalisation and iatrogenic increase in disability”.¹²³ The length of stay at the BAC was a contentious issue and was seen to be one “of the features of institutionalisation”.¹²⁴

On the other hand, McDermott argued there was a lack of evidence of institutionalisation effects on the Barrett cohort:

Now, in places like – in, for instances, the Barrett – and again, this is a non-evidence-based comment because we don’t have the data – but I would be concerned that if you had, for instance, regressed behaviour and people were doing things for you, you might learn regressed behaviour.¹²⁵

There was criticism that the BAC model put young people at risk of dislocation from their families, communities and home. Harden’s opinion was that “[b]ecause of its geographic location and model of care it required young people to be dislocated from their communities of origin, often for prolonged periods of time”.¹²⁶

The BAC infrastructure was not purpose built and was outdated

The BAC building was heavily criticised for being outdated, old, in deteriorating condition and generally not suitable for young people.¹²⁷ It was widely acknowledged that the building was not purpose built when the BAC opened in 1983/84. From as early as 1997 (around the first time the BAC was threatened with closure), the buildings were considered to be in a dilapidated state¹²⁸ and were deteriorating.¹²⁹ Sadler described them as “ancient in terms of current mental health facilities in Queensland”.¹³⁰ There was a lack of privacy for patients who had to share rooms, leading to issues of bullying and disrupted sleep.¹³¹ The layout of the building was problematic – the treatment rooms were considered too small, hard walls and protruding edges in the time out room presented risks, and there was no dedicated visitors’ room.¹³² The BAC facilities needed repair, refurbishment or replacement for many years prior to its closure. Lesley van Schoubroek (Queensland Mental Health Commissioner) noted “that the facility was rundown” when she was shown around in February 2014.¹³³

Erosion of permanent and experienced BAC staff

The erosion of the permanent and experienced staffing profile at the BAC was criticised, particularly by those who worked there.¹³⁴ Sadler was critical of understaffing, and explained that he often had to rely on masters and doctoral level psychology students to provide interventions to BAC patients.¹³⁵ Other BAC staff were critical of the erosion of highly experienced skill set, the reluctance to recruit permanent staff to fill vacant positions, the lack of nursing leadership and the over reliance on casual staff whose skill set was sometimes lacking.¹³⁶ These issues are addressed in more detail in chapter 23.

On-site school

The importance of education for adolescents with severe mental health issues

It is well recognised that education is an essential part of life for young people. For some young people suffering from severe and complex mental health disorders, access to education is interrupted by their illness. The stark reality is that the mainstream education system is often unable to meet their individual needs. For many of them, their best chance of returning to a normal life depends on participation in some form of education.¹³⁷

According to Philip Hazell, who is the Director of the Thomas Walker Hospital (Rivendell) Child, Adolescent and Family Mental Health Services in New South Wales, the best model of care and system of care for adolescents “builds in components that ensure the maintenance of patient physical and dental health and optimises education”.¹³⁸

This view is supported by many other experts who gave oral and written evidence to the Commission, including Kotzé¹³⁹ and David Ward,¹⁴⁰ a former social worker at the BAC.

A former BACSS principal Kevin Rodgers explained:

[The] school was very therapeutic... These were very damaged students in many parts of their life but for some of them school was still an okay part of their life, and so it was a way that they could see that part of them was okay while the therapists and other people worked with other parts, so it was very important to have that as part of the school. The other aspect of that was that the adolescents were too unwell to attend schools generally outside of the facility that they were in.¹⁴¹

Even students who were acutely unwell ...

[Redacted text block]

[Y]ou always work with the principle of least restrictive environment, so where adolescents could, we wouldn't want them to be at our school, we'd want them to be at local schools or attending education programs at TAFE or outside the centre. But... certainly it's a normalising experience for them to come to school and ... makes part of them feel that, okay, well, I've got lots of these parts of me that aren't okay, but ... I'm okay at school. Another thing I do want to mention that I haven't been able to yet is about ... one of the things that we really tried to do was to promote mindfulness with the kids, that it was part of the dialectic behaviour therapy, but we understood that ... with kids with post-traumatic stress disorder, they were concerned about past experience. For those who have anxiety they're worried about future experience. So if you can provide activities in a school that ... put them in the place of now and not worry about the future and the past, that is very therapeutic.¹⁴³

Rodgers' evidence is supported by Anne Reddie, who is the principal of Rivendell School, which provides on-site education for patients of the Walker and Rivendell adolescent units at the Concord Centre for Mental Health in New South Wales. She spoke of the importance of an on-site school as a means of encouraging adolescents to get out of the mindset of 'being sick'. Going to school is a typical teenage experience. Attendance at school by adolescents who have a mental illness allows them to maintain some semblance of normality.¹⁴⁴

The BACSS had two types of patients, namely inpatients of the BAC and day patients of the BAC.¹⁴⁵ It catered both for students who had not had any school engagement for a number of years and for those who were completing their QCS and applying for university positions.¹⁴⁶

All of the teachers employed at the school were S1 rated teachers.¹⁴⁷ Some had specialist skills in music or art.

Staff and physical amenities

The school was located in a pre-existing building adjacent to the BAC accommodation. It had three classrooms and each class had a form teacher. There were 5.6 full-time equivalent staff with 100 hours of teacher's aide time. School started at 9:30 am and finished at 3:30 pm.

There were four to five breaks throughout the school day including morning and afternoon tea and lunch.¹⁴⁸

As well as the three classrooms, the school had an indoor staff kitchen, an outdoor kitchen, a special outdoor art area and a separate office and administration area. In each of the classrooms, the students had access to computers, whiteboards and other school resources. The school established a garden where students planted and took individual responsibility for plants. The garden served also as a kitchen garden, and the herbs and vegetables were used in the Food Technology (Home Economics) classes.

Multi-disciplinary approach at BAC

The multi-disciplinary team approach to the treatment of the young people at the BAC was reflected in the level of interaction between the clinical and teaching staff. Each morning between 9:00 am and 9:30 am there was a meeting attended by both clinical and education staff when the clinical staff informed the education staff of any incidents that had occurred during the night which might impact on the behaviour of a young person during the day.¹⁴⁹ The clinical staff provided teachers with other relevant information such as whether a young person's medication had been altered and whether that might affect their capacity at school that day. They made the teachers fully aware of the mood and state the young people were in, whether they were well enough to attend school that day and what adjustments or allowances should be made for them in light of issues that had arisen overnight.¹⁵⁰ At the end of the school day, the education staff would inform the clinical staff of any issues concerning the young people before they returned to the BAC in the afternoon.¹⁵¹

There was also a weekly meeting of the clinical and allied health staff, a school teacher and the school principal when each patient's progress and status were examined in detail.

The education staff recorded educational updates on the clinical records located at the nurses' station in the ward. Information such as how the students coped and behaved on school excursions or any incidents that may have taken place during the school day were documented. In addition, education staff maintained up to date student files which included reports from allied health providers such as speech therapists and dieticians.¹⁵²

Syllabus

The principal of the school interviewed new students to obtain an understanding of their educational background including their results from previous schools and reports prepared by previous guidance officers. He had access to the students' clinical records. He used all of this information to assess how to best manage their educational needs.¹⁵³

Students were provided with an education program known as a 'Personal Education Plan' or PEP, which was tailored to their individual needs.¹⁵⁴ The PEP was developed in consultation with the teaching and support staff and the students' families or carers.¹⁵⁵ Alternatively, students had the option of working through programs provided by their base schools.¹⁵⁶

The subjects offered at BACSS included English, Physical Education, Food Technology (Home Economics), French, History, Mathematics, Life Skills and Drama. The school also had a work experience program and a 'Smart Moves' program which included exercise in the curriculum to increase the wellbeing of the students. At the start of each school day, students were encouraged to participate in some form of exercise such as walking, playing handball, skipping, completing an obstacle course, playing cricket, bicycle riding and others.¹⁵⁷ They were given opportunities to pursue their interests or keep up with activities they had been involved in at their previous schools.

Assessments and reports

The parents or families of BACSS students were encouraged to participate in school activities. Though geographic limitations often made this difficult, video conferencing facilities were utilised to enable both staff and students of the school to interact with the parents.¹⁵⁸ The school held concerts which students' families were invited to attend, as well as parent evenings which typically included a discussion on education as well as mental health issues.¹⁵⁹

Every six months reports were prepared and sent to parents who could arrange to meet with teachers.

A formal assessment of a student's level of attainment was provided by the School of Distance Education or TAFE for students enrolled in courses with those institutions. The teachers also assessed each student's current educational level based on a range of interactions including classroom observations, diagnostic assessments and formative assessments.

It was often possible to facilitate the students' return to their base schools. Some adolescents commenced their transition by attending their base schools two days per week while remaining at the BACSS on the other days. Sometimes transition was completed in time for an adolescent to enjoy a grade 11 and 12 high school experience.¹⁶⁰

(Endnotes

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- 31 Exhibit 288, Supplementary submission from Royal Australian and New Zealand College of Psychiatrists, 10 March 2016, p 1.
- 32 Transcript, Trevor Sadler, 1 March 2016, p 17-9 lines 17–30; Submissions of West Moreton Hospital and Health Service, para 6.1. Exhibit 189, Second supplementary statement of Trevor Sadler, 17 February 2016, p 2 para 5, did provide 12 drafts of the BAC model.
- 33 Exhibit 179, Supplementary statement of Trevor Sadler, 12 February 2016, p 14 para 65.
- 34 Transcript, closed hearing.
- 35 Confidential exhibit.
- 36 Confidential exhibit.
- 37 Exhibit 179, Supplementary statement of Trevor Sadler, 12 February 2016, p 42 para 177.

- 38 Confidential exhibit.
- 39 Transcript, Angela Clarke, 29 February 2016, p 16-29 lines 7–18.
- 40 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, p 9 para 40; Exhibit 1105, Queensland Health, Mental Health Unit, Internal Report: Child and Youth Mental Health: Beds, November 2003, p 10.
- 41 This figure is calculated on the 41 patients referred to by Counsel Assisting in the Opening Statements.
- 42 Exhibit 72, Statement of Judith Krause, 26 November 2015, Attachment W to that statement, Minutes of Meeting to Review Model of Service Delivery (MOSD), for Adolescent Integrated Treatment and Rehabilitation Centre (AITRC), Queensland Health, 10 February 2010, pp 445–460.
- 43 Transcript, Sharon Kelly, 22 February 2016, p 11-12 lines 26–29; Transcript, Anthony O’Connell, 23 February 2016, p 12-17 lines 25–27; “The BAC building was not purpose built, was effectively past its useful life, which necessitated ongoing patient management techniques to compensate for these shortcomings”; Submission on behalf of West Moreton HHS and Board, 23 March 2016, p 19 para 6.5.
- 44 Exhibit 189, Second supplementary statement of Trevor Sadler, 17 February 2016, Attachment A to that statement pp 5–207; Exhibit 72, Statement of Judith Krause, 26 November 2015, Attachment Y to that statement pp 458–505.
- 45 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 13 para 58.
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- 48 Exhibit 189, Second supplementary statement of Trevor Sadler, 17 February 2016, Attachment A to that statement, Model of service delivery dated 20 May 2012, p 179.
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- 50 Exhibit 189, Second supplementary statement of Trevor Sadler, 17 February 2016, Attachment A to that statement, Model of service delivery, dated 30 June 2009, p 36.
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- 57 Then the Director Planning and Partnerships, MHAODB.
- 58 Exhibit 1326, Email from Trevor Sadler to Leanne Geppert, Subject: “First two sections of MOSD”, 16 December 2009; Exhibit 1327, Adolescent Integrated Treatment and Rehabilitation Centre – Model of Service Guideline, undated.
- 59 Exhibit 179, Supplementary statement of Trevor Sadler, 12 February 2016, p 29 para 123.
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- 63 Exhibit 1372, Letter from Judi Krause to David Crompton enclosing draft Model of Service Delivery (MOSD) for the Adolescent Extended Treatment and Rehabilitation Centre (AETRC), dated 4 March 2010.
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- 68 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 23 para 118(a)-(d).
- 69 Exhibit 179, Supplementary statement of Trevor Sadler, 12 February 2016, p 24 para 107.
- 70 Exhibit 172, Supplementary statement of Cary Breakey, 9 February 2016, p 5 para 19.
- 71 Exhibit 179, Supplementary statement of Trevor Sadler, 12 February 2016, p 25 para 110.
- 72 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 24 para 117.
- 73 Exhibit 189, Second supplementary statement of Trevor Sadler, 17 February 2016, Attachment A to that statement, Model of service delivery, dated 30 June 2009, p 35.

- 74 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 24 paras 121–122.
- 75 Exhibit 106, Statement of Deborah Rankin, 11 October 2015, p 10 para 41.
- 76 Exhibit 179, Supplementary statement of Trevor Sadler, 12 February 2016, p 33 para 145.
- 77 Exhibit 179, Supplementary statement of Trevor Sadler, 12 February 2016, p 8 para 30.
- 78 Exhibit 179, Supplementary statement of Trevor Sadler, 12 February 2016, p 8 para 30.
- 79 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 22 para 110.
- 80 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 21 para 109.
- 81 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 22 para 111.
- 82 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 21 para 108.
- 83 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, pp 27–30 paras 139–155.
- 84 Transcript, William Kingswell, 24 February 2016, p 13-64 line 32; Exhibit 49, Statement of Lesley Dwyer, p 20 para 11.4(a); Transcript, Beth Kotzé, 9 March 2016, p 23-5 line 16; Transcript, Leanne Geppert, 19 February 2016, p 10-15 lines 1–2.
- 85 Transcript, Philip Hazell, 17 February 2016, p 8-36 lines 36–38; Transcript, Leanne Geppert, 19 February 2016, p 10-12 lines 4–5.
- 86 Transcript, Leanne Geppert, 19 February 2016, p 10-12 line 12.
- 87 Transcript, Leanne Geppert, 19 February 2016, p 10-12 lines 10–11.
- 88 Transcript, Beth Kotzé, 9 March 2016, p 23-5 lines 1–2.
- 89 Exhibit 68, Statement of William Kingswell, 21 October 2015, Attachment 7 to that statement, 2009 Review of the Barrett Adolescent Centre, p 170.
- 90 Transcript, Brett McDermott, 16 February 2016, p 7-63 lines 3–5 and p 7-69 lines 1–8.
- 91 Transcript, Trevor Sadler, 1 March 2016, p 17-37 line 24.
- 92 Transcript, Trevor Sadler, 1 March 2016, p 17-37 lines 26–27.
- 93 Transcript, Trevor Sadler, 1 March 2016, p 17-37 line 37.
- 94 Executive Director, Child and Youth Mental Health Services (CYMHS), Mater Health Service, at the time of the BAC closure; currently Professor of Psychiatry, James Cook University.
- 95 Transcript, Brett McDermott, 16 February 2016, p 7-47 lines 28–29.
- 96 Transcript, Patrick McGorry, 2 March 2016, p 18-4 lines 31–39.
- 97 Exhibit 172, Supplementary statement of Cary Breakey, 9 February 2016, p 3 para 14.
- 98 Transcript, Beth Kotzé, 9 March 2016, p 23-15 lines 27–29.
- 99 Transcript, Beth Kotzé, 9 March 2016, p 23-15 lines 29–31.
- 100 Medical Director, Forensic Adolescent Mental Health Alcohol and Other Drugs Program, CYMHS, CHQ.
- 101 Exhibit 60, Statement of Scott Harden, 10 February 2016, p 6 para 16.
- 102 Exhibit 29, Statement of Anne Brennan, 27 January 2016, p 4 para 4; Exhibit 84, Statement of Brett McDermott, 10 November 2015, BMCM-2 to that statement, Consultation on Aggression and Violence at the BAC, pp 62–110 para 4.4; Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 27 para 136(e).
- 103 Exhibit 123, Statement of Stephen Stathis, 15 January 2016, p 4 para 12; Exhibit 68, Statement of William Kingswell, 21 October 2015, 2009 Review of the Barrett Adolescent Centre, pp 170–229. (Trevor Sadler's response to the 2009 *Review of Barrett Adolescent Centre report* was that the BAC was not utilising this therapy in the way that the reviewers assumed it was).
- 104 Exhibit 68, Statement of William Kingswell, 21 October 2015, Attachment 2009 Review of the Barrett Adolescent Centre, p 171.
- 105 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 34 paras 172–173.
- 106 Exhibit 72, Statement of Judith Krause, 26 November 2015, Attachment W to that statement, 'Summary of Issues to consider when reviewing the Model of Service Delivery for Barrett Adolescent Centre (BAC)' attached to Meeting to Review Model of Service Delivery, 10 February 2010, pp 455–460.
- 107 Transcript, Beth Kotzé, 9 March 2016, p 23-45 lines 17–20. A specific example of the 'lack of alignment' criticism relates to young people with emerging Borderline Personality Disorder and eating disorders. Beth Kotzé's evidence was that "long-term inpatient care for eating disorders" and for "borderline personality disorder" was not documented in the NHMSPF, despite the BAC cohort having such patients with these diagnoses. See Transcript, Beth Kotzé, 9 March 2016, p 23-45 lines 11–17.
- 108 Exhibit 84, Statement of Brett McDermott, 11 November 2015, p 30 para 167.
- 109 Exhibit 84, Statement of Brett McDermott, 11 November 2015, p 30 para 167.

- 110 Transcript, Angela Clarke, 29 February 2016, p 16-30 lines 30–34.
- 111 Exhibit 72, Statement of Judith Krause, 26 November 2015, Attachment W to that statement, Minutes of Meeting to Review Model of Service Delivery (MOSD), for Adolescent Integrated Treatment and Rehabilitation Centre (AITRC), Queensland Health, 10 February 2010, pp 455–460.
- 112 Exhibit 172, Supplementary statement of Cary Breakey, 9 February 2016, p 6 para 27.
- 113 Transcript, Trevor Sadler, 10 March 2016, p 24-6 lines 6–10.
- 114 Transcript, Cary Breakey, 15 February 2016, p 6-38 lines 11–12.
- 115 Exhibit 172, Supplementary statement of Cary Breakey, 9 February 2016, p 5 para 22.
- 116 Transcript, Angela Clarke, 29 February 2016, p 16-30 line 17; Exhibit 29, Statement of Anne Brennan, 27 January 2016, p 3 para 3(b); Transcript, Stephen Stathis, 10 March 2016, p 24-82 lines 6–7; Transcript, Cary Breakey, 15 February 2016, p 6-38 lines 10–12.
- 117 Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment J to that statement, 2009 Review of Barrett Adolescent Centre (Final Report), pp 576–593.
- 118 Exhibit 976, Memorandum from Trevor Sadler to Shirley Wigan and others, Subject: "Response to the 2009 Review of Barrett Adolescent Centre by Gary Walter, Martin Baker and Michelle George", 6 May 2010. See also evidence regarding conflicting length of stay figures in Transcript, Lesley Dwyer, 23 February 2016, p 12-121 lines 29–32; Transcript, Lesley Dwyer, 23 February 2016, p 12-96 lines 39–40; Transcript, Stephen Stathis, 10 March 2016, p 24-61 lines 10–11; Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 26 para 136.
- 119 Transcript, Cary Breakey, 15 February 2016, p 6-38 lines 13–14; Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 55 para 264; Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment J to that statement, 2009 Review of Barrett Adolescent Centre (Final Report), pp 576–593; Transcript, Anne Brennan, 4 March 2016, p 20-33 line 16; Transcript, David Ward, 15 February 2016, p 6-57 lines 27–28; Transcript, Beth Kotzé, 9 March 2016, p 23-45 lines 3–8; Transcript, Philip Hazell, 17 February 2016, p 8-44 lines 41–43.
- 120 Exhibit 179, Statement of Trevor Sadler, 12 February 2016, p 24 para 106; Transcript, Trevor Sadler, 1 March 2016, p 17-60 lines 45–46; Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 26 para 136(b); Transcript, David Ward, 15 February 2016, p 6-57 lines 38–39; Transcript, Cary Breakey, 15 February 2016, p 6-38 lines 18–19; Transcript, Patrick McGorry, 2 March 2016, p 18-6 lines 14–16.
- 121 Transcript, Patrick McGorry, 2 March 2016, p 18-6 lines 24–25.
- 122 Exhibit 255, Statement of Myfanwy Pitcher, 25 February 2016, p 20 para 121; Transcript, William Kingswell, 24 February 2016, p 13-64 lines 30–32; Transcript, Lesley Dwyer, 23 February 2016, p 12-112 lines 37–38; Transcript, Beth Kotzé, 9 March 2016, p 23-6 lines 8–36.
- 123 Exhibit 288, Supplementary submission The Royal Australian and New Zealand College of Psychiatrists, 10 March 2016, p 4. Note, this was corrected in oral evidence to state "institutionalisation" instead of "deinstitutionalisation," Transcript, Michelle Fryer, 11 March 2016, p 25-12 lines 44–47.
- 124 Transcript, Brett McDermott, 16 February 2016, p 7-60 line 44.
- 125 Transcript, Brett McDermott, 16 February 2016, p 7-61 lines 11–15.
- 126 Exhibit 60, Statement of Scott Harden, 10 February 2016, p 6 para 16.
- 127 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment SK-8 to that statement, Wood, R 2012, *West Moreton Hospital and Health Condition Service: Report on the Condition of the Barrett Adolescent School and Accommodation*, pp 817–825; Exhibit 112, Statement of Trevor Sadler, 11 December 2015, Attachment I to that statement, Letter re 'Reply to the Draft Report on the Need For Child and Adolescent Secure Inpatient Services and the Re-development of Extended Treatment Adolescent in-patient services by the Barrett Adolescent Centre, pp 138–139; Exhibit 45, Statement of Susan Daniel, 30 October 2015, p 7 para 10(b).
- 128 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 45 para 219.
- 129 Exhibit 45, Statement of Susan Daniel, 30 October 2015, p 7 para 10(b).
- 130 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, Attachment I to that statement, Letter from Trevor Sadler to Peggy Brown regarding the 'Draft Report on the Need for Child and Adolescent Secure Services Inpatient Services and the Redevelopment of Extended Treatment Adolescent Inpatient Services', dated 5 November 2002, p 146.
- 131 Exhibit 1070, Howard, p 2007, Interim program improvements for Barrett Adolescent Centre at The Park – Centre for Mental Health; Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 18 para 90; Exhibit 87, Statement of Pdraig McGrath, 16 November 2015, p 11 para 9.10(b)(ii).
- 132 Exhibit 68, Statement of William Kingswell, 21 October 2015, Attachment 6 to that statement, 'Options study for Barrett Adolescent Centre at The Park Centre for Mental Health, December 2004' pp 136–169; Exhibit 87, Statement of Pdraig McGrath, 16 November 2015, p 11 para 9.10(b)(i); Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 18 paras 90–91; Exhibit 1070, Howard, p 2007, Interim program improvements for Barrett Adolescent Centre at The Park – Centre for Mental Health.
- 133 Exhibit 130, Statement of Lesley van Schoubroeck, 26 October 2015, p 7 para 26.

- 134 Exhibit 53, Statement of Kristi Geddes, 22 October 2015, Attachment KG-50 to that statement, Pre-interview statement of Anne Brennan, Part 9 Investigation into Statewide Transition and Care Planning Measures Following Closure of the Barrett Adolescent Centre, p 744, para 10(f); Exhibit 23, Statement of Matthew Beswick, 30 October 2015, pp 9–10 para 11(e); Exhibit 45, Statement of Susan Daniel, 30 October 2015, p 9 para 11(f); Exhibit 87, Statement of Padraig McGrath, 16 November 2015, p 16 para 14.6.
- 135 Transcript, Trevor Sadler, 10 March 2016, p 24-8 lines 37–40.
- 136 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 14 para 64; Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 5 para 15(f); Exhibit 143, Statement of Victoria Young, 30 October 2015, p 6 para 11(a); Exhibit 23, Statement of Matthew Beswick, 30 October 2015, p 10 para 11(j).
- 137 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG 8 May 2015, p 5.
- 138 Exhibit 63, Statement of Philip Hazell, 5 November 2015, p 17 para 97 (d).
- 139 Transcript, Beth Kotzé, 9 March 2016, p 23-7 lines 20–33.
- 140 Transcript, David Ward, 15 February 2016, p 6–57 lines 10–20.
- 141 Transcript, Kevin Rodgers, 2 March 2016, p 18-43 lines 21–27.
- 142
- 143 Transcript, Kevin Rodgers, 2 March 2016, p 18-57 lines 16–29.
- 144 Exhibit 108, Statement of Anne Reddie, 15 December 2015, p 9 para 43(b).
- 145 Exhibit 110, Statement of Kevin Rodgers, 10 December 2015, p 3 para 12.
- 146 Exhibit 1497, First Draft Proposal for Education Service Delivery following closure of BAC – Barrett and the Pursuit of Excellence – Current Education Provision.
- 147 S1 being the highest rating for teachers in Queensland.
- 148 Exhibit 110, Statement of Kevin Rodgers, 10 December 2015, p 3 para 11.
- 149 Exhibit 110, Statement of Kevin Rodgers, 10 December 2015, p 5 para 19.
- 150 Exhibit 1265, Statement of Megan Vizzard, 13 April 2016, p 5 para 22.
- 151 Exhibit 110, Statement of Kevin Rodgers, 10 December 2015, p 5 para 20.
- 152 Exhibit 19, Statement of Janine Armitage, 14 December 2015, p 5 para 15.
- 153 Exhibit 110, Statement of Kevin Rodgers, 10 December 2015, pp 4–5 para 18.
- 154 Exhibit 25, Statement of Peter Blatch, 22 October 2015, p 4 para 17.
- 155 Exhibit 1497, First Draft Proposal for Education Service Delivery following closure of BAC – Barrett and the Pursuit of Excellence – Current Education Provision.
- 156 Exhibit 19, Statement of Janine Armitage, 14 December 2015, p 3 para 10.
- 157 Exhibit 19, Statement of Janine Armitage, 14 December 2015, pp 5–6 para 18.
- 158 Exhibit 110, Statement of Kevin Rodgers, 10 December 2015, p 6 para 22.
- 159 Exhibit 110, Statement of Kevin Rodgers, 10 December 2015, p 6 para 23.
- 160 Exhibit 172, Supplementary statement of Cary Breakey, 9 February 2016, p 4 para 17.

2 Policy and planning context

Deinstitutionalisation

For at least fifty years, deinstitutionalisation of mental health facilities has been a major policy trend worldwide. Deinstitutionalisation involves the process of closing stand-alone health institutions and placing their “occupants into the community with or without follow-up care”.¹ The process is not restricted to mental health contexts; it is also applicable to contexts such as services for physical disabilities and intellectual disabilities.²

Both internationally and nationally, deinstitutionalisation of mental health services has been driven by a number of “interconnected forces”³ such as:

- changes in understanding of human and civil rights
- improved understanding about how people with mental health illnesses ought to be cared for
- developments in pharmaceutical treatments and improved knowledge about psychopharmacology
- improved understanding of the negative impact of institutional life
- better management of people with intellectual disabilities and geriatric illnesses
- cost containment and economic decision-making.⁴

Deinstitutionalisation should operate in conjunction with two parallel processes of *expansion of community care* (ensuring adequate care in the community once patients are no longer in institutions) and *mainstreaming* (locating acute psychiatric facilities at general hospital locations).⁵ This does not always occur. The global process of deinstitutionalisation is progressing at varying paces due in part to economic constraints, lack of social acceptance and the quality of the mental health systems.⁶ Research demonstrates the lack of uniform or linear approach to deinstitutionalisation in several countries, with mental health policies often “punctuated by interruptions and delays”.⁷

The consequences of deinstitutionalisation can lead to the “revolving door phenomenon” – the “rapid and repeated admission and discharge of people with mental health problems”.⁸ “Closing the front door” may then lead to “opening the back door” (that is, closing a psychiatric facility may then lead to increased hospital admissions).⁹ Other consequences of deinstitutionalisation may include:

- “re-institutionalisation”¹⁰ of patients in residential care homes or community based nursing homes
- “trans-institutionalisation” of people leaving mental health facilities who are then institutionalised into other government systems, such as correctional facilities¹¹ and
- crime victimisation and increased levels of homelessness.¹²

Developments occurred in the 1990s and 2000s, with various policies guiding the process of deinstitutionalisation.

Policy developments in the 1990s

International and national policy developments

In the 1990s there were major international and national developments in mental health policy and reform, including an Australian inquiry.

Mental health statement of rights and responsibilities 1991

In March 1991, Australian Health Ministers adopted the 'Mental health statement of rights and responsibilities'.¹³ The statement recognised the needs and rights of children and adolescents to be "treated in the most facilitative environment with the least restrictive or intrusive effective treatment".¹⁴ Consumer rights were explicitly set out, such as the right to expect integration of services to ensure continuity of care¹⁵ and the right to have "both the process of service provision and the outcome of treatment" evaluated.¹⁶ The statement guided national policy and practice and was one of the key documents in the overall 'National mental health strategy'.

United Nations Principles 1991

In December 1991, the General Assembly of the United Nations adopted 'Principles for the protection of persons with mental illness and for the improvement of mental health care'.¹⁷ These principles include:

- that the environment and living conditions of mental health facilities should be "as close as possible to those of the normal life of persons of similar age"
- that patients should be "treated in the least restrictive environment and with the least restrictive or intrusive treatment".¹⁸

The principles apply without discrimination on the ground of age. Although not legally binding or enforceable, they have become guiding principles for governments worldwide.¹⁹

National mental health strategy 1992

In April 1992, Australian Health Ministers endorsed the framework set out in the 'National mental health strategy'. The strategy reflected national and international recognition that the majority of mental health care could be delivered by community based services, that acute inpatient care should be delivered in general hospitals along with other acute health care, and that a small proportion of people with very severe mental illness need extended periods of care in psychiatric hospitals.²⁰

The 'National mental health strategy' has guided subsequent mental health reform throughout Australia. The strategy comprises three key documents:

- the 'Mental health statement of rights and rights and responsibilities' (1992, revised in 2012)²¹
- the 'National mental health policy' (1992, revised in 2008)²² and
- the 'National mental health plan' (1993, revised in 1998, 2003 and 2009).²³

The strategy recognised the importance of promotion, prevention and early detection,²⁴ and led to development of endorsed safety priorities such as the 'National standards for mental health services and practice standards for the workforce'.²⁵

National mental health policy 1992

The 'National mental health policy' 1992 had broad aims and objectives to guide mental health reform. It outlined a new approach to mental health care, moving from an institutional to a community care oriented approach,²⁶ while acknowledging that long-term inpatient care would be required for some people:

It is recognised that too much resource emphasis is currently given to separate psychiatric hospitals. In some cases it may be both possible and desirable to close them and replace them with a mix of general hospitals, residential, community treatment and community supported services. However, **a small number of people, whose disorder is severe, unremitting and disabling, will continue to require care in separate inpatient psychiatric facilities and these facilities will need to be maintained or upgraded to meet acceptable standards.**²⁷

(emphasis added)

National mental health plan 1993

In 1993, Australia's first 'National mental health plan 1993–1998' was endorsed.²⁸ This plan set out 12 priority areas²⁹ over a five year-period (1993–1998) with corresponding implementation strategies. It aimed to "strengthen the impetus for reform for mental health services" nationally.³⁰ Described as a "research and development phase", this first national mental health plan generated new information about measurement concepts, the extent of mental health disorders in the community as well as the development of new data standards.³¹

Burdekin report 1993

In September 1993, the 'Report of the national inquiry into the human rights of people with mental illness' (the Burdekin report) was delivered to the Australian Government. This inquiry was prompted by evidence outlined in the Human Rights and Equal Opportunity Commission's 1989 report, 'Our homeless children', which suggested that a disproportionate number of homeless children and young people were suffering from undiagnosed mental health problems, and subsequent research which showed that the human rights of individuals with mental illness were being ignored or violated.³²

The Burdekin report found that "the promise of more, and more effective, community-based services has yet to be realised"³³ and that "supported accommodation, bridging the gap between health and housing, is the single greatest need for people with a psychiatric disability".³⁴ It said:

The policy of deinstitutionalising psychiatric patients (or of not hospitalising them in the first place) was conceived in the belief that most people with a mental illness would be better off living and being treated in the community. It assumes they will have somewhere to live – an assumption which is frequently unfounded. Mentally ill people have great difficulty finding and keeping accommodation – due to poverty, discrimination and the nature of their disability.³⁵

The Burdekin report recommended that mental health services not attempt to treat patients with serious mental illnesses in the community in the absence of appropriate accommodation and adequately trained staff to provide such care.³⁶ It also observed:

While few would oppose deinstitutionalisation as a concept, there are disturbing signs that some States may be on the verge of closing down all institutions without providing any viable alternatives for some of the sickest and most vulnerable in our society – those for whom some type of “asylum” in the traditional sense is essential.³⁷

National mental health plan 1998

In July 1998, the second ‘National mental health plan 1998–2003’ was endorsed by Australian Health Ministers. It placed emphasis on population health issues and interventions and made clear it was “relevant for the whole system of mental health service delivery, both public and private”.³⁸ The plan retained the reform framework agreed upon in the 1992 ‘National mental health policy’ and acknowledged the ongoing structural reform of mental health services, in particular, the “reduced reliance on stand alone psychiatric hospitals”.³⁹ It created new priorities, one being the release of the statement ‘National information priorities and strategies’ in June 1999.⁴⁰

Queensland policy developments

International and national initiatives such as the ‘National mental health policy’ and the ‘National mental health plan’ had great impact on mental health care and reform in Queensland during the 1990s.⁴¹

Queensland mental health policy 1993

In 1993, Queensland’s first mental health policy was published. The ‘Queensland mental health policy’ provided the framework for reform in Queensland, consistent with the national objectives set out in the ‘National mental health strategy’ and ‘National mental health plan’.⁴² The policy recognised the needs of specific Queensland populations, for example Aboriginal and Torres Strait Islanders and people from Non-English Speaking Backgrounds (NESB).⁴³

Queensland mental health plan 1994

The first Queensland mental health plan (1994) coincided with major structural change of Queensland Health. As Queensland Health shifted from a centralised to a regionalised health care system, the 1994 plan focused on integrating services and systems to ensure equitable and continuous care.⁴⁴ It was replaced two years later by the ‘Ten year mental strategy for Queensland 1996’.⁴⁵

Future directions for child and youth mental health services 1996

In 1996, the ‘Future directions for child and youth mental health services’ policy statement was finalised. This was Queensland Health’s “first policy on mental health service provision for children and youth”.⁴⁶ It recognised that children and young people present different patterns and types of mental health problems and require special consideration of their developmental context and legal status.⁴⁷ This policy included the establishment of Queensland’s Child and Youth Mental Health Services (CYMHS), defining their role as linking young people with health practitioners, schools and community groups in a timely manner.⁴⁸

Ten year mental health strategy for Queensland 1996

The development of the 'Ten year mental strategy for Queensland 1996' corresponded with another reorganisation of Queensland Health (the return to 39 health districts). Released in 1997, the strategy was a key document for mental health reform in Queensland until 2003.⁴⁹ The strategy listed Queensland's immediate priorities, which included:

- establishing mainstreamed integrated services to promote continuity of care across service components
- providing locally available care through the more equitable distribution of mental health resources
- progressing the reform of psychiatric hospitals.⁵⁰

The strategy explained that mental health services are to be provided "in the least restrictive, most facilitative setting".⁵¹ The 'Ten year mental health strategy for Queensland 1996' noted "decentralisation of extended inpatient services from the existing psychiatric hospitals" was to be undertaken with planned new facilities.⁵² Extended inpatient services were to be "strengthened and transfer criteria will be used for people moving between District mental health services and supra-district extended inpatient services".⁵³

Policy developments in the 2000s

International and national policy developments

During the 2000s there were further significant international and national policy developments.

National mental health plan 2003

In July 2003, the 'National mental health plan 2003–2008' was endorsed by Australian Health Ministers.⁵⁴ This third revision of the national mental health plan emphasised structural changes to service delivery and four key priorities: promoting and preventing mental health, improving service responsiveness, strengthening quality and fostering innovation, research and sustainability.⁵⁵

National approach to mental health report 2006

In 2006, the Commonwealth Senate Select Committee on Mental Health released the report 'A national approach to mental health – from crisis to community'. It observed that mental health services "are failing some of the most vulnerable groups in society", including children and youth.⁵⁶ The report made 13 recommendations, including a recommendation to substantially increase national funding to match the disease burden of mental health,⁵⁷ the establishment of the 'Better mental health in the community' initiative⁵⁸ and increased funding for mental health research. It recommended that Australian Health Ministers reform the 1992 'National mental health strategy' to "guarantee the right of people with mental illness to access services in the least restrictive environment".⁵⁹ The report also made this observation about deinstitutionalisation:

[T]here is a general sense that mainstreaming and community care have not kept up with the pace of deinstitutionalisation. There are widespread problems with adequate accommodation, quality of care in the new settings, and perhaps most clearly of all, problems for people in gaining access to care in the new environment. In this environment, it is not surprising that the current policy direction is sometimes called into question.⁶⁰

National action plan on mental health 2006

In July 2006, the Council of Australian Governments (COAG) endorsed the 'National action plan on mental health 2006–2011'. Over five years, 18 measures were to be implemented to improve mental health services.⁶¹ This action plan committed \$4.1 billion to a range of mental health initiatives, extending beyond health to other key areas such as employment, education, corrective services and housing.⁶² State and territory governments committed a further \$1.6 billion, with most funding outlaid to ongoing service delivery and capital components (such as building new facilities or upgrading hospitals).⁶³

National mental health policy 2008

The 'National mental health policy' was revised in 2008 to take into account the ongoing need for national reform.⁶⁴ The 2008 policy emphasised the need for the continual monitoring and evaluation of mental health services, recognised the increased risk of certain life stages such as adolescence and explained the importance of housing to decrease "community resistance to deinstitutionalisation".⁶⁵

Adoption of UN Convention 2008

Important developments were occurring internationally during this time, with Australia signing the United Nations' 'Convention on the rights of persons with disabilities' in 2008.⁶⁶ The convention provides (among other things) that "the best interests of the child shall be a primary consideration" in "all actions concerning children with disabilities".⁶⁷

National mental health plan 2009

The 'Fourth mental health plan' was finalised in 2009 and set a five-year period (2009–2014) for early intervention and prevention, and strengthening partnerships across various sectors.⁶⁸ Five priority areas were identified:

- social inclusion and recovery
- prevention and early intervention
- service access, coordination and continuity of care
- quality improvement and innovation
- accountability – measuring and reporting progress.⁶⁹

The 'Fourth national mental health plan' noted the "shift to community based care and shortened inpatient episodes of care in less restrictive settings".⁷⁰ It also recognised the inherent tension between mental health services and child protection and youth justice services in "delivering treatment and care in the least restrictive environment".⁷¹ Of particular importance was the explicit commitment as part of the "service access, coordination and continuity of care" priority area in the plan: "Develop a "national service planning framework that establishes targets for the mix and level of the full range of mental health services, backed by innovative funding models"⁷².

This commitment is the 'National mental health service planning framework' (NMHSPF), described below.

Mental health statement of rights and responsibilities 2012

The 1991 'Mental health statement of rights and responsibilities' was updated in 2012. Described as an "aspirational document",⁷³ the 2012 statement emphasises the rights of the mentally ill to be "treated in the most facilitative environment with the least restrictive or intrusive response or

treatment”.⁷⁴ The statement explains that the responsibility for the support, development and implementation and evaluation of mental health programs rests with Australian governments.⁷⁵

Development of the draft national mental health service planning framework

The ‘National mental health service planning framework’ (NMHSPF) was listed as an action item in the ‘Fourth national mental health plan’.⁷⁶ The intention was to develop population-based planning models for mental health endorsed by input from expert groups.⁷⁷ Work on the NMHSPF commenced in 2010, and is still in progress. There has been limited distribution of a draft document and as at June 2016 there is no evidence to suggest it has been finalised.⁷⁸ The NMHSPF is discussed in more detail in chapter 15.

Queensland policy developments

Throughout the 2000s, Queensland continued to reform and revise its mental health strategy, including child and youth mental health services.

Queensland forensic mental health policy 2002

The objective of the ‘Queensland forensic mental health policy 2002’ was to guide the development and management of effective mental health services to mentally ill adults and young people involved in the criminal justice system. Developed under the ‘Queensland mental health plan 1994’ and the ‘Ten year mental health strategy for Queensland 1996’, it provided a framework for the delivery of services and a number of strategies to guide the implementation of that framework.⁷⁹

Queensland mental health strategic plan 2003

The ‘Ten year mental health strategy for Queensland 1996’ was superseded in 2003 by the ‘Queensland mental health strategic plan 2003–2008.’ This built on the mental health services reform that had occurred as part of the ‘Ten year mental health strategy for Queensland 1996’. It recognised several priority areas, including the need to continue the enhancement of specialised mental health services, strengthen service partnerships, and improve the use of data when planning and evaluating services.⁸⁰

Queensland Health mental health plan 2006

The ‘Queensland Health mental health plan 2006–2011’ was formulated as part of the response to the ‘National action plan on mental health 2006–2011’.

Queensland Health child and youth mental health plan 2006

The ‘Queensland Health child and youth mental health plan 2006–2011’ was developed within the broader context of the ‘Queensland mental health plan 2006–2011’.⁸¹ There were four new areas of major emphasis:

- development of the child and youth mental health workforce
- sufficient resourcing to ensure a statewide system of care for young people and their families
- matching the clinical needs of children and youth to a continuum of treatment options
- ensuring a holistic response via partnerships and collaborative practice.⁸²

Under this plan, the Barrett Adolescent Centre was to be redeveloped, with expansion of its day program and inpatient program.⁸³

The 2006 plan proposed a “hub and spoke” model for some treatment options to support sustainably the provision of safe, quality health services in regional, rural and remote areas of the state.⁸⁴ It recommended the redevelopment of the BAC as an 18-bed specialist inpatient unit, with provision for an additional eight day patients.⁸⁵ Two beds were to be designated as “swing” beds able to be used as a high dependency unit to provide a more contained environment if needed. The redevelopment was to include physical capacity for two additional beds “as needed”, and a two bedroom independent living unit as a step down option to facilitate transition from the inpatient setting to a less restrictive community-based setting. The plan also envisaged providing separate accommodation, in partnership with a non-government organisations (NGOs), for families and adolescents attending the day program from a distance.⁸⁶

Queensland plan for mental health 2007–2017

Published in June 2008, the ‘Queensland plan for mental health 2007–2017’⁸⁷ (QPMH) set five priority areas:

- promotion, prevention and early intervention
- improving and integrating the care system
- participation in the community
- coordinating care
- workforce, information, quality and safety.⁸⁸

The plan was underpinned by six principles:

- Consumers, families and carers are actively involved in all aspects of the mental health system.
- The mental health system promotes resilience and recovery.
- The mental health system is community-oriented, comprehensive, integrated and socially inclusive.
- Cooperation, collaboration and partnerships are key elements of the mental health system.
- Promotion, prevention and early intervention are integral to the mental health system.
- Mental health care is evidence-based, prioritising quality and safety.⁸⁹

A report in 2011 documented the progress of the QPMH, and provided updates about capital works projects. The progress report explained the economic impact on the Queensland mental health system of natural disasters and the global financial crisis.⁹⁰

Establishment of Queensland Mental Health Commission in 2013

The Queensland Mental Health Commission was established in 2013.⁹¹ Its purpose is to “drive ongoing reform towards a more integrated, evidence-based, recovery-orientated mental health and substance misuse system”.⁹²

The Queensland Mental Health Commission prepared the 'Queensland mental health, drug and alcohol strategic plan 2014–2019'. Four pillars of reform were identified:

- better services for those who need them, when and where they are required
- better promotion, prevention and early intervention initiatives to maintain wellbeing, prevent onset, and minimise the severity and duration of problems
- better engagement and collaboration to improve responsiveness to individual and community needs
- better transparency and accountability so the system works as intended and in the most effective and efficient way possible.⁹³

Decentralisation

Decentralisation is a "process of distributing power away from the centre of an organisation".⁹⁴ It is not specific to health or mental health services; it has its roots in other contexts such as politics and business⁹⁵. One of its aims is to "reduce the extent of central influence and promote local autonomy".⁹⁶

Decentralisation of health services involves the devolution of administrative, financial and/or service-delivery responsibility from the central government level to the local or district government level.⁹⁷

Decentralisation of health services in Australia

In August 2011, all Australian states and territories agreed to the decentralisation of health services in the 'National Health Reform Agreement':

The Commonwealth and the States agree that the establishment of Local Hospital Networks will decentralise public hospital management and increase local accountability to drive improvements in performance. Local Hospital Networks will be accountable for treatment outcomes and responsive to patients' needs and will make active decisions about the management of their own budget. They will have the flexibility to shape local service delivery according to local needs.⁹⁸

This agreement set out the "stronger devolution of governance to local hospital networks" throughout Australia.⁹⁹ The agreement's requirement to devolve "operational management for public hospitals and accountability for local delivery to the local level" led to the enactment of the *Hospital and Health Boards Act 2011* (Qld) and the establishment of Hospital and Health Services, discussed later in this report.

Decentralisation of mental health services in Queensland

The implementation of the 'Ten year mental strategy for Queensland 1996' involved specialised mental health services being delivered at the "District and/or network of Districts level".¹⁰⁰

This strategy aimed to provide "better access to a wider range of quality services for people with mental disorder, and to improve coordination with other health services".¹⁰¹ It also guided decentralisation of mental health services in Queensland:

- ... to enable people to receive extended inpatient services as close to their homes as possible.
- ... The rehabilitation and treatment focus of extended inpatient services will be strengthened and transfer criteria will be used for people moving between District mental health services and supra-district extended inpatient services.¹⁰²

Decentralisation of The Park

In September 1993, a consultant's report had recommended that the services offered by the three psychiatric hospitals in Queensland (including Wolston Park Hospital) be decentralised to sites closer to patients' homes.¹⁰³

Decentralisation of Wolston Park Hospital began soon after the release of the 'Ten year mental health strategy for Queensland' in 1997. In his written evidence, Aaron Groves (former Director of Mental Health) explained the "primary intention" of the decentralisation process outlined in that strategy was to move acute services away from Wolston Park.¹⁰⁴

In 1997, a transition team was established to oversee the transfer of staff and patients to other services. In April 1998, the Wolston Park Hospital Transition Team and the Hospital Redevelopment Project Team developed a plan entitled 'Critical pathways for the decentralisation of Wolston Park Hospital and the redevelopment of associated mental health services'.¹⁰⁵ This plan set out three phases for the redevelopment of Wolston Park: planning and initiation, establishment of transitional wards, and new mental health services.

Wolston Park Hospital was renamed The Park Centre for Mental Health ('The Park') in 2002. Decentralisation of The Park was a key component of the 2007 QPMH. According to Groves:

- The QPMH considered the nature and number of services that should remain at The Park site. In the medium term it was considered that The Park should be centred on the provision of forensic services, other sub-acute highly specialised services such as for those people with dual diagnosis (of intellectual disability) and for other non-clinical services such as research. It was not considered a suitable long-term viable option to retain extended treatment services for highly complex youth at The Park site.¹⁰⁶

Decentralisation and the Barrett Adolescent Centre

According to Groves, there was no specific plan for the BAC in the 1996 'Ten year mental health strategy for Queensland'.¹⁰⁷ The BAC was mentioned in the context of an analysis of the number of mental health beds available to children and youth in Queensland: "Barrett Adolescent Unit at the Wolston Park Hospital complex has 15 places to accommodate young people with serious mental disorders for medium lengths of stay".¹⁰⁸

The QPMH did not expressly mention relocation of the BAC, but the approved capital works program did.¹⁰⁹

Decentralisation and EFTRU

Planning for additional high secure beds and an Extended Forensic Treatment Rehabilitation Unit (EFTRU) at The Park extended over several years. There was concurrent planning for a replacement facility for the BAC at Redlands. EFTRU was intended to open by mid-December 2010, and the Redlands unit by mid-January 2011.¹¹⁰ The planning for EFTRU involved moving adult extended treatment and rehabilitation (ETR) patients and dual diagnosis (DD) patients to community care, refurbishing units they had occupied at The Park, and other construction work. There were delays in the commissioning of the community care units to which the ETR and DD patients were to be moved as well as building delays at The Park. The final inspection period for EFTRU ended in June 2013¹¹¹ and its first patients were transferred from the high secure unit from 29 July 2013.¹¹²

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3 The first six months of 2012

Structure of Queensland Health to 1 July 2012

Prior to 1 July 2012 Queensland Health comprised 17 Health Service Districts and a central head office.

The Health Service Districts had been declared as such by the Governor-in-Council pursuant to the *Health Services Act 1991* (now repealed).¹ They included the West Moreton Health Service District. They were not separate legal entities but geographic areas of the state, public sector hospitals or other public sector health service facilities. Each Health Service District had an advisory Health Community Council,² and a chief executive officer who reported directly to the Director-General.³

The central head office consisted of the office of the Director-General and nine divisions. Tony O'Connell was the Director-General from June 2011.⁴

The divisions, and those in charge of them, included:

- Division of the Chief Health Officer – Jeannette Young (from 2005)
- Health Planning and Infrastructure Division – Deputy Director-General John Glaister (from January 2011)
- Finance Procurement and Legal Services Division – Deputy Director-General Susan Middleditch (from May 2012)
- Policy, Strategy and Resourcing Division – Deputy Director-General Michael Cleary (from May 2010).

Subject to the Minister, the Director-General was responsible for overseeing 182 hospitals, 85 000 staff and a budget of approximately \$12 billion.⁵ In reality he had to rely on those briefing him to advise him of necessary details, information and risks before he made decisions. He was supported by the Executive Management Team whose members included the heads of the nine divisions and the chair of the CEO and Deputy Director-General Forum, executive committees and ad hoc committees. The executive committees included the Health Infrastructure and Projects Executive Committee, the National Health Reform Executive Committee, and the Integrated Policy and Planning Executive Committee.⁶ In 2012 two important ad hoc committees were formed: the Budget and Fiscal Examination Committee in April 2012 and the Budget Review Committee in May 2012.⁷

The Chief Health Officer provided high level medical advice to the Minister and the Director-General on health issues, including policy and legislative matters associated with the health and safety of the Queensland public.⁸

The Mental Health, Alcohol and Other Drugs Directorate (MHAODD) was part of the Division of the Chief Health Officer.⁹ It had responsibility for frontline mental health services as well as mental health policy and legislation.

The Executive Director of the MHAODD was responsible for the policy, planning, reform and performance reporting of the delivery of mental health services in Queensland and for providing advice about mental health services to the Director-General and the Minister.¹⁰ Aaron Groves fulfilled that role between 2005 and October 2011.¹¹ Thereafter William (Bill) Kingswell assumed the position.¹²

Jeannette Young (the Chief Health Officer) gave evidence of meeting regularly with Kingswell¹³ when she would “put to” him “things that the Director General might’ve spoken [to her] about or ideas that [she] had about progression of mental health”. She said that Kingswell would similarly “raise any issues that he had in his portfolio that he wanted to progress”.¹⁴

The Health Planning and Infrastructure Division had responsibility for statewide health service and infrastructure planning,¹⁵ including the planning and delivery of projects such as the adolescent mental health extended treatment unit at Redlands and the Extended Forensic Treatment Rehabilitation Unit (EFTRU) at The Park.

There were policies and guidelines to inform health service planning, including the Queensland Health Guide to Health Service Planning,¹⁶ as well as mechanisms for consultation with interested parties within Queensland Health, members of relevant professions and members of the community such as the Statewide Mental Health Network Child and Youth Mental Health Advisory Group, the Clinical Senate (a network of 65 clinicians who provided strategic advice to the Director-General on key issues and matters relating to health service delivery) and the Health Community Councils established under the *Health Services Act 1991*.

Change of government

A new Liberal National Party Government was elected on 24 March 2012.

Health Minister Lawrence Springborg made it known to the Director-General and other senior staff within the department that he expected major changes to service provision to be referred to him through the Director-General for his active consideration, and that he expected to be briefed about any significant decisions made or proposed by the Director-General. It was his practice to overrule decisions on significant matters if he disagreed with them.¹⁷

A tight fiscal environment

Two days after the March 2012 election, the new Premier announced a Commission of Audit into the state’s finances.

The Commission of Audit delivered an Interim Report on 15 June 2012 in which it identified an unsustainable debt position in Queensland, with projections that the debt across the Queensland Government would increase to approximately \$100 billion by 2017–2018.¹⁸

According to O’Connell, the Commission of Audit influenced the overall fiscal environment in which government agencies worked. Queensland Health had been significantly overspending Treasury allocations and had an underlying deficit which had been worsening over the previous five years, reaching an ‘overspend’ of approximately \$291 million in the 2010–2011 year.¹⁹

Queensland Health was required to reduce both operational spending and capital spending to stay within its budget allocated by the Treasury.²⁰ It was required to find \$100 to \$120 million in savings between the election and the end of the financial year on 30 June 2012.²¹ The Budget and Fiscal Examination Committee (which was led by Cleary and Young) was established in

April 2012, and the Budget Review Committee (chaired by the Minister or in his absence the Director-General) was established in May 2012.²²

In early May 2012, there were discussions within the MHAODD about covering a shortfall in Queensland's contribution to certain Commonwealth funded mental health projects. On 3 May 2012, Leanne Geppert, Director, Planning and Partnerships Unit, MHAODD, sent an email to Alan Mayer, Director of Mental Health Programs within the Health Planning and Infrastructure Division (HPID), stating:

It is highly likely that another project (?? Redlands Adolescent Extended Treatment Unit) will need to be ceased in order to guarantee we will cover the \$3.1M shortfall against ICT, escalation and land acquisition.²³

In a further email to Mayer on 4 May 2012 Geppert said:

Our plan is to 'offer' the Redlands project as a definite source for covering the shortfall in the [Cabinet Budget Review Committee] documents, and if we get the green light to proceed with the projects, the best way forward will be to pursue the options you outline below (before anything else).²⁴

The cessation of Redlands

Introduction

This section considers the May 2012 briefing note for approval (the May briefing note). Chapter 5 discusses the August 2012 briefing note for approval (the August briefing note). The effect of both briefing notes was to cease the Redlands Adolescent Extended Treatment Unit (RAETU) capital program (the Redlands project) and to redirect the funds allocated to the Redlands project to other projects.²⁵

There is controversy concerning the effect and interaction of the two briefing notes, which is discussed in detail in this chapter and in chapter 5.

The May 2012 briefing note

Contents

The May briefing note was a 'Briefing Note for Approval' addressed to the Director-General. It was prepared by Geppert, cleared by Kingswell (both of the Mental Health, Alcohol and Other Drugs Division), at the request of the Chief Health Officer (Jeannette Young), who verified its contents.

The proposal was that the Director-General approve the cessation of the Redlands project and provide the brief to the Minister for noting.

The May briefing note was signed as 'approved' by O'Connell as Director-General on 16 May 2012 and the box 'To Minister's Office for Approval' was ticked.

The briefing note records that the approval was critical because:

A Cabinet Budget Review Committee (CBRC) Submission has been prepared on the *Project Agreements for capital projects approved for Queensland health under the Health and Hospitals Fund 2010 Regional Priority Round* (HHF), and is potentially to be submitted in the week beginning 14 May 2012 – the strength of this CBRC Submission is reliant on the information in this Brief being approved and noted. [sic]

Under the heading 'Headline Issues' is this:

The top three issues are:

- The RAETU capital program has encountered multiple delays to date and has an estimated budget over run of \$1,461,224. Additionally, recent sector advice proposes a re-scoping of the clinical service model and governance structure for the Unit.
- There is an anticipated capital funding shortfall of \$3.1 million for the regional mental health HHF projects, relating to Information Communications Technology (ICT), escalation and land acquisition. It is proposed to fund this shortfall through cost savings resulting from the cessation of the 15-bed RAETU which has been funded under Stage 1 of the *Queensland Plan for Mental Health 2007–17* (QPMH).
- The HHF projects are critical in the reform of Queensland mental health services. The HHF projects focus on building community mental health service infrastructure in regional areas to facilitate a more integrated approach to service delivery in these areas – a key priority in the government's health reform agenda. This investment will address some of the inequities that exist for remote and rural consumers including lack of coordinated, integrated services that are close to their home.

The briefing note includes the following reasoning under the headings 'Background' and 'Consultation'. Under the heading 'Background':

The RAETU is one of the 17 projects funded under Stage 1 of the Queensland Mental Health Capital Works Program, and is intended to replace the Barrett Adolescent Centre, which is currently located at The Park Centre for Mental health (The Park).

Ceasing the 15-bed RAETU capital program will necessitate a review of the existing adolescent centre at The Park, and should give consideration to the benefits and disadvantages of this model of care. Limited sector consultation supports this review.

Under the heading 'Consultation':

Consultation regarding this Brief has included Health Planning and Infrastructure Division, Queensland Health (QH); limited consultation within the mental health sector; and the Intergovernmental Funding and Policy Coordination Unit, Strategic Policy, Funding and Intergovernmental Relations Branch, QH.

Further consultation will be conducted upon approval to proceed.

The briefing note continues:

The potential cost saving of not proceeding with the RAETU project is \$15,150,524 in capital, and \$1,824,979 in recurrent operating costs (from 2014–15). These savings can be reallocated to fund the shortfall associated with the HHF projects.²⁶

As already noted, the briefing note records that it was to go to the Minister for noting. However, Springborg does not recall receiving it (discussed below).²⁷ An email exchange on 25 June 2012 showed the decision was still awaiting Ministerial approval.²⁸ A further email exchange on 9 July 2012 showed it remained in the Minister's office as at that date.²⁹

Background

A report of the Site Evaluation Sub Group dated October 2008 considered a vacant site adjacent to the Redland Hospital at Cleveland the most appropriate option for the relocation of the BAC. Approval from the then Minister was obtained and the Redlands site was ultimately acquired.³⁰

On 1 April 2009, a memorandum from Aaron Groves (Senior Director, Mental Health Branch) recommended that district CEOs endorse an approval to proceed with the redevelopment of the BAC at Redlands.³¹

Subsequently, two groups were set up. *First*, David Crompton (the then acting Chair, Metro South Health Service District) established a Capital Works User Group (also called the Facility User Group). That group's task was to guide the redesign and development of the new unit at Redlands. Crompton was the chairperson. That committee first met on 20 August 2009. There was then a series of meetings (referred to as 'facility project team meetings' or 'user group meetings') between August 2009 and February 2012.

Second, on 27 January 2010, Crompton, Groves (then Director of Mental Health) and various representatives from the Mental Health Directorate, Mental Health Plan Implementation Team requested that Judi Krause (in her capacity as Chair of the former Child and Youth Mental Health State-wide Advisory Group) form another group to review the model of service delivery (MOSD).³² This group consisted of Erica Lee (Manager Mater CYMHS), Brett McDermott (Executive Director Mater CYMHS), Penny Brassey (Clinical Director, Townsville CYMHS), Michael Daubney (Clinical Director, Metro South CYMHS), James Scott (Child Psychiatrist, RCH CYMHS), Fiona Cameron (acting Statewide Principal Project Officer, CYMHS), Trevor Sadler (who provided input via email as he was overseas) and Krause. The evidence is that the MOSD review group met twice, and corresponded between sessions via email.

According to Crompton, the RAETU project was "significantly advanced" from the establishment of the user group, whose work included:

- a. the design of the proposed new facility
- b. the establishment of a team to review the model of service delivery
- c. liaison with the Department of Education and Training in relation to an education program at the Redlands site and the provision of funding.³³

On or about 28 August 2012, Crompton was informed by a memorandum from Glenn Rashleigh (Chief Health Infrastructure Office, Systems Support Services) that a decision had been made not to proceed with Redlands.³⁴ Crompton told the Commission that he was "not involved in any decision making process in relation to the cancellation of the project and cannot recall being informed prior to 28 August 2012 that the proposed redevelopment may not proceed".³⁵

Analysis of the May 2012 briefing note

The three reasons for ceasing the Redlands project set out in the May briefing note are multiple delays, budget overruns and recent sector advice.

Multiple delays

Estimated completion date

Cleary gave evidence that, based on the information provided to him as a member of the Budget Review Committee (BRC), he understood that by June 2012, the Redlands project had incurred multiple delays.³⁶

Kingswell said in a written statement to the Commission that by September 2012, there were no building approvals, the project was more than 12 months behind schedule and significantly over budget, and “at that time, the decision was made to cease the project”.³⁷ He said that O’Connell made the “ultimate decision to cease the project in September 2012”, following receipt of the May briefing note. This evidence is wrong. The decision had already been made by September 2012. It seems likely that, in preparing his statement, Kingswell incorrectly cited September instead of May 2012.

Counsel for Springborg made the submission that, notwithstanding the passage of time, the Redlands project was always estimated to be two years away from completion.³⁸

Crompton was asked if he had been conscious of concerns about delays at the time. He gave the following evidence:

CROMPTON: ... All builds were running to a degree behind schedule, so it was always conscious in my mind about delays in progress of projects. So those things are always in my mind.

FREEBURN: But nothing extraordinary?

CROMPTON: I wouldn’t have – look, that would be me postulating backwards whether I saw this one as extraordinary or not extraordinary. The fact that building projects are behind schedule remains always a concern for me as the person tasked with the responsibility of delivering mental health services in the area.³⁹

Reasons for delay

Drainage

Cleary’s evidence was that Kingswell had indicated that continuation of the Redlands project was inappropriate for a “range of reasons” including a watercourse on the site.⁴⁰ Counsel for O’Connell submitted that the multiple delays with the Redlands project included “drainage issues”.⁴¹ In his statement Kingswell referred to a lack of adequate drainage at the Redlands site.⁴²

Drainage was an issue resolved by the third of the user group meetings, on 15 October 2009.⁴³

After being shown Facility Project Team Meeting minutes by Counsel Assisting, Kingswell accepted the proposition that the drainage issues had been resolved by that date.⁴⁴ He told the Commission that he was unaware of the resolution of the drainage issues until he received a copy of the minutes, for the first time, in preparation for the Commission’s hearing.⁴⁵ Kingswell’s oral evidence was that at the time of preparing his statement for the Commission (dated 24 February 2016), he was unaware that the drainage issues had been resolved.⁴⁶

Koalas

In his statement Kingswell referred to “problems” related to koalas on the site.⁴⁷ Counsel for O’Connell submitted that the multiple delays with the Redlands project included the “koala corridor”.⁴⁸ Lesley Dwyer (Chief Executive Officer, West Moreton HHS) gave evidence of having “heard that there were issues regarding koalas on the site”.⁴⁹

Counsel for Springborg submitted that the significance of the problems presented by new koala-related environmental strategies was apparent from the fact that the issue was escalated to Glaister (Deputy Director-General, Health Planning and Infrastructure Division).⁵⁰ In response to questioning from Counsel for Springborg, O’Connell downplayed the significance of the koala issue when he said:

You can always eventually wait for koala approval to occur or you can always wait until funds become available to bridge the gap between the current spend. But something like, you know, a changing opinion about what’s best for the patients – you know, you have to take into account, and it becomes a very significant factor in the – putting it all together.⁵¹

Several recommendations were made by the Department of Environment and Resource Management (DERM) by letter dated 28 April 2011. Crompton’s evidence was that the Redlands project was being adapted to accommodate the koala population.⁵² Counsel for Kingswell relied on the submissions made by Counsel for O’Connell,⁵³ submitting that the true effect of DERM’s letter was to advise Queensland Health to “start again” and that the letter did not offer a ready solution to the “koala problem”.⁵⁴ In circumstances where the Redlands project was ultimately ceased, the Commission cannot determine whether the issue of the koala population would have ultimately been resolved or when.

Environmental issues

Geppert gave evidence that there were environmental “issues” associated with the site, considered to be “unresolvable” at the time.⁵⁵ She could not recall who had said this. Geppert said her “recollection of the period of time is that that was ... an accepted position by all stakeholders involved at all levels”.⁵⁶ Sharon Kelly (Executive Director Primary and Community Health, West Moreton HHS) asserted that Redlands was ceased because of “unresolvable” building and environmental issues, but she could not recall her source of information.⁵⁷

There is little doubt that drainage, koalas and other incidental environmental issues were obstacles impeding or delaying the Redlands project. But there is no evidence that they could not be resolved. Further, the Commission has found no evidence of any consultation about these issues with Crompton or the other user groups.

Budget overruns

Counsel for O’Connell submitted that there is a consistent thread in the documentation to support the proposition that the Redlands project was becoming an expensive and unworkable project.⁵⁸

Counsel for Springborg submitted that the Redlands project was consistently over-budget,⁵⁹ and that the ongoing delays and other problems with it led to the conclusion, at least within the MHAODB, that it was not a viable project.⁶⁰

Cleary recalled that at the time of a BRC meeting in or about July 2012, he spoke with Kingswell “to obtain advice” about the decision not to proceed with the Redlands project.⁶¹ He said Kingswell advised him that the Redlands project had encountered a significant budget overrun of approximately \$1.4 million.⁶²

Clery said that one of the reasons the Redlands project did not proceed was “a need to make budget savings across the whole of Queensland Health, in circumstances where the viability of the then capital project was of grave concern”.⁶³ A requirement to find \$120 million in savings is discussed below.

Other reasons provided by Kingswell are also discussed below.

Recent sector advice

According to the briefing note, recent sector advice proposed a rescoping of the clinical service model and governance structure for the Redlands unit.

Geppert, the author of the briefing note, was asked by Counsel Assisting to explain the phrase “recent sector advice”.⁶⁴ Her response was: “So sector advice would have been referring to the mental health system”.⁶⁵

The questioning continued:

FREEBURN: So who?

GEPPERT: I – I can’t provide you with the name around that. Proposing a rescoping of the clinical service model and governance structure for the unit, I imagine that that would have been referring to, potentially, the Barrett Adolescent Centre Unit itself.⁶⁶

In her written statement to the Commission, Young could not recall specific details of the recent sector advice referred to in the May briefing note.⁶⁷ In oral evidence, Young was asked what advice preceded the May briefing note. She replied that the advice she received was that the model of service proposed for Redlands was outdated. When asked whether, when she provided the May briefing note to O’Connell, she had satisfied herself that it was appropriate to request that the Redlands project be ceased, Young replied that she was confident that expert advice or clinical input had informed that decision. When asked where that clinical advice or expert input could be located, Young said that Kingswell “would have sought that advice”.⁶⁸

Young said that she was “certain the Executive Director would have also sought advice from child or adolescent psychiatrists”.⁶⁹ She gave evidence that officers under the supervision of the Executive Director of Mental Health (that is, Kingswell) would have carried out any stakeholder consultation that was undertaken. Young’s evidence was that she understood from Kingswell that there was stakeholder consultation, but she did not know the details.⁷⁰

Young said in oral evidence that, prior to the preparation of the May briefing note, there “would have been discussion” at her fortnightly meetings with Kingswell. She said the May briefing note was the culmination of those discussions,⁷¹ but she could not recall specifics of conversations or whether anyone else was involved.⁷²

In her written statement to the Commission, Young said the consultation would have occurred “at officer level under the supervision of the Executive Director” (Kingswell). She continued:

Although I cannot recall the detail, I would expect the ‘*limited sector consultation*’ was informal consultation as extensive consultation does not ordinarily occur until after there is ‘*in principle*’ approval to pursue a particular avenue of action.

Prior to seeking the Director-General’s approval, and prior to preparation of the briefing note, I would have consulted over an extended period with the Executive Director of Mental Health, who is an expert psychiatrist and, at the time, was also the statutory appointee to the

role of Chief Psychiatrist. I am certain the Executive Director would have also sought advice from child or adolescent psychiatrists.

I cannot recall the detail of any such advice, nor do I have control of any documents containing the advice. I believe the information would have been conveyed to me as part of my regular meetings with the Executive Director.

The only thing I can recall about the advice was that the model of care proposed at Redlands (being a single facility to serve the entire State) was out dated.

Before a briefing note such as the one in question is prepared, there are many discussions about the issue over many months, as the ideas the subject of the briefing note are tested and refined.

There is a fine balance to be struck in terms of the extent of consultation. There needs to be sufficient consultation to ensure the idea is worth pursuing, but the consultation should not be so extensive that it results in a waste of resources when there has not yet been endorsement by the Director-General to pursue the idea.

The 'limited consultation' typically undertaken at this stage of the process is not usually extensively documented. More detailed consultation typically occurs after the Director-General endorses the idea.⁷³

(emphasis in original)

In his written statement, Kingswell said that the recommendation to cancel the Redlands project, as contained in the May briefing note, was made by him and his team "after consultation with multiple stakeholders".⁷⁴ He went on to explain that there had been consultation with the Health Planning and Infrastructure Division and [sic] Queensland Health, and some limited consultation also with the "mental health sector", and the Intergovernmental Funding and Policy Coordination Unit, Strategic Policy, Funding and Intergovernmental Branch, Queensland Health⁷⁵ – that is, he repeated what appeared in the briefing note under 'Consultation'. Kingswell gave similar evidence in respect of decisions made with respect to the delivery of new service models.⁷⁶

Kingswell did not tell the Commission with whom in the "mental health sector" he, or his team, consulted. However, both in written and oral evidence, he repeatedly expressed his view that the BAC should be closed. He referred to having had numerous conversations about the decision to close it. He said that he had conversations about the closure with Dwyer, Kelly, Geppert, staff within his office and Cleary.⁷⁷ As at May 2012, the West Moreton HHS had not assumed responsibility for West Moreton Hospital and Health Services, and Dwyer and Kelly had not yet taken up relevant executive appointments within the new HHS. The Commission has located only limited documentation of consultations with members of the psychiatry profession and no evidence of consultation with the community. There is some evidence of (later) email communication with Scott Harden, a child and adolescent psychiatrist practising in Brisbane,⁷⁸ and evidence that Kingswell represented Queensland in the development of the draft 'National Mental Health Service Planning Framework' (NMHSPF) which is discussed in chapter 2. Otherwise, the "multiple stakeholders" appear to comprise only persons within Queensland Health.

There is no evidence that West Moreton Health Service District (as it then was) was consulted about the impact of the cessation of the Redlands project on the BAC or the services it then provided.⁷⁹ The Redlands project was within Metro South Health Service District and there is no evidence of any consultation with that district.

O'Connell was confident that the authors of the briefing note had carried out necessary consultations and that they considered cessation of the project was appropriate.⁸⁰ He pointed out that the document was authored by the second most senior officer in the Mental Health Branch (Geppert), cleared by the Executive Director (Kingswell) and verified by the Chief Health Officer (Young).⁸¹

Counsel for O'Connell submitted that retrospective forensic analysis has a tendency to overlook context. They noted that O'Connell was in charge of a vast health service, and that he would have received a substantial number of briefing notes every week. The submission continued that in this context, retrospectively to isolate one document for specific interrogation was unrealistic, and that the likely effect of such scrutiny would be "paralysing" on the office of the Director-General.⁸²

O'Connell conceded that the briefing note process could be improved by a devolution of decision-making to "lower down in the hierarchy".⁸³ He said the briefing note system necessitated the provision of succinct information to enable the Director-General to make decisions based on the most pertinent facts, and that it necessitated the Director-General having trust in the advice given.⁸⁴ He said that he would have expected those below him to have done the research and to have summarised its outcome for him. And on the basis of that summary, he would have made his decision.⁸⁵

When asked about the depth to which he would have expected those advising him to have researched an issue prior to summarising its results, O'Connell responded, "not as much depth as I think your question implies".⁸⁶ He said that while there was an opportunity for him to question the relevant signatories to the brief, he did not do this because what was being recommended "seemed to be logical and consistent" with various conversations in which he had been involved over the preceding months.⁸⁷

Not a contemporary model of care

Kingswell's evidence was that the BAC operated a highly controversial and arguably an outdated model of care.⁸⁸ Kingswell advised Cleary that the continuation of the Redlands project was not appropriate for a range of reasons including that there was work being undertaken nationally that indicated that institutional models of care were not considered contemporary under the draft NMHSPF.⁸⁹ Later, in emails in May and July 2013 Kingswell contended that the (draft) NMHSPF did not include, or was at odds with, models of care like the BAC.⁹⁰ (The issues of 'contemporary models of care' and the draft NMHSPF are discussed in chapter 15.)

Springborg does not recall whether he received the May 2012 briefing note (discussed below). However, he does recall that in 2012 he became aware that senior clinicians in the department had expressed the view that the BAC was not regarded as a contemporary model of care.⁹¹ His counsel submitted that the evidence from the decision-makers, O'Connell, Young and Kingswell, was that the most important factor in the cancellation of the Redlands project was the emerging clinical preference to care for patients currently treated in the BAC in more community-based, closer-to-home models of care.⁹²

Cleary's evidence about the reasons for the decision to cease the Redlands project was similar. He said he was told by Kingswell that the proposed model of care for Redlands was no longer considered contemporary.⁹³ Cleary said that, at the BRC meeting in July 2012, Kingswell recommended consideration of alternative models moving from institutional to community-based care.⁹⁴ Kingswell also said that continuation of the Redlands project was not appropriate for a range of reasons including that the proposed unit continued a model of care that was no

longer considered contemporary because contemporary models were moving from institutional care to community-based care.⁹⁵

Counsel for O’Connell submitted that the consideration of what constituted a ‘contemporary model of care’ was an important factor in the decision he took. They submitted that O’Connell took advice:

[i]n the understanding from years of exposure to relevant opinion that contemporary models of mental health care did involve increasing emphasis upon community-based care in favour of hospital-based or to use a pejorative term institutionalised-based care.⁹⁶

Counsel for Kingswell submitted that the suggestion that individuals ‘slavishly’ followed Kingswell’s advice “ignores the fact that each witness was eminently qualified to—and did—form their own independent view”.⁹⁷ To properly address this submission, the evidence of what each relevant witness said about the source of their advice is summarised below.

Table 3A: Sources of information

Cleary	Cleary gave evidence that Kingswell recommended consideration of alternative models moving from institutional to community-based care. ⁹⁸ Kingswell also indicated that continuation of the Redlands project was not appropriate for a range of reasons. These included that the proposed unit continued a model of service that was no longer considered contemporary, with work being undertaken nationally that indicated that an institutional model of service was not considered contemporary under the draft NMHSPF. ⁹⁹ Cleary said that Kingswell would have been the principal person from whom he took advice. ¹⁰⁰ He would also have taken advice regarding “these types of issues” from Gilhotra (the then Chief Psychiatrist) and he would have sought input from Dwyer. ¹⁰¹ (Gilhotra gives no evidence of providing any such advice. Dwyer was acting on advice she had received – see below.)
Geppert	Geppert was asked what ‘recent sector advice’ proposed a rescoping of the clinical service model; her response was that “sector advice would have been referring to the mental health system” but could not provide a name. ¹⁰²
Young	Young said that she received advice that the model of service proposed at Redlands was outdated, ¹⁰³ and that the current practice was to provide services in the community close to where patients ordinarily reside. ¹⁰⁴ She said there had been consistent advice from Kingswell and Gilhotra that contemporary practice, as reflected in the draft NMHSPF, was moving away from extended inpatient facilities towards community-based care. ¹⁰⁵ Young was asked if it was only Kingswell with whom she consulted; her response was that she could not recall if it was Groves or Kingswell. ¹⁰⁶ (This is inconsistent with the evidence of Groves who maintained he did not provide any such advice. Gilhotra gave no evidence of providing any such advice although he was not orally examined.) Young said that, prior to preparation of the May briefing note, and prior to seeking the Director-General’s approval, she would have consulted over an extended period with Kingswell. Young said she was “certain” Kingswell would have also sought advice from child or adolescent psychiatrists. ¹⁰⁷

Groves	At all material times, Groves considered that the BAC (or its services) would be relocated to Redlands. He held that view until October 2011 (after which he had no further involvement with the BAC/Redlands relocation). ¹⁰⁸ The evidence that Young consulted with Groves in May 2012 (and before that) is inconsistent with Groves' having relinquished the relevant obligations to Kingswell in October 2011.
Dwyer	Dwyer says the advice she received from people more expert than she was that the model of care was no longer considered to be contemporary. ¹⁰⁹ She said she received that advice from Kingswell and Cleary. ¹¹⁰ (Cleary said that he was acting on the advice of Kingswell – see above.)
O'Connell	O'Connell said he relied on advice provided to him by the relevant Deputy Directors-General, each of whom sought advice. He was confident that the authors of the briefing note carried out the necessary consultations and considered cessation of the project appropriate. ¹¹¹ O'Connell considered that their reasons for the recommendation were justified. ¹¹² In a supplementary statement, O'Connell was asked to provide details of the "emerging clinical preference" for community-based, closer to home models of care. ¹¹³ He said this was based on numerous conversations over the last two decades with adult and child psychiatrists, executives within state health departments and health care planners, as well as documents authored by mental health specialists. O'Connell was unable to provide names of the parties involved or dates of those conversations. ¹¹⁴

It is reasonably clear that Kingswell was the principal source of advice for the proposition that the Redlands project should be ceased because the model of care was not a contemporary one.

Kingswell's counsel submitted that Young gave evidence that the statement in the May briefing note that recent sector advice proposed a re-scoping of the clinical service model was based on consistent advice Young received from Groves, Gilhotra and, **to a lesser degree**, Kingswell (emphasis added).¹¹⁵ This is not supported by the evidence. As indicated above, Groves's evidence is that the cessation of the Redlands project was not considered during his employment.¹¹⁶ No evidence contradicts that. The extent of Gilhotra's evidence in relation to the relocation of the BAC is as follows:

To the best of my recollection, I was not involved in any formal discussions relating to the closure of the centre or the relocation of services to a new adolescent facility. In any meetings that I attended where the Barrett Adolescent Centre closure was discussed, my role as Director of Mental Health was to keep in mind compliance with the *Mental Health Act 2000* ("the Mental Health Act").¹¹⁷

Counsel for Kingswell submitted that his views were entirely consistent with those of other experts. They submitted that Kingswell's opinion that the Redlands model of care was not contemporary aligned with the views of other witnesses, including O'Connell, Young, Geppert and Cleary.¹¹⁸ Nevertheless, Kingswell's views were communicated to those witnesses and the Commission is satisfied that his views influenced the others' views.

According to Cleary, it was Kingswell who indicated that continuation of the Redlands project was inappropriate, and recommended a move from institutional to community-based care.¹¹⁹ When asked about the 'viability' of the project, Cleary said that his central concern was about

the advice that Kingswell's division had been providing, that an alternative service model would be appropriate.¹²⁰

The Commission found no evidence that O'Connell, or those advising him, sought or obtained child and adolescent psychiatric advice, or other expert advice, before O'Connell signed the May briefing note.

Counsel for O'Connell submitted that, as O'Connell was not a child and adolescent psychiatrist, he was dependent on the advice he received. The submission continued that, in understanding what constituted a contemporary model of care, both O'Connell and Cleary took advice from specialist psychiatrists employed in responsible positions, in particular, Kingswell, who regularly provided this kind of advice in his position as the senior person in the MHAODB.¹²¹ Counsel submitted that:

- whilst Kingswell was not a specialist child and adolescent psychiatrist, he was the senior person in the MHAODB
- the fact Kingswell was not a specialist child and adolescent psychiatrist could not, of itself, be a reason why a Director-General or Deputy Director-General would not listen to his advice;
- a Director-General or a Deputy Director-General expected that Kingswell's advice would be informed by knowledge acquired from a variety of appropriate sources¹²²
- the Director-General and Deputy Director-General would be expected to take this advice at face value, and without requesting source documents or details of the sources of the advice
- it would be 'quite impractical' to the functioning of the Department if the Director-General and Deputy Director-General were expected to say, in effect, 'show me all of your source documents'.¹²³

Counsel for O'Connell submitted that, instead, it was appropriate for the Director-General to:

... have some sense from their general knowledge that what is being spoken of seems right ... to say, look, over the years I have been exposed to literature and to orally expressed views about what are contemporary models of care in mental health. So what I am being told sounds consistent with what I have heard before. And that is in itself a reason to be prepared to accept the advice of your senior person in the Mental Health Branch that this is the course that should be followed.¹²⁴

Each decision will require its own particular approach. The Commission accepts that the advice of a senior person like Kingswell should be given great weight by a decision-maker and that it will usually be unnecessary to require access to his source documents.

O'Connell said that consideration of what constituted a 'contemporary model of care' was an important factor in the decision he took. And yet that topic does not feature in the May 2012 briefing note. Kingswell had not provided any written advice about it, even in a short memorandum, let alone his sources, or even references to his sources. The oral advice he had been providing about what was a contemporary model of care is not recorded at all in the May 2012 briefing note, which merely notes that:

- recent sector advice proposed a rescoping of the clinical service model and governance structure for the Redlands unit
- ceasing the Redlands project would necessitate a review of the BAC, and should give consideration to the benefits and disadvantages of this model of care
- limited sector consultation supported such a review.

In the circumstances, the Commission considers that it would have been appropriate to require an expert opinion or, at the least, inquire whether there was specialist advice underpinning the briefing note. Reliance on a general sense that the decision “seem[ed] right” and unrecorded oral advice not given in the context of the briefing note, in the absence of any evidence base, or expert opinion, or even a proper recording of the arguments, or analysis of the arguments, was too slight and insubstantial a basis for deciding to cancel the Redlands project.

Requirement to find \$100M–120M in savings

Queensland Health was required to find savings of \$100–120 million.¹²⁵

In that context, it was faced with an anticipated capital funding shortfall of \$3.1 million for certain projects where Commonwealth funding was conditional upon a financial contribution by the State. The State contribution was to be satisfied by reallocating funds already in the Health budget. There was a perception of immediacy about those Commonwealth funded projects, but not about the Redlands project.¹²⁶

The delays and budget overruns associated with the Redlands project and the views of senior officers in Queensland Health that it would not provide a contemporary model of care made it vulnerable to cancellation.¹²⁷

No consultation with David Crompton

More than two years before the May 2012 briefing note, on 5 March 2010, Crompton and his team had prepared a draft new model of care for Redlands.¹²⁸ By September 2010, Crompton’s model of service review group had finalised the model of service for the Redlands facility, but it had not been endorsed.¹²⁹

Counsel for Springborg submitted that delays to the project caused by delay in finalising the model of service were recognised in November 2011, and that as at mid-2012, there was still some consultation going on around the draft model.¹³⁰ However, that submission is based on Kingswell’s evidence that he thought finalising the model of service was an additional stumbling block to resolving the design and obtaining the building approvals.¹³¹ Suffice it to say that, Kingswell’s evidence on this point was rather equivocal¹³² and the contemporaneous documents (in particular the Mental Health Capital Works Program minutes and agenda papers)¹³³ as well as the oral evidence of Crompton,¹³⁴ make it clear that from September 2010 the model of service had been finalised but for endorsement – which was a matter for Kingswell, or his team.¹³⁵

In that context, it is surprising that:

- Crompton was not consulted in relation to the May briefing note.¹³⁶ In fact, he had not seen the document prior to preparing to give evidence to the Commission.¹³⁷
- The claim that the proposed Redlands model of care was not a contemporary model of care was not raised with Crompton, or his team.¹³⁸
- There is no evidence of any analysis of the criticisms of the proposed Redlands model of service.
- There are no specific details of this criticism. For example, what aspect of the Redlands model was not contemporary, and why?¹³⁹
- There is no evidence that any consideration was given to the work done by Crompton and his team and whether that proposed model of service could be implemented elsewhere – for example, as part of the proposed review necessitated by the decision.

Whether consideration given to the future of BAC

A logical question at the time the Redlands project was cancelled was: what were the consequences for the BAC and its patients? The evidence about this topic is mixed.

The briefing note says that ceasing the Redlands project “will necessitate a review of the existing adolescent centre at The Park, and should give consideration to the benefits and disadvantages of this model of care. Limited sector consultation supports this review”.

The BAC was to continue to operate

O’Connell’s evidence was that at the time of the decision to cease Redlands, alternative arrangements for the BAC clients were yet to be developed.¹⁴⁰ According to O’Connell, the development of the services to treat the type of patient who would be admitted to the BAC was a task still to be undertaken at the time of the decision to cease Redlands.¹⁴¹ O’Connell therefore envisaged that the BAC would continue to operate. He said that, at the time it was decided to cease the Redlands project, it was not necessary to have an alternative developed.¹⁴²

At the time of providing the May briefing note, Young had not reached a “concluded view” about what option should be pursued in place of the Redlands project.¹⁴³ She did not recall any detailed discussion about what would happen to the existing patients at the BAC. She said that at the time the decision to cease Redlands was made, she saw that there were three options:

1. The BAC facility at The Park would remain.
2. Another facility would be built somewhere else.
3. Other facilities being built for mental health services across the state would be enhanced.¹⁴⁴

Subsequently, Young conceded that there were only two realistic options available, namely finding somewhere other than Redlands and “adjusting the models of care” (i.e. options 2 and 3 above).¹⁴⁵ This was because, at the time, she held the view that the BAC was always going to close.¹⁴⁶

According to Cleary, based on the advice of Kingswell, the BAC was to continue operating in its then form and “no active, immediate consideration” was given to an alternative.¹⁴⁷

Kingswell’s evidence as to the consequences of ceasing Redlands was as follows:

Well, the consequences were quite obvious. The Redlands Project was a replacement for an existing facility. It would just mean that the facility would need to continue operating for some – you know, for some period of time until adequate replacement services were put in place.¹⁴⁸

The looming problem of EFTRU

It is in this context that the redevelopment plan for The Park becomes relevant (see chapters 2 and 14).

Kingswell gave evidence to the Commission that there was a “looming problem” associated with the potential co-location of the BAC and EFTRU at The Park.¹⁴⁹ However, that “looming problem” was not considered in making the decision to cease Redlands. It was not articulated as a consequence of the decision proposed in the May briefing note and only came to be considered after the decision had been made.

No consideration of the looming problem

The Commission found no evidence to suggest that, in deciding whether to approve the cessation of the Redlands project, O'Connell considered the consequences of the cessation of Redlands in circumstances where the imminent opening of EFTRU meant that the BAC would be unable to continue at The Park. Almost certainly, the reason O'Connell did not consider those consequences was that he was not advised (in the briefing note or otherwise) of those potential consequences. O'Connell gave evidence that he was "not aware that the redevelopment of The Park and/or the scheduled openings of the Kuranda Unit and EFTRU facility was relevant to the decision to not proceed with the Redlands unit".¹⁵⁰

Nevertheless, O'Connell appreciated the risks posed by The Park more generally. He said that he did not believe that refurbishment of the BAC was ever considered an option given the concern about having an adult forensic medical unit situated next to the BAC.¹⁵¹

And so, on the one hand, O'Connell made no inquiry about the co-location of the BAC and EFTRU because he was not aware of the "looming problem". On the other hand, he appreciated that there was a more general concern about the BAC continuing to operate adjacent to the adult forensic facilities.

Young gave evidence that she had no specific knowledge about EFTRU, or when it was scheduled to be opened.¹⁵² Therefore, potential co-location of the BAC and EFTRU was not a consideration she took into account as at May 2012.

Redlands was not a timely solution

Kingswell's evidence was that Redlands would never deliver a solution to the looming problem posed by EFTRU "in a timely way".¹⁵³ His Counsel submitted that it cannot be assumed that, even if the Redlands project had proceeded, it could have been available as a service to which to transition BAC patients.¹⁵⁴ It is certainly the case that delays may have caused Redlands not to be ready for some time. However, in that event, it is difficult to accept that some other interim options would not have been available.¹⁵⁵

No consideration of other consequences

There is only one reference to the consequences of cessation of Redlands in the May 2012 briefing note. It is in relation to a review of the BAC and its model of care:

Ceasing the 15-bed RAETU capital program will necessitate a review of the existing adolescent centre at The Park, and should give consideration to the benefits and disadvantages of this model of care. Limited sector consultation supports this review.¹⁵⁶

In her written evidence, Young stated that she would expect that the "limited sector consultation", referred to in the May 2012 briefing note was "informal consultation". Her evidence was that "extensive formal consultation does not ordinarily occur until after there is an '*in principle*' approval to pursue a particular avenue of action" (emphasis in original).¹⁵⁷ In her oral evidence, Young agreed that consultation that occurs after a decision is made is necessarily different from consultation that occurs before a decision.¹⁵⁸

There is no evidence that O’Connell considered, or had his attention drawn to, the other consequences of cessation, including:

- the length of time it would take to establish a contemporary model of care
- the needs of the BAC cohort
- services that were to be available in the interim if the BAC closed before another facility was opened.

During closing submissions, Counsel for O’Connell was asked by the Commissioner: “Would it not be reasonable to expect of someone in Dr O’Connell’s position that he would have asked, well, if I cancel Redlands what are the implications of my doing so?”¹⁵⁹ In response, Counsel for O’Connell submitted that:

- this issue was not canvassed with O’Connell in oral evidence¹⁶⁰
- the May briefing note passed through the Mental Health office and that, if there was “some relevant matter” to be brought to his attention, one would expect this to have occurred¹⁶¹
- an analysis of the implications was speculative because the difficulties with respect to the Redlands project (the ongoing environmental concerns, the budget overruns and so on) were such that Redlands would not provide an answer to the problem of co-location,¹⁶² that is, that the opening of EFTRU would precede the finalisation of Redlands and, therefore, the BAC would remain at The Park for some considerable time.

In his closing submissions, Counsel for O’Connell said:

Commissioner, what those making the decision about Redlands had in mind, whether this Commission accepts it to be right or not, there can be no doubt that it’s what they had in mind, was that the Redlands Project wasn’t going to happen any time soon ... But even if they were not right, but they believed that to be the case, why should any of them think that continuation of the Redlands Project at the pace that it might be expected to proceed was going to be any answer to a problem about the co-location of EFTRU and the Barrett Adolescent Centre come 2013, one might ask rhetorically.¹⁶³

The fact that Redlands, had it proceeded, may not have been available in a timely way does not mean there may not have been other options.

Was the decision-maker (O’Connell) presented with all the relevant facts necessary for him to make a properly informed decision? He was entitled to rely on those preparing the briefing note and the MHAODD. But he did not ask about the consequences of ceasing the Redlands project and none of those involved in the briefing note process considered it necessary to inform him about the consequences.

Review after the decision

It was only subsequent to the cancellation of Redlands that the issue of co-location of the BAC and EFTRU “reared its head”.¹⁶⁴ As Counsel for Springborg put it, “[i]t came into the dialogue on the evidence after Redlands had been cancelled”.¹⁶⁵

Counsel for Springborg submitted that the Commission should accept the evidence of Kingswell that it became urgent to close the BAC because of the risks associated with its co-location with EFTRU. They said there is no evidence to the contrary and that this was a judgment Kingswell was qualified to make.¹⁶⁶ Whilst that is true, the co-location problem was well known, at least by Kingswell, in May 2012 and prior to any urgency.

Young gave evidence that there is a myriad of ways expert advice can be obtained for a wide range of issues within the Department.¹⁶⁷ The decision to replace the BAC was a decision made with the involvement of experts under the QPMH.¹⁶⁸ However, the Commission found no evidence of expert input into the briefing note of May 2012, which resulted in a decision to cease its replacement (Redlands). This is evidenced in the following exchange between Counsel Assisting and Young:

- YOUNG: There are a range of ways that we get assistance with expert advice for a whole range of issues within the Department.
- FREEBURN: And there was no thought to do that before the decision was made to cease Redlands?
- YOUNG: I don't think so, no. I think at that stage the Director of Mental Health had gone and sought advice and then conveyed that to me, rather than setting up a formal process.
- FREEBURN: And I take it that advice to you was in conversations, not in written reports?
- YOUNG: I don't remember any written reports. I remember generalities of conversations.¹⁶⁹

Cleary's evidence is that, at the time the decision was taken not to proceed with the Redlands project, there was no discussion regarding an alternative.¹⁷⁰

Whether the May briefing note was sent to the Minister's office for approval

Counsel for Springborg submitted that there was no evidence that the May 2012 briefing note went to the Minister's office.¹⁷¹ His client characterised the decision to cease the Redlands project as one that was "independent" of him and made by the Director-General acting on the advice of the Chief Health Officer and Kingswell.¹⁷² That submission is correct.

The evidence is as follows:

- O'Connell believed his signing the May briefing note effectively ceased the Redlands project.¹⁷³
- No action was taken on the decision O'Connell made (possibly because the Minister's noting of it was awaited).¹⁷⁴
- An extract of a Cabinet-in-Confidence Cabinet Budget Review Committee (CBRC) document dated June 2012 was produced to the Commission; it recommended to Cabinet, among a number of possible cost-saving options, the "option" of "deferring" the Redlands project due to delays, a budget overrun and recent sector advice that proposed a re-scoping of the clinical service model.¹⁷⁵

Taken at its highest, the evidence might demonstrate that the May briefing note was sent to the Minister's office. There is certainly no evidence that the Minister remembered seeing it.

Counsel for O’Connell submitted, correctly in the Commission’s view, that:

- whilst O’Connell had understood that the Redlands project was cancelled when he signed the May briefing note, evidence subsequently received by the Commission indicated that that was not the case¹⁷⁶
- the significance of this was “modest” because the decision to cease Redlands was supported by all relevant individuals – those who provided the briefing note to O’Connell, O’Connell himself and, eventually, the Minister.¹⁷⁷

Conclusion

The proposal that the Director-General cease the Redlands project was not supported by any expert evidence. There were significant shortcomings in the advice provided. As explained above, there was no reference to Crompton or to the working groups. There was no analysis of the basis for criticisms of the model of care proposed for Redlands. And, importantly, O’Connell was not briefed on, and did not enquire about, the implications of ceasing Redlands and what this would mean for the BAC cohort and the future BAC cohort.

The Director-General’s decision to cease the Redlands project was not put into effect as the Department awaited noting by the Minister.

Be that as it may, there were three omissions from the May 2012 briefing note.

First, Kingswell was aware of the looming problem of the co-location of the BAC and EFTRU, but cleared the May 2012 briefing note without including that issue. In the Commission’s view the Director-General ought to have been given the full picture, including the impending co-location of the BAC and EFTRU and the risks associated with that co-location.

Second, Kingswell did not ensure the briefing note included advice about whether BAC or the Redlands Project was an essential health service, or any advice from at least one adequately qualified child and adolescent psychiatrist on this topic. And so, again the Director-General did not have the full picture when he considered the May 2012 briefing note, and his decision was made without the advantage of any expert evidence.

Third, there was limited or no consideration of the consequences of ceasing the Redlands project in circumstances where the BAC (which the Redlands project was intended to replace) had a limited lifespan. Kingswell was aware the BAC could not remain at The Park. To present the full picture to the Director-General, Kingswell should have ensured that the briefing note included advice on whether an extended inpatient facility was essential, and whether there were suitable alternatives to the Redlands Project.

Those omissions resulted in the Director-General being presented with a briefing note which omitted relevant information. It is impossible to say whether those omissions had any practical consequence. The Director-General may have made the same decision. And, as explained, it is likely that no action was taken on the decision, although it appears that the Minister subsequently took the view that the decision to cease the Redlands project had been made and that his consideration of the August 2012 briefing note was limited to re-allocation of the funds for that ceased project.

Counsel for Kingswell submitted that, in practice, briefing notes are “synoptic, not discursive” and if a briefing note, once forwarded to superiors, is not returned back down the line to “seek clarification”, it can be taken to be “sufficiently clear and complete”.¹⁷⁸

The Commission considers that, if the practice is not to include in a briefing note, at least in summary form, all the information necessary for the Director-General to make an informed decision, it is a poor practice. A decision-maker ought to be presented with the full picture. It is undesirable for issues, or relevant facts, to be omitted on the assumption that it is likely that the decision-maker acquired that information from conversations or from elsewhere. Good governance requires that a briefing note include a proper summary of all of the matters necessary for an informed consideration and weighing of all the relevant factors. And, in the Commission's view, especially in the case of decisions as important as the cessation of a project to replace a mental health facility for young people with severe and complex mental illness, it is unsafe for those preparing briefing notes to assume that a decision-maker will recognise when a briefing note is incomplete.

(Endnotes)

- 1 *Health Services Act 1991* (Qld) s 6.
- 2 *Health Services Act 1991* (Qld) s 28L.
- 3 Exhibit 94, Statement of Anthony O'Connell, 6 January 2016, p 2 para 2(a)(i).
- 4 Exhibit 94, Statement of Anthony O'Connell, 6 January 2016, p 2 para 2.
- 5 Exhibit 94, Statement of Anthony O'Connell, 6 January 2016, p 2 para 2(a)(i).
- 6 Exhibit 1437, Queensland Health Annual Report 2011-2012, Brisbane: Queensland Government, pp 93, 96-97.
- 7 Transcript, Michael Cleary, 25 February 2016, p 14-11 lines 27-35; Exhibit 40, Statement of Michael Cleary, 12 December 2012, p 5 para 18.
- 8 *Health Services Act 1991* (Qld) s 57C.
- 9 Transcript, Michael Cleary, 25 February 2016, p 14-5 lines 5-7.
- 10 Exhibit 58, Statement of Aaron Groves, 21 January 2016, p 3 para 13.
- 11 Exhibit 58, Statement of Aaron Groves, 21 January 2016, p 1 para 4, Attachment AG-1 to that statement, Curriculum Vitae of Aaron Groves, p 42.
- 12 Exhibit 68, Statement of William Kingswell, 21 October 2015, Attachment 1 to that statement, Curriculum Vitae of William Kingswell, p 25; Exhibit 58, Statement of Aaron Groves, 21 January 2016, p 5 para 22.
- 13 Transcript, Jeannette Young, 7 March 2016, p 21-67 lines 9-12.
- 14 Transcript, Jeannette Young, 7 March 2016, p 21-67 lines 17-21.
- 15 Exhibit 1437, Queensland Health Annual Report 2011-12, Brisbane: Queensland Government, p 15.
- 16 Exhibit 1077, Queensland Health Guide to Health Service Planning 2010, Brisbane: Queensland Government.
- 17 Transcript, Lawrence Springborg, 26 February 2016, p 15-38 lines 34-43.
- 18 Exhibit 40, Statement of Michael Cleary, 12 December 2012, p 8 para 30 (\$100 billion by 2017-2018), Attachment MIC-9 to that statement, Queensland Commission of Audit Interim Report June 2012, p 106 (\$100 billion by 2018-2019).
- 19 Transcript, Anthony O'Connell, 23 February 2016, p 12-12 lines 25-35, p 12-16 lines 15-21; Exhibit 94, Statement of Anthony O'Connell, 6 January 2016, pp 7-8 para 10(e).
- 20 Transcript, Anthony O'Connell, 23 February 2016, p 12-12 lines 30-35.
- 21 Transcript, Anthony O'Connell, 23 February 2016, p 12-18 lines 5-10; Exhibit 40, Statement of Michael Cleary, 21 December 2015, p 9 para 32.
- 22 Transcript, Michael Cleary, 25 February 2016, p 14-11 lines 27-35; Exhibit 40, Statement of Michael Cleary, 12 December 2012, p 5 para 18.
- 23 Exhibit 659, Emails between Alan Mayer, Leanne Geppert and others, Subject: "Redlands", 5 April 2012, p 2.
- 24 Exhibit 659, Emails between Alan Mayer, Leanne Geppert and others, Subject: "Redlands", 5 April 2012, p 1.
- 25 Exhibit 362, Briefing Note for Approval to Director-General Department of Health, Subject: "Cessation of the Redlands Adolescent Extended Treatment Unit Capital Program", 3 May 2012; Exhibit 666, Briefing Note for Approval to Minister for Health, Subject: "12 Rural Infrastructure Projects", 10 August 2012.
- 26 Exhibit 362, Briefing Note for Approval to Director-General Department of Health, Subject: "Cessation of the Redlands Adolescent Extended Treatment Unit Capital Program", 3 May 2012.

- 27 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, p 8 paras 36–38; Transcript, Lawrence Springborg, 26 February 2016, p 15-3 lines 20–27.
- 28 Exhibit 334, Email from Alan Mayer to Helen Doyle and Leanne Geppert, Subject: "Stage 1 Project - comments on project delays", 25 June 2012.
- 29 Exhibit 672, Emails between Jacqueline Ball, Michael Cleary and Leanne Geppert, Subject: "HHF letters to Hospital and Health Services", 9 July 2012.
- 30 Exhibit 43, Statement of David Crompton, 19 October 2015, p 7 paras 28, 29.
- 31 Exhibit 43, Statement of David Crompton, 19 October 2015, Attachment to that statement, Memorandum from Aaron Groves to David Theile and Pam Lane, Subject: "Adolescent Extended Treatment- Site Selection", p 154; See also Exhibit 43, Statement of David Crompton, 19 October 2015, p 7 para 32.
- 32 Exhibit 72, Statement of Judith Krause, 26 November 2015, p 15 para 60.
- 33 Exhibit 43, Statement of David Crompton, 19 October 2015, pp 9–10, para 37.
- 34 Exhibit 43, Statement of David Crompton, 19 October 2015, p 10 para 38.
- 35 Exhibit 43, Statement of David Crompton, 19 October 2015, p 10 para 39.
- 36 Exhibit 40, Statement of Michael Cleary, 21 December 2015, p 6 para 23.
- 37 Exhibit 68, Statement of William Kingswell, 21 October 2015, p 2 para 4.
- 38 Submissions on behalf of Lawrence Springborg, 23 March 2016, p 23 para 5.40.
- 39 Transcript, David Crompton, 16 February 2016, p 7-7 lines 32–39.
- 40 Exhibit 40, Statement of Michael Cleary, 21 December 2015, p 8 para 27.
- 41 Submissions on behalf of Anthony O'Connell, 23 March 2016, p 17 para 53.
- 42 Exhibit 68, Statement of William Kingswell, 21 October 2015, p 2 para 4.
- 43 Exhibit 243, Queensland Health Mental Health Capital Works Program, Meeting No 3, 15 October 2009, p 2.
- 44 Transcript, William Kingswell, 24 February 2016, p 13-12 lines 6–16.
- 45 Transcript, William Kingswell, 24 February 2016, p 13-12 lines 15–21.
- 46 Transcript, William Kingswell, 24 February 2016, p 13-12 lines 6–23.
- 47 Exhibit 68, Statement of William Kingswell, 21 October 2015, p 2 para 4.
- 48 Closing submissions on behalf of Anthony O'Connell, 23 March 2016, p 17 para 53.
- 49 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 2 para 5.2; Dwyer was the inaugural Chief Executive of West Moreton HHS, commencing in July 2012 and so her evidence here must be indirect.
- 50 Submissions on behalf of Lawrence Springborg, 23 March 2016, p 22 para 5.32.
- 51 Transcript, Anthony O'Connell, 23 February 2016, p 12-45 lines 35–44.
- 52 Transcript, David Crompton, 16 February 2016, p 7-9 lines 44–47; See Exhibit 242, Letter from Department of Environment and Resource Management to Department of Public Works regarding "Proposed Ministerial Designation - Redland Bay Hospital over lot 29 on SL11549 & lot 30 on SP106226 (21-25 Weippin Street, Cleveland) - Redland City Council - Response to the Draft Initial Assessment Report", 28 April 2011, p 3-6.
- 53 Submissions on behalf of Tony O'Connell, 23 March 2016, p 14 para 48.
- 54 Response to possible adverse findings – William Kingswell, 30 May 2016, Possible finding 3(e) pp 25–26 para 89.
- 55 Transcript, Leanne Geppert, 19 February 2016, p 10-4 line 40 – p 10-5 line 5.
- 56 Transcript, Leanne Geppert, 19 February 2016, p 10-5 lines 25–7.
- 57 Transcript, Sharon Kelly, 22 February 2016, p 11-14 line 30 – p 11-15 line 2.
- 58 Submissions on behalf of Anthony O'Connell, 23 March 2016, pp 20–21 para 66.
- 59 Submissions on behalf of Lawrence Springborg, 23 March 2016, p 25 para 5.40, p 26 para 5.41.
- 60 Submissions on behalf of Lawrence Springborg, 23 March 2016, p 25 para 5.40 and p 26 para 5.45.
- 61 Exhibit 40, Statement of Michael Cleary, 21 December 2015, p 7 para 25.
- 62 Exhibit 40, Statement of Michael Cleary, 21 December 2015, p 8 para 27.
- 63 Exhibit 40, Statement of Michael Cleary, 21 December 2015, p 8 para 28.
- 64 Transcript, Leanne Geppert, 19 February 2016, p 10-7 lines 12–16.
- 65 Transcript, Leanne Geppert, 19 February 2016, p 10-7 lines 16–21.
- 66 Transcript, Leanne Geppert, 19 February 2016, p 10-7 lines 19–21.

- 67 Exhibit 186, Statement of Jeannette Young, 15 February 2016, p 5 para 21.
- 68 Transcript, Jeannette Young, 7 March 2016, p 21-73 line 39 – p 21-74 line 30.
- 69 Exhibit 186, Statement of Jeannette Young, 15 February 2016, p 7 para 29.
- 70 Exhibit 186, Statement of Jeannette Young, 15 February 2016, p 8 para 35.
- 71 Exhibit 186, Statement of Jeannette Young, 15 February 2016, p 4 para 19.
- 72 Transcript, Jeannette Young, 7 March 2016, p 21-70 lines 34–40.
- 73 Exhibit 186, Statement of Jeanette Young, 15 February 2016, p 7-8 paras 28–34.
- 74 Exhibit 68, Statement of William Kingswell, 21 October 2015, p 2 para 4.
- 75 Exhibit 68, Statement of William Kingswell, 21 October 2015, p 2 para 4.
- 76 Exhibit 68, Statement of William Kingswell, 21 October 2015, p 14 para 23.
- 77 Exhibit 68, Statement of William Kingswell, 21 October 2015, p 5-6 para 19.
- 78 Exhibit 366, Email from Scott Harden to William Kingswell, Subject: "BAC", 14 September 2013, p 1.
- 79 Submissions on behalf of West Moreton HHS and the Board, 23 March 2016, p 20 para 6.12.
- 80 Exhibit 94, Statement of Anthony O'Connell, 6 January 2016, p 11 para 11(i).
- 81 Submissions of Anthony O'Connell, 23 March 2016, pp 21–22 para 70.
- 82 Submissions of Anthony O'Connell, 23 March 2016, p 22 para 71.
- 83 Transcript, Anthony O'Connell, 23 February 2016, p 12-52 lines 1–12.
- 84 Transcript, Anthony O'Connell, 23 February 2016, p 12-52 lines 2–5.
- 85 Transcript, Anthony O'Connell, 23 February 2016, p 12-52 lines 7-12.
- 86 Transcript, Anthony O'Connell, 23 February 2016, p 12-52 lines 27–30.
- 87 Transcript, Anthony O'Connell, 23 February 2016, p 12-18 lines 33–45.
- 88 Exhibit 68, Statement of William Kingswell, 21 October 2015, p 7 para 20(v).
- 89 Exhibit 40, Statement of Michael Cleary, 21 December 2015, p 7 para 27. See also Exhibit 437, Email from Sharon Kelly to "Sdlo" and Shelley-Lee Waller, Subject: "pertinent points for consideration of Barrett Adolescent Centre", 8 November 2012, p 1. Sharon Kelly said she assumed the source of that information was Kingswell (Transcript, Sharon Kelly, 22 February 2016, p 11-33 lines 1–3).
- 90 Exhibit 451, Emails between Bill Kingswell and Trevor Sadler, Subject: "The efficacy of 'Wraparound' services", 21 May 2013; Exhibit 759, Email from Leanne Geppert to Sharon Kelly and others, Subject: "YPARC email trail for your info", 11 July 2013; see also Transcript, William Kingswell, 24 February 2016, p 13-28.
- 91 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, p 52 para 40.
- 92 Submissions on behalf of Lawrence Springborg, 23 March 2016, p 17 para 6.11.
- 93 Transcript, Michael Cleary, 25 February 2016, p 14-8 lines 17–23.
- 94 Exhibit 40, Statement of Michael Cleary, 21 December 2015, p 7 para 25.
- 95 Exhibit 40, Statement of Michael Cleary, 21 December 2015, p 7 para 27.
- 96 Transcript, Geoffrey Diehm QC, Closing submissions on behalf of Anne Brennan, Michael Cleary, Anthony O'Connell, 11 April 2016, p 26-80 lines 27–35.
- 97 Submissions of William Kingswell, 23 March 2016, p 35 para 125.
- 98 Transcript, Michael Cleary, 25 February 2016, p 14-8 lines 16–23.
- 99 Transcript, Michael Cleary, 25 February 2016, p 14-10 line 36 – p 14-11 line 5.
- 100 Transcript, Michael Cleary, 25 February 2016, p 14-8 lines 31–39.
- 101 Transcript, Michael Cleary, 25 February 2016, p 14-8 lines 31–39.
- 102 Transcript, Leanne Geppert, 19 February 2016, p 10-7 lines 10–19.
- 103 Transcript, Jeannette Young, 7 March 2016, p 21-82 line 27 – p 21-83 line 8.
- 104 Transcript, Jeannette Young, 7 March 2016, p 21-82 lines 19–22.
- 105 Transcript, Jeannette Young, 7 March 2016, p 21-74 lines 22–30, p 21-98 lines 7–29.
- 106 Transcript, Jeannette Young, 7 March 2016, p 21-98 lines 7–29.
- 107 Exhibit 186, Statement of Jeannette Young, 15 February 2016, p 7 para 29.

- 108 Closing Submissions of Aaron Groves, 23 March 2016, p 3 para 12(b); Transcript, Jeannette Young, 7 March 2016, p 21-78 lines 1-12.
- 109 Transcript, Lesley Dwyer, 23 February 2016, p 12-120 lines 34-40.
- 110 Submissions on behalf of West Moreton HHS and Board, 23 March 2016, p 20 para 6.14(c); Transcript, Lesley Dwyer, 23 February 2016, p 12-121 lines 34-36.
- 111 Exhibit 94, Statement of Anthony O'Connell, 6 January 2016, p 11 para 11(i).
- 112 Exhibit 94, Statement of Anthony O'Connell, 6 January 2016, p 11 para 11(i).
- 113 Exhibit 94, Statement of Anthony O'Connell, 6 January 2016, p 7 para 10(a)(vi).
- 114 Exhibit 95, Supplementary statement of Anthony O'Connell, 6 February 2016, pp 3-4 para 4(a).
- 115 Submissions of William Kingswell, 23 March 2016, p 30 para 115.
- 116 Closing Submissions of Aaron Groves, 23 March 2016, p 4 para 19(a); Transcript, Jeannette Young, 7 March 2016, p 21-78 lines 1-12.
- 117 Exhibit 57, Statement of Jagmohan Gilhotra, 24 November 2015, p 2 para 10.
- 118 Submissions of William Kingswell, 23 March 2016, p 35 para 125.
- 119 Transcript, Michael Cleary, 25 February 2016, p 14-10 line 36 – p 14-11 line 5.
- 120 Transcript, Michael Cleary, 25 February 2016, p 14-6 lines 22-3.
- 121 Transcript, Geoffrey Diehm QC, Closing submissions on behalf of Anne Brennan, Michael Cleary, Anthony O'Connell, 11 April 2016, p 26-80 lines 27-42.
- 122 Transcript, Geoffrey Diehm QC, Closing submissions on behalf of Anne Brennan, Michael Cleary, Anthony O'Connell, 11 April 2016, p 26-81 lines 1-7.
- 123 Transcript, Geoffrey Diehm QC, Closing submissions on behalf of Anne Brennan, Michael Cleary, Anthony O'Connell, 11 April 2016, p 26-81 lines 12-17.
- 124 Transcript, Geoffrey Diehm QC, Closing submissions on behalf of Anne Brennan, Michael Cleary, Anthony O'Connell, 11 April 2016, p 26-81 lines 18-24.
- 125 Exhibit 40, Statement of Michael Cleary, 21 December 2015, p 9 para 32. This matter was agreed in submissions made to the Commission on behalf of Lawrence Springborg: Submission on behalf of Lawrence Springborg, 23 March 2016, p 32 para 5.78. Counsel for Kingswell submitted that the totality of the evidence indicates that in or before May 2012, Kingswell was informed by either Cleary or Young that approximately \$100-120 million worth of savings needed to be identified in the Queensland Health budget and that there was a clear urgency in the task: Submissions on behalf of William Kingswell, 23 March 2016, p 23 para 91. The State of Queensland's submissions were to the effect that it cannot be ignored that around the time of the decision to cease the Redlands project there was a whole of government budget strategy, which required Queensland Health to look in various areas for savings: Submissions on behalf of the State of Queensland, 23 March 2016, p 18 para 46(a).
- 126 Counsel for Springborg submitted that whilst a number of witnesses acknowledge the "tight fiscal environment" in which the decision to cancel the Redlands project was made, there is no evidence that funding issues caused the cessation of the project: Submissions on behalf of Lawrence Springborg, 23 March 2016, p 31 paras 5.72-5.73.
- 127 Counsel for O'Connell submitted that budgetary constraints seem to have been the precipitant to the decision to cease the Redlands project in the face of growing obstacles to the project proceeding. The submission was that the need for financial restraint was what made decision-makers look around to see where savings could be made. Notwithstanding this, Counsel for O'Connell submitted that, whilst budgetary constraints were in all likelihood the precipitating factor, they were not the only or even the determinative factor in the selection of the Redlands project as one to cease: Closing Submissions of Anthony O'Connell, 23 March 2016, p 13 paras 44, 46.
- 128 Exhibit 43, Statement of David Crompton, 19 October 2015, Attachment to that statement, Child and Youth Mental Health Service, Adolescent Extended Treatment and Rehabilitation Centre, Model of Service, pp 223-241.
- 129 Transcript, David Crompton, 16 February 2016, p 7-9 lines 29-33.
- 130 Submissions on behalf of Lawrence Springborg, 23 March 2016, p 25 para 5.35.
- 131 Transcript, William Kingswell, 24 February 2016, p 13-14 lines 34-35.
- 132 Transcript, William Kingswell, 24 February 2016, p 13-14 lines 34-40: "(Freeburn) So there are documents that suggest that there is either a final draft of the proposed model of service for Redlands or an all but final version? (Kingswell) Yeah. I'm not aware (Freeburn) Do you? (Kingswell) that that's the truth. I – I thought that there was still some consultation going on around that, and that, in fact, the final model of service had been an additional stumbling block to resolving the design and getting the building approvals going."
- 133 Exhibit 43, Statement of David Crompton, 19 October 2015, Attachment to that statement, Queensland Health, Mental Health Capital Works Program Meeting Minutes, 24 June 2010, pp 298-302, see especially p 300: "DC to communicate with CYMHS group indicating urgency for them to meet and finalise MOS. MOS required at 22 July FPTM".
- 134 Transcript, David Crompton, 16 February 2016, p 7-9 lines 29-33.

- 135 Transcript, William Kingswell, 24 February 2016, p 13-14 lines 27–32.
- 136 Transcript, David Crompton, 16 February 2016, p 7-7 line 19.
- 137 Transcript, David Crompton, 16 February 2016, p 7-7 lines 16–17.
- 138 O’Connell gave evidence that he was not aware of whether consultations before the May briefing note included Crompton or others involved in the work to develop a model of service: Exhibit 94, Statement of Anthony O’Connell, 6 January 2016, p 11 para 11(j).
- 139 Exhibit 94, Statement of Anthony O’Connell, 6 January 2016, p 11 para 11(j).
- 140 Exhibit 94, Statement of Anthony O’Connell, 6 January 2016, p 10 para 11(f).
- 141 Exhibit 94, Statement of Anthony O’Connell, 6 January 2016, p 13 para 13(b).
- 142 Exhibit 94, Statement of Anthony O’Connell, 6 January 2016, p 10 para 11(f).
- 143 Exhibit 186, Statement of Jeannette Young, 15 February 2016, p 9 para 39.
- 144 Transcript, Jeannette Young, 7 March 2016, p 21-77 lines 23–26.
- 145 Transcript, Jeannette Young, 7 March 2016, p 21-77 line 40.
- 146 Transcript, Jeannette Young, 7 March 2016, p 21-77 line 31–33.
- 147 Exhibit 40, Statement of Michael Cleary, 21 December 2015, p 9 para 34.
- 148 Transcript, William Kingswell, 24 February 2016, p 13-18 lines 14–17.
- 149 Transcript, William Kingswell, 24 February 2016, p 13-67 lines 19–25.
- 150 Exhibit 94, Statement of Anthony O’Connell, 6 January 2016, p 22 para 29(b).
- 151 Exhibit 94, Statement of Anthony O’Connell, 6 January 2016, p 13 para 13(a).
- 152 Transcript, Jeannette Young, 7 March 2016, p 21-71 lines 15–27.
- 153 Transcript, William Kingswell, 24 February 2016, p 13-11 lines 7–13.
- 154 Submissions on behalf of William Kingswell, 23 March 2016, p 27 para 107.
- 155 For example, delaying EFTRU, finding a temporary home for the BAC patients, or minimising the risks in some way. See the discussion of this topic in chapter 14.
- 156 Exhibit 362, Briefing Note for Approval to Director-General Department of Health, Subject: “Cessation of the Redlands Adolescent Extended Treatment Unit Capital Program”, 3 May 2012, p 2.
- 157 Exhibit 186, Statement of Jeannette Young, 15 February 2016, p 7 para 28.
- 158 Transcript, Jeannette Young, 7 March 2016, p 21-75 lines 46–47.
- 159 Transcript, Geoffrey Diehm QC, Closing submissions on behalf of Anne Brennan, Michael Cleary, Anthony O’Connell, 11 April 2016, p 26-81 lines 26–28.
- 160 Transcript, Geoffrey Diehm QC, Closing submissions on behalf of Anne Brennan, Michael Cleary, Anthony O’Connell, 11 April 2016, p 26-81 lines 31–32.
- 161 Transcript, Geoffrey Diehm QC, Closing submissions on behalf of Anne Brennan, Michael Cleary, Anthony O’Connell, 11 April 2016, p 26-83 lines 9–11.
- 162 Transcript, Geoffrey Diehm QC, Closing submissions on behalf of Anne Brennan, Michael Cleary, Anthony O’Connell, 11 April 2016, p 26-83 lines 11–16.
- 163 Transcript, Geoffrey Diehm QC, Closing submissions on behalf of Anne Brennan, Michael Cleary, Anthony O’Connell, 11 April 2016, p 26-83 lines 22–32.
- 164 Transcript, Geoffrey Diehm QC, Closing submissions on behalf of Anne Brennan, Michael Cleary, Anthony O’Connell, 11 April 2016, p 26-82 lines 38–39.
- 165 Transcript, Dominic O’Sullivan QC, Closing submissions on behalf of Lawrence Springborg, 12 April 2016, p 27-30 line 40.
- 166 Transcript, Dominic O’Sullivan QC, Closing submissions on behalf of Lawrence Springborg, 12 April 2016, p 27-31 lines 29–32.
- 167 Transcript, Jeannette Young, 7 March 2016, p 21-78 lines 1–4.
- 168 Closing submissions of Counsel Assisting, 17 March 2016, p 56 para 184.
- 169 Transcript, Jeannette Young, 7 March 2016, p 21-78 lines 3–12.
- 170 Exhibit 40, Statement of Michael Cleary, 21 December 2015, p 9 para 34.
- 171 Submissions on behalf of Lawrence Springborg, 23 March 2016, p 28 para 5.58.
- 172 Transcript, Lawrence Springborg, 26 February 2016, p 15-14 lines 13–16.

- 173 Transcript, Geoffrey Diehm QC, Closing submissions on behalf of Anne Brennan, Michael Cleary, Anthony O'Connell, 11 April 2016, p 26-79 lines 26-41; Exhibit 672, Emails between Jacqueline Ball, Michael Cleary and Leanne Geppert, Subject: "HHF letters to Hospital and Health Services", 9 July 2012.
- 174 Submissions on behalf of Anthony O'Connell, 23 March 2016, p 12 para 41.
- 175 Exhibit 252, [redacted] Agency submission pages 24 and 25, [redacted] pp 1-2.
- 176 Submissions on behalf of Anthony O'Connell, 23 March 2016, p 8 para 31.
- 177 Transcript, Geoffrey Diehm QC, Closing submissions on behalf of Anne Brennan, Michael Cleary, Anthony O'Connell, 11 April 2016, p 26-80 lines 1-6.
- 178 Response to possible adverse findings – William Kingswell, 30 May 2016, p 1, Preliminary points, para 2.

4 Changes from 1 July 2012

By the National Health Reform Agreement 2011, the State and Territory governments and the Commonwealth Government agreed to implement policy, planning and funding changes from 1 July 2012. These included the decentralisation of responsibility for the delivery of hospital and health services and the introduction of a purchaser provider model, by which a 'system manager' would purchase specified health services from Local Health and Hospital Networks using a national funding model and a national efficient price for the services.

Hospital and Health Services

The *Health and Hospitals Network Act 2011* (Qld) was passed in preparation for the introduction of the new public sector health system. Some of its provisions commenced in the first half of 2012, and some amendments were enacted shortly before the new system was to commence. The amendments included provisions for the establishment of Hospital and Health Services instead of Local Health and Hospital Networks and renaming the Act as the *Hospital and Health Boards Act 2011* (Qld).

From 1 July 2012 the Queensland public health system was comprised of Queensland Health (through its Director-General as chief executive) as the system manager and 17 Hospital and Health Services (HHSs) which were independent statutory bodies.¹

As system manager, Queensland Health had responsibility for the overall management of the state's public health system, including state-wide planning, managing state-wide industrial relations, managing major capital works, monitoring service performance, and issuing binding health services directives to the HHSs.²

Each HHS was governed by a Hospital and Health Board and managed by a Health Service Chief Executive.³ It had responsibility for the delivery of hospital and other health services in its local area.

The relationship between the system manager and a HHS was determined by the Act and a service agreement.

The West Moreton HHS was established prior to 1 July 2012, and Mary Corbett and Timothy Eltham were appointed as the Chair and Deputy Chair of its Board.⁴

The West Moreton HHS Service Agreement 2012–2013 was executed by the chief executive on behalf of Queensland Health as system manager and the chair of the Board on behalf of the HHS on 28 June 2012.⁵

On 1 July 2012 the West Moreton HHS assumed responsibility for the delivery of hospital and health services in its local area, including those provided at The Park.

Funding changes

A new model for Commonwealth funding of public hospitals was introduced by the National Health Reform Agreement 2011, namely a nationally consistent Activity Based Funding (ABF) based on a national efficient price where practicable, or otherwise block funding. This was to be progressively implemented; relevantly, for mental health services ABF was to be phased in from 1 July 2013.

Under the 2012–2013 service agreement between West Moreton HHS and Queensland Health, the BAC was block funded. However, it faced the prospect of change to ABF in 2013–14.

From July 2012, service agreements between Queensland Health and HHSs included budget allocations which were made after negotiations between the parties.⁶ Under the new arrangements, there was “greater discretion for HHS Boards to allocate and reprioritise funding so they could best meet the needs of their communities”.⁷

Administrative changes within Queensland Health

At the same time, there were changes in the administrative structure of Queensland Health. The functions of the department were realigned under three divisions and two business units, all overseen by the Office of the Director-General.

The three divisions were:

- the Health Service and Clinical Innovation Division
- the System and Policy Performance Division
- the System and Support Services Division.

Under the new structure, only the Deputy Directors-General reported directly to the Director-General. The Health Service Chief Executives reported to the boards of their HHSs. According to Tony O’Connell, the role of Director-General “fundamentally changed on 1 July 2012 to a role in which operational decisions deliberately became more distant from the Director-General”.⁸

Bill Kingswell as head of the Mental Health Alcohol and Other Drugs Branch (MHAODB) and Jeannette Young as Chief Health Officer now reported (independently)⁹ to Michael Cleary, who held the newly created position of Deputy Director-General, Health Service and Clinical Innovation,¹⁰ and Young “had no oversight or other responsibilities with respect to mental health issues”.¹¹ Cleary reported to the Director-General.¹²

Kingswell gave the following description of his responsibilities as Executive Director of the MHAODB:

I lead and influence policy development and legislative reform to ensure contemporary clinical practice and mental health service delivery in Queensland and support clinical governance activities to promote high quality and safe mental health alcohol and other drugs services.¹³

He became extensively involved in decisions concerning mental health policy in Queensland, including decisions to be made by West Moreton HHS in respect of The Park and the BAC. There was evidence before the Commission he had power to endorse (or not endorse) new models of care¹⁴ and also to forcibly close a service if deemed necessary due to patient risk.¹⁵

Mental Health Commission

On 1 July 2013 the Queensland Mental Health Commission (QMHC) was established as an independent statutory body by the *Queensland Mental Health Commission Act 2013*. Lesley van Schoubroeck was appointed as Mental Health Commissioner.¹⁶

The QMHC was set up to drive ongoing reform towards a more integrated, evidence-based, recovery-oriented mental health and substance misuse system.¹⁷ In doing so, it was to work with government and non-government sectors and with community members (including people with mental health and substance misuse issues, and their families, carers and support persons).¹⁸

The Queensland Mental Health and Drug Advisory Council was established by the same Act.

(Endnotes)

- 1 *Hospital and Health Boards Act 2011* (Qld) ss 7, 8.
- 2 *Hospital and Health Boards Act 2011* (Qld) ss 8(2), 8(3).
- 3 *Hospital and Health Boards Act 2011* (Qld) ss 7, 33.
- 4 Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 1 para 2.1(a); Exhibit 50, Statement of Timothy Eltham, 9 December 2015, p 1 para 2.3.
- 5 Exhibit 228, West Moreton 2012–13 Service Agreement executed by Dr O’Connell as Chief Executive, p 15; Transcript, Tony O’Connell, 23 February 2016, p 12–32 lines 31–47.
- 6 Exhibit 40, Statement of Michael Cleary, 21 December 2015, p 11 para 45.
- 7 Exhibit 40, Statement of Michael Cleary, 21 December 2015, p 11 para 46.
- 8 Exhibit 95, Supplementary statement of Anthony O’Connell, 6 February 2016, pp 8–9 para 17(a).
- 9 Jeannette Young’s evidence is that from 1 July 2012, Kingswell met with Cleary: Transcript, Jeannette Young, 7 March 2016, p 21–67 lines 14–15.
- 10 Exhibit 40, Statement of Michael Cleary, 21 December 2015, p 3 para 10.
- 11 Exhibit 186, Statement of Jeannette Young, 15 February 2016, p 2 para 9; Transcript, Jeannette Young, 7 March 2016, p 21–67 lines 1–5.
- 12 Exhibit 40, Statement of Michael Cleary, 21 December 2015, p 3 para 12.
- 13 Exhibit 68, Statement of William Kingswell, 21 October 2015, p 1 para 1.
- 14 Transcript, Leanne Geppert, 19 February 2016, p 10–12 lines 42–46.
- 15 Speaking notes prepared by Sharon Kelly in preparation for a meeting of the West Moreton Board on 24 May 2013 record that if the BAC did not close as planned, it is “Possible that ED of MHAODB [that is, Bill Kingswell] may pursue options to forcibly close service due to patient risk”; Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment SK-13 to that statement, p 884 para 6. Kelly confirmed, in oral evidence, that she understood this to be an option available to Kingswell: Transcript, Sharon Kelly, 22 February 2016, p 11–74 lines 1–6.
- 16 Exhibit 130, Statement of Lesley van Schoubroeck, 26 October 2015, p 2 para 4.
- 17 *Queensland Mental Health Commission Act 2013* (Qld) s 4(1).
- 18 *Queensland Mental Health Commission Act 2013* (Qld) s 5(5).

5 The August 2012 briefing note

Contents

The August 2012 briefing note was a briefing note for approval addressed to the Director-General. An accompanying briefing note for approval was addressed to the Minister for Health.¹ The author of the document was Rosemary Hood (Director of Health Infrastructure Office) and its contents were verified by Glenn Rashleigh (the Chief Health Infrastructure Officer within the Health Infrastructure Office).

The briefing note addressed to the Director-General proposed that he:

Note the planned strategy for the targeted rectification of the prioritised infrastructure issues and subsequent planning for 12 rural hospitals.

Note the recommended \$41 million funding strategy for 2012–2013 for the rural infrastructure rectifications from the Capital Program, of:

- Cessation of the Sunshine Coast Health Precinct and Caboolture Health Precinct projects;
- Cessation of the Replacement Adolescent Extended Treatment Unit, Redlands project;
- Deferral of the Townsville Medium Secure Rehabilitation Unit refurbishment project until 2013–2014.

Note that a further \$10.58 million is being allocated from “Closing the Gap” funding.

Note consultation will occur following approval of the recommended funding strategy.

[And that the Director-General] **Provide** this brief to the Minister for approval.²

The briefing note to the Director-General was described as ‘urgent’ because an announcement by the Minister was proposed to be made on 19 August 2012.

The briefing note to the Director-General was signed as ‘noted’ by Jeannette Young as acting Director-General on 17 August 2012 and the box ‘To Minister’s Office for Approval’ had a cross inserted.³

The briefing note addressed to the Minister made the recommendation that the Minister:

Approve the planned strategy for the targeted rectification of the prioritised infrastructure issues and subsequent planning for 12 rural hospitals.

Note the recommended \$41 million funding strategy for 2012–2013 for the rural infrastructure rectifications from the Capital Program, of:

- Cessation of the Sunshine Coast Health Precinct and Caboolture Health Precinct projects;
- Cessation of the Replacement Adolescent Extended Treatment Unit, Redlands project;
- Deferral of the Townsville Medium Secure Rehabilitation Unit refurbishment project until 2013–2014.

Note that a further \$10.58 million is being allocated from "Closing the Gap" funding".

Note consultation will occur following approval of the recommended funding strategy.

Note that the 2010 planning at 12 rural hospitals identified infrastructure issues.

Note that the funding strategy identified within existing capital program with minimum expenditure for targeted prioritised infrastructure rectification to improve safety and functionality in the short term.

Note that detailed planning will follow for medium and longer term solutions.

Note that the funding strategy relates to cessation and/or deferral of projects for replacement/ collocation of existing services and not service expansion.⁴

This briefing note addressed to the Minister was signed as 'noted' by the Minister's Chief of Staff on 27 August 2012 and signed as 'approved' by the Minister, Lawrence Springborg, on 28 August 2012.

Background

Preparation of the briefing note at the request of the Minister's office

Unlike the May 2012 briefing note, which was requested by the Chief Health Officer, the August 2012 briefing note was prepared by officers of the Health Infrastructure Office at the request of Vaun Peate, the Senior Department Liaison Officer within the Minister's office.

Springborg agreed with Counsel Assisting that, in his position as departmental liaison, Peate was effectively a liaison between the Minister's office and Queensland Health.⁵ Springborg gave evidence that the August briefing note would have originated from the Health Infrastructure Office in response to a request from his office.⁶ Springborg stated that briefing notes can "generate in a number of ways":

They can be by request from the Minister's office or if there are emergent issues or issues that the department or its officers or within the HHSs wish to inform the Minister of, that can – that process can start at that particular level.⁷

The issue of the 12 rural hospitals

Springborg gave evidence that in August 2012 he had recently become aware of an earlier report (concluded two years earlier)⁸ to the effect that 12 rural hospitals required immediate funding to address serious issues, such as fire safety, health and safety and access. He said that, if neglected any longer, those issues threatened the closure of the 12 hospitals.⁹ Springborg spoke of a "significant neglect of 12 hospitals".¹⁰ He said this needed to be addressed "immediately", because it was an issue as to whether those hospitals (which were "critical")¹¹ would be able to continue to operate.¹²

... and so postponing some projects and the cessation of a project, which was Redlands, which was recommended as not the most appropriate model of care, formed the basis to be able to access that funding to deal with **very, very significant emergent issues**.¹³

(emphasis added)

Springborg's evidence was that the allocation of the funding was a matter of "competing interests" and that the overall principal consideration was patient safety and care:

And we had an emergent issue where there were serious issues around patient safety and care in those hospitals which had been identified and not dealt with...¹⁴

... safety issues had compounded, and they were compromising the safe operation of those hospitals, so that work needed to be undertaken post-haste.¹⁵

Springborg made no criticism of Tony O'Connell (Director-General, Queensland Health), noting that he respected O'Connell and that one course of action (that which O'Connell put forward initially in May) subsequently became a different course of action based on the "emergent issues". He said that he doubted that in May, when O'Connell signed the earlier briefing note, the department was aware of the "emergent issues in those 12 hospitals".¹⁶

Analysis of the August 2012 briefing note

The earlier decision in May 2012

Counsel for Springborg submitted that their client's understanding was that the decision to cease the Redlands project had been made in May 2012 by the Director-General's approval of the May 2012 briefing note,¹⁷ and that this "original decision" to close or cease the Redlands project was a "clinical decision".¹⁸ The focus of the August 2012 briefing note, according to Counsel for Springborg, was on the re-allocation of funds from a project that had previously been cancelled. They submitted that, in August 2012, the emphasis was not on whether the earlier decision to cancel the project was correct or should be revisited,¹⁹ but on the use of the funds. Thus, a detailed analysis of the reasons for ceasing the Redlands project would not have been expected in August.

Balancing of competing demands

The Commission has found no evidence of any documents or reports addressing the consequences of the decision to cancel the three projects (and defer a fourth), or the consequences of the re-allocation of the funding. There was no documented consultation with the department. Springborg did not recall any documents or reports being produced in August 2012 which addressed the consequences of the decision to cancel three projects (and defer a fourth) or to re-allocate the funding:

No. But there was certainly information available to us beforehand that assisted us in making this decision.²⁰

... as we now know if we go back to the Director-General's briefing note in early May where he made a decision to cease the... Redlands project and also subsequent advice to that that this is no longer the... safe appropriate model of care for adolescents providing ... that is good background information which was no doubt provided orally and may have been in written form beyond the... briefing note that we now have here.²¹

Springborg was asked by Counsel Assisting how decisions could be made about cancelling or deferring projects, and re-allocation of their funding, in the absence of information relating to the associated consequences. Springborg's evidence was "we tried to make those decisions ... on

the best of available information to us”,²² and that “[W]e always try to make it based on what the emergent and urgent need is at the time and that was the basis of this decision”.²³

There is no doubt that Springborg placed emphasis on a ‘Preliminary Evaluation Report’ which identified the emergent infrastructure issues at the 12 rural hospitals. However, the balancing of competing demands for the total of \$51.58 million appears to have principally involved, on the one hand, the ‘Preliminary Evaluation Report’ on 12 rural hospitals and, on the other hand, advice to the Minister (principally from Kingswell, detailed below) that there were doubts that a purpose-built replacement of the BAC was an appropriate contemporary model of care.

The rural hospitals project was not significantly developed. The actual budget for the project was said to be a “low-confidence estimate”.²⁴

Clinical input and consultation

Introduction

The August 2012 briefing note addressed to the Director-General states that Kingswell recommended the cessation of the replacement Adolescent Treatment Unit at Redlands.²⁵ Under the heading ‘Consultation’ is this:

Dr Bill Kingswell, Executive Director – Mental Health, Alcohol and other Drugs recommended the cessation of the replacement Adolescent Extended Treatment Unit at Redlands ...²⁶

The briefing note to the Director-General and the briefing note to the Minister both say:

Consultation will occur **following** approval of the recommended funding strategy.²⁷
(emphasis added)

Thus, the decision was made before consultation had occurred, and (according to the briefing note to the Director-General) principally on the recommendation of Kingswell.

Springborg’s evidence and submissions

Counsel for Springborg submitted that:

- nothing had changed between May 2012 and August 2012 to suggest that the May 2012 decision to cease the Redlands project should be revisited²⁸
- it is difficult to see what proper basis the Minister would have had to “gainsay the advice of his Department”.²⁹

Springborg’s written evidence was that during 2012, he was aware that senior clinicians within the Department had expressed the view that:

- a facility like the Barrett Centre was not regarded as contemporary within the draft NMHSPF; and
- it was not the most appropriate model for caring for and treating severely troubled adolescents who required intensive inpatient or outpatient psychiatric care; and
- the preferred model involved the provision of services in the community, closer to the patient’s home, and a move away from what was regarded as long-term institutional care of the kind provided by the [BAC].³⁰

The written evidence of Springborg was also to this effect:

I became aware that the Redlands project had encountered significant delays, cost overruns, and problems with environmental issues (including the land being a koala habitat), and that expert clinicians had expressed doubts that a purpose-built replacement of the Barrett Centre was an appropriate contemporary model of care.³¹

Springborg remembered receiving and signing the August briefing note.³² He gave evidence that “by that stage”, he was “very familiar with the issues” regarding the proposed centre at Redlands and advice from Kingswell and the Chief Health Officer through the Director-General “that this project should be ceased as it was no longer considered an appropriate contemporary model of care”.³³ Springborg’s evidence was as follows:

I do remember this issue because there was discussion at the time around whether this was the right model of care for those who need care going forward. The advice on that was that it was no longer [an appropriate model], and that was the advice by very senior clinicians. And as a consequence of that, the decision which had been made in May of that year by the Director-General, acting on the advice of the Chief Health Officer and the now-Director of Mental Health and Alcohol and Drugs, was that this was not the appropriate model of care and the project should be ceased.³⁴

He said that, had he received advice indicating that “the institutional model of care” was the appropriate model of care going forward, he had “no doubt” that “funding would have been found”.³⁵ Later he said:

But, critically, if there had been any subsequent recommendations to me as Minister that an institutional care environment around adolescent patients was required, then I have no doubt that that would have been able to be accommodated through our budget surpluses which subsequently arose or through central government.³⁶

Properly understood, Springborg’s evidence was that in the months leading up to the August 2012 briefing note, he received advice (that is, oral advice) from Kingswell, Young and O’Connell, that the Redlands project should be ceased as it was no longer considered an appropriate contemporary model of care.³⁷ As it happens, (and as explained above in chapter 3) both O’Connell and Young were influenced by the views of Kingswell.

Kingswell’s evidence and submissions

Counsel for Kingswell submitted that the assertion in the briefing note that Kingswell “recommended” the cessation of the Redlands project was a “mischaracterisation of his conduct”.³⁸ He argued that there was no evidence that the Kingswell was involved in the preparation of the August 2012 briefing note or that he knew about it at the time.

The Commission accepts that Kingswell had no involvement in the preparation of the August 2012 briefing note, and that there is no evidence that he knew of it at the time. There is no suggestion that the specific recommendation referred to in the briefing note was made with his knowledge. And so it may be inaccurate to use the word “recommended” in this context.

Young’s evidence

Young (who signed the August briefing note in her capacity as acting Director-General) was asked if it had concerned her that money was being distributed seemingly without any expert advice or clinical input. She replied, “But that expert advice had already occurred earlier, that going ahead with the Redlands Project was not necessarily the best thing to do”.³⁹

She agreed that she was “going back to the May briefing note”.⁴⁰

Young gave evidence about the August 2012 briefing note and particularly the concept that consultation was to occur *after* the approval of the cessation of Redlands:

FREEBURN: At that point, August 2012, what was the future of the – or where were the inpatients at the Barrett Adolescent Centre going?

YOUNG: I don’t believe that had been determined at that stage.

FREEBURN: Right?

YOUNG: So this is seeking approval to cease the replacement of the unit to be based at Redlands and then saying consultation will occur following that approval.⁴¹

Later, this exchange with the Commissioner took place:

COMMISSIONER: Well, this briefing note affected not only the Redlands project which is a concern of this Commission but a number of other projects – Sunshine Coast, Townsville. Did you inquire whether there had been any consultation with the relevant health services associated with those projects?

YOUNG: I can’t remember whether or not I inquired. I would – it would be my normal practice to do so, but I just can’t remember whether or not I did that.

COMMISSIONER: Did you inquire whether the Infrastructure Branch of the Department of Health had been consulted about this briefing note?

YOUNG: It came from them, I believe, Commissioner. It came from the Chief Health Infrastructure Officer.

COMMISSIONER: I see. So you didn’t inquire whether he or anyone at his direction had consulted?

YOUNG: Sorry, Commissioner. I don’t remember whether I did or didn’t.⁴²

...

YOUNG: Often, the consultation that occurs before a decision is made is within Queensland Health. And you’re less likely to do broader consultation with the non-government sector, the private sector and so forth to affirm decisions being made. So it will vary depending on the decision that needs to be made.⁴³

Consultation

That issue of consultation deserves closer scrutiny.

The August 2012 briefing note, it will be recalled, specified that consultation was to occur following approval of the recommended strategy. The Commission found no evidence that consultation with any of the following stakeholders occurred before the approval:

- Queensland Health other than the Infrastructure Branch – as explained above, not even Kingswell and the MHAODB, a branch with a planning function, appear to have been consulted
- Metro South HHS (the HSS which was to ‘lose’ the project) or West Moreton HHS (the HSS responsible for the service Redlands was to replace)⁴⁴
- David Crompton (Executive Director Addiction and Mental Health Services, Metro South HHS) and his team who had prepared a model of service for Redlands
- expert child and adolescent psychiatrists or others who might have expressed a view on what were contemporary models of care
- the wider profession
- families or carers.

When asked by Counsel Assisting if it was common practice for health services to be consulted when funding for projects within their control was to be withdrawn, Springborg said that the decision to cease Redlands was made in May 2012 by the then Director-General and hence before the inception of the Hospital and Health Services.⁴⁵

West Moreton HHS was not informed of the cancellation of the Redlands project and the reallocation of the funding until after the decision had been made. See the discussion in chapter 7.

The Commission has not located documents recording advice to the Minister that the Redlands model of service was inappropriate and should be ceased. No such advice is recorded in the August briefing note itself, although the Minister appears to have relied on such advice in approving the proposal in the August 2012 briefing note.

It is appropriate that some business of government be conducted in meetings and conversations. However, as explained in chapter 15, there are good reasons for properly documenting important decisions and the reasons for those decisions.

Whether consideration given to the future of BAC

Funding

Springborg’s evidence was that necessary funding would have been found if he had been advised that a Redlands-type facility was the best way of caring for the adolescents who would have been its patients.⁴⁶

Other witnesses maintained there was no funding available for a “bricks and mortar” replacement.⁴⁷

Two points are relevant here. The first is that the availability of funding is not a static process. Funding may become available at a later time. The second is that whether funding is provided often depends on whether a case is made to the government of the day that such a service is needed, as well as the strength of the case that is put.

EFTRU

In 2008, EFTRU and the Redlands project were being planned concurrently. EFTRU was intended to open at The Park by mid-December 2010 and the Redlands unit was intended to open by mid-January 2011.⁴⁸

However, both projects were delayed: by mid-2012 construction of Redlands had not started and EFTRU was to open in 2013. Neither the May briefing note nor the August briefing note mentions the impending opening of EFTRU and the undesirability of a service such as EFTRU being co-located with a service such as that provided by the BAC.

The evidence is that it was not until around December 2012 that the EFTRU issue came to the Minister's notice.⁴⁹

Counsel for Springborg's closing submissions on the issue of EFTRU proceeded along similar lines to those of Counsel for O'Connell and Michael Cleary, namely, that Redlands would not provide a solution to the problem posed by EFTRU. Attention was directed to Kingswell's evidence that "Redlands was not going to deliver us the solution, not in any timely way – a solution to the looming problem".⁵⁰

Neither briefing note presented the Director-General or the Minister with all the relevant facts.

It was going too far to suggest that the Redlands project "could never provide a solution to the problem".⁵¹ The opening of EFTRU might have been delayed, or interim arrangements made, or risks managed. The acting Director-General and the Minister should have been presented with the full picture of the likely consequences so that a proper analysis could be done.

Counsel for Springborg submitted that the Minister would have made the assumption that significant concerns (if any existed) would have been escalated by Kingswell to Cleary, who would have raised them with the Director-General or the Minister directly if that was considered necessary: "His assumption [the Minister] is that if there were particular issues to do with EFTRU... Dr Kingswell would properly have escalated that up to him if Kingswell believed it was relevant".⁵²

However, there was no evidence that Kingswell knew of the August briefing note at the time it was being prepared and approved. It was prepared by the Health Infrastructure office at the request of the Minister's office.

Responsibility

That raises a related point: who was responsible for co-ordination of the replacement of the BAC and EFTRU?

Springborg's evidence was that it was not the role of the ministerial office to work on the alternative clinical models of care and that "any minister" would expect, upon receipt of advice that a model was no longer contemporary, those responsible would be working on the model of care.⁵³ He was not directly aware of who was working on alternative models.⁵⁴ The broad thrust of that is correct. The Minister relies on advice for detail and clinical matters.

Kingswell gave evidence that:

The operator of the facilities at The Park, which included both the Barrett Adolescent Centre and the proposed EFTRU, was WMHHS. It was responsible for putting in place the appropriate steps to transition the BAC patients and as to the scheduling of the opening of EFTRU ... Those matters were not within the control of MHAODB or QH. To the best of my knowledge, there was no individual within either MHAODB or QH who was responsible for co-ordinating the replacement of the BAC and the opening of the EFTRU.⁵⁵

In a supplementary statement, O'Connell gave evidence that:

The management of the closure of the BAC, the identification of replacement services, **and the opening of EFTRU** was a joint responsibility of the WMHHS and the CHQHHS in consultation with the Mental Health Branch of the Department of Health. No single person was entirely responsible for these activities.⁵⁶

(emphasis added)

The Commission prefers O'Connell's evidence on this point. From 1 July 2012 Queensland Health was the system manager with a planning role. Each had a joint responsibility.

Summary

The Commission found no evidence of any consideration of the impending co-location of EFTRU and the BAC (concerns which, on the evidence, were legitimate and well-founded). Apart from Kingswell's being aware of the problem, concerns about the co-location of those two services do not feature in the narrative until well after the decision not to proceed with Redlands. They were raised in a context where there was no existing plan for what was to happen to the BAC.

The Minister's evidence (which the Commission accepts) was that in all matters his concern was continuity of patient care.⁵⁷

After the August briefing note and the cancellation of Redlands, steps were taken to move for the closure of the BAC, citing EFTRU (see chapter 7).

There is nothing in the August briefing note about the implications of ceasing Redlands and what this would mean for existing services being provided at The Park. The decision to redirect the Redlands funding was made without any analysis of what that would mean for the BAC and, in particular, the patients treated by the BAC. For example, the Commission found no evidence of any consideration of whether funding for Redlands could be acquired from elsewhere.

Counsel for Springborg submitted that the decision to cease Redlands did not extend to a decision about the services that would, in due course, be provided following a closure of the BAC.⁵⁸ However, ongoing development of The Park as an adult forensic and secure unit, and in particular, the impending opening of EFTRU, made it undesirable for the BAC to continue to operate on that campus (see chapter 14). The Commission found no evidence that the Minister was made aware of this at the time of signing the August briefing note. In this respect he was poorly and inadequately advised.

The Commission found no evidence of any specific analysis or consideration of what constituted a 'contemporary model of service' and the length of time this would take to establish. This went beyond the clinical realm (which the Minister rightly left to the Department and to clinicians).

The Commission found no evidence that the Minister or his staff or the Department called for any analysis or discussion of the needs of the BAC cohort before the August 2012 briefing note was signed by the Minister. Counsel for Springborg submitted that further work would need to be done, later, to develop new replacement services.⁵⁹

The Commission found no evidence that it was suggested to the Minister that the BAC should remain open until new models became available or that the Minister requested details of what services were to be available in the interim in the event that the BAC closed before another facility was opened.

Conclusions

The decision to redirect the Redlands funding was a policy decision within the Minister's discretion. The Minister gave evidence of an emergent issue to repair 12 rural hospitals. He was plainly entitled to exercise his discretion to remove the funding from the Redlands project and to redirect it to the new, emergent issue.

However, this was a decision made without any substantive consultation with the Hospital and Health Services that were to be affected by the decision (that is, West Moreton HHS and Metro South HHS, respectively) and without consulting relevant child and adolescent psychiatric experts.

The Commission found no evidence of any analysis of the basis for criticisms of the model of service proposed for Redlands, or that the Minister was even made aware that a new model was in the course of being prepared for Redlands.

While blame for such failings cannot be attributed to any one individual, they are indicative of what may be a significant systemic issue within Queensland Health. The preparation and consideration of the briefing note was confined to the Health Infrastructure Office. The lack of consultation meant that wider issues, impacts or consequences of the decision were not considered beyond that office. As explained in chapters 3 and 15, good governance requires that a briefing note include a proper summary of all of the matters necessary to an informed consideration and weighing of all relevant factors.

The decision to cease the Redlands project was taken at a time when few community-based services were available for adolescents. As events have subsequently proved, it would take a long time to develop and implement new models of care.

The Minister ought to have been made aware of all relevant factors. He made a policy decision that was within his discretion to make. However, he had not been adequately advised.

There is one final aspect worthy of note. The relevant submissions of the four decision-makers can be summarised in this way:

- Springborg contends that the decision to cease the Redlands project had been made by the Director-General in May 2012 and there was no reason to revisit that decision in August 2012.
- O'Connell says that he made the decision in May 2012 but it was not actioned and he was not involved in the August 2012 decision.
- Young, who approved the August 2012 briefing note, said that the expert advice had been obtained in May 2012 and the decision that going ahead with the Redlands project was "not necessarily the best thing to do" had been made at that time.
- Kingswell said that while he is mentioned in the August 2012 briefing note to the Director-General as having recommended the cessation of the Redlands project, he had no involvement in that briefing note.

Thus, Springborg and Young were involved in the August 2012 briefing note but contend that the decision to cancel the Redlands project was made in May 2012. O'Connell and Kingswell were involved in the May 2012 briefing note, but put qualifications on what was decided at that time,⁶⁰ and say they were not involved in the August 2012 briefing note.

No person or entity accepted responsibility for the cancellation of the Redlands project.⁶¹

(Endnotes)

- 1 Exhibit 666, Briefing Note for Approval to Minister for Health, Subject: "12 Rural Infrastructure Projects", 10 August 2012.
- 2 Exhibit 666, Briefing Note for Approval to Minister for Health, Subject: "12 Rural Infrastructure Projects", 10 August 2012, p 5.
- 3 Exhibit 666, Briefing Note for Approval to Minister for Health, Subject: "12 Rural Infrastructure Projects", 10 August 2012, p 5.
- 4 Exhibit 666, Briefing Note for Approval to Minister for Health, Subject: "12 Rural Infrastructure Projects", 10 August 2012, p 1.
- 5 Transcript, Lawrence Springborg, 26 February 2016, p 15-5 lines 34–35.
- 6 Transcript, Lawrence Springborg, 26 February 2016, p 15-6 lines 33–36.
- 7 Transcript, Lawrence Springborg, 26 February 2016, p 15-6 lines 44–47.
- 8 Transcript, Lawrence Springborg, 26 February 2016, p 15-16 line 17.
- 9 Transcript, Lawrence Springborg, 26 February 2016, p 15-4 line 45 – p 15-5 line 7.
- 10 Transcript, Lawrence Springborg, 26 February 2016, p 15-4 line 46.
- 11 Transcript, Lawrence Springborg, 26 February 2016, p 15-8 line 30.
- 12 Transcript, Lawrence Springborg, 26 February 2016, p 15-5 lines 1–3.
- 13 Transcript, Lawrence Springborg, 26 February 2016, p 15-5 lines 4–7.
- 14 Transcript, Lawrence Springborg, 26 February 2016, p 15-5 lines 13–15.
- 15 Transcript, Lawrence Springborg, 26 February 2016, p 15-9 lines 1–2.
- 16 Transcript, Lawrence Springborg, 26 February 2016, p 15-41 lines 22–37.
- 17 Submissions on behalf of Lawrence Springborg, 23 March 2016, p 28 para 5.56.
- 18 Transcript, Lawrence Springborg, 26 February 2016, p 15-7 lines 13–14.
- 19 Submissions on behalf of Lawrence Springborg, 23 March 2016, p 35 para 5.92.
- 20 Transcript, Lawrence Springborg, 26 February 2016, p 15-16 lines 37–41.
- 21 Transcript, Lawrence Springborg, 26 February 2016, p 15-16 line 44 – p 15-17 line 3.
- 22 Transcript, Lawrence Springborg, 26 February 2016, p 15-17 lines 37–47.
- 23 Transcript, Lawrence Springborg, 26 February 2016, p 15-18 lines 1–2.
- 24 Exhibit 666, Briefing Note for Approval to Minister for Health, Subject: "12 Rural Infrastructure Projects", 10 August 2012, p 3 para 7.
- 25 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, p 9 para 40.
- 26 Exhibit 666, Briefing Note for Approval to Minister for Health, Subject: "12 Rural Infrastructure Projects", 10 August 2012, p 14.
- 27 Exhibit 666, Briefing Note for Approval to Minister for Health, Subject: "12 Rural Infrastructure Projects", 10 August 2012, pp 1, 5.
- 28 Submissions on behalf of Lawrence Springborg, 23 March 2016, p 35 para 5.92.
- 29 Submissions on behalf of Lawrence Springborg, 23 March 2016, p 34 para 5.83.
- 30 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, p 9 para 40.
- 31 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, p 26 para 137.
- 32 Transcript, Lawrence Springborg, 26 February 2016, p 15-3 lines 29–39.
- 33 Transcript, Lawrence Springborg, 26 February 2016, p 15-3 lines 29–39.
- 34 Transcript, Lawrence Springborg, 26 February 2016, p 15-4 lines 17–24.
- 35 Transcript, Lawrence Springborg, 26 February 2016, p 15-4 lines 27–30.
- 36 Transcript, Lawrence Springborg, 26 February 2016, p 15-8 lines 35–39.
- 37 Transcript, Lawrence Springborg, 26 February 2016, p 15-3 lines 36–39.
- 38 Response to possible adverse finding – William Kingswell, 30 May 2016, p 24 paras 78–79.
- 39 Transcript, Jeannette Young, 7 March 2016, p 21-73 lines 33–35.
- 40 Transcript, Jeannette Young, 7 March 2016, p 21-73 line 37.
- 41 Transcript, Jeannette Young, 7 March 2016, p 21-73 lines 8–13.
- 42 Transcript, Jeannette Young, 7 March 2016, p 21-75 lines 5–17.

- 43 Transcript, Jeannette Young, 7 March 2016, p 21-75 lines 40–44.
- 44 Transcript, Lawrence Springborg, 26 February 2016, p 15-13 lines 32–39.
- 45 Transcript, Lawrence Springborg, 26 February 2016, p 15-14 lines 22–32.
- 46 Transcript, Lawrence Springborg, 26 February 2016, p 15-26 lines 14–17. See also p 15-17 lines 28–35.
- 47 See, for example, Transcript, Leanne Geppert, 19 February 2016, p 10-15 lines 17–21.
- 48 Exhibit 1114, Mental Health Capital Works Program (MHCWP), Project Manager’s Monthly Progress Report, 29 February 2008, pp 19–20.
- 49 Exhibit 457, Supplementary statement of Lawrence Springborg, 10 March 2016, p 2 para 4.
- 50 Transcript, Dominic O’Sullivan QC, Closing submissions on behalf of Lawrence Springborg, 12 April 2016, p 27-34 lines 24–30.
- 51 Transcript, Dominic O’Sullivan QC, Closing submissions on behalf of Lawrence Springborg, 12 April 2016, p 27-40 lines 39–40; p 27-36 lines 27–29.
- 52 Transcript, Dominic O’Sullivan QC, Closing submissions on behalf of Lawrence Springborg, 12 April 2016, p 27–44 lines 29–32.
- 53 Transcript, Lawrence Springborg, 26 February 2016, p 15-23 lines 7–18.
- 54 Transcript, Lawrence Springborg, 26 February 2016, p 15-23 line 20.
- 55 Exhibit 979, Supplementary statement of William Kingswell, 22 March 2016, p 2 para 2(c).
- 56 Exhibit 448, Second supplementary statement of Anthony O’Connell, 8 March 2016, p 2 para 1(c).
- 57 Transcript, Dominic O’Sullivan QC, Closing submissions on behalf of Lawrence Springborg, 12 April 2016, p 27-45 lines 1–5.
- 58 Submissions on behalf of Lawrence Springborg, 23 March 2016, p 34 para 5.81(c).
- 59 Submissions on behalf of Lawrence Springborg, 23 March 2016, p 29 para 5.64.
- 60 Kingswell contends that the May 2012 briefing note was urgent and principally based on fiscal considerations: Submissions on behalf of William Kingswell, 23 March 2016, p 24 paras 94, 103. O’Connell says that the decision to cease the Redlands project was not a decision to close the BAC: Transcript, Anthony O’Connell, 23 February 2016, p 12-51 lines 5–7.
- 61 See the discussion of accountability and related concepts in chapter 15.

6 West Moreton Hospital and Health Service

The newly established West Moreton HHS assumed responsibility for the hospital and health services that had been administered by the West Moreton Health District of Queensland Health.

It was allocated an operating budget of \$373.3 million for the financial year 2012–2013.¹ With a workforce of approximately 2500 full time equivalent employees, it was one of the largest employers in the region.²

Lesley Dwyer was appointed as Health Service Chief Executive.³

West Moreton HHS inherited services (including The Park Centre for Mental Health) that were in poor financial shape, and it faced pressures mirroring those of its predecessor. Dwyer said in her statement:

At the time of my appointment as Health Service Chief Executive, West Moreton's predecessor entity (West Moreton Health Service District) had operated at a very significant budget overrun for a long time.

One of the priorities of my appointment was to bring the newly created WMHHS back into budget. Given the extent of the budget overrun historically, it was clear to me that significant cost reduction and internal efficiency improvement would be necessary to achieve this.⁴

She continued:

The uncoupling of the Darling Downs West Moreton Health Service District into two separate districts some years earlier had not been followed by an appropriate rationalisation of roles within WMHHS. There were roles in which the amount of work or breadth of responsibilities had significantly reduced but the role had not been adjusted, so there was excess capacity in the role which was not being used.

The uncoupling had distorted some reporting lines due to particular roles staying with one District rather than the other. As a result, the reporting structures were not necessarily optimal or logical.

The changes which were ongoing at The Park, such as the winding down of the Extended Treatment and Dual Diagnosis services and devolution of those patients to Community Care Units elsewhere, the development of the Extended Forensic Treatment and Rehabilitation Unit, construction of a new Community Care Unit at Gales, meant that staffing needs within WMHHS were in a state of change and it was appropriate to review staffing needs across the whole service.

Inappropriate rostering and overtime practices had developed informally within The Park which were contributing to a significant overspend on staff costs.

There was room for improvement in the nursing skills mix across many of the units, where staffing consisted solely or substantially of registered nurses but a mix of registered nurses and enrolled nurses would be as efficient.⁵

Sharon Kelly, the Executive Director, Mental Health and Specialised Services, prepared a 'Business Case for Change' which was presented to the Minister for Health in December 2012. It proposed a revised overarching organisational structure to promote the delivery of contemporary mental health and offender health services in West Moreton HHS, and recommended that it be implemented from 18 February 2013.⁶

The Park

In March 2012, the Mental Health Alcohol and Other Drugs Directorate (MHAODD) had commissioned a review of the financial position of The Park which had been facing a projected deficit of approximately \$5 million for the 2011–2012 financial year.⁷

That review of The Park was a collaborative process between the MHAODD and the West Moreton Health Service District. It was carried out by Karlyn Chettleburgh (Executive Director Mental Health & ATODS, Gold Coast Health Service District), with the assistance of Helen Doyle (Quality Assurance Manager, Queensland Health) who provided support and advice regarding The Park redevelopment program and associated reform activities.⁸

The Chettleburgh and Doyle report made recommendations to assist in progressing the reform agenda and to provide a platform for sound financial management of resources at The Park.⁹ It recommended that a sliding scale of resource allocation be developed to match staffing levels with occupancy, particularly with respect to the BAC.¹⁰ It identified the BAC as one of the areas disproportionately contributing to the deficit.¹¹

As at 1 July 2012, work to decentralise and redevelop The Park as part of the reform agenda under the Queensland Plan for Mental Health was ongoing.¹²

- The EFTRU facility was yet to open.¹³ Existing buildings were being refurbished and its model of service was progressing through the corporate endorsement process. Procurement of furniture, fittings, equipment and artwork was underway and issues identified by a fire services and equipment inspection were being progressed.¹⁴
- Final inspections of the Kuranda unit (the high security inpatient service) had been undertaken, and defects were being rectified. Orientation sessions relating to unit access and emergency procedures were being held.¹⁵
- The BAC was still operating on The Park campus.

Continuity of clinical staff

As at 1 July 2012:

- Terry Stedman had been employed as Director of Clinical Services, Wolston Park (subsequently The Park) for a period of 15 years.¹⁶
- Darren Neillie had been employed as Clinical Director, High Secure Inpatient Services since November 2007.¹⁷
- William Brennan had held the position of Director of Nursing at The Park for almost two years.¹⁸
- Pdraig McGrath had been acting in the position of Nursing Director, Secure Services at The Park for about three months.¹⁹

The BAC

The BAC was one of the non-adult and non-secure facilities still operating out of The Park at the commencement of the 2012–2013 service agreement.

Financial state

A report prepared by the Mental Health Alcohol and Other Drugs Branch (MHAODB) dated 2 August 2012 shows that for the 2011–2012 financial year, the BAC had a year to date (YTD) budget of \$3.873 million and an actual operational cost of \$4.180 million (that is, a budget variance of -\$307 034).²⁰ It was block-funded,²¹ with a recurrent operating cost of approximately \$5.6 million per annum.²²

Staff

By July 2012, Trevor Sadler had provided psychiatric care at the BAC for over 25 years, having worked there as a registrar and later as a consultant psychiatrist, since December 1986.²³

Dwyer gave evidence of her concern about staffing at the BAC:

From the time I commenced as Health Service Chief Executive, it seemed to me that it was difficult to attract and retain staff for BAC. I attributed this to the fact that it was well known that the intention was for BAC to close when the Redlands facility was ready to open, but there was a lot of uncertainty as to when this would happen and, more recently, whether it would happen at all. Some staff had left BAC because they did not want to work in that location, others may have left because of general uncertainty about the future of the BAC and in that environment of uncertainty it was difficult to attract new staff.²⁴

There had been a gradual reduction of staff at the BAC leading up to July 2012. Sadler's evidence, in particular, suggests that there was a 25 per cent reduction of staff over the period between 1986 and 2012.²⁵

In June 2012, just prior to the establishment of the West Moreton HHS, the permanent Nurse Unit Manager (NUM) of the BAC had retired but no one had been appointed as his permanent replacement.²⁶

The Commission has not been provided with details of the staffing complement as at 1 July 2012. However, a BAC staffing profile produced in 2014 but with the sub-heading "Process Nu: 11 July 2012,"²⁷ shows the following complement:

- 17 registered nurses – mental health (three temporary and the remainder permanent)
- two registered nurses – general (both temporary)
- four operational services officers (two temporary and two permanent)
- one speech therapist (permanent)
- one clinical leader (permanent)
- two clinical nurses (both permanent and with substantive registered nurse positions)
- one clinical ADON [acting Director of Nursing] (temporary)
- one registrar – psychiatry (temporary)
- three occupational therapists (one temporary)
- one psychiatrist (permanent)
- one psychologist (temporary)
- one social worker (permanent).

Witness statements obtained from a number of BAC nursing staff reveal that, in addition to Sadler, there were several other medium- to long-term staff members at the BAC when the West Moreton HHS assumed oversight responsibility for it. Examples include:

- Matthew Beswick (acting Clinical Nurse) had worked at the BAC for approximately seven years, having commenced in the role of Registered Nurse in 2005. In addition, he had undertaken an 18-month rotation at the BAC from mid-2001.²⁸
- Moira Macleod (Registered Nurse) had worked at the BAC for approximately five years, having commenced in 2007.²⁹
- Lourdes Wong (Registered Nurse) had worked at the BAC for just over five years, having commenced at the BAC in April 2007.³⁰
- Vanessa Clayworth (Clinical Nurse) had worked at the BAC for approximately four years, having commenced there in October 2008.³¹
- Stephen Sault (Registered Nurse) had worked at the BAC for four years, having commenced on 14 July 2008.³²
- Kimberley Sadler (Registered Nurse) had worked at the BAC for approximately three years, having commenced in about August/September 2009.³³

Absence of a plan for its future

The evidence before the Commission is consistent with West Moreton HHS having inherited the BAC largely without a plan for its future.

As outlined in earlier chapters, part of the reform agenda under the Queensland Plan for Mental Health was the decommissioning of the BAC and provision of a replacement.³⁴ However, unbeknown to West Moreton HHS, in May 2012, the Director-General of Queensland Health had approved the cessation of the replacement project at Redlands.³⁵

The decision to cease the Redlands project was not communicated to the West Moreton HHS until 29 August 2012,³⁶ or to the West Moreton Board until November 2012.³⁷ Some staff of the BAC reported not being advised that the Redlands project had been cancelled until 13 December 2012.³⁸

The significance of this lack of a plan for the BAC (and its patients) was intensified by several factors.

First, there was already disquiet surrounding the state of disrepair of the BAC building.³⁹ Given the plan to relocate the BAC to the Redlands, it is understandable that for some time little money had been spent on upgrading its infrastructure.

Secondly, an issue had been raised (by some) about the impending co-location of adolescents at the BAC with patients of EFTRU.⁴⁰

For example, Kelly's evidence is that when she commenced in her position in September 2012, she understood continuation of the BAC service at The Park to be "incompatible with the redevelopment plan and, specifically, that the co-location of adolescents with adults from the EFTRU service carried unacceptable risk for the adolescents".⁴¹

For present purposes it is relevant that:

- there had been concurrent planning for the Redlands and EFTRU projects over several years, but the Redlands project had fallen behind and by July 2012 it had been cancelled
- as at July 2012, the likely opening date for EFTRU had not been determined. Capital Works Working Group Meeting Minutes dated 18 June 2012 record that funds were being sought to complete work not included in the contract,⁴² however no anticipated opening date was recorded. According to Kelly and Dwyer, by this time EFTRU was at an advanced planning stage⁴³
- no assessment of any risk, or plan for the management of the co-location (aside from the original plan to relocate the BAC to the Redlands) had been developed.⁴⁴

Thirdly, there was unresolved debate⁴⁵ about BAC's model of care and whether it was "contemporary". Debate focused particularly on institutional versus community-based care, as well as on issues such as length of stay and a move towards providing care closer to patients' homes. Further analysis in respect of the issue of contemporary models of care is in chapter 14.

Finally, there was recognition (by some) of simmering issues around clinical governance at the BAC. A report by Garry Walker, Martin Baker and Michelle George in 2009 had raised concerns about the role, function and capacity of the BAC to provide an appropriate, effective and safe service.⁴⁶ However, it appears that no immediate or direct action was taken to remedy those concerns. Instead, the majority of the recommendations arising out of the review were described by a Model of Service Delivery Review Group as contingent upon the completion of the statewide model of service for the Redlands unit.⁴⁷

During oral closing submissions, Counsel for West Moreton HHS and Board explained that whilst matters such as governance had not been iterated in written form, "it was permeating through" in the sense that governance issues had been ongoing in the 2009 (and 2003) reviews.⁴⁸

BAC operating costs

BAC operating costs increased over four years from \$1574.48 per day in 2007–2008 to \$2448.20 per day in 2011–2012. The cost per day then decreased to \$1597.50 in 2012–2013.⁴⁹

The annual recurrent operating expenditure by the BAC in 2011–2012 and 2012–2013, based on various documents provided to the Commission, is set out in the table below.

Year	Operating costs for BAC per annum
2011–2012	\$5,600,000 ⁵⁰
	\$4,264,948⁵¹
	\$4,211,325 ⁵²
2012–2013	\$3,683,995 ⁵³

The figure highlighted in black appears most accurate.

By comparison, the average recurrent costs per acute inpatient bed day for child and adolescent mental health services in Queensland was \$1,493.21 per day in 2011–2012 and \$1,257.26 per day in 2012–2013.⁵⁴

Comment

It is non-contentious that the West Moreton HHS came into existence in a tight fiscal environment. Moreover, the operating costs of the BAC were comparatively high.

The HHS set about addressing financial problems it inherited from the West Moreton Health Service District through a series of 'Turn Around Plans'. It was ultimately successful in this regard.

Despite these financial pressures, the Commission has found no evidence that West Moreton's efforts to close the BAC were motivated by cost cutting.

(Endnotes)

- 1 Exhibit 1439, Queensland Health: Budget Paper 5 – Service Delivery Statements (Queensland State Budget 2012–13) p 169; Exhibit 228, West Moreton 2012/13 Service Agreement, p 39.
- 2 Exhibit 1240, WMHHS Strategic Plan – Path to Excellence: 2012–16, p 3.
- 3 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 1 para 2.1.
- 4 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 22 paras 12.1–12.2.
- 5 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015 p 22 para 12.4(a)–(e)
- 6 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 24 para 12.6 Attachments LD-10 and LD-12 to that statement, pp 107–109, 113–131.
- 7 Exhibit 260, Chettleburgh, K & Doyle H, Review of The Park Centre for Mental Health, Undertaken March/April 2012, p 1.
- 8 Exhibit 260, Chettleburgh, K & Doyle H, Review of The Park Centre for Mental Health, Undertaken March/April 2012, p 1.
- 9 Exhibit 260, Chettleburgh, K & Doyle H, Review of The Park Centre for Mental Health, Undertaken March/April 2012, p 1.
- 10 Exhibit 260, Chettleburgh, K & Doyle H, Review of The Park Centre for Mental Health, Undertaken March/April 2012, p 2.
- 11 Exhibit 260, Chettleburgh, K & Doyle H, Review of The Park Centre for Mental Health, Undertaken March/April 2012, p 12.
- 12 Exhibit 1101, Estimates Brief Number 17.15, Subject: "The Park Overview and Issues", authored by Sharon Kelly, 11 July 2013.
- 13 EFTRU did not open to its first consumers until 29 July 2013: Exhibit 737, West Moreton Board Committee Agenda Paper, 23 August 2013, p 2.
- 14 Exhibit 1100, Memo from Sharon Stannard to Leanne Geppert, Three Monthly Project Report April to June 2012, 16 July 2012.
- 15 Exhibit 1100, Memo from Sharon Stannard to Leanne Geppert, Three Monthly Project Report April to June 2012, 16 July 2012, p 1.
- 16 Exhibit 124, Statement of Terry Stedman, 16 October 2015, p 1 para 2.1 and Attachment TJS-1 to that statement, Curriculum Vitae of Terry Stedman, p 32. Terry Stedman's title was again changed in 2015 to that of Director of Clinical Services, Strategy and Performance, The Park Centre for Mental Health.
- 17 Exhibit 89, Statement of Darren Neillie, 23 October 2015, p 1 para 2.1.
- 18 Exhibit 30, Statement of William Brennan, 16 November 2015, p 1 para 2.2(a).
- 19 Exhibit 87, Statement of Pdraig McGrath, 16 November 2015, p 1 paras 2.1–2.2, Attachment PM-1 to that statement, Curriculum Vitae of Pdraig McGrath, p 33.
- 20 Exhibit 1430, Measures by Account, dated 2 August 2012. Cleary's evidence was that as at 1 July 2012, the operational budget for the BAC was approximately \$4.0 million annually: Exhibit 40, Statement of Michael Cleary, 21 December 2015, p 12 para 48.
- 21 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 24 para 12.9.
- 22 Exhibit 370, Draft Estimates Brief, Subject: "Closure of Barrett Adolescent Centre (BAC)" authored by Karissa Maxwell, 15 July 2014, p 2.
- 23 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 3 para 13(d).
- 24 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, pp 6–7 para 5.20.
- 25 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, Attachment O to that statement, pp 172–175; Exhibit 743 Staffing Issues at BAC, Trevor Sadler, July 2013.
- 26 Exhibit 109, Statement of Rosangela Richardson, 30 October 2015, p 7 para 11(c).
- 27 Exhibit 1481, Staffing Profile for Adolescent Unit, "Process Nu: 11-Jul-2012", 11 July 2012.

- 28 Exhibit 23, Statement of Matthew Beswick, 30 October 2015, p 1 para 1(d)–(e), Attachment 1 to that statement, Curriculum vitae of Matthew Beswick, p 22.
- 29 Exhibit 77, Statement of Moira Macleod, 5 November 2015, p 2 para 4.
- 30 Exhibit 140, Statement of Lourdes Wong, 22 December 2015, p 2 para 2(a).
- 31 Exhibit 38, Statement of Vanessa Clayworth, 27 October 2015, Attachment VC-1 to that statement, Curriculum vitae of Vanessa Clayworth, p 8.
- 32 Exhibit 113, Statement of Stephen Sault, 15 December 2012, p 2 para 2(a).
- 33 Exhibit 111, Statement of Kimberley Sadler, 14 December 2015, p 2 para 9.
- 34 Exhibit 40, Statement of Michael Cleary, 21 December 2015, pp 24-25 para 98.
- 35 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, Attachment LJS-2 to that statement, p 32.
- 36 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 2, para 5.3 and Attachment LD-4 to that statement, Memorandum from Glenn Rashleigh to Lesley Dwyer and Richard Ashby dated 28 August 2012, Subject: "Cancellation of Capital Delivery Project", p 74.
- 37 Exhibit 50, Statement of Timothy Eltham, 9 December 2015, p 14 para 12.1, Attachment TCE-7 to that statement, pp 83-85; Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 10 para 8.10(d).
- 38 For example, Megan Hayes: Exhibit 62, Statement of Megan Hayes, 20 November 2015, p 3 para 5.1, Attachment MH-2 to that statement, p 37.
- 39 Exhibit 186, Statement of Jeannette Young, 15 February 2016, p 8 para 36; Transcript, Jeannette Young, 7 March 2016, p 21-71 line 29 – p 21-72 line 6.
- 40 Michael Cleary's evidence is that when he visited The Park in "late 2012", Bill Kingswell discussed with him the redevelopment of The Park as an adult facility and the opening of the EFTRU facility: Transcript, Michael Cleary, 25 February 2016, p 14-29 lines 9–37. Lawrence Springborg's evidence is that he became aware in 2012 that one of the reasons why it was thought necessary to close BAC was because it was thought inappropriate to have young people co-located with EFTRU, due to risks to patients and staff of the BAC: Exhibit 457, Supplementary statement of Lawrence Springborg, 10 March 2016, p 4 paras 9–10.
- 41 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 7 para 9.1(h), p 12 para 11.11(b); Exhibit 437, Email from Sharon Kelly to SDLO, Subject: "pertinent points for consideration of Barrett Adolescent Centre", 8 November 2012.
- 42 Exhibit 635, Capital Works Working Group Meeting Minutes, 18 June 2012.
- 43 Transcript, Sharon Kelly, 22 February 2016, p 11-4 lines 13–17; Exhibit 987, Supplementary statement of Lesley Dwyer, 22 March 2016, p 3 para 1.4.
- 44 Transcript, Patrick McGorry, 2 March 2016 p 18-14 line 5, p 18-15 line 35; Transcript, Terry Stedman, 3 March 2016, p 19-44 line 15 – 19-47 line 30.
- 45 Exhibit 186, Statement of Jeannette Young, 19 February 2016, p 5 para 21; Transcript, Jeannette Young, 7 March 2016, p 21-70 lines 42–45.
- 46 Exhibit 124, Statement of Terry Stedman, 16 October 2015, Attachment TJS-7 to that statement, p 255.
- 47 Exhibit 220, Briefing note from Chief Executive Officer West Moreton Hospital and Health Service to Minister for Health, Subject: "Update and Finalisation – External Review Report of Barrett Adolescent Unit", 22 June 2011; Transcript, Kathryn McMillan QC, Closing submissions on behalf of West Moreton HHS and Board, 15 April 2016, p 28-49 lines 20–37, p 28-50 lines 10–14; Transcript, Jennifer Rosengren, Closing submissions on behalf of Trevor Sadler, 15 April 2016, p 28-69 lines 31–39; Exhibit 72, Statement of Judith Krause, 26 November 2015, Attachment W to that statement, p 298.
- 48 Transcript, Kathryn McMillan QC, Closing submissions on behalf of West Moreton HHS and Board, 15 April 2013, p 28-48 lines 36–44.
- 49 SCRGSP (Steering Committee for the Review of Government Service Provision) 2015, Report on Government Services 2015, Volume E, Health, Productivity Commission, Canberra, Table 12A.59 Mental Health Management.
- 50 Exhibit 370, Estimates Brief, Subject: "Closure of Barrett Adolescent Centre (BAC)", authored by Karissa Maxwell, dated 15 July 2014.
- 51 Exhibit 1084, Email Karissa Maxwell to Bill Kingswell dated 2 August 2012; Exhibit 1085, Briefing Note for Approval to Director-General Queensland Health, Subject: "Approval to close Barrett Adolescent Centre, The Park Centre for Mental Health", (unsigned) dated 1 November 2012, p 3.
- 52 Exhibit 1080, Estimates Brief Number 17.03, Subject: "Barrett Adolescent Centre – Strategy", dated 15 July 2013, Author Sharon Kelly, ED, MHSS.
- 53 Exhibit 1080, Estimates Brief Number 17.03, Subject: "Barrett Adolescent Centre – Strategy", dated 15 July 2013, Author Sharon Kelly, ED, MHSS.
- 54 SCRGSP (Steering Committee for the Review of Government Service Provision) 2015, Report on Government Services 2015, Volume E, Health, Productivity Commission, Canberra, Table 12A.59 Mental Health Management.

7 28 August 2012 to 8 November 2012

28 August 2012 – Memorandum from Rashleigh to Dwyer

On 28 August 2012, Lesley Dwyer, Chief Executive West Moreton Hospital and Health Service (HHS), received a memorandum from Glenn Rashleigh, Director, Capital Delivery Program, Chief Health Infrastructure Office, Queensland Health, advising of “the cancellation of the replacement Adolescent Mental Health Unit at Redlands from the current location at Wacol”.¹

Sharon Kelly sent an email to Terry Stedman, Clinical Director of The Park, William Brennan, Director of Nursing at The Park and Logan Steele, Service Manager, on 29 August 2012, asking them to provide her “with an outline of the consequential issues” which the cancellation of the Redlands replacement project would cause.²

In an email sent on 31 August 2012, Stedman stated:

I have no information about the government’s thinking on this. I have spoken with the Executive Director of MH Branch for advice. He is going to discuss further with the DDG this afternoon about how to proceed. I understand there is no certainty that this will lead to a proposal for a continuing inpatient program, including the current one. The first concern will be how to advise staff of this decision and the need to be able to provide some information about what happens next.³

4 September 2012 – Meeting between Kingswell and Cleary

Bill Kingswell gave evidence that he “met with the Deputy-Director General [sic] on or around 4 September 2012 and that, in respect of the BAC, my advice was that the BAC should be closed and replacement services developed”.⁴

11 September 2012 – Dwyer, Kingswell and Cleary visit the BAC

Dwyer gave evidence that she, Kingswell and Michael Cleary (the Deputy Director-General) visited the BAC on 11 September 2012.⁵ She said that they were shown around by Trevor Sadler, the then Clinical Director of the BAC, and BAC nurse Susan Daniel, and that Kingswell and Cleary asked questions about alternative services.⁶

Dwyer said that it “was in the course of these discussions that [she] became aware that MHAODB was still looking to close BAC, ie notwithstanding cancellation of the Redlands project, and were focused on the issue of alternative service options”.⁷ Her evidence was that:

Dr Kingswell advised that there [was] capacity in the system and closing BAC would not create a bed capacity problem, ie there was capacity for patients who would otherwise be at BAC to be accommodated in beds in other services, and an alternative service model should be directed to a contemporary model of care provided to patients in their local area rather than a State-wide single site.⁸

Dwyer told the Commission that her “understanding at and from that time was that the work that was required was in relation to investigating other options for the BAC patient cohort and services going forward”.⁹

4 October 2012 – Report on the condition of the BAC

On 4 October 2012, on her return from leave, Kelly received a ‘Report on the Condition of the Barrett Adolescent School and Accommodation’ prepared by Robert Wood, A/Building, Engineering and Maintenance Manager, Ipswich Hospital, West Moreton HHS and forwarded by Ray Chandler, Executive Director, Infrastructure and Ipswich Hospital Expansion, on 21 September 2012.¹⁰ The cover email from Wood stated, “My Estimate is \$400,000 to bring it back to good condition in the same layout etc that it is now”.¹¹

Kelly said that after reviewing the building report and consulting with others in West Moreton HHS, it was clear to her that: “(i) limited refurbishment of the BAC building was not feasible” and “(ii) continuation of the BAC service at The Park was incompatible with the services being commissioned at The Park... Specifically, the co-location of adolescents with the adults from the EFTRU service carried an unacceptable risk for the adolescents”.¹²

Dwyer received that report on the condition of the BAC.¹³ She said that whilst the costs in the report were:

... relatively modest compared to a major capital project ... [they] only represented minimum work to ‘make good’ the building and did not reflect the work that would have been needed to improve the clinical suitability of the building. There was no money in the budget for this work, and in any event, a capital upgrade of the building did not make sense when the BAC was considered an outdated model of care and unlikely to continue in more than the short term.¹⁴

15 October 2012 – Advice to Cleary from the Health Infrastructure Branch

On 15 October 2012, Cleary sought advice from the Health Infrastructure Branch (HIB) about whether maintenance and refurbishment work could be carried out at the BAC. According to Cleary the HIB indicated it was possible to undertake maintenance, that this could be managed through West Moreton HHS, and that a specific cost breakdown was not available. He also recalled the HIB advising that BAC was not suitable for complete refurbishment.¹⁵

25 October 2012 – Meeting between Kelly and the MHAODB

On 25 October 2012, Kelly met with Kingswell, Jagmohan Gilhotra (Director of Mental Health, Queensland Health), and Leanne Geppert (Director, Planning and Partnerships, MHAODB). She was told that the MHAODB believed the BAC was not aligned with future planning for The Park or the Queensland Plan for Mental Health (QPMH). She said that at the conclusion of the meeting, she understood that the MHAODB expected the West Moreton HHS “to continue on the established QPMH pathway for The Park which included closing the BAC”. She said, “it was acknowledged that closure would require [West Moreton] HHS to commence discussions with other services that could provide the support for the young people once BAC did not exist”.¹⁶

She gave evidence that from 25 October 2012, she believed “the intention was” to close the BAC once “clinical and other necessary supports were in place for the patients”.¹⁷

Kelly said that it “was probably Dr Kingswell” who told her that the MHAODB did not consider the BAC to be part of the service model for the delivery of adolescent mental health services going forward.¹⁸

It is apparent from Kelly’s evidence that, at that stage, she did not have an independent view on the issue but rather acted on advice from MHAODB:

FREEBURN: And do I take it that you were being informed of that. They weren’t your views; that was the branch informing you of their views?

KELLY: Yes. The – the reason for the meeting was I was new to The Park and I was seeking to ensure that I had a good orientation.¹⁹

When asked whether the plan, at that point, was to close the BAC by December 2012, Kelly replied:

The plan was to close the Barrett Adolescent Centre at a suitable date, noting the advice I received that a number of the – well, the majority of adolescents went home at a Christmas time or a school holiday period closure ... There was a suggestion that it would be possible for 2012, but that was not a definitive decision. That was something to take on board and understand what the consequences would be.²⁰

Kelly also gave evidence of her understanding of what had been intended in the QPMH:

FREEBURN: Can I just ask you: you spoke there about the closure of the Barrett Adolescent Centre being part of the Queensland Plan for Mental Health?

KELLY: Yes.

FREEBURN: In fact, the Queensland Plan for Mental Health had a new centre for Barrett, didn’t it?

KELLY: It wasn’t a new centre for Barrett. Barrett Adolescent Centre was a physical bricks and mortar service located at The Park.

FREEBURN: Right?

KELLY: Whatever the service was going to look like, it was not going to be called the Barrett moving forward.

FREEBURN: Well, forget about the labels. There was going to be a new Tier 3 facility at a location to be determined?

KELLY: There was to be in the plan in 2007; I understand that to be correct. Yes. But my reference here is to the Barrett bricks and mortar service at The Park.²¹

On 26 October 2012, Kelly sent a follow up email to Kingswell, Gilhotra and Geppert to “recap” the meeting held the day before. She copied Dwyer and Chris Thorburn, acting Director of Services Redesign, West Moreton HHS, into the email. In relation to the BAC, she said “we have all confirmed this is a somewhat sensitive issue as we define the future”.²² She wrote:

- I understand that a brief has gone to the Minister re BAC ... [T]he content of the brief did not clearly articulate that closure was the only option, however from our discussion and opinions I have gleaned from others the model for BAC is not aligned into the future planning for The Park or for Queensland Mental Health Plan. **[A]s such the option is to close BAC as early as December 2012** given that all or most of the consumers all go home for the Christmas break. [T]his would include the education program. [A]n alternate would be to close the beds but keep the day program for a period of time. [F]or any of this to occur I understand we need to commence discussions with other services that could provide the support for the young people once BAC does not exist.

...

- [A] meeting planned for next Friday between myself, Terry and Dr Sadler will now be expanded to include Leanne in the absence of Bill and I would like to include Chris Thorburn who is working with me on redesigning mental health WM. – [A]t this time we will advise that closure is not optional however needs to be planned.
- [A] strategic **stakeholder meeting** is to be arranged by Bill the week after next in regards to **meeting with the Mater services and others to map out what actions and requirements there are to ensure no young person is disadvantaged in this change. [A]nd is December achievable.**
- [P]rior to the Friday meeting a brief does need to be written that alerts appropriately as we are reasonable [sic] confident that the advice of closure will elicit community action for those families involved in BAC. [T]hus a clear communication plan and strategy is required.²³

(emphasis added)

On questioning by Counsel Assisting, Kelly said that while the attendees at the meeting agreed that the BAC should be closed, the date of December 2012 “was an option. It wasn’t a definitive decision”.²⁴

In relation to the proposed advice that “closure is not optional, however needs to be planned”, she said she meant that “the decision to close the BAC had been made but the dates and the planning for how it was to happen needed to be worked out”.²⁵

2 November 2012 – Cleary declines to clear the MHAODB briefing note of 1 November 2012

Cleary (Deputy Director-General from July 2012 to July 2015)²⁶ was asked to clear a draft briefing note dated 1 November 2012, prepared by Geppert and Kingswell. The briefing note proposed that the Director-General approve closure of the BAC and provide the briefing note to the Minister for noting. In his statement, Cleary said that he returned the briefing note to Kingswell observing that any consideration of changing the service model for this group of clients was a significant issue which needed to be led by West Moreton HHS who were responsible for this service.²⁷

In answer to questions from Counsel Assisting, Cleary confirmed he returned the briefing note to Kingswell on 2 November 2012 because he wanted it signed off by West Moreton HHS to indicate clearly that West Moreton HHS wanted the approval for closure. He also conceded that a change to a service model needed to be a decision based on expert clinical advice.²⁸

Cleary's reason for wanting West Moreton HHS to sign off in the closure approval request lay in the change in governance that resulted from the commencement of the *Hospital and Health Boards Act 2011* (Qld). In his view, this sort of matter now lay squarely with the West Moreton HHS and the West Moreton Board.²⁹

2 November 2012 – Meeting of Kelly, Sadler and Stedman

On 2 November 2012, Kelly organised a meeting with Trevor Sadler, Clinical Director of the BAC and Terry Stedman, Clinical Director of The Park, to discuss whether the BAC could be closed safely and the ramifications of doing so around Christmas 2012.

According to Kelly, Sadler and Stedman were to consider the issues confidentially and advise her further.³⁰ As Clinical Director of the BAC, Sadler was to "go away and think about it".³¹

According to Stedman, Kelly sought information from Sadler and him about what the closure of the BAC would involve and the logistics of closure,³² and she advised "to the effect that 'town' may want to progress the closure of BAC even though relocation of its services to Redlands would no longer occur". He understood Kelly to mean "MHAODB, the Department of Health or the Government generally".³³ Stedman gave evidence that Sadler told Kelly "it would be very difficult and not appropriate to close the BAC". Stedman said he thought closure was feasible, but that it could not be done quickly, because it would be necessary to ensure that there was an appropriate transition process for existing patients and that there were appropriate replacement services for adolescents going forward.³⁴

Sadler's evidence was that Kelly said that the BAC would close and the date of 31 December 2012 was mentioned.³⁵ He said Kelly advised him the decision had come from the MHAODB and that a group of experts would advise on alternative programs. He said he did not recall being informed of any transition plans for the adolescents. "They were simply to be relocated to acute inpatient units."³⁶

According to Sadler he told Kelly at that meeting that it would be difficult and not appropriate to close the BAC in the timeframe of December 2012.³⁷

2 November 2012 – Sadler emails his colleagues

After meeting with Kelly and Stedman on 2 November 2012, Sadler sent a number of emails. He sent one email to an email group QFCAP (Queensland Faculty of Child and Adolescent Psychiatrists) at 6.42 pm and another at 7.13 pm,³⁸ informing his colleagues that the Mental Health Alcohol Tobacco and other Drugs Directorate (MHATODD) had decided to close the BAC by Christmas that year.³⁹ He warned that the official closure announcement was about to be made and encouraged the psychiatrists to consider alternative care options for the adolescents.⁴⁰

He also sent emails to Sean Hatherill, Geoff Beames, Victoria Gladwell, Brett McDermott (Executive Director, Mater Child and Youth Mental Health Services) and William Bor on 5 November 2012.⁴¹

Later, Sadler phoned McDermott to inform him about the imminent closure.⁴²

8 November 2012 – McDermott’s evidence to the Queensland Child Protection Commission of Inquiry

On 8 November 2012, McDermott gave evidence to the Queensland Child Protection Commission of Inquiry.⁴³ McDermott decided to inform the Queensland Child Protection Commission of Inquiry about the closure of the BAC as he believed it was directly relevant to that Commission of Inquiry.⁴⁴ Specifically, he was asked this question by Counsel Assisting, Kathryn McMillan, “What do you understand as of this week is the fate of this centre?” His response was:

Yes, we’ve been informed that the centre will close at Christmas. You know, I’d like to bring this to the Commissioner’s attention. This is a decision by adult mental health directors who in my opinion know very little about child abuse and neglect, who know very little about child protection, who judge the centre by adult metrics like occupied bed days and length of stay ... I’m extremely concerned that this unit will be never recreated. You know, it’s obviously expensive ... but to lose this service would be [to] lose the place of last therapeutic help for some of our most traumatised Queensland adolescents.⁴⁵

(Endnotes)

- 1 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment 6 to that statement, p 810. See also Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 2 para 5.3, Attachment LD-4 to that statement, p 73.
- 2 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 6 para 9.1(f), Attachment SK-7 to that statement, p 811.
- 3 Exhibit 124, Statement of Terry Stedman, 16 October 2015, p 5 para 9.8, Attachment TJS-10 to that statement, p 317.
- 4 Exhibit 68, Statement of William Kingswell, 21 October 2015, pp 5–6 para 19.
- 5 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 3 para 5.4.
- 6 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 3 para 5.4.
- 7 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 3 para 5.4.
- 8 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 3 para 5.5.
- 9 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 13 para 7.1(c).
- 10 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, pp 5–6 para 9.1(g), Attachment SK-8 to that statement, Email from Ray Chandler to Lesley Dwyer and Sharon Kelly, Subject: “Barrett Adolescent condition summary”, 4 October 2012, attaching ‘Report on the Condition of the Barrett Adolescent School and Accommodation’, pp 815–825.
- 11 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment SK-8 to that statement, Email from Robert Wood to Ray Chandler, Subject: “Barrett Adolescent condition summary”, 21 September 2012, p 816.
- 12 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 7 para 9.1(h)(i)(ii).
- 13 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 3 para 5.8.
- 14 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 4 para 5.9.
- 15 Exhibit 40, Statement of Michael Cleary, 21 December 2015, pp 9–10 paras 36–37.
- 16 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 8 paras 9.5–9.6.
- 17 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 8 para 10.1.
- 18 Transcript, Sharon Kelly, 22 February 2016, p 11-5 lines 15–16.
- 19 Transcript, Sharon Kelly, 22 February 2016, p 11-5 line 41 – p 11-6 line 3.
- 20 Transcript, Sharon Kelly, 22 February 2016, p 11-5 lines 41–44 and p 11-6 lines 1–3.
- 21 Transcript, Sharon Kelly, 22 February 2016, p 11-6 line 42 – p 11-7 line 7.
- 22 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment SK-9 to that statement, pp 826–827.
- 23 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment SK-9 to that statement, pp 826–827.
- 24 Transcript, Sharon Kelly, 22 February 2016, p 11-6 line 17.
- 25 Transcript, Sharon Kelly, 22 February 2016, p 11-9 lines 6–8.
- 26 Exhibit 40, Statement of Michael Cleary, 21 December 2015, p 2 para 8, Attachment MIC-4 to that statement, p 86.

- 27 Exhibit 40, Statement of Michael Cleary, 21 December 2015, Attachment MIC-14 to that statement, p 459.
- 28 Transcript, Michael Cleary, 25 February 2016, p 14-19 lines 30–46.
- 29 Transcript, Michael Cleary, 25 February 2016, p 14-23 line 21 – p 14-24 line 30.
- 30 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 9 para 10.4.
- 31 Transcript, Sharon Kelly, 22 February 2016, p 11-11 lines 25–32.
- 32 Exhibit 124, Statement of Terry Stedman, 16 October 2015, pp 5–6 para 9.10.
- 33 Exhibit 124, Statement of Terry Stedman, 16 October 2015, pp 5–6 para 9.10.
- 34 Exhibit 124, Statement of Terry Stedman, 16 October 2015, pp 5–6 paras 9.10–9.11.
- 35 Transcript, Trevor Sadler, 1 March 2016, p 17-4 lines 7–12.
- 36 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 46 para 226.
- 37 Exhibit 124, Statement of Terry Stedman, 16 October 2015, p 6 para 9.11.
- 38 Exhibit 449, Batch of emails collated by Trevor Sadler to child psychiatrists, Subject: "Learning of closure", 15 November 2012, pp 1–2; Transcript, Trevor Sadler, 1 March 2016, p 17-69 lines 31–35.
- 39 Exhibit 449, Batch of emails collated by Trevor Sadler to child psychiatrists, Subject: "Learning of closure", 15 November 2012, pp 1–2.
- 40 Exhibit 449, Batch of emails collated by Trevor Sadler to child psychiatrists, Subject: "Learning of closure", 15 November 2012, pp 1–2.
- 41 Transcript, Trevor Sadler, 1 March 2016, p 17-70 lines 3–9.
- 42 Exhibit 84, Statement of Brett McDermott, 10 November 2015, p 17 para 94.
- 43 Exhibit 84, Statement of Brett McDermott, 10 November 2015, p 17 paras 92–93.
- 44 Exhibit 84, Statement of Brett McDermott, 10 November 2015, p 18 para 100.
- 45 Transcript, Brett McDermott, 8 November 2012, Queensland Child Protection Commission of Inquiry, p 33-58 lines 2–19. Available from: <<http://www.childprotectioninquiry.qld.gov.au/hearings/transcripts>>. [18 December 2015].

8 After McDermott's disclosure

Reactions to McDermott's disclosure

Reactions of the profession

After Trevor Sadler, Clinical Director of the Barrett Adolescent Centre (BAC), sent an email to members of the Faculty of Child and Adolescent Psychiatry on 2 November 2012, a number of child and adolescent psychiatrists voiced concerns about the potential closure of the BAC.

Rebecca Wild,¹ Anja Kriegeskotten,² Graham Martin³ and Penny Brassey⁴ responded to Sadler's email and expressed serious concern. Some psychiatrists wrote to State and Federal Ministers in an attempt to prevent the closure.

Michelle Fryer, Chair of the Queensland Branch of the Faculty of Child and Adolescent Psychiatry, wrote to the Minister for Health, Lawrence Springborg, on 9 November 2012 expressing concern on behalf of members of the Faculty who had contacted her.⁵

In a letter to the Minister, Wild said the BAC provided "a multi faceted therapeutic environment that includes flexible schooling". She said the BAC "can't be reproduced in an acute setting" and that she was "afraid Queenslanders are about to lose a life saving... service".⁶

On 11 November 2012, child and youth psychiatrist, James Scott, wrote to the Minister expressing his view that the closure of the BAC would result in "an enormous gap in care"⁷ He said the BAC played "an important role in preventing these young people from suicidal acts or alternatively committing offences resulting in lengthy incarceration". Like Wild, he considered that acute inpatient units "cannot provide the same care as the Barrett".⁸

On 11 November 2012, Sue Wilson, another child and youth psychiatrist, wrote to her local member Scott Emerson MP expressing her grave concerns about the BAC closure, particularly without consultation with clinicians, consumers and carers or the provision of viable and safe alternative treatment options.⁹

On 12 November 2012, Victoria Gladwell, child and youth psychiatrist, wrote to the Minister stating, "the imminent closure of the Barrett Adolescent Centre, BAC, is alarming for it will have far-reaching, detrimental implications". She described the withdrawal of essential residential treatment such as the BAC as "short sighted at best and ... in fact discriminatory towards mental illness and youth" (emphasis removed).¹⁰ Gladwell predicted a number of detrimental outcomes of closing the BAC.¹¹

There is some evidence that the closure of the BAC was discussed at a meeting of the Queensland Branch of the Royal Australian and New Zealand College of Psychiatrists, and also at a meeting of the Faculty of Child and Adolescent Psychiatry.

For example, on 9 November 2012, Dan Siskind (Chair of the Queensland Branch of the College) emailed Bill Kingswell asking if he would like to share any thoughts on behalf of the MHAODB at the next Branch meeting. Kingswell replied:

Barrett [C]entre costs about \$6m recurrent to run. It can identify no outcomes. It is attached to the most expensive school in Aus that records no [N]aplan results.

It is run down, 50% occupied and uses a controversial model of care that does not appear anywhere in the NMHSPF taxonomy.

We have built 8 new beds at Toowoomba and 6 are under construction at Townsville. The rest of the SE runs 50% occupancy. We do not need this bed stock. This service could be provided in existing beds, expanded day services and NGO respite and we could do it within existing resources.

Other than that I can think of no reason not to retain Barrett.¹²

Further, BAC founder, Cary Breakey gave evidence that on 27 November 2012 he attended a meeting of the Faculty. He said there was "lengthy discussion about the BAC". His impression of the meeting was that there was general support for the BAC service continuing in some form.¹³

Reactions of BAC staff

There is evidence that McDermott's disclosure caused concern and anger amongst staff, particularly because a public announcement was made before they were officially informed.¹⁴

The disclosure, in combination with the cancellation of the Redlands project, led to their being concerned about their ongoing employment.¹⁵

Former BAC Special School (BACSS) teacher Margaret Nightingale said that following McDermott's disclosure, staff were concerned for patients as well as for their own jobs.¹⁶ She gave evidence of an "increase in [health] staff changes because there was no clarity about what was happening with the BAC".¹⁷

Georgia Watkins-Allen, a BAC psychologist, said she was concerned about being removed from the BAC at a crucial stage of the adolescents' treatment.¹⁸ She said the extent of staffing changes at this time caused her to question the security of her position at the BAC.¹⁹

Deborah Rankin, a teacher at the BACSS, gave similar evidence that health staff were very concerned about job security and many began to look at other workplaces.²⁰ Rankin said that after McDermott's disclosure there seemed to be a belief among some of the BACSS staff that what action would be taken to prevent the closure and that it would not happen.²¹ She said there was a "sense of uncertainty" until the official closure announcement in August 2013.²²

Justine Oxenham, also a teacher at the BACSS, gave written evidence that "long term staff members with a deep understanding of the complex issues and cases at the [BAC] started to leave, and were replaced by new staff members who did not have the same level of understanding of the case work at the [BAC]".²³

Kimberley Sadler, a registered nurse at the BAC, recalled a number of rumours in the workplace about the BAC's future, starting just before Christmas 2012. She said she "became concerned that no one had spoken to the night staff about the plan for the BAC and its closure and so [she] emailed [West Moreton HHS executive Sharon] Kelly to ask her to meet with night staff".²⁴

Darren Bate, a teacher at the BACSS, wrote to numerous politicians, voicing his support for the continuation of the BAC and the BACSS.²⁵ In his letter to the Minister for Education, Bate said, "Students, parents and staff at the school are very distressed – not only at the prospect of the closure of the school, but also the manner in which this information has been transmitted and the lack of an apparent plan for continuation of this vital service".²⁶

Public reactions

There was significant public concern about McDermott's disclosure. Members of the public contacted State and Federal politicians, asking them to take action to keep the BAC open.²⁷ Lesley Dwyer (Health Service Chief Executive, West Moreton HHS) gave evidence that West Moreton HHS received "a number of letters and emails from members of the public, which at times included individual parents of current BAC patients". She said West Moreton HHS responded to correspondence.²⁸

On 15 November 2012, the Queensland Teachers' Union wrote to the Director-General of the Department of Education Training and Employment (as it then was) expressing concerns about the closure of the BAC and formally requesting a reversal of the decision.²⁹

Save the Barrett campaign

Following the announcement by McDermott, Alison Earls started an online petition colloquially known as 'Save the Barrett'. Her goal was to lobby the Government to keep the BAC open indefinitely.³⁰

The petition was entitled 'Don't Close the Barrett Adolescent Centre!' and was directed "To: Qld State Government – Qld Premier Campbell Newman; Qld Health Minister Lawrence Springborg; Minister for Education, Training and Employment John-Paul Langbroek".³¹ It was hosted by the website 'CommunityRun', an arm of the 'GetUp!' website, which administers online petitions.³²

The petition was tabled in the Queensland Parliament on 5 March 2013. At that date it had 4 093 'signatures'. Ultimately, it received at least 4 651 'signatures'.³³

Earls established a website, 'savebarrett.org'. The website provided links to media coverage on the BAC, contact information for relevant government officials, and a news page where various updates were posted.³⁴

Earls also sent numerous emails and letters to Mental Health Commissioner Lesley van Schoubroeck³⁵ and members of West Moreton HHS, amongst others.³⁶

Parliamentary petition

On 16 November 2013, a parliamentary e-petition was set up by Annastacia Palaszczuk MP (then leader of the Opposition) and sponsored by Jo-Ann Miller MP, calling on the government to reverse its closure decision.³⁷ Like Earls' petition, this petition cited the risk to the young people who were cared for by the BAC. It attracted 1 093 signatures and was tabled in the Queensland Parliament on 5 March 2013 together with the e-petition set up by Earls.³⁸

Reactions of families

A number of parents of BAC patients gave evidence that the news, in November 2012, of the potential closure of the BAC was distressing.³⁹ One parent explained "... it meant that the future treatment and care of my [child] was again uncertain".⁴⁰

Following McDermott's disclosure, many parents and families lobbied to keep the BAC open. There is evidence of parents and families of BAC patients and former BAC patients contacting their local MPs, BAC staff, members of the psychiatry profession, members of the West Moreton HHS executive, the Director-General of Health and the Mental Health Commissioner.⁴¹

One parent said they contacted Sharon Kelly (Executive Director Mental Health and Specialised Services, West Moreton HHS) because they "found it very upsetting" that the potential closure of the BAC was unexpectedly announced.⁴²

Another parent sent a letter to Dwyer on 13 November 2012. That parent received what they described as "a standard letter from West Moreton HHS stating that no final decision had been made".⁴³

Several parents and families gave evidence of their involvement in the "Save the Barrett" campaign.⁴⁴ One parent said they [redacted]
[redacted]⁴⁵ Another parent said:

[redacted]
[redacted] ...⁴⁶

There is also evidence that families were in contact with the media who reported on parents' concerns about the welfare of their children.⁴⁷

Reactions of BAC patients

Unsurprisingly, McDermott's disclosure had an impact on BAC patients. One patient gave evidence patients were told about the potential closure of the BAC at a meeting with staff. The patient expressed the view that:

After they told us that BAC might close, I felt terrible. We had no idea what was going to happen to us and we thought that they [redacted]

[redacted]
[redacted]⁴⁸

Another patient said, "There was a lot of fear, confusion, and uncertainty".⁴⁹

Sadler said there was "considerable turmoil with the announcement of the closure and [he] felt this further development would have adverse implications for many of the adolescents, where a sense of stability was essential to their progress".⁵⁰

The Principal of the BACSS at the time, Kevin Rodgers, expressed a similar view:

The leak of the information in November 2012 had a detrimental effect on the students. We had spent the previous five years planning for the new facility at Redlands. During this period a number of valued clinical staff left because they would be unable to travel to Redlands for work. The leak announcement in November 2012 exacerbated these issues.⁵¹

A number of parents and families gave evidence to the Commission that the potential closure of the BAC caused their child distress.⁵² [redacted]

[redacted]⁵³
[redacted]
[redacted]⁵⁴

Following McDermott's disclosure, a number of patients and former patients became involved in the "Save the Barrett" campaign.⁵⁵

[redacted] attended Parliament House to meet with politicians about the possible closure of the BAC.⁵⁶

In November 2012, a former patient [redacted]⁵⁷

Messages after McDermott's disclosure

Given the unexpected nature of McDermott's disclosure, many BAC staff, patients, parents and families became aware of the intention to close the BAC through media reports.⁵⁸ In the weeks following McDermott's disclosure, West Moreton HHS issued a series of communications to staff and parents and carers of BAC patients.

Messages to staff

On 9 November 2012, Kelly, Dwyer, Padraig McGrath (acting Director of Nursing, Secure Services, West Moreton HHS) and William Brennan (Director of Nursing, The Park) met with BAC staff and BACSS staff.⁵⁹ According to Kelly, the purpose of the meeting was to "advise [the staff] that no decision had been made around service delivery".⁶⁰ Dwyer's evidence was that the meeting was held "to reassure staff and reiterate that The Park site had been designated for forensic secure patients and WMHHS would be looking at other models of care but that we would keep staff involved in that process".⁶¹

The majority of staff members attended this meeting, including educational staff.⁶² They were informed that West Moreton HHS would be convening an Expert Clinical Reference Group (ECRG) to advise on service delivery options.⁶³

A number of BAC staff have evidence that, during the meeting, they were provided with the following reasons for closure of the BAC:

- the BAC model of service was outdated and/or it was more appropriate for adolescents to be treated closer to their homes and family
- the building was no longer fit for purpose
- funding cuts
- BAC patients were at a potential risk from adult patients at The Park.⁶⁴

Kelly told the Commission that she "had extensive meetings with staff around closure issues" between 9 November 2012 and when BAC closed in January 2014.⁶⁵

Angela Clarke, a speech pathologist at the BAC, gave evidence that after staff meetings with Kelly and Dwyer she:

often walked away from those meetings having received information that was conflictual so, for example, in some meetings we were told there's no decision but within that same meeting we would often hear the opinion being given that, you know, it couldn't stay open, it couldn't be rebuilt, we couldn't stay on the grounds of the forensic service.⁶⁶

BACSS teacher Margaret Nightingale said, "Dwyer gave a very mixed message about the future of the Barrett Adolescent Centre".⁶⁷ She explained, "I recall querying how they could say that there had been no decision to close when they were also saying that the BAC could no longer remain

in the current buildings and that there was no funding to build a new location nor was there any other alternative location".⁶⁸

Following the meeting, Kelly sent a follow up email to staff, in which she stated:

Given the current speculation and in the interests of our staff, patients and their families I am keen to inform you about the present thinking in relation to the future of adolescent services at The Park.

1. I can confirm that high level discussions have been taking place in regards to the future of Barrett Adolescent Services in the context of the 'Redlands option' no longer being available.
2. Any decision will take into account that the role and structure of The Park facility is that of an adult forensic service, and have regard to concerns held by some stakeholders regarding the co-location of adolescent services and adult forensic/secure services.
3. The West Moreton Hospital and Health Service supports the national reform agenda to ensure young people are treated closer to their homes in the least restrictive environment, and with minimum possible disruption to their families, educational, social and community networks. As all of you would be aware, the National Mental Health Service Planning Framework clearly recommends community-based and non-acute care settings for the care of mental health consumers, particularly young people.

We gave a commitment to staff today to ensure that **as soon as information becomes available they will be kept up-to-date ...**⁶⁹

... **Once any decision is made I am committed to consultation about the implementation of any organisational change, particularly in regard to minimising the impact of any change on staff.**

(emphasis added)

Kelly's "commitment" to keep staff up-to-date as soon as information becomes available" was not fulfilled in that staff were not always kept up to date about the closure of the BAC.

Messages to families

Shortly after McDermott's disclosure, a pro forma letter signed by Dwyer was emailed to parents and carers of BAC patients on 12 November 2012. The letter stated:

It was always our intention to ensure that discussions about the future model of adolescent mental health included our clinicians, patients and their families.

Unfortunately information and concerns were raised with the media before thorough planning and consultation could commence.⁷⁰

(emphasis added)

Dwyer's letter included the following messages to families:

- West Moreton HHS and the MHAODB had commenced "discussions with key experts, other health services and staff regarding the future model of adolescent mental health care in Queensland".
- Redlands was no longer an option.
- the current condition of the BAC building at The Park was "no longer fit for purpose".
- The Park was to become an "adult high forensic centre" and it was "no longer appropriate to have adolescents at The Park".
- in light of Redlands no longer being built, West Moreton HHS had commenced reviewing the model of mental health care for adolescents in Queensland to ensure it was in line with "expert clinical opinion and research".
- West Moreton HHS supports the National Reform Agenda to "ensure young people are treated closer to their homes, in the least restrictive environment, and with minimum possible disruption to their families, educational, social and community networks".
- the National Mental Health Service Planning Framework clearly recommends community based and non-acute settings, particularly for adolescents.⁷¹

The letter also stated that West Moreton HHS intended to consult widely and assured families that they would be "kept up to date as information becomes available".⁷²

There are three things to note about this letter.

First, there is no evidence that West Moreton HHS intended to consult with families prior to McDermott's announcement. In an email Kelly sent on 26 October 2012 to Kingswell, Gilhotra, Geppert, Dwyer and Thornton, to "recap" a meeting the previous day, Kelly discussed closing the BAC as early as December 2012. She identified that a "clear communication plan and strategy" was required with respect to families, but did not mention anything about consulting families or staff. While there may have been a plan to provide families with some information about the closure, there was no plan to provide them with an opportunity to contribute to the decision-making, apart from by means of consumer and carer representatives on the ECRG.

Given this email was sent in October 2012, at a time when West Moreton HHS was thinking about closing the BAC "as early as" December 2012, it was not accurate for Dwyer to have said "we always intended to consult families and staff". Further discussion of the 25 October 2012 meeting is in chapter 7.

Second, Dwyer's statement that it was "no longer appropriate to have adolescents at The Park" because The Park was to become an "adult high forensic centre" was vague and did not include important information. Families were not told that EFTRU was planned to open in June/July 2013⁷³ and that EFTRU was unsafe or constituted an "unacceptable risk" to BAC patients.⁷⁴

Third, while there is evidence⁷⁵ that by 9 November 2012 West Moreton HHS and the MHAODB had commenced discussions with "key experts and other health services" regarding alternative models of care (discussed in chapter 7), there is no evidence that any formal consultation had commenced, or that the BAC had been compared with "expert clinical opinion and research". Dwyer's letter to families was sent before the Planning Group and the Expert Clinical Reference Group (ECRG) had been convened. The Planning Group first convened on 21 November 2012⁷⁶ and the ECRG commenced on 7 December 2012. This is discussed in chapter 9.⁷⁷

(Endnotes)

- 1 Exhibit 449, Batch of emails collated by Trevor Sadler to child psychiatrists, Subject: "Learning of closure", 15 November 2012, p 3.
- 2 Exhibit 449, Batch of emails collated by Trevor Sadler to child psychiatrists, Subject: "Learning of closure", 15 November 2012, pp 14–15.
- 3 Exhibit 449, Batch of emails collated by Trevor Sadler to child psychiatrists, Subject: "Learning of closure", 15 November 2012, pp 15–16.
- 4 Exhibit 449, Batch of emails collated by Trevor Sadler to child psychiatrists, Subject: "Learning of closure", 15 November 2012, p 24.
- 5 Exhibit 1068, Letter from Michelle Fryer to Lawrence Springborg, 9 November 2012.
- 6 Exhibit 449, Batch of emails collated by Trevor Sadler to child psychiatrists, Subject: "Learning of closure", 15 November 2012, pp 22-23.
- 7 Exhibit 114, Statement of James Scott, 4 February 2016, p 7 paras 30–32, Attachment JS-3 to that statement, Letter from James Scott to Lawrence Springborg, 11 November 2012, p 51.
- 8 Exhibit 114, Statement of James Scott, 4 February 2016, p 7 paras 32–33, Attachment JS-3 to that statement, Letter from James Scott to Lawrence Springborg, 11 November 2012, p 51.
- 9 Exhibit 991, Letter from Sue Wilson, to Scott Emerson MP, 11 November 2012.
- 10 Exhibit 1063, Letter from Victoria Gladwell to Lawrence Springborg MP, 21 November 2012, p 1.
- 11 Exhibit 1063, Letter from Victoria Gladwell to Lawrence Springborg MP, 21 November 2012, p 2.
- 12 Exhibit 363, Emails between Dan Siskind and William Kingswell, Subject: "Barrett", 9–10 November 2012.
- 13 Exhibit 172, Supplementary statement of Cary Breakey, 9 February 2016, pp 6–7 para 28.
- 14 Exhibit 87, Statement of Pdraig McGrath, 16 November 2015, pp 4–5 para 6.4; Exhibit 30, Statement of William Brennan, 16 November 2015 p 5 para 5.3.
- 15 Transcript, Cary Breakey, 15 February 2016, p 6-46 lines 7–10.
- 16 Exhibit 177, Supplementary statement of Margaret Nightingale, 25 January 2016, p 9 para 41.
- 17 Exhibit 177, Supplementary statement of Margaret Nightingale, 25 January 2016, p 7 para 32.
- 18 Confidential exhibit.
- 19 Exhibit 137, Supplementary statement of Georgia Watkins-Allen, 30 January 2016, p 8 para 26.
- 20 Exhibit 106, Statement of Deborah Rankin, 11 October 2015, p 19 para 76.
- 21 Exhibit 106, Statement of Deborah Rankin, 11 October 2015, p 19 para 72.
- 22 Exhibit 106, Statement of Deborah Rankin, 11 October 2015, p 19 para 74.
- 23 Exhibit 247, Supplementary statement of Justine Oxenham, 24 February 2016, pp 4–5 para 8.
- 24 Exhibit 111, Statement of Kimberley Sadler, 14 December 2015, p 11 para 70.
- 25 Exhibit 20, Statement of Darren Bate, 13 November 2015, pp 7–8 para 22.
- 26 Exhibit 20, Statement of Darren Bate, 13 November 2015, Attachment F to that statement, Letter from Darren Bate to John-Paul Langbroek, 13 November 2012, p 25.
- 27 Exhibit 1062, Email from Linda Asprey to Tim Nicholls, 18 November 2012; Confidential exhibits.
- 28 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 31 para 17.2.
- 29 Exhibit 110, Statement of Kevin Rodgers, 10 December 2015, Attachment C to that statement, p 50.
- 30 Exhibit 1452, Letter from Alison Earls to the Commissioner, 17 September 2015, p 2.
- 31 Exhibit 1065, Print out of the e-petition on the 'Community Run' website.
- 32 Exhibit 1452, Letter from Alison Earls to the Commissioner, 17 September 2015, p 2.
- 33 Exhibit 1065, Print out of the e-petition on the 'Community Run' website.
- 34 Exhibit 1066, Various print outs of the savethebarrett.org website.
- 35 Exhibit 130, Statement of Lesley van Schoubroeck, 26 October 2015, Attachment L to that Statement, pp 113–114.
- 36 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 31 para 17.2.
- 37 Screenshot of the Queensland Parliament e-petitions website, Closed e-petitions, Subject: "Save the Barrett Adolescent Centre", closing date 4 March 2013.

- 38 Exhibit 1064, Screenshot of the Queensland Parliament e-petitions website, Closed e-petitions, Subject: "Save the Barrett Adolescent Centre", closing date 4 March 2013.
- 39 Confidential exhibits.
- 40 Confidential exhibit.
- 41 Exhibit 130, Statement of Lesley van Schoubroeck, 26 October 2015, Attachment L to that Statement, pp 100, 102–104, 107, 111; Confidential exhibits.
- 42 Confidential exhibit.
- 43 Confidential exhibit.
- 44 Confidential exhibits.
- 45 Confidential exhibit.
- 46 Confidential exhibit.
- 47 Transcript, Lawrence Springborg, 26 February 2016, p 15-45 lines 15–19; Confidential exhibit.
- 48 Confidential exhibit.
- 49 Confidential exhibit.
- 50 Exhibit 179, Supplementary statement of Trevor Sadler, 12 February 2016, p 15 para 68.
- 51 Exhibit 110, Statement of Kevin Rodgers, 10 December 2015, p 7 para 27.
- 52 Confidential exhibit.
- 53 Confidential exhibit.
- 54 Exhibit 137, Supplementary statement of Georgia Watkins-Allen, 30 January 2016, p 18 para 59.
- 55 Confidential exhibits.
- 56 Confidential exhibit.
- 57 Confidential exhibit.
- 58 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 49 para 230; Exhibit 91, Statement of Margaret Nightingale, 24 November 2015, p 15 para 62; Exhibit 106, Statement of Deborah Rankin, 11 October 2015, p 17 para 63; Exhibit 110, Statement of Kevin Rodgers, 10 December 2015, pp 6–7 para 26; Confidential exhibits.
- 59 Exhibit 87, Statement of Padraig McGrath, 16 November 2015, pp 4–5 para 6.4; Exhibit 30, Statement of William Brennan, 16 November 2015, p 5 para 5.3.
- 60 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, pp 23–24 para 17.1.
- 61 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, pp 15–16 para 10.1.
- 62 Exhibit 137, Supplementary statement of Georgia Watkins-Allen, 26 November 2015, p 6 para 20; Exhibit 177, Supplementary statement of Margaret Nightingale, 25 January 2016, p 8 para 35.
- 63 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, pp 23–24 para 17.1.
- 64 Exhibit 69, Statement of Mara Kochardy, 29 October 2015, p 11 para 14; Exhibit 137, Supplementary statement of Georgia Watkins-Allen, 30 January 2016, pp 6–7 para 22; Exhibit 45, Statement of Susan Daniel, 30 October 2015, p 11 para 14; Exhibit 109, Statement of Rosangela Richardson, 30 October 2015, p 9 para 14; Exhibit 113, Statement of Stephen Sault, 15 December 2015, pp 11–12 para 12.
- 65 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 24 para 17.2.
- 66 Transcript, Angela Clarke, 29 February 2016, p 16-26 lines 24–32.
- 67 Exhibit 91, Statement of Margaret Nightingale, 24 November 2015, p 15 para 63.
- 68 Exhibit 177, Supplementary statement of Margaret Nightingale, 25 January 2016, p 8 para 36.
- 69 Exhibit 45, Statement of Susan Daniel, 30 October 2015, Attachment to that statement, Email from Sharon Kelly to WM TeamConnect, Subject: "ATTN STAFF: Update regarding Barrett Adolescent Centre", p 28.
- 70 Exhibit 45, Statement of Susan Daniel, 29 October 2015, Attachment to that statement, pp 30–31; Exhibit 91, Statement of Margaret Nightingale, 24 November 2015, Attachment J to that statement, p 48.
- 71 Exhibit 45, Statement of Susan Daniel, 29 October 2015, Attachment to that statement, pp 30–31.
- 72 Exhibit 45, Statement of Susan Daniel, 29 October 2015, Attachment to that statement, pp 30–31.
- 73 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 9 para 10.6(a).
- 74 Exhibit 66, Statement of Sharon Kelly, 16 October 2015 p. 12 para 11.11(b).

- 75 Evidence of these discussions prior to 12 November 2012 includes: Kelly recorded in her email to Kingswell, Gilhota, Geppert, Dwyer and Thorburn on 26 October 2012, that Kingswell was to meet with the "Mater services and others to map out what actions and requirements there [were]"; Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment SK-9 to that statement, pp 826–827; Kelly had met with Sadler and Stedman to seek their advice about the closure, and during Kingswell, Cleary and Kelly's visit to the BAC on 11 September 2012; Exhibit 66, Statement of Sharon Kelly, 16 October 2015 at p 9 para 10.4; On 11 September 2012 Kingswell and others visited the BAC and Kingswell asked Sadler and Susan Daniel "questions about alternative services"; Exhibit 49, Statement of Ms Dwyer, 6 November 2015, p 3 para 5.4. See chapter 7.
- 76 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 39 para 30.2.
- 77 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment SK-26 to that Statement, Fast Facts 2, p 955.

9 Barrett Adolescent Strategy

Introduction – November 2012 to May 2013

The McDermott disclosure on 8 November 2012 spurred the West Moreton Hospital and Health Service (HHS) executive to action.

On 9 November 2012, Sharon Kelly¹ sent an email to Leanne Geppert² (copied to Bill Kingswell,³ Jagmohan Gilhotra⁴ and Lesley Dwyer⁵). Kelly asked Geppert to convene a meeting (which had already been proposed) of “key strategic partners” to consider mental health strategies required, options, implications etc.”⁶

This was the first move by West Moreton HHS to consult more broadly with “key experts, [and] other health services”⁷ about alternative models of service for the BAC.

Geppert responded to Dwyer’s email that day, saying that the purpose of the meeting should be to “... clarify the events of this week, identify next steps/tasks in the process, and identify the steering committee to progress the work of establishing the alternative models of service for the State”.⁸

The following chapter sets out the events that ensued from this point, up until just prior to the meeting of the West Moreton Board on 24 May 2013.

15 November 2012 – meeting with “key strategic partners”

On 14 November 2012, Dwyer sent out an email invitation (drafted by Geppert and her team)⁹ to a number of Dwyer’s “colleagues” for the 15 November 2012 meeting. The invitation was sent to Kelly, Trevor Sadler and Terry Stedman from West Moreton HHS, and Geppert and Kingswell from the MHAODB. Also included were Brett McDermott, and representatives from the Townsville, Metro South, Logan, Children’s Health Queensland, Gold Coast Hospital and the Darling Downs Hospital and Health Services.¹⁰ It stated:

Recent media reports have raised to the forefront the role and future of the [BAC] at The Park.

I am seeking your support, advice and collaboration in relation to developing an alternative model or models of service to replace the services currently provided at the Barrett Adolescent Centre (BAC), at The Park – Centre for Mental Health.

Initial high level discussion had commenced with Mental Health Branch and senior staff at The Park, as you would be aware, the Redlands Adolescent Extended Treatment capital project has been recently cancelled.

The BAC facility at The Park is approaching 40 years of age and has been identified by the Australian Council of Healthcare Standards as unsafe and necessitating urgent replacement. Further, there is concern regarding its co-location with adult forensic and secure services at The Park.

At this point in time, no decision has been made by the West Moreton Hospital and Health Board and the purpose of the planned meeting tomorrow, Thursday, is to provide some clarity and commence discussions in regards to the next steps for determining the solution and alternate [sic] services for this consumer group.¹¹

(emphasis added)

The proposed meeting took place on 15 November 2012, chaired by Dwyer.

In a report to the West Moreton Board on 23 November 2012, Dwyer said:

A meeting was held on Thursday, 15 November 2012 with key Child and Youth Psychiatrists, WMHHS Chief Executive and Executive Director Mental Health and Specialised Service and System Manager with agreement reached that a Planning Group be formed to lead the planning, consultation and development of options and final recommendation for decision. This Planning Group will be supported by a clear communication strategy, a consumer consultation strategy and an expert clinical reference group with appointed membership from representative groups as well as interstate and national experts.

An action plan will be developed with the Planning Group by Wednesday, 21 November 2012 and provided to the Board for endorsement.¹²

16 November 2012 – the Project Plan

On 16 November 2012, Chris Thorburn (then acting Director of Services Redesign, West Moreton HHS) prepared a "Barrett Adolescent Strategy" Project Plan (the Project Plan).¹³

Kelly was the executive sponsor of the Project Plan, and Dwyer was the executive delegate.¹⁴ In her oral evidence, Kelly explained the role of the executive sponsor as follows:

- FREEBURN: It says that you're the executive sponsor. What does that mean?
- KELLY: Well, I was the Executive Director of Mental Health and Specialised Services. So it was my responsibility to oversee the actual plan itself.
- FREEBURN: Okay. So while somebody else may have written it, you certainly would've checked it?
- KELLY: Yes. That's correct. So Chris would – had written this plan as part of a broader mental health strategy. Yes.¹⁵

The Project Plan assumed that the services then provided at the BAC would not remain on the campus of The Park after June 2013, which according to Kelly, was the anticipated commencement time for EFTRU.¹⁶ It noted, "As there is no longer a current capital allocation to rebuild BAC on another site, the models of care to be developed must exclude this as an option".¹⁷

The following diagram, taken from the Project Plan, shows that a Planning Group was to be established, which would be responsible for establishing an Expert Clinical Reference Group (ECRG), as well as developing consumer consultation and communication strategies.¹⁸

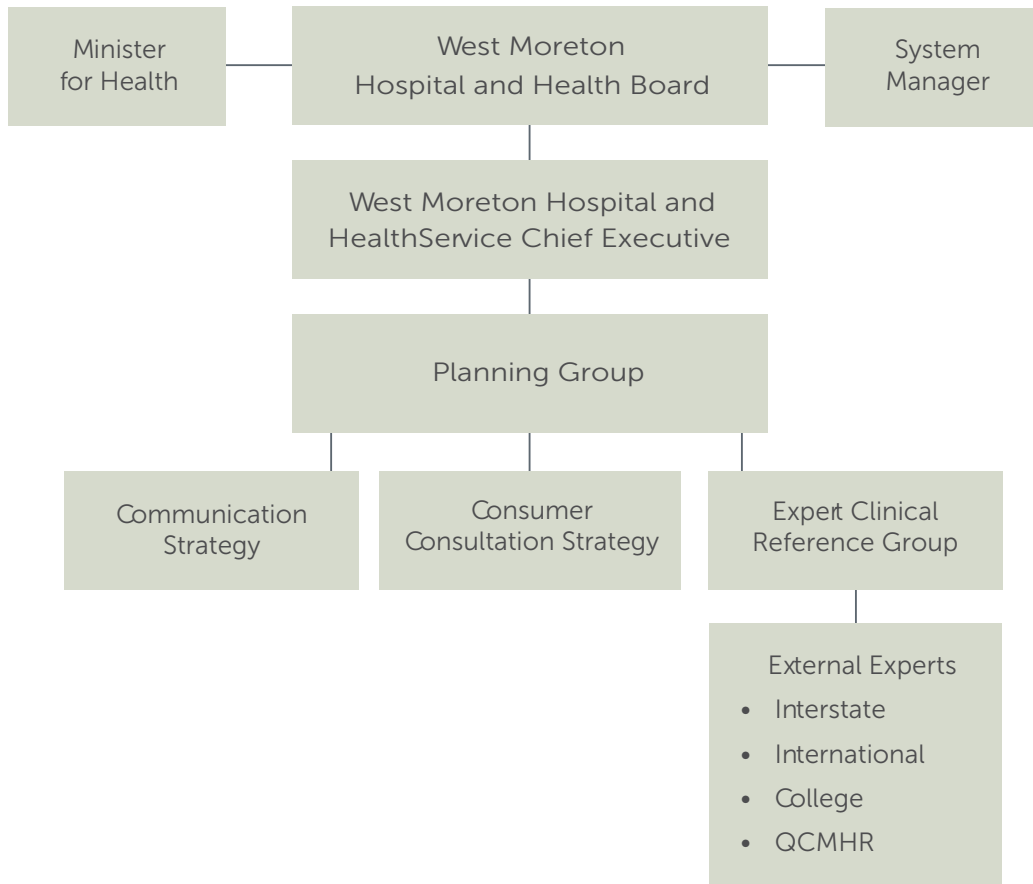


Figure 9A: Governance structure for the Barrett Adolescent Strategy

21 November 2012 – the Planning Group

The Planning Group first convened on 21 November 2012.¹⁹ It reported to the Health Service Chief Executive, Dwyer,²⁰ who in turn reported to the West Moreton Board.²¹

The Planning Group comprised the following members:

- Kelly, Chair
- Thorburn, then Director of Strategy Mental Health and Specialised Services
- Kingswell, Executive Director Mental Health, MHAODB
- Geppert, then Director Planning and Partnerships, MHAODB
- David Hartmann, Clinical Director, Community Youth Mental Health Service (CYMHS), Townsville Hospital and Health Service
- Trevor Sadler, Clinical Director, BAC
- Stephen Stathis, Psychiatrist, Child and Family Therapy Unit, Children’s Health Queensland HHS (CHQ)
- Michelle Bond, Principal, Royal Children’s Hospital School
- Naomi Ford, Rowdy Communications (in relation to communication strategy).²²

In this section, each of the Planning Group’s broad areas of responsibility are considered.

The meetings of the Planning Group, and its recommendations, are discussed in chapter 10.

Area of responsibility 1: Communication strategy

Communication strategy was one of the three broad areas of responsibility of the Planning Group. Kelly's evidence is that, as chair of the Planning Group, she "co-ordinated" the communication strategy.²³

In addressing this responsibility, the Planning Group took advice from public relations firm, Rowdy PR.²⁴ A representative from Rowdy PR, Naomi Ford, was a member of the Planning Group.

Ford's evidence is that she drafted the Communication Plan, dated 20 November 2012, which was appended to the Project Plan.²⁵

Two questions arise: what was the communication strategy, and to whom was the 'communication' directed?

The Communication Plan identified 'Internal Stakeholders' and 'External Stakeholders' to whom it applied. The 'internal' persons and bodies comprised (adopting the descriptions used in the Communication Plan):

- West Moreton HHS Board, Executive and Senior Management Team
- Clinicians, other staff and management working within West Moreton HHS
- Health Minister and key advisors
- Queensland Health Director-General, Deputy Directors-General and Executive Directors (including Mental Health Alcohol and Other Drugs Branch)
- Senior Heads of Department
- Education Queensland
- Education Minister
- Director-General of Education Queensland.

The 'external' persons and bodies comprised (again, adopting the descriptions used in the Communication Plan):

- the Premier and other Queensland Government Ministers
- media
- existing and potential patients of BAC
- general public
- broader health professionals, including GPs
- Australian Medical Association
- members of parliament
- local government
- opposition parties
- relevant unions
- professional colleges
- other Hospital and Health Services
- non-government organisations.

The essence of the communication strategy is set out in the Communication Plan by way of a table under the heading 'Action plan internal and external stakeholders'.²⁶ It identifies types of communication for particular target audiences, and details the specific message that is to be delivered to each, and by whom and when. It identifies various risks and issues.

The table included a specific action item for responding to correspondence from BAC patients, the general public and politicians. It identified an 'issue/risk' that the correspondence writer might go to the media, and required that West Moreton HHS's "Chief Executive/Executive Team" "Develop [a] standard response regarding background of project, reasoning etc [but] ... ensure [the] response is updated to reflect various phases of project". The item was allocated a high priority level.

Area of responsibility 2: Consumer Consultation Strategy

The Planning Group's second broad area of responsibility was Consumer Consultation Strategy.

According to Ford, Rowdy PR developed a "Stakeholder Engagement Plan" for the Barrett Adolescent Strategy, at the direction of Dwyer, Kelly and Thorburn.²⁷ Ford's evidence was that "Both the Communication Plan and the Stakeholder Engagement Plan contain similar material, as the messages provided to both media and stakeholders should generally be consistent".²⁸

Ford developed an initial draft of the Stakeholder Engagement Plan on 1 December 2012,²⁹ which was discussed by the Planning Group at its meeting on 5 December 2012.³⁰ The initial draft described "existing BAC patients & families" as internal stakeholders, and "potential patients of BAC" as external stakeholders. The Minutes of the 5 December 2012 Planning Group meeting record some (limited) discussion about the draft plan: "Additional feedback to be forwarded as required[.] Naomi [Ford] to add patients to internal stakeholders[.] Follow up meeting to be held to discuss making plan operational".

On 12 December 2012, Ford developed a revised draft of the Stakeholder Engagement Plan,³¹ which coincides with the date of the second meeting of the Planning Group.

The second version describes "patients and families" as internal stakeholders, however it also includes "existing and potential patients of BAC" as external stakeholders. There is no explanation for the second draft's distinction between "patients and families" on the one hand, and "existing and potential patients of BAC" on the other. Later in the plan, "current BAC consumers & their families" are listed as "primary external stakeholders". It is difficult to reconcile these two aspects of the plan. Perhaps an error was made.

In any event, despite the direction of the Planning Group to add “patients” to the list of internal stakeholders, it is clear from the balance of the second Stakeholder Engagement Plan that current BAC patients and their families were part of the external stakeholder group.

Before considering the type of engagement required, it is relevant to note that both versions of the Stakeholder Engagement Plan specified three (increasing) levels of engagement, as shown in the following table (extracted from the 12 December 2012 plan).

Engagement level

<p>Information: One-way relationship where information provided to stakeholders and the community.</p>	<p>[Internal and external stakeholders]: General community, media, WMHHS staff other than BAC staff), consumers and families, AMA, Members of Parliament, Opposition parties</p>
<p>Consultation: Two-way relationship, where community views are sought and there is an opportunity to influence the final outcome.</p>	<p>[Internal and external stakeholders]: BAC staff, consumers, relevant unions, other HHSs (including CEs), NGOs, System Manager, EQ (incl DG and Minister for Education)</p>
<p>Active participation: Communities and individuals are actively involved in project decisions; the community can help manage the process of developing solutions; there are opportunities for shared agenda setting and deliberation on issues and solutions.</p>	<p>[Internal stakeholders]: Clinicians (clinical reference group in particular), Minister for Health, WMHHS Board</p>

In a table headed ‘Stakeholder and issues analysis’, which is reproduced below (with emphasis added), it is clear that “current BAC consumers [and] their families” required engagement at the level of “consultation” (only), and were to receive “regular updates”. BAC staff were to receive “information, consultation and active participation”, and were to receive weekly or fortnightly updates.

Internal stakeholders

Issues	Primary stakeholders	Secondary stakeholders	Engagement need	Communication and engagement tools
<ul style="list-style-type: none"> • Opposed to closure of BAC • Lack of faith in WM HHS finding sustainable solution • High expectation on service delivery • Opposed to change • Want cost effective statewide solution (Minister's office) • Solution must consider political ramifications • Lack of understanding of need for change 	<ul style="list-style-type: none"> • BAC staff • Office of the Minister 	<ul style="list-style-type: none"> • Other WMHHS staff • System Manager • Education Qld 	<ul style="list-style-type: none"> • High level engagement required – information, consultation and active participation • Need to be kept up-to-date regularly (weekly or fortnightly if possible) • Need to feel part of solution • Garner support for project • Open & honest communication 	<ul style="list-style-type: none"> • Fact sheets • Newsletter updates • All staff emails • Face-to-face meetings/forums • Correspondence /letters • Intranet updates • Internet updates • E-alerts • Memos/briefing notes

External stakeholders

Issues	Primary stakeholders	Secondary stakeholders	Engagement need	Communication and engagement tools
<ul style="list-style-type: none"> • Do not understand project • Swayed by negative comment/inaccurate information • Political ramifications 	<ul style="list-style-type: none"> • Current BAC consumers & their families • Office of Premier • Other HHS • Professional Colleges • NGOs 	<ul style="list-style-type: none"> • Media • General public • AMA • Relevant unions • Local Governments • Members of Parliament 	<ul style="list-style-type: none"> • Consultation (primary stakeholders) • Information (secondary stakeholders) • Create awareness & understanding of project • Open and honest communication • Regular updates 	<ul style="list-style-type: none"> • Newsletters • Fact sheets • Media responses/releases • Press conferences • Internet updates • Face-to-face meetings • E-alerts • Social media • Letters/correspondence • Memos/briefing notes

The Stakeholder Engagement Plan outlined a process to be followed with respect to the evaluation of the plan. That process was premised on the understanding that Thorburn was to evaluate the volume and nature of stakeholder feedback using a feedback log, and to do so on a fortnightly basis after each project milestone (planning, scoping, decision-making). The plan required Thorburn to track stakeholder feedback on a daily basis, and Rowdy PR to consider using a stakeholder survey at the end of the project “to determine if [stakeholders were] happy with [the] level of communication”.

Although Ford was on the Planning Group and prepared both the Communication Plan and the Stakeholder Engagement Plan, she was uncertain whether the Stakeholder Engagement Plan was unequivocally adopted by West Moreton HHS:

In these Plans, I made certain recommendations in relation to the mode and frequency of communications with BAC staff and families of BAC patients. WMHHS was responsible for considering the feasibility of these recommendations, however I believe that my recommendations were generally adopted.³²

It is not clear whether the Stakeholder Engagement Plan was formally endorsed by West Moreton HHS. It was not appended to the Project Plan (whereas the Communication Plan was). Further, there appears to be some overlap between the Stakeholder Engagement Plan and Communication Plan. As noted above, the Communication Plan provides for fact sheets to be sent to “WMHHS staff, consumers, general public, media” and responses to be sent by West Moreton HHS to correspondence received from “BAC existing patients [and] staff”.³³

Further detail in respect of the Fact Sheets, is included below.

Area of responsibility 3: Formation of ECRG

The third broad area of responsibility assumed by the Planning Group was the formation of the ECRG. Kelly’s evidence is that the Planning Group settled the terms of reference for the ECRG (discussed below), and identified and invited the specialists who became members of it.³⁴

According to Kelly, the purpose of the ECRG was to:

Provide expert clinical advice to promote the development of a contemporary evidence based model of care to meet the needs of adolescent mental health consumers who experience severe and persistent psychiatric symptomatology that significantly interferes with social, emotional, behavioural and psychological functioning and development.³⁵

Membership of the ECRG

The ECRG had broad representation from child and adolescent psychiatrists.³⁶ It included a substantial number of practising clinicians from various disciplines who had broad experience in the child and youth mental health sector.³⁷ Its members were:

- Geppert, Chair
- Sadler, Clinical Director, BAC
- Michelle Fryer, Faculty of Child and Adolescent Psychiatry
- James Scott, Consultant Psychiatrist Early Psychosis, Metro North HHS
- Hartmann, Clinical Director, Community Youth Mental Health Service (CYMHS), Townsville HHS
- Philip Hazell, Director, Infant Child and Adolescent Mental Health Services, Sydney and South Western Sydney Local Health Districts

- Josie Sorban, Director of Psychology, CYMHS, Children's Health Queensland HHS
- Amanda Tilse, Operational Manager, Alcohol and Other Drugs and Campus Mental Health Services, Mater Children's Hospital
- Amelia Callaghan, State Manager Queensland, Northern Territory, and Western Australia, Headspace
- Emma Hart, Nurse Unit Manager, Adolescent Inpatient Unit and Day Service, Townsville HHS
- Kevin Rodgers, Principal, Barrett Adolescent Centre Special School
- a consumer representative
- a carer representative.³⁸

ECRG's terms of reference

Draft terms of reference for the ECRG were first circulated amongst the Planning Group on 27 November 2012, in advance of the Planning Group's second meeting the next day, 28 November 2012.³⁹

The ECRG provided feedback on the draft terms of reference at its first meeting on 7 December 2012. In particular, ECRG members expressed concern that the terms of reference did not clearly articulate the severity and complexity of the target consumer group or articulate alignment with current state models of service and planning frameworks. The ECRG also expressed concern that the timeframes identified in the Barrett Adolescent Strategy Project Plan (Project Plan) were ambitious.⁴⁰ The minutes record that Geppert was to forward this feedback, including recommended changes to the terms of reference, to the Planning Group.⁴¹

By 9 January 2013, when the ECRG held its second meeting, this appears to have occurred. The minutes of the 9 January 2013 meeting record that the feedback on the terms of reference was to be considered by the Planning Group at its next meeting on 18 January 2013.⁴²

At the third ECRG meeting on 13 February 2013, Geppert noted that she was still awaiting a response from the Planning Group in relation to amendments to the ECRG's terms of reference. The minutes record that the relevant changes had been made to the terms of reference and "forwarded to Sharon Kelly for the Planning Group" to consider at its meeting on 25 January 2013.⁴³

The ECRG's terms of reference were probably not settled until 26 February 2013, when Geppert distributed a final version to the ECRG members, observing that it was endorsed by West Moreton HHS and incorporated feedback from the ECRG members.⁴⁴

Those terms of reference provide that the function of the ECRG was to consider model(s) of care that would:

- clearly articulate a contemporary model(s) of care for sub-acute mental health treatment and rehabilitation for adolescents in Queensland
- be evidence-based, sustainable and align with Queensland mental health policy, current statewide models of service, National mental health policy, National mental health service planning frameworks and future funding models
- take into account the Clinical Services Capability Framework (for Mental Health) and
- replace the existing Statewide services provided by Barrett Adolescent Centre – The Park.⁴⁵

The ECRG was to "... provide its recommendation regarding contemporary model(s) of care to the Planning Group as per the Project Plan for the Barrett Adolescent Strategy".⁴⁶

While the ECRG's terms of reference said what was within its remit, they did not explicitly say what was outside its remit. Nevertheless, the Project Plan did so in these terms: "As there is no longer a current capital allocation to rebuild BAC on another site, the model(s) of care to be developed must exclude this as an option".⁴⁷

Further discussion in respect of the ECRG, including details of the report of the ECRG, can be found in chapter 10.

Relationship between the Planning Group and the ECRG

In cross examination, Kelly said the following about the respective functions of the Planning Group and the ECRG:

So the Expert Clinical Reference Group was just that; they were expert clinicians ... pulled together to provide some recommendations and some advice. The Planning Group was responsible for synthesising both their recommendations as well as overlaying it with the political context, the organisational and operational context.⁴⁸

Counsel for Springborg provided a useful analysis of the respective roles of the ECRG and the Planning Group. He wrote:

It is apparent that the Planning Group comprised persons with considerable expertise in both clinical care and public health administration. Importantly, and unlike the members of the ECRG, these persons were all employees of the Department of Health, or a relevant HHS. They were, accordingly, more intimately and directly involved in the practical application of any recommendation made by the ECRG, and with the practical issues that affected the continued operation of the BAC at The Park.

The evidence is that in considering the ECRG Report and making recommendations, the Planning Group considered a wider range of factors than the ECRG. In particular, the Planning Group considered issues such as the risks associated with keeping the BAC open, and weighed them against the risks identified by the ECRG from closing the BAC before the new statewide model of care was fully implemented. It would therefore be quite wrong to consider the ECRG Report as the only input into the Planning Group's deliberations, or to regard the Planning Group as simply being an administrative body.⁴⁹

(citations removed)

This analysis of the roles of the two groups in practice, aligns with the theory posited in the Project Plan and governance structure in it.

23 November 2012

Meeting of the West Moreton Board

At a meeting of the West Moreton Board on 23 November 2012, Dwyer tabled a Health Service Chief Executive Report, which included an item 'Potential Closure of the Barrett Adolescent Unit'. In that report she advised:

- in accordance with the "Statewide Mental Health Plan", The Park was to become an adult forensic centre
- EFTRU was anticipated to be operational in July 2013
- it would no longer be appropriate to have young teenagers on a campus for adults in a medium to high security setting
- in August 2012 the Health Minister had approved the redirection of funds previously allocated to the Redlands Project
- the BAC building was no longer fit for purpose
- the Planning Group was to be supported by a clear communication strategy, a consumer consultation strategy and an Expert Clinical Reference Group (with appointed membership from representative groups as well as interstate and national experts)
- an action plan (presumably the project plan) was to be developed.⁵⁰

Letter to a parent from Mary Corbett

On 23 November 2012, a parent received a letter from Mary Corbett, Chair of the Board, in response to a letter the parent had sent to the Minister. Relevantly, that letter:

- said that the Board was "aware of the anxiety created by the alleged imminent closure" of the BAC
- assured the parent that the West Moreton Board was committed to ensuring Queensland's adolescents would have access to the mental health treatment and care they needed
- stated that no final decision about the BAC had been made⁵¹
- said that West Moreton HHS was collaborating with an ECRG who would develop a contemporary and evidence based model of care, that met the needs of adolescents requiring longer term mental health treatment.

The letter further stated that a communication plan had been developed to ensure that all stakeholders would be kept up to date regarding the progress in the development of the model of care, and that consultation would be "broadly based" prior to a decision being made.⁵²

30 November 2012 – Fast Facts 1

On 30 November 2012, West Moreton HHS commenced issuing a series of "Fast Facts" bulletins, which were distributed to patients, families, staff and other child and youth mental health services in Queensland. They were also posted to the West Moreton HHS website for public access.⁵³

The Fast Facts were drafted by Ford, using information she gained from attending Planning Group meetings and information provided to her by Dwyer, Kelly, Thorburn and Geppert.⁵⁴ One parent, who did not directly receive Fast Facts until August 2013, said the Fast Facts were useful in understanding the ECRG process.⁵⁵

Fast Facts 1 was issued on 30 November 2012.

It stated that “no final decision” about the BAC had been made and that no decision would be made until all recommendations of the ECRG had been considered.⁵⁶ This message was repeated in Fast Facts 2 to 5.⁵⁷ Significantly, Fast Facts 1 assured readers that they would receive updates “such as this one on a regular basis”.⁵⁸

Fast Facts 1 informed readers that “we are investigating alternative models of care to determine if there are better treatment options for young people in Queensland” and explained briefly the purpose of the ECRG. Under the heading ‘Why is this happening?’, Fast Facts 1 cited three reasons: *first*, to ensure adolescents received care that was “evidence-based” and “where possible, closer to their home”; *second*, the BAC buildings were “no longer able to support contemporary models of care”; and *third* The Park was to “continue to expand its capacity as a high secure forensic adult mental health facility” and there were “concerns” that The Park was not “a suitable environment for adolescents”.

Fast Facts 1 did not inform readers that EFTRU was planned to open June/July 2013⁵⁹ or that EFTRU was unsafe for the BAC patients or constituted an “unacceptable risk” to them. Under the heading ‘Is this about budget cuts?’, West Moreton HHS denied it was about “cost cutting”. Fast Facts 1 stated that “all funding for services provided by BAC will continue well into the future”.⁶⁰

While it was true that the operational funding for the BAC was not being cut, Fast Facts 1 failed to inform readers that the funding allocated for the Redlands Project had been reallocated to other projects. This is significant because without this information, families, carers and staff would likely not have appreciated that there was no option of redeveloping or rebuilding the BAC.

11 December 2012 – Fast Facts 2

Fast Facts 2 was issued on 11 December 2012. It stated that the ECRG had met for the first time on 7 December 2012, and that once it had finished its deliberations, it would make recommendations to the Planning Group, after which a decision would be made about the BAC.

Notably, Fast Facts 2 included the heading, “Is it true that Barrett Adolescent Centre will close regardless of the recommendations of the expert clinical reference group?” and in response stated, “No final decision ... has been made, what we are doing is investigating whether there are other models of care that can better meet the needs of adolescents who require longer term mental health treatment”.⁶¹

This message left open the prospect of the BAC remaining open, or at least there being a replacement of the BAC model. Yet the Project Plan, discussed above, expressly recognised that there was no prospect of the BAC remaining at The Park and that there was equally no prospect of rebuilding the BAC at another site.⁶²

14 December 2012 – Meeting West Moreton and Minister

At a meeting of the West Moreton Board on 14 December 2012, Corbett facilitated an in-camera discussion with the Minister for Health, Lawrence Springborg, and the Director-General, O’Connell.⁶³ Dwyer and Kelly were present from West Moreton HHS.⁶⁴

The meeting was not specifically convened in order to discuss the BAC. It was, however, a topic of discussion.⁶⁵

Documentary evidence

The authorised minutes of the West Moreton Board meeting record:

BOARD IN CAMERA

The Board held an in-camera session from 11.15am to 11.50am with the Hon Lawrence Springborg, Dr Tony O’Connell and Neil Hamilton-Smith.

No one from West Moreton HHS or Board prepared, or caused to be prepared, any contemporaneous note or record of the substance of the matters discussed at the meeting.

Neil Hamilton-Smith (then Principal Policy Adviser to Springborg) attended the meeting with Springborg on 14 December 2012.⁶⁶ According to Hamilton-Smith, it was usual practice for staffers like him to take iPad notes of meetings they attended with the Minister.⁶⁷ Unfortunately, no iPad note could be located and provided to the Commission. Ministerial office iPads were returned to the Ministerial Services Branch upon the change of government in 2015,⁶⁸ and Hamilton-Smith did not retain a copy of the data on his iPad.⁶⁹

Two key documents relevant to the meeting on 14 December 2012 were provided to the Commission by West Moreton HHS. Both were prepared in advance of the meeting.

The first is a briefing note for noting dated 11 December 2012 from the Health Service Chief Executive, West Moreton HHS to the Director-General. This briefing note says that it should be noted by the Director-General, Tony O’Connell, and provided to the Minister “for information”.⁷⁰

The second is a board committee agenda paper, prepared in preparation for the meeting of the West Moreton Board on 14 December 2012, concerning “Mental Health Strategy”, to which proposed “talking points” for Kelly are attached.⁷¹ Corbett’s evidence was that these “talking points” reflect what was said at the meeting.⁷²

The briefing note records two “Headline Issues”: first, that a meeting of the Minister, the Chair of the West Moreton Board, the Chief Executive of West Moreton HHS, and the Executive Director of Mental Health and Specialised Services was scheduled for 14 December 2012, and, second, that the intention was to brief the Minister on “... the proposed changes to and current significant issues in the MH&SS, WMHHS”.⁷³

One of the ‘Key issues’ listed is:

... there are a number of concurrent issues impacting on the MH&SS, such as the future model of care to replace services provided by Barrett Adolescent Centre, revised processes for Limited Community Treatment, [and] the future commissioning of Extended Forensic Treatment and Rehabilitation beds ...⁷⁴

There is one attachment to the briefing note, described as a “Proposed topic overview for the meeting between Minister for Health and West Moreton Hospital and Health Service”.⁷⁵ This lists six issues for discussion at the meeting, two of which are directly relevant:

- Barrett Adolescent Centre (BAC) – project plan, planning group & expert clinical reference group
- Extended Forensic Treatment and Rehabilitation Service (EFTRU) new 20 bed unit – opening early 2013.⁷⁶

In relation to the BAC, the “talking points”⁷⁷ record that:

As the Redlands Unit Project has ceased and there is no longer a capital allocation to relocate BAC, an alternative, contemporary, statewide model(s) of care must be developed to replace the services currently provided by BAC.⁷⁸

Under the heading ‘Major Changes’ the talking points record, in respect of the BAC, that an ECRG “consisting of experienced multidisciplinary child and youth mental health clinicians has been formed to recommend alternative model(s)”.⁷⁹ It notes that the West Moreton Board and the MHAODB have approved the governance of the process.⁸⁰ Significant media interest and “stakeholder angst” are described as being “managed through a communication and stakeholder engagement plan” (emphasis added).⁸¹

There is a further series of bullet points identifying “assumptions” pertaining to the “development of alternative model(s)” under the heading ‘Risks/actions moving forward’.⁸² Three of these assumptions are that:

- the services provided by BAC will not [be provided] at The Park after June 2013⁸³ (Early 2013 is the date identified elsewhere in the document for the scheduled opening of EFTRU.)
- the “endorsed model(s) of care will be incorporated into forward planning for the implementation of components of the remainder of the [QPMH]”
- “there will be robust evaluation criteria applied to determine the quality and effectiveness of the endorsed model(s) of care”.⁸⁴ It is also stated that “the endorsed model of care will be implemented in a two staged process, i.e. it will initially be applied to meet the needs of the current consumers in BAC and then implemented more widely across the state ...”.⁸⁵

In relation to EFTRU, the talking points contain an overview of the proposed service. It is recorded that “EFTRU has been designed to meet the needs of High Secure Inpatient Service (HSIS) consumers who no longer require the physical/procedural security of high security”.⁸⁶ It is noted that the rationale for EFTRU is managing a number of HSIS patients in a less restrictive setting on The Park campus “due to the slow rate of Limited Community Treatment (LCT) progress”.⁸⁷

On the face of the document, the recorded ‘Risks/actions moving forward’ do not explicitly mention any risks posed by EFTRU patients to BAC patients. At most, the statement that no services provided by the BAC will be provided on The Park campus after June 2013 may be an oblique reference to this perceived risk.

Further discussion in respect of EFTRU, and the risk of co-location with the BAC, is in chapter 14.

West Moreton evidence

The oral and written evidence about the 14 December 2012 meeting is relatively limited.

In her statement, Kelly did no more than state that she attended the meeting and attach the “talking points” prepared in advance of it. She said that the talking points were prepared not for her but for Corbett.⁸⁸ The document, however, explicitly records it contains “Proposed Talking Points for Executive Director Mental Health and Specialised Services”.⁸⁹

Corbett said in her statement that she met with Springborg, Kelly and Dwyer on 14 December 2012.⁹⁰ The purpose of the meeting was to discuss the mental health services provided by West Moreton HHS generally.⁹¹ Corbett attached the “talking points” document and the briefing note discussed above. Corbett’s evidence is that the proposed talking points reflect the matters discussed at the meeting. She was briefly cross-examined by Counsel for Springborg about her recollection of meetings with the Minister.⁹²

O’SULLIVAN: I asked you about the meeting on 15 July [2013]. Do you have any other recollection about other meetings with the Minister, or is that about it?

CORBETT: So I know we met in December 2012.

O’SULLIVAN: Yes?

CORBETT: That was a general meeting around general changes for mental health. And there was another meeting in – if I can go to my – can I go to my statement and refer to the timeframe for it? It’s in my statement.

...

O’SULLIVAN: Yes. Am I right to think that you don’t have any particularly detailed recollection of what was said at those meetings?

CORBETT: My recollection is they were update meetings for the Minister on matters of significance.

O’SULLIVAN: Yes?

CORBETT: Which is really the only reason we would’ve had a meeting with the Minister.

Corbett’s supplementary statement does not address the December 2012 meeting with the Minister.

Dwyer’s evidence is that she attended at least two meetings⁹³ with the Minister, one of them on 14 December 2012.⁹⁴ The purpose of the meeting was to discuss West Moreton Mental Health Services, including the BAC.⁹⁵

Neither of Dwyer’s supplementary statements to the Commission addresses the December 2012 meeting with the Minister.

The Minister’s evidence

In his written evidence, Springborg does not give an account of the matters discussed at the meeting on 14 December 2012. His evidence is that he visited the BAC in late 2012.⁹⁶ At about that time, he came to understand that an expert group had been assembled by West Moreton to consider what the best model of care was for adolescents who had been, or would be, referred to the BAC.⁹⁷ Springborg states that during his time as Minister, he had a number of formal and informal meetings with Corbett, and Dwyer, when the BAC was discussed.⁹⁸

Springborg’s general recollection was that:

My main concern at this time was if the Barrett Centre was to be closed, then adequate replacement services had to be in a place from that time onward. I conveyed this to Dr Corbett and Ms Dwyer in the meetings that I had with them where the Barrett Centre was discussed.⁹⁹

In his oral evidence, Springborg was taken to the speaking notes prepared for Kelly.¹⁰⁰ He agreed that the issue of the development of an alternative contemporary statewide model to replace the services then provided by the BAC was discussed at the meeting in December 2012.¹⁰¹ He also agreed that at the time, or very close to it, he was told of the existence of the ECRG.¹⁰²

Springborg was asked about the timing of the opening of EFTRU, and its relevance to the BAC:

FREEBURN: You'll see that when we go back to the Barrett Adolescent Centre there's services – there's a statement there:

Services currently provided by Barrett Adolescent Centre will not remain on the campus post June 2013.

And then this one says about EFTRU – it's opening early 2013. Do you recall any discussion either on this occasion or any other occasion where those two things were linked?

SPRINGBORG: Yes.

FREEBURN: Do you understand the question?

SPRINGBORG: Yes.

FREEBURN: You do recall those things being linked?

SPRINGBORG: Yes, I do.

FREEBURN: On this occasion or some subsequent occasion?

SPRINGBORG: It would have been very close. If it wasn't on that occasion, it would be either leading up to it or subsequent to that. But I think it was on that occasion. Yes.

FREEBURN: And what do you recall about that discussion?

SPRINGBORG: If I can give a response around that. Barrett was to close. I've said that previously. The – The Park facility was being repurposed around adult mental health care for a range – and going towards more of a – for some people more of a residential-type model in there – lower security. And that, of course, compounded some of the safety issues there so therefore led to some of the other considerations around the closure of the Barrett Adolescent Centre. And I'll just finalise by saying that that meeting also reinforced that there should be no closure of BAC until such time as the transition services had been properly delivered to the patients who were there.

FREEBURN: Right. So there were two considerations about Barrett Adolescent Centre?

SPRINGBORG: Yes.

FREEBURN: There was the consideration that – concern about EFTRU?

SPRINGBORG: Mmm.

FREEBURN: And the concern about making sure you had enough time to put transition plans in place?

SPRINGBORG: Yes.¹⁰³

Springborg acknowledged that the dates “by early 2013” and “June 2013” did not precisely overlap.¹⁰⁴

In a supplementary statement to the Commission, Springborg stated:

It is my understanding that as at approximately December 2012, WMHHS was proposing to open EFTRU in early 2013. My recollection as to when, from whom and in what circumstances I became aware of the proposal to open EFTRU at The Park in early 2013 is that which I gave in oral evidence on 26 February 2016 ... [the relevant passage is extracted above]: namely, as best I recall, I became aware in about late 2012 that the re-purposing of The Park to provide more residential-type services to some forensic patients was proposed to be implemented in early 2013, and whilst I cannot be certain of precisely when I obtained this understanding, it was probably at the meeting with Dr Corbett, Ms Dwyer and Ms Kelly in December 2012. As best I can recall, I was not told that this new unit was called “EFTRU”. That name was not familiar to me in 2012 or 2013.¹⁰⁵

As to the connection between the closure of the BAC, and the opening of EFTRU, Springborg’s evidence was that:

My clearest recollection is that I was advised that the changes to The Park meant that the Barrett Centre could not continue there, and in particular, because the expansion carried risks to the patients and staff at the Barrett Centre. It is likely that the issue was discussed at the meeting with Dr Corbett, Ms Dwyer and Ms Kelly in December 2012. However, I may well have become aware of this before then.¹⁰⁶

Conclusions

The recollections of Kelly, Dwyer, Corbett, and Springborg about the meeting on 14 December 2012 are general in nature. The Commission is satisfied that Hamilton-Smith made an iPad note of the discussion. However, the note could not be located and so was of no assistance to the Commission. No other contemporaneous note or record of the meeting was made.

The notion of replacement services for existing BAC patients was discussed in only the most general terms. That is understandable given the high-level nature of meetings with a Minister. Springborg’s evidence is that the meeting “reinforced” that there should be no closure of the BAC until transition services had been properly delivered. It is clear that what those services would entail was a matter yet to be determined.

This is likely to have been the first time the existence of EFTRU and its relevance to the BAC decision-calculus was made clear to the Minister. This was acknowledged by Counsel for Kingswell,¹⁰⁷ notwithstanding that in May 2012 Kingswell was very conscious of the risks that would be posed by EFTRU.¹⁰⁸

The Commission adopts the summary of the meeting on 14 December 2012 by Counsel for Springborg:

On 14 December 2012, WMHHS representatives (Dr Corbett, Ms Dwyer, and Ms Kelly) met with the Minister. The need to develop an alternative contemporary State-wide model of care was discussed. It is likely that at this meeting the WMHHS representatives discussed with Mr Springborg that EFTRU was proposed to open in 2013, and the increased risk that EFTRU posed to the BAC patients.¹⁰⁹

(citations removed)

It is apparent from the speaking notes that as at December 2012, the idea of developing and providing replacement services for current BAC patients and for a wider “consumer group” was under discussion. The speaking notes include:

[T]he endorsed model of care will be implemented in a two staged process, i.e. it will initially be applied to meet the needs of the **current consumers in BAC** and then **implemented more widely across the state** as per the parameters of the endorsed model of care.¹¹⁰

(emphasis added)

At that time, the dichotomy between individualised wrap around services for BAC patients on the one hand and a new replacement model of service on the other was yet to emerge.

The Minister’s evidence is that he told Kelly and Dwyer that adequate “replacement” services must be in place before the BAC was closed. His evidence does not address what he understood by the term “replacement services” at that time. But the unchallenged evidence of Corbett is that the speaking notes reflect what he was told at the meeting. According to those notes, current BAC patients would receive services under the “endorsed model of care”.

1 February 2013 to 21 May 2013

Three more Fast Facts were issued between 1 February 2013 and 21 May 2013.

Fast Facts 3

The third Fast Facts was issued on 1 February 2013. It stated that the ECRG had met three times and would continue to do so on a fortnightly basis.¹¹¹ This Fast Facts asked, “How can I be sure that this decision will not be rushed?” In response it said, “We don’t want to rush this. We want to get it right. That’s why we will not make any decisions until after a thorough investigation of models of care”.

Fast Facts 3 also stated that “all options for statewide models of care will be investigated” and that the exercise was not about cost cutting. Fast Facts 3 has similar problems to Fast Facts 1 and 2 (outlined above).

Fast Facts 4

The fourth Fast Facts, issued on 4 March 2013, informed readers that the ECRG had met six times and was “finalising an analysis of adolescent mental health care requirements across the State”. Readers were told that the ECRG was expected to submit its recommendations to the Planning Group in late April 2013. The Fast Facts informed consumers, staff and families that consumer and carer representatives had been invited to join the ECRG.¹¹²

This Fast Facts assured readers that the future of the BAC would be based on the ECRG recommendations and that West Moreton HHS was committed to making sure young mental health consumers received “the right treatment at the right time”. Readers were also assured that no decisions would be made until all options for statewide models of care had been investigated by the ECRG.

However, Fast Facts 4 did not inform readers about the restricted scope of the service models under development by the ECRG, as discussed at its meeting on 27 February 2013. In particular, the minutes from that meeting state:

- it was noted that in the Planning Group project plan it is stated that the capital allocation previously attached for the rebuild of BAC is no longer available and BAC will not be built at an alternative site.
- a point of clarification was therefore sought to determine whether the service model the ECRG is developing should be an 'ideal' or one that takes into account the restrictions of budget.
- agreement that the ECRG will determine an ideal model and alternative models that identify the risks of not including particular components within the ideal. The final model must be within budgetary limits.¹¹³

The restrictions on the ECRG to the effect that, while it was to look at 'ideal' models, it was also being asked to determine a final model within budgetary limits, and with identified risks, were omitted from the message in Fast Facts 4.

Fast Facts 5

The fifth Fast Facts was issued on 21 May 2013.¹¹⁴ It was brief. It informed readers that the ECRG had met on 24 April 2013 for the last time and had submitted recommendations to the Planning Group. At this stage, families, carers and staff were not provided with the ECRG Report or any recommendations and were given no indication of the content of the recommendations.

Despite including a heading, "Have any recommendations been made about the future of Barrett Adolescent Centre?", the Fast Facts did not make it clear whether the ECRG had made any recommendations about the future of the BAC. Instead, it repeated the message that "no decision will be made" about the BAC until all the ECRG recommendations had been "carefully considered". This was unclear and lacking in transparency.

In particular, ECRG recommendations 2 and 3 were relevant to BAC families, carers and staff and were not communicated. The essence of recommendation 2 was that although the BAC could not continue in its current form at The Park and there were difficulties with funding and other resources "a design-specific and clinically staffed bed-based service is essential for adolescents who require medium-term extended care and rehabilitation".¹¹⁵ Recommendation three included the statement that "interim service provision if BAC closes and Tier 3 is not available is associated with risk".¹¹⁶ Footnote 3 to the ECRG Table stated alternative services were not the "clinically preferred or optimal solution, and significant risks are associated with this interim measure".¹¹⁷

Fast Facts 5 also omitted to inform readers of Kelly's view, which she expressed in an email to Dwyer on 21 April 2013, that, regardless of the ECRG's recommendations, she did not "agree to continuing the BAC as an interim step as it will never close if that happens and the safety of the unit is such that I believe we are better off without the tier 3 for a period of time with a consulting service supporting other units".¹¹⁸

Fast Facts 5 again assured readers that they would continue to receive regular updates.¹¹⁹ However, following Fast Facts 5 on 21 May 2013, no further communications about the BAC closure were issued to BAC patients, their families and carers or BAC staff by West Moreton HHS until 6 August 2013.¹²⁰

(Endnotes)

- 1 Executive Director Mental Health and Specialised Services, West Moreton HHS.
- 2 Geppert's substantive position was Director of Planning and Partnerships, MHAODB. In early 2013, she applied for a position with West Moreton HHS. She was seconded to West Moreton HHS as the Director of Strategy, Mental Health and Specialised Services, West Moreton HHS in January 2013. In January 2015, this became Geppert's permanent position (see Exhibit 55, Statement of Leanne Geppert, 16 October 2015, p 2 para 2.5).
- 3 Executive Director, Mental Health Alcohol and Other Drugs Branch (MHAODB).
- 4 Director, Mental Health and Chief Psychiatrist, Queensland Health.
- 5 Health Service Chief Executive, West Moreton HHS.
- 6 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, Attachment LG-12 to that statement, Emails between Sharon Kelly and Leanne Geppert, 9 November 2012, pp 116–117.
- 7 Exhibit 45, Statement of Susan Daniel, 29 October 2015, Attachment to that statement, 12 November 2012, pp 30–31.
- 8 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, Attachment LG-12 to that statement, Emails between Sharon Kelly and Leanne Geppert, Subject: "strategic partnership meeting for BAC changes", p 116.
- 9 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, p 14 para 7.4, Attachment LG-12 to that statement, Subject: "strategic partnership meeting for BAC changes", p 116.
- 10 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, Attachment LG-12 to that statement, Email from Lesley Dwyer to Sean Hatherill and others, Subject: "Information re Barrett Adolescent Centre Stakeholder Meeting", 14 November 2012, p 118.
- 11 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, Attachment LG-12 to that statement, Email from Lesley Dwyer to Sean Hatherill and others, Subject: "Information re Barrett Adolescent Centre Stakeholder Meeting", 14 November 2012, p 118.
- 12 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, Attachment LD-9 to that statement, Health Service Chief Executive Report for the Board, 23 November 2012, p 106.
- 13 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 9 para 10.5, Attachment SK-10 to that statement, Barrett Adolescent Strategy Project Plan, pp 843–857.
- 14 Exhibit 122, Statement of Stephen Stathis, 5 November 2015, Attachment D to that statement, Barrett Adolescent Strategy Project Plan, p 59; Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 10 para 11.2(a).
- 15 Transcript, Sharon Kelly, 22 February 2016, p 11-13 lines 20–26.
- 16 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 9 para 10.6(a), Attachment SK-10 to that statement, Barrett Adolescent Strategy Project Plan, p 779.
- 17 Exhibit 122, Statement of Stephen Stathis, 5 November 2015, Attachment D to that statement, Barrett Adolescent Strategy Project Plan, p 61.
- 18 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment SK-10 to that statement, Barrett Adolescent Strategy Project Plan, pp 846 and 847.
- 19 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 39 para 30.2.
- 20 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 11 para 11.5.
- 21 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 12 para 11.8.
- 22 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 11 para 11.4.
- 23 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, pp 39–40 para 30.4(c).
- 24 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 40 para 30.9.
- 25 Exhibit 51, Statement of Naomi Ford, 1 December 2015, p 3 para 9, Attachment C to that statement, pp 26–27.
- 26 Exhibit 51, Statement of Naomi Ford, 1 December 2015, Attachment E to that statement, p 79.
- 27 Exhibit 51, Statement of Naomi Ford, 1 December 2015, p 3 para 9.
- 28 Exhibit 51, Statement of Naomi Ford, 1 December 2015, p 3 para 10.
- 29 Exhibit 51, Statement of Naomi Ford, 1 December 2015, Attachment D to that statement, p 33.
- 30 Exhibit 51, Statement of Naomi Ford, 1 December 2015, Attachment F to that statement, Minutes of West Moreton HHS Barrett Adolescent Strategy Planning Group, 5 December 2012, p 89.
- 31 Exhibit 51, Statement of Naomi Ford, 1 December 2015, Attachment D to that statement, pp 52–56.
- 32 Exhibit 51, Statement of Naomi Ford, 1 December 2015, p 3 para 10.
- 33 Exhibit 51, Statement of Naomi Ford, 1 December 2015, Attachment E to that statement, p 79.
- 34 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 10 para 11.2(b)(i)–(ii).

- 35 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment SK-11 to that statement, ECRG Terms of Reference, p 858.
- 36 Submissions on behalf of West Moreton HHS and Board, 23 March 2016, p 22 para 7.13.
- 37 Submissions on behalf of West Moreton HHS and Board, 23 March 2016, p 22 para 7.13.
- 38 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, pp 36–37 paras 26.3(a)–(m).
- 39 Exhibit 1513, Email from Kris Antal, Subject: "Agenda - Barrett Adolescent Planning Group Actions", 27 November 2012; Exhibit 1514, West Moreton Hospital and Health Service, Terms of Reference: Expert Clinical Reference Group - Barrett Adolescent Strategy, 26 November 2012.
- 40 Exhibit 119, Statement of Josie Sorban, 11 December 2015, Attachment E to that statement, ECRG meeting minutes, 7 December 2012, p 32.
- 41 Exhibit 119, Statement of Josie Sorban, 11 December 2015, Attachment E to that statement, ECRG meeting minutes, 7 December 2012, p 32.
- 42 Exhibit 119, Statement of Josie Sorban, 11 December 2015, Attachment E to that statement, ECRG meeting minutes, 9 January 2013, p 38.
- 43 Exhibit 119, Statement of Josie Sorban, 11 December 2015, Attachment E to that statement, ECRG meeting minutes, 13 February 2013, p 63.
- 44 Exhibit 1515, Email from Leanne Geppert to Expert Clinical Reference Group Members, Subject: "Terms of Reference ECRG Final", 26 February 2013. Note that the final version of the ECRG terms of reference enclosed to this email is dated 30 November 2012; Exhibit 1519, West Moreton Hospital and Health Service - Barrett Adolescent Strategy Planning Group, Meeting Minutes, 18 January 2013.
- 45 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment SK-11 to that statement, ECRG Terms of Reference, p 858.
- 46 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment SK-11 to that statement, ECRG Terms of Reference, p 859.
- 47 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment SK-10 to that statement, Barrett Adolescent Strategy Project Plan, p 845.
- 48 Transcript, Sharon Kelly, 22 February 2016, p 11-75 line 47 – p 11-76 line 4.
- 49 Submissions on behalf of Lawrence Springborg, 23 March 2016, p 43 paras 5.135–5.136.
- 50 Exhibit 308, West Moreton Board Committee Agenda Papers and Meeting Minutes, 23 November 2012 to 28 February 2014, pp 3–4.
- 51 Confidential exhibit.
- 52 Confidential exhibit.
- 53 Exhibit 51, Statement of Naomi Ford, 1 December 2015, p 4 para 13.
- 54 Exhibit 51, Statement of Naomi Ford, 1 December 2015, p 4 para 13.
- 55 Transcript, closed hearing.
- 56 Exhibit 51, Statement of Naomi Ford, 1 December 2015, Attachment K to that statement, Fast Facts 1, p 117.
- 57 Exhibit 51, Statement of Naomi Ford, 1 December 2015, Attachment K to that statement, Fast Facts 2–5, pp 119–123.
- 58 Exhibit 51, Statement of Naomi Ford, 1 December 2015, Attachment K to that statement, Fast Facts 1, p 118.
- 59 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 9 para 10.6(a), Attachment SK-26 to that statement, Fast Facts 1, p 953.
- 60 Exhibit 66, Statement of Sharon Kelly, 16 October 2015 p 12 para 11.11(b), Attachment SK-26 to that statement, Fast Facts 1, p 953.
- 61 Exhibit 51, Statement of Naomi Ford, 1 December 2015, Attachment K to that statement, Fast Facts 2, p 119.
- 62 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 9 para 10.6(a); Exhibit 122, Statement of Stephen Stathis, 5 November 2015, Attachment D to that statement, Barrett Adolescent Strategy Project Plan, p 59.
- 63 Exhibit 308, Minutes of meeting of West Moreton Board, 14 December 2012, p 19.
- 64 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 24 para 17.3.
- 65 Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 7 para 8.2.
- 66 Exhibit 1541, Statement of Neil Hamilton-Smith, 27 May 2016, p 1 paras 6–7.
- 67 Exhibit 1541, Statement of Neil Hamilton-Smith, 27 May 2016, p 1 para 7.
- 68 Exhibit 1541, Statement of Neil Hamilton-Smith, 27 May 2016, p 1 para 12.
- 69 Exhibit 1541, Statement of Neil Hamilton-Smith, 27 May 2016, p 1 para 12.

- 70 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-4 to that statement, Briefing Note for Noting to the Director-General Queensland Health, Subject: "Meeting between the Minister and the Chair, West Moreton Hospital and Health Board, dated 11 December 2012, pp 69–71.
- 71 Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 7 para 8.2(b).
- 72 Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 7 para 8.2(b).
- 73 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-4 to that statement, Briefing Note for Noting to the Director-General Queensland Health, Subject: "Meeting between the Minister and the Chair, West Moreton Hospital and Health Board, dated 11 December 2012, p 69.
- 74 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-4 to that statement, Briefing Note for Noting to the Director-General Queensland Health, Subject: "Meeting between the Minister and the Chair, West Moreton Hospital and Health Board, dated 11 December 2012, p 69.
- 75 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-4 to that statement, Briefing Note for Noting to the Director-General Queensland Health, Subject: "Meeting between the Minister and the Chair, West Moreton Hospital and Health Board, dated 11 December 2012, p 69.
- 76 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-4 to that statement, Briefing Note for Noting to the Director-General Queensland Health, Subject: "Meeting between the Minister and the Chair, West Moreton Hospital and Health Board, dated 11 December 2012, p 71.
- 77 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-5 to that statement, West Moreton Hospital and Health Board – Board Committee Agenda Paper dated 14 December 2012, pp 72–80.
- 78 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-5 to that statement, West Moreton Hospital and Health Board – Board Committee Agenda Paper dated 14 December 2012, p 77.
- 79 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-5 to that statement, West Moreton Hospital and Health Board – Board Committee Agenda Paper dated 14 December 2012, p 77.
- 80 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-5 to that statement, West Moreton Hospital and Health Board – Board Committee Agenda Paper dated 14 December 2012, p 77.
- 81 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-5 to that statement, West Moreton Hospital and Health Board – Board Committee Agenda Paper dated 14 December 2012, p 77.
- 82 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-5 to that statement, West Moreton Hospital and Health Board – Board Committee Agenda Paper dated 14 December 2012, p 77.
- 83 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-5 to that statement, West Moreton Hospital and Health Board – Board Committee Agenda Paper dated 14 December 2012, p 77.
- 84 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-5 to that statement, West Moreton Hospital and Health Board – Board Committee Agenda Paper dated 14 December 2012, p 78.
- 85 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-5 to that statement, West Moreton Hospital and Health Board – Board Committee Agenda Paper dated 14 December 2012, p 78.
- 86 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-5 to that statement, West Moreton Hospital and Health Board – Board Committee Agenda Paper dated 14 December 2012, p 78.
- 87 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-5 to that statement, West Moreton Hospital and Health Board – Board Committee Agenda Paper dated 14 December 2012, p 78.
- 88 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 24 para 17.3; Attachment SK-20 to that statement, Document entitled 'Meeting with Minister for Health, dated 14 December 2013, pp 919–923.
- 89 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment SK-20 to that statement, Document entitled 'Meeting with Minister for Health, dated 14 December 2013, p 919.
- 90 Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 7 para 8.2.
- 91 Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 7 para 8.2.
- 92 Transcript, Mary Corbett, 18 February 2016, p 9-75 lines 40 – p 9-76 line 15.
- 93 The meetings occurred on 14 December 2012 and 15 July 2013. Dwyer recalls a meeting on 2 December 2012. She is unsure whether the Minister was present for some or all of the meeting. She recalls that Ministerial advisors were present. Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, pp 16–17 para 10.5.
- 94 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, pp 16–17 para 10.5(a).
- 95 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, pp 16–17 para 10.5(a).
- 96 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, p 9 para 41.
- 97 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, p 10 para 44.
- 98 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, p 10 para 45.
- 99 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, p 11 para 56.
- 100 Transcript, Lawrence Springborg, 26 February 2016, p 15-29 line 5.

- 101 Transcript, Lawrence Springborg, 26 February 2016, p 15-29 lines 27-34.
- 102 Transcript, Lawrence Springborg, 26 February 2016, p 15-29 lines 43-45.
- 103 Transcript, Lawrence Springborg, 26 February 2016, p 15-30 lines 14-47.
- 104 Transcript, Lawrence Springborg, 26 February 2016, p 15-31 lines 1-5.
- 105 Exhibit 457, Supplementary statement of Lawrence Springborg, 10 March 2016, p 2 para 4.
- 106 Exhibit 457, Supplementary statement of Lawrence Springborg, 10 March 2016, p 4 para 10.
- 107 Transcript, Adrian Duffy QC, Closing submissions on behalf of William Kingswell, 15 April 2016, p 28-8 lines 37-40.
- 108 Transcript, William Kingswell, 24 February 2016, p 13-19 line 31, p 13-20 line 14.
- 109 Submissions on behalf of Lawrence Springborg, 23 March 2016, p 40 para 5.120.
- 110 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-5 to that statement, West Moreton Hospital and Health Board – Board Committee Agenda Paper dated 14 December 2012, p 78.
- 111 Exhibit 51, Statement of Naomi Ford, 1 December 2015, Attachment K to that statement, Fast Facts 3, p 121.
- 112 Exhibit 51, Statement of Naomi Ford, 1 December 2015, Attachment K to that statement, Fast Facts 4, p 122.
- 113 Exhibit 211, Minutes of the Expert Clinical Reference Group meeting, 27 February 2013, p 2.
- 114 Exhibit 51, Statement of Naomi Ford, 1 December 2015, Attachment K to that statement, Fast Facts 5, p 123.
- 115 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services", p 2.
- 116 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services", p 4.
- 117 Exhibit 1390, ECRG Proposed Service Model Elements Table, pp 5-6.
- 118 Exhibit 740, Email from Sharon Kelly to Lesley Dwyer, Subject: "progression of Barrett Adolescent Centre Expert reference group", 21 April 2013, p 1.
- 119 Exhibit 51, Statement of Naomi Ford, 1 December 2015, Appendix K to that statement, p 123.
- 120 Exhibit 51, Statement of Naomi Ford, 1 December 2015, Appendix K to that statement, p 123.

10 The ECRG and the Planning Group

Introduction

This chapter examines the final recommendations of the Expert Clinical Reference Group (ECRG) and the Planning Group, the processes they followed, and their deliberations. The membership, scope, and functions of the ECRG and Planning Group are described in chapter 9.

Parts 1 and 2 of this chapter summarise and analyse the ECRG's and the Planning Group's respective recommendations and their deliberations. Part 3 examines the argument raised by the parties that the ECRG recommended a Tier 3 "service" and not necessarily a standalone, 'bricks and mortar' facility. Part 4 draws together some conclusions.

The ECRG report

The ECRG's final report dated 8 May 2013 was sent to the Planning Group.

It consisted of two documents, which are worthy of separate consideration. The first was a preamble which set out the context to the ECRG report and its brief, as well as its key messages and recommendations (the ECRG Preamble, Key Messages and Recommendations). The second was a table containing the ECRG's description of the elements of their proposed service model (the ECRG Table).

It acknowledged that the BAC was "unable to continue operating in its current form" at The Park.¹ In the ECRG's view, that necessitated "careful consideration of options for the provision of mental health services for adolescents ... requiring extended treatment and rehabilitation in Queensland".² Hence, the ECRG said, it was convened "to explore and identify alternative service options for this target group".³

The ECRG Table, it said, was "not a model of service" but "a conceptual document that delineate[d] the key components of a service continuum type for the identified target group".⁴ The ECRG Table proposed four "tiers" of service provision for the target group – Tiers 1, 2a, 2b and 3 as follows:

- Tier 1 – Public Community Child and Youth Mental Health Services (existing);
- Tier 2a – Adolescent Day Program (existing and new);
- Tier 2b – Adolescent Community Residential Service/s (new); and
- Tier 3 – Statewide Adolescent Inpatient Extended Treatment and Rehabilitation Service (new).

The “target group” was specified in the ECRG Table. The target age was 13 to 17 years with flexibility in the upper age limit depending on the individual adolescent’s presenting issue and developmental age.⁵ The diagnostic profile of the target group was described in this way:

- Severe and persistent mental health problems that significantly interfere with social, emotional, behavioural and psychological functioning and development.
- Treatment refractory/non responsive to treatment – have not been able to remediate with multidisciplinary community, day program or acute inpatient treatment.
- Mental illness is persistent and the consumer is a risk to themselves and/or others.
- Medium to high level of acuity requiring extended treatment and rehabilitation.⁶

The development of both documents by the ECRG is outlined below.

Part 1 – The ECRG

As detailed in chapter 9, one of the Planning Group’s tasks was to establish an expert group to consider models of care for adolescents with severe and persistent mental illness. Leanne Geppert was the chair of the ECRG. Vaoita Turituri was the secretariat, responsible for distributing agendas and minutes of meetings. Both Geppert and Turituri were from the Planning and Partnerships Unit of the Mental Health Alcohol and Other Drugs Branch (MHAODB). Geppert was the Director of that Unit.

Meetings of the ECRG

The ECRG met on eight occasions between 7 December 2012 and 24 April 2013. Minutes of seven of those meetings have been produced to the Commission. An agenda for the ECRG’s final meeting on 24 April 2013 was produced to the Commission but the minutes of that meeting were unable to be located by Queensland Health because of a failure to log any.⁷ The Commission has been unable to determine which ECRG members attended that last meeting. Trevor Sadler (a member of the ECRG and Clinical Director of the BAC) said that, “one of the problems with the minutes of these meetings [is] that not all views are documented”.⁸ The Commission has taken this into account when considering the content of the minutes and the evidence of ECRG members about the meetings.

The dates on which these meetings occurred, and the ECRG members who attended, are set out in the table below. An ECRG meeting scheduled for 30 January 2013 was cancelled the day before due to flooding of the meeting venue.⁹

Initially, the ECRG was to meet weekly but, at its third meeting on 16 January 2013, it decided “to change [the] meeting schedule to fortnightly to allow members to digest reading material and for the secretariat to progress actions arising out of meetings”.¹⁰

ECRG member	Meeting date	07 Dec 12 ¹¹ 09 Jan 13 ¹² 16 Jan 13 ¹³ 13 Feb 13 ¹⁴ 27 Feb 13 ¹⁵ 13 Mar 13 ¹⁶ 27 Mar 13 ¹⁷ 24 Apr 13 ¹⁸							
		1	2	3	4	5	6	7	8
Leanne Geppert (Chair)	Director, Planning and Partnerships Unit, MHAODB	✓	✓	✓	✓	✓	✓	✓	✓
Amelia Callaghan	Headspace, State Manager, QLD and NT	✓	✓	✓	Apology	Apology	✓	✓	✓
Michelle Fryer	QFCAP, RANZCP	✓	Apology	✓	Apology	✓	Apology	✓	✓
Emma Hart	Nurse Unit Manager, Adolescent Inpatient Unit and Day Service, Townsville HHS	✓	✓	✓	Apology	✓	Apology	✓	✓
David Hartman	Clinical Director, CYMHS, Townsville	✓	Apology	Apology	✓	Apology	✓	✓	Apology
Professor Phillip Hazell	Director, CAMHS, Sydney Local Health District & Thomas Walker Hospital (Rivendell)	✓	✓	✓	Apology	✓	✓	✓	✓
Kevin Rodgers	Principal, Barrett School	✓	Apology	✓	✓	✓	✓	✓	✓
Trevor Sadler	Clinical Director, BAC	Cary Breakey attended as proxy.	✓	✓	✓	✓	✓	✓	✓
James Scott	Consultant Psychiatrist, RBWH	Apology	✓	Apology	✓	Apology	✓	✓	✓
Josie Sorban	Director of Psychology, CYMHS	✓	✓	✓	✓	✓	Apology	✓	✓
Amanda Tilse	Operational Manager, Alcohol, Other Drugs and Campus Mental Health Services, Mater Children's Hospital	✓	✓	Apology	✓	Apology	✓	✓	✓
Confidential	Carer representative ¹⁹	N/A	N/A	N/A	N/A	✓	✓	✓	✓
Confidential	Consumer representative ²⁰	N/A	N/A	N/A	N/A	✓	Apology	Apology	Apology

The ECRG's deliberations

The ECRG timeline and process

While some ECRG members thought that the ECRG's process for developing its model was unclear, others described it as "impressive and efficient", particularly given the size and complexity of the task.²¹ Philip Hazell commented that "the process allowed for frank discussions and disagreement" and also involved a lot of work outside of ECRG meetings.²²

The Project Plan, as outlined in chapter 9, initially proposed that the ECRG meet between 30 November 2012 and 22 February 2013, with a preferred model to be developed and endorsed by the West Moreton Board in late February 2013. Although this timeframe was later extended to April 2013, there is evidence that the process was still rushed. James Scott's opinion was that with more time, a literature review and investigation into all potential care options for adolescents with complex mental health needs may have been useful:

The application of more time and research and a broader consideration of available options, would have in all probability resulted in better outcomes from the ECRG. If I am ever to be invited to participate in a similar process again, I will most certainly require that a full review of care option[s] be conducted which would then inform the final model to be established.²³

After the first meeting of the ECRG on 7 December 2012, Geppert provided a summary of the meeting to the Planning Group. Geppert also gave written evidence that, throughout the ECRG process, she provided informal updates to Sharon Kelly as chair of the Planning Group, and to Bill Kingswell, as her line manager.²⁴

The ECRG used a template to structure its consideration of the proposed elements in the service model, including the target group profile.²⁵ At its second meeting on 9 January 2013 it agreed that, due to time constraints, the draft template of service model elements, which later became the ECRG Table, would be populated by Turituri, who was to use the information discussed at the meeting. The Table would also be "linked to the national frameworks". It was further agreed that, once populated, the draft template would be distributed to ECRG members for comment out of session.²⁶

The populated table was discussed at the ECRG meeting on 16 January 2013.²⁷ Following this meeting, a revised version of the draft service model elements was sent to the ECRG members for further consideration. ECRG members were asked to track any amendments or editorial changes to the document.²⁸

By February 2013, it became apparent that the timeframe envisaged in the Project Plan was unachievable.²⁹ Amelia Callaghan said that participation in the ECRG was "short term (i.e. a few months) as there was a sense of urgency given the timeframe to stop services at the BAC site at that stage was June 2013".³⁰ Scott also noted that "the ECRG was established with a sense of urgency from the start".³¹

On 19 February 2013, Geppert submitted a request to West Moreton Hospital and Health Service (HHS) for an extension of time until 19 April 2013. The reasons Geppert gave for the extension included the significant workloads of the senior expert clinicians on the ECRG, delays attributed to the Christmas holidays, and flooding of the building in which ECRG meetings were usually held. In her request Geppert also noted that because members had not been able to allocate enough time to complete research and other activities out of session, extra time had to be allocated within meetings for these tasks.³²

The need for an extension of time is not mentioned in the minutes of ECRG meetings prior to 27 February 2013, when the ECRG met and received an update in relation to it. The minutes suggest that by this time, the extension had been considered by West Moreton HHS.³³ Further changes to the ECRG timeframe were discussed at its seventh meeting on 27 March 2013.³⁴

One or both of the ECRG meetings on 27 February 2013 and 13 March 2013 used a workshop format to work through the service descriptions and critical elements of the service model.³⁵ Geppert facilitated the workshop/s and it appears that Kingswell (MHAODB) and Peter Steer (Children's Health Queensland HHS) may have attended part of the workshop.³⁶ Emma Hart subsequently said that the purpose of the workshop format was to "brainstorm and discuss transfer of care, the proposed models of care and review the tiers of the model to identify strengths, weaknesses and opportunities for future services".³⁷ ECRG members also appear to have worked out of session on either side of, or in between, the workshop/s to revise the service elements table (what ultimately became the ECRG Table).³⁸

At the ECRG meeting on 27 March 2013, Sadler offered to develop a preamble to the recommendations, which would include a description of the challenges faced by the ECRG in developing the proposed model and a statement that existing services needed to be expanded rather than contracted. Sadler also proposed that the preamble acknowledge that an ideal model involved a full spectrum of services, including a Tier 3. The minutes note, "combination of Tier 2 and 3 as a compromise".³⁹

On 17 April 2013, version 2 of the draft service model elements table was circulated to ECRG members for comment.⁴⁰ They provided feedback on version 2 between 17 April 2013 and 19 April 2013. That feedback was recorded by Geppert in a register⁴¹ and a number of amendments were subsequently made. According to Scott, a number of ECRG members were not comfortable with aspects of the draft versions, and comments provided by Sadler by email on 22 April 2013 were consistent with the feedback provided by ECRG members to Geppert during previous meetings.⁴²

On 23 April 2013, version 3 was circulated to the ECRG members who provided further feedback.⁴³ The final meeting of the ECRG was held on 24 April 2013. An agenda for that meeting was produced to the Commission but no minutes were produced because none were logged.⁴⁴

Callaghan said she recalled, albeit not clearly, that some members of the Planning Group may have attended one of the ECRG meetings to reply to the recommendations.⁴⁵

Between 24 April 2013 and the finalisation of the report on 8 May 2013, the ECRG members corresponded by email. On 24 April 2013, there was significant email discussion about the proposed duration of treatment in the ECRG report.⁴⁶ The consumer representative commented on it. In addition, Fryer and the carer representative⁴⁷ made some suggested amendments to the preamble.⁴⁸

On 6 May 2013, Geppert circulated version 4 of the ECRG report to the members of the ECRG for further comment.⁴⁹ Most members endorsed this version by reply email the same day or on 7 May 2013.⁵⁰ Sadler endorsed it. He noted a few concerns about wording, but observed that the flexibility in some of the statements in the report, or in the subsequent process of developing a model of service delivery, meant that these issues could be addressed at a later stage.⁵¹

On 7 May 2013, Geppert sent an email to Sharon Kelly entitled "Update ECRG Barrett".⁵² It reads:

Just an update. Of the 12 [ECRG] members, I have endorsement of preamble and service elements doc from 10 (incl Trevor [Sadler] and Kev Rodgers from BAC school). Philip (sic)

Hazell from nsw is away on sabbatical and will not be able to respond. The other will be fine – I will f/up tomorrow but expect no probs. Based on this, I expect to submit to you for dissemination tomorrow. [sic]

On 8 May 2013, Geppert emailed the ECRG members a final version (version 5) of the report.⁵³ She noted that a few “minor” changes had been made and asked that they notify her if they had any concerns with the highlighted amendments. Geppert said that she had been asked to send the final versions to Kelly that day and that she would copy them into her email to Kelly.⁵⁴ Twenty-five minutes later, having received no responses to her email, Geppert sent Kelly the final version of the report, copying in the ECRG members.⁵⁵ In the end, Hazell was unable to endorse the final version because he was away. However, there is no suggestion that he did not agree with its substance.

Several ECRG members gave evidence that they were not subsequently provided with copies of the Planning Group recommendations.⁵⁶

A pre-determined model?

A number of ECRG members told the Commission they felt that they were being asked to support a model which had already been determined prior to the convening of the ECRG. For example, Scott said that his “impression from Geppert’s direction during initial meetings of the ECRG was that the role of the ECRG was essentially to support a model of care that the Government or the Department or someone within those bodies had already developed”.⁵⁷ Scott said that the ECRG was defiant about the proposed use of acute inpatient services, and instead proposed “a model of care that maintained many of the features of the BAC”.⁵⁸

Callaghan and Kevin Rodgers echoed this view. Callaghan understood that the “ECRG report was not to advocate for the continued operation of the BAC in its current form or at its current location”, though this was not documented anywhere or expressly said.⁵⁹ Callaghan referred to conversations about a lack of funding for a replacement and the BAC not being a contemporary model of care with a sound evidence base, as informing her understanding.⁶⁰ However, Callaghan said that the ECRG’s final report was not influenced by its apparently having been asked to work within these “parameters”.⁶¹

Rodgers’ view was that the service elements put forward by the ECRG described clinical practice at the BAC, despite the conclusion that the BAC would close having been already reached.⁶² In particular, Rodgers noted that “it seemed better not to use the word ‘Barrett’ in a description of clinical practice”.⁶³ He said:

I remember being impressed by clinical staff members closest to Queensland Health who at times appeared to struggle between what they were being asked to do by the government and what their knowledge of best clinical practice was telling them to say. I’m pleased... that the latter always won out.⁶⁴

According to Scott, Geppert seemed concerned that the proposed model, which retained features of the BAC, “would not be well received by corporate office”, but nonetheless agreed to incorporate the recommendations of the ECRG.⁶⁵

Josie Sorban on the other hand gave evidence that interaction between the Planning Group and the ECRG occurred through their chair, Geppert, and that to her knowledge, the Planning Group did not appear to have direct influence on the ECRG’s decision making.⁶⁶

Inclusion of carer and consumer representatives in the ECRG

Ahead of its first meeting on 7 December 2012, the ECRG was asked to consider letters sent to the Minister by members of the mental health profession, which formed part of a communications log.⁶⁷ Letters that had been sent to the Minister by numerous carers and other members of the public were not referred to the ECRG.

The inclusion of consumer and carer representatives in the ECRG membership was first canvassed at the ECRG's second meeting on 9 January 2013. The ECRG considered that their inclusion was appropriate, integral to service planning, and internationally accepted best practice in mental health.⁶⁸ In particular, the minutes of that meeting record:

Questions about whom and whether it should be a former consumer of Barrett Adolescent Centre (BAC) or whether a general consumer would suffice [were] debated. Noted that it was important that the consumer representative have an appreciation of the degree of unwellness [sic] and severity that this consumer group experience. Such a representative would provide valuable input and insight.

Noted that the consumer representative will need to be linked to or understand the experience and severity of the target group and service type but is not necessarily limited to those who are past or present consumers of BAC. The target group and service type was yet to be determined.

Decision to nominate a consumer or carer rep. should be based on the target group and service profile.⁶⁹

Geppert undertook to obtain feedback from the Planning Group at its meeting on 18 January 2013 in relation to the ECRG's recommendation to include a consumer or carer representative in its membership.⁷⁰

By 22 January 2013, the Planning Group had endorsed the inclusion of consumer and carer representatives in the ECRG and the existing ECRG members were invited to submit nominations for those roles.⁷¹ On 2 February 2013, Scott nominated a carer representative, who was the [redacted] Rodgers may have nominated the consumer representative, who was a former patient of the BAC.

The minutes of the ECRG meeting on 13 February 2013 record agreement on the carer and consumer representatives and that West Moreton HHS would "develop a process for the support and debrief of these individuals as required".⁷³

However, at that stage West Moreton HHS's commitment as to remuneration for the carer and consumer representatives was unclear.⁷⁴ The ECRG noted that it was "standard practice to remunerate consumer and carer representatives for meeting, reading time and travel".⁷⁵ Geppert agreed to raise the issue with the Planning Group by the next ECRG meeting.⁷⁶ It is clear from minutes of the Planning Group meeting on 20 February 2013 that the MHAODB took responsibility for remunerating carer and consumer representatives.⁷⁷

At the meeting on 13 February 2013, ECRG members considered that the carer and consumer representatives were distinct from the BAC parent group and that:

There should be a different process driven by West Moreton HHS for the views of the parent group to be considered. The ECRG are seeking a broader perspective that includes perspectives of the parents of clients that have not or cannot access BAC.⁷⁸

It is unclear whether, by whom, or when this message was communicated to West Moreton HHS. There is no evidence that steps were, in fact, taken to obtain the views of parents in the period the ECRG was deliberating.

On 25 February 2013, formal invitations were issued to the carer and consumer representatives, who then attended their first ECRG meeting on 27 February 2013.⁷⁹

At its meeting on 13 February 2013, the ECRG also recommended that support be provided to the consumer and carer representatives by Kerry Geraghty, who was the Consumer Consultant at Mater Child and Youth Mental Health Services.⁸⁰ Geraghty was to have no voting or other rights on the ECRG.⁸¹ An invitation was sent to Geraghty on 26 February 2013.⁸²

The Commission has not been provided with any document setting out the role of the consumer and carer representatives and it is not specified in the ECRG's terms of reference.⁸³

Overall then, it appears that the role of the consumer and carer representatives was not formally defined. The likelihood is that their views were not expressly representative of the views of other consumers and carers. A parent of a BAC patient gave evidence about whether they had contact with the ECRG carer representative. The following exchange occurred:

MUIR: Just finally ... you were asked some questions ... about your knowing that there was a carer [redacted] contact on the ECRG?

PARENT: Yes.

MUIR: Did [redacted] ever contact you?

PARENT: No.

MUIR: And as far as you know did [redacted] ever make contact with any of the [redacted] parents that you were in – well, in contact with?

PARENT: No.⁸⁴

Nor is there evidence that other consumers and carers had contact with the designated representatives on the ECRG.

The consumer and carer representatives both had active input into the ECRG's report. Specifically:

On 22 April 2013, the carer representative gave feedback to the ECRG with respect to the length of stay issue, outlining how many adolescents had only started to settle into a facility such as the BAC in the first six months. The carer representative also gave feedback with respect to the importance of staff consistency from the consumer's perspective.⁸⁵

On 23 April 2013, the consumer representative gave detailed feedback about their experience staying in short stay mental health facilities, and the benefit to a young person of a longer stay of about 12 months. The consumer representative also gave feedback about the importance of continuity of staff.⁸⁶

The input of the consumer and carer representatives was formally acknowledged in the preamble to the report of the ECRG.⁸⁷

EFTRU

At the ECRG's seventh meeting on 27 March 2013, Geppert noted:

With the opening of EFTRU, it is likely that there will be forensic patients on the grounds with access to BAC. This is seen as a risk for young people.

EFTRU is a new model of service and there is uncertainty as to whether the risks to adolescents in BAC have been assessed for patients likely to transition to EFTRU.

It was noted that there are differing opinions to whether these consumers will pose a risk to the adolescents on site and a comment that there are ongoing myths being perpetuated about forensic consumers.

Furthermore, it was noted by staff from BAC that currently, forensic patients on leave already have access to the BAC grounds with no incident and question the validity of the claim around increased risk due to forensic consumers.⁸⁸

Sadler observed at that meeting that the relative risks of not having the BAC, as opposed to the chance of an incident with a forensic client, had not been weighed up.⁸⁹ EFTRU is discussed further in chapter 14.

The ECRG's key messages

There were seven key messages and recommendations.

Key message 1: Broader consultation and formal planning processes are essential in guiding the next steps required for service development, acknowledging that services need to align with the National Mental Health Service Planning Framework

The ECRG explained that the proposed service model elements document is a conceptual document and not a model of service. It made these recommendations:

- a. Further work will be required at a statewide level to translate these concepts into a model of service and to develop implementation and funding plans.
- b. Formal planning including consultation with stakeholder groups will be required.⁹⁰

The ECRG Table set out over-arching principles including:

- promote wellness and help young people and their families in a youth oriented environment
- provide services either in, or as close to, the young person's local community
- collaborate with other external services to offer continuity of care and seamless service delivery, enabling the young person and their family to transition to their community and services with ease
- treat consumers and their families/carers in a supportive therapeutic environment provided by a multidisciplinary team of clinicians and community based staff
- have flexible options from 24 hour inpatient care to partial hospitalisation and day treatment with ambulant approaches; step up/step down
- acknowledge the essential role that educational/vocational activities and networks have on the recovery process of a young person.⁹¹

Key message 2: Inpatient extended treatment and rehabilitation care (Tier 3) is an essential service component and that it should be prioritised

Under this heading, the ECRG made the following points:

- It is understood that the combination of day program care, residential community-based care and acute inpatient care has been identified as a potential alternative to the current BAC or the proposed Tier 3 in the following service model elements document.

- From the perspective of the ECRG, Tier 3 is an essential component of the overall concept, as there is a small group of young people whose needs cannot be safely and effectively met through alternative service types (as represented by Tiers 1 and 2).
- The target group is characterised by severity and persistence of illness, very limited or absent community supports and engagement, and significant risk to self and/or others. Managing these young people in acute inpatient units does not meet their clinical, therapeutic or rehabilitation needs.
- The risk of institutionalisation is considered greater if the young person receives medium-term care in an acute unit (versus a design-specific extended care unit).
- Clinical experience shows that prolonged admissions of such young people to acute units can have an adverse impact on other young people admitted for acute treatment.
- Managing this target group predominantly in the community is associated with complexities of risk to self and others, and also the risk of disengaging from therapeutic services.⁹²

The ECRG therefore recommended that a Tier 3 service be prioritised to provide extended treatment and rehabilitation for adolescents with severe and persistent mental illness.⁹³

In the preamble, the ECRG acknowledged “constraints associated with funding and other resources (eg there is no capital funding to build BAC on another site)”.⁹⁴ It continued:

The ECRG was also mindful of the current policy context and direction for mental health services as informed by the National Mental Health Policy (2008) which articulates that ‘*non acute bed-based services should be community based wherever possible*’. A key principle for child and youth mental health services, which is supported by all members of the ECRG, is that young people are treated in the least restrictive environment possible, and one which recognises the need for safety and cultural sensitivity, with the minimum possible disruption to family, educational, social and community networks.⁹⁵

(emphasis in original)

The preamble concluded as follows:

It is understood that BAC cannot continue in its current form at TPCMH [The Park Centre for Mental Health]. However, it is the view of the ECRG that like the Community Care Units within the adult mental health service stream, a design-specific and clinically staffed bed-based service is essential for adolescents who require medium-term extended care and rehabilitation. This type of care and rehabilitation program is considered life-saving for young people, and is available currently in both Queensland and New South Wales (e.g., The Walker Unit).⁹⁶

Key message 3: Interim service provision if BAC closes and Tier 3 is not available is associated with risk

The ECRG made three points.⁹⁷ The first was:

Interim arrangements (after BAC closes and before Tier 3 is established) are at risk of offering sub optimal clinical care for the target group and attention should be given to the therapeutic principles of safety and treatment matching, as well as efficient use of resources (e.g., inpatient beds).

This is emphasised in footnote 3 to the ECRG Table:

Until funding and location is available for Tier 3, all young people requiring extended treatment and rehabilitation will receive services through Tiers 1 and 2a/b (i.e., utilising existing CYMHS community mental health, Day Programs and Acute Inpatient Units until the new Day Programs and residential service providers are established). It is emphasised that this is not proposed to be a clinically preferred or optimal solution, and significant risks are associated with this interim measure.

The second point was:

In the case of BAC being closed, and particularly if Tier 3 is not immediately available, a high priority and concern for the ECRG was the 'transitioning' of current BAC consumers, and those on the waiting list.

Those issues were complemented by these recommendations:

- a. Safe, high quality service provision for adolescents requiring extended treatment and rehabilitation requires a Tier 3 service alternative to be available in a timely manner if BAC is closed.
- b. Interim service provision for current and 'wait list' consumers of BAC while Tier 3 service options are established must prioritise the needs of each of these individuals and their families/ carers. 'Wrap around care' for each individual will be essential.

The ECRG was also concerned about the dissipation and loss of specialist staff skills and expertise if the BAC closed and Tier 3 was not established in a timely manner. It recommended:

- c. BAC staff (clinical and educational) must receive individual care and case management if BAC closes, and their specialist skill and knowledge must be recognised and maintained.

Key message 4: Duration of treatment

Under this heading, the ECRG made the following points:

- A literature search by the ECRG identified a weak and variable evidence base for the recommended duration of treatment for inpatient care of adolescents requiring mental health extended treatment and rehabilitation.
- Predominantly, duration of treatment should be determined by clinical assessment and individual consumer need; the length of intervention most likely to achieve long term sustainable outcomes should be offered to young people.
- As with all clinical care, duration of care should also be determined in consultation with the young person and their guardian. Rapport and engagement with service providers is pivotal.⁹⁸

The ECRG made this recommendation as to duration of treatment:

'Up to 12 months' has been identified by the ECRG as a reasonable duration of treatment, but it was noted that this depends on the availability of effective step-down services and a suitable community residence for the young person. It is important to note that like all mental health service provision, there will be a range in the duration of admission.⁹⁹

Key message 5: Education resources essential: on-site school for Tiers 2 and 3

In key message 5 the ECRG noted that “education is an essential part of life for young people” and that “comprehensive educational support underpins social recovery and decreases the likelihood of the long term burden of illness”.¹⁰⁰ Importantly, it recognised that the mainstream education system is frequently unable to meet the needs of young people requiring extended mental health treatment and that “education is often a core part of the intervention required to achieve a positive prognosis”.¹⁰¹ It recommended:

- a. Access to on-site schooling (including suitably qualified educators), is considered essential for Tiers 2 (day programs) and 3. It is the position of the ECRG that a Band 7 Specific Purpose School (provided by Department of Education, Training and Employment) is required for a Tier 3 service.
- b. As an aside, consideration should also be given to the establishment of a multi-site, statewide education service for children/adolescents in acute units (hub and spoke model).¹⁰²

Key message 6: Important for governance to be with CYMHS; capacity and capability requires further consideration

In its deliberations, the ECRG considered whether residential therapeutic community care for adolescents requiring extended mental health care could be provided by the non-government or private sector. Members raised a number of concerns about similar services in the child safety sector, including variably skilled/trained staff who often had limited access to support and supervision, high staff turnover which adversely affected consumer trust and rapport, and variable engagement in collaborative practice with specialist services such as CYMHS.¹⁰³ In key message 6 the ECRG observed that there was as yet “no true precedent set in Queensland”. It made these recommendations:

- a. It is considered vital that further consultation and planning is conducted on the best service model for adolescent non-government/private residential and therapeutic services in community mental health. A pilot site is essential.
- b. Governance should remain with the local CYMHS or treating mental health team.
- c. It is essential that residential services are staffed adequately and that they have clear service and consumer outcome targets.¹⁰⁴

Key message 7: Equitable access to AETRS for all adolescents and families is high priority; need to enhance service provision in North Queensland (and regional areas)

The ECRG considered equity of access for North Queensland consumers and their families a high priority. It recommended:

- a. Local service provision to North Queensland should be addressed immediately by ensuring a full range of CYMHS services are available in Townsville, including a residential community-based service.
- b. If a decision is made to close BAC, this should not be finalised before the range of service options in Townsville are opened and available to consumers and their families/carers.¹⁰⁵

ECRG Table

In relation to Tier 3, the ECRG Table contains the following:

Proposed Service Model Elements Adolescent Extended Treatment and Rehabilitation Services (AETRS)	
Attribute	Details
Key Distinguishing Features of an AETRS	<p>Tier 3: Level 6 CSCF [Clinical Services Capability Framework].</p> <p>Statewide Inpatient Extended Treatment and Rehabilitation Service (24h/7d)¹⁰⁶</p> <ul style="list-style-type: none"> • <u>Possible Location</u>: S.E. Qld. Source of capital funding and potential site not available at current time. Acknowledge accessibility issues for young people outside S.E. Qld.¹⁰⁷ • For young people whose needs could not be met by Tiers 1 and 2 above, due to risk, severity or need for inpatient extended treatment and care. These young people’s needs are not able to be met in an acute setting. • In-patient therapeutic milieu, with capacity for family/carer admissions (i.e. family rooms). • All other appropriate and less restrictive interventions considered/ tested first. • Proposal for approximately 15 beds – this requires formal planning processes. • Medium term admissions (approximately up to 12 months; however, length of stay will be guided by individual consumer need and will therefore vary). • Delivers integrated care with the local CYMHS of the young person. • Individualised, family and group rehabilitation programs delivered through day and evening sessions, available 7 days/week. These must include activity based programs that enhance the self esteem and self efficacy of young people to aid their rehabilitation. As symptoms reduce, there is a focus on assisting young people to return to a typical developmental trajectory. • Consumers will only access the day sessions (i.e. Day Program components) of the service if they are an admitted consumer. • Programs maintain family engagement with the young person, and wherever possible adolescents will remain closely connected with their families and their own community. • Young people will have access to a range of educational or vocational support services delivered by on-site school teachers and will be able to continue their current education option.¹⁰⁸ There is an intentional goal that young people are integrated back to mainstream community and educational/vocational activities. • Flexible and targeted programs will be delivered across a range of contexts including individual, school, community, group and family.

Suggested modelling attributes	
Average duration of treatment	<p>Tier 3:</p> <p>Level 6 Statewide Inpatient Extended Treatment and Rehabilitation Service (24h/7d)</p> <ul style="list-style-type: none"> Up to 12 months; flexibility will be essential. There will be wide variation in individual consumer need and their treatment program; length of stay will need to be responsive to this. Young people may be discharged from this Service to a Day Program in their local community.
Staffing Profile	<p>Tier 3:</p> <p>Level 6 Statewide In-patient Extended Treatment and Rehabilitation Service (24h/7d)</p> <ul style="list-style-type: none"> Multidisciplinary, clinical. DETE.
Additional notes	
Referral Sources and Pathways	<p>While service provision across all Tiers of this AETRS continuum is based on interdisciplinary collaboration and cross-agency contribution, a referral to Tiers 2a, 2b and/or 3 will require a CYMHS assessment (i.e., single point of entry).</p> <p>Increased accessibility to AETRS for consumers and their families across the state is a key priority.</p> <p>The Tier 3 statewide service will establish a Statewide Clinical Referral Panel. All referrals will be received and assessed by the Panel, which has statewide representation from multidisciplinary mental health clinicians and community sector.</p>
Complexities of Presentation	<ul style="list-style-type: none"> Voluntary and involuntary mental health consumers. The highest level of risk and complexity.

Part 2 – The Planning Group

As outlined in chapter 9 the Planning Group's role and functions included:

- establishing the ECRG to consider models of care and report to the Planning Group; and
- making recommendations to the Health Service Chief Executive regarding matters within the project scope.¹⁰⁹

Kelly was the chair of the Planning Group.¹¹⁰ Kris Antal (Executive Support Officer, Allied and Community Health, Mental Health and Specialised Services, West Moreton HHS) was the secretariat responsible for distributing agendas and minutes to Planning Group members.¹¹¹

Meetings of the Planning Group

The Planning Group met on eight occasions between November 2012 and May 2013, as shown on the table below.

Planning Group Member	Date of meeting	21 Nov 12 ¹¹²	28 Nov 12 ¹¹³	05 Dec 12 ¹¹⁴	12 Dec 12 ¹¹⁵	18 Jan 13 ¹¹⁶	20 Feb 13 ¹¹⁷	26 Mar 13 ¹¹⁸	15 May 13
	Meeting number	1	2	3	4	5	6	7	8
Sharon Kelly (Chair)	ED, Mental Health and Specialised Services, WM HHS	✓	✓	Apology	✓	✓	✓	✓	✓*
Michelle Bond	Education	✓	✓	✓	✓	✓	Apology	Apology	✓*
	Queensland								
Cary Breakey	BAC (proxy for Sadler)	✓	✓	✓	✓	N/A	N/A	N/A	N/A
Naomi Ford	Director, Rowdy PR (WM HHS)	✓	✓	✓	✓	Apology	✓	Apology	✓*
	Communications for 23/7/13 mtg)								
Leanne Geppert	Director, Planning and Partnerships Unit, MHAODB	✓	✓	Apology	Apology	✓	✓	✓	✓*
David Hartman	Clinical Director, CYMHS, Townsville HHS	✓	✓	Apology	✓	✓	Apology	✓	Apology*
Bill Kingswell	A/Executive Director, MHAODB	✓	✓	Apology	✓	Apology	Apology	✓	✓*
Trevor Sadler	Clinical Director, BAC	Apology	Apology	Apology	Apology	✓	✓	✓	✓*
Stephen Stathis	Clinical Director, CYMHS	N/A	✓	Apology	Apology	✓	✓	✓	✓*
Chris Thorburn	Director, Service Redesign, WM HHS	✓	✓	✓ (Acting Chair)	✓	✓	✓	✓	N/A*

* There are no minutes from the ECRG meeting on 15 May 2013. Thus, the records of the attendance at that meeting are assumed from the handwritten notes of an unidentified person which record the comments of some members of the Planning Group¹⁹ and from the evidence of the chair, Sharon Kelly which is discussed below.

The minutes of the Planning Group meetings on 21 and 28 November 2012, and 5 December 2012, are brief. Relevantly, the minutes of the meeting on 21 November 2012 note the development of the ECRG terms of reference and the nomination of members of the ECRG as action items.¹²⁰ At its third meeting on 5 December 2012, the Planning Group noted the final draft of the ECRG terms of reference.¹²¹

Interestingly, the minutes of the fourth meeting on 12 December 2012 note that:

Following request from Breakey – divergent views (when they occur) will be noted in the record of future meetings.¹²²

The Planning Group met again on 18 January 2013, when Geppert provided an update in relation to the ECRG:

3 ECRGs held to date, looking at service element description(s), continuum of care, service gaps and current underutilisation of services.

ECRG to have a 2 week break to allow comments back to the Chair.

Chair is still seeking approval from ECRG to have names released.

Acknowledgment of Obligations to be signed by ECRG members.

Suggested changes to TOR of the ECRG approved by the Planning Group including a consumer and carer representative. – update TOR.¹²³

At its sixth meeting on 20 February 2013, the Planning Group approved the ECRG's request for an extension of time to complete its work.¹²⁴

The Planning Group met again on 26 March 2013 and noted that:

ECRG have held 2 workshops and a draft document representing the outcome of the workshops will be sent to the ECRG for endorsement.

A proposed service model has been developed around a set of principles developed by the ECRG.

The proposed model consists of Tier 1, Tier 2a, 2b, and Tier 3.

Lengthy discussion ensued regarding differing views between the ECRG and the Planning Group. It was noted that the TOR for the Project Plan provide the context for the development of a model.

ECRG is meeting again on 27 March to discuss draft document on proposed service elements. There will need to be costings calculated for proposed new service models.

A consultation process will need to be determined – WMHHS to liaise with CHQHHS.¹²⁵

The Planning Group meeting on 15 May 2013

On 7 May 2013, the Planning Group was asked to meet in person and/or by teleconference, and several dates and times were suggested. As events unfolded, the meeting date was 15 May 2013. The meeting was expected to last about an hour and the suggested times for it were 8.00 am and 1.00 pm.¹²⁶ Trevor Sadler said he could attend on 15 May 2013 at 8.00 am.¹²⁷ So, too, could Leanne Geppert¹²⁸ and Stephen Stathis.¹²⁹ David Hartman could not attend at that time.¹³⁰ In lieu, Kelly proposed to 'catch up' with him on 13 or 14 May by telephone.¹³¹

Sharon Kelly sent the Planning Group members copies of the ECRG Preamble, Key Messages and Recommendations and the ECRG Table on 13 May 2013.¹³² They received a draft of the decision

table in which their recommendations later appeared. Kelly advised them, "Our task will be to review each recommendation and identify actions moving forward. A table has been attached to assist in your review process".¹³³

The Planning Group met on 15 May 2013. However, the Commission has not been able to locate any final or even draft minutes of that meeting. No relevant email accounts contain any reference to minutes. When told by Counsel Assisting that no minutes of the Planning Group meeting on 15 May 2013 had been located, Kelly's evidence was:

I don't know if there were minutes prepared for that meeting. I am surprised they were unable to find minutes for that meeting.¹³⁴

...

I am surprised that there are no minutes. The group was very good at minute-taking. I don't recall why there are no minutes ...¹³⁵

The Commission is satisfied that no minutes were taken.

However, there is a set of handwritten notes,¹³⁶ on a hard copy of the draft decision table, which record feedback from five members of the Planning Group – Stathis, Sadler, Kingswell, Kelly, and Michelle Bond. There is no recorded feedback from the other members – Chris Thorburn, Geppert, Hartman and Naomi Ford. Kelly says that Ford, who was not clinically qualified, attended in her capacity as an advisor on communications strategy, and that it is not surprising there were no handwritten notes or opinions attributed to her.¹³⁷ Thorburn had left West Moreton HHS by that date and was no longer a member of the Planning Group.¹³⁸ Presumably, Hartman did not attend because he had earlier said he could not, and presumably Geppert attended because she said she would.

Kelly said the notes are not in her handwriting.¹³⁹ In oral evidence before the Commission, she could not identify whose handwriting it was.¹⁴⁰ Subsequently, Kelly said that on further reflection, she thought the handwriting was Geppert's.¹⁴¹ Geppert was not asked if it was her handwriting or if she attended the meeting.

Kelly said that after the meeting on 15 May 2013, she collated the comments of the Planning Group members into what became the Planning Group's recommendations document.¹⁴² However, her evidence was, "I wouldn't imagine the handwritten notes would have been circulated but the final document, I imagine, would have been circulated for confirmation".¹⁴³

None of the documents produced to the Commission records the circulation of the Planning Group's recommendations to its members for comment or endorsement. Sadler, for one, said he did not see the Planning Group's recommendations until 6 August 2013.¹⁴⁴

Kelly was asked whether there was any basis for saying that the members of the Planning Group agreed with the comments of the persons to whom the handwritten notes were attributed, or whether those notes were just a collection of various comments put into the Planning Group recommendations. Her response was, "If you're unable to find minutes, I can't verify the decision-making process".¹⁴⁵ The Commission is also unable to verify that process.

Also on 15 May 2013, the agenda paper for the 24 May 2013 West Moreton Board meeting was first prepared,¹⁴⁶ presumably sometime after the Planning Group meeting that morning. The final Planning Group recommendations were attached to the agenda paper. The preparation of the agenda paper is considered in further detail in chapter 11.

The Planning Group's recommendations

The Planning Group's recommendations document deals with each of the seven key messages and recommendations of the ECRG. It is in the form of a table containing the ECRG recommendations in the left column and the Planning Group recommendations in the right column.

The handwritten notes of the Planning Group meeting on 15 May 2013 record "all" in the "accept" column for a number of items. There was also a "reject" column, but none of the ECRG recommendations was expressly rejected.

1. Broader consultation and formal planning processes are essential in guiding the next steps required for service development, acknowledging that services need to align with the National Mental Health Service Planning Framework

ECRG Recommendations	Planning Group Recommendations
a) Further work will be required at a statewide level to translate these concepts into a model of service and to develop implementation and funding plans.	Accept. The responsibility for this task at a statewide level sits with the Mental Health Alcohol and Other Drugs Branch and the Children's Health Services. A collaborative partnership is proposed.
b) Formal planning including consultation with stakeholder groups will be required.	Accept. This body of work should be incorporated into the statewide planning and implementation process (as above).

¹The handwritten notes ascribe the comment against ECRG recommendation 1(a) "Acknowledge statewide implications" to SS (Stephen Stathis) and "MB" (Michelle Bond). They ascribe the comment against recommendation 1(b), "Contestability is relevant", "eg. Mater, WM HHS", "how far do we want to consult?" to Stathis and the comment "We would consult prior to putting out for contestability" to "SK" (Sharon Kelly).

2. Inpatient extended treatment and rehabilitation care (Tier 3) is an essential service component

ECRG Recommendations	Planning Group Recommendations
<p>a) A Tier 3 service should be prioritised to provide extended treatment and rehabilitation for adolescents with severe and persistent mental illness.</p>	<p>Accept with caveats.</p> <p>Further work is needed to detail the service model for a Tier 3. Models involving a statewide, clinical bed-based service (such as the Barrett Adolescent Centre) are not considered contemporary within the National Mental Health Service Planning Framework (<i>in draft</i>). However, there are alternative bed-based models involving clinical and non-clinical service components (e.g., Y-PARC in Victoria) that can be developed in Queensland to meet the requirement of this recommendation.</p> <p>Contestability reforms in Queensland may allow for this service component to be provider agnostic.</p>

(emphasis in original)

The handwritten notes of the Planning Group meeting record "TS" (Trevor Sadler) accepted and that "BK" (Bill Kingswell) and Stathis accepted with caveats. They record that Kingswell observed, "NMHSPF has come to a different point of view. No level 6 unit supported by taxonomy".¹⁴⁷

Sadler gave evidence that he and Kingswell disagreed about the need for a Tier 3 service, which resulted in his sending an email to Kingswell on 21 May 2013 about the efficacy of interim or 'wraparound services' as a substitute for a Tier 3 service.¹⁴⁸

Stathis and Kelly seem to have raised the contestability point.

In her written statement, Kelly said she understood ECRG recommendation 2 to be an attempt to maintain [the] status quo.¹⁴⁹ She said she had received assurances from Kingswell that a youth residential extended treatment facility would be established in South East Queensland by around January 2014.¹⁵⁰

Geppert said she understood Planning Group recommendation 2 to mean that the Planning Group accepted that a Tier 3 service was very important but that there was a range of different ways in which a Tier 3 service could be developed or implemented as a model of care in itself.¹⁵¹ She said she did not have a concept of 'Tier 3' being a building as in 'bricks and mortar':

[A] tier 3 service, to me, is what you would classify as the most – the highest level of service with the most extensive and comprehensive resources to provide, I guess, young people with maybe, particularly complex or particularly unusual – or a combination of both symptoms or mental health problems that need to be supported.¹⁵²

3. Interim service provision if BAC closes and Tier 3 is not available is associated with risk

ECRG Recommendations	Planning Group Recommendations
a) Safe, high quality service provision for adolescents requiring extended treatment and rehabilitation requires a Tier 3 service alternative to be available in a timely manner if BAC is closed.	Accept.
b) Interim service provision for current and 'wait list' consumers of BAC while Tier 3 service options are established must prioritise the needs of each of these individuals and their families/carers. 'Wraparound care' for each individual will be essential.	<p>Accept.</p> <p>While this may be a complex process for some consumers and their individual needs, it was noted that this course of action could start immediately, and that it was feasible. The potential to utilise current BAC operational funds (temporarily) to 'wrap-around' each consumer's return to their local community was noted as a significant benefit.</p> <p>The relevant local community should play a lead role in the discharge of the consumer from BAC and their return to home. The local services need to be consulted around their ability to provide 'wrap-around' care.</p>
c) BAC staff (clinical and educational) must receive individual care and case management if BAC closes, and their specialist skill and knowledge must be recognised and maintained.	<p>Accept.</p> <p>The ECRG and the Planning Group strongly supported this recommendation.</p>

The handwritten meeting notes say that Stathis noted, "ECRG were very strong" on point 3(a) and that "[t]here needs to be planning around an alternative if BAC closes". In relation to 3(b), Stathis observed, "Yes, \$ will be freed up to support local services [and] theoretically this will work". The notes attribute the following to Kingswell concerning 3(b):

- This could start immediately.
- Important to utilise BAC funding to wrap-around current consumers so they have local support.
- Opportunity to create own model of wrap around.
- BAC inappropriate service. The Park is to become a forensic site. Cannot keep this service open.
- If cannot put them in acute units, then have to provide alternative option.

In relation to 3(c) and the phrase, "must be recognised and maintained", the handwritten notes attributed to Sadler: "particularly highlighted this".¹⁵³

A “key message back” from Sadler was: “If tier 3 not available, consultation needed HHS around their ability to provide wraparound care”.¹⁵⁴ In his oral evidence, Sadler said that he was quite concerned about whether wrap around services would be an adequate solution in the circumstances and that he expressed those concerns at the meeting of the Planning Group.¹⁵⁵

Stathis responded to the ECRG recommendation in this way: “Other HHS may not have appetite for wraparound care s. w. [statewide] consultation is essential and CHS should be involved as a lead”. Then “endorsed by TS” appears.¹⁵⁶

In her written evidence Kelly stated that, so far as she was concerned, the ECRG’s statement to the effect that closing the BAC before a replacement Tier 3 service was available carried with it a risk was not persuasive of anything. Her view was that providing services in a mental health environment is always associated with risk.¹⁵⁷ She said the issue was whether the risk could be managed and that she interpreted ECRG recommendation 3 as recognising that the risks associated with closure of the BAC could be managed effectively.¹⁵⁸

During her oral evidence, Kelly was asked to identify where, in the ECRG report, it was said that the risks associated with closing the BAC without a Tier 3 in place could be managed effectively. Ultimately, she conceded that those words did not appear in the ECRG report, but said she believed they could be implied.¹⁵⁹

EFTRU

Kelly said that the risk associated with leaving the BAC open after EFTRU opened was discussed at the Planning Group meetings but it was not discussed “in relation to the recommendations to go forward” nor was it part of their recommendations, because “that was always part of the ... discussions moving forward”.¹⁶⁰ EFTRU is discussed further in chapter 14.

4. Duration of treatment

ECRG Recommendations	Planning Group Recommendations
a) ‘Up to 12 months’ has been identified by the ECRG as a reasonable duration of treatment, but it was noted that this depends on the availability of effective step-down services and a suitable community residence for the young person. It is important to note that like all mental health service provision, there will be a range in the duration of admission.	<p>Accept with caveats.</p> <p>This issue requires further deliberation within the statewide planning process.</p> <p>The duration of treatment needs some parameters to be set, however, this is primarily a clinical issue that is considered on a case-by-case basis by the treating team and the consumer.</p>

The handwritten notes of the meeting ascribe “intentionally vague” and “agreed part of planning process and clinical planning” to Stathis.¹⁶¹

5. Education resource essential: on-site school for Tiers 2 and 3

ECRG Recommendations	Planning Group Recommendations
<p>a) Access to on-site schooling (including suitably qualified educators), is considered essential for Tiers 2 (day programs) and 3. It is the position of the ECRG that a Band 7 Specific Purpose School (provided by Department of Education, Training and Employment) is required for a Tier 3 service.</p>	<p>Accept with caveats.</p> <p>The Planning Group recommends removing “Band 7” from the ECRG recommendation. All educational services need to be evaluated by Department of Education, Training and Employment (DETE) on a case-by-case basis, taking into consideration service model, location, student numbers and complexity.</p> <p>The Planning Group supports the statement that educational resources are essential to adolescent extended treatment and rehabilitation services.</p> <p>The Planning Group recommends consultation with DETE once a statewide model is finalised.</p>
<p>b) As an aside, consideration should also be given to the establishment of a multi-site, statewide education service for children/adolescents in acute units (hub and spoke model).</p>	<p>Accept with caveat.</p> <p>The Planning Group recommends this statement should be changed to read as:</p> <p>Strong consideration should be given to the establishment of a multi-site, statewide education service for children/adolescents in acute units (hub and spoke model).</p>

(emphasis in original)

In relation to 5(a), the handwritten notes of the meeting link Band 7 with “SL3 (about 100 students a day and complexities)”. They ascribe the words “happy to accept as written” to Stathis.¹⁶² To Bond, they ascribe accepting 5(a), but noting that “Band 5 is lowest possible. Need to identify model and then evaluate education model is [sic] needed”; “take ‘Band 7’ out”.¹⁶³ Sadler is noted as having “‘grave reservations’ about suggestion to remove 5(a)”.¹⁶⁴ A “key message back” ascribed to Bond is “reinforce that education is part of focus on each child”.¹⁶⁵

In relation to 5(b), the handwritten notes say “strong support” from all. “5a and 5b is ed[ucation] dep[artment] issue to follow through”. Stathis is credited with the re-wording of the ECRG’s recommendation, except that “Special” is in the handwritten notes rather than “Strong” as appears in the final recommendations.¹⁶⁶

Kelly’s views about Recommendation 5 were less enthusiastic. She said she was unconvinced that attendance rates or levels of achievement for this cohort of students were enhanced by having a dedicated on-site school. She based this view on her observation of the BAC patients many of whom she said attended school off-site and others not at all. While she agreed that education for this cohort of patients was important, she questioned whether it needed to be provided on site or could be adequately provided externally.¹⁶⁷

6. Residential Service: Important for governance to be with CYMHS; capacity and capability requires further consideration

ECRG Recommendations	Planning Group Recommendations
a) It is considered vital that further consultation and planning is conducted on the best service model for adolescent non-government/private residential and therapeutic services in community mental health. A pilot site is essential.	Accept. Note that this service could be provider agnostic.
b) Governance should remain with the local CYMHS or treating mental health team.	Accept.
c) It is essential that residential services are staffed adequately and that they have clear service and consumer outcome targets.	Accept.

In the handwritten notes of the meeting, there is an unattributed statement in relation to 6(a): “provider agnostic”. The comment “emphasise we should consider contestability per public and private providers” is ascribed to Stathis.¹⁶⁸ The comment “residential service essential to making Townsville independent and this could be pilot site” is ascribed to Sadler.¹⁶⁹

7. Equitable access to AETRS for all adolescents and families is high priority; need to enhance service provision in North Queensland (and regional areas)

ECRG Recommendations	Planning Group Recommendations
a) Local service provision to North Queensland should be addressed immediately by ensuring a full range of CYMHS services are available in Townsville, including a residential community-based service.	Accept.
b) If a decision is made to close BAC, this should not be finalised before the range of service options in Townsville are opened and available to consumers and their families/carers.	Accept.

Part 3 – The ‘bricks and mortar’ question

The issue

In their written submissions, Counsel for the State of Queensland argued that the ECRG report did not, on its face, require a Tier 3 service to be a ‘bricks and mortar’ facility.¹⁷⁰ They argued that the words “service” and “facility” are not identical and ought not be conflated.¹⁷¹ Similar submissions were made on behalf of West Moreton HHS,¹⁷² Lawrence Springborg¹⁷³ and Kingswell.¹⁷⁴

Counsel for Springborg submitted that “the ECRG did not define precisely what they meant by ‘Tier 3’”.¹⁷⁵

Counsel for Kingswell submitted that it is “not clear” that the ECRG supported a new facility.¹⁷⁶ He submitted that the fact the ECRG report repeatedly referred to a “service” rather than a “facility” is telling. He argued that the word “service” indicated that the ECRG report actually recommended a comprehensive system of care, rather than the construction of a building.¹⁷⁷

The underlying contention in the submissions for the State of Queensland, West Moreton HHS, Springborg and Kingswell is that the ECRG supported a Tier 3 service, as opposed to a single service provided out of a ‘bricks and mortar’ facility. On that basis, the ECRG cannot be regarded as having recommended that the BAC remain open or that it be replaced by a ‘Tier 3’ facility.

Conversely, Counsel Assisting submitted that the term ‘Tier 3’, as used in the ECRG report, does mean a facility in the sense of a design-specific and clinically staffed bed-based service.¹⁷⁸ They submitted that the phrase “Tier 3 service” means a service provided at or by such a facility.

This section examines these arguments, drawing on the summary and analysis of the evidence contained in Parts 1 and 2.

ECRG Report

An examination of what the ECRG in fact meant must begin with what is said in its report and, specifically, in the ECRG Preamble, Key Messages and Recommendations, and the ECRG Table.

What is said in both documents supports the contention that a “Tier 3” is a ‘facility’ as opposed to a ‘service’.

The Preamble briefly defines “Tier 3” as a “Statewide Adolescent Inpatient Extended Treatment and Rehabilitation Service”. The term “inpatient”, as used in that phrase, connotes a person who stays in some physical health facility such as a hospital. The ECRG again refers to Tier 3 as involving an “inpatient” service in Recommendation 2.

The ECRG was alert to the argument that the BAC cohort could be properly cared for by a combination of other CYMHS service types, including community mental health clinics, day programs, residential community-based care, and acute inpatient or hospital facilities.¹⁷⁹ These “alternative service types” are represented by Tiers 1 and 2.¹⁸⁰ The ECRG rejected that argument. It said:

However, it is the view of the ECRG that like the Community Care Units within the adult mental health service stream, a **design-specific and clinically staffed bed-based service** is essential for adolescents who require medium-term extended care and rehabilitation. This type of care and rehabilitation program is considered life-saving for young people, and is available currently in both Queensland and New South Wales (e.g. The Walker Unit).¹⁸¹

(emphasis added)

The expressions “design-specific” and “bed-based” connote an inpatient residential facility. The examples given by the ECRG were all residential facilities (that is, Community Care Units, The Walker Unit, and the BAC). Further, the ECRG compared the risks of institutionalisation in an “acute unit” with the risks of institutionalisation in a Tier 3 service, which it described as a “design specific extended care unit”.¹⁸²

The ECRG Table¹⁸³ describes the component elements of a Tier 3 service. The elements provide for 24/7 care, albeit at a site not currently available, with 15 beds and an on-site school. Tier 3 was

equated with CSCF Level 6.¹⁸⁴ 'CSCF' is the Clinical Services Capability Framework¹⁸⁵ and Level 6 involves an inpatient facility.¹⁸⁶ The reference to "beds" and "site" are also indicative of a facility.

Thus, it is reasonably clear from the actual words used by the ECRG that it was referring to a service conducted from a "bricks and mortar" facility.

Other contemporaneous evidence

Two contemporaneous emails support the view that the ECRG was speaking of a 'facility'.

First, shortly before the ECRG report was finalised, Geppert emailed Kelly on 21 April 2013, stating, "ECRG members are unanimous in wanting a **level 6 extended treatment and rehabilitation unit** in Queensland to remain in the service elements document as Tier 3" (emphasis added).¹⁸⁷

The use of the word "unit" in this context is consistent with a facility, as is the reference to 'level 6'.

Second, the repetitive use of the expression "Tier 3 service" is explained by an email Geppert sent to the ECRG members on 8 May 2013. In that email, she said that in preparing the final version of the ECRG documents, the use of the word "service" was preferred for the sake of consistency and also to reflect the broader function of a Tier 3. Geppert said:

... the Tier 3 descriptor ('Statewide Adolescent Inpatient Extended Treatment and Rehabilitation Unit') sometimes used the word 'unit' and sometimes 'service'. For consistency, I changed it all [i.e. all the references] to 'service' which also captures the broader function of what we have discussed for Tier 3 (ie., beds + step up/down and rehab programs).¹⁸⁸

The reference to a 'service' is plainly intended to include a bed-based service combined with other services, such as step up/step down facilities and rehabilitation programs. This is the "broader function" of Tier 3.

Witnesses

Hazell, a member of the ECRG, said that the fact there was no funding to build a new facility "was not antagonistic to the idea of developing a model of care that involved tier 3 services".¹⁸⁹ He said that "other creative solutions such as refurbishment of an existing facility or alternative accommodation for the service" remained.¹⁹⁰ While Hazell did use the word "service", his two "other creative solutions" for replacing the BAC involved a physical facility.

Callaghan, another member of the ECRG, expressed concern about the interchangeable use of "BAC", "Tier 3", and "sub-acute extended inpatient unit".¹⁹¹ She said: "I do think we need a tier 3 service. I'm not convinced that it needs to be an inpatient unit" like the BAC.¹⁹² She later qualified this saying that while there is a need for subacute inpatient stays, her concern was with an extended length of stay, particularly like that at the BAC.¹⁹³

Stathis gave a presentation to the Mental Health Branch Leadership Forum on 29 April 2014 in which he summarised the recommendations of the ECRG, describing Tier 3 as a "subacute bed-based unit" and "hospital based".¹⁹⁴ Kingswell, on the other hand, said he was "frustrated" with the term 'Tier 3',¹⁹⁵ and that he was not and is still not sure what it means.¹⁹⁶

At the seventh meeting of the ECRG on 27 March 2013, Rodgers expressed concern about the sustainability of an education component linked to an "8-10 bed adolescent *unit*" (emphasis added).¹⁹⁷

In the Commission's view the wording of the ECRG report is unambiguous: it was referring to bricks and mortar facility rather than a service.

Tier 3 is a facility

The ECRG recommended a Tier 3 facility; that is, a design-specific and clinically staffed bed-based service.

In oral submissions, Counsel for the State and Springborg qualified their initial written submissions referred to above in response to the arguments advanced by Counsel Assisting about the interpretation of the ECRG report.

Counsel for the State of Queensland submitted that "the point that we were making is ... not to conflate the facility, which has a connotation of a standalone building like Barrett, as opposed to a service, which can be within another facility, like subacute beds at Lady Cilento".¹⁹⁸ Whether subacute beds in an acute unit is what the ECRG supported is a separate, different question. Significantly, the ECRG expressly decided that "Managing these young people in acute inpatient units does not meet their clinical, therapeutic or rehabilitation needs".¹⁹⁹ This issue is discussed in chapter 14.

Counsel for Springborg contended that Counsel Assisting's submissions were incomplete because they did not discuss what happened after the ECRG finalised its report or the reception of the ECRG's report, particularly by the Planning Group.²⁰⁰ The Commission considers that the wording of the ECRG report is clear and that it is not necessary (if permissible) to have regard to the subsequent interpretations placed upon it by the Planning Group, or indeed, the witnesses referred to above.

Part 4 – Conclusions

One of the ECRG's key messages was that a 'Tier 3' service was "an essential service component". It expressly said that there was a small group of young people whose needs could not be safely and effectively met through day and community programs (as represented by Tiers 1 and 2a/b).

The ECRG reached that view whilst acknowledging that:

- a. there were funding constraints
- b. non-acute bed-based services should be community-based wherever possible
- c. young people are to be treated in the least restrictive environment possible
- d. they were told that the BAC could not continue at The Park and that their brief was to explore alternatives to the BAC (or equivalent models of care).

In the event that the BAC closed and an alternative Tier 3 facility was not available, the ECRG:

- a. warned that there was a risk, indeed a significant risk, to the patients or future patients
- b. specified that any interim service provision for the BAC patients, and the BAC waitlist patients, must prioritise the needs of the patients and involve 'wrap around' care.

The ECRG emphasised that a Tier 3 should be available in a timely manner if the BAC was closed.

The Commission has concluded that the ECRG was speaking of a 'bricks and mortar' inpatient extended treatment and rehabilitation service.

The absence of minutes of the Planning Group meeting on 15 May 2013 makes it difficult to conclude what, if anything, the Planning Group decided about the ECRG's final report of

8 May 2013, the Planning Group's reasons, or its reasoning process. The handwritten notes of the meeting suggest that one or more Planning Group members either disagreed with, or were not willing to accept, the ECRG's view that a 'Tier 3' service was essential. Likewise, one or more Planning Group members commented that the transfer of the BAC patients to alternative or interim service options was feasible, could commence immediately notwithstanding the absence of a Tier 3, and should involve 'wraparound care'. These comments are reflected in the final version of the Planning Group's recommendations as presented to the West Moreton Board on 24 May 2013.

The Planning Group, or at least one or more of its members, considered that the closure of the BAC was feasible to commence "now". The ECRG, on the other hand, effectively recommended against the closure of the BAC unless a Tier 3 facility was available in a timely way. It is therefore inaccurate to say that the Planning Group "accepted", even with "caveats", the recommendations of the ECRG. The Planning Group's comments were at loggerheads with the ECRG's recommendations.

(Endnotes)

- 1 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG 8 May 2016, p 1.
- 2 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG 8 May 2016, p 1.
- 3 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG 8 May 2016, p 1.
- 4 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG 8 May 2016, p 2.
- 5 Exhibit 1390, ECRG Proposed Service Model Elements Table, pp 5–6.
- 6 Exhibit 1390, ECRG Proposed Service Model Elements Table, p 6.
- 7 Exhibit 1517, Barrett Adolescent Strategy – Expert Clinical Reference Group Agenda, 24 April 2013; Exhibit 1518, Summary of Expert Clinical Reference Group – Terms of Reference, 30 November 2012. Note also that it is the evidence of Leanne Geppert that the relevant minutes are held by the MHAODB (Queensland Health) and as such, she does not have access to them. Exhibit 55, Statement of Leanne Geppert, 16 October 2015, p 9 para 5.1.
- 8 Exhibit 179, Supplementary statement of Trevor Sadler, 12 February 2016, p 30 para 131.
- 9 Exhibit 1516, Email from Leanne Geppert to Expert Clinical Reference Group Members, Subject: "CANCELLED ECRG Meeting (Barrett Adolescent Strategy) on 30/1/13", 29 January 2013.
- 10 Exhibit 119, Statement of Josie Sorban, 11 December 2015, p 3 para 12, Attachment E to that statement, ECRG meeting minutes, 16 January 2013, p 52.
- 11 Exhibit 119, Statement of Josie Sorban, 11 December 2015, Attachment E to that statement, ECRG meeting minutes, 7 December 2013, pp 32–37.
- 12 Exhibit 119, Statement of Josie Sorban, 11 December 2015, Attachment E to that statement, ECRG meeting minutes, 9 January 2013, pp 41–47.
- 13 Exhibit 119, Statement of Josie Sorban, 11 December 2015, Attachment E to that statement, ECRG meeting minutes, 16 January 2013, pp 50–55.
- 14 Exhibit 119, Statement of Josie Sorban, 11 December 2015, Attachment E to that statement, ECRG meeting minutes, 13 February 2013, pp 60–63.
- 15 Exhibit 458, Minutes of the Expert Clinical Reference Group meeting, 27 February 2013.
- 16 Exhibit 119, Statement of Josie Sorban, 11 December 2015, Attachment E to that statement, ECRG meeting minutes, 13 March 2013, pp 66–70.
- 17 Exhibit 119, Statement of Josie Sorban, 11 December 2015, Attachment E to that statement, ECRG meeting minutes, 27 March 2013, pp 73–79.
- 18 The Commission has been unable to locate minutes from this meeting.
- 19 Confidential.
- 20 Confidential.

- 21 Exhibit 114, Statement of James Scott, 4 February 2016, p 10 para 55; Exhibit 63, Statement of Philip Hazell, 5 November 2015, p 13 para 72.
- 22 Exhibit 63, Statement of Philip Hazell, 5 November 2015, p 13 para 72.
- 23 Exhibit 114, Statement of James Scott, 4 February 2016, pp 10–11 para 58.
- 24 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, p 11 para 5.6(d).
- 25 Exhibit 119, Statement of Josie Sorban, 11 December 2015, Attachment E to that statement, ECRG meeting minutes, 9 January 2013, pp 41–47.
- 26 Exhibit 119, Statement of Josie Sorban, 11 December 2015, Attachment E to that statement, ECRG meeting minutes, 9 January 2013, p 46.
- 27 Exhibit 119, Statement of Josie Sorban, 11 December 2015, Attachment E to that statement, ECRG meeting minutes, 16 January 2013, p 52.
- 28 Exhibit 119, Statement of Josie Sorban, 11 December 2015, Attachment E to that statement, ECRG meeting minutes, 16 January 2013, p 43.
- 29 Exhibit 1520, Barrett Adolescent Strategy – Expert Clinical Reference Group, Extension of Timeframes Request, 19 February 2013.
- 30 Exhibit 32, Statement of Amelia Callaghan, 14 January 2016, p 12 para 13(b).
- 31 Exhibit 114, Statement of James Scott, 4 February 2016, p 10 para 55.
- 32 Exhibit 1520, Barrett Adolescent Strategy – Expert Clinical Reference Group, Extension of Timeframes Request, 19 February 2013.
- 33 Exhibit 458, Minutes of the Expert Clinical Reference Group meeting, 27 February 2013, p 2.
- 34 Exhibit 119, Statement of Josie Sorban, 11 December 2015, Attachment E to that statement, ECRG meeting minutes, 27 March 2013, pp 74–75.
- 35 Exhibit 119, Statement of Josie Sorban, 11 December 2015, Attachment E to that statement, ECRG meeting minutes, 13 March 2013, p 67.
- 36 Exhibit 61, Statement of Emma Hart, 25 January 2016, p 6 para 24.
- 37 Exhibit 61, Statement of Emma Hart, 25 January 2016, p 6 para 24.
- 38 Exhibit 119, Statement of Josie Sorban, 11 December 2015, Attachment E to that statement, ECRG meeting minutes, 13 March 2013, p 70.
- 39 Exhibit 119, Statement of Josie Sorban, 11 December 2015, Attachment E to that statement, ECRG meeting minutes, 27 March 2013, p 77.
- 40 Exhibit 215, Email from Vaoita Turituri to Kevin Rodgers and others, Subject: “Proposed Service Model Elements”, 17 April 2013; Exhibit 1521, Barrett Adolescent Strategy – Expert Clinical Reference Group – Proposed Service Model Elements – Adolescent Extended Treatment and Rehabilitation Services (AETRS) and Preamble.
- 41 Exhibit 1451, ECRG Feedback Register April 2013.
- 42 Exhibit 114, Statement of James Scott, 4 February 2016, pp 10–11 paras 54, 59–61.
- 43 Exhibit 963, Email from Leanne Geppert to Expert Clinical Reference Group members, Subject: “V3 Final Proposed service model elements for Adolescent Extended and Rehabilitation Services and Preamble”, 23 April 2013.
- 44 Exhibit 1517, Barrett Adolescent Strategy – Expert Clinical Reference Group Agenda, 24 April 2013; Exhibit 1518, Summary of Expert Clinical Reference Group – Terms of Reference, 30 November 2012.
- 45 Exhibit 32, Statement of Amelia Callaghan, 14 January 2016, p 17 para 18.
- 46 Exhibit 1522, Email from [confidential] to Trevor Sadler, Subject: “FINAL Proposed service model elements for Adolescent Extended and Rehabilitation Services”, 24 April 2013; Exhibit 1523, Email from Michelle Fryer to Expert Clinical Reference Group Members, Subject: “v3 Preamble 23.04.13 MF.doc” and preamble, 24 April 2013.
- 47 Confidential.
- 48 Exhibit 1537, Emails between [confidential] and Michelle Fryer and others, Subject: “Preamble”, 25 April 2013.
- 49 Exhibit 174C, Email from Trevor Sadler to Kevin Rodgers and others, Subject: “V4 Service model elements for Adolescent Extended and Rehabilitation Services & V4 Preamble”, 6 May 2013; Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: “Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)”, Version 5, Endorsed by ECRG 8 May 2013.
- 50 Exhibit 175, Email from James Scott to Kevin Rodgers and others, Subject: “V4 Service model elements for Adolescent Extended and Rehabilitation Services & V4 Preamble”, 6 May 2013; Exhibit 174A, Email from Michelle Fryer to Kevin Rodgers and others, Subject: “V4 Service model elements for Adolescent Extended and Rehabilitation Services & V4 Preamble”, 6 May 2013; Exhibit 965, Email from Leanne Geppert to Expert Clinical Reference Group members, Subject: “V4 Service model elements for Adolescent Extended and Rehabilitation Services and Preamble”, 6 May 2013; Exhibit 1524, Email from [confidential] to Trevor Sadler and others, Subject: “V4 Service model elements for Adolescent Extended and Rehabilitation Services & V4 Preamble”, 7 May 2013; Exhibit 1525, Email from David Hartman to [confidential] and others, Subject: “V4

- Service model elements for Adolescent Extended and Rehabilitation Services & V4 Preamble”, 7 May 2013; Exhibit 1526, Email from Amelia Callaghan to Leanne Geppert and others, Subject: “V4 Service model elements for Adolescent Extended and Rehabilitation Services & V4 Preamble”, 7 May 2013.
- 51 Exhibit 174C, Email from Trevor Sadler to Kevin Rodgers and others, Subject: “V4 Service model elements for Adolescent Extended and Rehabilitation Services & V4 Preamble”, 6 May 2013, p 1.
- 52 Exhibit 1538, Email from Leanne Geppert to Sharon Kelly, Subject: “Update ECRG Barrett”, 7 May 2013.
- 53 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: “Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)”, Version 5, Endorsed by ECRG 8 May 2016..
- 54 Exhibit 958, Email from Leanne Geppert to Expert Clinical Reference Group members, Subject: “Endorsed Preamble and Service Model Elements for Adolescent Extended Treatment and Rehabilitation Services”, 8 May 2013.
- 55 Exhibit 1455, Email from Leanne Geppert to Sharon Kelly, Subject: “Endorsed Preamble and Service Model Elements for Adolescent Extended Treatment and Rehabilitation Services”, 8 May 2013.
- 56 See for example, Exhibit 63, Statement of Philip Hazell, 5 November 2015, p 14 para 82; Exhibit 114, Statement of James Scott, 4 February 2016, p 12 para 67; Exhibit 119, Statement of Josie Sorban, 11 December 2015, p 7 para 31.
- 57 Exhibit 114, Statement of James Scott, 4 February 2016, p 9 para 47.
- 58 Exhibit 114, Statement of James Scott, 4 February 2016, p 9 para 51.
- 59 Exhibit 32, Statement of Amelia Callaghan, 14 January 2016, p 13 para 13(d)(ii); Transcript, Amelia Callaghan, 17 February 2016, p 8-56 lines 14–28.
- 60 Transcript, Amelia Callaghan, 17 February 2016, p 8-56 lines 38–44.
- 61 Transcript, Amelia Callaghan, 17 February 2016, p 8-63 lines 22–27.
- 62 Exhibit 110, Statement of Kevin Rodgers, 10 December 2015, p 21 paras 92–93.
- 63 Exhibit 110, Statement of Kevin Rodgers, 10 December 2015, p 21 para 92.
- 64 Exhibit 110, Statement of Kevin Rodgers, 10 December 2015, p 21 para 93.
- 65 Exhibit 114, Statement of James Scott, 4 February 2016, p 9 para 52.
- 66 Exhibit 119, Statement of Josie Sorban, 11 December 2015, p 7 paras 29–30.
- 67 Exhibit 1527, Email from Vaoita Turituri to Amelia Callaghan and others, Subject: “Expert Clinical Reference Group Agenda”, 7 December 2012. The letters were from James Scott, Michelle Fryer, Cary Breakey, Rebecca Wild, Lyndall Kleinschmidt, and Victoria Gladwell. (The reactions of the profession to the proposed closure are discussed further in chapter 8.) The ECRG was also referred to a response written to Angela Clarke who was a teacher at the BAC school.
- 68 Exhibit 119, Statement of Josie Sorban, 11 December 2015, Attachment E to that statement, ECRG meeting minutes, 9 January 2013, p 43.
- 69 Exhibit 119, Statement of Josie Sorban, 11 December 2015, Attachment E to that statement, ECRG meeting minutes, 9 January 2013, p 43.
- 70 Exhibit 119, Statement of Josie Sorban, 11 December 2015, Attachment E to that statement, ECRG meeting minutes, 16 January 2013, p 51.
- 71 Exhibit 1071, Email from Vaoita Turituri to Reference Group Members, Subject: “Consumer and Carer representation_ ECRG”, 22 January 2013.
- 72 Confidential; Exhibit 1071, Email from James Scott to Vaoita Turituri, Leanne Geppert and Trevor Sadler, Subject: “Re: Consumer and Carer representation_ ECRG”, 2 February 2013.
- 73 Exhibit 119, Statement of Josie Sorban, 11 December 2015, Attachment E to that statement, ECRG meeting minutes, 13 February 2013, p 61.
- 74 Exhibit 119, Statement of Josie Sorban, 11 December 2015, Attachment E to that statement, ECRG meeting minutes, 13 February 2013, p 61.
- 75 Exhibit 119, Statement of Josie Sorban, 11 December 2015, Attachment E to that statement, ECRG meeting minutes, 13 February 2013, p 61.
- 76 Exhibit 119, Statement of Josie Sorban, 11 December 2015, Attachment E to that statement, ECRG meeting minutes, 13 February 2013 p 62.
- 77 Exhibit 122, Statement of Stephen Stathis, 5 November 2015, Attachment E to that statement, Planning Group Meeting Minutes, 20 February 2013, p 85.
- 78 Exhibit 119, Statement of Josie Sorban, 11 December 2015, Attachment E to that statement, ECRG meeting minutes, 13 February 2013, p 62.
- 79 Exhibit 1529, Email from Kris Antal to [confidential], Subject: “Letter of Invitation - Consumer Representative Expert Clinical Reference Group”, 25 February 2013; Exhibit 1530, Email from Kris Antal to [confidential], Subject: “Letter of Invitation - Consumer Representative Expert Clinical Reference Group”, 25 February 2013.
- 80 Exhibit 119, Statement of Josie Sorban, 11 December 2015, Attachment E to that statement, ECRG meeting minutes, 13 February 2013, pp 61–62.

- 81 Exhibit 1528, Email from Sharon Kelly to Chris Thorburn, Subject: "Fwd: ECRG", 20 February 2013.
- 82 Exhibit 1531, Email from Leanne Geppert to Kerry Geraghty, Subject "Letter of Invitation - Consumer Representative Expert Clinical Reference Group", 26 February 2013.
- 83 Exhibit 114, Statement of James Scott, 4 February 2016, Attachment JS-8 to that statement, ECRG Terms of Reference, p 94.
- 84 Transcript, closed hearing.
- 85 Exhibit 1451, ECRG Feedback Register April 2013, pp 6–7.
- 86 Exhibit 1451, ECRG Feedback Register April 2013, pp 10–11.
- 87 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG 8 May 2016, p 2.
- 88 Exhibit 119, Statement of Josie Sorban, 11 December 2015, Attachment E to that statement, ECRG meeting minutes, 27 March 2013, pp 74–75.
- 89 Exhibit 119, Statement of Josie Sorban, 11 December 2015, Attachment E to that statement, ECRG meeting minutes, 27 March 2013, p 77.
- 90 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG 8 May 2016, p 3.
- 91 Exhibit 1540, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG 8 May 2013, p 1.
- 92 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG 8 May 2016, p 3.
- 93 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG 8 May 2016, p 4.
- 94 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG 8 May 2016, p 2.
- 95 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG 8 May 2016, p 2.
- 96 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG 8 May 2016, p 2.
- 97 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG 8 May 2016, p 4.
- 98 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG 8 May 2016, p 4.
- 99 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG 8 May 2016, pp 4–5.
- 100 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG 8 May 2016, p 5.
- 101 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG 8 May 2016, p 5.
- 102 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG 8 May 2016, p 5.
- 103 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG 8 May 2016, p 5.
- 104 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG 8 May 2016, p 6.
- 105 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG 8 May 2016, p 6.
- 106 Note to the ECRG Table: The Department of Health acknowledges the dedicated school and expertise provided by the Department of Education Training and Employment (DETE). The Department of Health values and supports partnership with DETE to ensure that adolescents have access to appropriate educational/vocational and vocational options to meet their educational/vocational needs.
- 107 The text of this note to the ECRG Table (footnote 3) emphasising that interim service provision through Tiers 1 and 2a/b is not clinically preferred or optimal and is associated with significant risks has already been set out.
- 108 Note to the ECRG Table: The provision of education at this level requires focused consideration; an on-site school and education program is proposed as a priority.
- 109 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, pp 9–10 para 10.7.

- 110 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 16 para 11.19; Transcript, Sharon Kelly, 22 February 2016, p 11-18 lines 29–30.
- 111 Exhibit 1513, Email from Kris Antal, Subject: "Agenda - Barrett Adolescent Planning Group Actions", 27 November 2012.
- 112 Exhibit 1534, West Moreton Hospital and Health Service – Barrett Adolescent Strategy Planning Group, Meeting Minutes, 21 November 2012.
- 113 Exhibit 122, Statement of Stephen Stathis, 5 November 2015, Attachment E to that statement, p 77.
- 114 Exhibit 1535, West Moreton Hospital and Health Service – Barrett Adolescent Strategy Planning Group, Meeting Minutes, 5 December 2012.
- 115 Exhibit 1536, West Moreton Hospital and Health Service – Barrett Adolescent Strategy Planning Group, Meeting Minutes, 12 December 2012.
- 116 Exhibit 1519, West Moreton Hospital and Health Service – Barrett Adolescent Strategy Planning Group, Meeting Minutes, 18 January 2013.
- 117 Exhibit 122, Statement of Stephen Stathis, 5 November 2015, Attachment E to that statement, p 85.
- 118 Exhibit 122, Statement of Stephen Stathis, 5 November 2015, Attachment E to that statement, p 87.
- 119 Exhibit 222, Barrett Adolescent Strategy Planning Group file notes, 14 May 2013.
- 120 Exhibit 1534, West Moreton Hospital and Health Service - Barrett Adolescent Strategy Planning Group, Meeting Minutes, 21 November 2012.
- 121 Exhibit 1535, West Moreton Hospital and Health Service - Barrett Adolescent Strategy Planning Group, Meeting Minutes, 5 December 2012.
- 122 Exhibit 1536, West Moreton Hospital and Health Service - Barrett Adolescent Strategy Planning Group, Meeting Minutes, 12 December 2012.
- 123 Exhibit 1519, West Moreton Hospital and Health Service - Barrett Adolescent Strategy Planning Group, Meeting Minutes, 18 January 2013.
- 124 Exhibit 122, Statement of Stephen Stathis, 5 November 2015, Attachment E to that statement, p 85.
- 125 Exhibit 122, Statement of Stephen Stathis, 5 November 2015, Attachment E to that statement, p 87.
- 126 Exhibit 1453, Email from Kris Antal to Planning Group members, Subject: "Urgent Teleconference – Barrett Adolescent Centre Planning Group", 7 May 2013; Exhibit 957, Email from Leanne Geppert to Expert Clinical Reference Group members, Subject: "Endorsed Preamble and Service Model Elements for Adolescent Extended Treatment and Rehabilitation Services", 8 May 2013.
- 127 Exhibit 1454, Email from Trevor Sadler to Planning Group, Subject: "Urgent Teleconference – Barrett Adolescent Centre Planning Group", 7 May 2013.
- 128 Exhibit 1456, Email from Leanne Geppert to Kris Antal, Subject: "Urgent Teleconference – Barrett Adolescent Centre Planning Group", 7 May 2013.
- 129 Exhibit 1453, Email from Stephen Stathis to Planning Group, Subject: "Re: Urgent Teleconference – Barrett Adolescent Centre Planning Group", 7 May 2013.
- 130 Exhibit 1457, Email from David Hartman to Planning Group, Subject: "Re: Urgent Teleconference – Barrett Adolescent Centre Planning Group", 7 May 2013; Exhibit 1458, Emails between David Hartman, Kris Antal and Sharon Kelly, Subject: "Urgent Teleconference – Barrett Adolescent Centre Planning", 8 May 2013.
- 131 Exhibit 1458, Emails between David Hartman, Kris Antal and Sharon Kelly, Subject: "Urgent Teleconference – Barrett Adolescent Centre Planning", 8 May 2013.
- 132 Exhibit 1460, Email from Sharon Kelly to Planning Group, Subject: "BAC consideration of recommendations for planning group meeting Wednesday 15 May", 13 May 2013.
- 133 Exhibit 1460, Email from Sharon Kelly to Planning Group, Subject: "BAC consideration of recommendations for planning group meeting Wednesday 15 May", 13 May 2013.
- 134 Transcript, Sharon Kelly, 22 February 2016, p 11-18 lines 43–45.
- 135 Transcript, Sharon Kelly, 22 February 2016, p 11-22 lines 32–34.
- 136 Exhibit 222, Barrett Adolescent Strategy Planning Group file notes, 14 May 2013.
- 137 Response to possible adverse finding – Sharon Kelly, 29 May 2016, p 5, Possible finding 3, para 4(d).
- 138 Response to possible adverse finding – Sharon Kelly, 29 May 2016, p 5, Possible finding 3, para 4(e).
- 139 Transcript, Sharon Kelly, 22 February 2016, p 11-19 lines 1–11.
- 140 Transcript, Sharon Kelly, 22 February 2016, p 11-21 lines 42–43.
- 141 Response to possible adverse finding – Sharon Kelly, 29 May 2016, p 4, Possible finding 3, para 4(c).
- 142 Response to possible adverse finding – Sharon Kelly, 29 May 2016, p 2, Possible finding 2.
- 143 Transcript, Sharon Kelly, 22 February 2016, p 11-22 lines 38–40.

- 144 Exhibit 179, Supplementary Statement of Trevor Sadler, 12 February 2016, p 31 para 133.
- 145 Transcript, Sharon Kelly, 22 February 2016, p 11-24 lines 40–41.
- 146 Exhibit 1443, Email from Leanne Geppert to Leslie Dwyer, Naomi Ford, and Sharon Kelly, Subject: "Final draft BAC Board Paper and 3 Attachments for Approval", 15 May 2013.
- 147 The ECRG's Tier 3 mapped to CSCF Level 6.
- 148 Exhibit 451, Emails between Trevor Sadler and William Kingswell, Subject: "Re: The efficacy of 'wraparound' services", 21 May 2013.
- 149 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 38 para 28.2(b).
- 150 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 17 para 11.24.
- 151 Transcript, Leanne Geppert, 19 February 2016, p 10-25 lines 13–17.
- 152 Transcript, Leanne Geppert, 19 February 2016, p 10-60 line 46 – p 10-61 line 4.
- 153 Exhibit 222, Barrett Adolescent Strategy Planning Group file notes, 14 May 2013, p 6.
- 154 Exhibit 222, Barrett Adolescent Strategy Planning Group file notes, 14 May 2013, p 14.
- 155 Transcript, Trevor Sadler, 9 March 2016, p 23-97 lines 16–19.
- 156 Exhibit 222, Barrett Adolescent Strategy Planning Group file notes, 14 May 2013, p 14.
- 157 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 38 para 28.2(c).
- 158 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 38 para 28.2(c).
- 159 Transcript, Sharon Kelly, 22 February 2016, p 11-27 line 42 – p 11-28 line 2.
- 160 Transcript, Sharon Kelly, 22 February 2016, p 11-76 line 45 – p 11-77 line 2; p 11-77 lines 19–22.
- 161 Exhibit 222, Barrett Adolescent Strategy Planning Group file notes, 14 May 2013, p 7.
- 162 Exhibit 222, Barrett Adolescent Strategy Planning Group file notes, 14 May 2013, p 8.
- 163 Exhibit 222, Barrett Adolescent Strategy Planning Group file notes, 14 May 2013, p 8.
- 164 Exhibit 222, Barrett Adolescent Strategy Planning Group file notes, 14 May 2013, p 8.
- 165 Exhibit 222, Barrett Adolescent Strategy Planning Group file notes, 14 May 2013, p 14.
- 166 Exhibit 222, Barrett Adolescent Strategy Planning Group file notes, 14 May 2013, p 9.
- 167 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 39 para 28.2(d).
- 168 Exhibit 222, Barrett Adolescent Strategy Planning Group file notes, 14 May 2013, p 10.
- 169 Exhibit 222, Barrett Adolescent Strategy Planning Group file notes, 14 May 2013, p 10.
- 170 Submissions on behalf of the State of Queensland, 23 March 2016, p 80 para 303.
- 171 Submissions on behalf of the State of Queensland, 23 March 2016, p 80 paras 301, 303.
- 172 Submissions on behalf of West Moreton HHS, 23 March 2016, p 23 para 7.16(b).
- 173 Submissions on behalf of Lawrence Springborg, 23 March 2016, p 54 para 6.21(a).
- 174 Submissions on behalf of William Kingswell, 23 March 2016, p 46 para 160, p 58 para 197.
- 175 Submissions on behalf of Lawrence Springborg, 23 March 2016, p 54 para 6.21(a).
- 176 Submissions on behalf of William Kingswell, 23 March 2016, p 46 para 160, p 58 para 197.
- 177 Submissions on behalf of William Kingswell, 23 March 2016, p 46 para 160, p 58 para 197.
- 178 Transcript, Paul Freeburn QC, Closing submissions of Counsel Assisting, 11 April 2016, pp 26-7 to 26-12.
- 179 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG, 8 May 2013, p 2.
- 180 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG, 8 May 2013, p 2.
- 181 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG, 8 May 2013, p 2.
- 182 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG 8 May 2016, p 3.
- 183 Exhibit 1540, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG 8 May 2013.
- 184 Exhibit 1540, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG, 8 May 2013, p 4.

- 185 Exhibit 1370, Clinical Services Capability Framework version 3.1, 29 September 2014.
- 186 Exhibit 1370, Clinical Services Capability Framework version 3.1, 29 September 2014.
- 187 Exhibit 740, Email from Leanne Geppert to Sharon Kelly, Subject: "progression of Barrett Adolescent Centre Expert reference group", 21 April 2013; Transcript, Leanne Geppert, 19 February 2016, p 10-18 lines 16–20.
- 188 Exhibit 958, Email from Leanne Geppert to Expert Clinical Reference Group members, Subject: "Endorsed Preamble and Service Model Elements for Adolescent Extended Treatment and Rehabilitation Services", 8 May 2013.
- 189 Transcript, Philip Hazell, 17 February 2016, p 8-33, lines 40–41.
- 190 Transcript, Philip Hazell, 17 February 2016, p 8-33 lines 43–46.
- 191 Transcript, Amelia Callaghan, 17 February 2016, p 8-59 lines 1–4.
- 192 Transcript, Amelia Callaghan, 17 February 2016, p 8-59 lines 4–6.
- 193 Transcript, Amelia Callaghan, 17 February 2016, p 8-59 lines 16–23.
- 194 Exhibit 735, Presentation by Stephen Stathis to the Mental Health, Alcohol and Other Drugs Branch Leadership Matters forum, April 2014.
- 195 Transcript, William Kingswell, 24 February 2016, p 13-23 lines 35–39.
- 196 Transcript, William Kingswell, 24 February 2016, p 13-23 line 45 – p 13-24 line 4.
- 197 Exhibit 119, Statement of Josie Sorban, 11 December 2015, Attachment E to that statement, ECRG meeting minutes, 27 March 2013, p 73.
- 198 Transcript, Elizabeth Wilson QC, 11 April 2016, p 26-64 lines 22–28.
- 199 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG 8 May 2013, p 3.
- 200 Transcript, Dominic O'Sullivan QC, 12 April 2016, p 27-59 lines 39–44.

11 West Moreton Board meeting on 24 May 2013

Introduction

The West Moreton Hospital and Health Board (the Board) met on 24 May 2013,¹ from 9.00 am to 5.45 pm. This meeting was not convened specifically to deal with the BAC.² (Nor were any other Board meetings convened specifically for that purpose.) However, Mary Corbett said that, at its previous meeting on 26 April 2013, the Board had instructed Sharon Kelly to ensure that the strategy for the future of the BAC was developed and brought back to the Board for approval.³ The minutes of the 26 April 2013 Board meeting confirm this.⁴

The Board members who were in attendance on 24 May 2013 were:

Mary Corbett (Chair)
Timothy Eltham (Deputy Chair)
Robert McGregor
Melinda Parcell
Alan Fry
Julie Cotter

Paul Casos sent an apology.

Lesley Dwyer, Chief Executive of West Moreton HHS, was in attendance as an ex officio standing invitee.

Sharon Kelly, Executive Director Mental Health and Specialised Services of West Moreton HHS, also joined the meeting to make a presentation to the Board about the BAC. Kelly was the Chair of the Planning Group.

Neither Dwyer nor Kelly was a member of the Board.

The Commission received written and oral evidence about this meeting from Corbett, Eltham, Dwyer and Kelly. Only two of the six Board members present at the meeting gave evidence. The Commission has accorded substantially more weight to the minutes of the meeting, and to other contemporaneous records, than it has to the recollections of Corbett and Eltham about what transpired. Eltham, for one, said that he did not have a "clear recollection" of the meeting.⁵

Eltham gave evidence about the nature of the meeting that day.⁶ The papers distributed to Board members the week before the meeting ran to about 441 pages plus 25 pages of financial reporting. The meeting lasted approximately eight hours and dealt with weighty matters, including the adoption of the strategic plan for the next four years. The BAC was considered in the afternoon session.

Eltham explained the Board's expertise. He said:

[W]ell, all of the Board were not mental health clinicians and only two of the Board members are medical clinicians. So we're not experts in the actual service provision around this particular group of clients.⁷

Understandably, the Board relied and acted upon the advice provided to it. The evidence suggests that it did not do so without question.

The agenda paper

The agenda paper⁸ entitled, 'Barrett Adolescent Strategy – Recommendations' (the agenda paper) shows Kelly as the 'author'.⁹

Although dated 15 May 2013, the agenda paper does not seem to have been finalised until about 16 or 17 May 2013.¹⁰ Dwyer approved it.¹¹ Concurrently with the initial preparation of the agenda paper, the Planning Group met by teleconference in the morning of 15 May 2013 to consider the ECRG report. (See chapter 10.)

Corbett and Eltham said that the agenda papers for Board meetings were received by members one week prior to a meeting.¹² Kelly's evidence was that this was usually the Friday before the Board meeting the following Friday.¹³ The relevant Friday was 17 May 2013. Attached to the agenda paper were:

Attachment 1: The ECRG Preamble, Key Messages and Recommendations

Attachment 2: The ECRG 'Proposed Service Model Elements' Table

Attachment 3: The Planning Group Recommendations

Attachment 4: Media Holding Statement.

Corbett and Eltham likely read both the agenda paper and the attachments at the time.¹⁴

Dwyer and Kelly "co-presented" the agenda paper at the Board meeting.¹⁵ Ahead of the meeting, Geppert prepared notes for Kelly to aid her presentation.¹⁶ These notes show Kelly's thinking about the issues presented to the Board, and help in understanding aspects of the agenda paper. They may not necessarily reflect what was actually said to the Board.

The two-page agenda paper proposed that the Board:

Note the attached recommendations of the Expert Clinical Reference Group (ECRG) (Attachments 1 and 2).

Approve recommendations from Barrett Adolescent Strategy Planning Group (Attachment 3).

Approve development of a communication and implementation plan, inclusive of finance strategy, to support the closure of Barrett Adolescent Centre (BAC) on 30 September 2013.

Approve media statement (Attachment 4).

Note the need for a verbal briefing (at the earliest convenience) between the Minister for Health, and the West Moreton Hospital and Health Board Chair and Chief Executive.

The agenda paper provided the following information by way of background:

5. The Park is designated to become an adult secure forensic facility within the Queensland Plan for Mental Health 2007-17. This process will progress to the next stage when the Extended Forensic Treatment and Rehabilitation Unit (EFTRU) opens on 28 July 2013. The provision of adolescent services within the future forensic environment is not considered appropriate or safe, and poses a potential risk to adolescent consumers.
6. The current BAC is an aged facility that has been designated not-fit-for-purpose in the provision of inpatient services into the future. The state-funded capital project to build a replacement facility for BAC in Redlands has ceased due to unresolvable building and environmental barriers, and none of this capital funding is available to build the facility elsewhere.

Kelly did not recall any "specific discussion" at the Board meeting about the co-location of the BAC and EFTRU and the redevelopment of The Park (paragraph 5). However, she said that it had been part of the background discussions around the meeting and had been presented to the Board on previous occasions.¹⁷ The presence of the EFTRU issue in the agenda paper shows that the Board was at least told of it.

Kelly could also not recall the source of the information that the Redlands project had had "unresolvable" issues.¹⁸ However, she said it was "well known".¹⁹

Under the heading 'Key Issues or Risks', the agenda paper articulates several propositions.

First, at paragraph 8, that the Planning Group had "accepted all recommendations of the ECRG, with some caveats for note". In fact, the Planning Group disagreed with the ECRG's strongly expressed views that a design-specific clinically staffed sub-acute bed-based 'Tier 3' facility was an essential service component.

Secondly, at paragraph 9, that the ECRG Report,²⁰ and the ECRG Table, "allows for the safe and timely closure of BAC". Kelly understood this to be accurate, "at the time and in my understanding of the information I had".²¹ In fact, rather than allowing for the "safe and timely" closure of the BAC, the ECRG warned against the closure of the BAC without a Tier 3 service being available in a timely manner. The ECRG said that a Tier 3 was an "essential service component" and that an interim period without a Tier 3 service was "associated with risk".

Thirdly and Fourthly, that:

10. Given 10 out of 16 young people from the current BAC inpatient group are aged 17 years or over, and that the length of stay is up to 2 years in several cases, it is considered clinically adequate to provide a four month timeframe to complete discharge planning and aim to close BAC 30 September 2013.
11. The closure of BAC is not dependent on the next stages of progressing and consulting on a statewide service model; instead, the closure process is relevant to the needs of the current and wait-list consumer group of BAC, and the capacity for 'wrap-around' care in their local community services. The Planning Group noted this was feasible to commence now.

Kelly told the Commission she could not recall the source of the statement that it was clinically adequate to provide a four month timeframe²² to transition the current BAC patients and aim to close the BAC by 30 September 2013. However, she implied that it was not the ECRG.²³ There is no document available to the Commission recording any advice to that effect. Concerning the

four month timeframe, Kelly's notes state at point 1, "four month lead in time will support the closure process". At point 7 her notes read:

4 mths identified as suitable timeframe because majority of current patients are 17 or over, and have had extended lengths of stay beyond 12 mths (which was indicated as admission timeframe by ECRG).

Kelly said that West Moreton HHS had responsibility only for the current and waitlist patients at the BAC. They could be appropriately cared for with "wraparound" services and hence the closure of the BAC, "was not reliant on a final, statewide service model" but was dependent on ensuring that "every adolescent that we had in our care at that particular point in time was provided with appropriate services moving forward".²⁴

The agenda paper implies that adolescents in need of Tier 3 care in the future were the State's concern and not West Moreton's. The closure of the BAC, the agenda paper effectively says, was "not dependent" on the status of an alternative statewide service. In contrast, the ECRG warned against closing the BAC without a Tier 3 service being operational shortly thereafter, and that if there were an interim period without a Tier 3 service, it would be associated with risk.

Kelly's notes propose at point 7 to "[b]ring in senior clinician to support transition and closure. Funds available for this". Kelly said that at that meeting, "there was certainly a plan to bring a senior clinician" in to "support the transition process".²⁵ Subsequently, Vanessa Clayworth, a senior nurse, was brought in to support the acting Clinical Director of the BAC, Anne Brennan.²⁶

Under the heading 'Consultation', the agenda paper states:

16. It is proposed that West Moreton HHS will develop a new communication and implementation plan with regard to the closure of BAC to ensure sensitive and comprehensive communication with consumers, families, staff, key stakeholders, and the community.

Similarly, Kelly's notes state at point 1, "[w]ill prepare comprehensive communication plan" and at point 5, "[c]omprehensive and sensitive communication plan for staff, consumers, sector stakeholders, community, etc".

West Moreton's communication with families, patients and staff of the BAC is examined in chapters 22 and 23.

Under the heading 'Financial and Other Implications', the agenda paper states:

17. It is not possible at this stage to detail financial implications. It is proposed that WMHHS convene a finance working group (as part of a broader implementation plan) to define the operational funds associated with the BAC, and to submit a plan to the Board for the transfer of these funds to the HHSs that will deliver the alternative service/s. The Mental Health Alcohol and Other Drugs Branch is recommended working group member.

18. Historically, intentions to close BAC have generated significant consumer, staff and community concern, and have attracted media attention. It is anticipated that this will be partially addressed through the recommendations of the ECRG and Planning Group, and the identification of alternative, local service delivery.

Kelly's notes state at point 2 that "MHAODB has committed funds from QPMH [Queensland Plan for Mental Health] to support closure project, and indicated commitment to resourcing a transition process (staffing and consumer movement)". Again at point 2, her notes propose the establishment of an "overarching committee within WM HHS to lead closure process – one of

the workgroups will be managing financial processes”, and at point 8, another workgroup to manage “Human Resource and IR [Industrial Relations] processes”.

Kelly’s notes at point 1 state that, concerning paragraph 18, the “current local MP supports BAC to remain open”. At point 1 her notes say that her plan to deal with the “community and political response” was to “reassure that services will not cease altogether if BAC closes – the needs of this consumer group will still be met, and importantly, will be met closer to their own homes and community”.

Under the heading ‘Strategic and Operational Alignment’, the agenda paper states:

19. Both the ECRG and the Planning Group have been mindful that the final endorsed model(s) of care:
 - a. need to clearly articulate a contemporary model(s) of care for extended treatment and rehabilitation for adolescents in Queensland; and
 - b. be evidenced based, sustainable and align with statewide mental health policy, service planning frameworks and funding models.
20. The closure of BAC and removal of adolescent services from The Park forensic site aligns with both the strategic direction of the HHS and the Queensland Plan for Mental Health 2007–17.

Paragraph 19 was a fair representation of issues considered by the ECRG and the Planning Group. However, paragraph 20 was inaccurate in that it did not also say that the QPMH provided for a replacement for the BAC on another site.

Attachment 4 to the agenda paper is a media holding statement.²⁷ It contains two alternative statements depending on the decision of the Board. The first is headed, “If no decision is made”. The second is headed, “If decision is made to close the BAC”.

The minutes

The minutes of the meeting of 24 May 2013²⁸ were reviewed at the next Board meeting on 28 June 2013 and confirmed as accurate. They are certified and signed by the Chair, Corbett.

The minutes state that the following occurred, in relation to Item 5.1, “Barrett Adolescent Centre”:

Sharon Kelly, Executive Director Mental Health and Specialised Services, joined the meeting. The Board discussed the recommendation from the Planning Group that proposes the closure of the Barrett Adolescent Centre (BAC) and the issues that this presents. The Board recognized that the Barrett facility is no longer suitable but is concerned that there is currently no alternative for consumers. The Board noted the recommendations of the Barrett Adolescent Strategy Planning Group, and the need to move as rapidly as possible to an alternative model based on those recommendations.

ACTION: Minister to be updated regarding proposed closure, plan for development of alternatives and community engagement strategy.

ACTION: Minister’s approval to be sought to not accept any further patients into BAC.

ACTION: WMHHS to engage with Children’s Health Services and the Mental Health Alcohol and Other Drugs Branch re planning for future model of care.

ACTION: WMHHS to pursue discharge of appropriate current patients with appropriate 'wrap around' services.

DECISION: The Board approved the development of a communication and implementation plan, inclusive of finance strategy, to support the proposed closure of BAC.

Sharon Kelly left the meeting.

That is all the minutes record about the BAC. Corbett said that the minutes of the Board's meeting on 24 May 2013, and Board minutes more generally, are "reflective of actions and decision rather than necessarily discussion".²⁹ They do not record who said what, detailed reasons for the actions and decision, or how those resolutions were reached.

Corbett says of her record-keeping as Chair of the Board meetings, including that on 24 May 2013:

I have no diary notes of the meeting. I destroy any notes I make during Board Meetings once the Minutes are approved. This is in accordance with recognised good governance practices and is to ensure that there is one single statement of decisions made by the Board.³⁰

Eltham kept his notes from the meeting.³¹

The following sections consider the four "action" items in the minutes.

ACTION: Minister to be updated regarding proposed closure, plan for development of alternatives and community engagement strategy.

Not only was the Minister for Health to be "updated", but Corbett says that his "approval" was to be sought "around the closure".³² Kelly's notes at point 3 state that the Minister "has been kept updated" and that he had a "strong interest". His "position" was that there be "value for money service provision that is closer to patient homes". Kelly's notes at point 5 also state that "sector stakeholders anticipated to support closure option and work in a positive way with WM HHS around closure and patient transitions".

When Corbett was asked to explain what was meant by "plan for development of alternatives", her answer was, "I would have imagined that in the course of this a number of opportunities were being pursued".³³ Corbett, like Eltham, either could not fully recall what those opportunities were or did not know then. Kelly's notes at point 4 say that the alternative service options were "[a]s suggested by ECRG". And "Consumers will still be able to access extended treatment and rehabilitation – but within a more contemporary service model. Includes WM consumers".

ACTION: Minister's approval to be sought to not accept any further patients into BAC.

Kelly's notes at point 7 state, "[s]hould immediately instigate a 'no new admissions' policy for BAC".

Corbett understood that the Minister later gave his approval although she did not recall "seeing anything in writing".³⁴ The Commission has not been able to locate any documentation from the Minister noting his approval to this specific item.

As discussed in chapter 12, the Minister gave his support to the closure at a meeting on 15 July 2013.

Counsel Assisting invited Corbett and Eltham to say where they envisaged young people with mental illness might have gone if they could no longer be cared for by the BAC. They both replied that this was a clinical matter on which they could not comment.³⁵ Nonetheless, Corbett said, “the Board’s concern was around, always, the safe care of the adolescents” and “it was always the Board’s concern that there were appropriate services available to patients”.³⁶

The Board did give some consideration to the question of the care for both the current and future patients of the BAC.³⁷ The minutes note that it was “concerned that there is currently no alternative for consumers”.

ACTION: WMHHS to engage with Children’s Health Services and the Mental Health Alcohol and Other Drugs Branch re planning for future model of care.

Under the heading ‘Consultation’, the agenda paper states at paragraph 15 that:

The next phase of statewide consultation and service planning for adolescent extended treatment and rehabilitation services is proposed to be collaboratively led by Children’s Health Services and the Mental Health Alcohol and Other Drugs Branch.

Corbett stated:

WMHHS was aware that CHQHHS, which was responsible for the governance of adolescent mental services on a State-wide basis, was leading a project to identify and develop new, contemporary models of care for adolescent mental health on a State-wide basis which would provide the care necessary for this cohort of patients.³⁸

Corbett said that, after this meeting, the Board’s focus was on the provision of “wrap around care” for the patients of the BAC, not the finalisation of a model for a new statewide service although “it was known that that was happening in a kind of parallel sense”.³⁹ She said, “West Moreton’s role in that was really to talk about service models and understand the services that were available”.⁴⁰ The West Moreton HHS executives “progressed” these discussions.⁴¹

The division of responsibility between West Moreton HHS and Children’s Health Queensland HHS is discussed in chapter 26.

The action item also placed the Board’s decision in a statewide context. Kelly’s notes state at point 1:

Regional and rural services need better access, particularly for medium and long stay treatment types targeted towards adolescents.

Other services within the CYMHS program spectrum are being expanded (Townsville and Toowoomba Acute Day Program, move to add more Day Programs across Qld, move to introduce NGO services).

ACTION: WMHHS to pursue discharge of appropriate current patients with appropriate ‘wrap around’ services.

The Board were told that this action was feasible and could commence immediately. When read together, the agenda paper and the Planning Group recommendations support and advance that view.

Corbett and Eltham were each asked to explain their understanding of the term “wrap around services”.

Corbett described “wrap around services” as a “package of care” comprised of services designed to meet, and which would vary according to, the individual needs of each patient.⁴² Kelly understood the term ‘wrap around’ in a similar way.⁴³

Similarly, Eltham said “wrap around” care is a “generic term” used to describe a “suite of services” or a “constellation of services ... or an aggregation of services which are tailored to the individual needs of the patient and also have been geared to ensure that the care they require will be available to them when and where they require it”.⁴⁴ Importantly, he said that “wrap around” also:

implies ... a level of service provision which was greater than would have been normally provided by community mental health services as outpatient treatment. It required ... quite a range of services being melded together into ... a very comprehensive package or suite of services for each individual client.⁴⁵

Kelly said the task of developing the “wrap around” for each patient was primarily the responsibility of “the clinical director and others in the clinical team” as it was a “clinical area”.⁴⁶ She said:

I would imagine that every good, sound clinician is experienced at designing appropriate wraparound services for complex care people. It is about knowing what’s out there and wrapping that service around them and identifying where there is a gap, and then we were able to troubleshoot, I suppose, those gaps.⁴⁷

After the meeting and leading up to the closure of the BAC, the Board received reports and assurances from Dwyer and Kelly that current patients were being transitioned to appropriate ‘wrap around’ services and discharged from the BAC. This is discussed in chapter 19.

DECISION: The Board approved the development of a communication and implementation plan, inclusive of finance strategy, to support the proposed closure of BAC.

The minutes do not record a decision by the Board to close the BAC. Rather, they record that the Board approved the development of a communication and implementation plan, inclusive of finance strategy “to support the proposed closure of BAC”.

This must be considered in the context of discussions between Queensland Health (in particular the MHAODB) and West Moreton HHS which had begun soon after the cancellation of the Redlands project and the re-allocation of the funding for it. The West Moreton Board could not unilaterally decide to close the BAC. Under the new organisational structure introduced by the *Hospital and Health Boards Act 2011* (Qld), closure of the BAC required a joint approach by Queensland Health and West Moreton.⁴⁸ As explained in chapter 12, amendment of the service agreement was necessary, which depended on agreement between Queensland Health as system manager and West Moreton HHS by its Board (or in the absence of agreement, a decision by the Minister).⁴⁹ Steps towards the proposed closure had already been taken, including the formulation of the Barrett Adolescent Strategy Plan, the creation of the broadly-based Planning Group, the establishment of the ECRG, the Planning Group’s receipt of the ECRG’s report, and the Planning Group’s recommendations to the West Moreton Board.

At its meeting on 24 May 2013 the West Moreton Board decided to take further steps to support the proposed closure.

An earlier decision?

Various parties advanced the contention that the decision to close the BAC had been made some time in 2008.

In 2008 Cabinet approved the QPMH and the companion budget document.⁵⁰ That is, Cabinet adopted the QPMH and in doing so decided in principle that the BAC should be closed and a replacement should be established on another site. The 'in principle' nature of Cabinet's decision meant that further decisions would have to be made to implement it – decisions about development of the replacement and decisions about the circumstances and timing of the closure of the BAC.

In approving the QPMH, Cabinet did not decide that the BAC should be closed regardless of the provision of a replacement. The closure of the BAC and the provision of a replacement were always linked (as recognised in the May 2012 Briefing Note, discussed in chapter 3, which expressly notes that ceasing the Redlands project would necessitate a review of the BAC).

Five years had passed since Cabinet had approved the QPMH. The planned replacement had been cancelled. Queensland Health and West Moreton were considering closing the BAC in 2013. That required a consideration of the nature and form of the replacement that was to be provided for the current patients and for those who might otherwise be expected to be its future patients.

The advice the Board received

As observed, the following documents were before the Board:

1. The complete ECRG report – that is, both (a) the ECRG Preamble, Key Messages and Recommendations, and (b) the ECRG 'Proposed Service Model Elements' Table;
2. The Planning Group's Recommendations – that is, the table showing ECRG Recommendations in the left column and Planning Group Recommendations in the right column; and
3. The agenda paper 'authored' by Kelly.

The minutes record that the Board:

- discussed the recommendation from the Planning Group that proposed the closure of the Barrett Adolescent Centre and the issues that it presented
- noted the recommendations of the Barrett Adolescent Strategy Planning Group, and the need to move as rapidly as possible to an alternative model based on those recommendations.

The minutes do not record why the Board preferred the recommendations of the Planning Group to those of the ECRG where they differed – or indeed, whether the Board even considered the ECRG report. Eltham said that was because the Board had "no reason not to accept those recommendations [of the Planning Group]".⁵¹ He was not concerned by them. Hence, there was no "need to go back to the ECRG recommendations in preference [of the Planning Group]".⁵²

The agenda paper did not engage with the ECRG's advice that a Tier 3 facility like the BAC was essential, and that there were risks associated with closing the BAC if an alternative Tier 3 facility was not available in a timely way.

Paragraph 9 of the agenda paper asserted that the ECRG's Table "allows for the safe and timely closure of the BAC". However, the ECRG report said nothing about whether the BAC should be closed. Rather, in its Preamble it recited its understanding that the BAC could not continue in its current form at The Park.

Paragraph 11 of the agenda paper asserted:

The closure of BAC is not dependent on the next stages of progressing and consulting on a statewide service model; instead, the closure process is relevant to the needs of the current and wait-list consumer group of BAC, and the capacity for 'wrap-around' care in their local community services. The Planning Group noted this was feasible to commence now.

The ECRG's recommendation about the nature of interim service provision for current and waitlist patients was made in the context of its warnings that interim service provision would be associated with risk and that a replacement Tier 3 service (that is, "a design-specific and clinically staffed bed-based service") was essential and should be provided in a timely manner.

Eltham recalled someone at the meeting asking whether the BAC could be closed without a replacement Tier 3 and either Kelly or Dwyer answering "yes".⁵³ He said that, in general, there was "some ambivalence about the certainty with which a Tier 3 program was required".⁵⁴

Corbett said that while there were risks associated with closing the BAC without a replacement Tier 3, there were also risks associated with the patients remaining at the BAC, and that the risks needed to be balanced. She said she was satisfied that the risks associated with the transition were able to be appropriately managed and mitigated.⁵⁵ The Commission has not found any written advice or risk assessment to that effect.

Eltham said that the risk referred to by the ECRG was not specified or quantified,⁵⁶ and he knew that no one investigated the level of that risk.⁵⁷

Kelly said:

The ECRG's statement that not providing a Tier 3 service carried a risk, was not, of itself, persuasive of anything. Providing services in a mental health environment is always associated with risk. The important issue is whether that risk can be managed.⁵⁸

The Planning Group's Recommendations document said the transition of the BAC patients to alternative services was "feasible" and could commence "now". It seems likely, then, that the Board did not undertake any assessment of the risks of closing the BAC in the absence of a replacement Tier 3.

The Board was not provided with the reasons why the Planning Group had placed caveats on some of the ECRG's recommendations. Corbett said she could not "speak to the analysis that was done by the Planning Group ahead of the report".⁵⁹ In hindsight, she and Eltham agreed that the Planning Group's recommendations were really "commentary" on the ECRG report, or could be interpreted in that way, although the Board had understood them at the time as "recommendations".⁶⁰

Finally, it is worth observing that Dwyer seems to have held a view contrary to the ECRG about the need for a Tier 3. The following exchange occurred during the hearings:⁶¹

- FREEBURN: Do you accept ... that the ECRG was saying that a tier 3 or a subacute bed-based option was an essential element?
- DWYER: I think the Expert Clinical Reference Group was very clear that in their expert opinion that they felt that that was required for a small number of adolescents from across the state.
- FREEBURN: And you accepted that?
- DWYER: I accepted that that was their opinion.
- FREEBURN: I take it from that answer you didn't agree?
- DWYER: As I said in the first part of my statement, I'm not a mental health clinician, and the reason that the Expert Clinical Reference Group, you know, was put into place was to be able to garner a range of expert opinions, but they were also asked to look at other states and other models. But their recommendation was that there was a Tier 3 service as part of a suite of services for an ongoing state-wide adolescent mental health service.

In other words, Dwyer acknowledged what the ECRG had recommended but she was not willing to accept it or agree to their recommendations.

Conclusions

The complete ECRG Report, as well as the Planning Group Recommendations, were placed before the Board.

The agenda paper advanced propositions which were inconsistent with the ECRG Report. In omitting key messages of the ECRG, it gave a distorted view of what the ECRG had said.

The West Moreton Board decided to take steps to support the proposed closure. In doing so, it accepted that the BAC should be closed.

The Commission cannot speculate on whether the outcome of the Board meeting would have been different if the agenda paper had been differently cast.

(Endnotes)

- 1 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-20 to that statement, West Moreton Hospital and Health Board Meeting Minutes of 24 May 2013, pp 169–176.
- 2 Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 26 para 17.17.
- 3 Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 15 para 11.2(a).
- 4 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-18 to that statement, West Moreton Hospital and Health Board Meeting Minutes of 26 April 2013, Item 2.3, p 140.
- 5 Exhibit 50, Statement of Timothy Eltham, 9 December 2015, p 32 para 24.1.
- 6 Transcript, Timothy Eltham, 18 February 2016, p 9-24 lines 3–12.
- 7 Transcript, Timothy Eltham, 18 February 2016, p 9-14 lines 14–17.
- 8 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-19 to that statement, West Moreton Hospital and Health Board Committee Agenda Paper for Meeting of 24 May 2013, dated 15 May 2013, pp 146–147.
- 9 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, pp 10–11 para 11.2(c); Transcript, Sharon Kelly, 22 February 2016, p 11-14 lines 22–23.

- 10 Exhibit 1446, Email from Kris Antal to Leanne Geppert and Sharon Kelly, Subject: "Urgent Review – Final Reformatted - Board Paper BAC", 16 May 2013.
- 11 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 16 para 10.3.
- 12 Transcript, Timothy Eltham, 18 February 2016, p 9-13 lines 8–10; Transcript, Mary Corbett, 18 February 2016, p 9-52 lines 11–12.
- 13 Transcript, Sharon Kelly, 22 February 2016, p 11-14 lines 18–20.
- 14 Transcript, Mary Corbett, 18 February 2016, p 9-59 line 15; Transcript, Timothy Eltham, 18 February 2016, p 9-6 line 11.
- 15 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 11 para 11.2(d); Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 14 para 8.4.
- 16 Exhibit 745, Email from Leanne Geppert to Sharon Kelly, Subject: "extra info for BAC and Board Mtg today", 24 May 2013; Exhibit 746, "Confidential – WM HH Board Meeting", 24 May 2013; Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 11 para 11.2(d), Attachment SK-13 to that statement, pp 884–885.
- 17 Transcript, Sharon Kelly, 22 February 2016, p 11-77 lines 8–17, 31–34.
- 18 Transcript, Sharon Kelly, 22 February 2016, p 11-14 line 25 – p 11-15 line 9.
- 19 Transcript, Sharon Kelly, 22 February 2016, p 11-14 lines 37–39.
- 20 Transcript, Sharon Kelly, 22 February 2016, p 11-15 line 16.
- 21 Transcript, Sharon Kelly, 22 February 2016, p 11-15 lines 11–14.
- 22 Transcript, Sharon Kelly, 22 February 2016, p 11-17 lines 5–7.
- 23 Transcript, Sharon Kelly, 22 February 2016, p 11-17 lines 9–11.
- 24 Transcript, Sharon Kelly, 22 February 2016, p 11-17 line 34 – p 11-18 line 3.
- 25 Transcript, closed hearing.
- 26 Transcript, closed hearing.
- 27 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-19 to that statement, West Moreton Hospital and Health Board Committee Agenda Paper for Meeting of 24 May 2013, pp 167–168.
- 28 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-20 to that statement, West Moreton Hospital and Health Board Meeting Minutes of 24 May 2013, pp 169–176.
- 29 Transcript, Mary Corbett, 18 February 2016, p 9-49 lines 27–28.
- 30 Exhibit 42, Supplementary statement of Mary Corbett, 21 December 2015, p 2 para 1.3(c).
- 31 Exhibit 50, Statement of Timothy Eltham, 9 December 2015, Attachment TCE-21 to that statement, 'Handwritten notes written by Timothy Eltham 24 May 2013', p 185.
- 32 Transcript, Mary Corbett, 18 February 2016, p 9-43 lines 23–26.
- 33 Transcript, Mary Corbett, 18 February 2016, p 9-47 lines 14–19.
- 34 Transcript, Mary Corbett, 18 February 2016, p 9-48 lines 1–3.
- 35 Transcript, Timothy Eltham, 18 February 2016, p 9-9 lines 4–11; Transcript, Mary Corbett, 18 February 2016, p 9-47 lines 34–45.
- 36 Transcript, Mary Corbett, 18 February 2016, p 9-47 lines 34–45.
- 37 Exhibit 50, Statement of Timothy Eltham, 9 December 2015, p 25 paras 21.1–21.2.
- 38 Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 33 para 22.1(d).
- 39 Transcript, Mary Corbett, 18 February 2016, p 9-60 lines 14–33; Transcript, Timothy Eltham, 18 February 2016, p 9-9 lines 21–36, p 9-20 line 31 – p 9-21 line 24.
- 40 Transcript, Mary Corbett, 18 February 2016, p 9-48 lines 9–13.
- 41 Transcript, Mary Corbett, 18 February 2016, p 9-48 lines 15–18.
- 42 Transcript, Mary Corbett, 18 February 2016, p 9-48 lines 27–30, p 9-51 lines 14–19, p 9-56 lines 38–43.
- 43 Transcript, Sharon Kelly, 22 February 2016, p 11-18 lines 5–9.
- 44 Transcript, Timothy Eltham, 18 February 2016, p 9-7 lines 15–35, p 9-9 lines 38–41.
- 45 Transcript, Timothy Eltham, 18 February 2016, p 9-7 lines 21–24.
- 46 Transcript, Sharon Kelly, 22 February 2016, p 11-18 lines 11–12; Transcript, Mary Corbett, 18 February 2016, p 9-48 lines 32–34, p 9-56 lines 41–43.
- 47 Transcript, Sharon Kelly, 22 February 2016, p 11-18 lines 19–23.
- 48 *Hospital and Health Boards Act 2011* (Qld) s 37.

- 49 *Hospital and Health Boards Act 2011* (Qld) s 38.
- 50 Confidential exhibit.
- 51 Transcript, Timothy Eltham, 18 February 2016 p 9-4 lines 36–39.
- 52 Transcript, Timothy Eltham, 18 February 2016, p 9-4 lines 36–39.
- 53 Transcript, Timothy Eltham, 18 February 2016, p 9-10 line 37 – p 9-11 line 2.
- 54 Transcript, Timothy Eltham, 18 February 2016, p 9-29 lines 33–37.
- 55 Exhibit 41, Statement of Mary Corbett, 23 October 2015, pp 33–34 para 22.2.
- 56 Transcript, Timothy Eltham, 18 February 2016, p 9-11 lines 14–15.
- 57 Transcript, Timothy Eltham, 18 February 2016, p 9-11 line 17.
- 58 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 38 para 28.2(c).
- 59 Transcript, Mary Corbett, 18 February 2016, p 9-45 lines 14–16.
- 60 Transcript, Timothy Eltham, 18 February 2016, p 9-4 lines 41–47; Transcript, Mary Corbett, 18 February 2016, p 9-45 lines 11–12.
- 61 Transcript, Lesley Dwyer, 23 February 2016, p 12-97 lines 28–42.

12 The decision to close the BAC

Authority to close the BAC

The main function of a Hospital and Health Service (HHS) is to deliver all of the hospital and other health services that are outlined in its service agreement.¹

The chief executive of the Department of Health (that is, the Director-General) is required to enter into a binding service agreement with the chief executive of each HHS, which is to be executed by the chair of the relevant Hospital and Health Board (Board).²

A service agreement must be for a term of not longer than three years.³ For a new service agreement, the chief executive and the HHS must enter into negotiations at least six months before the expiry of the existing service agreement.⁴ In the event the chief executive and the HHS are unable to agree upon the terms of an agreement, then the Minister has power to decide.⁵

In addition to listing the hospital and other services to be provided by the HHS, each service agreement will prescribe:

- the funding to be provided to the HHS for the provision of services, including the way in which the funding is to be provided
- performance measures for the provision of services by the HHS
- the performance and other data to be provided by the HHS.⁶

In the event either the chief executive or the HHS wishes to amend the terms of a service agreement (for example, to add or remove particular health services that are to be provided by the HHS), then the party wanting to amend the agreement must give written notice of the proposed amendment to the other party.⁷

Should the parties be unable to agree on a proposed amendment, then the Minister has power to decide.⁸ The Minister also has power to give a HHS a written direction about a matter relevant to the performance of its functions, if satisfied that doing so is necessary in the public interest.⁹

West Moreton HHS service agreement

On 28 June 2012, Director-General Tony O'Connell signed the first service agreement in respect of the West Moreton HHS (the 2012–13 service agreement).¹⁰ That agreement was expressed to operate for the period 1 July 2012 to 30 June 2013.¹¹

Schedule 2 to the 2012–13 service agreement contained a list of the services West Moreton HHS was required to provide, and for which it was to receive funding from the department.¹² The relevant provisions of Schedule 2 are as follows:

Facilities

The HHS is responsible for operating the following hospital facilities. ...

- Ipswich Hospital
- Gatton Hospital
- Laidley Health Service
- Boonah Health Service
- Esk Health Service
- The Park Centre for Mental Health

Clinical Services Provided

...

Statewide Services

The HHS has oversight responsibility for the following statewide services¹³ provided by the Park:

- Extended treatment and rehabilitation/dual diagnosis
- high security program
- adolescent unit services

(citation, emphasis added)

It is undisputed that the reference to “adolescent unit services”, beneath the heading ‘Statewide Services’, is a reference to the Barrett Adolescent Centre (BAC). It is the case, therefore, that from 1 July 2012 until 30 June 2013, West Moreton HHS had “oversight responsibility” for the services provided by the BAC at The Park, and received funding from the Department of Health for doing so.

The term “oversight responsibility” is not defined in the *Hospital and Health Boards Act 2011* (the Act) or in the 2012–13 service agreement. Counsel for West Moreton HHS and Board submitted that the term would reasonably be considered to include the exercise of governance over a service including risk management and performance assessment and, if appropriate, forming an opinion as to whether the service should continue to operate.¹⁴

Counsel Assisting made the submission, in closing, that the term should be interpreted by reference to the Act and the provisions of the service agreement, to mean a role in providing for and running the BAC service, which would include supervision and watchful care.¹⁵

These two definitions are not inconsistent. The Commission accepts and adopts a combination of both.

Consistent with the provisions of the Act summarised above, the 2012–13 service agreement allowed for the amendment of provisions during “amendment windows”,¹⁶ with this to occur by way of written notice of the proposed amendment being given to the other party.

The 2012–13 service agreement provided that negotiation of proposed amendments was to occur through a tiered process, commencing with a relationship management group¹⁷ and culminating, if unresolved, with the Health Minister.¹⁸ It is understandable that in respect of significant amendments (such as the cessation of a statewide service), decisions might be progressed up the tiers.

Importantly, at all levels beneath the Minister, it was necessary for there to be agreement between a representative of the Department of Health, and a representative of the West Moreton HHS or Board. That is, it was not possible for any amendment to be made unilaterally.

In order to fully understand the tiered structure it is helpful to reproduce below the diagram from the 2012–13 service agreement.

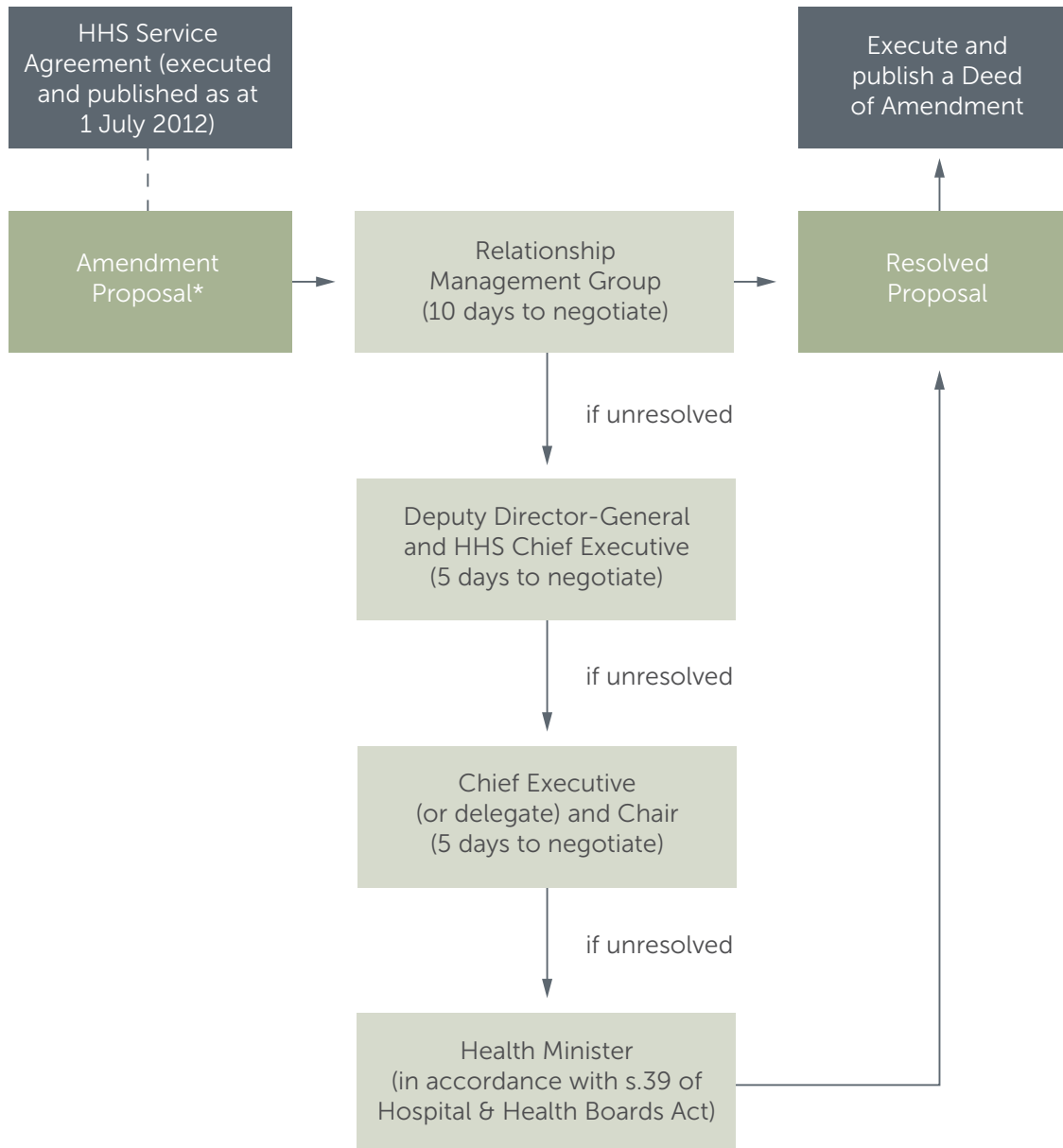


Figure 12A: Amendment Proposal Negotiation and Resolution¹⁹

Applying this structure, with respect to the BAC, agreement could be reached to remove a service from the 2012–13 service agreement:

- by agreement between a member of West Moreton HHS's Relationship Management Group²⁰ and a representative of the Department of Health; or
- by agreement between West Moreton HHS's Chief Executive (Lesley Dwyer) and the Deputy Director-General (Michael Cleary); or
- by agreement between the Chair of the West Moreton Board (Mary Corbett) and the Director-General (Tony O'Connell); or
- by the Health Minister (Lawrence Springborg).

Although no amendments were made (or formally sought) during the life of the 2012–13 service agreement, there is evidence that discussions about the removal of the BAC from the West Moreton HHS service agreement began in around early November 2012. The elevation of these discussions was broadly in line with the tiered structure provided for in the service agreement.

On 20 and 28 June 2013, the Department of Health and West Moreton HHS respectively entered into a new agreement to replace the 2012–13 service agreement upon its expiration.²¹ The new agreement (the 2013–16 service agreement) was to operate from 1 July 2013 until 30 June 2016.²²

Like the 2012–13 service agreement, the 2013–16 service agreement provided that the West Moreton HHS had responsibility for, among other services, operating The Park facilities. Importantly, it continued to provide that West Moreton HHS had oversight responsibility for the BAC, including reference to it beneath a general clinical services heading as "adolescent unit services", and beneath a new mental health services heading as the "Adolescent Extended Treatment and Rehabilitation Centre (state-wide)".²³

While there are some slight differences between the 2012–13 and 2013–16 service agreements, including extensions in the timeframe for amendment negotiations, these differences are not material for present purposes.

1 November 2012: Draft briefing note

On 1 November 2012, Cleary received an unsolicited draft briefing note from the Mental Health and Other Drugs Branch.²⁴ The briefing note was drafted as coming from Cleary's office (being the Health Service and Clinical Innovation Division team) and addressed to Director-General Tony O'Connell.

The briefing note requested that O'Connell approve the closure of the BAC, and provide the brief to the Minister for Health for noting. The note was marked as critically urgent on the basis that the West Moreton HHS Mental Health Service Executive Director (presumably, Sharon Kelly) would be "seeking approval from the West Moreton HHS Board to close the BAC in December 2012".²⁵

Presumably, it was the view of the Mental Health Alcohol and Other Drugs Branch (MHAODB), which had prepared the note, that the approval of the Director-General was a precondition of Kelly obtaining the approval of the West Moreton Board.

The draft briefing note was not progressed by Cleary.

Cleary returned the draft briefing note to Bill Kingswell, Executive Director of the MHAODB. He told the Commission that he did so because changing the service model for the BAC group of clients was a significant issue and would need to be led by the West Moreton HHS, which was responsible for the BAC service.²⁶ That is, it was not to be led by Cleary's team, which formed part of the Department of Health.

Presumably to reinforce this point, on 2 November 2012 Cleary typed an annotation on to the draft briefing note. That annotation read:

Dear Team

Can we please add a signature box for the CE [Chief Executive] Ipswich and West Morton [sic] HHS so that it is clear that the HHS is seeking this approval.

I would also suggest that we clarify if the Board of the HHS has considered and approved this.

We should also add a section in that indicated that subject to approval being provided that a project and communication plan will be developed and provided to the DG.

Kind regards

Michael Cleary

Friday, 2 November 2012²⁷

Following the non-progression of the 1 November 2012 briefing note, there is evidence that representatives of West Moreton HHS commenced discussions internally with the West Moreton Board and then, as required by the 2012–13 service agreement, externally, with representatives of the Department of Health.

West Moreton lays groundwork for closure

6 May 2013: Meeting with the Deputy Director-General

On 6 May 2013 there was a meeting between Dwyer of West Moreton HHS, and Cleary. The topic of the meeting was the proposed closure of the BAC.

Also in attendance at this meeting were Kelly from West Moreton HHS, Peter Steer (Chief Executive, Children's Health Queensland HHS (CHQ)), and two Department of Health representatives, Kingswell and Leanne Geppert (Director Planning and Partnerships, MHAODB).

Cleary's evidence in respect of the meeting was as follows:

I recall that the meeting was to discuss the pathway for obtaining Ministerial consideration of a proposal from the WMHHS Board for a new model of care for adolescents with serious mental health issues in Queensland and, as part of this, **the proposed discontinuation of services provided through the BAC.**²⁸

(emphasis added)

There is no evidence before the Commission that Cleary was asked to, or in fact did, agree on behalf of the Department of Health to the proposal by West Moreton HHS to close the BAC, at this meeting.

24 May 2013: Meeting of the West Moreton Board

On 24 May 2013, there was a meeting of the West Moreton Board. This meeting is analysed in detail in chapter 11 of this report.

For present purposes, it is relevant to note that Kelly presented a board committee agenda paper entitled the 'Barrett Adolescent Strategy – Recommendations' recommending the West Moreton Board support the closure of the BAC, and suggesting 30 September 2013 as the closure date. However, the Board did not endorse the proposed closure date.²⁹

The minutes of the meeting, authorised by Corbett as Chair on 28 June 2013, make it clear that closure of the BAC would only be actioned with some level of input and/or approval from the Health Minister. Specifically, they record, as action items, that the "Minister [is] to be updated regarding proposed closure, plan for development of alternative services and community engagement strategy" and "Minister's approval to be sought to not accept any further patients into BAC".³⁰

17 June 2013: Meeting with the Director-General

Following the meeting with the Deputy Director-General on 6 May 2013, West Moreton HHS elevated discussions about BAC's closure, scheduling a meeting with O'Connell on 17 June 2013.

The meeting with O'Connell was attended by Dwyer, Kelly, Geppert and Cleary.

Strictly followed, the amendment negotiation structure in the service agreement required that Corbett, as Chair of the West Moreton Board, negotiate directly with O'Connell as Director-General. However, clearly Dwyer and Kelly were meeting with O'Connell with Corbett's support, having obtained the Board's approval to elevate the proposed closure, at the Board meeting on 24 May 2013.

The Commission has been provided with no minutes or other notes documenting the meeting of 17 June 2013. O'Connell made no reference to the meeting in his written statement.

Some insight into the purpose of the meeting can be gained from the following email, which Kelly sent to Cleary on 14 June 2013, forwarding the calendar invitation for the meeting:

As discussed this will be the opportunity to advise the Director General regarding the board considerations around Barrett.

Regards
Sharon³¹

Cleary recalls that, at this meeting, Kelly and Dwyer briefed O'Connell on the proposed new model of care for adolescents and, as part of that, the proposed discontinuation of the services through the BAC. Cleary described the purpose of the meeting as being "to seek support from the Director-General for a meeting with the Minister".³²

In her written statement, Geppert described the meeting on 17 June 2013 as "a verbal briefing provided by Lesley Dwyer" to O'Connell. Geppert's evidence was that she did not make any direct contribution.³³ Dwyer's evidence was that O'Connell and Cleary "confirmed in principle support for the closure of BAC and development of a new model of service".³⁴

The Commission has found no evidence that O'Connell was asked to agree, or did agree, to the closure of the BAC at the meeting on 17 June 2013. Corbett was not present at the meeting.

Instead, as will be seen below, it appears that he left the matter open for further consideration at a meeting with the Health Minister (which Corbett did attend).

28 June 2013: Meeting of the West Moreton Board

On 28 June 2013, there was a meeting of the West Moreton Board. With respect to the future of the BAC, the minutes of the meeting, signed by Corbett as Chair on 26 July 2013, state merely that the Board "Noted the contents of the Agenda Paper".

The agenda paper, which had been prepared by Kelly, stated relevantly, as follows:

Key Issues or Risks

2. WMHHS to engage with Children's Health services and the Mental Health Alcohol and Other Drugs Branch re planning for future model of care for adolescent services.
 - a. A meeting was held Tuesday June 11th between Lesley Dwyer, Chief Executive WMHHS, Dr Peter Steer, Chief Executive Children's Health Services, Leanne Geppert, Acting Director of Strategy MH&SS and Sharon Kelly ED MH&SS WMHHS to agree the following:
 - i. In principle agreement reached that Children's HHS will partner with The Mental Health Branch to progress a statewide service model.
 - ii. Agreement that the timeliness of the development and implementation of a statewide service model is a priority for WMHHS as the decision to cease providing services at the Barrett Adolescent Service is contingent on a viable service model being available.
 - b. A meeting was held Monday June 17th with the Director General (Dr O'Connell), DDG Health Services and Clinical Innovation (Dr Cleary), Lesley Dwyer, Sharon Kelly and Leanne Geppert.
 - i. In principle support of the plan for closure of Barrett Adolescent Service with an understanding the new model of service is identified and developed.
 - ii. Agreement of HSCI [Health Service and Clinical Innovation, Department of Health] support for the shared model planning process.
3. WMHHS to pursue discharge of appropriate current patients from Barrett Adolescent Centre with appropriate 'wrap around' services.
 - a. As identified at The Board, until a decision is confirmed in regards to the plans for Barrett Adolescent Centre clinical services will continue to be provided and consumers discharged as appropriate. Any targeted discharge planning for current consumers that is related to closure of the service will raise concerns within the consumers, staff and families and potential wider community prior to a clear decision and communication strategy being in place and available.
4. Minister to be updated regarding proposed closure of Barrett Adolescent Centre, plan for development of alternatives and community engagement strategy as well as decision not to accept any further patients into BAC
 - a. Meeting planned for Monday July 15th between Minister, Board Chair West Moreton HHS and Chief Executive West Moreton HHS.
 - b. Communication plan and strategy in draft development at current time.

- c. Decision to not accept patients into BAC can only be advised to staff once decision to close the service and move to alternate model is known.

...

Recommendation

That the West Moreton Hospital and Health Board:

Note actions attend within month of June to align with Board decision in principle to close Barrett Adolescent Service. [sic]

Note the verbal briefing between the Minister for Health, and the West Moreton Hospital and Health Board Chair and Chief Executive is diarised for Monday 15 July.³⁵

(emphasis added)

8 July 2013: Briefs to Director-General and Minister

Discussions about the closure of the BAC continued following the commencement of the 2013–16 service agreement, and were elevated further to the Health Minister.

On 8 July 2013, Dwyer sent a briefing note to O’Connell with the subject heading ‘Barrett Adolescent Strategy Meeting’. The briefing note had been drafted by Geppert, cleared by Kelly and its content verified by Dwyer.³⁶

The briefing note to the Director-General requested that O’Connell note a meeting scheduled with the Health Minister on 15 July 2013,³⁷ and provide the brief to the Minister “for information”.

The headline issues included that the West Moreton Board had approved the closure of the BAC, “dependent on alternative, appropriate care provisions for the adolescent target group **and the meeting with the Minister for Health**”³⁸ (emphasis added). The briefing note gave details of alternative services being planned, stating:

The Department of Health is urgently progressing planning for Youth Prevention and Recovery Care (Y-PARC) services to be established in Queensland by January 2014. This service type would provide an alternative care option for the adolescent target group currently accessing BAC.

Attached to the briefing note to the Director-General were two documents:

- a West Moreton HHS ‘Issues and Incident Management Plan’
- the ECRG report, dated 8 May 2013³⁹ (which Springborg informed the Commission he did not read).⁴⁰

The Issues and Incident Management Plan stated, under the heading ‘Key Messages’:

- Adolescents requiring longer term mental health treatment will continue to receive the high quality of care suited to their individual needs.
- BAC will close at the end of December 2013, when alternative service options will become available.
- The Park is [a] secure and forensic mental health facility. As part of The Park, this means BAC is not an appropriate environment for the treatment of adolescents.

The accompanying briefing note to Minister Springborg requested, in part, that he note the meeting on 15 July 2013, and note also that the West Moreton Board “had approved the closure

of the BAC dependent on alternative, appropriate care provisions [sic] for the adolescent target group and the meeting with the Minister for Health”.

On the morning of the proposed meeting, that is, on 15 July 2013, the Director-General’s office sent an email to the Health Minister’s office referring to the meeting and attaching an (unsigned) electronic copy of the briefing note to the Director-General (with its various attachments) as well as the brief to the Health Minister.⁴¹ The email stated that a hard copy of the briefing note was “progressing through” to the Minister’s office.⁴²

O’Connell signed the briefing note addressed to him on 15 July 2013. It is unclear whether this was before, or after the meeting.

The briefing note to the Minister was signed by the Minister’s Chief of Staff, Mark Wood,⁴³ on 31 July 2013.⁴⁴

12 July 2013: Preparation of ‘talking points’ for discussion with Minister

On 12 July 2013, Kelly prepared for Dwyer, a document entitled ‘Talking Points for Discussion with the Health Minister’, in preparation for a meeting with the Minister for Health on 15 July 2013. That document included the following points:

- West Moreton HHB considered 7 recommendations of the Expert Clinical Reference Group on 24 May 2013.
- Board approval to close BAC is dependent on alternative, appropriate service provisions for the adolescent target group.
- There has been no public announcement about the future of BAC to date.
- Any announcement is dependent on your support.
- The Department of Health is progressing planning for Youth Prevention and Recovery Care (Y-PARC) services to be established in Queensland by January 2014. (This has already been announced to the sector through another process.)
- This service would provide one alternative care option for the adolescent target group currently accessing BAC.
- Agreement has been reached that the strategy will be finalised through a partnership between West Moreton HHS, Children’s Health Queensland and the Department of Health.
- It is proposed that BAC will close in December 2013 in alignment with the opening of the Y PARC.⁴⁵

(emphasis added)

15 July 2013: Meeting of West Moreton and the Minister

At 4.00 pm on 15 July 2013, the foreshadowed meeting was held between the Minister for Health, Springborg, Corbett (Chair of the West Moreton Board), and Dwyer and Kelly from West Moreton HHS.⁴⁶ O’Connell did not attend.

The Commission is satisfied that one of Springborg’s ministerial staff probably Neil Hamilton-Smith, his then Principal Policy Adviser, accompanied him to the meeting. It was usual practice for ministerial staff to make notes of meetings on office iPads.⁴⁷ As observed in chapter

9, ministerial iPads were returned to the Ministerial Services Branch upon the change of government in 2015, and no iPad notes were able to be located.

No one from West Moreton made any note of the discussions at the meeting, or the agreement reached.

Counsel for West Moreton HHS and the West Moreton Board said there was no evidence of any expectation that a note or other record would be made of the meeting. They submitted that there was no evidence that a note was required, and that no witness was asked whether a note or other record should or would usually have been made in respect of such a meeting.

The Commission considers that, given the significance of the topic being discussed, the production of some record would have been prudent. Records promote accountability and transparency. They document what, where and when a decision was made, and the reasons for it. They record who was involved in a decision and under what authority, and provide evidence of government and individual activity. Records play an important role in retaining corporate memory and enable the review and understanding of processes and decisions. A record of the meeting of 15 July 2013 would certainly have been of assistance to the Commission, and presumably also of assistance to witnesses who were asked to give evidence in respect of the meeting.

Notwithstanding this, the Commission does not find that any particular adverse outcome flowed from the absence of a record of the meeting.

In her initial and supplementary written statements, Corbett's evidence was merely that at the meeting on 15 July 2013, the Health Minister "was supportive of the closure of BAC with a proposed date of 31 December 2013".⁴⁸

She said the Minister was advised (presumably by her) that the Board supported the closure of the BAC, dependent on alternative, appropriate care provisions for the adolescents.⁴⁹ In her second supplementary statement, Corbett recalled that the Minister requested, among other things, that a communications plan be developed and that the Mental Health Commissioner and the Leader of the Opposition be advised.⁵⁰ Corbett did not state specifically what this advice was to be. She did not recall any specific discussion about the alternative services, and she had no recollection of there being any discussion regarding a Y-PARC.⁵¹

Dwyer's evidence was initially equally lacking in detail: she said she was present at the meeting on 15 July 2013, and the Minister expressed and confirmed support for the closure of BAC.⁵² In her supplementary statement, Dwyer described the meeting as "fairly brief" (approximately 20 minutes) and said that the Minister was "clear in his support for closing BAC".⁵³ She said that Springborg did not ask a lot of questions, but she recalled advising him that West Moreton HHS would keep the BAC open until alternative services were identified for the BAC patients.⁵⁴ She recalled him asking why they were not building a fence around the Extended Forensic Treatment Rehabilitation Unit (EFTRU).

According to Dwyer, there was no discussion about services for particular adolescents. Instead, there was a general discussion about development of a range of alternative services for adolescents with extended mental health treatment needs.⁵⁵ Dwyer does not recall any discussion regarding the opening of a Y-PARC, although closing the BAC in December 2013, as was then planned, would have aligned with the projected commencement date for the Y-PARC.⁵⁶

Kelly's evidence was that the decision to close the BAC was made by the Health Minister, but she was not aware of the date of that decision.⁵⁷

Springborg's evidence in respect of the matters discussed at the meeting on 15 July 2013 was in fairly general terms. When asked to comment on a diary appointment for the meeting,⁵⁸ he responded that he would "expect that this was one of the meetings [he] had with Dr Corbett and Ms Dwyer".⁵⁹ He gave further evidence that he "had a number of meetings, both formally and informally" with Corbett and Dwyer, during which the BAC was discussed.⁶⁰

In response to a further notice issued by the Commission, Springborg gave the following further evidence in respect of the 15 July 2013 meeting:

I have some recollection of this meeting. During this meeting, I discussed with Dr Corbett and Ms Dwyer the closure of the Barret Adolescent Centre (BAC). To the best of my recollection, I believe that we discussed that the West Moreton Board had received the ECRG report, and that the West Moreton Board agreed with the closure of the BAC. I believe I conveyed to Dr Corbett and Ms Dwyer my view that if BAC was to be closed, then adequate replacement services had to be in place from that time onward. I believe that Dr Corbett and Ms Dwyer agreed with that view. I believe I was told that West Moreton HHS was working on a plan to appropriately transition all BAC patients to alternative care.⁶¹

Springborg did not specifically recall being told at the meeting on 15 July 2013 that it was proposed to close the BAC in December 2013, or that the BAC's closure would be aligned with the opening of a Y-PARC.⁶²

On 17 July 2013, Kelly cleared a briefing note to Lesley van Schoubroeck (Mental Health Commissioner), which was verified by Dwyer on 18 July 2013. That briefing note contained the following reference to the meeting of 15 July 2013:

Consultation was most recently conducted with the Minister for Health on 15 July 2013, with his support to proceed following communication with the Director-General, Department of Education, Training and Employment and the Queensland Mental Health Commissioner.⁶³

Finally, around the time of the meeting on 15 July 2013, Kelly prepared 'Estimates Brief 17.03' dated 15 July 2013, which stated: "The Minister has supported the decision to close BAC by [the] end of December 2013 following some key stakeholder communication".⁶⁴

Counsel for Springborg submitted that the Commission should find that, based on the briefing he received, the Minister supported the decision to close the BAC, and communicated that to Corbett and Dwyer at the meeting on 15 July 2013.⁶⁵ They submitted further that the Commission ought also find that the Minister made it clear that if the BAC was to be closed, adequate replacement services should be provided.⁶⁶

23 July 2013: Meeting of West Moreton HHS, CHQ, Department of Health

On 23 July 2013, there was a meeting between representatives of West Moreton HHS and CHQ, as well as with Kingswell on behalf of MHAODB, Queensland Health. It was chaired by Dwyer.

There is no mention in the minutes of that meeting of who made the decision to close the BAC by December 2013, or when. The minutes record the following in respect of the BAC:

2.0 Matters for Decision/Discussion

2.1 Update on Barrett Adolescent Strategy (LD [Lesley Dwyer] & SK [Sharon Kelly])

- Key stakeholders engaged in communication process and supportive, including Department of Education and Training & Employment (DETE).
- No public announcements to-date regarding future of Barrett Adolescent Centre (BAC).
- Planning to close BAC 31/12/13.
- WM HHS will ensure ongoing service provision for BAC consumer group as needed until an alternative service is identified to meet individual need.

...

2.2 Update on Department of Health (DoH) Service Planning – Youth Prevention and Recovery Care Model (BK [Bill Kingswell])

- DG approval to dedicate \$2M recurrent from the ceased Redlands build towards a YPARC service as a pilot site (new to Qld) ...
- BK has confidence in procurement timeline to open YPARC service by January 2014 ...

Recommendations:

- Invite CHQ HHS and WM HHS to meeting with Metro Sth HHS and DoH. Include Chief Executives.
- In addition to YPARC, Youth Residential Rehab Service identified as important component of service continuum if BAC closes. A portion of existing BAC operational funds could be utilised to fund this service type.
- Statewide service provision an essential factor for consideration.

2.3. Next Steps (all)

- Communication and media plan high priority
- Discussion regarding ongoing referrals to BAC, and risks associated with transition from current BAC clinical model to new YPARC clinical model in Dec/Jan.

Recommendations:

- Joint communication plan is essential between key stakeholders attending today – consistent clear messages, and clear governance over Strategy.
- Barrett Adolescent Strategy will now move into the Implementation Phase.
- CHQ HHS will lead the implementation phase ...⁶⁷

Kingswell made an iPad note of the meeting on 23 July 2013. That note recorded the following:

Meeting re-BAC 23 July 2013
Peter Steer
Lesley Dwyer
et al

Brief to minister

BAC closure dependent on replacement services Ed Qld has endorsed the school closure[.]
Not in public space yet[.] No date for closure unit aiming at Dec 31[.]

Discussed possibility of establishing Y-PARC model using existing Logan space.

CHQ to oversight [sic] the establishment of an implementation group to commence work by early next week.

Follow up meeting with Peter Steer, Lesley Dwyer and Richard Ashby within the month.⁶⁸

Further discussion in respect of Kingswell's iPad note is contained in chapter 26.

26 July 2013: Meeting of West Moreton Board

There was further discussion of the future of the BAC at the meeting of the West Moreton Board on 26 July 2013. The meeting agenda paper relating to the BAC is worth setting out at length:

Key Issues or Risks

2. Minister to be updated regarding proposed closure of BAC, plan for development of alternatives and community engagement strategy as well as decision not to accept any further patients into BAC.
 - a. Meeting held with Minister Monday 15 July 2013.
 - b. Minister supportive of briefing and closure on the proposed date of 31 December 2013. (emphasis added)
 - c. Minister requested the following actions occur prior to announcement of closure
 - i. Communication plan and frequently asked questions to be confirmed with his communications office.
 - WMHHS Communications Naomi Ford to action by Tuesday 23 July.
 - ii. Communication with QMH Commissioner to occur.
 - Verbal briefing with Commissioner occurred early July; formal brief regarding decision provided to Commissioner Thursday 18 July.

Leader of Opposition be advised of decision.

 - Progression occurring through WMHHS Communications.
 - iii. Department of Education – Director General be briefed prior to announcement ...
3. Development of alternate service options
 - a. A formal announcement was made by the Department of Health this week for the progression of a YPARC service through NGO tender process; to be established by January 2014. YPARC will provide one option of alternative care for adolescents in the target group.

...
4. Timing of announcement
 - a. A detailed plan regarding the timing of the announcement is required to ensure staff and consumers are advised prior to a broader public announcement. This planning is underway.

- b. Due to the recent announcement of the YPARC tender by the Department of Health, a new wave of growing concern is occurring across the sector regarding the future of BAC.

...

Recommendation

That the West Moreton Hospital and Health Board:

Note actions within the month of July that support the in-principle decision of the Board to close the Barrett Adolescent Centre (BAC). (emphasis added)

Note the closure date of BAC has been advised to the Minister for Health as 31 December 2013.⁶⁹

The meeting minutes record less detail. Beneath the heading 'Matters For Noting', the minutes, signed by Corbett on 23 August 2013, state as follows:

5.2 Chief Executive Report (Agenda Item 5.1)

...

CE and Chair also provided an update on their meeting with the Minister to discuss the South West Growth Corridor Planning Study and the proposed closure of Barrett Adolescent Centre.

The Board noted that all references to the closure of the Barrett Adolescent Centre in the agenda paper for Agenda Item 7.2 (Barrett Adolescent Centre Update) must be read as referring to the proposed closure of Barrett Adolescent Centre in light of the fact that no firm decision to close the facility has been made until alternative options for providing improved models of care have been identified.

...

7.2 Barrett Adolescent Centre Update

The Board noted the contents of the agenda paper, noting the point made with respect to this paper at Agenda Item 5.2.

6 August 2013: Closure announcement by the Minister

On 6 August 2013, the Health Minister, Springborg publicly announced the closure of the BAC in an interview on Brisbane radio station ABC 612.⁷⁰ A detailed discussion of the announcement is contained in chapter 16 of this report.

The Commission accepts the submission of Counsel for O'Connell that the manner in which the Health Minister made the announcement is indicative of the fact that he considered himself to have been actively involved in the decision.⁷¹

During the interview, Springborg stated relevantly as follows:

Some time by early 2014 that centre will be closing as we actually come up with a range of new options to actually deliver those services to people closer to their own home ... in their own home town.

...

[W]e expect to have the [new service] options available to people in early 2014 and the transition will start sometime in the early part of 2014 as we build up services in other areas around the State.⁷²

Counsel for West Moreton HHS and Board submitted that the Minister's promise of new service options being available by early 2014 was consistent with the advice being provided to West Moreton HHS by Kingswell about a Y-PARC being online by December 2013/January 2014.⁷³ This is true in so far as a Y-PARC could have been *one of* the "range of new options" being promised by Springborg.

Amendment of service agreements

On 21 January 2014 and 30 January 2014 respectively, Cleary (then Director-General, Department of Health) and Susan Johnson (Chair of CHQ's Board), signed a Deed of Amendment in respect of CHQ's 2013/14 – 2015/16 service agreement.⁷⁴

Beneath the heading 'Hosted Services', the Deed of Amendment stated that CHQ would continue to host and deliver the "Statewide Adolescent Extended Treatment and Rehabilitation (AETR) Implementation Strategy" steering committee.⁷⁵ This strategy is discussed in detail in chapter 27, but for present purposes it is relevant to note that the steering committee was responsible for devising new mental health services for the adolescent category (such as those who previously may have accessed the BAC).

On 6 and 29 August 2014 respectively, Ian Maynard (the then Director-General) and Corbett, signed a Deed of Amendment in respect of West Moreton HHS's service agreement.⁷⁶

The Deed of Amendment contained all of the amendments agreed to by the parties through an amendment window that had commenced on 16 May 2014.⁷⁷ This included the removal of the BAC ("Adolescent Extended Treatment and Rehabilitation Centre (state-wide)") from the list of mental health services over which West Moreton HHS was to have oversight responsibility.⁷⁸ Although a reference to "adolescent unit services" remained beneath The Park's general clinical services heading,⁷⁹ it appears this was in error. It is not in dispute that it was intended the BAC be removed from the service agreement.⁸⁰

Who made the decision to close the BAC, and when?

A number of witnesses and their legal representatives advanced the proposition that the decision to close the BAC was made in 2008, at the time of the decision to relocate the BAC service to the Redlands.⁸¹

For example, Counsel for West Moreton HHS and Board submitted that neither of their clients had the legal authority to "decide", nor was either asked to decide, to close BAC. They submitted that the decision was made in around 2007/08.⁸² Corbett's evidence was that the decision to close the BAC had been made before the Board was formally established in 2012.⁸³ Counsel for Springborg submitted that the decision to close the BAC was made in about 2008, followed by another decision, in May 2012, not to proceed with the Redlands project.⁸⁴

The Commission does not accept this proposition. The 2008 "decision" to close the BAC on the campus of The Park was one aspect of a plan to build a replacement for the BAC at the Redlands site. The Cabinet approved budget decision in respect of The Queensland Plan for Mental Health 2007–2017 speaks of developing a new 15-bed adolescent extended care unit following the closure of the BAC at The Park. It does so under the heading of \$121

million for 276 new upgraded or redeveloped acute and extended treatment beds that meet contemporary standards. It is clear that the intention was for old (the BAC) to be replaced with new (the Redlands).

The plan was to relocate the BAC, not to cease to provide an adolescent extended care unit entirely.

That said, the Commission is satisfied that from about 2008, there was a certain inevitability about the closure of the BAC building and, in particular, the cessation of the BAC at The Park.

On the question of who made the closure decision and when, Counsel for the State of Queensland submitted that there was no one entity responsible for the decision. Instead, they submitted, there was a "continuum of decisions by a number of entities, with each decision along the continuum affirming in principle the direction that the matter was heading, being towards the ultimate closure of the BAC".⁸⁵

As Counsel Assisting submitted, it was apparently not in contest that all of the relevant persons agreed with the decision to close the BAC in various ways.⁸⁶ Certainly, all had some input into the decision to close the BAC. However, the Commission does not accept that this means no one was ultimately responsible for the decision.

Counsel for West Moreton HHS and Board submitted that without the approval of the Department and the Minister's endorsement of that approval, BAC could not and would not have been closed.⁸⁷ That is not strictly so.

As Counsel for O'Connell submitted, a decision to close the BAC could have been made by a number of officers of West Moreton HHS and Queensland Health as permitted by the terms of the service agreement. Their submission, which the Commission accepts, is that a decision could have been made by West Moreton Board with the assent of the Director-General, if the question were not resolved at lower levels.⁸⁸

However, it is not in dispute that the matter was elevated beyond the Director-General, to the Health Minister.

Counsel for Springborg submitted that the Minister's consent was not required to amend a service agreement (to remove a service),⁸⁹ and there was no role for the Minister in the process unless he felt the need to issue a directive which, they submitted, would have been an "extraordinary act".⁹⁰

That may be true. However, the Health Minister had made it known that he expected to be consulted about a decision such as the closure of a facility. During cross-examination by Counsel for O'Connell, Springborg made the following statements:

DIEHM: As a Minister and in particular in the important role of Minister for Health it would be right to suppose that it was your practice that if you became aware of a decision that had been made, for instance, by the Director-General about a significant matter that you disagreed with that you would be prepared to overrule the decision?

SPRINGBORG: That is – that is correct.

DIEHM: Alright. And in that respect one of the things that you, to fulfil your responsibilities, expected was that you would be briefed by the Director-General about significant decisions that he proposed or had made?

- SPRINGBORG: Yes.
- ...
- DIEHM: Yes. And it may well be the case that you would often accept the advice – almost always accept the advice provided to you, but you reserved that right to yourself?
- SPRINGBORG: Absolutely.
- DIEHM: And you certainly made it known to the Director-General and other senior staff within the Department of Health that that was the position?
- SPRINGBORG: Absolutely.⁹¹

During oral evidence, O’Connell told the Commission that he understood the Health Minister expected to be kept abreast of any “major change in mental health policy”, having “the option to veto” any decision that he, as Director-General, might have (then) made.⁹²

Cleary gave similar evidence, informing the Commission in his written statement that when Springborg became Health Minister in 2012, he “specifically requested that any decisions about major changes to service provision be referred to him through the Director-General so that they could be given active consideration”.⁹³

Cleary considered that the authority to approve the closure of the BAC rested with the Government and, in particular, the Health Minister.⁹⁴ He agreed with the proposition put to him by Counsel Assisting, that any decision affecting the operation of the BAC would be a major change to service provision, and warrant referral to the Health Minister.⁹⁵

It is not in dispute that the Health Minister endorsed and agreed with the closure of the BAC.⁹⁶

As has been noted earlier, if the Minister did not approve of a decision of the Director-General, it was open to him to exercise his power under section 44F of the *Hospital and Health Boards Act 2011*, to direct the Director-General to do otherwise.

Although discussions in respect of the closure of the BAC were elevated in line with the service agreement’s amendment negotiation structure, there was clearly some blurring between levels.

For example, while the service agreement requires that the Director-General negotiate directly with the Chair of the Board, in this case the Director-General met with the Chief Executive of the Health Service (Dwyer), albeit with the approval of the Board’s Chair. Further, while the structure states that the Minister is to make amendment decisions unilaterally, in this case he met with the Chair of the Board and the Health Service Chief Executive.

Question for determination

Was the decision to close the BAC, a decision that was reached at the meeting on 17 June 2013, by way of agreement between the Director-General (O’Connell) and Dwyer (who attended the meeting with the approval of the West Moreton Board and, impliedly, of Corbett as Chair)?

Alternatively, did O’Connell step back and allow Springborg, as Health Minister, to make the decision at the meeting with Corbett on 15 July 2013, knowing that it was the Minister who held the ultimate authority⁹⁷ in respect of any amendment to the service agreement?

Submissions of the parties

Counsel Assisting submitted that practically the decision to close the BAC was purportedly made by the West Moreton Board on 24 May 2013, with the agreement of the Minister (by means of his apparent agreement in the meeting on 15 July 2013 or by his office noting a briefing note on 31 July 2013 or by his public announcement on 6 August 2013), and with the support of the Department of Health and the agreement of Kingswell.⁹⁸

Counsel for Springborg submitted that, without being in a position to precisely state when, the formal decision to close the BAC “was made by the Director-General and [West Moreton HHS] when they agreed to amend the Service Agreement”.⁹⁹

In contrast, Counsel for Kingswell submitted that the decision to close the BAC “crystallised on 15 July 2013, when the Minister for Health gave his support to the decision of the West Moreton HHS on 23[sic] May 2013 ‘to support the proposed closure of BAC’”.¹⁰⁰

A different position was adopted by Counsel for West Moreton HHS and Board. They submitted that their clients’ role in the closure was limited to determining the timing of the closure and how to do so, “subject to the concurrence of the Department”.¹⁰¹ They submitted that:

- Neither of their clients had the legal authority to “decide” to close the BAC and neither purported to do so, save in respect of the physical act of closing the doors of the BAC once all patients had been transitioned or discharged.¹⁰²
- The West Moreton Board accepted advice and “supported the closure of BAC” subject to a number of matters, one of them being “the approval of the Department or the Minister for Health”.¹⁰³

Findings

After considering all of the available evidence and the submissions, the Commission is satisfied that the decision to close the BAC was made on 15 July 2013 by Corbett, as Chair of the West Moreton Board, and Springborg, as Health Minister.

Although a decision to amend the service agreement to remove the BAC could have been reached between, for example O’Connell as Director-General and Corbett as the Chair of the West Moreton Board, the Commission finds that the West Moreton Board plainly appreciated that it would and should only proceed to close the service if it had the Health Minister’s approval.

That approval was gained in discussion with Corbett on 15 July 2013.

(Endnotes)

- 1 *Hospital and Health Boards Act 2011* (Qld) s 19(1).
- 2 *Hospital and Health Boards Act 2011* (Qld) ss 35(1), 35(2). The exception to this is that provided for under s 317, which allows the chief executive to decide the terms of a service agreement if the chief executive considers that there is not a reasonable time to negotiate and enter into the first agreement with a HHS.
- 3 *Hospital and Health Boards Act 2011* (Qld) s 36.
- 4 *Hospital and Health Boards Act 2011* (Qld) s 37.
- 5 *Hospital and Health Boards Act 2011* (Qld) s 38(3).
- 6 *Hospital and Health Boards Act 2011* (Qld) s 16(1).
- 7 *Hospital and Health Boards Act 2011* (Qld) s 39(1).
- 8 *Hospital and Health Boards Act 2011* (Qld) s 39(3).

- 9 *Hospital and Health Boards Act 2011* (Qld) s 44(1).
- 10 As allowed for under *Hospital and Health Boards Act 2011* (Qld) s 317, the service agreement was not signed by the Chair of the West Moreton Board on the basis that the chief executive considered there was not a reasonable time to negotiate and enter into the first service agreement.
- 11 Exhibit 228, West Moreton 2012–13 Service Agreement, p 7.
- 12 Exhibit 228, West Moreton 2012–13 Service Agreement, pp 18–25.
- 13 The phrase “statewide service” is defined under the 2012–13 service agreement to mean: “services for the whole of Queensland provided from only one or two service bases within Queensland as self-sufficiency in these services cannot be maintained due to the inadequate volume of cases. The service may include a statewide regulatory, coordination and/ or monitoring role”. Kingswell gave evidence to the Commission that “According to the Health Service Agreement, the WMHHS has oversight responsibility for the delivery of an adolescent extended treatment and rehabilitation centre for the State of Queensland. Accordingly, the service could accept referrals from anywhere in the State”: Exhibit 68, Statement of William Kingswell, 21 October 2015, p 4 para 9.
- 14 Submissions on behalf of West Moreton HHS and Board, 23 March 2016, p 88 para 10.
- 15 Closing submissions of Counsel Assisting, 17 March 2016, p 48 para 159.
- 16 The amendment windows were on 31 August 2012, 30 November 2012, 28 February 2013 and 17 May 2013.
- 17 The 2012–13 service agreement defines a “Relationship Management Group” to include Executive Directors from the Finance, Access Improvement Service, Planning and Healthcare Purchasing areas, as well as Senior Executive representatives nominated by the HHS, including the Chief Finance Officer, Chief Operating Officer, Director of Performance or equivalent: Exhibit 228, West Moreton 2012–13 Service Agreement, p 5.
- 18 Exhibit 228, West Moreton 2012–13 Service Agreement, p 8.
- 19 Exhibit 228, West Moreton 2012–13 Service Agreement, p 8.
- 20 The 2012–13 service agreement defines a “Relationship Management Group” to include Executive Directors from the Finance, Access Improvement Service, Planning and Healthcare Purchasing areas, as well as Senior Executive representatives nominated by the HHS, including the Chief Finance Officer, Chief Operating Officer, Director of Performance or equivalent: Exhibit 228, West Moreton 2012–13 Service Agreement, p 5.
- 21 Exhibit 182, West Moreton Hospital and Health Service 2013/14 – 2015/16 Service Agreement, p 17.
- 22 Exhibit 182, West Moreton Hospital and Health Service 2013/14 – 2015/16 Service Agreement, p 6.
- 23 Exhibit 182, West Moreton Hospital and Health Service 2013/14 – 2015/16 Service Agreement, p 27.
- 24 Exhibit 40, Statement of Michael Cleary, 21 December 2015, p 19 para 84(i).
- 25 Exhibit 40, Statement of Michael Cleary, 21 December 2015, Attachment MIC-14 to that statement, Draft Briefing Note for Approval to Director-General Queensland Health, re approval to close Barrett Adolescent Centre, p 459.
- 26 Exhibit 40, Statement of Michael Cleary, 21 December 2015, pp 19–20 para 84(i).
- 27 Exhibit 40, Statement of Michael Cleary, 21 December 2015, Attachment MIC-14 to that statement, Draft Briefing Note for Approval to Director-General Queensland Health, re approval to close Barrett Adolescent Centre, p 459.
- 28 Exhibit 40, Statement of Michael Cleary, 21 December 2015, p 21 para 84(viii).
- 29 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment SK-12 to that statement, Board Committee Agenda Paper for meeting of 24 May 2013, p 860.
- 30 Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 21 para 14.11(b), Attachment MC-20 to that statement, p 174.
- 31 Exhibit 1462, Email from Sharon Kelly to Michael Cleary, Subject: “Barrett Adolescent Strategy–Delegated”, 17 June 2013.
- 32 Exhibit 40, Statement of Michael Cleary, 21 December 2015, p 21 para 84(viii).
- 33 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, p 13 para 6.1(c).
- 34 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 17 para 10.6.
- 35 Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 8 para 8.3, Attachment MC-6 to that statement, pp 82–83.
- 36 Exhibit 667, Briefing Note for Noting to Minister for Health, Subject: “Barrett Adolescent Strategy Meeting”, 16 July 2013.
- 37 Exhibit 671, Briefing Note for Noting to Minister for Health, Subject: “Barrett Adolescent Strategy Meeting”, 8 July 2013, p 2.
- 38 Exhibit 671, Briefing Note for Noting to Minister for Health, Subject: “Barrett Adolescent Strategy Meeting”, 8 July 2013, p 2.
- 39 The briefing note attached the Preamble and Recommendations of the ECRG, but not the Proposed Service Model Elements document. Also absent were the recommendations of the Planning Group.
- 40 Transcript, Lawrence Springborg, 26 February 2016, p 15–34 lines 42–45.
- 41 Exhibit 1463, Email from SDLO to Mark Wood, Subject: “BR057157 – Barrett Adolescent Strategy Meeting”, 15 July 2013; Exhibit 1464, Attachment to Email from SDLO to Mark Wood, Briefing Note for Noting to Director-General Queensland Health, Subject: “Barrett Adolescent Strategy Meeting”, 8 July 2013 (unsigned), and Briefing Note to Minister for Health, Subject: “Barrett Adolescent Strategy Meeting”, 8 July 2013 (unsigned); Exhibit 1465, Attachment to Email from SDLO to

- Mark Wood, ECRG report; Exhibit 1466, Attachment to Email from SDLO to Mark Wood, West Moreton HHS Issues and Incident Management Plan, 15 July 2013.
- 42 Exhibit 1463, Email from SDLO to Mark Wood, Subject: "BR057157 – Barrett Adolescent Strategy Meeting", 15 July 2013.
- 43 Transcript, Lawrence Springborg, 26 February 2016, p 15–32 lines 12–13; Transcript, Dominic O'Sullivan QC, Closing submissions on behalf of Lawrence Springborg, 12 April 2016, p 27–80 lines 31–33.
- 44 Exhibit 671, Briefing Note for Noting to Minister for Health, Subject: "Barrett Adolescent Strategy Meeting", 8 July 2013.
- 45 Exhibit 1280, Document titled 'Talking Points for Discussion with Health Minister', dated 12 July 2013.
- 46 Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 7 para 8.3; Exhibit 42, Supplementary statement of Mary Corbett, 21 December 2015, p 2 para 1.5.
- 47 Exhibit 1541, Statement of Neil Hamilton-Smith, 27 May 2016, p 1 paras 7, 10, 11.
- 48 Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 21 para 14.13.
- 49 Exhibit 1474, Second supplementary statement of Mary Corbett, 17 May 2016, p 2 para 2.2.
- 50 Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 21 para 14.13, Exhibit 1474, Second supplementary statement of Mary Corbett, 17 May 2016, p 1 para 1.1.
- 51 Exhibit 1474, Second supplementary statement of Mary Corbett, 17 May 2016, p 2 para 2.1.
- 52 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 14 para 7.1(e), p 15 para 8.5 and p 16 para 10.5(b).
- 53 Exhibit 1473, Second supplementary statement of Lesley Dwyer, 17 May 2016, p 1 paras 1.3–1.4.
- 54 Exhibit 1473, Second supplementary statement of Lesley Dwyer, 17 May 2016, p 1 para 1.5.
- 55 Exhibit 1473, Second supplementary statement of Lesley Dwyer, 17 May 2016, p 3 para 2.4.
- 56 Exhibit 1473, Second supplementary statement of Lesley Dwyer, 17 May 2016, p 2 paras 2.1–2.3.
- 57 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 13 paras 11.12 – 11.13.
- 58 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, Attachment LJS-6 to that statement, Diary Appointment - Meeting with Dr Mary Corbett WMHHS re Barratt [sic] Adolescent Centre, p 56.
- 59 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, p 11 para 55.
- 60 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, p 10 para 45.
- 61 Exhibit 1471, Second supplementary statement of Lawrence Springborg, 12 May 2016, pp 1–2 para 3.
- 62 Exhibit 1471, Second supplementary statement of Lawrence Springborg, 12 May 2016, p 2 para 4.
- 63 Exhibit 130, Statement of Lesley van Schoubroeck, 3 December 2015, Attachment F to that statement, Briefing Note from Lesley Dwyer to Mental Health Commissioner, p 50.
- 64 Exhibit 1080, Estimates Brief Number 17.03, Subject: "Barrett Adolescent Centre – Strategy", dated 15 July 2013, Author Sharon Kelly, ED, MHSS. The Commission is conscious that this document may be subject to a claim of Parliamentary Privilege. However, the document has become part of the evidence without objection and, in any event, the document is cited here as explaining an historical fact which is not controversial – namely that at the meeting on 15 July 2013 the Minister supported the decision to close the BAC. The Commission does not seek to question or impeach the content of the document: see s 8 of the *Parliament of Queensland Act 2001*.
- 65 Submissions on behalf of Lawrence Springborg, 23 March 2016, p 48 para 5.155, referring to Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, p 16 para 81.
- 66 Submissions on behalf of Lawrence Springborg, 23 March 2016, p 48 para 5.155, referring to Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, p 11 paras 53–57.
- 67 Exhibit 207, Minutes of Barrett Adolescent Strategy Planning Group, 23 July 2013, pp 1–2.
- 68 Exhibit 1128, Notes written by Bill Kingswell, at Barrett Adolescent Strategy Meeting, 23 July 2013.
- 69 Exhibit 308, West Moreton Board Committee Agenda Papers and Meeting Minutes, 23 November 2012 to 28 February 2014 as provided by Timothy Eltham, pp 129–130.
- 70 Exhibit 307, Transcript of ABC 612 interview with Lawrence Springborg, 6 August 2013.
- 71 Submissions on behalf of Anthony O'Connell, 23 March 2016, p 8 para 28.
- 72 Exhibit 307, Transcript of ABC 612 interview with Lawrence Springborg, 6 August 2013.
- 73 Submissions on behalf of West Moreton HHS and Board, 23 March 2016, p 27 paras 7.46–7.47.
- 74 Exhibit 245, Children's Health Queensland Hospital and Health Service 2013/14 – 2015/6 Service Agreement Deed of Amendment, January 2014.
- 75 Exhibit 245, Children's Health Queensland Hospital and Health Service 2013/14 – 2015/6 Service Agreement Deed of Amendment, January 2014, pp 8–9.
- 76 Exhibit 183, West Moreton Hospital and Health Service 2013/14 – 2015/16, Service Agreement Deed of Amendment, pp 7–8.

- 77 Exhibit 183, West Moreton Hospital and Health Service 2013/14 – 2015/16, Service Agreement Deed of Amendment, p 6.
- 78 Exhibit 183, West Moreton Hospital and Health Service 2013/14 – 2015/16, Service Agreement Deed of Amendment, Appendix 1 – July 2014 Revision of the 2013–16 service agreement, p 43 clause 6.2.4.
- 79 Exhibit 183, West Moreton Hospital and Health Service 2013/14 – 2015/16, Service Agreement Deed of Amendment, Appendix 1 – July 2014 Revision of the 2013–16 service agreement, p 37 clause 3.2.8.
- 80 In their closing submissions, Counsel for West Moreton HHS and Board acknowledged that in the course of 2014, the obligation on West Moreton HHS to provide the BAC was removed from the service agreement: Submissions on behalf of West Moreton HHS and Board, 23 March 2016, p 89 para 14.
- 81 For example, Submissions on behalf of West Moreton HHS and Board, 23 March 2016, p 21 para 7.4.
- 82 Submissions on behalf of West Moreton HHS and Board, 23 March 2016, p 21 para 7.4.
- 83 Transcript, Mary Corbett, 18 February 2016, p 9-43 lines 31–37 – p 9-44 lines 15–17. See also Submissions on behalf of West Moreton HHS and Board, 23 March 2016, p 26 para 7.37.
- 84 Submissions on behalf of Lawrence Springborg, 23 March 2016, p 17 para 5.1(a) and p 18 paras 5.1(b) and 5.3.
- 85 Submissions on behalf of the State of Queensland, 23 March 2016, pp 14–15 para 37.
- 86 Transcript, Paul Freeburn QC, Closing submissions of Counsel Assisting, 11 April 2016, p 26-7 lines 7–10.
- 87 Submissions on behalf of West Moreton HHS and Board, 23 March 2016, p 27 para 7.43.
- 88 Submissions on behalf of Anthony O’Connell, 23 March 2016, p 7 para 25.
- 89 Submissions on behalf of Lawrence Springborg, 23 March 2016, p 49 para 5.164.
- 90 Submissions on behalf of Lawrence Springborg, 23 March 2016, p 49 para 5.168.
- 91 Transcript, Lawrence Springborg, 26 February 2016, p 15-38 lines 35–43 – p 15-41 lines 8–13.
- 92 Transcript, Anthony O’Connell, 23 February 2016, p 12-54 line 13 – p 12-55 line 19.
- 93 Exhibit 40, Statement of Michael Cleary, 21 December 2015, p 17 para 74.
- 94 Exhibit 40, Statement of Michael Cleary, 21 December 2015, p 17 para 74.
- 95 Transcript, Michael Cleary, 25 February 2016, p 14-13 lines 32–35.
- 96 Submissions on behalf of Lawrence Springborg, 23 March 2016, p 50 para 5.170, referring to Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, p 16 para 81.
- 97 S 44F of the *Hospital and Health Boards Act 2011* (Qld) states that the Director-General is subject at all times to the direction of the Health Minister.
- 98 Closing submissions of Counsel Assisting, 17 March 2016, pp 49–50 para 163.
- 99 Submissions on behalf of Lawrence Springborg, 23 March 2016, p 49 para 5.165.
- 100 Submissions on behalf of William Kingswell, 23 March 2016, p 1 para 3, p 38 para 142.
- 101 Submissions on behalf of West Moreton HHS and Board, 23 March 2016, p 21 para 7.5.
- 102 Submissions on behalf of West Moreton HHS and Board, 23 March 2016, p 26 para 7.36.
- 103 Submissions on behalf of West Moreton HHS and Board, 23 March 2016, pp 25–26 para 7.35(a) and (b).

13 Decision to cease on-site integrated education program

The role or involvement of the Department of Education in the decision to close the BAC

As set out in chapter 1, an essential component of the BAC was its co-location with the Barrett Adolescent Centre Special School (BACSS) which ran an on-site integrated education program. The BACSS was established by the Department of Education in the mid-1980s and although it was located in a building owned by Queensland Health,¹ it was funded by the Department of Education and Training (Department of Education).²

Despite the collaboration of Queensland Health and the Department of Education in operating the BAC and the BACSS for over 25 years, the evidence before the Commission was that the Department of Education had virtually no role and only some limited involvement (through having a representative³ on the Expert Clinical Reference Group (ECRG) and on the Planning Group) in the decision to close the BAC.

November 2012

The evidence Brett McDermott gave to the Queensland Child Protection Commission of Inquiry on 8 November 2012⁴ is discussed in chapter 7.

That evidence caused a flurry of media interest and came as a surprise not only to the education staff at the BACSS, but also to some of the executives in the Department of Education.

Later on 8 November 2012, Serena Mariott, an administrative officer at the BACSS, received a call from a newspaper reporter asking for a comment on the closure of the BAC.⁵ Throughout the day media reports of the closure of the BAC were broadcast on local radio and later that evening on the ABC television news bulletin.⁶

The evidence of Peter Blatch, the Assistant Regional Director, School Performance, Metropolitan Region, was that at that point, "DETE⁷ had not been involved in any discussions and were totally unaware [of the intention to close the BAC] prior to the announcement [by McDermott]".⁸

Blatch said that on 8 November 2012, Trevor Sadler, the Clinical Director of the BAC, told him informally that the BAC was likely to close⁹ and that Sharon Kelly, Executive Director Mental Health and Specialised Services, West Moreton HHS telephoned him a few days later and confirmed this likelihood.¹⁰

On 9 November 2012, Lesley Dwyer, Chief Executive, West Moreton HHS and Kelly convened a meeting with health and education staff at the BAC.¹¹ One of the teachers present at the meeting recalled that staff were told by Dwyer that McDermott's comments were just conjecture, that there was nothing 'firm' about it, and that no decision had been made about the future of the BAC.¹² Dwyer recalled that this meeting was to "reassure staff" and:

reiterate that The Park site had been designated for forensic secure patients and WMHHS would be looking at other models of care but that we would keep staff involved in that process. We spoke about the supports available for staff. Staff were upset, some were angry at the prospect of BAC being closed.¹³

On 12 November 2012, Kevin Rodgers, the Principal of the BACSS, received a telephone call from an ABC journalist informing him of a plan to close the BAC and inviting him to provide a comment. Rodgers' evidence was that this news came as a complete surprise to him, particularly since he had just finished presenting the BACSS' strategic plan for the next four years.¹⁴

Early to mid-2013

Blatch said that in early 2013, at the request of Chris Rider, Regional Director, and Patea Walton, Deputy Director-General, State Schools, he convened a small working group to develop options for the relocation of the BACSS. Other members of this group included Deborah Rankin, the then acting Principal of the BACSS, Michelle Bond, who was the Principal of the Royal Children's Hospital Special School, and Judith Duckner, Regional Manager responsible for staffing.¹⁵ The relocation working group was to consider all options available for relocating the BACSS and to make recommendations on the most suitable option for relocation. In his oral evidence, Blatch said that the Department of Education could not commence making alternative arrangements regarding the future of the BACSS until they knew what the new model of mental health provision was going to be.¹⁶

In May 2013, Education Minister John-Paul Langbroek announced that eight Queensland state schools had been identified for community consultation regarding proposed closure as part of the 2013 School Viability Assessment.¹⁷ The BACSS was not included in this list.¹⁸

July – August 2013

On 19 July 2013, Walton became aware of the plan to close the BAC and of a proposal to relocate the BACSS in an email she received from Blatch, attaching a briefing note for noting to the Queensland Mental Health Commissioner prepared by Dwyer.¹⁹

On 5 August 2013, Blatch received a telephone call from either Kelly or Leanne Geppert, the Director of Strategy for Mental Health and Specialised Services, West Moreton HHS, telling him that an announcement that the BAC would close was to be made the next day, that the date of closure was still to be determined, but that it was likely to be by the end of January 2014.²⁰ Blatch recalled that he was told during this conversation that the Department of Education could no longer use the name "Barrett Adolescent Centre Special School". Blatch's evidence was that he told either Kelly or Geppert that the name of a school could be changed only with ministerial approval and only after significant community consultation.²¹

Education staff were officially made aware of the decision to relocate the BACSS on 21 August 2013, during a visit to the school by Blatch and Duckner.²²

Following the closure announcement on 6 August 2013, the Department of Education considered there was no question of closing the BACSS, because:

- a number of students at the school were in their senior years of schooling and continuity of education provision to them was a priority
- the prescribed process for closing any state school was a lengthy one, requiring significant consultation
- in May/June 2013, the Minister for Education had made a public announcement that no more Queensland schools would be closed.²³

Relocation to Yeronga

The BACSS ceased operating at the Wacol site at the end of 2013. The Yeronga State High School was identified by the relocation working group as the only suitable option for the relocation of the BACSS for the 2014 school year. Blatch said that it was chosen because of its geographical location, namely its proximity to the local CYMHS and to the Lady Cilento Children's Hospital. There was also an area and building set away from the current high school, which would allow the new BACSS to operate independently.²⁴

Consequences of the cessation of the on-site integrated education program

At its seventh meeting on 27 March 2013, the ECRG noted that "there is a cost to losing BAC including 25 years of culture, knowledge and experience".²⁵ Rodgers said that the "seamless relationship between education and health ... will be forever lost".²⁶

Whilst technically the BACSS at Wacol did not close, the BACSS as reincarnated first at Yeronga and after at Tennyson ultimately bore little resemblance to the BACSS at Wacol.

The written submissions on behalf of teacher Justine Oxenham²⁷ recognised, and the Commission accepts, that the "uncoupling" of health and education when the BAC closed, meant that:

- students lost the immediate benefit of close quarter clinical support during their school hours
- educators lost the ability to quickly access clinical and healthcare assistance when required in the classroom (which could be up to several times a day)²⁸
- considering adolescent mental healthcare holistically, the ability for educators, mental health clinicians and allied health professionals to collaborate in a multi-disciplinary milieu was lost to the state adolescent mental health system.

In his oral evidence, Blatch said that he would have hoped for earlier consultation about the closure decision and he was not sure if West Moreton HHS realised that the BACSS was actually part of the Department of Education.²⁹ While Blatch's latter comment was not substantiated on the evidence, his first comment about earlier consultation has some force. The briefing note for noting prepared by Dywer on 19 July 2013, refers to a communication process and consultation about the proposed next stages for closure of the BAC with [amongst others] "the Department of Education, Training and Employment".³⁰ However, there seems to have been little if any consultation by West Moreton HHS with the Department of Education about the impact of closing the BAC on the BACSS and the inevitable uncoupling of health and education.³¹

The consequences of that uncoupling are discussed in more detail in chapter 29.

(Endnotes)

- 1 Transcript, Peter Blatch, 25 February 2016, p 14-101, lines 20–30.
- 2 Over the years, the Department of Education was run in conjunction other departments, for example, in March 2012, the then Department of Education and Training (DET) became the Department of Education Training and Employment (DETE), <<http://education.qld.gov.au/library/edhistory/state/chronology-name.html>>. [31 May 2016]; Exhibit 25, Statement of Peter Blatch 20 November 2015, p 31 para 9.
- 3 Kevin Rodgers; Michelle Bond.
- 4 Exhibit 84, Statement of Brett McDermott, 10 November 2015, p 17 para 92.
- 5 Exhibit 106, Statement of Deborah Rankin, 11 October 2015, p 17 para 63.
- 6 Exhibit 96, Statement of Justine Oxenham, 24 November 2015, p 6 para 11(a).
- 7 Department of Education, Training and Employment (citation added).
- 8 Exhibit 25, Statement of Peter Blatch, 20 November 2015, p 12 para 32; Exhibit 134, Statement of Patrea Walton, 21 October 2015, Attachment C to that statement, Email from Peter Blatch to Patrea Walton and others, Subject: "Barrett Adolescent Strategy and our school – Confidential", 19 July 2013, p 33.
- 9 Exhibit 25, Statement of Peter Blatch, 20 November 2015, p 12 para 32.
- 10 Exhibit 25, Statement of Peter Blatch, 20 November 2015, p 12 para 32.
- 11 Exhibit 49, Statement of Lesley Dwyer, 6 November 2016, p 15 para 10.1
- 12 Exhibit 19, Statement of Janine Armitage, 14 December 2015, p 7 para 24.
- 13 Exhibit 49, Statement of Lesley Dwyer, 6 November 2016, pp 15–16 para 10.1.
- 14 Exhibit 110, Statement of Kevin Rodgers, 10 December 2015, p 7 para 26.
- 15 Exhibit 25, Statement of Peter Blatch, 20 November 2015, pp 14–18 paras 37–49; The fifth member was Cliff uskopf, Regional Manager responsible for facilities.
- 16 Transcript, Peter Blatch, 25 February 2016, p 14-102 lines 15–21.
- 17 As required by Chapter 2, Part 3, Sections 18 and 20 of the *Education (General Provisions) Act 2006*, these proposed school closures were published in the Government Gazette on 10 May 2013.
- 18 Exhibit 1499, Queensland Teacher's Union Submission to Senate Select Committee on Certain Aspects of Queensland Government Administration related to Commonwealth Government Affairs dated November 2014.
- 19 Exhibit 134, Statement of Patrea Walton, 21 October 2015, Attachment C to that statement, Email from Peter Blatch to Patrea Walton and others, Subject: "Barrett Adolescent Strategy and our school – Confidential", 19 July 2013, p 33.
- 20 Exhibit 25, Statement of Peter Blatch, 20 November 2015, p 13 para 33.
- 21 Exhibit 25, Statement of Peter Blatch, 20 November 2015, p 13 para 35.
- 22 Exhibit 106, Statement of Deborah Rankin, 11 October 2015, p 16 para 62.
- 23 Submissions on behalf of the State of Queensland, 23 March 2016, p 29 para 76.
- 24 Exhibit 25, Statement of Peter Blatch, 20 November 2015, p 14 para 40.
- 25 Exhibit 119, Statement of Josie Sorban, 11 December 2015, Attachment E to that statement, ECRG meeting minutes, 27 March 2013, p 64.
- 26 Exhibit 119, Statement of Josie Sorban, 11 December 2015, Attachment E to that statement, ECRG meeting minutes, 27 March 2013, p 64.
- 27 Final Submissions on behalf of Justine Oxenham, 23 March 2016, pp 10–13 para 14.
- 28 Transcript, Kevin Rodgers, 2 March 2016, p 18-56 line 35 – p 18-57 line 14.
- 29 Transcript, Peter Blatch, 25 February 2016, p 14-103 lines 44–47 – p 14-104 lines 1–8.
- 30 Exhibit 134, Statement of Patrea Walton, 21 October 2015, Attachment C to that statement, pp 19 and 20.
- 31 Again, it is accepted that Kevin Rodgers and Michelle Bond were members of the ECRG/Planning Group.

14 Analysis of the reasons for closing the BAC

Introduction

The Commission's terms of reference call for not only an inquiry into the actual decision to close the BAC,¹ but also an inquiry into the "bases" or reasons for the decision² and "the information, material, advice, processes, considerations and recommendations that related to or informed the closure decision and the decision-making process related to the closure decision".³

In this chapter the reasons for the closure of the BAC are analysed. The decision-making process is evaluated in chapter 15.

Before analysing the reasons for the closure, it is necessary to explain the broad context, including the Redlands project, what happened after that project was cancelled, and the reasons for closing the BAC that emerged.

Context

Redlands

On 25 February 2008 Cabinet endorsed the Queensland Plan for Mental Health 2007–2017 (QPMH).⁴ That Cabinet decision, and the companion budget document Outline of the 2007–08 State Budget Outcomes for Mental Health,⁵ provided for the improvement of mental health facilities for people in acute and extended treatment facilities by the provision (amongst other developments) of a new 15-bed adolescent extended care unit following the closure of the BAC at The Park. In other words, there was to be a replacement for the BAC.

The sum of \$121.55 million was provided for this and a number of other projects (including the development of an Extended Forensic Treatment Rehabilitation Unit (EFTRU) at The Park, which is discussed below). That sum was said to be "for 276 new, upgraded or redeveloped acute and extended treatment beds that meet contemporary standards".⁶ In other words, the new, upgraded and redeveloped facilities were to meet modern standards.

A number of witnesses acknowledged that the QPMH and the decision to replace the BAC were based on expert advice.⁷

Replacement of the BAC

In October 2008 a Site Evaluation Subgroup produced a report entitled 'Site Options Paper for the Redevelopment of the Barrett Adolescent Centre'.⁸ The report considered five options which had been identified by the Area Health Services:

- Rogers Street, Spring Hill
- Child and Family Therapy Unit – Royal Brisbane and Women's Hospital
- land adjacent to Redland Hospital
- Meakin Park (three kilometres from Logan Hospital)
- The Park.

The report described Redlands and The Park as the only two architecturally viable options. Redlands was the preferred option, largely due to the undesirability of having adolescents on the same campus as adult forensic patients (as would be the case at The Park).

On 19 May 2009, Cheryl Furner (acting Senior Director, Mental Health Branch) wrote a memorandum to a number of senior administrators (David Theile, Pam Lane, Monica O'Neill and David Crompton) thanking them for their advice endorsing the recommendation of the Site Selection Subgroup to redevelop the BAC at Redlands. The memorandum records that: "The Mental Health Capital Works Working Group accepts this advice".⁹ That is, the advice that Redlands be chosen as the site for the replacement of the BAC was accepted.

David Crompton (Executive Director Addiction and Mental Health Services, Metro South Hospital and Health Service (HHS)) then established a 'user group' to guide the redesign and development of the new unit on the Redlands site. Another group was established to consider the model of service delivery for the Redlands project.¹⁰

New model of service

At this time, Judi Krause was the chair of the Child and Youth Mental Health Statewide Advisory Group.¹¹ On 27 January 2010, Crompton, Aaron Groves (Director of Mental Health) and others asked her to form a group to review the model of service delivery (MOSD) at the BAC and to prepare a model of service delivery for the new unit at Redlands.¹²

Prior to convening the group, Krause summarised the issues for consideration in reviewing the MOSD at the BAC as outlined in previous reviews and reports.¹³ With reference to the report by Walter, Baker and George '2009 Review of Barrett Adolescent Centre'¹⁴ she identified these issues: governance; clinical model; nursing model of care; patient journey; treatment evaluation; clinical leadership; staffing profiles; and nursing staff training and education.¹⁵ Krause presented this summary to the MOSD Review Group at its first meeting on 10 February 2010, noting that Trevor Sadler (Clinical Director, BAC) had disputed large parts of the 2009 review.

On 3 March 2010, Krause emailed Crompton attaching a draft MOSD for Redlands.¹⁶ It was finalised (but for endorsement by the MHAODD¹⁷ of Queensland Health) on 22 July 2010, with Redlands site planning then re-commencing and user group meetings progressing.¹⁸

The model of care proposed for the Redlands unit responded to several of the criticisms of the BAC. The table below illustrates this.

Criticism of BAC	Proposed Redlands model
<p>Standalone facility</p> <p>Isolated in clinical governance – needs to sit as part of a continuum of care within the broader CYMHS system¹⁹</p>	<p>Adjacent to a hospital</p> <p>Envisaged that Redland Hospital would support acute medical emergencies and other medical issues that could be managed locally²⁰</p> <p>Integrated into CYMHS continuum of care²¹</p> <p>Clinical governance to be incorporated within the Queensland Children’s Hospital (the Mater in the interim period) – this would facilitate reporting relationships, clinical supervision, patient safety issues, staff development & conformity with national mental health reform agenda²²</p> <p>Access to a range of specialists who could provide support²³</p>
<p>Length of stay average of 13 months²⁴</p> <p>Sadler’s average of 9.5 months in his MOSD, for endorsement 26 March 2009²⁵</p>	<p>Length of stay specified</p> <p>Six month targeted and phased treatment program²⁶</p> <p>Specific cases where admission exceeded six months to be presented to an intake panel for review²⁷</p>
<p>Referral by CYMHS or private psychiatrist. Sadler said a comprehensive clinical assessment occurred prior to the decision to admit – MOSD meeting 10 February 2010 BAC “referral criteria/ exclusion criteria unclear”²⁸</p>	<p>Refined referral process²⁹</p> <p>Referrals to be reviewed by a multidisciplinary intake panel³⁰ – “build upon existing comprehensive assessment of the adolescent (thorough treatment history from service providers and carers with a view to assessing the likelihood of therapeutic gains by attending”³¹</p>
<p>Therapies were listed but no particular sense of the continuum of care, the progression of therapies – this needed to be more clearly defined³²</p>	<p>Refined treatment process³³</p> <p>Suite of evidence-based treatments tailored to suit the individual’s needs³⁴</p>
<p>Discharge planning commenced only on review of therapeutic and developmental progress³⁵</p>	<p>Refined discharge process³⁶</p> <p>More “assertive” discharge planning to commence at point of admission, including addressing potential significant obstacles to discharge³⁷</p>
<p>Long waiting times³⁸</p>	<p>Proposed 3-6 month timeframe for admission³⁹</p>
<p>No family accommodation or step down accommodation</p>	<p>Therapeutic residential and step down accommodation and a family stay unit⁴⁰</p>

Figure 14A: How the Redlands project responded to criticisms of BAC

Decision to cease Redlands

As explained in chapters 3 and 5, in May 2012 and August 2012, the Redlands project was ceased, and the funding for that project was re-allocated to other priorities.

The reasons for ceasing Redlands

The reasons for ceasing the Redlands project expressed in the briefing notes were:

- in the May 2012 briefing note: "multiple delays ... an estimated budget over run of \$1,461,224 [and that] recent sector advice proposes a re-scoping of the clinical service model and governance structure for the Unit"
- in the August 2012 briefing note: the recommendation by William Kingswell (Executive Director of the Mental Health Alcohol and Other Drugs Branch) that the replacement Adolescent Extended Treatment Unit at Redlands be ceased.

The evidence before the Commission shows that the decision to cease the Redlands project was made in a tight fiscal environment in which Queensland Health had been asked to find savings of \$100 million to \$120 million. In relation to the May briefing note, Kingswell said:

We had a new government in Queensland and they were looking for money for regional infrastructure, as I understood it. The only one that could reasonably be stopped completely was the Redlands adolescent project. And so I made some inquiries about the impact of that from Health Infrastructure Division and within my own Branch. And that was the project that we contributed to the cause ...⁴¹

Based on his understanding of advice from senior clinicians within Queensland Health, Lawrence Springborg, the Minister for Health, thought that the proposed adolescent extended treatment rehabilitation centre at Redlands would not provide a contemporary model of care. In his written evidence he said:

During 2012 I was aware that senior clinicians within the Department had expressed the view that a facility like the Barrett Centre was not regarded as contemporary with the draft National Mental Health Service Planning Framework, and that it was not the most appropriate model for caring for and treating severely troubled adolescents who required intensive inpatient or outpatient psychiatric care, and that the preferred model involved the provision of services in the community, closer to the patient's home, and a move away from what was regarded as long-term institutional care of the kind provided by the Barrett Centre.⁴²

The Minister's reference to "a facility like the Barrett Centre" makes it clear that the advice of the senior clinicians, at least as he understood it, was that institutional models like the BAC, and its replacement at Redlands, were not regarded as contemporary. The Minister's view, based on the advice of senior clinicians, was that the preferred model for treating severely troubled adolescents requiring intensive inpatient or outpatient psychiatric care was a community-based model rather than a model that involved long-term institutional care of the kind provided by the BAC.

The central idea here is that it was not contemporary for young persons to be treated in an institution, and that it was preferable for them to be cared for in community-based care.

It was not only the Minister's actions that were informed by that central idea. Other witnesses had similar views. As explained in chapter 3, Kingswell was the principal source of the advice to a number of others (such as Lesley Dwyer (West Moreton HHS Chief Executive), Michael Cleary (Deputy Director-General) and Jeannette Young (Chief Health Officer) that the Redlands project did not include an appropriate model of care. The Director-General, Tony O'Connell, thought there was an emerging clinical preference for community-based, closer-to-home models of care.⁴³ That central idea, that contemporary care for these adolescents should be in the form of community-based care rather than institutional care, informed not only the decision to cease the Redlands project but also the subsequent decision to close the BAC.

It will be necessary to return to this central idea or the 'overarching philosophy' later in this chapter.

Post-Redlands

Plans to close the BAC proceeded.⁴⁴ However, when Brett McDermott (Executive Director, Mater CYMHS) publicly announced that the BAC was to close,⁴⁵ steps were taken to devise and implement the Barrett Adolescent Strategy Project Plan.⁴⁶ That plan led to the establishment of the Planning Group and the ECRG.

Leanne Geppert (the then Director Planning and Partnerships, MHAODB) gave evidence that the BAC could not stay at The Park because the BAC building could not be suitably refurbished and because The Park was undergoing redevelopment to become an adult-only forensic and secure mental health facility.⁴⁷

At a meeting on 15 November 2012, West Moreton HHS sought the support, advice and collaboration of key stakeholders including MHAODB, Townsville HHS, Mater CYMHS, Metro South HHS, CHQ HHS, Gold Coast HHS and Darling Downs HHS in developing an alternative model of service to replace the services then being provided at the BAC. Geppert's team within the MHAODB drafted the email invitation to that meeting, which was sent by Dwyer. The email noted that the BAC facility had been identified by the Australian Council on Healthcare Standards (ACHS) as unsafe and necessitating urgent replacement, and that there was concern about its co-location with adult forensic and secure services at The Park.⁴⁸

Sharon Kelly's evidence was that from the time she became the Executive Director, Mental Health and Specialised Services (in September 2012) she was aware of the possibility of the BAC being closed for the following reasons:

- The QPMH provided funding for a number of projects across the State including a redevelopment project that involved major changes to the adult mental health services at The Park.
- Under that redevelopment project, The Park would provide services for adult forensic and secure patients only, comprising a High Secure In-patient Service, a new EFTRU and a Secure Mental Health Rehabilitation Unit (SMHRU) for adults. All other clinical services on The Park campus would be closed. This meant:
 - i. Extended Treatment and Dual Diagnosis adult services would be closed with patients transferring to community care models.
 - ii. a Community Care Unit would be built off-site. (A number of these were also being built in other HHS areas with funding provided under the QPMH.)
 - iii. adolescent mental health services would not be located on The Park campus.

- The physical facility of the BAC was unsuitable for the provision of clinical in-patient care.
- The Park redevelopment had progressed, but the Redlands project had been slowed by environmental challenges and other difficulties.⁴⁹

On 28 August 2012, Glenn Rashleigh, Director – Capital Delivery Program in the Health Infrastructure Office, sent a memorandum to Dwyer, the Chief Executive West Moreton HHS, “to advise of a decision by government to cancel or defer a small number of capital delivery projects”, saying “this includes the cancellation of the replacement Adolescent Mental Health Unit at Redlands from its current location at Wacol”.⁵⁰

After reviewing a building report on the BAC,⁵¹ and consulting with others within the HHS, Kelly came to the view that:

- limited refurbishment of the BAC building was not feasible
- continuation of the BAC service on The Park campus was incompatible with the services being commissioned at The Park under the redevelopment project – specifically, the co-location of adolescents with adults from EFTRU carried unacceptable risk for the adolescents.

On 25 October 2012, Kelly attended a meeting at the MHAODB with Kingswell, Jagmohan Gilhotra (Chief Psychiatrist, Queensland Health), and Geppert. She was informed that the MHAODB considered that the BAC, a ‘bricks and mortar’ residential and educational long stay facility with a statewide catchment, was not aligned to future planning for The Park or to the QPMH, and that it was not part of the model for the delivery of adolescent mental health services going forward.⁵²

On 8 November 2012, Kelly sent an email with the subject ‘Pertinent Points for Consideration of BAC’⁵³ to the Departmental Liaison Office⁵⁴ with copies to Cleary, Gilhotra, Geppert and Dwyer. It contained the following points:

- National and state policy direction is to ensure that young people are treated close to their homes in the least restrictive environment with the minimum possible disruption to their families, educational, social and community networks.
- The National Mental Health Service Planning Framework due for completion in July 2013 does not include provision for non-acute adolescent inpatient services as per the current model at Barrett. The Framework does include sub-acute community-based services for adolescents.
- Planning is required to align with the National Mental Health Service Planning Framework that recommends sub-acute community based services for adolescents.
- The deinstitutionalisation of services currently provided at The Park Centre for Mental Health is part of the reform agenda under the Queensland Plan for Mental Health 2007-2017 (QPMH) and will result in only forensic and secure services being provided at the facility by July 2013.
- Concerns have been raised about the co-location of BAC with adult forensic and secure services delivered by The Park Centre for Mental Health.
- Under the QPMH, it was determined that the development of a new model of care for BAC was required.
- The Redlands Adolescent Extended Treatment Unit (RAETU), funded under the QPMH, was intended to replace BAC. This project has ceased due to unresolved environmental issues and budget overruns and hence is no longer a sustainable capital works project for Queensland Health.

- Recent sector advice proposes a re-scoping of the BAC service model and governance structure to ensure a contemporary evidence based model of care is being provided for adolescents with serious mental illness.
- The average bed occupancy rate for BAC is 43 per cent. This is less than half of the 15 beds currently available in this unit.
- The age and condition of the building has been identified by the ACHS as unsafe, necessitating urgent replacement.

Those points appear to be a compilation of the reasons for the closure expressed to that point.

Then, after McDermott's public disclosure on 8 November 2012 (that the BAC was to close in December 2012),⁵⁵ the Planning Group and the ECRG were formed. Their respective remits, deliberations and reports are discussed elsewhere in chapters 9 and 10.

Significantly, the ECRG prepared a 'service model elements' document which proposed 4 tiers of service provision for adolescents requiring extended mental health treatment and rehabilitation, namely:

Tier 1 – Public Community Child and Youth Mental Health Services (existing)

Tier 2a – Adolescent Day Program Services (existing and new)

Tier 2b – Adolescent Community Residential Services (new)

Tier 3 – Statewide Adolescent Inpatient Extended Treatment and Rehabilitation Service (new).

The ECRG, it will be recalled from chapter 10, emphasised that a 'Tier 3' service was an essential component of service provision and that there were risks if the BAC closed and no 'Tier 3' service was available in a timely manner.

Kelly, the Executive Director Mental Health and Specialised Services and the chair of the Planning Group, gave the following reasons for recommending that the BAC be closed:

- The building infrastructure of the BAC facility was not purpose built, was not suited to the continued provision of services of the kind being provided at the BAC, and not suitable for redevelopment.
- The development of The Park, in particular the development of EFTRU, constituted an unacceptable level of risk to adolescents accommodated in a low/no security environment on the site.
- MHAODB, which had State-wide responsibility and governance in relation to the planning for mental health service delivery, advised Kelly that the closure of the BAC was to occur as it aligned to the QPMH.
- The ECRG identified that there was risk associated with closure of the BAC, but alternative care models could be developed, and the consensus view of the specialist clinicians on the Planning Group was that the risks for individual BAC patients could be managed through individualised care planning.
- The WMHBB was adamant that any closure of BAC would not occur until such arrangements were in place.⁵⁶

West Moreton HHB's support for closure

On 24 May 2013 the West Moreton Board considered the closure of the BAC. That meeting is discussed in chapter 11.

The minutes of the West Moreton Board meeting on 24 May 2013 do not record specific reasons for closure, apart from a statement that "the Barrett facility is no longer suitable".⁵⁷

Mary Corbett, the Chair of the Board, gave evidence that the decision to close the BAC had been made in 2008 when there was a decision to relocate it to Redlands.⁵⁸ She attributed the "imperatives" to move towards alternative services and to remove patients from the BAC to two matters: first, the recognition in the QPMH, and more widely, that in the future model of care patients would receive care closer to home,⁵⁹ and, second, "other risks associated with the Barrett staying open" – presumably the impending co-location with EFTRU.⁶⁰

Tim Eltham, the Deputy Chair, also considered that the decision to close the BAC had been made when there was a decision to replace it in the mid to late 2000s.⁶¹ His evidence was that, when the decision to withdraw funding for the Redlands facility was made in 2012, the West Moreton Board was advised that it was nonetheless inappropriate to continue the BAC in its present form and at The Park because:

- The Park was well advanced on a transition process whereby all adult non-secure services were being closed and adult non-forensic patients were being transferred to community based care services, some within West Moreton HHS and others in a number of other areas, consistently with the goal of enabling patients to access care in their local communities. The Park would become an adult forensic patient service only [sic], comprising high and medium secure patients.⁶² The West Moreton HHB was advised that co-locating non-secure vulnerable adolescent patients with the types of patients in the secure and medium secure adult forensic services presented risks to the adolescent patients, and it would not be an optimal therapeutic environment for the adolescents.
- The BAC building was dilapidated and was struggling to achieve accreditation from the ACHS.
- Extended institutionalised care was not considered a contemporary model of care for patients of the kind being cared for at the BAC.⁶³

According to Eltham, those reasons for closing the BAC were not changed by the decision not to build the Redlands facility. From his perspective, there was a presumption that the decision to close the BAC still stood. To the extent that there was a further decision to close it (that is, a decision to close the BAC in the absence of a replacement inpatient unit), he considered that that decision was made by the then Minister for Health, Lawrence Springborg in about August 2013.⁶⁴

The Minister's announcement and subsequently

As discussed in chapter 12, the Minister announced the impending closure on ABC 612 radio on 6 August 2013.⁶⁵ His announcement recorded the reasons for closure as follows:

- the BAC being an "ageing facility"
- "it's in the middle of an adult mental health facility"
- the desirability of delivering "those services to people closer to their own home"
- past low occupancy rates.

After the BAC had closed, in an email to Michael Cleary and Ian Maynard (the then Director-General) on 14 July 2014, subject: 'Rationale for closing Barrett Adolescent Centre', Bill Kingswell made the following comments:

The BAC was opened in 1983 on the Wolston Park Hospital site. At that time it was co-located with the Barrett Centre (acute mental health unit) that served the acute MH needs of the West Moreton District Health Service.

It functioned as an extended treatment rehabilitation unit for adolescents. It attracted controversy, a number of reviews and a number of threats to its continued existence that were resisted by staff and a committed group of parents, whose children had used the service.

In the mid to late 90's the Wolston Park Hospital was extensively redeveloped and all acute services moved offsite, leaving an extended treatment and rehabilitation service, a medium secure mental health service, a service for those with intellectual disability and mental illness and the High Secure Facility for the forensic mental health population. Over time it became increasingly difficult to justify leaving an adolescent centre on the same campus as adults many of whom were detained in relation to very serious offences.

In the recent past an extensive project conducted by the Commonwealth developed the National Mental Health Service Planning Framework. This work is still in draft but does not describe the model of service provided by the BAC which has become increasingly out of step with contemporary treatment models.

However, the events of September 2013 highlighted/reinforced the need for urgent action. Parents complained ...

[REDACTED]

On review by the CEO of West Moreton HHS it was clear that there was a significant failure of governance within the unit. Critical incidents were not being reported beyond the unit. The CEO had no other option other than to investigate alternative care arrangements for this group of vulnerable young persons.⁶⁶

The list of reasons

That examination of the context has distilled the following reasons for the closure of the BAC:

- the age, condition and unsuitability of the buildings: limited refurbishment was not feasible
- the continued redevelopment of The Park as envisaged by the QPMH would result in the co-location of the BAC and adult forensic and secure services, in particular EFTRU
- contemporary models of care involved the provision of services in the community, closer to the patient's home, and a move away from what was regarded as long-term institutional care; in particular:
 - Planning was required to align with the National Mental Health Service Planning Framework that recommended subacute community based services for adolescents (and did not include provision for sub-acute/non-acute adolescent inpatient services)
 - The BAC was not aligned to the QPMH; a new (or re-scoped) model of care was required
 - Alternative care models could be developed
 - The length of stay at the BAC was too long
- the average bed occupancy rate for the BAC was only 43 per cent
- poor clinical governance of the BAC
- financial considerations.

Each of those reasons can now be analysed.

Reason 1: Ageing and unsuitable infrastructure

Introduction

The BAC accommodation and the on-site school were in adjoining buildings on The Park. Both are about 35 years old.

As can be seen from the 'Context' section of this chapter, the age and unsuitability of the infrastructure was a commonly cited reason for closing the BAC. Across the evidence of different witnesses, the meaning of 'unsuitable' takes on two broad forms. *First*, there is general agreement that the buildings were not suitable in so far as they were not purpose-built. *Second*, many witnesses contended that the BAC buildings were unsuitable in that they were unsafe and needed to be urgently replaced. Much of the evidence in support of the second form of unsuitability is based on reports by the ACHS, an independent organisation responsible for reviewing performance, assessment and accreditation of healthcare facilities.

Some witnesses said that the buildings were dilapidated because they had fallen into a state of disrepair while the Redlands project was on foot. Others said there had been no funding for refurbishment.

It is necessary to analyse the veracity of these propositions and, as a first step, it is important to identify the evidence of the unsuitability of the BAC buildings.

Evidence on the unsuitability of the BAC buildings

Minister, Director-General and Deputy Director-General

Springborg, the Minister, said he understood that one of the reasons for the 2013 decision to close the BAC was “the facility was ageing, and no longer safe for the patients and staff”.⁶⁷

The then Director-General, Tony O’Connell, recalls that in late 2012 he:

... received a copy of a Memorandum that the CEO of WMHHS sent to all HHS Chief Executives on 12 November 2012 advising them that the Redlands project had been discontinued, that the old BAC buildings were no longer fit for purpose, that WMHHS in partnership with MH Branch QH was commencing discussions with key experts, other health services and staff regarding the future model of adolescent mental health care in Queensland.⁶⁸

The briefing note sent to O’Connell in advance of the meeting on 15 July 2013 involving the Minister, Corbett, Dwyer and Kelly says (among other things): “The BAC cannot continue to provide services ... because the capital fabric of BAC is no longer fit for purpose”.⁶⁹

Cleary (Deputy Director-General) also recalls that, during meetings in 2013, one of the concerns raised was, “The buildings were now not ... considered suitable for the service provision”.⁷⁰ Cleary gave evidence that, earlier, on 15 October 2012 he sought advice from the Health Infrastructure Branch regarding whether there was an option to undertake maintenance and refurbishment of the BAC. He recalls being advised it was possible but not suitable.⁷¹

West Moreton Board

The evidence of Corbett, the Chair of the West Moreton Board, is that on 9 November 2012 she received an email from Dwyer, forwarding an email from Kelly, which stated, “[t]he age and condition of the building has been identified by the Australian Council on Healthcare Standards as unsafe, necessitating urgent replacement”.⁷² On 9 November 2012, Corbett, in turn, sent an email conveying that information to other members of the West Moreton Board, including Eltham, the Deputy Chair.⁷³

The board committee agenda paper for the 24 May 2013 West Moreton Board meeting states:

The current BAC is an aged facility that has been designated not-fit-for-purpose in the provision of inpatient services into the future. The state-funded capital project to build a replacement facility for BAC in Redlands has ceased due to unresolvable [sic] building and environmental barriers, and none of this capital funding is available to build the facility elsewhere.⁷⁴

Attachment 1 to that agenda paper, the ECRG report, states: “... the current BAC building has been identified as needing substantial refurbishment”.⁷⁵

Similarly, the evidence of Eltham is that in 2012, despite the cessation of the Redlands project, it was “... inappropriate to continue BAC in its present form and at its then location because ...”,⁷⁶ among other things, “The BAC building was dilapidated and was struggling to achieve accreditation from the Australian Council on Healthcare Standards”.⁷⁷ As to the decision to close the BAC, Eltham’s understanding was “The BAC building was dilapidated and was not a welcoming or therapeutic environment for young people”.⁷⁸

West Moreton HHS executive

Kelly's evidence was that one of the reasons for recommending closure of the BAC was:

The building infrastructure of the BAC facility was not purpose built, was not suited to the continued provision of services of the kind being provided at BAC and not suitable for redevelopment. Continued provision of services of the kind provided at BAC at that physical location was therefore contra indicated.⁷⁹

Her evidence was that when she commenced in the role of Executive Director, she was aware of the possibility of the BAC being closed, because:

It had been recognised since at least 2007 that the physical facility of BAC was unsuitable for the provision of clinical in-patient care. A project had identified a site at Redlands as the preferred option and funds were allocated in the Queensland Plan for Mental Health for that project.⁸⁰

Kelly and Dwyer referred to a 'Report on the Condition of the Barrett Adolescent School and Accommodation' dated 21 September 2012 by Robert Wood, the acting Building, Engineering and Maintenance Manager, Ipswich Hospital, West Moreton HHS (the 2012 West Moreton Report).⁸¹

Kelly explained that the 2012 West Moreton Report "... indicated the layout was not suitable for an in-patient service".⁸² Kelly said that, after reviewing it and consulting others, it was clear to her that "[l]imited refurbishment of the BAC building was not feasible".⁸³ In relation to the same report, Dwyer said:

The costs detailed in the report were relatively modest by comparison to a major capital project, however only represented minimum work to 'make good' the building and did not reflect the work that would have been needed to improve the clinical suitability of the building. There was no money in the budget for this work, and in any event, a capital upgrade of the building did not make sense when the BAC was considered an outdated model of care and unlikely to continue in more than the short term.⁸⁴

Dwyer's evidence was that "The building had also been the subject of adverse findings on annual audits undertaken by the Australian Council on Healthcare Standards".⁸⁵ Dwyer said that "[she] considered the option of improving the existing BAC building or rebuilding it on The Park campus, but did not accept such an option because ... There was no capital funding for a new building or upgrades, and in the absence of support from MHAODB, none would be available".⁸⁶

Mental Health Alcohol and Other Drugs Branch

Kingswell's evidence was:

The BAC had been earmarked for re-development in the Mental Health Plan. As a consequence, no significant upgrade to the building had occurred for many years and the building fabric was deteriorating and unsuitable for a modern mental health service. All other patient amenities on the same site had been completely rebuilt and the balance of the Barrett Centre Buildings demolished in the mid 1990's.⁸⁷

Geppert's evidence was that in August 2012, when the formal decision to cease the Redlands project was confirmed, she understood that one of the reasons the BAC could not stay at The Park site was "... due to the BAC building not being able to be suitably refurbished ...". Therefore, "... [she] was aware the 'bricks and mortar' facility of BAC was to be closed ...".⁸⁸ In an email drafted for Dwyer to send to key stakeholders ahead of a meeting on 15 November 2012, Geppert wrote,

"The BAC facility at The Park is approaching 40 years of age and has been identified by the Australian Council on Healthcare Standards as unsafe and necessitating urgent replacement".⁸⁹

Trevor Sadler's evidence

Trevor Sadler, Clinical Director of the BAC, said in his written statement that the "... two aspects of the building [the four-bed dormitories and communal bathrooms] were particularly detrimental to the progress of the adolescents" and was one of the reasons the length of stay for some of the patients was longer than ideal.⁹⁰ The issue of length of stay is discussed below.

Dwyer recalled that at a "walk around" on 11 September 2012:⁹¹

Dr Sadler was pointing out respects in which physical aspects of the BAC building were sub-optimal for the service, for example that the dormitory accommodation placed constraints on accepting new patients because dormitories had to be gender-segregated so the service could not accept a male patient even if the service was not full, if the available beds were in the female dorm rooms. One of the female patients also pointed out damage and dilapidation in various areas.⁹²

After the closure announcement

Patient safety continued to be a theme after the closure announcement by the Minister on 6 August 2013. Shortly after the announcement, West Moreton HHS and Children's Health Queensland HHS issued a FAQ document to the parents and carers of existing patients, BAC staff, and parents and carers of waitlist patients. In answer to the question "Is this a cost cutting exercise?", it said:

No, this is about the safety and wellbeing of young Queenslanders in need of mental health support services and treatment. The Queensland Government has committed a further \$2 million dollars to support the new models of care and services.⁹³

Reports on the unsuitability of the BAC buildings

It can be seen that the evidence of the witnesses as to the safety of the BAC were not based on their own observations but on reports. It is therefore necessary to look at those reports.

2012 West Moreton report on the condition of the BAC buildings

The purpose of the 2012 West Moreton Report⁹⁴ was to "... identify capital or redevelopment level works which are necessary to allow the Adolescent Mental Health service to effectively operate from the Barrett Adolescent site for the foreseeable future".⁹⁵ That report was based on "[a] recent inspection and ... tri-annual Building Condition Assessments".⁹⁶ It confirmed that the BAC buildings had not been purpose-built, and recommended "redesign and/or rebuilding" if they were to be utilised in the long term. It identified \$390 000 worth of repairs⁹⁷ intended "to bring the buildings back to good condition".⁹⁸

In short, it found that specific repairs could be undertaken to allow the BAC buildings to be utilised for the "foreseeable future".

Annual ACHS reports

The 2012 West Moreton Report had been preceded by several survey reports of the Australian Council on Healthcare Standards (ACHS). The Commission was provided with ACHS reports for the years 2008,⁹⁹ 2011¹⁰⁰ and 2012.¹⁰¹

2008 ACHS report

The 2008 ACHS report expressed support for the plan to relocate the BAC to the Redlands site and recommended that this work be "... expedited to enable care and services to be provided for adolescent patients in a purpose-built facility which facilitates a safe health environment and maximises the safety, comfort and needs of the community".¹⁰²

As an interim measure, the 2008 ACHS report included, as a "high priority recommendation", that within 60 days, written confirmation of approval be obtained (with necessary budget allocation to immediately make environmental modifications to the BAC building to reduce risk to acceptable levels, and to improve patient and staff safety. Recommended modifications included the removal and replacement of glass with Perspex, the replacement of the front entrance door with an aluminium frame and toughened glass, and modification of the High Dependency Unit.¹⁰³

A ministerial briefing note, cleared by Pam Lane (District Manager West Moreton South Burnett Health Service District on 2 September 2008, updated the then Health Minister on the accreditation status following the 2008 ACHS report.¹⁰⁴ In part, the briefing note stated that "The ACHS has advised the District that a one year conditional accreditation can only be granted due to the continued delay of the redevelopment of Barrett Adolescent Centre".¹⁰⁵ The briefing note included a plan for Lane to discuss with Aaron Groves (Director, Mental Health Services the requirement for a clear action plan and timeframe for the proposed redevelopment of the BAC. It further noted that minor capital works were to be completed at the BAC, including the construction of a High Dependency Unit within the existing building.¹⁰⁶

In her written statement to the Commission, Lane confirmed that following receipt of the 2008 ACHS report, she obtained the required approval for the recommended modifications to the BAC, and all modifications were subsequently carried out.¹⁰⁷

The Commission observes that the 2008 ACHS report did not recommend that the BAC be closed until Redlands was developed, but that it be maintained (or modified until the replacement service was in place.

2011 ACHS report

The 2011 ACHS report referred to the delay in the relocation of the BAC to Redlands. It described the continuation of the BAC services at The Park, pending the relocation, as "... a challenging physical environment".¹⁰⁸

The report acknowledged that considerable work had been carried out on the safety and security of the BAC, but noted that it remained "a 'run down' environment with dark corridors and lounge furniture in need of repair".¹⁰⁹ Specifically, it found that "... the overall environment would benefit from further modifications to the lighting and repairs to the furniture".¹¹⁰

The report recommended that steps be undertaken to "[i]mprove the environment of the Barrett Unit e.g. dark corridors and furniture requiring repair".¹¹¹ It is unclear whether this recommendation was carried out. The report did not recommend the BAC be closed until it was relocated.

2012 ACHS report

The 2012 ACHS report of the survey conducted on 20-24 August 2012, made recommendations similar to those in the 2011 report. It recommended that West Moreton HHS "[i]mprove the environment of the Barrett Unit e.g. dark corridors and furniture requiring repair".¹¹² It noted that

funding had been set aside to buy new furniture for the unit, with particular focus on replacing the couch that was worn and torn,¹¹³ and that a quotation to build skylights into the building to alleviate the dark corridors had been obtained. It noted that this work would not be carried out until the new financial year.¹¹⁴

There was no finding or recommendation that the building not continue to be used by the BAC.

Conclusions

It is not contentious that the BAC infrastructure was old and not purpose-built.

However, in his written evidence, the Minister went further and said that “the facility was ageing, and no longer safe for the patients and staff”.¹¹⁵ The Commission accepts that he said this on the strength of advice he had received.

The claims that the ACHS had said the BAC buildings were unsafe, and in need of urgent replacement had wide currency. For example, Kelly advised Dwyer, by an email on 8 November 2012, that: “The age and condition of the building has been identified by the Australian Council on Healthcare Standards as unsafe, necessitating urgent replacement”.¹¹⁶ Dwyer passed that email on to Corbett who then passed the information on to the West Moreton Board.¹¹⁷ On 14 November 2012 Dwyer told staff that the BAC facility had been identified by the ACHS as unsafe and necessitating urgent replacement.¹¹⁸

At the time when it was made, that claim was inaccurate. While the 2008 ACHS report had identified safety concerns, the physical modifications it recommended were attended to by Lane. None of the subsequent ACHS reports produced to the Commission identified any lack of safety for patients or staff. Instead, the reports continued to recommend various improvements, such as the replacement of old furniture. The reports after 2008 did not say that the building was unsafe or needed “urgent replacement”. However, the claim that the building was unsafe and needed urgent replacement remained current. It was not accurate.

Reason 2: Co-location with EFTRU

Introduction

As noted above, the QPMH and the associated budget document, 2007–08 State Budget Outcomes for Mental Health, included provision for 20 additional extended treatment beds for forensic patients in a redevelopment at The Park.¹¹⁹ The plan was to create an Extended Forensic Treatment and Rehabilitation Unit (EFTRU). The planning for EFTRU extended over several years. There was concurrent planning for the BAC replacement facility at Redlands. EFTRU was intended to open by mid-December 2010, and the Redlands unit by mid-January 2011.¹²⁰

As explained above, one of the reasons for the decision to close the BAC was that:

- the BAC was operating in an environment at The Park which involved principally adult forensic and secure services and, in particular,
- if the BAC continued at The Park, it would be co-located with EFTRU.

Kingswell's evidence

In his evidence to the inquiry, Kingswell explained what he described as a "looming problem" at the time that the future of the Redlands project was being considered:

Well, I suppose – I guess it's the perspective you took to the reasons that the Redlands Adolescent Centre was closed. So there were a number of, I think, policy reasons – sorry, not proceeded with. I think there were a number of policy reasons and it was a project in peril. It was unlikely to be built in any time soon and we had a looming problem with the Barrett Adolescent Centre on the site that it was on and we needed a solution to that. Redlands wasn't going to deliver that solution for us, not in a timely way.¹²¹

Kingswell explained further:

FREEBURN: So at the time you recommended that the Redlands project cease, did you consider that the Barrett Adolescent Centre would continue in its current form?

KINGSWELL: I thought it would continue until we had satisfactory arrangements for the very few young people that remained in that centre and that remained on its waitlist. I thought there was an urgency to close it. I was concerned about the extended – the EFTRU, they call it, the Forensic Treatment Rehabilitation Unit, I think, that was to open onsite. I think this Inquiry has heard quite a lot of information that, in my view, is not true, that there was no risk posed to these adolescents that I'm sure you're aware that I was the Director of Forensic Services for the southern half of the State for many years, up until about 2005. And I'd been working at Wolston Park since 1994. So I had a fair visibility of Barrett Adolescent Centre and other facilities on that site. The John Oxley Memorial Hospital which preceded the existing high secure unit used to admit 350 patients a year and 25 per cent of those patients were there in relation to fine default. So if the most dangerous thing you'd ever done was not pay a fine, nobody really cared and you could walk around the grounds and you probably didn't pose a risk to anybody much. That changed over time and particularly changed with the *Mental Health Act 2000* which was proclaimed in 2002 which allowed mentally ill offenders to be managed in any mental health facility in the state that was prepared to accept the risk. And it constrained the activities of the high secure unit at The Park to only those people that had committed very serious offences; predominantly homicide, attempt homicide and other – you know, rape, very high level offending. The perimeter of the high secure unit is about five metres high and even the dog squad couldn't get over it. The EFTRU is a very different model of service. It's like a community care unit for mentally ill offenders. It's open. They can walk out. It has a gate. The likelihood of some harm coming to an adolescent on that site might not have been high and perhaps the immediacy wasn't urgent either, but the magnitude of the problem that you were going to visit if something went awry was going to be catastrophic, and had anything like that occurred I'd be sitting in front of an inquiry asking a – answering a very different set of questions. People would be asking what were you thinking leaving a group of vulnerable children on that site with that population?¹²²

Other evidence

The founding Medical Director of the BAC, Cary Breakey's, evidence was that there had never been any threats or incidents arising from the location of forensic patients alongside BAC: "The risk of harm from forensic patients is not a valid concern as Security Patients were sited at Wolston Park along with BAC since 1983 with far less monitoring capacity than today, with no threats or incidents arising".¹²³

That there had been no threats or incidents is beside the point. There is some force in Kingswell's evidence that the harm if the risk event eventuated may have been catastrophic.

A recognised risk

A number of other witnesses were concerned about the proposed co-location of the BAC and the mainly forensic population of The Park.¹²⁴ Indeed, it does not appear to be controversial that the co-location with the forensic unit was a recognised risk. The absence of previous threats or incidents arising from the BAC's location within The Park was only one factor relevant to the assessment of the risks. And it is likely that EFTRU, and its proximity to the BAC, posed a greater risk than in the past. Certainly, that is the tenor of Kingswell's evidence quoted above.

However, it is surprising that there is no evidence of a written or detailed consideration or assessment of the risk posed by the co-location of the BAC and EFTRU by Queensland Health or West Moreton HHS.

EFTRU had commenced operations by the time Anne Brennan (acting Clinical Director, BAC) arrived in September 2013. She took some steps to ensure that BAC patients were accompanied whilst in the grounds.¹²⁵ The patients admitted to EFTRU in those early stages were limited in number and, presumably, carefully selected for the level of risk they posed.¹²⁶ Otherwise, there seems to have been no assessment of the gravity or likelihood of the risks or of the measures that could or needed to be undertaken to eliminate or minimise the risks.

It is probable that the risks of co-location were well recognised and were, for that reason, not assessed or the subject of a long-term risk management strategy. Of course, the co-location issue would not have arisen if the Redlands project had proceeded in a timely way.

In general terms, the co-location of the BAC and EFTRU appears to be a legitimate reason for re-locating the BAC to another location. But there are some problems. First, the co-location had been in prospect for some years, without any planning for it. Second, in May and August 2012 Queensland Health was considering ceasing the Redlands project and allocating the Redlands funding to other priorities. Consideration of those proposals ought to have brought the prospect of the BAC's 'looming' co-location with EFTRU into sharp focus. If the BAC was to continue on The Park site, it was an obvious problem. But there is no evidence the co-location issue was brought to the attention of the Director-General, or the Minister, or that it was taken into account. Third, it is puzzling that two planning decisions, both based on the QPMH, namely to re-locate the BAC and to locate EFTRU on The Park campus, became a reason to close the BAC. If the two facilities could not co-exist on the same site in the long term, it is not logical that the only solution was to close one of them. It is a reason to search for an alternative site.

Other alternatives – such as delaying the opening of EFTRU until a replacement for the BAC was found, or finding a temporary home for the BAC patients, or considering refurbishing an existing facility or other alternative accommodation,¹²⁷ or assessing and eliminating or minimising the risks of co-location – appear not to have been considered.

More likely than not, other options were not considered because there were other reasons for closure – as explained elsewhere in this chapter.

As stated above, the co-location of the BAC and EFTRU appears to be a legitimate reason for re-locating the BAC to another location. However, in the Commission's view, the impending co-location was not, on its own, a legitimate reason to close the BAC. Closing a mental health facility like the BAC on the basis of its co-location with another facility required, at the least, some assessment of the risks of co-location versus the risks of closing the facility without a replacement being in place. There is no evidence before the Commission of even a rudimentary assessment of those comparative risks.

Reason 3: Not a contemporary model of care

Introduction: evidence as to non-contemporary models of care

A number of witnesses gave evidence that one or more of the models of care for the BAC, the Redlands project, and an adolescent inpatient extended treatment and rehabilitation service (described as a 'Tier 3' facility by the ECRG) were not contemporary models of care. Their evidence was that contemporary rationales favoured care in the community, close to existing family and social supports.

For example, Springborg's evidence was that:

the Barrett [Adolescent] Centre represented an outdated model of care that Queensland should move away from. My understanding was that long-term and institutional care was no longer considered to be best practice, and that the preferred model involved caring for young people in their community and closer to home.¹²⁸

The Director-General, Tony O'Connell, emphasised a "... move more to community-based support ...".¹²⁹

Michael Cleary said that Kingswell told him:

- the proposed unit [at Redlands] contained a model of care that was not now considered contemporary [and that] ... institutional models of care were not considered contemporary under the draft "National Mental Health Service Planning Framework"¹³⁰
- the model of care [at BAC] was no longer consistent with best practice.¹³¹

Kingswell's evidence was that:

Firstly, the centre [BAC] had been operated as a therapeutic community for many years and, as such, it was a highly controversial and, some would argue, outdated, model of care. No other jurisdiction in Australia runs a centre where adolescents are hospitalised for years within a standalone psychiatric institution. A number of reviews over the years had recommended that the BAC be reformed or closed and replaced with alternative services but these had not been actioned.¹³²

Mary Corbett said that "Under the QPMH there was a need to develop a contemporary, evidence based model of care for adolescent mental health".¹³³ In her oral evidence Corbett also added that the model of care at BAC was not aligned with the draft NMHSPF and was not therefore an up-to-date model.¹³⁴

Tim Eltham's evidence was that "Extended institutionalised care was not considered a contemporary model of care for patients of the kind being cared for at BAC".¹³⁵ Eltham expanded:

The model of care at BAC consisted of long term institutionalised care in a centralised State-wide facility which for many patients meant they were disconnected from their family, friends, school, local community and other supports. Over a lengthy period, the philosophy of mental health care had moved away from institutionalised models and towards care in the community close to existing supports, where this was possible. The BAC model did not reflect current national or State based approaches, which emphasised care in the patient's local community and reduced reliance on hospitalisation. The closure of BAC was intended to reflect and occur in conjunction with the development of alternative service options which better reflected this contemporary approach to care.¹³⁶

In her witness statement Lesley Dwyer said that, although it was not her decision, she supported the decision to close the BAC. She said that the matters to which she attributed greatest weight included the following:

The fact that BAC was not a contemporary model of care. I am not a mental health clinician, however I was advised, and was able to confirm by considering the operations of BAC, that the BAC model ... was contrary to the contemporary model which emphasised community-based, locally provided, non-institutional care for patients not requiring acute admission.¹³⁷

In her oral evidence, when she was taken to that paragraph, Dwyer said:

FREEBURN: Alright. Are you able to say in what respects it was not a contemporary model of care?

DWYER: It was a residential model that had a length of stay that was quite long; I think, you know, sort of, an average from about, I think, 10 months. But some of the clients had been involved with Barrett for about two years. That meant that, for many of them, there was a dislocation from their family and social networks, and from what I had been advised and had been able to read, ... that is something that is not considered to be contemporary for that long period in time. I was also aware that [indistinct] model that we had and particularly around the accommodation was also not what they would call a conducive, therapeutic environment.¹³⁸

Sharon Kelly said she was advised by the MHAODB that the closure of the BAC was to occur as the closure was aligned with the QPMH.¹³⁹

Different interpretations of non-contemporary models of care?

In closing submissions Counsel Assisting argued that the evidence demonstrated that some witnesses used the expression 'not a contemporary model of care', and similar expressions, to indicate one or more of these things:

- extended stays in an institution were undesirable – and risked institutionalisation
- contemporary models of care emphasise community-based, locally provided and non-institutional care
- the BAC or Redlands model was not consistent with the QPMH
- the BAC or Redlands model was inconsistent with the draft NMHSPF
- the model of care was outdated
- the model of care did not have an evidence base
- the types of therapy used were unsuitable.¹⁴⁰

Counsel for Cleary and O’Connell argued that in fact the witnesses were speaking of the same thing:

Commissioner, the point of reference though to that first passage from Dr Cleary’s evidence that we did take you to was to say that when people were speaking of the plan or the planning framework with respect to contemporary models of care – or when people spoke of therapy services that were closer to the community of origin for the patients and when people spoke of institutionalisation they were speaking of one and the same concept, that is, the idea – the **overarching philosophy that care should be provided to patients of mental health services including, in the instance of adolescents, that kept them more engaged with their communities of origin and less dependent upon an institution as may be the case in a hospital setting to the extent possible.** So each of those references that Mr Freeburn took you to, Commissioner, in our submission, are just different ways of these people saying effectively the same thing even though they acknowledge that there will be a residual need for a small number of beds to continue to be provided.¹⁴¹

(emphasis added)

There were certainly two related central themes in the criticism of the BAC, Redlands and Tier 3 models as ‘not contemporary’. The first was that bed-based extended treatment and rehabilitation in an institution was not appropriate for adolescents, except for a small number of patients.¹⁴² The second was that long lengths of stay lead to institutionalisation, which is adverse to the well-being of the adolescents.

It is necessary to look at some specific aspects of the concept of ‘contemporary models of care’. In particular:

- Is there an ‘overarching philosophy’ (and to what extent does it apply to the BAC cohort)?
- To what extent do the principles of evidence-based medicine apply?
- What is the influence of lengths of stay and the risks of institutionalisation?
- What was the relevance of the QPMH to the models of care proposed for Redlands and the decision to close the BAC?
- What is the influence of the draft National Mental Health Service Planning Framework?

Each aspect is considered below.

The overarching philosophy of “least restrictive” environment in mental health care

Graham Martin, an experienced child and adolescent psychiatrist, gave evidence to the Commission that the idea that it is preferable to treat patients (whether adult or adolescent) in the community, rather than as inpatients, is one that has been around a long time.¹⁴³ Indeed, the principle of preferring the “least restrictive” option, which underpins all Australian mental health policy and legislation, derives from the 1991 UN Principles for the Protection of People with Mental Illness and for the Improvement of Mental Health Care.¹⁴⁴

O’Connell gave evidence to similar effect. He traced the emerging clinical preference for community-based care and support to the Richmond Report written for the NSW Department of Health in 1983,¹⁴⁵ and to the re-publication of that report by the NSW Mental Health Commission in October 2014, as well as the QPMH.¹⁴⁶

The importance of this principle in this context is not controversial.¹⁴⁷

Even so, the 1993 Burdekin report warned against deinstitutionalisation without the provision of viable alternative services, including accommodation.¹⁴⁸ Similarly, Patrick McGorry (Professor of Youth Mental Health, University of Melbourne) gave evidence of a “false dichotomy” of “hospital versus community”, which posits that “you can do everything in the community” and “beds are sort of unnecessary”. He said that approach ultimately results in governments providing inadequate numbers of acute beds, “let alone long-term beds”, and a community investment which is “actually shrinking”.¹⁴⁹

When asked about the appropriateness of closing a sub-acute extended treatment and rehabilitation service, such as the BAC, before the replacement model of care had been finalised and implemented, Patrick McGorry said that:

Closing a facility caring for the most severely ill and disabled without an alternative approach is a microcosm of the kind of irresponsible deinstitutionalisation that has plagued mental health reform over the past 3 decades around the world.¹⁵⁰

Does the overarching philosophy exclude bed-based care?

The overarching philosophy of the “least restrictive” care option itself recognises a “more restrictive” option may be appropriate where a patient’s clinical needs can be adequately met only in that way. In her oral evidence, Beth Kotzé (Director of Mental Health – Children and Young People, NSW) did not rule out the possibility of inpatient stays as an option, suggesting that:

The best contemporary evidence supports that mental health care should be based in the community where young people live and are connected to their family, peers and community, with access to more intense levels of specialist day and inpatient care when it is not possible to provide the type or intensity of treatment or clinical risk management in a less restrictive setting. The phase of inpatient care should be as brief as possible to achieve symptom control and/or manage clinical risk and/or address significant disability with discharge to community-based care facilitated as soon as possible. This may require a period of intensive community-based care in the post discharge period.¹⁵¹

Similarly, O’Connell acknowledged the overarching philosophy but said:

I have not suggested that there is never a need for certain mental health patients to be hospitalized (acutely or in extended bed-based care), nor have I acted in a way that would suggest that. The BAC did not close while I was Director-General.¹⁵²

Those views of O’Connell and Kotzé are reflected in the QPMH. That policy acknowledges the overarching philosophy which prefers treatments which impose the least restriction on the patient’s rights as possible.¹⁵³ But that policy, and its associated budget documents, expressly provided \$121.55 million for 276 new, upgraded or redeveloped acute and extended treatment beds that met contemporary standards.¹⁵⁴ Part of that provision of \$121.55 million for 276 new, upgraded or redeveloped beds was for a capital works project to develop a new 15-bed adolescent extended care unit following closure of the BAC at The Park.

Thus, the policy, based as it was on expert advice,¹⁵⁵ proposed that the BAC move from The Park campus and be replaced with a new bed-based unit. The replacement facility became the Redlands project. Importantly for present purposes, the replacement envisaged by the policy was institutional care, but institutional care in a different location.

The ECRG report, which was prepared by a number of experts, including five child and adolescent psychiatrists, acknowledged the validity of other CYMHS service types, including community health clinics, day programs and acute inpatient units.¹⁵⁶ However, the ECRG strongly articulated that those other service types were not as effective in providing safe, medium-term extended care and rehabilitation to the target group. Specifically, the ECRG said that "... a design-specific and clinically staffed bed-based service is essential for adolescents who require medium term extended care and rehabilitation".¹⁵⁷

More recently, the Statewide Sub-Acute Beds Discussion Paper prepared by Sophie Morson in January 2016 (Statewide Sub-Acute Beds Discussion Paper) concluded that "... extended admission with a rehabilitative focus may be warranted for a small sub-set of young people, with provision made on a case by case basis considering the needs of individual young people and their circumstances".¹⁵⁸

In short, the overarching philosophy, which prefers the least restrictive option, and a resulting preference for community-based care, does not exclude the need for extended admissions for a small group of adolescents who require medium term extended care and rehabilitation.

Redlands, the BAC and the decisions

Earlier in this chapter, it was explained that the planning for the Redlands project had progressed on the basis that it would provide institutional care according to a new model of care. The new model of care proposed for Redlands responded to several of the criticisms of the BAC, including the criticism that the length of stay at the BAC was too long. It involved a six month targeted and phased treatment program; specific cases where admission exceeded six months were to be presented to an intake panel for review.¹⁵⁹

The proposed model for Redlands also involved a 'refined treatment process', comprising a suite of evidence-based treatments tailored to suit the individual's needs.¹⁶⁰ Thus, the proposed model for Redlands met the concerns raised in respect of the BAC's therapies.

However, as explained in chapters 3 and 5, the Redlands project was cancelled and the funding for the project was re-allocated to other priorities. That decision was based on the 'overarching philosophy' that it is preferable to treat patients in the community, rather than as inpatients in an institution. Some examples of that rationale for the decision are as follows:

- the Minister said he had been told by senior clinicians that a facility like the BAC was not regarded as contemporary within the draft National Mental Health Service Planning Framework (NMHSPF)
- The Deputy-General, O'Connell, thought there was an emerging clinical preference for community-based, closer to home, models of care
- Cleary, who was advised by Kingswell, considered that the proposed unit at Redlands was now not considered contemporary with work being undertaken nationally that indicated an institutional model of service was not considered contemporary within the draft NMHSPF.

The 'overarching philosophy' may have lain behind the vague expression "re-scoping of the clinical service model" in the May 2012 briefing note.

In any event, two interrelated points need to be made here. The *first* is that, as explained above, the overarching philosophy is not absolute. The evidence is clear that not all of the 'target' group, that is, adolescents with severe and persisting mental illness, can be treated in community-based care. A small number of young people require extended admission in an institution with a rehabilitative focus. Thus, it is flawed reasoning to rely on the overarching philosophy as a basis for ceasing the Redlands project or for closing the BAC. The BAC was the only facility of its type in the state. Had the Redlands project been completed as the replacement for the BAC, it would have been the only facility of its type in the state.

The *second* is that the decisions to cease Redlands and to close the BAC can be justified only if there were some clear principle, or clinical evidence, that bed-based care was unnecessary and that the 'target' adolescents could be properly cared for in a community-based setting.

The next section of this chapter comprises an examination of the evidence, principally the expert evidence, to assess whether there is support for the view that institutions are unnecessary or may become unnecessary.

The AMHETI continuum

From February 2014, shortly after the BAC closed, Children's Health Queensland HHS commenced developing a suite of mental health services for adolescents and young people with severe and persistent mental illness. The suite is called the Adolescent and Mental Health Extended Treatment Initiative (AMHETI). Chapter 28 explains the implementation of the AMHETI suite. Chapter 28 explains each of its components.

A number of expert witnesses commented on whether there will be a residual need for an extended sub-acute inpatient service (such as the BAC or Redlands or a 'Tier 3') when the AMHETI continuum is fully implemented.

Brett McDermott, for example, was asked by counsel for the State of Queensland whether the AMHETI suite of services would reduce the need for any patient extended stays in acute facilities.¹⁶¹ McDermott was reluctant to agree that the need for extended stays would be reduced for two reasons. First, he considered that it is too early to do this assessment. Second, it has not been established that the AMHETI "continuum" is operating in the way it should be operating (for example, one patient could be simultaneously case managed by the Assertive Mobile Youth Outreach Service (AMYOS), accommodated by the Youth Resi and attending a day program). He said:

Now, we haven't established that that's happened, to my knowledge. It might be happening and that would be magnificent. But sometimes what you'd find is that the care is, in fact, disintegrated and a different cohort go to here and a different cohort go to there. In which case, it will not replace the comprehensiveness that it's meant to.¹⁶²

While McDermott said in his written statement that: "[t]he principle of access to care close to home is not in favour of a state-wide long stay inpatient unit such as the BAC ...",¹⁶³ his oral evidence was that he had "no doubt" that some people have to leave home to get some form of more intensive treatment experience.¹⁶⁴ In his written statement, McDermott's evidence was that he strongly supported the relocation of the BAC to Redlands and that, on the closure of the BAC, it was appropriate for it to be replaced by a similar facility with an updated model of care.¹⁶⁵

Stephen Stathis (Clinical Director of Child and Youth Mental Health Services, CHQ) expressed the view that there may be limited need for adolescent sub-acute beds if the whole of the continuum were endorsed and funded.¹⁶⁶ In his oral evidence, Stathis provided a more nuanced view. He said that, notwithstanding the fact that a more extensive suite of services will provide a greater number of “less restrictive” options and increase the likelihood that a young person can receive treatment closer to home, there was always going to be a small subset of young people who do not respond to community care and for whom a longer inpatient stay may be required. Stathis stressed that it is hard to get an evidence-base on the most appropriate treatment for this subset.¹⁶⁷ That issue is discussed in more detail below.

On behalf of the Royal Australian and New Zealand College of Psychiatrists (the College), Michelle Fryer also said that development of more intensive services, such as AMYOS, along with education and residential facilities, may reduce or remove the need for sub-acute inpatient services.¹⁶⁸ However, Fryer agreed that Queensland does not yet have a full suite of services. She noted that the future is promising in the development of more services like AMYOS.¹⁶⁹

Anne Brennan, the acting Clinical Director of the BAC from September 2013 to the closure in January 2014, was responsible for arranging the transitions of the BAC patients. Brennan’s view was that:

[m]any of the Barrett patients are able to be treated with the services currently available such as CYMHS, AMYOS, day programs and treatment in acute beds in local hospitals. However there are some who require a medium term residential facility which provides not only nursing observation and attention to reduction or prevention of self harm but also education and vocational training and socialisation. There are no such services currently.¹⁷⁰

All of the AMHETI suite of services are not yet available in Queensland. McDermott, Stathis, Fryer and Brennan all agree that, at least until the full suite is available, there is a need for a longer term inpatient facility. What the position will be if, and when, the full suite becomes available is a difficult question. McDermott thought it was too early to say. Stathis was worried about the lack of an evidence base but considered that there may be a small subset of young people for whom longer inpatient stays may be required. Fryer took the view that the full suite may reduce or remove the need for sub-acute inpatient services. Brennan’s opinion was that there are some young people who require a medium term residential facility.

As can be seen from chapter 28, there have been delays in establishing the AMHETI suite of services. Those delays are attributable to a variety of reasons: funding and procurement, logistical delays (such as governance issues and negotiation of service agreements and funding arrangements), acquiring sufficiently qualified staff. No evidence before the Commission suggests that the full suite of services is likely to be available across the State in the near future. That being the case, it is necessary to look at the expert evidence on whether there is a present need for a medium term inpatient facility. The Commission had the benefit of evidence from a number of experts on this issue.

Evidence on the residual need for an inpatient facility

The expert opinion

The four experts referred to above (McDermott, Stathis, Fryer and Brennan) all acknowledged that, until the full suite was available (and possibly even after it became available, there was a need for a medium term inpatient facility.

James Scott, a child and adolescent psychiatrist and one of the members of the ECRG, took a more neutral view. Scott was less certain about the need for an inpatient extended treatment and rehabilitation unit for adolescents than he had been when he was on the ECRG:

I am less certain about – I think that there are possibly – there are other community models that operate around the world and other jurisdictions where there’s specialist therapies available to provide care for young people in the community. As a rule, as an absolute rule, young people are best cared for at home with their families. So whenever that can take place, it should. What that often requires is extra disability support. It requires specialised and intensive therapy to be available in the community settings. And when those other services aren’t available – and also extra educational support as well, schools being willing to look after these kids and educate these kids. When those aren’t available, that’s where we sort of find that young people can’t be managed in a community and, thus, are needing an inpatient facility to look after them.¹⁷¹

Scott’s view was that the need for an inpatient facility depended on whether there were sufficient services to support community treatment. When cross-examined by counsel for three of the young people’s families about whether it was beneficial to continue to provide a Tier 3 service in the future, Scott stated “... I’m not strongly of a view that there should be or shouldn’t be a Tier 3 model in place. I think that people need to have a really good look at what the evidence is and what the other alternatives might be before investing such a large sum of money into such a facility”.¹⁷²

Another member of the ECRG, Philip Hazell, remained supportive of the ECRG’s second “key message” that inpatient extended treatment and rehabilitation (Tier 3) is an essential service component. However, he stressed the importance of this facility being only one component of a broader suite of community services.¹⁷³ He explained:

For a state the size of Queensland, I consider that a lack of a Tier 3 service for adolescents will create difficulties and put pressure on the other levels of service, including ‘bed block’ for acute inpatient units... Facilities such as the Walker unit and the BAC are important in any statewide mental health service, in order to take away the demands from the acute units.¹⁷⁴

Graham Martin (retired Professor of Child and Adolescent Psychiatry, UQ) acknowledged the paucity of evidence for inpatient extended treatment and rehabilitation.¹⁷⁵ It was nevertheless Martin’s view that there is still a need for a facility or facilities that can provide longer-term inpatient care:

There will always be damaged people and young people who need longer term care. Some of these will need inpatient care, protection from adverse family dynamics or abuse of one form or another, and the time necessary to get them to the point of reintegration to society. I believe we do need a facility or facilities that can provide longer-term inpatient care even if this is limited to the 6 months as I believe is recommended by the Faculty of Child and Adolescent Psychiatry of the Royal Australian and New Zealand College of Psychiatrists ... It may be that we need also to consider a number of other emerging semi-residential community programs to take pressure off the available inpatient beds (if such pressure is a reality).¹⁷⁶

McGorry acknowledged the overarching philosophy of emerging adult mental health that community-based treatment is more beneficial than long-term inpatient care because of the risk of institutionalisation. Nonetheless, his evidence was that, for a cohort similar to the BAC (severely damaged patients), longer inpatient admissions are necessary and need to be available.¹⁷⁷

Scott Harden, a child and adolescent psychiatrist, expressed a similar view:

... [T]here are a small number of severely disabled young people with treatment resistant mental health problems who may require extended treatment and rehabilitation. They generally have a poor long-term prognosis. Clearly they require treatment services.¹⁷⁸

But Harden did not support the model of a long-term, bed-oriented inpatient or residential facility:

[t]he group of young people who require treatment by such a service are likely to require a prolonged, predominantly rehabilitative and recovery oriented approach to treatment. This is a strongly psychosocial set of interventions although clearly medical treatments are often critical in combination with these approaches. If it is possible, it is most important that these treatments, often requiring some years of intervention, are undertaken as close as possible to the young person's community of origin or their community that will support them in to the future ...

... a comprehensive, developmentally sensitive and best practice approach will not be "bed-oriented", that is the idea of a "facility" focused predominantly around inpatient or residential care. Instead a flexible range of interventions should be targeted at the needs of the young people ... If there are clear synergies from meeting more than one need with one intervention that is useful, however an inflexible approach where all needs are thought to be met by one intervention such as prolonged inpatient care is as I have previously described is unhelpful, outdated and often damaging.¹⁷⁹

(emphasis added)

Aaron Groves, who has considerable experience in planning health services in Queensland, Western Australia and South Australia, explained in his oral evidence that:

... whichever state I have looked at, there seems to be a common group of people who are not well-served by acute units. They are not well-served by community-based services. They are not well-served by wraparound however that's defined. And from time to time they come into contact with and will need a much more comprehensive package of services. Whether you call it subacute – and I know that the language has varied considerably ... *[i]t's about needing to have treatment and rehab.*¹⁸⁰

The College and expert reports

The College

The overall position articulated by Fryer, on behalf of the College, was that:

... the RANZCP supports consideration of a medium-term inpatient unit that provides extended treatment and rehabilitation. However, there are risks in models like these, such as; institutionalisation; diverting attention from community based models. Models that focus on minimising duration of stay while maximising therapeutic gains (generally cited at 3 to 6 months as a maximum) are preferable. There is concern that longer lengths of stay carry risks of deinstitutionalisation [sic] and iatrogenic increase in disability.¹⁸¹

In other words, the College favours a medium-term inpatient unit, but cautions that there are risks and stays should be minimised.

Statewide Sub-Acute Beds Discussion Paper

As explained above, the Statewide Sub-Acute Beds Discussion Paper prepared by Sophie Morson in January 2016 concluded that “extended admission with a rehabilitative focus may be warranted for a small sub-set of young people, with provision made on a case by case basis considering the needs of individual young people and their circumstances”.¹⁸²

ECRG Report

The ECRG report was prepared by a group with considerable expertise, including five child and adolescent psychiatrists, and allied health professionals and carer and consumer representatives.¹⁸³ The ECRG’s report stated that:

... it is the view of the ECRG that like the Community Care Units within the adult mental health service stream, a design-specific and clinically staffed bed-based service is essential for adolescents who require medium-term extended care and rehabilitation.¹⁸⁴

The ECRG was strongly of the view that a ‘Tier 3’ facility was an essential service component, and, if no Tier 3 was available, there were risks to patients. Whilst there was some argument about whether the ECRG were speaking of a Tier 3 as a ‘service’ or a ‘bricks and mortar’ facility, the Commission is satisfied that the ECRG plainly had in mind a ‘bricks and mortar’ facility.¹⁸⁵

Breakey and Sadler

The founder of the BAC, Cary Breakey, perhaps predictably, strongly advocated for the model of a long-term inpatient facility with an on-site school:

... the model of long-term inpatient care coupled with an onsite school offered by BAC until its closure is the most effective model care for adolescents with at the severe end of mental health issues, who had already exhausted existing safe community options....¹⁸⁶

[t]here is no more contemporary model that is effective in treating this group of adolescents. By the time patients reached BAC, almost all had recurrent failed admissions to acute units. These units did not have the capacity to care for the patients, and could not provide an opportunity for the patients to become comfortable with staff in a two week period.¹⁸⁷

Trevor Sadler, as a member of the ECRG, and as the Clinical Director of the BAC until September 2013, also supported the need for a BAC/Redlands/Tier 3 type facility. Sadler’s statements and his oral evidence gave considerable detail of the care administered at the BAC as well as the challenges faced by the BAC.

Other jurisdictions

William Kingswell, the Executive Director of the Mental Health Alcohol and Other Drugs Branch, gave evidence that there is no similar centre in any of the other Australian states, other than the Walker Unit in New South Wales, which he said “... runs on a very different model of care”.¹⁸⁸ He said:

So that means that 20-odd million Australians seem to get by without a Barrett Adolescent Centre. Those jurisdictions must manage these – this cohort in some other way and apparently do so successfully.¹⁸⁹

In his oral evidence, Stathis stated generally that "... there are very few dedicated subacute units anywhere in the world. And from the discussions I've had, these are closing. They're not opening any new ones".¹⁹⁰ When the Commissioner questioned him about the Walker Unit, and the proposed opening of the Bentley Adolescent Unit in Western Australia, Stathis acknowledged these inter-state examples and said:

So it may well be that if there was a subacute unit with a new contemporary model of service, we may well find that the patients there look very different in terms of diagnostic profiles to the patients that had been admitted to the Barrett.¹⁹¹

Sadler gave evidence of having connections with a number of overseas adolescent services and of having visited facilities with features similar to the BAC in the United Kingdom and Switzerland in 2010 and 2011.¹⁹²

The evidence from Philip Hazell, the Director of the Thomas Walker Hospital (Rivendell), does not support the view that the Walker or Rivendell units treat a different cohort (or that they are at risk of closing).

Walker and Rivendell units in New South Wales

Hazell provided a detailed description of the Walker¹⁹³ and Rivendell¹⁹⁴ units in his statement and oral evidence:

The Walker and Rivendell units are part of the Concord Centre for Mental Health. The Walker unit is located on the grounds of the Concord Hospital, [and] the Rivendell unit is located on land adjacent to the hospital. The two units are linked operationally, but administratively separate.¹⁹⁵

Notwithstanding the administrative separation, the range of clinical interventions for patients is common to both the Rivendell and Walker units ... differing only in intensity.¹⁹⁶

Rivendell

The Rivendell unit opened in 1978. It is a state-wide service which "... provides specialist multidisciplinary assessment and subacute integrated treatment and rehabilitation to young people between 12 and 18 years with persistent mental illness/es that lead to significant impairment ... The focus of the Rivendell unit is on rehabilitation, reinstating young people into an educational program ... and integrating them back into their families".¹⁹⁷

The on-site Rivendell School provides an educational program aimed at rehabilitation and restoration of developmental tasks. In most instances, "Rivendell patients ... have been unable to attend school for a prolonged period despite active community interventions"¹⁹⁸ and so "... admission to the Rivendell unit is a step up from less intensive community treatment, while for a minority it is a step down from more intensive treatment in another inpatient setting (such as the Walker unit)".¹⁹⁹ The level of admission ranges from day admission to partial hospitalisation (four nights per week with the patient returning home on weekends), with an on-call consultant child and adolescent psychiatrist 24 hours a day, 7 days a week. Family meetings generally occur at least fortnightly and "... admission to the Rivendell unit typically does not exceed six months (two school terms)".²⁰⁰

Walker

The Walker unit opened on 4 May 2009. Hazell describes the Walker unit as "[e]ssentially a scaled-up Rivendell model".²⁰¹ It "operate[s] a 12-bed state-wide inpatient long stay unit for young people between 12 and 18 years experiencing severe and unremitting" mental illness".²⁰²

The Walker unit has capacity to provide involuntary treatment for patients. It does not have a day program – if a young person is well enough to attend a day program, they are generally transitioned to the Rivendell unit or elsewhere.²⁰³ The unit also has a family pod within the unit so parents and other family members can stay for a period of a week or so working intensively with the young person.²⁰⁴ “Although there is an admission cap of aged 18, the Walker unit does not arbitrarily discharge patients simply because they turn 18 ... [but rather the] admission will continue until the Walker team and the referrer each agree that discharge is appropriate”.²⁰⁵

Most patients admitted to the Walker unit have had a substantial period of treatment in an acute inpatient setting, have significant level of risk and are characterised as being “atypical ... that is they have features or complexities to their situation which are not commonly encountered in routine CAMHS inpatient work”.²⁰⁶ Patients who are admitted to the Walker unit fall into four main groups including those with:

- unremitting psychosis
- unremitting mood disorder (generally bipolar, rather than unipolar depression)
- neurodevelopmental disorders such as autism (usually complicated by intercurrent psychosis or mood disorder or unremitting/unrelenting suicidality arising from any cause)
- borderline personality disorder - typically, at any one time, two of the 12 patients at the Walker unit have an emerging borderline personality disorder, however staff try to cap the number of such admissions at two because of difficulties managing the ward milieu.²⁰⁷

Hazell gave evidence that since its opening in 2009, there have been moves to try to have the Walker unit accept a mix of acute and longer stay patients and to include patients with sole diagnosis of an eating disorder.²⁰⁸ His evidence was that “[e]ither of these changes would be bad clinical practice, and [he] was involved in successfully resisting both [proposals]”.²⁰⁹

Philip Hazell

Hazell did not agree that the Walker/Rivendell cohort was comprised of a majority of intellectually impaired young people and/or young people with severe psychosis. He said:

I’ve looked at the diagnostic data over several years for the Walker unit. Patients with psychosis make up about 50 per cent of the cohort. The remaining 50 per cent are made up of a combination of young people with severe and relentless suicidality from any cause, severe and treatment-resistant mood disorder, and neuropsychiatric conditions, typically autism. But the autism group also overlap with our psychosis group, so we have – quite a few of our patients with psychotic illness also have autism. Now, within the patient population we don’t exclude young people with intellectual disabilities, so they form part of the patient group, but they certainly don’t form a large part of the patient group. Their incidence within the unit kind of reflects their prevalence in the community.²¹⁰

The Commission accepts the evidence of Hazell on the diagnostic profile of the Walker/Rivendell cohort.

The Bentley Adolescent Unit in Western Australia

The Commission wrote to the Mental Health Commission (MHC) in Western Australia seeking information regarding the Bentley Adolescent Unit (BAU). On 12 April 2016, the MHC advised that the model of service for the youth inpatient sub-acute and non-acute unit proposed for the BAU had not yet been developed, but it provided some general information about the proposed service.

The MHC advised that the service will target males and females aged 16 to 24 years with:

... severe, persisting and unremitting mental illness and associated significant disturbance in behaviour which precludes their receiving treatment in a less restrictive environment, but does not require acute inpatient care. It would also include people with co-occurring mental health, alcohol and other drug problems.²¹¹

In relation to the above target age range, the MHC explained that:

establishing a dedicated youth service will include the reconfiguration of existing adult community and inpatient services (currently seeing individuals aged 18-64 years). The reconfiguration plans are not yet complete or fully defined, and require further work with the [Department of Health] ...

[t]here are many obstacles to reconfiguration and these are currently being explored by [the MHC] and the [Department of Health]. Potential obstacles may include organisational structures, referral pathways, transition from infant, child and adolescent services to youth services, transition from youth services to adult services, integration and collaboration with specialised statewide services (such as eating disorders, perinatal etc.) as many would be too small to support a dedicated youth stream, and advocating for a youth stream to services which are not funded by the State.²¹²

The MHC advised that the proposal is for services to be "trauma informed and [to] include specialist behavioural and symptom management programs, individualised and group rehabilitation programs and recovery-oriented planning to support transition to more independent living".²¹³ "It is [also] envisaged that age appropriate educational programs will be available within the subacute inpatient service".²¹⁴ It is intended that the service will actively engage individuals, their families and carers in discharge planning and the service will work as part of an "integrated model which has developed pathways to support individuals to access a range of services following discharge".²¹⁵ The intended average length of stay for the proposed service had not been definitively established at that stage.²¹⁶

Some interim conclusions

The preponderance of that expert evidence supports the view that there is at least a small group of adolescents who require a medium-term inpatient facility.

That discussion raises the diagnostic profile, and the severity, complexity and acuity associated with the patients' mental illness proposed to be treated in extended treatment and rehabilitation units discussed by the experts above (sometimes broadly described as 'the BAC cohort').

The cohort – Treatment-resistant patients

As explained in more detail in the confidential volume, a significant number of the transition clients at the BAC in 2013 had prior admissions to other services, including acute units. Many had multiple admissions prior to admission to the BAC.

Breakey gave evidence in his statement that "[t]he adolescents admitted to the BAC tended in my view to have more severe and complex mental health conditions than those who could be successfully treated by community or acute services".²¹⁷ Sadler gave similar evidence that:

[a]s a general statement, BAC accommodated those adolescents who do not easily fit within the services provided by other models. BAC allowed adolescents to seek treatment within a stable cohort of adolescents and I believe that continuity of care, coupled with a stable cohort of adolescents is lacking in the AMHETI.²¹⁸

Fryer's supplementary submission on behalf of the College defined the diagnostic profile of the patients who might be cared for in a medium-term inpatient unit that provided extended treatment and rehabilitation:

[p]atient groups most likely to require sub-acute care are those with treatment resistant psychosis. A subset of patients with intractable suicidality may also derive benefit, with careful selection and a focus on return to the community and community care.²¹⁹

The Statewide Sub-Acute Beds Discussion Paper sets out three categories of young people for whom this type of service may be appropriate, stating:

[a] small sub-group of young people may benefit from extended inpatient admission, specifically: those experiencing severe psychosis with limited social and family support; young people with a life-threatening eating disorder and co-existing medical complications that requires considerable supervision, in the context of minimal family support; and/or those young people with severe and/or complex mental illness that have not sufficiently responded to treatment in a less restrictive setting.²²⁰

Hazell had similar views, except his view was that patients with restrictive eating disorders need access to specialised medical care and are therefore better managed in general hospital beds or combined mental health/medical units.²²¹

In his oral evidence, Groves described the cohort of adolescents which require such treatment as follows:

... there was a clear need for a service for the group of adolescents with severe longstanding mental health problems that had not done well within the acute CYMHS service system. This group was often but not exclusively, characterised by having high levels of distress, behavioural disturbance, backgrounds that often involved high levels of complex trauma or deprivation or neglect, together with the possibility that they had also been in institutional care or for long periods or had lived out of home. It also consisted of a group who had been either non-responsive or only partially responsive to standard first line treatment approaches.²²²

It is probably not a worthwhile exercise to attempt to define, in an exhaustive way, the cohort. Certainly there are a variety of diagnoses, and some patients with co-morbidities (including emerging borderline personality disorders). The important point, as Groves explained, is that the cohort comprises patients who have not responded to other, less restrictive models of care.

There was a variety of evidence concerning the number of patients who are likely to need treatment in such a facility. McDermott thought that (assuming Step Up/Step Down facilities were available) a very small number of adolescents, probably three to five, would need such a facility.²²³ Brennan said that she had not researched the area, and so it was beyond her expertise, but commented that "[i]t should be a small number".²²⁴ Similarly, when questioned about one of the options under consideration, involving a 22-bed facility, Sadler commented that "I would have concerns about a 22 bed unit; I think that is large".²²⁵

The Commission has determined that there were 17 transition clients some of whom were able to be transitioned relatively easily. (See chapter 21.) Some on the waitlist were suffering very severe mental illness. The numbers are difficult to gauge, but it seems likely that the number of adolescents in Queensland requiring inpatient extended treatment and rehabilitation at any time is fewer than 20. That raises a geographical issue: is there a need for decentralised inpatient extended treatment and rehabilitation facilities, and is it practical?

The geographical problem

The Chief Health Officer, Jeannette Young, recalls discussion and debate about whether it was better to have a single service in a single location or whether it was preferable to provide services throughout the state.²²⁶

The AMHETI Business Case identified “location of services” as a key issue for Queensland in particular, stating that:

[a] significant complexity for service delivery in Queensland is the geographic spread of consumers across the state. As demonstrated below, Queensland has the third highest population in Australia with the second largest land mass, over double the size of NSW and up to seven times that of Victoria.

The location and implementation of services will need to be prioritised against the demand for services based on population data.²²⁷

Stathis gave the following oral evidence:

Economies of scale are important, and I guess that is also one of the reasons we were looking at Step Up Step Down units – Y-PARCS²²⁸ in the northern cluster and ... in the central and southern clusters. And notwithstanding the real difficulties people in regional areas have, about 70, 75 per cent of the population is clustered in the south-east corner as defined from roughly the Sunshine Coast down to the border. So that’s also what we’re grappling with ... providing services across such a decentralised state but also trying to focus on the 70, 75% in the south-east corner.²²⁹

On the basis of that evidence, it is sufficient to note that, in developing the AMHETI suite, Stathis and his team have a focus on decentralising facilities such as Step Up Step/Down Units.

However, given the relatively small number of adolescents likely to be cared for in an inpatient extended treatment and rehabilitation facility, the practicalities are likely to require that such a facility be located in the south east of the state.

Summary

Thus, the preponderance of the evidence is that, whilst there is a clear preference for and emphasis on community care, a small group of adolescents still require treatment in an inpatient extended treatment and rehabilitation facility. Two witnesses (Stathis and Fryer) considered it possible that such a facility might not be needed if the full suite of AMHETI services were available. However, no expert went so far as to say that, once the full suite of AMHETI services was available, there would be no need for that facility. The only qualification is that some experts, such as Scott, took the view that when, and if, there are further services in place there may be a prospect that a Tier 3 or medium term sub-acute facility will become unnecessary. In any event, no witness gave evidence that Queensland yet had the full suite of services available or that the full suite was imminent.

Counsel for the State of Queensland submitted that many of the expert psychiatrists have recognised that there might be a residual need for a bed-based unit for a small group of young people even with the full AMHETI suite.²³⁰ Similarly, the discussion paper prepared by Morson, offers the view that:

Family-focussed treatment interventions delivered in community settings have demonstrated benefits for a range of severe mental illnesses experienced by young people. However, a small sub-group of young people may benefit from an extended admission, especially if compounded by significant comorbidity, including intellectual/developmental impairment.²³¹

It follows that the overarching philosophy of “least restrictive” environment in mental health care was of limited assistance in deciding whether the BAC ought to have been closed. This philosophy indicates a preference for treatment in the community, but it does not exclude an inpatient service such as the BAC, or its proposed replacement at Redlands.

Alternative facilities / services

The criticism that the BAC/Redlands/Tier 3 institutional model was not contemporary was, on some occasions, accompanied by the claim that the ‘target’ group of young people could be cared for in ‘existing beds’, that is in adolescent acute units, or in Y-PARC services to be established.

For example, on 10 November 2012, Kingswell sent an email to Dan Siskind (the then Chair of the College’s Queensland Branch), explaining that the BAC service “could be provided in existing beds, expanded day services and NGO [Non-Government Organisation] respite and ... could [be done] ... within existing resources”.²³²

And, in July 2013 the Department of Health began planning for a Youth Prevention and Recovery Care (Y-PARC) service, which it was intended would provide an alternative care option for adolescents with severe and persistent mental illness.²³³ The Commission also heard evidence of sub-acute ‘swing’ beds being made available for extended treatment adolescent patients at the Mater Child and Youth Mental Health Service and, later, at the Lady Cilento Children’s Hospital.²³⁴

It is therefore necessary to consider the suitability of these two options for adolescents with severe and persistent mental illness.

Acute units for non-acute patients?

Eight witnesses, each with some level of expertise in the area of child and adolescent psychiatry, gave evidence as to the difficulties accommodating sub-acute patients in acute units, such as that at the Lady Cilento Children’s Hospital.²³⁵

The clinicians identified issues with length of stay as well as the potential exacerbation of attachment issues and anxieties associated with a lack of continuity in staff and patient cohorts. They described acute units as ‘more medicalised’ and as lacking in the typical and normative aspects of an adolescent’s life. The clinicians explained that acute units are generally unsettled environments, owing to the continuing intake of highly distressed individuals. They identified this as problematic both from a rehabilitation perspective and also in terms of resource allocation.

Of significance is the evidence of Peter Parry, who is the current Medical Director responsible for the adolescent mental health inpatient unit at the Lady Cilento Children’s Hospital. Parry explained that:

- [redacted] sub-acute patients have used the ‘swing’ beds at Lady Cilento²³⁶
- the four ‘swing’ beds are frequently used by acute patients and it is not uncommon for all 11 beds to be occupied²³⁷
- ... adolescents with chronic suicidal, challenging or aggressive behaviours related to problems of personality development and complex developmental trauma can regress in an inpatient setting and can adversely affect other patients in the inpatient unit, with the result that ‘the combination of this group of extended treatment patients with acute patients together on an inpatient unit is likely to be deleterious to both groups’²³⁸

- [he] worked for five years in a child and adolescent mental health inpatient unit in Adelaide where we ended up with a number of long term patients from the group with personality problems because of a lack of accommodation for them in the community at that time. This led to dramatic worsening of their emotional and behavioural problems with a deleterious effect on the inpatient milieu and other patients on the unit²³⁹
- In 2000 [he] visited a number of adolescent mental health inpatient units whilst on a study trip to the United Kingdom. It was widely accepted practice to avoid having patients with chronic personality problems and self-harming behaviours on inpatient units with acute patients, apart from brief crisis admissions.²⁴⁰

Kotzé initially gave guarded approval to the concept of treating sub-acute patients in an acute ward. However, after being shown the ECRG report, she agreed with the ECRG that managing young people such as those who accessed the BAC in acute inpatient units does not meet their clinical, therapeutic or rehabilitation needs.²⁴¹ While Stathis seemed to take some comfort from the fact that there had been little demand for the sub-acute/swing beds, he conceded, in his oral evidence, that sub-acute beds in an acute unit were 'suboptimal' and 'not ideal'.²⁴²

The ECRG report concluded that clinical experience had shown "prolonged admissions of young people to acute units can have an adverse impact on other young people admitted for acute treatment".²⁴³

Thus, the evidence of the experts is strongly against treating these young people in acute units and, in fact, identifies risks for both cohorts in attempting to mix the two in one unit.

Y-PARC

Introduction

It will be recalled that on 15 May 2013 the Planning Group met to consider the ECRG's recommendations (see chapter 10). The ECRG's second recommendation was that:

A Tier 3 service should be prioritised to provide extended treatment and rehabilitation for adolescents with severe and persistent illness.

When considering that recommendation, one or more members of the Planning Group accepted the recommendation "with caveats". The caveats appear to be in these terms:

Further work is needed to detail the service model for a Tier 3. Models involving a statewide, clinical bed-based service (such as the Barrett Adolescent Centre) are not considered contemporary within the National Mental Health Service Planning Framework (in draft).²⁴⁴ However, **there are alternative bed-based models involving clinical and non-clinical service components (e.g., Y-PARC in Victoria) that can be developed in Queensland to meet the requirement of this recommendation.**

Contestability reforms in Queensland may allow for this service component to be provider agnostic.²⁴⁵

(emphasis added)

Thus, some members of the Planning Group proposed that a Y-PARC facility be developed as an alternative to the Tier 3 service which the ECRG recommended as essential and as requiring priority.

It is therefore necessary to explain the Y-PARC service type and whether that service type is properly an alternative to the Tier 3 service recommended by the ECRG.

The Y-PARC service type

Y-PARC (Youth Prevention and Recovery Care) has been a service type operating in Victoria. There are four Y-PARC facilities in Victoria.²⁴⁶ Three are operated by MIND Australia.²⁴⁷ The Y-PARC concept was adapted from the Prevention and Recovery Care (PARC) model, established for adults in Victoria in 2003.²⁴⁸ Y-PARCs are based on a collaboration between Mind Australia (a community managed mental health service supporting people recovering from the effects of mental health problems), local child and youth mental health services, and local non-government community support services (in the case of Dandenong the community support service is Youth Support and Advocacy Service, which has a youth focus).²⁴⁹

The target age range for Y-PARCs is 16 to 25 years. The maximum admission length is 28 days,²⁵⁰ and the facilities are collaboratively staffed with clinical staff from the local child and youth mental health services and workers from the relevant non-government support services.²⁵¹

Y-PARC and ECRG's "tier classification system"

That brief summary of the Y-PARC service demonstrates that it is a very different model from that described as a Tier 3 service by the ECRG and from the types of inpatient extended treatment and rehabilitation services considered by the various experts (as discussed earlier in this chapter). Judi Krause, currently the Divisional Director of Children's Health Queensland HHS, considered that a number of modifications would be required before a Y-PARC service would qualify as a Tier 3 facility, namely:

- decrease the age range to 14-17 years
- broaden the catchment from local to cluster based or state-wide
- increase the length of maximum stay to 3 months
- provide in-reach education and vocational support to students with an aim of linking them back to their communities on discharge or an outreach model to a local school.²⁵²

Y-PARC and the Step Up/Step Down proposal

Ultimately, the Y-PARC was adapted to become the Step Up/Step Down (SUSD) component of the Adolescent Mental Health Extended Treatment Initiative (AMHETI).²⁵³ Stathis noted that the SUSD broadly adopted the Y-PARC design, with an external location away from a hospital campus and collaborative operational management in partnership with an NGO.²⁵⁴ Stathis provided evidence of some differences between the Y-PARC and SUSD, namely:

- Timeframe: Y-PARC one month, SUSD up to three months
- Geographic cover: Y-PARC is within a health service district, SUSDs are to transcend HHS boundaries
- Schooling and vocational education: Y-PARC patients are older and few attend schools, SUSD will encourage and support engagement with school or vocational education
- Clinical governance: Y-PARC consultant psychiatrist manages the local acute inpatient unit whereas this may not be the case for the SUSD units as they won't be integrated into a single local HHS.²⁵⁵

The evidence of Ingrid Adamson (secretariat for the Adolescent Mental Health Extended Treatment Initiative Steering Committee) was that the SUSD model was consistent with the ECRG's Tier 2b, namely "Adolescent Community Residential Service/s (new)".²⁵⁶

Therefore, what the members of the Planning Group had in mind, in adding their 'caveat' to the effect that a Y-PARC service was an alternative to the 'Tier 3', was an entirely different service type. Certainly a Y-PARC service was not going to supply a "Statewide Adolescent Inpatient Extended Treatment and Rehabilitation Service", recommended as essential by the ECRG.

Evidence base

In some cases the criticism that the BAC/Redlands/Tier 3 models of care, or treatments and therapies, were not contemporary were accompanied by the criticism that those models, treatments, or therapies were not evidence-based.²⁵⁷ That criticism was occasionally in the indirect form that the BAC was to be replaced with evidence-based models of care, or treatments and therapies.²⁵⁸

Evidence-based models of care

Counsel for Sadler explained that there was a paucity of evidence-based outcome research to support many mental health treatment programs.²⁵⁹ A number of medical witnesses spoke of the significant challenges in collating research for the very small group of young people who were treated by the BAC.²⁶⁰

Stathis' view was that there was "limited compelling evidence to support in-patient extended treatment and rehabilitation for young people suffering mental health problems".²⁶¹ McDermott could not say whether or not there is a relatively small number of adolescents who require extended inpatient residential treatment because "we don't have evidence either way".²⁶²

McGorry was of the view the phrase 'evidenced-based' was overused and becoming a rapidly devalued term.²⁶³ He said it was very difficult to obtain high level evidence for determining appropriate models of care, particularly for a cohort such as the BAC patients:

FREEBURN: So is the problem – is one of the problems with the higher level of study the difficulty with having a comparator?

McGORRY: Yeah. Yeah, that's right because – and especially when you – when you're dealing with, you know, a small – you know, the tip of the iceberg but the sort of population we're talking about here. They're not that numerous in a – in a sense and – and it's not – they're – they're a group that have got a whole range of problems too so they don't fit into neat diagnostic categories that you can just compare one group with the other. So it's extremely challenging to get really high level evidence for this group of patients. You can extrapolate evidence from other, you know, overlapping groups and try to apply them to the treatment of these patients but that's probably the best you can actually do. And you can also look at models in other parts of the world which may have been evaluated and compare. And, yet, you know, for this particular group of patients there isn't a great deal of really good international research.²⁶⁴

As Fryer explained, there is no evidence base which supports community-based treatment over extended inpatient stays or vice versa:

- FREEBURN: Does the current evidence base support a particular form of intervention over another and what I mean by that is can we say that community care might assist a particular group of adolescents over brief inpatients stays over intermediate stays or long stays?
- FRYER: To my knowledge the short answer to that question is no, we don't have the evidence. Within subpopulations we're [able] to say that the evidence for some disorders might indicate – or experience it's probably better to say would indicate that for young people with, for example, treatment resistance to their psychosis there is more evidence of an inpatient rehabilitation-type setting being useful whereas for others there is less evidence and more evidence for models of community care. We still have a long way to go in being able to give a definitive answer to your question.²⁶⁵

Martin was of the view that this paucity of evidence was due to a lack of program and outcome evaluation.²⁶⁶ He said such evaluation processes need to be sufficient enough to make recommendations about treatment:

- MUIR: During the course of the inquiry, we have heard some evidence about there being limited compelling evidence for extended inpatient treatment. But as I understand your evidence, what you might say to that is that's because there's not the evaluation process and outcomes process in place to which ... you can go ... ?
- MARTIN: Well, I think that's right, and I think – can I just make a distinction here. Outcomes are not such things as length of stay or coming back into hospital. Those are outputs. They're things that happen down the track. The only outcomes that matter are whether these kids feel good, function well and can manage their lives and their families if that's appropriate. We don't do that. We're not supported to do that ...
- Now, there are – there must be blocks somewhere about releasing data or releasing results or misperceptions of what those results might be telling people about your services. My personal belief is we must not only do the work, but we must disseminate it to make sure that other people don't make the same mistakes we do if we're making mistakes.²⁶⁷

Thus, it is not possible to say that contemporary models of care are only those models that are evidence-based. On the contrary, while it is preferable to base models on a solid evidence base, it is not always possible to do so, especially for a cohort as small as the BAC cohort.

The ECRG

As noted in chapter 9, the ECRG's terms of reference reflect that its task was, in part, to develop a contemporary model of care that was "evidence based".²⁶⁸

James Scott, a member of the ECRG with significant experience in the area of child and adolescent psychiatry, acknowledged in his written statement that the ECRG had not conducted any systematic search of all potential care options, or gathered all available literature and information on those options.²⁶⁹

However, the preamble to the ECRG report is clear that in making its recommendations (including the recommendation that a Tier 3 was an essential service component), the ECRG did give consideration to evidence-based models of care and services:

... the ECRG met regularly to define the target group and their needs, conduct a service gap analysis, consider community and sector feedback, and review a range of contemporary, **evidence-based** models of care and service type ... **The ECRG have considered evidence** and data from the field, national and International benchmarks, clinical expertise and experience, and consumer and carer feedback to develop a service model elements document for Adolescent Extended Treatment and Rehabilitation Services in Queensland.²⁷⁰

(emphasis added)

Evidence-based treatment and therapies

Details of BAC's intervention methods are discussed in chapter 1. Several witnesses gave evidence that the treatment and therapy approaches at the BAC were not evidence-based.

McDermott said:

... from an empirical and evidence based medicine perspective, over the more than 20 years of operation of the BAC, I am not aware of one scientific publication that provided evidence of effectiveness of the therapy provided by the BAC – for example, evidence of symptom reduction, resolution of disorders, less impairment or higher functioning.²⁷¹

McDermott acknowledged, however, that "many child and adolescent mental health treatment approaches" have a poor evidence base.²⁷²

It was the view of Scott Harden (Medical Director, Forensic Adolescent Mental Health Alcohol and Other Drugs Program, CYMHS, CHQ) that the BAC's treatment approaches had been misaligned for decades, stating:

In my view the BAC model of care and treatment was an appropriate one when that unit was opened. It had ceased being consistent with best practice approaches to such treatment probably two decades ago. It was a stand-alone unit in an isolated area with no associated child and youth mental health services ...²⁷³

When Anne Brennan took up her position at the BAC in September 2013, she was concerned that she "did not observe intensive family work or family therapy" and that "liaison with communities of origin seemed lacking".²⁷⁴ Graham Martin was similarly critical (in general) of the BAC providing services to adolescents in isolation, without considering their family connections.²⁷⁵

A 2009 Review of Barrett Adolescent Centre report found that the BAC's milieu therapy and adventure therapy were not sufficient for the BAC cohort.²⁷⁶ Sadler responded, clarifying that "[a]dventure therapy [was] less than 15% of the time spent" by the two BAC clinicians spoken to by the review team, and that the adventure therapy program was run on 20 days of the year.²⁷⁷

The 2009 criticism was repeated in the Statewide Sub-Acute Beds Discussion paper, without reference to Sadler's response:

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.²⁷⁸

In his supplementary statement, Stephen Stathis referred to that Discussion paper (then in draft) as evidence supporting his concern that the BAC model of care was not current.²⁷⁹

Summary

Therefore, while there were a number of criticisms of the model of care, treatments and therapies at the BAC as not evidence-based or inadequate, there is evidence that many adolescent mental health treatments have a poor evidence base. In any event, such criticisms would be a reason to review and adjust the treatments and therapies at the BAC rather than logical or proper reasons to close the BAC. That is especially so given that the preponderance of the evidence favours the view, originally expressed by the ECRG, that inpatient extended treatment and rehabilitation is an essential service component.

To some extent the criticisms of the model of care, treatment and therapies at the BAC were themselves outdated. That is because until May 2012 it was proposed to replace the BAC with Redlands. Redlands was to include an updated model of care and treatment regime.

Length of stay and risks of institutionalisation

The criticism of long lengths of stay

As noted in chapter 1, patients' length of stay was a common criticism of the BAC. The length of stay at the BAC was a contentious issue and it was feared that the long lengths of stay led to "... features of institutionalisation".²⁸⁰ Several witnesses expressed concern about the rising length of stay at the BAC over the years.²⁸¹

The lengthy periods of stay at the BAC were not "considered contemporary"²⁸² by Beth Kotzé. Brennan's impression was that when she commenced as the acting Clinical Director BAC in September 2013, "[l]ength of admissions appeared to [her] to be longer than what" she recalled when she worked at the BAC in the 1993/94 period.²⁸³ A speech pathologist who worked at the BAC from 2000–2014, Angela Clarke, had "... concerns about length of stay".²⁸⁴ Sadler agreed that "... the length of stay was too long for some adolescents".²⁸⁵ From an examination of the oral evidence and written submissions, it does not appear that anyone refuted the length of stay increasing over the years, with reports indicating increases of four to six months over 12 years.²⁸⁶

Kingswell, in his statement explaining the reasons for the closure of the BAC, stated "[n]o other jurisdiction in Australia runs a centre where adolescents are hospitalised for years within a stand-alone psychiatric institution".²⁸⁷

The BAC length of stay data

Length of stay data for BAC patients was provided by Queensland Health and analysed by the Commission. For the period 2002–2003 the median length of stay was 15 days. By 2013–2014 it was recorded as 27 days. The mean length of stay also increased over time, from 29 days in 2002–2003 to 119 days 2013–2014:

Financial year ^a	Mean (average)	Median (midpoint) ^b	Mode (most frequent)	Minimum	Maximum
2002-2003	29.228	15	14	1	137
2003-2004	54.154	34.5	20	1	399
2004-2005	62.967	23.5	14	1	377
2005-2006	54.857	39	2	1	279
2006-2007	41.016	16	3	1	276
2007-2008	65	21	2	1	450
2008-2009	62.97	29.5	2	1	601
2009-2010	44.237	14	3	1	373
2010-2011	64.512	36	1	1	330
2011-2012	64.758	43	1	1	295
2012-2013	34.371	18.5	2	1	277
2013-2014 ^c	119.29 ^d	27	17	1	978 ^e
Total	54.46	22	2	1	978

Figure 14B: Length of stay (in days) for BAC patients

Notes:

^a Data are reported per financial year by discharge date.

^b Median (the midpoint) is 50 per cent of the data is below the midpoint and 50 per cent of the data is above the midpoint.

^c 2013/2014 is not a full financial year, as the BAC closed in January 2014.

^d Given the closure of the BAC in January 2014, this higher than usual average length of stay is to be expected, given that the date is reported as date of discharge rather than date of admission.

^e

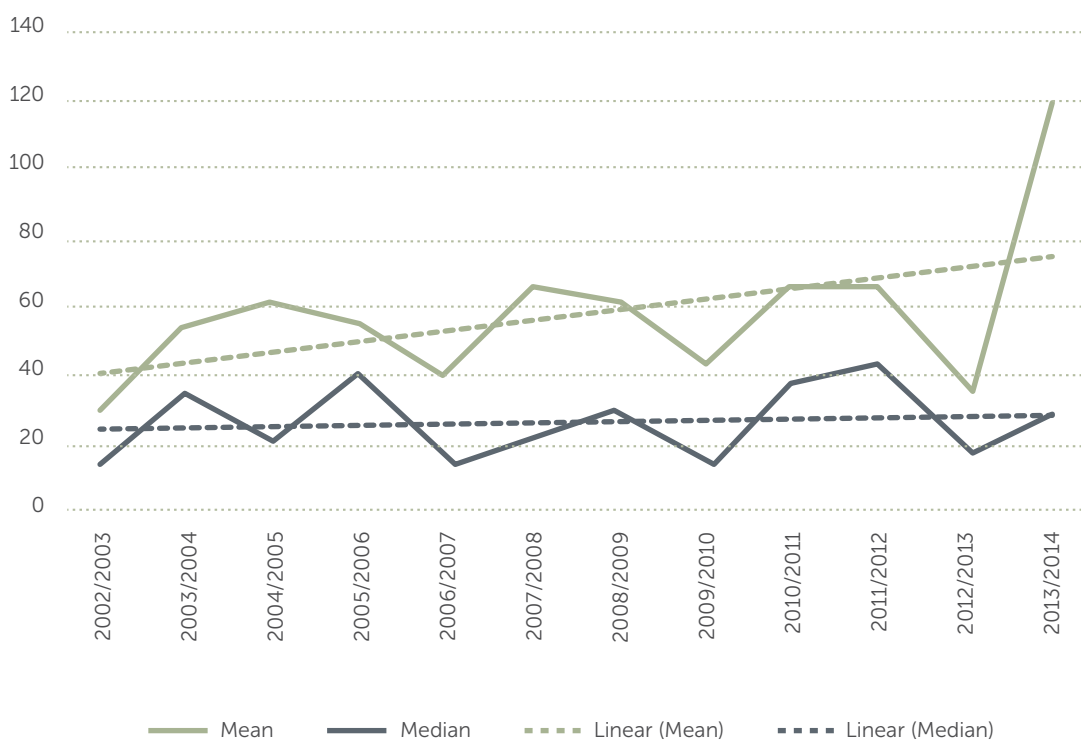


Figure 14C: Mean and median length of stay (in days) 2002/03 to 2013/14

Source: Queensland Health Hospital Admitted Patient Data Collection (QHAPDC). Data prepared by the Analysis and Accountability Team, Clinical Systems, Collections and Performance Unit, MHAODB, Queensland Health.

According to Trevor Sadler, the way in which the length of stay data is recorded by Queensland Health reflects the individual nature of each young person's care and transition arrangements:

So there would be times when we thought they were staying well enough, there would be times when a person might start off as a day patient, require an inpatient admission, go back to being a day patient. So we were flexible with regard to times. So it would be the total time that they spent with us, whether or not it was a day patient, inpatient or a partial hospitalisation.²⁸⁸

Groves had concerns, in that shorter lengths of stay are desirable so as to "... try and mitigate institutionalisation effects from long lengths of stay".²⁸⁹

Lengths of stay can be impacted by both individual and systemic factors.

Individual factors leading to longer lengths of stay

Several witnesses gave evidence that a patient's diagnosis (or diagnoses) and the type of therapy they required at the BAC affected their length of stay. Breakey was aware that there were "... progressively more complex and more difficult kids in the unit and that their stays were longer".²⁹⁰ Sadler gave evidence that "... the clinical severity and complexity of adolescents with mental health issues is increasing"²⁹¹ in the BAC cohort. In response to the 2009 Review of the Barrett Adolescent Centre report, the increasing complexity of BAC patients was recognised by Sadler who noted the "individual needs of an increasingly complex group of clients".²⁹²

For some young people with possible emerging personality disorders, Brennan suggested psychotherapy was required and explained "... that [it] is very long-term and needs to be taken slowly".²⁹³ The "very complex reasons" for an adolescent to have a lengthy stay included,

according to David Ward (social worker, BAC), “entrenched pathology”.²⁹⁴ He went further to suggest that “[s]ome of the conditions were chronic and simply were very hard to budge, despite the best efforts of staff and the treatment we provided”.²⁹⁵

Sadler described some adolescents as having “enormous difficulty describing emotions and being able to work psychologically”²⁹⁶ and some with complex PTSD reportedly took “up to six months just to trust staff”.²⁹⁷ In his oral evidence, Sadler explained that some BAC patients “... didn’t engage until four or five months and then their treatment started to begin after that period”.²⁹⁸ The individual needs of young patients may have also included the need to stabilise medication and to work with their treatment resistance, as outlined by Kotzé:

So, for example, we would know – we do know that even with the best available treatments, a very large percentage of people with psychosis, for example, experience some degree of treatment resistance and may need to be in hospital for extended periods of time in order to have changes of medication and adequate trials. We know that people with bipolar affective disorder may also experience that.²⁹⁹

Brennan gave evidence of a need for flexibility when determining the length of stay for young people:

I think there’s always got to be flexibility. It’s definitely as the patient requires and as their needs change I think it’s important to note – to recognise that a [person on] admission, hopefully, is a very different person in terms of their functioning three to six months later.³⁰⁰

The importance of flexibility and being responsive to young people’s needs was also highlighted in Cary Breakey’s oral evidence, when he said:

I guess each individual kid stay related to where that kid was at, and they were moved on as soon as they were ready. Sometimes we’d test it out too soon. Sometimes we were fairly anxious about the outcomes, and that delayed the kid being discharged.³⁰¹

Graham Martin also agreed with the need to have a flexible approach in working with each young person:

... when you’re working in this area you are trying to do the job to enable the young person to live their lives sensibly, sanely, happily in the community, ultimately. And so you work with them for as long as it’s going to take.³⁰²

However, this flexibility also needed to be weighed in terms of the benefits and deleterious effects of long-term stay. Michelle Fryer, in her oral evidence, said that the potential benefits needed to be carefully considered:

One needs to be responsive to their needs but also have careful consideration of not just the benefits or potential benefits but also the potential risks of any intervention that’s undertaken”.³⁰³

Philip Hazell’s evidence was that longer lengths of stay indicated the severity of the problems young people were experiencing. However, longer lengths of stay also created complications:

But the complications of spending longer in hospital, it’s longer time away from opportunities to interact with family, re-engage with school and so on. So it’s keeping the young person away from their normative experiences.³⁰⁴

Systemic factors leading to longer lengths of stay

Length of stay can also be influenced by systemic factors, such as issues with staffing stability or finding appropriate services for the transition of young people.

Sadler suggested in his oral evidence (when questioned about the 2009 review recommendations) that it was “certainly our aim to limit the stay but there were circumstances beyond our control at that time which made it difficult”.³⁰⁵ Sadler acknowledged the systemic factors contributing to the increased length of stay at the BAC, “such as staffing,”³⁰⁶ “the difficulties in providing family interventions,” the “lack of a step down unit” at the BAC and the lack of “supported accommodation”.³⁰⁷ In addition, Sadler suggested that accommodating adolescents in a four-bed dormitory was a reason for protracted lengths of stay in that it contributed to poor peer relationships, and managing negative peer interactions generally resulted in a moratorium on the therapeutic and rehabilitation benefits of other interventions.³⁰⁸

Criticisms of lengthy periods of admission for BAC patients may have been an artefact of the lack of other appropriate services for young people. Ward suggested “more systemic organisational issues, such as the lack of step-down program between [BAC] and the adult system” impacted a young person’s length of stay.³⁰⁹ McGorry suggested that although people may have been “critical ... about the lengths of stay but you just look at what else would’ve been possible for them and [it was] very little”.³¹⁰ Breakey also suggested that “finding facilities in the community and having the other services ready was very important for each of the kids that we discharged over the years”.³¹¹ Sadler argued that a barrier to service delivery was a lack of a step down facility at the BAC:

... I thought that the lack of accommodation or Step Down facilities was a major thing which kept them, some of them there – when I say the inpatient care, my thought was that there were some adolescents who required lesser levels of – well, they could live in accommodation that was, well, offsite but that would be – provide them with skills.³¹²

There were difficulties in locating services for the young people, for example, “... child safety often didn’t provide a placement for the young person for them to go back to”.³¹³ Breakey agreed with the proposition “that availability of services or certain services could’ve reduced lengths of stay” for some of the young people at the BAC.³¹⁴ Long lengths of stay, as argued by McGorry, were sometimes attributable to young people having nowhere else to go, had they not remained at BAC: “I think the long lengths of stay were just a kind of a testament to the fact there was nothing else for these kids or very little else for them”.³¹⁵

Multiagency disconnection and the lack of integration with other mental health services may have contributed to a young person’s protracted length of stay at the BAC. This is another example of how systemic factors impact on service availability, as articulated by Clarke:

There were a lot of very complex issues, not always related to the young person, not always related to the model of service; very broad sort of systemic issues that touched on service availability and, you know, other issues that meant young people were at Barrett for longer than was ideal.³¹⁶

Breakey gave evidence that, had the BAC been better supported from a systemic point of view (for example, better support from other services), young people may have been able to have shorter lengths of stay:

The plan at the BAC was always to get adolescents back to their families and the communities in the shortest time possible, if BAC had been better supported with other services, this could have been achieved faster.³¹⁷

As noted above, the model of service for Redlands finalised in July 2010 was designed to improve the discharge planning for patients. The model of service treatment program included “assertive discharge planning to integrate the adolescent back into their community and appropriate local treatment services”.³¹⁸ To achieve this, the model of service ensured “[a] comprehensive recovery and discharge management plan that includes community reintegration will be in place prior to admission for all adolescents”.³¹⁹

This model of service also determined a targeted maximum admission length of six months.³²⁰ It further indicated:

- in some specific cases an admission beyond six months may be considered, if clinically indicated
- where the length of stay is proposed to exceed six months the case must be presented to the intake panel for review following the initial six month admission.³²¹

Stephen Stathis gave evidence that those developing an overarching model of service for sub-acute beds for young people “proposed a maximum admission time of about six months with a review after three months which incorporated an intensive family assessment”.³²² Various other witnesses had firm views. For example, Terry Stedman believed six months to be a reasonable time period:

I think that there’s a general view that for longer term, long stay treatment plans that six months is a reasonable target for most people and most programs. So that’s that kind of timeframe. So I just think if – if a program was working in a kind of contemporary way with a lot of attention to progressing things, I think five or six months should be reasonable.³²³

Of course, an intended length of stay does not necessarily translate to actual experience. For example, in his oral evidence, Hazell suggested that the “[t]he length of stay for patients of the Walker unit has crept up over time. Initially the typical length of stay was around 6 months. The most recent figure for average length of stay in the Walker unit is 159 days, but there have been several admissions lasting for over a year”.³²⁴

An emphasis on institutionalisation

A number of witnesses placed heavy emphasis on the risks posed by institutionalisation on the adolescents admitted to the BAC or who may be admitted to a similar facility. Some examples are as follows:

- a. McDermott said that the BAC cohort will have some degree of institutionalisation because they have been in the unit for so long,³²⁵ the risk of institutionalisation was, he said, a primary driver for his desire for a shorter length of stay.³²⁶
- b. Hazell was asked about whether institutionalisation was a risk in the Walker Unit in NSW, and what steps were taken to deal with it; he answered by reference to the concept of ‘dependency’:

We ... assess our patients at the outset for a range of risks and one of them is dependency – dependency on the unit and the unit actually getting in the way of the person’s maturation and development. So we recognise that from the outset and we have many steps to mitigate against that.³²⁷

- c. O’Connell described a general trend, across the whole country, towards community-based services rather than institutionalisation.³²⁸ Later in his evidence O’Connell described an “overwhelming sense” that there was “this tidal wave of opinion which was emerging

over the years that there was a move away from institutionalisation – not for everybody but increasingly”.³²⁹

- d. Kingswell said his overriding concern was that young people who were housed in the BAC “were housed there for months and years and sometimes two, three years. The consequences of that is going to be institutionalisation”.³³⁰
- e. Fryer, on behalf of the College, expressed concern about the risks of institutionalisation inherent in long-term and medium-term inpatient units.³³¹ Her evidence was that “longer lengths of stay carry risks of institutionalisation and iatrogenic increase in disability”.³³²

Meaning of institutionalisation

What, then, does the term “institutionalisation” mean?

Patrick McGorry explained the concept of institutionalisation in this way:

McGARRY: Well, the concept of institutionalisation describes what happens to human beings when they’re – when they spend a period of time in a relatively closed institution such as a hospital or a mental hospital, a prison, a convent, a monastery. People – there are certain effects that that has ... on people and they become less able to function independently and a whole lot of other negative effects - which led to a major reform starting in the middle of the last century which saw, I suppose, and particularly in this case, the downsizing and ... in many cases closing of the old 19th century mental hospitals. And unfortunately as I – I don’t know if you want me to go on about this but...

FREEBURN: Yes, please?

McGARRY: ... what – what then happened in every developed country was a complete failure to provide the appropriate community services to make those older institutions unnecessary.³³³

On behalf of the College, Fryer explained:

In addition, the long-term inpatient care of adolescents risks dislocation from their family, school, peers and local community. The isolation from community combined with a decrease in skills and confidence to manage living in the community (institutionalisation) can worsen the prognosis for patients in long-stay units and make it increasingly difficult to discharge them to a lower level of care.³³⁴

Brett McDermott spoke of a person being outside their normal family context, including by reason of being in the military or in prison, and as a result being in danger of taking up some idiosyncratic behaviours and elements of that environment.³³⁵

Beth Kotzé said:

Okay. I can certainly talk to the – the topic in the light of current experience within New South Wales. So within New South Wales, as a result of the development of a plan by the New South Wales Mental Health Commissioner, it has been determined that New South Wales will complete the process of ... de-institutionalisation that was become [sic, begun] some decades ago. As part of that, [institutionalisation] has been defined as people staying in a hospital setting for longer than 365 days, and this setting is a – is a whole of life setting, if you like, where the person is a patient within a context, that a whole variety of their needs are met, so they don’t actually need to leave that setting in order to have those needs met, and this results in an acquiring of a disability that may affect that person’s ongoing life.³³⁶

In her written evidence, Kotzé described institutionalisation as creating the risk of enduring or even lifetime disadvantage through disruption to a young person's functioning and psychosocial development.³³⁷

Bill Kingswell described the concept of institutionalisation specifically by reference to the BAC:

Well, it's quite likely that you will come to that Centre [the BAC] at a point of time with a set of skills. They might be from your education or whatever. After two years in that Centre of having your meals prepared, your clothes washed, your bed made, all of your relationships are peculiar in that they're constrained to a group that share serious mental disorder with you, that you're miles away from family and school and other social connections - it's likely to be quite a disturbing experience, I would have thought, and you will emerge from that with none of the skills you came in with.³³⁸

Of course, Kingswell's evidence, in particular, assumes that the adolescent admitted to the BAC arrives there with a set of skills, as well as an appropriate background involving a family, school and other social connections. As explained in chapter 1 many of the young people admitted to the BAC arrived there with a background of school refusal, and/or with limited social connections, and/or with problematic family relationships.

Cary Breakey took the view that the "criticism focuses too much on the concept of institutionalisation, and ignores rehabilitation". Many young people had "been institutionalised in their home as mental health patients" before coming to the BAC, and the challenge for the BAC staff was to get patients living back in the community.³³⁹

While the concerns about the risks of institutionalisation of the young people admitted to the BAC (or similar facilities) must be acknowledged, there is some complexity to the issue. The risks of institutionalisation must be balanced against two factors. First, the ability of the service to mitigate the risks (for example by assisting the adolescent to develop appropriate relationships). Second, the risks inherent in the situation of the young person not being admitted to the BAC, such as the risk of being left in a home where the young person may be, in effect, housebound, or where they have refused to attend school for a significant period, or where the family or social relationships are themselves counter-productive.

An added complexity to the concept of institutionalisation is the length of stay. In her first submission, Fryer, on behalf of the College, was concerned about the risks of institutionalisation and expressed that concern in relation to "long-term inpatient care" (emphasis added).³⁴⁰ In her second submission on behalf of the College, Fryer explained:

As outlined in the submission to the Inquiry, overall the RANZCP supports consideration of a **medium term** in-patient unit that provides extended treatment and rehabilitation. However, there are concerns about the risks inherent in such models e.g. from institutionalisation ... As the Commission has heard, it is essential that there is ... a focus on minimising duration of stay while maximising therapeutic gains (generally cited at 3 to 6 months as a maximum). There is a concern that longer lengths of stay carry risks of [institutionalisation]³⁴¹ and iatrogenic increase in disability. Evaluation of this is difficult, as long lengths of stay are likely to be associated with the most severe illness. Careful follow-up studies are required to elucidate the risks and benefits, including relationships between illness severity, duration of admission and outcome.³⁴²

(emphasis added)

Fryer's particular concern was protracted admissions, by which she meant admissions of more than 12 months.³⁴³ Kotzé appeared to be similarly concerned that an average stay of 365 days was a very long time.³⁴⁴

Obviously enough, as Fryer explained, the longer the stay the greater the risk of institutionalisation.

Addressing institutionalisation

The profile of BAC patients changed over the years.³⁴⁵ As adolescent acute units opened between 1996 and 2001, those units treated acute patients and the BAC increasingly looked after young people with severe and persisting mental illnesses. Breakey's evidence puts the BAC in context:

The BAC opened in the absence of any other adolescent inpatient units. I did not have a vision of the length of stay in 1983–1984, but aimed to admit the adolescents early, before they did too much damage to themselves. At that time, I would not have anticipated very long stays. However, by the late 1990s the severity of conditions of the BAC patients had increased. I think this reflected both increased severity across the increasing population, and community and acute CYMHS services dealing with all but the most severe – who then were referred to BAC.³⁴⁶

Thus, the risks posed by institutionalisation were there from at least the 1990s and were made worse by the increasing complexity of patients treated by the BAC.³⁴⁷ The progressively longer stays appear not to have led to any serious attempt to address institutionalisation at the BAC. Sadler's evidence was that there was a process to prepare the young people for when they went into the community or to adult services.³⁴⁸

However, beyond that (and subject to the discussion below), there appears to have been no other attempt by Queensland Health to address the risks of institutionalisation. Notably, for a number of the years this was in the context of limited alternatives for the BAC cohort. As detailed earlier,³⁴⁹ the adolescent acute units commenced to become available in the period from 1996 to 2001 and then, more recently, further options became available.

A valid criticism of the length of stay, based on the risks of institutionalisation, should logically result in a review of the model of service, rather than a decision to close. As it happens, the model of service had been reviewed as part of the Redlands project and it is likely that it was, in part, in response to concerns about the length of stay at the BAC.

As explained earlier in this chapter, the model of service for Redlands proposed a six month targeted and phased treatment program. Specific cases where admission exceeded six months were to be presented to an intake panel for review. That regime was no doubt arrived at with the object of achieving a balance between the risks of institutionalisation and the risks of discontinuing extended treatment and rehabilitation.

Queensland Plan for Mental Health 2007–2017

It will be recalled that Corbett gave, as one of the reasons for the decision to close the BAC that "Under the QPMH there was a need to develop a contemporary, evidence based model of care for adolescent mental health".³⁵⁰ Referencing the QPMH as defining contemporary, evidence-based models of care and as justifying the closure of the BAC, involves some difficult logical steps.

First, as explained above, there is the difficulty identifying any relevant evidence base.

Second, it is true that the QPMH promoted a community-oriented, comprehensive, integrated and socially inclusive health system. It envisioned those with mental illness recovering to “live productive lives in their communities”, and to do so “[r]ecovering emphasises the need for a comprehensive community based service system that works to address the full impact of mental illness”.³⁵¹

Yet, the focus of the QPMH was certainly not entirely on community-based services.³⁵² It is true, also, that one of the principles of the QPMH was that mental health care be evidence-based, prioritising quality and safety.³⁵³ However, the QPMH expressly provided \$121.55 million to expand the range of acute and extended treatment beds (by providing more than 140 new beds) and to upgrade existing services to meet contemporary standards.³⁵⁴ The QPMH did not dictate either community-based or inpatient care. Both were recognised as necessary.

Third, the Outline of the 2007–08 State Budget Outcomes for Mental Health, which was approved by Cabinet at the same time as the QPMH, expressly provided that the \$121.55 million was to be used to develop a new 15-bed adolescent centre extended care unit to replace the BAC.³⁵⁵

Thus, it is difficult to see how the BAC was inconsistent with the principles in the QPMH, particularly when the QPMH and its accompanying budget document expressly provided for a replacement of the BAC to meet contemporary standards. It was, in fact, more accurate to say the opposite, namely that the BAC was aligned to the QPMH because it provided for an upgraded replacement for the BAC.

National Mental Health Service Planning Framework (NMHSPF)

On 9 November 2012 (the day after Brett McDermott appeared before the Queensland Child Protection Commission of Inquiry), Dan Siskind (the then Chair of the College’s Queensland Branch) emailed Bill Kingswell advising that the College had expressed concerns about the closure of the BAC.

Kingswell responded:

Barrett centre costs about \$6m recurrent to run. It can identify no outcomes.

It is attached to the most expensive school in Aus that records no naplan results. It is run down, 50% occupied and uses a controversial model of care that does not appear anywhere in the NMHSPF taxonomy.

We have built 8 new beds at Toowoomba and 6 are under construction at Townsville. The rest of the SE runs 50% occupancy.

We do not need this bed stock. This service could be provided in existing beds, expanded day services and NGO respite and we could do it within existing resources.

Other than that I can think of no reason not [sic] to retain Barrett.³⁵⁶

Thus, at that stage, Kingswell expressed the view that the BAC model of care did not fit within the National Mental Health Service Planning Framework (NMHSPF). Further, as noted above, Kingswell thought that the services provided at the BAC could be provided by other existing services.

Reliance on the NMHSPF

Later, Kingswell made clear his view that the Tier 3 recommended by the ECRG was “at odds” with the (draft) NMHSPF. On 21 May 2013, shortly after the ECRG had reported to the Planning Group, Kingswell told Sadler:

I do not pretend to be a Child trained psychiatrist.

You need to persuade your colleagues on the NMHSPF expert ref grp that this is a model that should prevail.³⁵⁷

And, in his email to Stathis on 11 July 2013 Kingswell said: “The tier 3 recommended by the ECRG is at odds with the National Mental Health Service Planning Framework and will struggle to attract attention in the ABF model priority for state funding”.³⁵⁸

Other witnesses appear to have relied on Kingswell’s view that a Tier 3 model was inconsistent with the draft NMHSPF. For example, Michael Cleary’s evidence to the inquiry was that Kingswell advised him that the continuation of the Redlands project was not appropriate for a range of reasons including:

... the proposed unit continued a model of care that was now not considered contemporary. Contemporary models were moving from institutional care to community based care. Dr Kingswell indicated that there was work being undertaken nationally that indicated that institutional models of care were not considered contemporary under the draft ‘National Mental Health Service Planning Framework’.³⁵⁹

Sharon Kelly’s email of 8 November 2012, prepared for the purposes of a brief to the Minister’s office, states that:

The National Mental Health Service Planning Framework currently being developed by the Commonwealth Government, due for completion in July 2013 does not include provision for non-acute adolescent inpatient services as per the current model at Barrett. The Framework does include subacute community based services for adolescents.

Planning is required to align with the National Mental Health Service Planning Framework that recommends subacute community based services for adolescents.³⁶⁰

In her oral evidence Kelly said that she assumed the source of that information was “someone like Dr Kingswell”.³⁶¹

The reliance on Kingswell’s view of the draft NMHSPF did not go unquestioned. In an email on 6 September 2013 Stathis wrote this to Kingswell:

I understand that the Tier 3 model recommended by the ECRG is at odds with the National MHSPF and will struggle to attract attention in the ABF [activity-based] model of funding. However, I’ve been told that the draft National MHSPF document, which defines what will be In-scope and Out of Scope under the proposed Service Planning Framework, is not publically available. If this is the case, how can we write up a model of services for a draft document that we don’t have access to?

Could you please advise.³⁶²

There is no evidence of a reply.

It is a matter of some significance that a representative of Children’s Health Queensland as senior as Stathis was not able to access the draft NMHSPF by September 2013. This, of course, was after the decision to close the BAC had been made and after it had been announced.

A number of parties made separate submissions to the Commission on the draft NMHSPF.³⁶³ There was some controversy about the draft framework and its relevance.

Kingswell's frustration with the terminology

Counsel for Kingswell argued that the draft NMHSPF is significant in two respects only:

The NMHSPF has primary significance because it uses terminology which the ECRG was expected to employ, but did not. The NMHSPF has secondary significance because it reflects contemporary thinking that institutionalised models of care are outdated.

Otherwise, the NMHSPF has no particular significance to the matters that the Commission must consider.³⁶⁴

He submitted that the "... evidence establishes that Kingswell's frustration with the ECRG Report related to its terminology, not its recommendations".³⁶⁵ In his oral submissions he highlighted Kingswell's evidence on his reaction to the ECRG's report:

DUFFY: And if we scroll down to heading 3 [in the ECRG report]— so one more page down, please – you can see the recommendation I took you to:

A tier 3 service should be prioritised?

KINGSWELL: Yes.

DUFFY: Did you agree with that?

KINGSWELL: I wasn't happy with the language, but I was happy with the intent.³⁶⁶

And then Kingswell's counsel emphasised his client's evidence:

KINGSWELL: So, yes, I – it was completely comfortable with the idea that we needed extended inpatient facilities for a group of adolescents, tier 3, whatever you call it. Yes.³⁶⁷

While Kingswell did give oral evidence that he was frustrated with the ECRG's terminology rather than its recommendations,³⁶⁸ the likelihood is that he was more frustrated with the substance of the ECRG's recommendations than with its terminology.

First, in response to the ECRG's recommendation that "A Tier 3 service should be prioritised to provide extended treatment and rehabilitation for adolescents with severe and persistent mental illness" Kingswell, who was a member of the Planning Group, noted or contributed³⁶⁹ the following comments:

Accept with the following considerations.

Further work is needed to detail the service model for a Tier 3. **Models involving a statewide, clinical bed-based service (such as the Barrett Adolescent Centre) are not considered contemporary within the National Mental Health Service Planning Framework (in draft).**

However, there are alternative bed-based models involving clinical and non-clinical service components (e.g., Y-PARC in Victoria) that can be developed in Queensland to meet the requirement of this recommendation.

Contestability reforms in Queensland may allow for this service component to be provider agnostic.³⁷⁰

(emphasis added)

There, Kingswell was plainly stating the view that models of care involving statewide clinical bed-based service (like the BAC) were not considered contemporary within the draft NMHSPF. As a matter of substance, Kingswell was suggesting the Tier 3 recommended by the ECRG ought to be altered because of its inconsistency with the contemporary models recognised by the draft NMHSPF. That suggests a substantive complaint rather than a quibble about terminology.

Similarly, in an email to Kelly on 11 July 2013 Geppert attributes the following remark to Kingswell: "Why are they [the ECRG] hanging on to this Tier 3 nonsense? I had thought we could not have been clearer that there was no \$ and no support for the model".³⁷¹ That is more consistent with a frustration with the model proposed by the ECRG than frustration with the terminology used by the ECRG.

There is a further complication. Kingswell said his frustration stemmed from his understanding that the ECRG had been asked to constrain its thinking within the NMHSPF which, he said, was the policy document of all Australian Governments. He said it would have helped if there had been a consistency of language.³⁷² However, the ECRG's terms of reference do not specify the terminology to be used although they specify that the model should align with "... Queensland mental health policy, current statewide models of service, National mental health policy, National mental health service planning frameworks and future funding models".³⁷³ As Kingswell and his counsel acknowledged, it may be that the ECRG was not aware of the NMHSPF terminology.³⁷⁴ As explained below, the distribution of the draft NMHSPF was limited, especially prior to October 2013.³⁷⁵

Kingswell's counsel submitted that his client strenuously attempted to implement every one of the ECRG's recommendations. As discussed below, there is certainly evidence that Kingswell made efforts to establish a service equivalent to Victoria's Y-PARC model. However, there is no evidence of his attempting to establish a Tier 3 as recommended by the ECRG.

NMHSPF – a reflection of contemporary thinking

Kingswell's counsel submitted that:

16. Dr Kingswell plainly believed that the BAC model of care was outdated. That is because, in his view, the BAC model of care represented an institutionalised, rather than community-based, model of care. Dr Kingswell is not alone disfavoured institutionalised models of care. Many witnesses gave evidence to similar effect. It is unnecessary to recite their evidence here.
17. The NMHSPF is relevant to models of care only in this way. The NMHSPF reflects contemporary medical opinion that community-based care is preferable to institutionalised care. The NMHSPF is not the source of this medical opinion, it merely reflects it. The NMHSPF did not instigate the shift in medical opinion away from institutionalised care, towards community-based care: this shift had been occurring for decades.
18. When Dr Kingswell proposed that the Redlands Project could be cancelled, he did so, in (small) part, because he believed that the Redlands Project envisioned an outdated model of care. Dr Kingswell believed the Redlands model of care was outdated because of contemporary medical opinion, not because of the NMHSPF.³⁷⁶

It is undoubtedly true, as explained earlier in this chapter, that there is an overarching philosophy that young people are to be treated in the least restrictive environment possible, and one which recognises the need for safety and cultural sensitivity, with the minimum possible disruption to

family, educational, social and community networks.³⁷⁷ That overarching philosophy nevertheless recognises that some mentally ill young people will require an acute service or, as Beth Kotzé explained, the NMHSPF “supports that there are some young people who would benefit from longer stays in hospital” such as the Walker Unit in NSW.³⁷⁸

Witness interpretations of the draft NMHSPF

The State of Queensland and the Minister submitted that there was insufficient evidence as to the application and the proper interpretation of the draft NMHSPF.³⁷⁹ On this point Kingswell’s counsel disagreed and submitted that the Commission had already heard sufficient evidence from appropriately qualified experts, namely Kingswell and Kotzé.³⁸⁰

In fact, six witnesses gave evidence on the application and interpretation of the draft NMHSPF: Kingswell, Kotzé, Groves, Krause and Kevin Fjeldsoe. It is worth examining the evidence of each.

Kingswell’s oral evidence on the draft NMHSPF did not quite match the strength of his email to Stathis that: “The tier 3 recommended by the ECRG is at odds with the National Mental Health Service Planning Framework...”³⁸¹ or his email complaint to Geppert about the Tier 3 being nonsense and not supported.³⁸²

When, in the course of his oral evidence, Kingswell was taken to the draft NMHSPF service element ‘Subacute Intensive Care Service (Hospital)’ there was this exchange:

FREEBURN: And the last category Subacute Intensive Care Service (Hospital) – that would cover the Barrett Adolescent Centre?

KINGSWELL: Well, that’s not my understanding. My understanding is that it was never envisaged that this sub-category would include and child and youth element.

FREEBURN: And where did you get that understanding from?

KINGSWELL: From the planning team.

FREEBURN: But we obviously can separately look at the word content of this sub-category, can’t we?

KINGSWELL: Well, I’d need to go to the service element descriptor to see what’s intended by subacute intensive care service but I was not ever – my attention was never brought to that being intended for adolescents.³⁸³

It is significant that Kingswell was not inclined to support his views by reference to the terms of the draft NMHSPF. Instead, he based his interpretation on an understanding he gained from the planning team, and on his attention not having been directed to the fact that this service element was intended for adolescents.

It is difficult to see, in Kingswell’s oral evidence, support for the proposition that the draft NMHSPF actually excludes or is “at odds” with the Tier 3 proposed by the ECRG.

However, Kevin Fjeldsoe, who was one of the Queensland’s representatives on the NMHSPF project team, took the view that the category ‘Subacute Intensive Care Service (Hospital)’ was intended as a secure adult unit to be accessed by adults and selected young people with special needs in very rare circumstances.³⁸⁴

The submissions for the State and those for Kingswell placed some emphasis on Kotzé's evidence. However, Kotzé was prepared to accept that the draft NMHSPF supports a bed-based service:

MUIR: Do you agree that the framework doesn't support a bed-based service?

KOTZE: Look, it does. I mean, the framework – **the framework supports that there are some young people who would benefit from longer stays in hospital.** Now, if you just take the Walker Unit, its average length of stay is in the order of 90 days. If you add the leave beds in, it's in the order of 135 days. But its median length of stay, so the middle point of the frequency distribution, is actually 42 days. So, in fact, it recognises – and – **and that's recognised within the model.** There are some young people who would benefit from that longer – longer stay. What the model – and – and that – and that's, really, most particularly young people with those enduring and relapsing mental illnesses like the psychoses and the affective disorders. What the model – what you won't find in the model is, for example, the very long lengths of stay under the Mental Health Act. You also will not find, for example, long length of stay for people with eating disorders. Now, you have to know where to find that in – in the model, but if you take that particular group you won't find that. You also won't find, for example, extended inpatient stay supported for the group of people who have strong emotional dysregulation, which is the borderline personality disorder group in adult – in adulthood. You wouldn't actually go looking for that in this model. You would find that information, for example, from the NHMRC Guidelines for Borderline Personality Disorders. So there's quite a lot of unpicking that has to be done beneath the general statements.³⁸⁵

(emphasis added)

As a result of discussions with colleagues involved in developing the draft NMHSPF, Kotzé came to the view that the BAC was not operating a contemporary model of care.³⁸⁶ But that view was based on discussions, not on an application of the draft NMHSPF.

Aaron Groves' evidence was that the BAC as a service type fits within the category of "subacute bed-based services (residential and hospital or nursing home based)".³⁸⁷ However, he noted that the BAC model of service required amendment. That is consistent with Kotzé's evidence.

To similar effect was the evidence of Judi Krause. Krause is presently the Divisional Director of Child and Youth Mental Health Service (CYMHS), Children's Health Queensland Hospital and Health Service. From December 2009 until March 2014 she was either the acting or permanent Executive Director of CYMHS. Krause is not a medical practitioner but trained as a psychiatric nurse. Her training included a student rotation at the BAC.³⁸⁸ As an experienced medical administrator, her views deserve considerable respect.

Krause's evidence was that, in her opinion, the BAC would best be described as Service Element 3.2.5 [sic, 2.3.2.5] Sub Acute Intensive Care Hospital in the draft NMHSPF.³⁸⁹ However, Krause points out that the difference is that the length of stay for that service element is recommended to be 120 days with an expected maximum stay of less than 180 days. She points out that the BAC regularly exceeded those time recommended frames within the NMHSPF and that the NMHSPF is a high level document where the operational elements are not articulated in the extracts of the NMHSPF that she has been privy to.³⁹⁰

Philip Hazell (an ECRG member and the Director of the Thomas Walker Hospital (Rivendell)), thought it was not appropriate for the Planning Group to use the draft NMHSPF as a justification for closing the BAC.³⁹¹

The result is that, of the four senior medical practitioners and two senior health administrators who gave evidence on the issue, only Kingswell and Fjeldsoe took the view that a Tier 3 facility is not recognised in the draft NMHSPF taxonomy. Kingswell took that view in his 2013 emails, but did not appear to go that far in his oral evidence. Fjeldsoe interpreted the relevant category as a secure adult unit.

Aaron Groves specifically said that the BAC service type fits within the taxonomy and Kotzé, a child and adolescent psychiatrist, cited the Walker Unit as an example of what was recognised by the draft NMHSPF (although she pointed out that very long stays under the Mental Health Act and some illnesses and disorders would not be found in the framework).

Hazell said it was inappropriate to use the draft NMHSPF as a basis for closing the BAC.

The State of Queensland and Kingswell urged the Commission to prefer the evidence of Kingswell and Kotzé over the evidence of Groves on the basis that, in contradistinction to the others, Groves had involvement with the draft NMHSPF only in its very early stages.³⁹² As to that submission:

- As explained above, on this point, Kotzé’s evidence is consistent with Groves’ evidence.
- Kingswell’s oral evidence did not quite match the insistence in his emails that a Tier 3 facility was “at odds” with the draft NMHSPF.
- Approximately 200 experts from all over Australia have met as part of the NMHSPF process³⁹³ and it would hardly have been practicable for this Commission to attempt to analyse which of them, whether they be on the executive or direct contributors, could give the most reliable interpretation of the draft NMHSPF.
- In fact, not surprisingly, the executive and the other contributors changed over time, including from November 2012, to October 2013, to now.
- The submission that Groves was involved only at the early stages is wrong.³⁹⁴

The West Australian interpretation

Kotzé explained that the draft NMHSPF was utilised “for the first time” in the proposed Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025.³⁹⁵

In that plan, under the heading ‘10.4. What the Modelling Tells Us’, are these categories of service types:

- ‘Subacute hospital short stay’ (average length of stay of between 35 days and six months)
- ‘Non-acute hospital long stay’ (average length of stay is 365 days).³⁹⁶

The West Australian 2015–2025 plan provides that, by the end of 2017, to prepare for the future, the aim is to convert the Bentley Adolescent Unit into a statewide 14 bed sub-acute service for youth, that is, for those aged 16 to 24 years of age.³⁹⁷

As noted earlier in this chapter, the Commission received a letter from the MHC of Western Australia dated 12 April 2016 which explained that, whilst the model of service for the Bentley Adolescent Centre had not yet been developed, the proposed services at the Bentley Adolescent Centre are based on the service elements ‘2.3.2.5 - Sub-Acute Intensive Care Service (Hospital)’ and ‘2.3.3.1 - Non-Acute Intensive Care Service (Hospital)’ in the NMHSPF.³⁹⁸

That categorisation by the MHC is consistent with the evidence of Groves and Kotzé to the effect that the draft NMHSPF does include adolescent inpatient facilities such as the Walker Centre.

Interpretation of the draft NMHSPF itself

Counsel for the Minister argued that the proposed model of care for Redlands was not consistent with either of the potential service elements under the draft NMHSPF, namely 'Sub-Acute Intensive Care Service – Hospital' (Service Element 2.3.2.5) and 'Non-Acute – Intensive Care Service – Hospital' (Service Element 2.3.3.1). Essentially, the argument was that the words "selected young people with special needs" in the draft NMHSPF ought to be interpreted as meaning 16- to 25-year-olds. By way of contrast, it was argued, the Redlands facility was intended to accommodate 13- to 17-year-olds.

It is to be doubted that the draft NMHSPF can be interpreted in that way. In drafting the phrase "adults, older adults and selected young people with special needs" it is hard to imagine that the clinical specialists were drawing clean, legalistic lines between young people aged 15 and those aged 16. And, elsewhere in the draft NMHSPF, in relation to sub-acute step up/step down units, the expression used is "young people (12–17) and/or adolescents (16–25)". That suggests the former expression is intended to cover those aged 12–17.

In any event, even assuming the Minister's interpretation to be correct, the point being made is that the service categories in the draft NMHSPF do not precisely align with those in the proposed Redlands model of service. That the target age groups do not align cannot be taken too far. As Kotzé said, "the framework supports that there are some young people who would benefit from longer stays in hospital".³⁹⁹ That differs from Kingswell's email to the effect that the Tier 3 recommended by the ECRG was nonsense or "at odds" with the draft NMHSPF.

The NMHSPF – agreed or draft?

Counsel for the State of Queensland submitted that all States and Territories have agreed to the Framework taxonomy.⁴⁰⁰ However, that submission is not based on any specific evidence of an express agreement by the States and Territories. The State seeks to imply such an agreement from the conduct of the States and Territories in: the distribution and acceptance of a USB of the Excel modelling tool in October 2013; the use of the tool in Western Australia and by Children's Health Queensland; the evidence of Kotzé and Kingswell; and the work undertaken by the various experts.

It is certainly the case that when all Health Ministers agreed to the Fourth National Mental Health Plan in September 2009 they agreed to the **development** of the NMHSPF as one of the foundation actions of the plan.⁴⁰¹ It is also the case that the distribution and development of the components of the NMHSPF has proceeded, particularly since October 2013. However, there is no evidence of an agreement by all States and Territories to the draft NMHSPF or to its taxonomy.

Of course, the draft NMHSPF is plainly an important piece of research work and deserving of considerable respect. It has been developed over the period 2010–2016, with the October 2013 meeting of the NMHSPF Executive introducing the major components of the NMHSPF.⁴⁰² The components of the draft NMHSPF were distributed to each of the States either at or shortly after the October 2013 meeting.

At the time of his emails in mid-2013, Kingswell must have been relying on an earlier version of one component, namely the Service Element and Activity Descriptions document of November 2012.⁴⁰³ That version is different from the October 2013 version of the same element

which is described as the "Final First Draft". The relevant categories are similar, but the document was plainly a work in progress.

Even as recently as August 2015 the draft NMHSPF was still in draft, had undergone some testing, and required further work before it could be signed off as a genuinely national product.⁴⁰⁴

To the contrary is Kingswell's evidence. Kingswell said he was frustrated with the ECRG because:

- "they had been asked to constrain their thinking within the National Mental Health Service Planning Framework" and had failed to do so
- that failure had occurred in a context where it "was important to do so in that that [the draft NMHSPF] was the policy document of all Australian governments".⁴⁰⁵

However, no other evidence suggests that the draft NMHSPF had become a policy document of all Australian governments.

Kingswell agreed that the NMHSPF was under construction,⁴⁰⁶ and had modest ambitions,⁴⁰⁷ and was not intended to be exhaustive.⁴⁰⁸ He was unable to identify any component of the draft NMHSPF, other than Communiques, which was available to the profession.⁴⁰⁹

Kingswell agreed also that the estimator tool was in draft and needed a lot of work.⁴¹⁰ He said that otherwise it was a complete document.⁴¹¹ When shown the watermark on the service elements component to the effect "Draft-in-confidence: not for citation" he agreed that: "Certain elements, yes [are in draft]. Well you can consider the whole thing in draft, but there are some elements of it that are unlikely to change, large chunks of it that are unlikely to change".⁴¹²

In fact, as Counsel Assisting pointed out, there were significant changes between, on the one hand, the service elements in the November 2012 version of the draft NMHSPF and, on the other hand, the same components in the October 2013 version of the draft NMHSPF.⁴¹³

As Counsel Assisting submitted, the limited distribution of the draft NMHSPF, and its protection with a password, appears to be a deliberate choice, so that (as Groves explained) some use could be made of the draft, and then it could be refined and developed, and inaccuracies could be rectified, and then there could be more widespread use of the draft. Thus:

- a. On 26 August 2015 the CEO of the National Mental Health Commission told a Senate Committee that the (Commonwealth) Department of Health had declined to provide his Commission with a copy of the NMHSPF.⁴¹⁴
- b. On 22 December 2015, by email, the (Commonwealth) Department of Health also declined to provide this Commission of Inquiry with access to the NMHSPF saying that:

The first phase of the NMHSPF Project was completed in mid-2014 with the Executive Group's advice stating that further refinement, validation, sensitivity analysis and testing of the draft NMHSPF was required prior to distribution for use in real world mental health service planning situations. There are recognised technical issues with this version of the NMHSPF. As per the advice provided by Dr Kingswell to you, the intellectual property for the draft NMHSPF is owned by the NSW Government.⁴¹⁵

- c. In the evidence before this Commission, even a psychiatrist as senior as Stephen Stathis, the Medical Director of CYMHS, had not read or received a copy of the NMHSPF in 2016 (except for two pages).⁴¹⁶

The limited distribution of the draft NMHSPF, and its use “for the first time” in the proposed Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025, all suggests that Aaron Groves was correct to describe the draft NMHSPF as “still in its developmental stage”⁴¹⁷ and Patrick McGorry was correct to describe it as a “work in progress”.⁴¹⁸

Cautions on the use of the draft NMHSPF

It is important to bear in mind the cautions in the draft NMHSPF itself, namely:

- “[T]he NMHSPF will not account for every circumstance or service possibly required by an individual or group, but will allow for more detailed understanding of need for mental health service across a range of service environments.”
- “The NMHSPF will capture the types of care required, but will not define who is best placed to deliver the care. Decisions about service provision will remain the responsibility of each state/ territory and the Australian Government.”⁴¹⁹

Beth Kotzé expressed a similar concern in saying that the draft NMHSPF was “the general map” and that other processes were involved.⁴²⁰ Groves described the draft NMHSPF as “still in its developmental stage”⁴²¹ and McGorry described it as a “work in progress”.⁴²²

And, of course, the Executive Group for the draft NMHSPF have directly advised this Commission that further refinement, validation, sensitivity analysis and testing of the draft NMHSPF was required prior to its distribution for use in real world mental health service planning situations. They also explained that there are recognised technical issues with this version of the NMHSPF.⁴²³

Similarly, a letter from Brian Woods, the Project Director of the NMHSPF to Alison Earls on 9 September 2013 acknowledges the necessity for some inpatient care of adolescents with severe and complex mental health disorders, and explains that this is an evolving area:

Please note that various models of care were considered by the Expert Working Groups and consideration was given to international and national reviews of the issues surrounding non-acute inpatient mental health units for adolescents. Across jurisdictions, these facilities report a low occupancy level over a long period of time and access to services from rural and regional populations is often difficult. It has been recognised that to remain relevant in a comprehensive health care system, **it is likely the model of extended inpatient care of adolescents will continue to evolve with a clear focus on adolescents with severe and complex mental health disorders.** International guidelines have indicated that inpatient care is regarded as necessary only for the most severe and complex young people and the emphasis is on intensive day patient, community-focussed programs and step-up/step-down youth mental health care.⁴²⁴

(emphasis added)

Another reason for caution is the evidence of Brett McDermott that:

Much of the policy documentation relating to child and youth mental health has no direct impact on facilities such as the BAC. However, there are national and state principles that are clearly relevant. The most relevant, in my opinion, are the delivery of least restrictive care, access to services close to home, the overarching child and youth principle of developmentally appropriate services (that encourage normalisation rather than pathology), and a commitment to service evaluation.⁴²⁵

Presumably McDermott’s view that much of the policy documentation had no direct impact on facilities such as the BAC was related to the relatively small cohort.

Conclusion on the draft NMHSPF

Overall, there is much to be said for the submission of counsel for Kingswell that this Commission should not attach a great deal of significance to the draft NMHSPF because it is reflective of modern medicine. And he was right to say that there was a general shift in philosophy from institutional care to community-based care had been occurring for decades.⁴²⁶

However, that shift did not mean, and does not mean, there was and is no place at all for institutional care.

Kingswell's expressed opinions, which were influential in the period from May 2012 to August 2013, took the approach that Tier 3 facilities were not contemporary at all because they were at odds with or were not recognised by the draft NMHSPF.

The Commission is not satisfied that the draft NMHSPF can be used as basis for excluding a particular type of care. It is a guide or general map for States and Territories and each State and Territory is entitled to consider how best to use it. As it happens, the draft NMHSPF does include a category similar to Tier 3 facilities, namely Service Element 2.3.2.5 which is said to have application to "adults, older adults and selected young people with special needs". Whether that signifies a composite facility or separate facilities is likely to depend on how each State and Territory chooses to use the draft NMHSPF as a guide and on all the other factors they can legitimately consider.

Reason 4: Low bed occupancy

Another of the criticisms of the BAC was that it had a low bed occupancy rate.⁴²⁷

Bed occupancy is measured by counting the persons sleeping in beds at midnight on a given day. This measure takes no account of patients on approved leave (for example, weekend leave with their families) or of day patients.

The BAC model of treatment and rehabilitation was directed to reintegrating young persons into their communities.⁴²⁸ As part of that process, they were frequently allowed leave to spend time with their families and then return to the BAC. If they were on leave when the bed occupancy count was taken, their beds were recorded as unoccupied.

In March and April 2012, Karlyn Chettleburgh and Helen Doyle undertook a review of The Park at the request of Kingswell. Their report stated, relevantly:

Barrett Adolescent Unit (BAU) – the BAU was identified as one of the areas that was disproportionately contributing to the current deficit. In reviewing their YTD financial performance they are 8% in deficit (\$201,000) which is not acceptable from a financial management perspective but is not a significant contributor to the current deficit ... This unit has occupancy rates of 60%, however low occupancy rates are not unusual within Child and Youth units associated with high levels of approved leave, including day and overnight leave, to ensure that community, family, social and educational links are maintained as much as possible...⁴²⁹

The Commission is satisfied that, to the extent low bed occupancy was relied on as a justification for closing the BAC, the reasoning was flawed.

Reason 5: Clinical governance

The evidence

One of the reasons why Kingswell considered the BAC should be closed was as follows:

... [O]n 5 September 2013 the parents of a patient of the BAC complained ... [specifics of the complaint removed]. It emerged from my discussions with executive staff from the WMHHS that a number of incidents of this nature had in fact occurred at the BAC and had not been escalated to the WMHHS executive, as they should have been. The emergence of these incidents pointed to a serious failure of governance of the BAC. I understand that as a result of these perceived failures, the Clinical Director, Dr Trevor Sadler was stood down.⁴³⁰

When it was pointed out to Kingswell, during his oral evidence, that the complaint had been made one month *after* the decision was made to close the BAC, he conceded that the complaint did not contribute to the decision to close the BAC. According to Kingswell, the complaint contributed to the decision around the timing of the BAC's closure, explaining that it "accelerated the need to close [the BAC] and find alternative care for the young people that were resident in that facility".⁴³¹

Submissions

Counsel for Sadler submitted:⁴³²

5. The decision to close the BAC was communicated by the Mental Health Alcohol and Other Drugs Branch (MHAODB) to Ms Kelly at a meeting on 25 October 2012. The reasons did not relate to clinical governance issues.⁴³³ (reference in original)
6. Prior to the announcement of the closure decision, there were numerous documents created relevant to the decision to close. These included Agenda Papers for the WMHHS Board meetings, Minutes of the WMHHS Board meetings, Briefing Notes to the Director-General and Briefing Notes to the then Minister for Health. In none of these documents are clinical governance issues raised as a reason for closing the BAC.
7. On 2 November 2012, Sharon Kelly met with Drs Sadler and Stedman to inform them that the BAC would be closing. On 5 or 6 August 2013, Lesley Dwyer met with Dr Sadler and Nurse Clayworth to inform them that the BAC would be closing in early 2014. One would have thought that if clinical governance had been one of the reasons for closure, Ms Kelly and Ms Dwyer would have raised this with Dr Sadler at their respective meetings. They did not.
8. Ms Kelly was requested by the Commission to address a number of issues in a statutory declaration. One of these issues was 'the reasons for the decision to close BAC'. In response to this request, Ms Kelly relevantly stated 'From my perspective ... the reasons for closure were....'. She provided three reasons, none of which relate to clinical governance concerns.
9. Ms Dwyer, was also requested by the Commission to address a number of issues in a statutory declaration. One of these was 'any concerns Ms Dwyer had about the BAC'. In response to this request, Ms Dwyer raised her concerns regarding the physical aspects of the BAC building, the proximity of the BAC to The Park adult mental health services, that the BAC was not consistent with contemporary models of community linked care and staffing issues which seemed to be associated with the fact that it was well known that the BAC was to close when the Redlands facility was ready to open. Once again, none of Ms Dwyer's concerns relate to clinical governance issues at the BAC.⁴³⁴ (reference in original)

On the other hand, Counsel for West Moreton HHS and Board submitted that the incident involving the standing down of Sadler must be seen as calling into question the governance of the BAC.⁴³⁵ They submitted that the closure of the BAC was hastened by the lack of governance and “crisis type management”.⁴³⁶

Analysis

There is considerable force in the submission of Counsel for Sadler that the governance issue had no part to play in the decision to close the BAC. In fact, it ultimately became both Kingswell’s and West Moreton’s position that the incident was not a reason for the decision to close the BAC, but that it was a reason for accelerating the closure.

There are two points to be made here. The *first* is that, whilst Kingswell ultimately retreated to the position that the incident was a reason for the acceleration of the closure, there was no evidence that, in fact, the plans to close the BAC were accelerated because of the incident. Certainly, as a result of the incident, Sadler was replaced by Brennan with the consequences which are explained in chapter 16. However, there is no evidence to the effect that West Moreton HHS or Board or the Director-General or the Minister decided, in effect, ‘we must close the BAC more quickly now’.

The *second* is that, by its nature, a lack of governance would be unlikely to be a reason to close or even accelerate the closure of a health facility. If there were a lack of clinical governance in a health facility, the immediate response of the entity responsible for the facility would surely be to investigate and resolve any issues of clinical governance and to do that quite independently of any proposed closure. Here, the responsible entity responded to the issue of clinical governance by moving quickly to replace the clinical director and to investigate the incident.⁴³⁷

The Commission is unable to see any direct connection between the incident raising concern about clinical governance and the closure of the BAC.

Reason 6: Financial considerations

In chapters 3 and 6 consideration was given to the influence of budgetary pressures on the decision to close the BAC. Essentially, whilst it appears that West Moreton Board inherited a difficult financial position, and there was pressure to make savings, there is no evidence of a direct connection between those financial pressures and the decision to close the BAC.

Conclusions

The decision to close the BAC, and to do so without the existence or prospect of a replacement, was an important clinical decision. Deciding to close the only Tier 3 service available in Queensland in the absence of a replacement involved an assumption that a Tier 3 is not an essential element of mental health services and that the mental health needs of the Barrett cohort could be safely and effectively met through alternative service types.

Counsel for the State of Queensland submitted that a ‘service’ and a ‘facility’ should not be ‘conflated’ and that a Tier 3 service is not necessarily an inpatient bed-based service.⁴³⁸ Notwithstanding that submission, they contended that two sub-acute beds at the Mater Hospital and later four sub-acute swing beds at the Lady Cilento Children’s Hospital provided an interim equivalent Tier 3 service until an inpatient bed-based service was established.⁴³⁹

Of course, the ECRG was of the opposite view. It took the view that a Tier 3 is an essential service as there is a small group of young people whose needs cannot be safely met through alternative service types (as represented by Tiers 1 and 2).⁴⁴⁰ The ECRG warned that managing this group predominantly in the community would be associated with complexities of risk to those young people and others, and also disengagement from therapeutic services.⁴⁴¹

Many experts who gave evidence to this inquiry, including child and adolescent psychiatrists, held views consistent with those of the ECRG. Indeed, there are only two qualifications to that view. The *first* is that some experts, such as Scott, took the view that, when, and if, there are further services in place, a Tier 3 or medium term sub-acute inpatient facility may become unnecessary. The *second* is that Kingswell dissented from the views of the experts. He considered that a Tier 3 facility was not contemporary as it was not recognised in the draft NMHSPF taxonomy. The Commission prefers the views of ECRG and the many experts whose evidence was consistent with those views.

Old, unsuitable and unsafe

The age and unsuitability of the BAC infrastructure was commonly cited as a reason for closing the BAC. That reason was given some added force by some who described the building as unsafe for patients and staff. It is true that the building was not purpose-built and was old. However, the descriptions of it in 2012 and 2013 as unsafe were based on a 2008 ACHS report which had been responded to and superseded by a number of reports, including a 2012 report. The 2012 report did not list any safety concerns and recommended only superficial improvements to the building and furniture. No careful assessment seems to have been made of the building improvements that were necessary.

There is a further, more fundamental problem. Even assuming the age, unsuitability, and even the safety of the building were reasons to close the BAC, those unsatisfactory features of the building were not reasons for both closing the building and closing it without there being a replacement in prospect. Whatever the state of the BAC's physical structure, it hardly justified a decision to close the BAC and to do so without a replacement.

Co-location with EFTRU

Similarly, it was plainly legitimate to consider the risks presented by co-locating the BAC and EFTRU, and by locating the BAC within The Park which comprised largely adult forensic facilities. However, the consideration of that risk was devoid of any written or detailed assessment of the extent of the risks, and how they might be managed.

This reason may have justified a closure of the BAC in association with a replacement service, but it did not justify a closure of the BAC without any replacement in prospect. That is because such a decision is essentially a clinical decision that necessarily involves a conclusion that a Tier 3 service is unnecessary.

Not contemporary

Neither the QPMH nor the draft NMHSPF can be regarded as defining what is, or is not, a contemporary model of care. In so far as the concept of a 'contemporary model of care' has some established meaning, it refers to the general shift in philosophy from institutional care to community-based care that had been occurring for decades. However, as explained earlier in

this chapter, that overarching philosophy is not an absolute rule, and it has limited application to the vulnerable adolescents discussed here, who have severe and persistent mental illnesses and who are not able to be treated in less restrictive care.

The preponderance of the evidence is that, whilst there is a clear preference for and emphasis on community care:

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

Therefore, adherence to the phrase 'not a contemporary model of care' is too simplistic, and too distant from the complexity of the analysis required. It was not a clinical justification for the decision to close the BAC with no equivalent replacement in prospect.

Other reasons

The evidence does not establish that occupancy rates, or governance, or financial considerations were proper reasons for the closure.

Financial reasons and costs might legitimately be balanced against the clinical decision involved in closing the BAC. Those are matters within the prerogative of the government of the day. The decision to close the BAC appears to have been made in the absence of financial considerations, although plainly the context involved some financial pressure.

(Endnotes)

- 1 *Commissions of Inquiry Order (No. 4) 2015*, 16 July 2015, Term of Reference 3(a).
- 2 *Commissions of Inquiry Order (No. 4) 2015*, 16 July 2015, Term of Reference 3(b).
- 3 *Commissions of Inquiry Order (No. 4) 2015*, 16 July 2015, Term of Reference 3(c).
- 4 Exhibit 445, [REDACTED] Subject: "The Queensland Plan for Mental Health 2007–2017", [REDACTED]
- 5 Exhibit 445, [REDACTED] Subject: "The Queensland Plan for Mental Health 2007–2017", [REDACTED] p 49.
- 6 Exhibit 445, [REDACTED] Subject: "The Queensland Plan for Mental Health 2007–2017", [REDACTED] p 52.
- 7 Exhibit 58, Statement of Aaron Groves, 21 January 2016, p 11 para 51; Transcript, Sharon Kelly, 22 February 2016, p 11–7 lines 24–26; Transcript, Anthony O'Connell, 23 February 2016, p 12–20 lines 24–29; Transcript, William Kingswell, 24 February 2016, p 13–18 lines 28–36.
- 8 Exhibit 43, Statement of David Crompton, 19 October 2015, p 7 para 28.
- 9 Exhibit 43, Statement of David Crompton, 19 October 2015, pp 7–8 para 33, unmarked Attachment to that statement, 'Memorandum, Subject: "Site Selection Adolescent Extended Treatment Unit, 19 May 2009"; p 207.
- 10 Exhibit 43, Statement of David Crompton, 19 October 2015, p 8 para 34.
- 11 Exhibit 72, Statement of Judi Krause, 26 November 2015, p 15 para 60.
- 12 Exhibit 72, Statement of Judi Krause, 26 November 2015, p 15 para 60; Exhibit 72, Statement of Judi Krause, 26 November 2015, Attachment V to that statement, Minutes of Facility Project Team Meeting – Redland - New 15 Bed Adolescent ETU, Day Centre & School, 4 February 2010, p 451.

- 13 Exhibit 72, Statement of Judi Krause, 26 November 2015, Attachment W to that statement, Minutes of meeting to Review Model of Service Delivery, 10 February 2010, pp 458–460.
- 14 Exhibit 68, Statement of William Kingswell, 21 October 2015, Attachment 7 to that statement, 2009 Review of the Barrett Adolescent Centre, p 170.
- 15 Exhibit 72, Statement of Judi Krause, 26 November 2015, Attachment W to that statement, Minutes of meeting to Review Model of Service Delivery, 10 February 2010, p 459. Note the discussion of the criticisms of the BAC model in chapter 1.
- 16 Exhibit 43, Statement of David Crompton, 19 October 2015, p 9 para 37(b).
- 17 Mental Health and Other Drugs Division (as the MHAODB was known prior to the changes on 1 July 2012).
- 18 Exhibit 225, Briefing note to Minister for Health, Subject: "23–31 Weippin Street, Cleveland Land Use", 5 October 2011.
- 19 Exhibit 72, Statement of Judi Krause, 26 November 2015, Attachment W to that statement, Minutes of meeting to Review Model of Service Delivery, 10 February 2010, p 455.
- 20 Exhibit 72, Statement of Judi Krause, 26 November 2015, Attachment Y to that statement, Letter from Judi Krause to David Crompton enclosing draft Model of Service Delivery (MOSD) for Barrett Adolescent, p 485.
- 21 Exhibit 72, Statement of Judi Krause, 26 November 2015, Attachment Y to that statement, Letter from Judi Krause to David Crompton enclosing draft Model of Service Delivery (MOSD) for Barrett Adolescent, p 485.
- 22 Exhibit 72, Statement of Judi Krause, 26 November 2015, Attachment, Y to that statement, Letter from Judi Krause to David Crompton enclosing draft Model of Service Delivery (MOSD) for Barrett Adolescent, p 485.
- 23 Exhibit 72, Statement of Judi Krause, 26 November 2015, Attachment Y to that statement, Letter from Judi Krause to David Crompton enclosing draft Model of Service Delivery (MOSD) for Barrett Adolescent, p 486.
- 24 This figure is calculated on the 41 patients referred to by Counsel Assisting in the Opening: Transcript, Catherine Muir, 15 February 2016, pp 6-21–6-22.
- 25 Exhibit 179, Supplementary statement of Trevor Sadler, 17 February 2016, Attachment A to that statement, Model of Service for Mental Health in Queensland – Service Guideline for the Adolescent Extended Treatment Centre, for endorsement 26 March 2009, p 61.
- 26 Exhibit 72, Statement of Judi Krause, 26 November 2015, Attachment Y to that statement, Letter from Judi Krause to David Crompton enclosing draft Model of Service Delivery (MOSD) for Barrett Adolescent, p 486.
- 27 Exhibit 665, Adolescent Extended Treatment and Rehabilitation Centre, Model of Service, 31 August 2011.
- 28 Exhibit 72, Statement of Judi Krause, 26 November 2015, Attachment W to that statement, Minutes of meeting to Review Model of Service Delivery 10 February 2010, p 429.
- 29 Exhibit 72, Statement of Judi Krause, 26 November 2015, Attachment Y to that statement, Letter from Judi Krause to David Crompton enclosing draft Model of Service Delivery (MOSD) for Barrett Adolescent, p 486.
- 30 Exhibit 72, Statement of Judi Krause, 26 November 2015, Attachment Y to that statement, Letter from Judi Krause to David Crompton enclosing draft Model of Service Delivery (MOSD) for Barrett Adolescent, p 486.
- 31 Exhibit 665, Adolescent Extended Treatment and Rehabilitation Centre, Model of Service, 31 August 2011, p 1.
- 32 Exhibit 72, Statement of Judi Krause, 26 November 2015, Attachment W to that statement, Minutes of meeting to Review Model of Service Delivery 10 February 2010, p 429.
- 33 Exhibit 72, Statement of Judi Krause, 26 November 2015, Attachment Y to that statement, Letter from Judi Krause to David Crompton enclosing draft Model of Service Delivery (MOSD) for Barrett Adolescent, p 486.
- 34 Exhibit 72, Statement of Judi Krause, 26 November 2015, Attachment Y to that statement, Letter from Judi Krause to David Crompton enclosing draft Model of Service Delivery (MOSD) for Barrett Adolescent, p 486; Exhibit 665, Adolescent Extended Treatment and Rehabilitation Centre, Model of Service, 31 August 2011.
- 35 Exhibit 189, Second supplementary statement of Trevor Sadler, 17 February 2016, Attachment A to that statement, Adolescent Integrated Treatment and Rehabilitation Centre Model of Service Guideline, p 82; Exhibit 72, Statement of Judith Krause, 26 November 2015, Attachment Y to that statement, Letter from Judi Krause to David Crompton enclosing draft Model of Service Delivery (MOSD) for Barrett Adolescent, p 486.
- 36 Exhibit 72, Statement of Judi Krause, 26 November 2015, Attachment Y to that statement, Letter from Judi Krause to David Crompton enclosing draft Model of Service Delivery (MOSD) for Barrett Adolescent, p 486.
- 37 Exhibit 72, Statement of Judith Krause, 26 November 2015, Attachment Y to that statement, Letter from Judi Krause to David Crompton enclosing draft Model of Service Delivery (MOSD) for Barrett Adolescent, p 486.
- 38 Exhibit 72, Statement of Judith Krause, 26 November 2015, Attachment W to that statement, Minutes of meeting to Review Model of Service Delivery 10 February 2010, p 429.
- 39 Exhibit 72, Statement of Judith Krause, 26 November 2015, Attachment W to that statement, Minutes of meeting to Review Model of Service Delivery 10 February 2010, p 430.
- 40 Exhibit 189, Second supplementary statement of Trevor Sadler, 17 February 2016, Attachment A to that statement, Model of Service for Mental Health in Queensland, Service Guideline for the Adolescent Extended Treatment Centre, p 59.

- 41 Transcript, William Kingswell, 24 February 2016, p 13-10 lines 36–40; note that this reason does not appear in Kingswell’s statement.
- 42 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, p 9 para 40.
- 43 Exhibit 94, Statement of Anthony O’Connell, 6 January 2016, p 7 para 10(a)(vi).
- 44 See chapter 7.
- 45 See chapter 8.
- 46 See chapter 9.
- 47 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, p 5 para 3.6.
- 48 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, Attachment LG-12 to that statement, Email from Leanne Geppert to Sharon Kelly dated 9 November 2012 and email from Lesley Dwyer dated 14 November 2012, p 71–73.
- 49 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 5 para 9.1(a)–(d).
- 50 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment SK-6 to that statement, Memorandum: Cancellation of Capital Delivery Project, from Glenn Rashleigh to Lesley Dwyer and Richard Ashby, 28 August 2012, p 810.
- 51 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment SK-8 to that statement, Email from Ray Chandler to Lesley Dwyer and Sharon Kelly, 4 October 2012, Fwd: Barrett Adolescent condition summary, p 815.
- 52 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 7 paras 9.2–9.8, Attachment SK-9 to that statement, Email from Sharon Kelly to Bill Kingswell, Jagmohan Gilhotra and Leanne Geppert, 26 October 2012: WMHHS and mental health plans, p 826.
- 53 Exhibit 437, Email from Sharon Kelly to “Sdlo” and Shelley-Lee Waller, Subject: “pertinent points for consideration of Barrett Adolescent Centre”, 8 November 2012.
- 54 The email is to “sdlo” which appears to be a departmental liaison office or officer: Transcript, Sharon Kelly, 22 February 2016, p 11-33 line 25.
- 55 Exhibit 84, Statement of Brett McDermott, 10 November 2015, pp 17–18 paras 92-100.
- 56 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, pp 12–13 para 11.11(a)–(e).
- 57 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-20 to that statement, Minutes of West Moreton Board meeting, 24 May 2013, p 173.
- 58 Transcript, Mary Corbett, 18 February 2016, p 9-43 lines 30–44.
- 59 Transcript, Mary Corbett, 18 February 2016, p 9-46 lines 30–44.
- 60 Transcript, Mary Corbett, 18 February 2016, p 9-46 lines 38–44.
- 61 Exhibit 50, Statement of Timothy Eltham, 9 December 2015, p 19 para 18.1.
- 62 In fact, adult non-forensic patients in need of secure services were to continue being cared for at The Park (citation added).
- 63 Exhibit 50, Statement of Timothy Eltham, 9 December 2015, p 20 para 18.3.
- 64 Exhibit 50, Statement of Timothy Eltham, 9 December 2015, p 20 para 18.4.
- 65 Exhibit 307, Transcript of ABC 612 interview with Lawrence Springborg, 6 August 2013.
- 66 Exhibit 1284, Email from William Kingswell to Michael Cleary and Ian Maynard, Subject: “Question 2”, 14 July 2014.
- 67 Exhibit 120, Statement of Lawrence Springborg, p 16 para 77(a); Exhibit 307, Transcript of ABC 612 interview with Lawrence Springborg, 6 August 2013.
- 68 Exhibit 95, Supplementary statement of Anthony O’Connell, 6 February 2016, p 5 para 8.
- 69 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, Attachment LJS-5 to that statement, p 46.
- 70 Exhibit 40, Statement of Michael Cleary, 21 December 2015, p 19 para 80(i).
- 71 Exhibit 40, Statement of Michael Cleary, 21 December 2015, pp 9–10, paras 36–37.
- 72 Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 10 para 8.10(g), Attachment MC-11 to that statement, Email from Sharon Kelly to Lesley Dwyer forwarded to Mary Corbett, Subject: “Fwd: pertinent points for consideration of the Barrett Adolescent Centre”, 9 November 2012, pp 111–113.
- 73 Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 10 para 8.11, Attachment MC-12 to that statement, Email from Mary Corbett to Board Members, Subject: “Fwd: Barrett”, 9 November 2012, p 114–115.
- 74 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-19 to that statement, West Moreton Hospital and Health Board – Board Committee Agenda Paper dated 24 May 2013, p 146.
- 75 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-19 to that statement, West Moreton Hospital and Health Board – Board Committee Agenda Paper dated 24 May 2013, p 149.
- 76 Exhibit 50, Statement of Tim Eltham, 9 December 2015, p 20 para 18.3.
- 77 Exhibit 50, Statement of Tim Eltham, 9 December 2015, p 20 para 18.3(b).

- 78 Exhibit 50, Statement of Tim Eltham, 9 December 2015, p 25 para 20.1(b).
- 79 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 12 para 11.11(a).
- 80 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 6 para 9.1(c).
- 81 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment Exhibit SK-8 to that statement, Email from Ray Chandler to Lesley Dwyer and Sharon Kelly attaching email from Robert Wood, West Moreton HHS Report on the Condition of the Barrett Adolescent School and Accommodation, 4 October 2012, pp 815–825.
- 82 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 6–7 para 9.1(g).
- 83 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 7 para 9.1(h)(i).
- 84 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 4 para 5.9.
- 85 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 7 para 5.23.
- 86 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 21 para 11.6, 11.6(b).
- 87 Exhibit 68, Statement of William Kingswell, 21 October 2015, p 7 para 20(v).
- 88 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, pp 4–5 paras 3.5–3.6.
- 89 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, Attachment LG-12 to that statement, Email from Lesley Dwyer to Sean Hatherill and others, Subject: "Information re Barrett Adolescent Centre Stakeholder Meeting", 14 November 2012, p 118.
- 90 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 18 paras 90-92, p 26 para 136(b). Dr Sadler's evidence was that accommodating adolescents in a four bed dormitory contributed to poor peer relationships which delayed therapy and rehabilitation.
- 91 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 7 para 5.22.
- 92 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 3 para 5.6
- 93 Exhibit 1291, Barrett Adolescent Centre FAQ sheet, 6 August 2013, p 2.
- 94 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment Exhibit SK-8 to that statement, Email from Ray Chandler to Lesley Dwyer and Sharon Kelly attaching email from Robert Wood, West Moreton HHS Report on the Condition of the Barrett Adolescent School and Accommodation, 4 October 2012, pp 817–825.
- 95 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment SK-8 to that statement, Email from Ray Chandler to Lesley Dwyer and Sharon Kelly attaching email from Robert Wood, West Moreton HHS Report on the Condition of the Barrett Adolescent School and Accommodation, 4 October 2012, p 817.
- 96 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment SK-8 to that statement, Email from Ray Chandler to Lesley Dwyer and Sharon Kelly attaching email from Robert Wood, West Moreton HHS Report on the Condition of the Barrett Adolescent School and Accommodation, 4 October 2012, p 817.
- 97 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment SK-8 to that statement, Email from Ray Chandler to Lesley Dwyer and Sharon Kelly attaching email from Robert Wood, West Moreton HHS Report on the Condition of the Barrett Adolescent School and Accommodation, 4 October 2012, pp 817–820.
- 98 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment SK-8 to that statement, Email from Ray Chandler to Lesley Dwyer and Sharon Kelly attaching email from Robert Wood, West Moreton HHS Report on the Condition of the Barrett Adolescent School and Accommodation, 4 October 2012, p 820.
- 99 Exhibit 1292, Report of the Organisation Wide Survey for the ACHS Evaluation and Quality Improvement Program, West Moreton South Burnett Health Service District, 18–22 August 2008.
- 100 Exhibit 1286, Report of the Organisation Wide Survey for the ACHS Evaluation and Quality Improvement Program, Darling Downs – West Moreton Health Service District – Division of Mental Health, 12 September 2011.
- 101 Exhibit 1288, Report of the Organisation Wide Survey for the ACHS Evaluation and Quality Improvement Program, West Moreton Hospital and Health Service, 20–24 August 2012.
- 102 Exhibit 1292, Report of the Organisation Wide Survey for the ACHS Evaluation and Quality Improvement Program, West Moreton South Burnett Health Service District, 18–22 August 2008, pp 40, 64.
- 103 Exhibit 1292, Report of the Organisation Wide Survey for the ACHS Evaluation and Quality Improvement Program, West Moreton South Burnett Health Service District, 18–22 August 2008, pp 49, 50, 64.
- 104 Exhibit 1289, Briefing note for Information, from Pam Lane to Minister Robertson, Subject: "ACHS Organisation Wide Survey Recommendations and Accreditation Status for West Moreton South Burnett Health Service District", 2 September 2008, p 1.
- 105 Exhibit 1289, Briefing note for Information, from Pam Lane to Minister Robertson, Subject: "ACHS Organisation Wide Survey Recommendations and Accreditation Status for West Moreton South Burnett Health Service District", 2 September 2008, p 1.
- 106 Exhibit 1289, Briefing note for Information, from Pam Lane to Minister Robertson, Subject: "ACHS Organisation Wide Survey Recommendations and Accreditation Status for West Moreton South Burnett Health Service District", 2 September 2008, p 1.

- 107 Exhibit 75, Statement of Pamela Lane, 23 October 2015, p 14 para 3.66.
- 108 Exhibit 1286, Report of the Organisation Wide Survey for the ACHS Evaluation and Quality Improvement Program, Darling Downs – West Moreton Health Service District – Division of Mental Health, 12 September 2011, p 11.
- 109 Exhibit 1286, Report of the Organisation Wide Survey for the ACHS Evaluation and Quality Improvement Program, Darling Downs – West Moreton Health Service District – Division of Mental Health, 12 September 2011, p 52.
- 110 Exhibit 1286, Report of the Organisation Wide Survey for the ACHS Evaluation and Quality Improvement Program, Darling Downs – West Moreton Health Service District – Division of Mental Health, 12 September 2011, p 62.
- 111 Exhibit 1286, Report of the Organisation Wide Survey for the ACHS Evaluation and Quality Improvement Program, Darling Downs – West Moreton Health Service District – Division of Mental Health, 12 September 2011, p 62.
- 112 Exhibit 1288, Report of the Organisation Wide Survey for the ACHS Evaluation and Quality Improvement Program, West Moreton Hospital and Health Service, 20–24 August 2012, p 140.
- 113 Exhibit 1288, Report of the Organisation Wide Survey for the ACHS Evaluation and Quality Improvement Program, West Moreton Hospital and Health Service, 20–24 August 2012, p 140.
- 114 Exhibit 1288, Report of the Organisation Wide Survey for the ACHS Evaluation and Quality Improvement Program, West Moreton Hospital and Health Service, 20–24 August 2012, p 140.
- 115 Exhibit 120, Statement of Lawrence Springborg, p 16 para 77(a); Exhibit 307, Transcript of ABC 612 interview with Lawrence Springborg, 6 August 2013, p 1.
- 116 Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 10 para 8.10(g), Attachment MC-11 to that statement, Email from Sharon Kelly to Lesley Dwyer forwarded to Mary Corbett, Subject: "Fwd: pertinent points for consideration of the Barrett Adolescent Centre", 9 November 2012, p 112.
- 117 Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 10 para 8.11, Attachment MC-11 to that statement, Email from Sharon Kelly to Lesley Dwyer forwarded to Mary Corbett, Subject: "Fwd: pertinent points for consideration of the Barrett Adolescent Centre", 9 November 2012, p 111, Attachment MC-12 to that statement, Email from Mary Corbett to Board Members, Subject: "Fwd: Barrett", 9 November 2012, p 114.
- 118 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, Attachment LG-12 to that statement, Email from Lesley Dwyer to others, Subject: "Information re Barrett Adolescent Centre Stakeholder Meeting", 14 November 2012, p 118.
- 119 Exhibit 445, [REDACTED], Subject: "The Queensland Plan for Mental Health 2007–2017", [REDACTED], p 52.
- 120 Exhibit 1114, Mental Health Capital Works Program, Project Manager's Monthly Progress Report, 29 February 2008, pp 19–20 See also the discussion of this topic in chapter 2.
- 121 Transcript, William Kingswell, 24 February 2016, p 13-11 lines 7–13.
- 122 Transcript, William Kingswell, 24 February 2016, p 13-19 line 31 – p 13-20 line 14.
- 123 Exhibit 27, Statement of Cary Breakey, 29 September 2015, p 8 para 42(b).
- 124 Exhibit 307, Transcript of ABC 612 interview with Lawrence Springborg, 6 August 2013; Exhibit 50, Statement of Timothy Eltham, 9 December 2015, p 20 para 18.3(a).
- 125 Transcript, Anne Brennan, 4 March 2016, p 20-10 lines 38–41.
- 126 Transcript, Terry Stedman, 3 March 2016, p 19-46 lines 11–22; Exhibit 89, Statement of Darren Neillie, 23 October 2015, pp 6–7 para 7.6(a)–(b).
- 127 Transcript, Philip Hazell, 17 February 2016, p 8-33 lines 33–46.
- 128 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, p 16 para 77(c).
- 129 Transcript, Anthony O'Connell, 23 February 2016, p 12-23 line 6.
- 130 Exhibit 40, Statement of Michael Cleary, 21 December 2015, p 7 para 27.
- 131 Exhibit 40, Statement of Michael Cleary, 21 December 2015, p 19 para 80(iii).
- 132 Exhibit 68, Statement of William Kingswell, 21 October 2015, p 7 para 20(v).
- 133 Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 24 para 17.11(c).
- 134 Transcript, Mary Corbett, 18 February 2016, p 9-62 lines 26–45.
- 135 Exhibit 50, Statement of Timothy Eltham, 9 December 2015, p 20 para 18.3(c).
- 136 Exhibit 50, Statement of Timothy Eltham, 9 December 2015, p 25 para 20.1(c).
- 137 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 20 para 11.4(a).
- 138 Transcript, Lesley Dwyer, 23 February 2016, p 12-96 lines 37–45.
- 139 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 13 para 11.11(c).
- 140 Transcript, Paul Freeburn QC, Closing submissions of Counsel Assisting, 11 April 2016, p 26-13 line 45 – p 26-14 line 18.

- 141 Transcript, Geoffrey Diehm QC, Closing submissions on behalf of Anne Brennan, Michael Cleary, Anthony O'Connell, 11 April 2016, p 26–76 lines 18–31; see also the submissions of Ms McMillan (which adopted Mr Diehm's submissions on this point at Transcript, Kathryn McMillan QC, Closing submissions on behalf of West Moreton HHS and West Moreton Board, 15 April 2016, p 28–46 line 34–35.
- 142 The 'exception' identified here is discussed later in this chapter.
- 143 Transcript, Graham Martin, 11 March 2016, p 25–25 lines 9–10.
- 144 United Nations, Resolution 46/119 also known as *Resolution on the protection of persons with mental illness and for the improvement of mental health care*, Principles 9 (1) 'Treatment' and Principle 13 (2) 'Rights and conditions in mental health facilities'. Available from: <<http://www.un.org/documents/ga/res/46/a46r119.htm>>. [13 May 2016].
- 145 The Report of the Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled (by David Richmond) 1983. Available from: <<http://nswmentalhealthcommission.com.au/node/1521>>.
- 146 Exhibit 95, Supplementary statement of Anthony O'Connell, 6 February 2016, p 4 para 4(b). Note the discussion later in this chapter of O'Connell's qualification that he was distinctly not saying that there is never a need for certain mental health patients to be hospitalized (acutely or in extended bed-based care).
- 147 Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 20 para 14.10, Attachment MC-19 to that statement, West Moreton Hospital and Health Board – Board Committee Agenda Paper dated 24 May 2013 which attached ECRG report, pp 149–153.
- 148 Human Rights and Equal Opportunity Commission 1993, *Human rights and mental illness: report of the national inquiry into the human rights of people with mental illness*, Canberra: Australian Government Publishing Service, p 144.
- 149 Transcript, Patrick McGorry, 2 March 2016, p 18–3 lines 10–25.
- 150 Exhibit 86, Statement of Patrick McGorry, 3 February 2016, p 16 para 56.
- 151 Exhibit 71, Statement of Beth Kotzé, 18 December 2015, p 5 para 19.
- 152 Exhibit 95, Supplementary statement of Anthony O'Connell, 6 February 2016, p 4 para 4(b).
- 153 Exhibit 208, Queensland Plan for Mental Health 200–72017, p 11.
- 154 Exhibit 445, [REDACTED] Subject: "The Queensland Plan for Mental Health 2007–2017", [REDACTED] p 52.
- 155 Exhibit 58, Statement of Aaron Groves, 21 January 2016, p 11 para 51; Transcript, Anthony O'Connell, 23 February 2016, p 12–20 lines 24–29; Transcript, William Kingswell, 24 February 2016, p 13–5 lines 19–21; Transcript, Sharon Kelly, 22 February 2016 p 11–7 lines 24–26.
- 156 See the discussion of the ECRG report in chapter 10.
- 157 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment SK-12 to that statement, to that statement, West Moreton Hospital and Health Service Board Committee Agenda Paper dated 24 May 2013, p 865; Exhibit 114, Statement of James Scott, 4 February 2016, pp 11–12 para 66.
- 158 Exhibit 280, Statewide Sub-Acute Beds Discussion Paper, January 2016, p 88.
- 159 Exhibit 665, Adolescent Extended Treatment and Rehabilitation Centre, Model of Service, 31 August 2011, pp 1–2. See the discussion later in this chapter of the topic of institutionalisation.
- 160 Exhibit 72, Statement of Judi Krause, 26 November 2015, Attachment Y to that statement, Letter from Judi Krause to David Crompton enclosing draft Model of Service Delivery for Barrett Adolescent, pp 485–486.
- 161 Transcript, Brett McDermott, 16 February 2016, p 7–54 lines 3–6. Note that the question is premised on the present position in Queensland where there is no sub-acute facility and sub-acute patients can be cared for in sub-acute beds in acute units such as those at Lady Cilento Children's Hospital.
- 162 Transcript, Brett McDermott, 16 February 2016, p 7–54 lines 40–44; See also Exhibit 63, Statement of Philip Hazell, 5 November 2015, p 17 para 97.
- 163 Exhibit 84, Statement of Brett McDermott, 10 November 2015, p 30 para 170.
- 164 Transcript, Brett McDermott, 16 February 2016, p 7–49 lines 5–16.
- 165 Exhibit 84, Statement of Brett McDermott, 10 November 2015, p 29 paras 163–164.
- 166 Exhibit 123, Supplementary statement of Stephen Stathis, 15 January 2016, p 15 para 45.
- 167 Transcript, Stephen Stathis, 10 March 2016, p 24–55 lines 9–26.
- 168 Exhibit 144, Submission from Royal Australian and New Zealand College of Psychiatrists, 3 December 2015, pp 3–4.
- 169 Transcript, Michelle Fryer, 11 March 2016, p 25–18 lines 12–13. As to the College's overall position, see the discussion below.
- 170 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, p 6 para 5(e); Transcript, Anne Brennan, 4 March 2016, p 20–24 lines 35–40.
- 171 Transcript, James Scott, 17 February 2016, p 8–8 lines 29–41.
- 172 Transcript, James Scott, 17 February 2016, p 8–27 lines 28–31.

- 173 Exhibit 63, Statement of Philip Hazell, 5 November 2015, p 17 para 97; Exhibit 86, Statement of Patrick McGorry, 3 February 2016, p 16 para 52.
- 174 Exhibit 63, Statement of Philip Hazell, 5 November 2015, p 14 para 78, p 16 para 94.
- 175 See the later discussion in this chapter of the evidence base.
- 176 Exhibit 306, Supplementary statement of Graham Martin, 19 February 2016, p 14 para 31.
- 177 Exhibit 86, Statement of Patrick McGorry, 3 February 2016, pp 12–13 para 39.
- 178 Exhibit 60, Statement of Scott Harden, 10 February 2016, p 6 para 15.
- 179 Exhibit 60, Statement of Scott Harden, 10 February 2016, p 6 para 17, p 7 para 20.
- 180 Transcript, Aaron Groves, 16 February 2016, p 7-83 lines 13–20.
- 181 Exhibit 288, Supplementary submission from Royal Australian and New Zealand College of Psychiatrists, 10 March 2016, p 4.
- 182 Exhibit 280, Statewide Sub-Acute Beds Discussion Paper, January 2016, p 88.
- 183 Chapter 10 discusses the ECRG report.
- 184 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG 8 May 2013, p 2.
- 185 As to the controversy in the evidence of the witnesses, see: Transcript, William Kingswell, 24 February 2016, p 13-23 line 45 – p 13-24 line 4; Transcript, Amelia Callaghan, 17 February 2016, p 8-58 line 30 – p 8-59 line 6. For a discussion of the controversy see chapter 10.
- 186 Exhibit 27, Statement of Cary Breakey, 29 September 2015, p 7 para 39.
- 187 Exhibit 27, Statement of Cary Breakey, 29 September 2015, p 8 para 42(a).
- 188 Transcript, William Kingswell, 24 February 2016, p 13-65 line 39.
- 189 Transcript, William Kingswell, 24 February 2016, p 13-65 lines 40–42. See also Transcript, William Kingswell, 24 February 2016, p 13-19 lines 22–25 (where Kingswell describes the patients at the Walker Unit as mostly psychotic patients).
- 190 Transcript, Stephen Stathis, 10 March 2016, p 24-71 lines 39–41.
- 191 Transcript, Stephen Stathis, 10 March 2016, p 24-71 lines 45–47. See also Transcript, Stephen Stathis, 10 March 2016, p 24-55 lines 36–39.
- 192 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 5 para 27.
- 193 Exhibit 63, Statement of Philip Hazell, 5 November 2015, pp 5–11 paras 25–54.
- 194 Exhibit 63, Statement of Philip Hazell, 5 November 2015, pp 4–5 paras 13–24.
- 195 Exhibit 63, Statement of Philip Hazell, 5 November 2015, pp 3–4 para 8.
- 196 Exhibit 63, Statement of Philip Hazell, 5 November 2015, p 4 para 11.
- 197 Exhibit 63, Statement of Philip Hazell, 5 November 2015, p 4 paras 14, 17.
- 198 Exhibit 63, Statement of Philip Hazell, 5 November 2015, p 5 para 19.
- 199 Exhibit 63, Statement of Philip Hazell, 5 November 2015, p 5 para 19.
- 200 Exhibit 63, Statement of Philip Hazell, 5 November 2015, p 4 para 15.
- 201 Exhibit 63, Statement of Philip Hazell, 5 November 2015, p 5 paras 25.
- 202 Exhibit 63, Statement of Philip Hazell, 5 November 2015, p 5 paras 26.
- 203 Exhibit 63, Statement of Philip Hazell, 5 November 2015, p 5 para 27.
- 204 Transcript, Philip Hazell, 17 February 2016, p 8-38 lines 25–29.
- 205 Exhibit 63, Statement of Philip Hazell, 5 November 2015, p 9 para 44.
- 206 Exhibit 63, Statement of Philip Hazell, 5 November 2015, p 7 para 35(c).
- 207 Exhibit 63, Statement of Philip Hazell, 5 November 2015, p 8 paras 36–37.
- 208 Exhibit 63, Statement of Philip Hazell, 5 November 2015, p 11 paras 52–53.
- 209 Exhibit 63, Statement of Philip Hazell, 5 November 2015, p 11 para 54.
- 210 Transcript, Philip Hazell, 17 February 2016, p 8-38 lines 10–20.
- 211 Exhibit 1264, Letter from Timothy Marney to Margaret Wilson QC, Subject: "The Conversion of the Bentley Adolescent Unit", 12 April 2014, p 1.
- 212 Exhibit 1264, Letter from Timothy Marney to Margaret Wilson QC, Subject: "The Conversion of the Bentley Adolescent Unit", 12 April 2014, p 4.

- 213 Exhibit 1264, Letter from Timothy Marney to Margaret Wilson QC, Subject: "The Conversion of the Bentley Adolescent Unit", 12 April 2014, p 1.
- 214 Exhibit 1264, Letter from Timothy Marney to the Commissioner, Subject: "The Conversion of the Bentley Adolescent Unit", 12 April 2014, p 2.
- 215 Exhibit 1264, Letter from Timothy Marney to Margaret Wilson QC, Subject: "The Conversion of the Bentley Adolescent Unit", 12 April 2014, p 2.
- 216 Exhibit 1264, Letter from Timothy Marney to Margaret Wilson QC, Subject: "The Conversion of the Bentley Adolescent Unit", 12 April 2014, p 1.
- 217 Exhibit 172, Supplementary statement of Cary Breakey, 25 January 2016, p 3 para 12.
- 218 Exhibit 179, Supplementary statement of Trevor Sadler, 12 February 2016, p 42 para 177.
- 219 Exhibit 288, Supplementary submission from Royal Australian and New Zealand College of Psychiatrists, 10 March 2016, p 4.
- 220 Exhibit 280, Statewide Sub-Acute Beds Discussion Paper, January 2016, p 85.
- 221 Exhibit 63, Statement of Philip Hazell, 5 November 2015, p 16 paras 92–93.
- 222 Exhibit 58, Statement of Aaron Groves, 21 January 2016, p 16 para 89.
- 223 Transcript, Brett McDermott, 16 February 2016, p 7-44 lines 39–46.
- 224 Transcript, Anne Brennan, 4 March 2016, p 20-24 lines 40–43.
- 225 Transcript, Trevor Sadler, 1 March 2016, p 17-36 lines 15–33.
- 226 Transcript, Jeannette Young, 7 March 2016, p 21-70 lines 6–24.
- 227 Exhibit 618, AMHETI Business Case, Children's Health Queensland Hospital and Health Service version 4.0, 16 July 2014, p 14.
- 228 See the discussion of Y-PARCs later in this chapter.
- 229 Transcript, Stephen Stathis, 10 March 2016, p 24-73 lines 19–31.
- 230 Submissions on behalf of the State of Queensland, 23 March 2016, p 80 para 306.
- 231 Exhibit 280, Statewide Sub-Acute Beds Discussion Paper, January 2016, p 6.
- 232 Exhibit 363, Email from Dan Siskind to William Kingswell, Subject: "Barrett", 10 November 2012.
- 233 Exhibit 667, Briefing Note for Noting to Minister for Health, Subject: "Barrett Adolescent Strategy Meeting", 16 July 2013. See chapter 12.
- 234 Exhibit 72, Statement of Judith Krause, 26 November 2015, p 22 para 85; Transcript, Cary Breakey, 15 February 2016, p 6-39 lines 40-45.; Exhibit 359, Supplementary statement of Anne Brennan, 22 February 2016, p 6 para 11; Transcript, Stephen Stathis, 10 March 2016, p 24-94 lines 41–47, p 24-99 lines 5–9.
- 235 Transcript, James Scott, 17 February 2016, p 8-13 lines 4–18; Transcript, Aaron Groves, 16 February 2016, p 7-84 line 35 – p 7-85 line 8; Transcript, Brett McDermott, 16 February 2016, p 7-43 line 40 – p 7-44 line 30; Transcript, Cary Breakey, 15 February 2016, p 6-53 lines 20-30; Transcript, David Ward, 15 February 2016, p 6-58 lines 20–30; Transcript, Philip Hazell, p 8-37 line 30 – p 8-38 line 5; Transcript, Anne Brennan, p 20-61 line 25 – p 20-62 line 10; Transcript, Anthony O'Connell, 23 February 2016, p 12-24 lines 10–15.
- 236 Exhibit 176, Statement of Peter Parry, 4 February 2016, pp 3–4 para 11.
- 237 Exhibit 176, Statement of Peter Parry, 4 February 2016, p 3 para 8.
- 238 Exhibit 176, Statement of Peter Parry, 4 February 2016, p 7 para 21.
- 239 Exhibit 176, Statement of Peter Parry, 4 February 2016, p 7–8 para 22.
- 240 Exhibit 176, Statement of Peter Parry, 4 February 2016, p 8 para 22.
- 241 Transcript, Beth Kotzé, 9 March 2016, p 23-10 lines 16–23.
- 242 Transcript, Stephen Stathis, 10 March 2016, p 24-49 lines 1–40.
- 243 Exhibit 66, Statement of Sharon Kelly, 16 October 201, Attachment SK-14 to that statement, Proposed Service Model Elements – Adolescent Extended Treatment and Rehabilitation Services, p 837.
- 244 The National Mental Health Service Planning Framework is discussed later in this chapter.
- 245 Exhibit 66, Statement of Sharon Kelly, Attachment SK-15 to that statement, West Moreton Hospital and Health Service – Expert Clinical Reference Group Recommendations Barrett Adolescent Strategy July 2013, pp 841–848.
- 246 Exhibit 723, Youth Mental Health Commitments Committee – Components of the Adolescent Mental Health Extended Treatment Initiative, undated, p 7.
- 247 Mind Australia, 2016, *Prevention and Recovery Care Services*. Available from: <[https://www.mindaustralia.org.au/need-help/mind-services-in-victoria/mind-victoria/residential-services/residential-services-parcs-\(prevention-and-recovery-care-services\).html](https://www.mindaustralia.org.au/need-help/mind-services-in-victoria/mind-victoria/residential-services/residential-services-parcs-(prevention-and-recovery-care-services).html)>.

- 248 Austin Health 2016, *Prevention and Recovery Care Services*, Available from: <<http://www.austin.org.au/mentalhealth.NEAMHS/PARCS/>>.
- 249 Exhibit 1468, Adolescent Extended Treatment and Rehabilitation Models, Summary of Site visits to Victoria, 14–16 August 2013.
- 250 Exhibit 74, Second supplementary statement of Judi Krause, 4 February 2016, p 33 para 67(a).
- 251 Exhibit 125, Statement of Peter Steer, 15 December 2015, Attachment G to that statement, Children’s Health Hospital and Health Service Board Papers and Briefing Notes (redacted), pp 344–480.
- 252 Exhibit 74, Second supplementary statement Judith Krause, 4 February 2016, p 32 para 67(a).
- 253 See the discussion of the AMHETI components in chapter 28.
- 254 Exhibit 123, Supplementary statement of Stephen Stathis, 15 January 2016, p 9 para 26.
- 255 Exhibit 123, Supplementary statement of Stephen Stathis, 15 January 2016, p 9 para 27.
- 256 Transcript, Ingrid Adamson, 11 March 2016, p 25–51, line 35.
- 257 Transcript, William Kingswell, 24 February 2016, p 13–62 lines 10–14; Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 24 para 17.11(c); Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 15 para 9.1(a); Exhibit 72, Statement of Judi Krause, 26 November 2015, Attachment W to that statement, ‘Minutes of meeting on 10 February 2010’, pp 428, 431.
- 258 For example, Fast Facts 1, issued by West Moreton HHS on 30 November 2012 included the statements, “We want to ensure adolescents receive the best possible care that is evidence-based ...”, and “The final model of care will be based on state and national mental health frameworks and will be evidence-based”: Exhibit 51, Statement of Naomi Ford, 1 December 2015, Attachment K to that statement, pp 117–118. The West Moreton HHS Barrett Adolescent Strategy Project Plan included, as an Outcome, that the “final endorsed model(s) of care will be evidenced based, sustainable and align with statewide mental health policy ...”. Key Messages were expressed to include the message that West Moreton HHS was “working closely with mental health experts to ensure the new model of care for Queensland’s adolescents is appropriate and based on best available evidence”: Exhibit 51, Statement of Naomi Ford, 1 December 2015, Attachment E, p 68, p 77; Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 10 para 8.10(e), p 24 para 17.11(c).
- 259 Submissions of behalf of Trevor Sadler, 23 March 2016, p 4 para 20; see also Transcript, Jennifer Rosengren, Closing submissions on behalf of Trevor Sadler, 15 April 2016, p 28–70 lines 8–15.
- 260 Transcript, Terry Stedman, 3 March 2016, p 19–49 line 40; Transcript, Stephen Stathis, 10 March 2016, p 24–55 lines 19–20; Transcript, Michelle Fryer, 11 March 2016, p 25–11 lines 16–20; Transcript, Patrick McGorry, 2 March 2016, p 18–4 line 17 – p 18–5 line 7; Transcript, Graham Martin, 11 March 2016, p 25–31 line 18, p 25–32 line 42 – p 25–33 line 3; Transcript, Brett McDermott, p 7–49 lines 31–34; Exhibit 306, Supplementary statement of Graham Martin, 19 February 2016, pp 4–5 para 11.
- 261 Exhibit 122, Statement of Stephen Stathis, 5 November 2015, p 2 para 7.
- 262 Transcript, Brett McDermott, 16 February 2016, p 7–65 line 33 – p 7–66 line 3.
- 263 Transcript, Patrick McGorry, 2 March 2016, p 18–4 lines 17–20.
- 264 Transcript, Patrick McGorry, 2 March 2016, p 18–4 line 41 – p 18–5 line 6.
- 265 Transcript, Michelle Fryer, 11 March 2016, p 25–11 lines 27–36.
- 266 Exhibit 306, Supplementary statement of Graham Martin, 19 February 2016, p 4 para 10.
- 267 Transcript, Graham Martin, 11 March 2016, p 25–32 lines 8–32.
- 268 Exhibit 114, Statement of James Scott, 4 February 2016, Attachment JS-8 to that statement, ECRG terms of reference, p 94.
- 269 Exhibit 114, Statement of James Scott, 4 February 2016, p 10 para 56.
- 270 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: “Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)”, Version 5, Endorsed by ECRG 8 May 2013, pp 1–2.
- 271 Exhibit 84, Statement of Brett McDermott, 10 November 2015, p 29 para 161
- 272 Exhibit 84, Statement of Brett McDermott, 10 November 2015, p 31 para 172.
- 273 Exhibit 60, Statement of Scott Harden, 10 February 2016, p 6 para 16
- 274 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, p 4 para 4.
- 275 Transcript, Graham Martin, 11 March 2016, p 25–28 lines 19–24, p 25–40 lines 13–20.
- 276 Exhibit 68, Statement of William Kingswell, 21 October 2015, Attachment to that statement, 2009 Review of the Barrett Adolescent Centre, p 171.
- 277 Exhibit 68, Statement of William Kingswell, 21 October 2015, Attachment to that statement, 2009 Review of the Barrett Adolescent Centre, p 171.
- 278 Exhibit 280, Statewide Sub-Acute Beds Discussion Paper, January 2016, p 21.
- 279 Exhibit 123, Supplementary statement of Stephen Stathis, 15 January 2016, p 2 para 7.
- 280 Transcript, Brett McDermott, 16 February 2016, p 7–60 line 44.

- 281 For example, see Transcript, Stephen Stathis, 10 March 2016, p 24-82, lines 6–7.
- 282 Transcript, Beth Kotzé, 9 March 2016, p 23-45 lines 1–23.
- 283 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, p 3 para 3(b).
- 284 Transcript, Angela Clarke, 29 February 2016, p 16-30 line 17.
- 285 Exhibit 179, Supplementary statement of Trevor Sadler, 12 February 2016, p 38 para 165.
- 286 See chapter 1 – Introduction and context, Criticisms of the BAC model of care, Increasing lengths of stay.
- 287 Exhibit 68, Statement of William Kingswell, 21 October 2015, p 7 para 20(v).
- 288 Transcript, Trevor Sadler, 1 March 2016, p 17-16 lines 9–13.
- 289 Transcript, Aaron Groves, 16 February 2016, p 7-78 lines 34–35.
- 290 Transcript, Cary Breakey, 15 February 2016, p 6-38 lines 13–14.
- 291 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 55 para 264.
- 292 Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Exhibit J to that statement, 2009 Review of Barrett Adolescent Centre (Final Report), pp 576–593.
- 293 Transcript, Anne Brennan, 4 March 2016, p 20-33 line 16.
- 294 Transcript, David Ward, 15 February 2016, p 6-57 lines 27–28.
- 295 Transcript, David Ward, 15 February 2016, p 6-57 line 28–30.
- 296 Exhibit 179, Supplementary statement of Trevor Sadler, 12 February 2016, pp 38–39 para 165.
- 297 Exhibit 179, Supplementary statement of Trevor Sadler, 12 February 2016, p 39 para 165.
- 298 Transcript, Trevor Sadler, 10 March 2016, p 24-7 line 19–20.
- 299 Transcript, Beth Kotzé, 9 March 2016, p 23-45 lines 3–8.
- 300 Transcript, Anne Brennan, 4 March 2016, p 20-33 line 27–30.
- 301 Transcript, Cary Breakey, 15 February 2016, p 6-38 lines 14–17.
- 302 Transcript, Graham Martin, 11 March 2016, p 25-29 lines 35–37.
- 303 Transcript, Michelle Fryer, 11 March 2016, p 25-12 lines 40–42.
- 304 Transcript, Philip Hazell, 17 February 2016, p 8-44 lines 41–43.
- 305 Transcript, Trevor Sadler, 1 March 2016, p 17-60 lines 45–46.
- 306 Exhibit 179, Supplementary statement of Trevor Sadler, 12 February 2016, p 24 para 106.
- 307 Transcript, Trevor Sadler, 10 March 2016, p 24-8 lines 33–34.
- 308 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 26 para 136(b).
- 309 Transcript, David Ward, 15 February 2016, p 6-57 lines 37–39.
- 310 Transcript, Patrick McGorry, 2 March 2016, p 18-6 lines 24–25.
- 311 Transcript, Cary Breakey, 15 February 2016, p 6-38 lines 18–19.
- 312 Transcript, Trevor Sadler, 10 March 2016, p 24-6 lines 6–10.
- 313 Transcript, Angela Clarke, 29 February 2016, p 16-30 lines 25–26.
- 314 Transcript, Cary Breakey, 15 February 2016, p 6-38 lines 21–22.
- 315 Transcript, Patrick McGorry, 2 March 2016, p 18-6 lines 14–16.
- 316 Transcript, Angela Clarke, 29 February 2016, p 16-30 lines 30–34.
- 317 Exhibit 172, Supplementary statement of Cary Breakey, 9 February 2016, p 6 para 27.
- 318 Exhibit 72, Statement of Judi Krause, 26 November 2015, Attachment Y to that statement, Letter from Judi Krause to David Crompton enclosing draft Model of Service Delivery (MOSD) for Barrett Adolescent, p 488.
- 319 Exhibit 72, Statement of Judi Krause, 26 November 2015, Attachment Y to that statement, Letter from Judi Krause to David Crompton enclosing draft Model of Service Delivery (MOSD) for Barrett Adolescent, p 490.
- 320 Exhibit 72, Statement of Judi Krause, 26 November 2015, Attachment Y to that statement, Letter from Judi Krause to David Crompton enclosing draft Model of Service Delivery (MOSD) for Barrett Adolescent, p 488.
- 321 Exhibit 72, Statement of Judi Krause, 26 November 2015, Attachment Y to that statement, Letter from Judi Krause to David Crompton enclosing draft Model of Service Delivery (MOSD) for Barrett Adolescent, p 488.
- 322 Transcript, Stephen Stathis, 10 March 2016, p 24-55 lines 45–47.
- 323 Transcript, Terry Stedman, 3 March 2016, p 19-42 lines 26–30.

- 324 Exhibit 63, Statement of Philip Hazell, 5 November 2015, p 10 para 48.
- 325 Transcript, Brett McDermott, 16 February 2016, p 7-33 lines 5–7.
- 326 Transcript, Brett McDermott, 16 February 2016, p 7-62 line 5–7; see also Aaron Groves' evidence at Transcript, 16 February 2016, p 7-8 line 35.
- 327 Transcript, Philip Hazell, 17 February 2016, p 8-39 lines 32–35.
- 328 Transcript, Anthony O'Connell, 23 February 2016, p 12-39 lines 25–30.
- 329 Transcript, Anthony O'Connell, 23 February 2016, p 12-53 lines 11–13.
- 330 Transcript, William Kingswell, 24 February 2016, p 13-62 line 13–14.
- 331 Transcript, Michelle Fryer, 11 March 2016, p 25-19 line 39 – p 25-20 line 4; Exhibit 144, Submission from Royal Australian and New Zealand College of Psychiatrists, 3 December 2015, p 2; see discussion below.
- 332 Exhibit 288, Supplementary submission The Royal Australian and New Zealand College of Psychiatrists, 10 March 2016, p 4. Note, in oral evidence, this was corrected to state "institutionalisation" instead of "deinstitutionalisation". See Transcript, Michelle Fryer, 11 March 2016, p 25-12 lines 42–47.
- 333 Transcript, Patrick McGorry, 2 March 2016, p 18-2 line 42 – p 18-3 line 7.
- 334 Exhibit 144, Submission from Royal Australian and New Zealand College of Psychiatrists, 3 December 2015, p 2.
- 335 Transcript, Brett McDermott, 16 February 2016, p 7-60 line 40 – p 7-61 line 20.
- 336 Transcript, Beth Kotzé, 9 March 2016, p 23-5 lines 34–44
- 337 Exhibit 71, Statement of Beth Kotzé, 18 December 2015, p 5 para 18.
- 338 Transcript, William Kingswell, 24 February 2016, p 13-62 lines 26–33; Dr Sadler, on the other hand, gave evidence of some steps taken to make the adolescent more independent: Transcript, Trevor Sadler, 1 March 2016, p 17-18 line 42 – p 17-19 line 5.
- 339 Exhibit 172, Supplementary statement of Cary Breakey, 9 February 2016, p 5 para 22.
- 340 Exhibit 144, Submission from Royal Australian and New Zealand College of Psychiatrists, 3 December 2015, p 2.
- 341 The supplementary submission from the Royal Australian and New Zealand College of Psychiatrists originally said there was concern about "risks of deinstitutionalisation". Michelle Fryer corrected this to "institutionalisation" in her oral evidence: see Transcript, Michelle Fryer, 11 March 2016, p 25-12 line 44 – p 25-13 line 1.
- 342 Exhibit 288, Supplementary submission from Royal Australian and New Zealand College of Psychiatrists, 10 March 2016, p 4.
- 343 Exhibit 144, Submission from Royal Australian and New Zealand College of Psychiatrists, 3 December 2015; Transcript, Michelle Fryer, 11 March 2016, p 25-13 lines 5–6.
- 344 Transcript, Beth Kotzé, 9 March 2016, p 23-12 lines 29–31.
- 345 See Chapter 1, Introduction and context, The Barret Cohort.
- 346 Exhibit 172, Supplementary statement of Cary Breakey, 9 February 2016, p 6 para 23.
- 347 See the discussion of this topic above regarding individual factors.
- 348 Transcript, Trevor Sadler, 1 March 2016, p 17-18 line 42 – p 17-19 line 5.
- 349 See Chapter 1, Introduction and context, Clinical context.
- 350 Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 24 para 17.11(c).
- 351 Exhibit 208, Queensland Plan for Mental Health 2007–2017, p 3.
- 352 Exhibit 445, [REDACTED], Subject: "The Queensland Plan for Mental Health 2007–2017", [REDACTED] p 16.
- 353 Exhibit 445, [REDACTED], Subject: "The Queensland Plan for Mental Health 2007–2017", [REDACTED] p 16.
- 354 Exhibit 445, [REDACTED], Subject: "The Queensland Plan for Mental Health 2007–2017", [REDACTED] p 35.
- 355 Exhibit 445, [REDACTED], Subject: "The Queensland Plan for Mental Health 2007–2017", [REDACTED] p 52.
- 356 Exhibit 363, Email from Dan Siskind to William Kingswell, Subject: "Barrett", 10 November 2012.
- 357 Exhibit 451, Email exchange between Bill Kingswell and Trevor Sadler, Subject: "The efficacy of 'Wraparound' services", 21 May 2013.
- 358 Exhibit 759, Email from Leanne Geppert to Sharon Kelly and others, Subject: "YPARC email trail for your info", 11 July 2013; see also Transcript, William Kingswell, 24 February 2016, p 13-28 lines 10–15.
- 359 Exhibit 40, Statement of Michael Cleary, 21 December 2015, p 7 para 27.

- 360 Exhibit 437, Email from Sharon Kelly to "Sdlo" and Shelley-Lee Waller, Subject: "pertinent points for consideration of Barrett Adolescent Centre", 8 November 2012.
- 361 Transcript, Sharon Kelly, 22 February 2016, p 11-33 lines 2-3.
- 362 Exhibit 703, Email from Stephen Stathis to Bill Kingswell, Subject: "Some questions from yesterday's teleconference", 6 September 2013.
- 363 The State of Queensland, Springborg, Kingswell and Counsel Assisting.
- 364 Supplementary submissions on behalf of William Kingswell on the draft NMHSPF, 19 April 2016, p 2 paras 5-6.
- 365 Supplementary submissions on behalf of William Kingswell on the draft NMHSPF, 19 April 2016, p 4 para 13.
- 366 Transcript, William Kingswell, 24 February 2016, p 13-23 lines 25-33.
- 367 Transcript, William Kingswell, 24 February 2016, p 13-24 lines 2-4.
- 368 Transcript, William Kingswell, 24 February 2016, p 13-23 lines 25-33, p 13-29 lines 29-43, p 13-44 lines 39-44.
- 369 There are no minutes of the Planning Group meeting on 15 May 2013. There are, however, handwritten notes of contributions from 'BK' (Bill Kingswell), 'SS' (Stephen Stathis) 'MB' (Michelle Bond) & 'TS' (Trevor Sadler): Transcript, William Kingswell, 24 February 2016, p 13-27 lines 1-6; Transcript, Sharon Kelly, 22 February 2016, p 11-23 lines 16-19.
- 370 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, pp 15-16 para 11.18, Attachment SK-15 to that statement, pp 308-312; Exhibit 222, Barrett Adolescent Strategy Planning Group file notes, 14 May 2013; Transcript, Sharon Kelly, 22 February 2016, p 11-19 lines 1-5.
- 371 Exhibit 759, Email from Leanne Geppert to Sharon Kelly and others, Subject: "YPARC email trail for your info", 11 July 2013.
- 372 Transcript, William Kingswell, 24 February 2016, p 13-23 line 35 - p 13-24 line 4.
- 373 Exhibit 68, Statement of William Kingswell, 21 October 2015, Attachment to that statement, 'Terms of Reference for the CEO Oversight Committee', p 230.
- 374 Transcript, William Kingswell, 24 February 2016, p 13-45 lines 9-17; Supplementary submissions on behalf of William Kingswell on the draft NMHSPF, 19 April 2016, p 2 para 7.
- 375 See later discussion on the distribution of the draft NMHSPF.
- 376 Supplementary submissions on behalf of William Kingswell on the draft NMHSPF, 19 April 2016, p 5 paras 16-18.
- 377 Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 20 para 14.10, Attachment MC-19 to that statement, p 145.
- 378 Transcript, Beth Kotzé, 9 March 2016, p 23-17 lines 30-31.
- 379 Supplementary submissions on behalf of the State of Queensland on the draft NMHSPF, 15 April 2016, p 15 para 25; Further submissions on behalf of Lawrence Springborg on the draft NMHSPF, 15 April 2016, p 1 para 3, p 4 para 3.
- 380 Supplementary submissions on behalf of William Kingswell on the draft NMHSPF, 19 April 2016, p 8 para 28.
- 381 Exhibit 759, Email from Leanne Geppert to Sharon Kelly and others, Subject: "YPARC email trail for your info", 11 July 2013; see also Transcript, William Kingswell, 24 February 2016, p 13-28 lines 13-15.
- 382 Exhibit 759, Email from Leanne Geppert to Sharon Kelly and others, Subject: "YPARC email trail for your info", 11 July 2013.
- 383 Transcript, William Kingswell, 24 February 2016, p 13-48 line 39 - p 13-49 line 2, p 13-35, p 13-37.
- 384 Exhibit 1428, Statement of Kevin Fjeldsoe, 9 May 2016, pp 6-7 paras 34-39.
- 385 Transcript, Beth Kotzé, 9 March 2016, p 23-17 line 29 - p 23-18 line 2; see also Transcript, Beth Kotzé, 9 March 2016, p 23-45 lines 1-23.
- 386 Transcript, Beth Kotzé, 9 March 2016, p 23-5 lines 15-16.
- 387 Exhibit 58, Statement of Aaron Groves, 21 January 2016, p 36 para 211.
- 388 Exhibit 72, Statement of Judith Krause, 26 November 2015, p 3 para 7.
- 389 Exhibit 74, Second supplementary statement of Judith Krause, 4 February 2016, pp 22-23.
- 390 Exhibit 74, Second supplementary statement of Judith Krause, 4 February 2016, pp 22-23.
- 391 Exhibit 63, Statement of Philip Hazell, 5 November 2015, p 15 paras 84-86.
- 392 Supplementary submissions on behalf of the State of Queensland on the draft NMHSPF, 15 April 2016, pp 6-14 para 15; Supplementary submissions on behalf of William Kingswell on the draft NMHSPF, 19 April 2016, p 8 para 30.
- 393 Exhibit 71, Statement of Beth Kotzé, 18 December 2015, pp 14-15 para 61(c).
- 394 Aaron Groves attended the October 2013 meeting of the NMHSPF Executive which introduced the components of the draft NMHSPF: Exhibit 58, Statement of Aaron Groves, 21 January 2016, p 35 para 198; Aaron Groves is presently South Australia's representative on the Jurisdictional Panel and is a member of the Expert group, Exhibit 1426, Mental Health Drug & Alcohol Principal Committee Minutes, 29 May 2015.
- 395 Exhibit 315, Western Australian Mental Health, Alcohol and Other Drugs Services Plan 2015-2025; Note that this version is the 'Consultation Draft' of March 2015. The final version was issued in December 2015. For the purposes of this discussion there are no substantive differences; see also Transcript, Beth Kotzé, 9 March 2016, p 23-11 lines 1-17.

- 396 Exhibit 315, Western Australian Mental Health, Alcohol and Other Drugs Services Plan 2015–2025, p 50; this list of categories is not an exhaustive list of those listed in the report.
- 397 Exhibit 315, Western Australian Mental Health, Alcohol and Other Drugs Services Plan 2015–2025, p 56.
- 398 Exhibit 1264, Letter from Timothy Marney to Margaret Wilson QC, Subject: "The Conversion of the Bentley Adolescent Unit", 12 April 2014.
- 399 Transcript, Beth Kotzé, 9 March 2016, p 23-17 line 29 – p 23-18 line 2.
- 400 Supplementary submissions on behalf of the State of Queensland on the draft NMHSPF, 15 April 2016, p 1 para 3, p 15 para 21, p 17 para 32; Further submissions on behalf of the State of Queensland, in response to NMHSPF, 17 May 2016, p 2–3 paras 1–8.
- 401 Exhibit 58, Statement of Aaron Groves, 21 January 2016, p 34, paras 189–190.
- 402 Exhibit 58, Statement of Aaron Groves, 21 January 2016, p 35 para 198.
- 403 Transcript, William Kingswell, 24 February 2016, p 13-33 – p 13-34, p 13-64; Exhibit 289, National Mental Health Service Planning Framework "Service Element and Activity Descriptions", Version 1.0, 1 November 2012.
- 404 Exhibit 973, The Senate Select Committee on Health, Fourth Interim Report "Mental Health: A Consensus for Action", 8 October 2015, p 50; see also Exhibit 974, Proof Committee Hansard, Senate Select Committee on Health "Health Policy, Administration and Expenditure", 26 August 2015, pp 56–58, the evidence relied on in that report of Ms Janet Anderson, First Assistant Secretary, Health Services Division, Department of Health and Mr Mark Cormack, Deputy Secretary, Strategic Policy and Innovation, Department of Health.
- 405 Transcript, William Kingswell, 24 February 2016, p 13-23 line 35 – p 13-24 line 4.
- 406 Transcript, William Kingswell, 24 February 2016, p 13-32 lines 10–12.
- 407 Transcript, William Kingswell, 24 February 2016, p 13-33 lines 10–11.
- 408 Transcript, William Kingswell, 24 February 2016, p 13-32 lines 43–44, p 13-37 lines 11–14: "Well, it – it can't be exhaustive but it – but it is many, not all. And when it says it's not exhaustive, it's not exhaustive because there are significant differences between jurisdictions particularly around...".
- 409 Transcript, William Kingswell, 24 February 2016, p 13-32 lines 39–41.
- 410 Transcript, William Kingswell, 24 February 2016, p 13-32 lines 24–32.
- 411 Transcript, William Kingswell, 24 February 2016, p 13-32 line 32.
- 412 Transcript, William Kingswell, 24 February 2016, p 13-33 lines 18–25.
- 413 Submissions of Counsel Assisting on the draft NMHSPF, 14 April 2016, p 16 para 57.
- 414 Exhibit 973, The Senate Select Committee on Health, Fourth Interim Report "Mental Health: A Consensus for Action", 8 October 2015, p 50.
- 415 Exhibit 1067, Email from Jan Williamson to Mark Lynch, Subject: "Barrett Adolescent Centre Commission of Inquiry", 22 December 2015; note that a copy of the NMHSPF was subsequently provided to the Commission by William Kingswell.
- 416 Transcript, Stephen Stathis, 10 March 2016, p 24-30 lines 24–35; he appears to have received only documents relating to Step Up/Step Down type facilities.
- 417 Exhibit 58, Statement of Aaron Groves, 21 January 2016, p 36 para 209.
- 418 Transcript, Patrick McGorry, 2 March 2016, p 18-8 lines 35–39.
- 419 Exhibit 375, National Mental Health Service Planning Framework Project Charter, 27 January 2012, p 92; Exhibit 378, National Mental Health Service Planning Framework Project Communique Issue 1, September 2011; see also Exhibit 973, The Senate Select Committee on Health, Fourth Interim Report "Mental Health: A Consensus for Action", 8 October 2015, pp 49–50.
- 420 Transcript, Beth Kotzé, 9 March 2016, p 23-12 lines 4–5.
- 421 Exhibit 58, Statement of Aaron Groves, 21 January 2016, p 36 para 209.
- 422 Transcript, Patrick McGorry, 2 March 2016, p 18-8 lines 35–39.
- 423 Exhibit 1067, Email from Jan Williamson to Mark Lynch, Subject: "Barrett Adolescent Centre Commission of Inquiry", 22 December 2015.
- 424 Confidential exhibit.
- 425 Exhibit 84, Statement of Brett McDermott, 11 November 2015, p 30 para 167.
- 426 Supplementary submissions on behalf of William Kingswell on the draft NMHSPF, 19 April 2016, p 5 para 17.
- 427 Exhibit 363, Email from Dan Siskind to William Kingswell, Subject: "Barrett", 10 November 2012.
- 428 Exhibit 27, Statement of Cary Breakey, 29 September 2015, p 6 para 32.
- 429 Exhibit 260, Chettleburgh, K & Doyle H, Review of The Park Centre for Mental Health, Undertaken March/April 2012, p 12.

- 430 Exhibit 68, Statement of William Kingswell, 21 October 2015, p 8 para 20(v).
- 431 Transcript, William Kingswell, 24 February 2016, p 13-4 line 39 – p 13-5 line 2.
- 432 Submissions on behalf of Trevor Sadler, 23 March 2016, pp 1–2 para 5–9.
- 433 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, pp 7–8 paras 9.2–9.8, Attachment SK-9 to that statement, pp 826–827.
- 434 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, pp 5–7 paras 5.17–5.20.
- 435 Submissions on behalf of West Moreton HHS and Board, 23 March 2016, p 26 para 8.6.
- 436 Submissions on behalf of West Moreton HHS and Board, 23 March 2016, p 26 para 8.6.
- 437 For present purposes it is unnecessary to consider whether the standing down of the Clinical Director was a proportionate and appropriate response.
- 438 Submissions on behalf of the State of Queensland, 23 March 2016, p 80 para 301.
- 439 Submissions on behalf of the State of Queensland, 23 March 2016, pp 69–70 paras 256–259.
- 440 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment SK-12 to that statement, West Moreton Hospital and Health Service Board Committee Agenda Paper dated 24 May 2013 attaching copy of ECRG report, p 814.
- 441 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment SK-12 to that statement, West Moreton Hospital and Health Service Board Committee Agenda Paper dated 24 May 2013 attaching copy of ECRG report, p 815.

15 Evaluation of the decision-making process

Introduction

The Commission's terms of reference in paragraph 3(c) require it to make a careful and independent inquiry into the information, material, advice, processes, considerations and recommendations that related to or informed the closure decision and the decision-making process related to the closure decision. The reference to "decision-making process" requires an inquiry into, as the State submits, "the decision-making process of government and the efficacy of the processes of government",¹ in relation to the decision to close the BAC.

An analysis of the reasons for closing the BAC is found in chapter 14. This chapter is premised on the findings in previous chapters.

In this chapter, the Commission's evaluation of the decision-making process is based on standards of good governance and public administration without an assumption that the decision was "right" or "wrong".²

The Commission takes the view that no expert evidence was or is required either to establish basic principles of good public administration or to evaluate the actions of the respective decision-makers.³ That evaluation is the Commission's task.

In this chapter, the general term "decision-makers" means those persons or entities who were involved in the decision-making process. Where necessary, reference is made to specific persons or entities and certain actions or decisions.

Roles and responsibilities

At the outset, it is necessary to examine the roles and responsibilities of the various decision-makers.

Ministers

A Minister's duties, functions and powers generally depend upon convention unless specifically conferred by legislation. Section 44 of the *Hospital and Health Boards Act 2011* (Qld) (HHB Act) provides that the Minister may, with certain exceptions,⁴ give a Hospital and Health Service (HHS) a written direction about a matter relevant to the performance of its functions under the HHB Act if the Minister is satisfied it is necessary to do so in the public interest.⁵ A HHS must comply with that direction.⁶

The Minister did not issue a written direction about the closure of the BAC. Nevertheless, his views were influential. As Counsel for Anthony O'Connell (Director-General) submitted:

The Minister had made it known that a decision such as the closure of a facility was a matter that he had to be consulted about; it was a decision requiring his approval before it could be acted upon. ... If the Minister did not approve, it was open to him to exercise his power

under s.44 to direct it to do otherwise or under s.44F if necessary or applicable. As a matter of practicality either because of that power or otherwise, West Moreton plainly appreciated it would and should only proceed if it had the Minister's approval.⁷

A Minister is responsible to the people through the Parliament for the administration of the Minister's portfolio.

Departments and Directors-General

The State has all the powers, and the legal capacity, of an individual.⁸ It generally acts through its departments and their chief executives, who are also known as Directors-General. As explained in chapters 3 and 4, Queensland Health was one large organisation up until 30 June 2012.

The Director-General, subject to the Minister, had overall responsibility for the management, administration and delivery of public sector health services in the State. From 1 July 2012, the public sector health system comprised individual HHSs, governed by boards, and Queensland Health as the system manager.

The HHB Act decentralised control of the public sector health system to the HHSs and gave Queensland Health, through its Director-General, primarily a '*System Manager*' function. This involves, among other things, a purchaser-provider relationship with each of the individual HHSs. However, the overall management of the public sector health system remains the responsibility of Queensland Health, through the Director-General.⁹

The functions of the Director-General of Queensland Health under the HHB Act include:

- a. to provide strategic leadership and direction for the delivery of public sector health services in the State;
- b. to promote the effective and efficient use of available resources in the delivery of public sector health services in the State;
- c. to develop statewide health service plans, workforce plans and capital works plans;
- d. to manage major capital works for proposed public sector health service facilities.¹⁰

With certain exceptions, the Director-General is subject to any direction given by the Minister for Health.¹¹ The HHB Act leaves much of the administration of Queensland Health to the discretion and judgment of the Director-General, including the frequency and detail of briefings to the Minister.

Chief Health Officer

The Chief Health Officer¹² provides "high-level medical advice to the chief executive and the Minister on health issues, including policy and legislative matters associated with the health and safety of the Queensland public".¹³

Hospital and Health Boards

A Hospital and Health Board controls its HHS.¹⁴ Each such board consists of five or more members appointed by the Governor in Council.¹⁵ From those members, a Chair and Deputy Chair are appointed by the Governor in Council.¹⁶ A board member is to act impartially and in the public interest.¹⁷

HHS Chief Executives

A board appoints the Chief Executive of its HHS.¹⁸ The HHS Chief Executive is subject to the board's direction.¹⁹ The Chief Executive's role is to "manage" the HHS.²⁰

Protection from liability

The following officials, amongst others, are not civilly liable for any act done, or omission made, honestly and without negligence under the HHB Act:²¹

- Board members
- HHS Chief Executives
- Chief Executive (Director-General).

Civil liability attaches instead to the HHS, or in the case of the Chief Executive, to the State.²²

Relationships

The professional relationships between key persons involved in decisions relating to the closure of the BAC had a considerable influence both on that decision-making process and on the relevant decisions.

There was a significant degree of co-dependency and an over-reliance on the views of colleagues, with little or no questioning or scrutiny of those views. William Kingswell (acting Director of Mental Health Alcohol and Other Drugs Branch (MHAODB) was influential. Many relied on, and actively sought, his advice. In particular, his views were largely accepted by Sharon Kelly (Executive Director, Mental Health and Specialised Services, West Moreton HHS) and Lesley Dwyer (Chief Executive, West Moreton HHS). Leanne Geppert (Director of Strategy, West Moreton HHS) was part of Kingswell's team until early 2013 when she was seconded to a position within West Moreton HHS²³ and largely assisted Kelly. In turn, Mary Corbett (Chair, West Moreton Board) largely accepted the views of the executives, Dwyer and Kelly, who presented a united front (at least in relation to the BAC).

The decision to close the BAC had clear clinical implications requiring the independent expertise of child and adolescent psychiatrists. Kingswell was not a child and adolescent psychiatrist; he was a forensic psychiatrist.

Minister, Directors-General, Kingswell

Kingswell's influence on Lawrence Springborg (the Minister for Health), Anthony O'Connell (Director-General), Michael Cleary (Deputy Director-General, Health Services and Clinical Innovation Division), and Jeannette Young (Chief Health Officer) in relation to the cessation of the Redlands project, is explained in chapters 3 and 5.

Queensland Health, MHAODB and West Moreton HHS

When giving evidence about the July 2012 governance changes, Cleary said this about the assistance the department gave to HHSs and Boards:

During the transition phase – and this is, in my mind, a very early period of the transition, there were often circumstances that arose where you would need to facilitate or assist some of the health services to obtain decisions. Previously, decisions may have come through a

departmental officer through to the Minister and there was a – a fairly standard pathway for that. This meeting was convened by the West Moreton Hospital and Health Service to discuss how they would progress a significant decision through to the Minister’s office and the advice that was provided at that time was that it would be appropriate to meet with the then Director-General to discuss the proposal and – and the various considerations that would need to be given to that proposal and then to seek to meet with the Minister to discuss the matter.²⁴

The evidence before the Commission reflects the reality that Queensland Health, primarily through its MHAODB, had significant involvement in the closure of the BAC and related decisions by West Moreton HHS.

From at least October 2012, Kingswell appears to have had considerable interaction with, and influence over, decisions made by West Moreton relating to the BAC. Kingswell’s contact was primarily with Kelly who, in turn, briefed Dwyer.²⁵

For example, as discussed in chapter 7, on 1 November 2012, as Deputy Director-General, Cleary received a draft brief from MHAODB (that is, Kingswell’s branch) for approval to close the BAC. Cleary returned the brief to Kingswell and noted that any consideration of changing the service model for this group of patients was a significant issue and, under the new operating model within Queensland Health, would need to be led by West Moreton HHS.²⁶

The evidence before the Commission reveals that from the time of her commencement as Executive Director in September 2012, Kelly perceived Kingswell as a trusted ‘advisor’ and, in some instances, ‘instructor’. Both Kelly and Dwyer appear to have consistently accepted the advice and views of Kingswell, and to have proceeded to act in accordance with his expressed views. For example:

- a. Kelly’s evidence is that she attended the meeting with Kingswell (and others from the MHAODB) on 25 October 2012 “to **receive a briefing** ...as to the State-wide perspective on mental health service planning and the role of [West Moreton HHS] in it” (emphasis added).²⁷ During oral evidence, Kelly described this meeting as “a briefing from the most senior people in mental health across the state”.²⁸
- b. Kelly’s evidence is that, at the meeting on 25 October 2012, she was “**informed** ... that the BAC service ... was not considered by MHAODB to be part of the service model for the delivery of adolescent mental health services going forward” (emphasis added).²⁹ Kelly accepted this advice and she proceeded to communicate that view to others.³⁰
- c. Dwyer gave evidence that she was “advised” that the BAC model of care was contrary to contemporary models.³¹ When asked by Counsel Assisting by whom she was advised, Dwyer’s evidence was that she “was advised by a number of people. I think, initially, I was advised by the director of mental health within Queensland Health, Bill Kingswell, and also Leanne Geppert”.³² Dwyer accepted this advice.
- d. Dwyer gave evidence that the BAC model of care did not have rehabilitation as an element. When asked by Counsel Assisting how she arrived at that understanding, Dwyer’s evidence was that there “were two things that led to [her] forming that view. One was that it certainly had been expressed by both Kingswell and also it had been alluded to by Geppert and at that time I was becoming aware that there had been some previous reviews”.³³
- e. When asked about her understanding that the closure of the BAC would not create a bed capacity problem, Dwyer’s evidence was “Kingswell certainly did say that, that there were the other beds”.³⁴ Again, Dwyer appears to have accepted this advice from Kingswell.

Geppert and MHAODB and West Moreton HHS

At the time of the commencement of the HHB Act and the establishment of West Moreton HHS, Geppert held the position of Director, Planning and Partnerships Unit, which formed part of Kingswell's team at the MHAODB.

Cleary gave evidence about a meeting with Dwyer on 13 November 2012 at which he "discussed the secondment of Leanne Geppert to assist with the planning, communication and engagement" in respect of the governance that West Moreton HHS proposed to put in place to review the BAC model of care.³⁵

In early 2013, Geppert was seconded from MHAODB to the position of Director of Strategy, with West Moreton HHS.³⁶ She retained her substantive position with MHAODB.³⁷

From this point onwards, Geppert assisted Kelly. For example, Geppert prepared 'dot points' for Kelly on 18 March 2013 for a meeting about the service model proposal provided by the ECRG.³⁸ Geppert again provided Kelly with 'dot points' in preparation for Kelly's attendance at the meeting of the West Moreton Board on 24 May 2013.³⁹

Geppert moved permanently to West Moreton HHS as Director of Strategy in January 2015.⁴⁰

Kelly and Dwyer

As Executive Director (Mental Health and Specialised Services), Kelly assumed responsibility for "strategic leadership" and "responsibility for accountability for the day to day delivery of the mental health and specialised services within [West Moreton HHS]". In that position Kelly held "statewide leadership responsibilities" for the BAC.⁴¹ Kelly reported to Dwyer.

Kelly and Dwyer shared what appears to have been a mutually supportive relationship. They presented to stakeholders what could be described as a 'united front'. For example:

- a. On 21 April 2013, Kelly sent an email to Dwyer in which she said:

"Lesley, I **hope I have your support** that we do not agree to continuing BAC as an interim step as it will never close if that happens and the safety of the unit is such that I believe we are better off without the tier 3 for the period of time with a consulting service supporting other units" (emphasis added).⁴²
- b. Dwyer gave evidence about the West Moreton Board meeting on 24 May 2013, saying that Kelly had prepared a board paper "which Kelly presented **and I supported**" (emphasis added).⁴³
- c. Kelly and Dwyer generally attended meetings at which the BAC was discussed together.⁴⁴
- d. Dwyer gave evidence that Kelly would prepare reports about the BAC ahead of meetings of the West Moreton Board which she would approve prior to their inclusion in board papers.⁴⁵
- e. In respect of the monitoring of the transition arrangements, Dwyer's evidence is that responsibility rested with Kelly, but she "checked to ensure arrangements were appropriate and effective by receiving regular reports from Ms Kelly as to the progress of the transitions".⁴⁶

Kelly, Dwyer and the West Moreton Board

It is difficult to assess the relationship between Kelly and Dwyer on the one hand and the West Moreton Board on the other. The Commission's attention was necessarily limited to the issues concerning the BAC.

The available evidence indicates that the West Moreton Board was, in one respect at least, cautious in its acceptance of propositions put to it for approval by Kelly and Dwyer. On the other hand, the Board also demonstrated a level of trust and confidence in what was proposed to them.

For example, as explained in chapter 11, the West Moreton Board met on 24 May 2013 and considered a recommendation in the agenda paper, which was authored by Kelly, to progress the closure of the BAC. The agenda paper gave a proposed closure date of 30 September 2013. However, the West Moreton Board declined to fix any particular date for closure.

At various times between May 2012 and late-2013, the West Moreton Board issued to Kelly what have been described by Corbett as "instructions to WMHHS", concerning the operations or management of the BAC:⁴⁷

- a. At a meeting on 26 April 2013, the West Moreton Board instructed Kelly that the strategy for the future of the BAC was to be developed and brought back to the West Moreton Board for approval.⁴⁸
- b. At a meeting on 24 May 2013, the West Moreton Board instructed Kelly that, until a decision in regard to the plans for the BAC was confirmed, clinical services were to continue to be provided and patients were to be discharged as appropriate.⁴⁹
- c. At a meeting on 27 September 2013, the West Moreton Board instructed Kelly that it could not advise a firm date for the closure of the BAC in the absence of an alternative model. The West Moreton Board supported the parties working toward early 2014 for transfer to a more appropriate model but instructed that closure of the BAC was contingent on an appropriate model of care being developed and a clear plan being in place for the transition of current patients.⁵⁰

From the evidence before the Commission, it appears that Corbett sought the involvement of Kelly and Dwyer when matters concerning the BAC were elevated for discussion. For example:

- a. on 14 December 2012, Kelly and Dwyer both accompanied Corbett to a meeting with the Minister to discuss West Moreton mental health services⁵¹
- b. on 15 July 2013, Kelly and Dwyer both accompanied Corbett to a meeting with the Minister to discuss the BAC⁵²
- c. on 2 December 2013, Dwyer accompanied Corbett to a meeting with the Minister and representatives of Children's Health Queensland HHS and Children's Health Queensland Board.⁵³

The briefing note process

The Commission heard from Springborg, O'Connell, Cleary, Young and Kingswell about decision-making within Queensland Health, and in particular, the briefing note process.

Briefing notes are formal written documents which serve at least two broad functions. *First*, briefing notes "for noting" seek to inform or report to the Director-General and/or the Minister about projects, decisions, or events within the Department. *Second*, briefing notes "for approval",

seek a decision on an important matter by the Director-General and/or the Minister. There appears to have been a demarcation between briefing notes that were “for noting” and those for “approval”.

The detail and style of briefing notes changed over time and according to the preferences of the relevant Minister and Director-General.

Briefing notes were arranged in sets: *first*, the Director-General’s version; and *second*, the Minister’s version. The Minister’s version was typically an abbreviated one page document based on the detailed briefing note given to the Director-General. The briefing note to the Director-General was usually up to about three pages long. A set of briefing notes might include attachments, typically to the Director-General’s version. The Minister’s and Director-General’s briefing notes each had a signature section where the Minister or Director-General was to circle either “Approved” or “Noted” indicating the decision made, as well as a place for a signature and date. There was a section where the Minister or Director-General could write comments. The Minister’s version also had a signature box where the Minister’s Chief of Staff could “note” the contents of the briefing note.

Typically, a briefing note sent to the Director-General for “approval” then went to the Minister only for “noting”.

The briefing note process was not limited to briefing notes alone. The process was often supplemented or preceded by telephone conversations, informal face-to-face meetings and discussions about the topic at executive meetings.⁵⁴ Springborg said that, as Minister, he would “assimilate and accumulate information based on the sources and the advice that [he would] receive”.⁵⁵

Jeannette Young (Chief Health Officer) explained that a briefing note is often the formal record of a strategic issue that has been the subject of consultation over an extended period.⁵⁶ She said that at other times, a briefing note can “come out of the blue” if it is about an emergent issue.⁵⁷ Briefing notes may be generated deep within a department or be requested by senior departmental executives or the Minister.

Each briefing note has a number of signatories: usually, an author, a clearer, a verifier and an endorser. The notes are often “generated by a fairly low-level officer” but then they are “checked by various officers who add a level of experience and expertise” to the briefing note before it is presented to the Director-General and/or the Minister.⁵⁸ The information contained within the briefing note may be sourced from various materials available to the author or the persons who verify it. Those sources may be documents, reports, meetings, or conversations.

Of course, the knowledge and perspective of the Director-General and/or Minister will differ from the knowledge of the authors and signatories. The Director-General or Minister may have a broader strategic knowledge and less knowledge of the detail. That broader knowledge may come from various sources, including other governmental processes, such as other briefing notes, Cabinet Budget Review Committee meetings, meetings with the Premier, Ministers and Treasury officials, as well as ‘external’ sources such as Federal Members of Parliament, constituents, lobbyists, etc.⁵⁹ Hence, there may be “considerations” which go beyond what appears in a briefing note.⁶⁰

A curious aspect of some briefing notes is that they have no “reject” option but only an option to “approve” or “note”. However, the evidence before the Commission is that a Director-General can either agree to, or disagree with (and hence possibly veto), a proposal for approval. Without making a decision, he or she may make comments on the briefing note or send it back to the

department requesting further information, seeking clarification or asking that they reconsider the proposal. A Minister may do likewise. Further, if a Minister disagrees with a decision of a Director-General, the Minister retains the right to veto such a decision.⁶¹

A continuum of decisions?

The decision to close the BAC was an important decision. High-level decision-makers were briefed and involved. That was necessary and appropriate. The Commission's concerns, however, are with how that process was conducted.

Steps were taken towards closure of the BAC apparently without any express consideration of who had the legal authority to close it. The question of the authority to close is explored in chapter 12. With the possible exception of Cleary, none of those involved appears to have given specific attention to what procedures were necessary.⁶²

Counsel for the State submitted that, during the course of the Inquiry, there was:

... an assumption that it is possible to identify a single action or defining moment in time that constitutes the closure decision and that, therefore, it is possible to definitively identify:

- (a) who purported to make the closure decision and when; and
- (b) who had the legal authority to make the closure decision.⁶³

The State submitted that, on the evidence, this assumption was unfounded. Instead, the State argued:

... the decision-making process was multifarious. No one entity had the responsibility to make the closure decision. It was a continuum of decisions by a number of entities, with each decision along the continuum affirming in principle the direction that the matter was heading, being towards the ultimate closure of the BAC.⁶⁴

The evidence in chapter 12 reveals that the State is correct to describe the process as multifarious. However, the decision to close the BAC was not the result of a "continuum of decisions". While it is true that the decision-making process involved a number of persons and entities who made varying contributions at different times leading to the ultimate decision to close the BAC, it is possible to identify *who had the authority* to make the closure decision, *who made that decision*, and *when*. As explained in chapter 12, a decision to close required agreement between West Moreton HHS and Queensland Health. A number of steps were taken to lay the groundwork for that agreement, such as the meeting of the West Moreton Board on 24 May 2013. While that agreement could have been reached between the Director-General and Corbett, as Chair of the West Moreton Board, the Commission's view is that the decision was made on 15 July 2013 at a meeting between the Minister and Corbett.

Three problems

The actual decision-making process which led to the decision to close the BAC had three broad problems:

- a lack of appropriate consultation
- some deficiencies in the consideration, including the reasons for the decision
- an absence of proper documentation recording key outcomes and decisions.

Each is considered below.

Issue 1: Consultation

Introduction

This section considers whether there was an obligation to consult, whether consultation was consistent with basic principles of good decision-making and public administration, and whether there was appropriate consultation in relation to the decision to close the BAC.

Principles and standards of consultation

The guiding principles

Section 5 of the *Hospital and Health Boards Act 2011* (Qld) (HHB Act) provides:

The object of this Act is to establish a public sector health system that delivers high quality hospital and other health services to persons in Queensland having regard to the principles and objectives of the national health system.

The object is mainly achieved by:

strengthening local decision-making and accountability, local consumer and community engagement, and local clinician engagement; and

providing for Statewide health system management including **health system planning**, coordination and standard setting; and

balancing the benefits of the local and system-wide approaches.

(emphasis added)

Principles “intended to guide the achievement of this Act’s object” are set out in section 13. By section 13(2):

A person must have regard to the guiding principles when performing a function or exercising a power under this Act.

(emphasis added)

In other words, these principles must be taken into consideration, although there are no prescribed consequences of failure to do so.

The guiding principles include:

- (h) there should be **engagement with clinicians, consumers, community members and local primary healthcare organisations** in planning, developing and delivering public sector health services.

(emphasis added)

These provisions can be contrasted with the guiding principle in section 4A(g) of the (now repealed) *Health Services Act 1991* (Qld) (HS Act) that there should be “**collaboration with clinicians** in planning, developing and delivering public sector health services”. The Chief Executive, general managers of health services and district managers had to have regard to the guiding principles in the HS Act.⁶⁵

Under the HHB Act there should be “engagement” rather than “collaboration” with various categories of people, not just clinicians.

There may be little substantive difference between the concept of 'collaboration' under the HS Act and the concept of 'engagement' under the HHB Act. Both concepts require more than the provision of information to stakeholders. To 'collaborate' is to cooperate, or to work one with another or jointly. To 'engage' is to occupy the attention or efforts of a person, or to involve that person. However, the terms are not synonymous. Collaboration involves a certain level of engagement. A person who collaborates is likely to be engaged. A person who is engaged is not necessarily someone who is participating in a collaborative process.

The extent of collaboration and engagement is not specified in either Act. However, the Legislature plainly intended that the collaboration or engagement would guide the planning, development and delivery of public sector health services, and that the extent to which it should do so would vary depending on the circumstances.

Further, one of the functions of a Hospital and Health Service under section 19(2) of the HHB Act is:

- (n) to consult with health professionals working in the Service, health consumers and members of the community about the provision of health services.

Other standards

Other legislation and policy and administrative frameworks call for mental health services to seek the participation and feedback of consumers, families and carers in the planning, delivery and evaluation of mental health services, as well as in policy development. These include:

- *Carer's (Recognition) Act 2008* (Qld) and its Charter⁶⁶
- National Standards for Mental Health Services 2010⁶⁷
- Queensland Plan for Mental Health 2007–2017⁶⁸
- Consumer, Carer and Family Participation Framework 2010.⁶⁹

Although they do not create legal rights or impose legally enforceable obligations, they point to the desirability of consultation with the BAC patients, families and carers in the decision-making process about the BAC's future.

What consultation occurred?

Introduction and summary

As will be explained below:

- there was a lack of proper consultation in the decision to cease the Redlands project
- in the progress towards the closure of the BAC:
 - there was very limited consultation until the establishment of the ECRG in December 2012
 - the engagement with the ECRG constituted a high level of consultation with clinicians and other professionals
 - however, the consultation with patients, carers and families was limited in that the consumer and carer representatives on the ECRG did not actually represent the BAC patients, families and carers.

The guiding principles are premised on the basis that consultation will occur in a genuine way in that the decision-makers will take into account the views of the stakeholders who are consulted. If the decision-makers do not take those views into account, the benefits of consultation will be lost. The benefits of the engagement with the ECRG were lost through a series of events which are explained below.

In short, Queensland Health and West Moreton HHS appear not to have taken the views of the ECRG into account.

Consultation – experts

As chapters 3 and 5 demonstrate, there was a lack of consultation with various stakeholders about the cessation of the Redlands project. In particular, there was no consultation with:

- child and adolescent psychiatrists
- David Crompton who had led the preparation of a draft new model of care for Redlands
- West Moreton Health Service District or the Metro South Health District or their successors
- patients, families or carers.

Had there been consultation, and had the May and August 2012 briefing notes contained more information, the Director-General and/or Minister might have been better informed of the rationale for the Redlands project, the nature and extent of the problems it had encountered, and the likely consequences of its cessation. The Commission cannot speculate whether the decision would have been different. Nevertheless, the importance of consultation is that it better informs the decision-maker(s) and so can assist in the making of ‘better’ decisions.

Each briefing note states that some consultation had occurred. The May 2012 briefing note referred to “limited sector consultation”. Plainly, that phrase was not very informative about precisely what consultation had occurred. The likelihood is that any consultation was indeed “limited”, and confined to one part of the “sector”, that is, part of Queensland Health.

The August 2012 briefing note was more transparent about what consultation had occurred. It said that Kingswell had recommended the cessation of Redlands. However, there are three difficulties. *First*, consultation with one person (and perhaps the Queensland Health Infrastructure Branch) is a rather narrow consultation process. *Second*, Kingswell denied knowing of the August briefing note at the time. It did not progress through his branch and it is unlikely he actually gave that advice – at least for the purposes of that briefing note. *Third*, the “consultation will occur following approval” approach is inconsistent with the guiding principles which require engagement with clinicians, consumers, community members and local primary healthcare organisations in planning, developing and delivering public sector health services. Those guiding principles envisage consultation about what planning decisions should be made, rather than merely consultation about the consequences of a decision that has already been made.

The May 2012 briefing note observed that ceasing the Redlands project would “necessitate a review” of the BAC and its model of care. In August 2012, after West Moreton HHS was informed about the cancellation of the Redlands project, there were discussions involving West Moreton HHS and Queensland Health, including the MHOADB, about what could and should happen to the BAC as discussed in chapters 7 and 8. An intention to close the BAC emerged. On 25 October 2012 Kingswell, Jagmohan Gilhotra (acting Director of Patient Safety) Gilhotra and Geppert communicated that intention to Kelly. There is no evidence of any consultation with child and adolescent psychiatrists, patients, families or carers at that point.

After McDermott's public exposure of the intention to close the BAC on 8 November 2012, as discussed in chapter 8, West Moreton in consultation with Queensland Health then set up the processes under the Project Plan as outlined in chapter 9. The deficiencies in consultation with experts that had existed in the period between August and November 2012 were then, to a significant extent, remedied by the establishment of the Planning Group and the ECRG under the Project Plan.

As outlined in chapters 9 and 10, the expertise and knowledge of the ECRG was considerable, particularly in the sub-specialty of child and adolescent psychiatry. Allied health professionals, an educator, and consumer and carer representatives also had input. The group was representative and multi-disciplinary. Although its timeframe was limited, the ECRG produced a report about the appropriate model of care for adolescents with severe and persistent mental illness. In doing so, it resisted some pressure to exclude from its consideration what was, in its opinion, an essential facility, namely a 'Tier 3' (i.e. a Statewide Adolescent Inpatient Extended Treatment and Rehabilitation Service).

The ECRG reported to the Planning Group. The Planning Group's role was to consider the ECRG's report and to make recommendations to the Health Service Executive regarding the model or models of care required to meet the needs of adolescents in Queensland for extended treatment and rehabilitation.⁷⁰ As explained in chapters 9 and 10, the Planning Group's membership was diverse and it possessed considerable expertise and experience within the mental health and public administration sectors as well as education. The Planning Group reported to the West Moreton Board.

However, the ECRG's report was either not considered or misinterpreted, and the expertise of that group was lost. More detail on this is set out later in this chapter under 'Consideration'.

Consultation – patients, families and carers

As explained in chapter 9, the Project Plan was to some extent equivocal about the level of involvement of patients, carers and families. The evidence, on balance, is that these persons were not intended to have any 'active participation'. Instead, patients, carers and families were to be kept informed of the processes, and there was an opportunity for consultation rather than provision for consultation.

The participation of the consumer and carer representatives on the ECRG was at its initiative. Their participation was not a deliberate decision or plan on the part of West Moreton HHS. It did not form part of the Project Plan, or the ECRG's initial terms of reference.

The carer representative attended at least three of the eight ECRG meetings and the consumer representative attended at least one. Both representatives had active input into the report of the ECRG. However, their roles were not formally defined and so were partly dependent on what they made of them. It is likely that the designated carer and consumer representatives did not have any contact with BAC patients or their families or carers.

Beyond the involvement of the carer and consumer representatives in the ECRG, there is no evidence of any two-way consultation with BAC families and consumers by West Moreton HHS and Queensland Health. Moreover, there is no evidence of any West Moreton HHS-driven process for receiving the views of patients, families and carers, let alone any scope for those views to influence the decision-making about the BAC.

The involvement of the consumer and carer representatives in the ECRG shows an element of consultation and participation in decision-making on the part of consumers and carers, which,

at first glance seems to align with the guiding principles. However, a distinction can be drawn between a consumer or carer contributing their own personal views, and a person representing or reflecting the views of consumers and carers as stakeholders.

The policies and standards discussed above give carers the 'right' to independently determine who will represent their views. Notably, the ECRG carer representative was not independently appointed by the carers of BAC patients. Moreover, the ECRG minutes expressly record that the carer representative was separate from the BAC parent group. The substantive problem was that there was no communication or contact between the BAC patients, families and carers, on the one hand, and the consumer and carer representatives on the ECRG on the other.

Notwithstanding the important, but perhaps limited, consultation with consumers and carers in the ECRG process, in general, the consultation with patients, families or carers was not broad or thorough enough. Yet, on the other hand, O'Connell expected that there had been consultation with patients and families.⁷¹

Issue 2: Consideration

Introduction

An analysis of the various reasons offered at different times for closing the BAC is found in chapter 14. This section is not concerned with the merits of each of those reasons, or with the merits of the ultimate decision to close the BAC. Rather, it is concerned with the nature and extent of the consideration given by the decision-makers to the decision.

It is difficult to ascertain the factors that actually influenced the decision to close the BAC because the decision was not properly documented.⁷² This section examines the level of consideration that was given, and ought to have been given, to the question of whether the BAC should be closed.

Level of consideration

The decisions to cease the Redlands project and to close the BAC were important ones.⁷³ For three decades the BAC had cared for many young people with severe and complex mental health needs. In ceasing the Redlands project and in closing the BAC, there was no plan for the BAC's replacement. And so, from clinical and public health administration perspectives, there was a need for the decision-makers to consider carefully both decisions, properly considering the facts and the issues.

Analysis of the consideration

Context

The 'in principle' 2008 decision to replace the BAC with a new unit was based on expert advice. Then, a team was formed to review the model of service at the BAC and prepare a new model of service delivery for the new unit at Redlands. The proposals for the Redlands unit responded to several of the criticisms made of the BAC. However, the Redlands project was cancelled in 2012. The reasons why it was cancelled are examined in chapters 3, 5 and 14. As explained earlier, upon the cancellation of Redlands, some of the reasons for replacing the BAC became reasons for closing it. New reasons also emerged.

Chapter 14 examines the reasons for the closure of the BAC. In broad brush, how the reasons emerged, and their nature, involved different people with different roles in the decision-making process and different opinions. In many cases, the reasons were stated in general terms and important details were left out. Through generalisation, some reasons were exaggerated. The reasons became distant from the facts. In many instances, the reasons offered by some of the decision-makers were based on what others had told them. Those reasons were then repeated orally, in briefing notes, and in emails.

No analysis

Importantly, the reasons advanced for closing the BAC were never examined in detail or carefully analysed. There was no proper analysis of the cases for and against, or of the alternatives, or of the risks and consequences.

As a result, throughout the decision-making process, there was no proper, if any, risk assessment or consideration of:

- at the time of the May and August 2012 briefing notes, the consequences for the BAC if the Redlands project was discontinued
- the risks of keeping the BAC open, including:
 - the risks to the patients of the BAC
 - the risks of co-location with EFTRU
 - the risks of postponing the opening of EFTRU if the BAC was to stay open and the risks of co-location were unacceptable
- the risks of closing the BAC, including the risks to the well-being of both its current and waitlist patients
- whether there was a need for a BAC, Redlands or Tier 3 type facility.

As explained in chapter 14, the decision to close the BAC, and to do so without the existence or prospect of a replacement, was an important clinical decision made on the assumptions that:

- a Tier 3 is not an essential element of mental health services
- the mental health needs of the BAC cohort can be safely and effectively met through existing, or soon to be established, service types.

Alternatives

Because the reasons advanced for the cessation of the Redlands project and the closure of the BAC were never examined in detail or carefully analysed, there was no proper analysis of any alternatives to the BAC.⁷⁴

The ECRG recommended that a Tier 3 service be prioritised. However, that recommendation was not implemented. It is likely that the ECRG's recommendation was not implemented because of the assumptions that a Tier 3 was not essential and that the needs of the BAC cohort could be met through other service types.

As at July 2013 the only suggestions of alternatives to the BAC were the ECRG's recommendation that new service model elements be developed and the Planning Group's comment that an alternative bed-based model such as Y-PARC could be developed. There was no reasonable basis for assuming that new services based on the ECRG's new service model elements would be in place by the time of the BAC's projected closure. The result was that the only alternatives considered were existing services, an adaptation of the Victorian Y-PARC service and (later) the use of sub-acute beds in acute units (see the discussion of these alternatives in chapter 14).

Queensland Health and West Moreton HHS ought to have considered a Tier 3 as a replacement for the BAC and ought not to have set a date by which they expected the closure to occur. The target date for closure should have been set by reference not only to the process of transition but also by reference to when the new services would be available.

It is worth noting Philip Hazell's evidence was that there were other 'creative' alternatives to a new Tier 3 building such as refurbishing an existing facility or finding alternative accommodation for the service.⁷⁵ However, there is no evidence that any alternatives like that were considered. That is, no doubt, because it was assumed that a Tier 3 was not essential.

ECRG

As explained in chapters 9 and 10, the ECRG members included child and adolescent psychiatrists and persons with considerable experience in adolescent mental health and related disciplines. The membership was broadly representative. It had consumer and carer representatives.

The ECRG's report explained the nature of the work involved in the production of its report. The ECRG said that it had considered community and sector feedback, reviewed contemporary, evidence-based models of care and service types, evidence and data from the field, national and international benchmarks, clinical expertise and experience, and consumer and carer feedback.⁷⁶

The ECRG considered that a Tier 3 facility was essential and warned that closure of the BAC without an alternative 'Tier 3' service being available in a timely manner would be associated with risks to patients. Despite that clear warning, the BAC closed. Thus, West Moreton HHS and Queensland Health acted contrary to the expert advice they had sought and received. Why they did so is difficult to pinpoint.

The result was that the ECRG's report was either misunderstood or not considered. Certainly no representative of Queensland Health or West Moreton heeded its key messages.

And, the subsequent decision to close the BAC was impliedly attributed to the ECRG's recommendations. For example, a media statement distributed to staff and families and carers of the BAC patients dated 6 August 2013 stated as follows:

West Moreton Hospital and Health Service Chief Executive Lesley Dwyer and Children's Health Queensland Chief Executive Peter Steer today said adolescents requiring extended mental health treatment and rehabilitation will receive services through a new range of contemporary service options from early 2014.

Dwyer said the young people who were receiving care from Barrett Adolescent Centre at that time, would be supported to transition to other contemporary care options that best meet their individual needs.

She said West Moreton Hospital and Health Service had heard the voices of staff, consumers and their families, and engaged an expert clinical reference group over the past eight months.

"After taking into consideration the recommendations of the expert clinical reference group and a range of other key issues in national and state mental health service delivery, the West Moreton Hospital and Health Board determined that the Barrett Adolescent Centre is no longer an appropriate model of care for these young people," Dwyer said.⁷⁷

That media statement suggests that the recommendations of the ECRG were taken into account in determining that the BAC was no longer an appropriate model of care, and should be closed, and that it should be replaced by a new range of contemporary service options. Other communications at the time contained similar messages.

The Commission has found no evidence to support the statement that West Moreton HHS had “heard” the voices of staff, consumers and their families in the sense of paying any attention to those voices.

The Planning Group

The Planning Group met on 15 May 2013 to consider the final ECRG report. At least some members of the Planning Group disagreed with what the ECRG said about the need for a ‘Tier 3’ facility as the alternative to the BAC. However, the absence of any minutes of the Planning Group’s meeting make it difficult to determine the nature and extent of that disagreement.

The Planning Group’s “recommendations” were merely some comments of some members of the Planning Group on the ECRG report and did not include:

- a. any specific recommendations
- b. any analysis or explanation of the Planning Group’s reasoning
- c. any reasons for recommending the closure of the BAC.

The Planning Group recommendations distorted the ECRG’s report by ‘accepting’ its recommendations but applying ‘caveats’ which undermined its substantive content.

The process adopted by the Planning Group may be contrasted with the process adopted by the ECRG in producing its report. The ECRG met numerous times and its report was produced with input from all members of the group. The end product was a report endorsed by all members of the ECRG. In contrast, the Planning Group’s approach suffered from a lack of group input and an absence of any agreement on its contents.

The agenda paper

The agenda paper for the West Moreton Board meeting on 24 May 2013 was prepared by Kelly. Geppert assisted with the preparation and Dwyer approved the paper. Dwyer and Kelly then co-presented the agenda paper to the Board. As explained in chapter 11, the agenda paper advanced these propositions:

- the Planning Group accepted all the recommendations of the ECRG, with some caveats for note, when in fact the Planning Group’s comments disagreed with the ECRG’s strongly held view that a Tier 3 was essential
- the ECRG report allowed for the safe and timely closure of the BAC – when the ECRG warned against the closure in the absence of another Tier 3 facility
- it was clinically adequate to provide a four-month timeframe to closure – the source of that clinical advice was not the ECRG or any person who could be identified
- the closure of the BAC was not dependent on the next stages of progressing and consulting on a statewide service model.

As explained in chapter 10, the Planning Group recommendations were at loggerheads with those of the ECRG. The agenda paper (and probably the co-presentation) did not draw to the Board’s attention to critical features of the ECRG report.

The West Moreton Board meeting

The Board's decision was based at least in part on the agenda paper and its recommendations. Discussions which may have taken place were not recorded. The Board is likely to have conflated the ECRG recommendations, the Planning Group 'recommendations', the agenda paper, and the presentation to the Board by Dwyer and Kelly. According to the minutes, the Board "noted" the Planning Group's recommendations, but not the ECRG report. It is likely that Kelly and Dwyer did not identify for the Board the key recommendations of the ECRG or, importantly, the conflict between the recommendations of the ECRG and the balance of the other material presented to the Board.

The Board agreed to the closure of the BAC in these circumstances:

- there was no plan in place for the care of the patients then admitted to the BAC, or the patients then on the BAC waitlist, or the patients who might otherwise have been admitted to the BAC in the future;
- the ECRG's recommendations were interpreted as, in effect, agreeing to or recommending the closure of the BAC.

In fact, as explained, the ECRG stated that a Tier 3 service was essential and recommended against closing the BAC without another Tier 3 service being available in a timely manner.

What the Board decided at that meeting proceeded from the agenda paper and its recommendations. The Commission's view is that the Board members were entitled to rely on the information given to them. However, the information given to them was inaccurate.

Minister

The Minister did not read the ECRG report.⁷⁸ It may well have been reasonable for a Minister not to read a report such as this. However, there is no evidence that any representative of either West Moreton HHS or Queensland Health summarised the ECRG report for the Minister, or that anyone in the Ministerial office read it for him.

Non-ECRG research

No research was undertaken at the time of the decision.

In late 2013 and early January 2014 the patients of the BAC were to be transitioned to appropriate "wrap around" services based on their individual needs. At that time no proper analysis was undertaken of the needs of the current BAC patients and the extent to which their needs and those of other young people who might otherwise have accessed the BAC could be met by existing, or new, community-based services. Moreover, there was no realistic assessment of what new models of care it was feasible to have in place by the time of the BAC's closure.

Issue 3: Documentation

The importance of and need for documentation

As explained in chapter 12, the Commission considers that, given the significance of the decisions being made, the production of some documentary record of meetings would have been prudent. Records promote accountability and transparency. They document what, where and when a decision was made, and the reasons for it. They record who was involved in a decision and under what authority, and provide evidence of government and individual activity.

Documentary records play an important role in retaining corporate memory and enabling the review and understanding of processes and decisions.

The evidence shows that at critical points in the decision-making process there was a failure of proper documentation.

Documentation of meetings

There is no written record of several meetings, including the meetings of Minister for Health, Springborg, with Corbett, Dwyer and Kelly on 14 December 2012 and 15 July 2013.⁷⁹ The Commission accepts that the Minister's advisor would have made notes of the meeting on an iPad. However, there is no explanation for the absence of notes by the West Moreton representatives.

There are no minutes of the Planning Group meeting on 15 May 2013, an important meeting where the Planning Group placed caveats on some of ECRG recommendations. Apart from some handwritten notes of comments there is no record of what the Planning Group members decided at that meeting.

The decision on 15 July 2013 to close the health facility was not documented until many months after the closure of the BAC. This is extraordinary.

Briefing notes

Need for quality

The briefing notes with which this Commission has been concerned and, in particular, the May and August 2012 briefing notes, show, as Counsel Assisting submitted:

- little or no comprehensive reasoning
- reasons which use glib explanations
- little or no grounding in facts or verification of those facts⁸⁰
- no reference to expert views for clinical decisions
- little or no reference to the consequences of the decisions.⁸¹

Importantly, a briefing note needs to include a summary of all the information that is necessary for a decision-maker to be fully informed about the issue. The level of information that is required to be in a briefing note will vary according to the issue, the knowledge or expertise of the decision-maker, and the nature of the proposed decision.

Oral discussions as a substitute for briefing notes

Counsel for Springborg submitted:

Counsel Assisting regard it as unsatisfactory that the parties engaged in oral discussions in addition to briefing notes. But there is nothing inappropriate in decision-makers having oral discussions around a decision in addition to considering the written reports and briefs. Professionals constantly discuss matters with peers. It is a proper and useful way to assist communication.⁸²

Of course, oral discussions about important issues are appropriate and necessary. But those discussions do not displace the need for a carefully prepared briefing note that properly and comprehensively achieves its purpose: that is, briefing the decision-maker with a summary of

all of the information that is necessary to make a fully informed decision. In the Commission's view, it is a mistake to exclude certain matters from a briefing note on the assumption that the decision-maker will recall earlier discussions and take the detail of those discussions into account appropriately.

Trust in departmental officers as a substitute

The briefing process involves senior departmental officers placing trust and confidence in their colleagues. O'Connell implied that briefing notes were to be trusted because, amongst other things, "[t]he people who would be recommending these actions to me would be highly reputable people".⁸³ He said that the size of the organisation meant that there had to be "a level of trust throughout the organisation".⁸⁴ O'Connell explained:

... there has to be a sense of cascading down of both responsibility and accountability to officers below, and ... that's why the appointment of senior officers in a government department are such important appointments, because they have to be people who are able to prioritise, to balance, to assess situations and to be suspicious about decisions that are being asked of them.⁸⁵

The Commission accepts that. However, a senior departmental officer can, and should, question statements in a briefing note that are not clear or that are a cause of concern. A briefing note should address the relevant reasons, be grounded in fact, and (where appropriate) include summaries of, or references to, expert advice, as well as an examination of the consequences of the decision (including risk assessments where appropriate).

There is a danger of Chinese Whispers. O'Connell said:

Yes, of course there's that danger, and, you know, it's possible that ... mistakes have been made at each level in the decision-making by each of the officers at each of the levels. But the more levels there are, the more secure the process is overall, but, possibly also, the more delayed the process is ... in acting.⁸⁶

It is doubtful that 'extra' layers of process would necessarily result in the absence of mistakes, or in a more sound result.

Retrospectivity

Counsel for O'Connell submitted:

Retrospective forensic analysis has a tendency to overlook context. It is noted O'Connell was operating a very big operation with very many employees over very many facilities providing no doubt literally millions of health services every year, many of them involving very grave and serious implications. He would see no doubt thousands of documents providing instruction every year and a substantial number of briefing notes every week. To retrospectively isolate one document in the context described above as requiring specific interrogation is unrealistic. Its practical correction would likely be paralysing for the office of the Director-General. If the advice upon which it was based was wrong, the criticism lies elsewhere.⁸⁷

Nonetheless getting the critical decisions right is crucial. There is no more important role of Director-General, or the other leaders in Queensland Health.

The decisions to cease the Redlands project and to close the BAC were important decisions. They were not routine or everyday decisions. It can hardly be paralysing to subject significant decisions, such as these, to scrutiny. And it is unlikely to be paralysing to require that the decision-making process adopted by Queensland Health involve a careful briefing of the decision-maker with a summary of all of the information that is necessary for them to make a fully informed decision. It cannot assist the decision-maker, and it is likely to hinder the process, for relevant considerations to be omitted from a briefing note.

Conclusions

The conclusions to be drawn from this chapter are as follows:

1. The nature of the professional relationships between the key persons involved in the decision-making process meant that there was an over-reliance on the views of some (principally Kingswell) and there was little or no questioning or scrutiny of those views.
2. There was an approach to decision-making involving different contributions by different people and entities at different times but no specific, careful consideration of all of the relevant considerations. The result was that no one person or entity assumed responsibility and accountability for the processes of the decision-making.
3. The Commission has not identified any occasion when a person or entity properly considered the merits of the proposal to close the BAC. There was no decision-making process which properly assessed and analysed the relevant factors.
4. The decisions based on the May and August 2012 briefing notes involved little or no consultation, contrary to the 'Guiding Principles' and related guides.
5. There was also little or no consultation when the MHAODB communicated its intention to close the BAC in late October 2012.
6. The engagement of the ECRG did involve significant child and adolescent psychiatric expertise, as well as allied health professionals, an educator, and consumer and carer representatives.
7. However, whilst consumer and carer representatives were participants in the ECRG process, they were not actually representatives of the BAC patients and carers in that the consumer and carer representatives had no contact with the BAC patients and carers.
8. The consideration of the issues was flawed. In particular:
 - a. There was no proper consideration of the consequences of the decisions in May and August 2012.
 - b. There was no proper risk assessment of consequences of keeping the BAC open, including in relation to the co-location with EFTRU.
 - c. The ECRG report was either misinterpreted or not considered – largely as a result of the Planning Group's actions, and the agenda paper prepared by the West Moreton HHS Executive, and the Executive's presentation to the West Moreton Board.
 - d. At the West Moreton Board Meeting on 24 May 2013 the Board members were entitled to rely on the information given to them. However, the information given to the Board was inaccurate.
9. The documentation of meetings left much to be desired. In particular, there is no explanation for the absence of notes of the West Moreton HHS representatives in respect of meetings with the Minister on 14 December 2012 and 15 July 2013. The Planning Group's decisions, recommendations and deliberations on 15 May 2013 were not properly documented. And, the decision to close the BAC was not recorded until months after it had closed.

10. The briefing notes of May and August 2012 had limited grounding in facts, no proper analysis, an absence of careful reasoning, an absence of reference to relevant expertise or to expert advice, and little or no consideration of the consequences of the decisions.

None of those factors should be considered in isolation. The poor consultation, for example, may well have led to flawed consideration. Overall, there was a deficient process of decision-making, especially given the relative significance of the decision and the potential impact on vulnerable adolescents with severe and persistent mental illness.

(Endnotes)

- 1 Submissions on behalf of the State of Queensland, 23 March 2016, p 4 para 2(a)(i).
- 2 Submissions on behalf of Lawrence Springborg, 23 March 2016, pp 14–15 para 2.75.
- 3 There were submissions to the contrary: Submissions on behalf of Lawrence Springborg, 23 March 2016, pp 52–53 paras 6.13, 6.17; Response to possible adverse findings – State of Queensland, 31 May 2016, pp 16–18 paras 34–37.
- 4 *Hospital and Health Boards Act 2011* (Qld) s 44(3).
- 5 *Hospital and Health Boards Act 2011* (Qld) s 44(1).
- 6 *Hospital and Health Boards Act 2011* (Qld) s 44(5).
- 7 Submissions on behalf of Anthony O’Connell, 23 March 2016, p 7 para 26.
- 8 *Constitution of Queensland 2001* (Qld) s 51(1).
- 9 *Hospital and Health Boards Act 2011* (Qld) s 8(2).
- 10 *Hospital and Health Boards Act 2011* (Qld) s 45(a)–(d).
- 11 *Hospital and Health Boards Act 2011* (Qld) s 44F.
- 12 *Hospital and Health Boards Act 2011* (Qld) s 52.
- 13 *Hospital and Health Boards Act 2011* (Qld) s 53.
- 14 *Hospital and Health Boards Act 2011* (Qld) s 22.
- 15 *Hospital and Health Boards Act 2011* (Qld) s 23.
- 16 *Hospital and Health Boards Act 2011* (Qld) s 25.
- 17 *Hospital and Health Boards Act 2011* (Qld) s 31.
- 18 *Hospital and Health Boards Act 2011* (Qld) s 33(1).
- 19 *Hospital and Health Boards Act 2011* (Qld) s 33(4).
- 20 *Hospital and Health Boards Act 2011* (Qld) s 33(1), (4).
- 21 *Hospital and Health Boards Act 2011* (Qld) s 280(1).
- 22 *Hospital and Health Boards Act 2011* (Qld) s 280(3).
- 23 See the discussion of Geppert’s position below.
- 24 Transcript, Michael Cleary, 25 February 2016, p 14–24, lines 13–23.
- 25 For example, Kelly’s evidence is that after the meeting with MHAODB on 25 October 2012 she spoke with Dwyer and “informed her of my meeting with MHAODB”: Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 8 para 10.2.
- 26 Transcript, Michael Cleary, 25 February 2016, p 14–25 lines 1–37; Exhibit 40, Statement of Michael Cleary, 21 December 2105, pp 19–20 para 84(i).
- 27 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 7 para 9.2.
- 28 Transcript, Sharon Kelly, 22 February 2016, p 11–9, lines 10–29.
- 29 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 8 para 9.5.
- 30 On 2 November 2012, Kelly met with Stedman and Sadler and advised them that closure of the BAC was not optional, however needed to be planned: Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment SK-9 to that statement, Email from Sharon Kelly to Bill Kingswell, Jagmohan Gilhotra and Leanne Geppert, copied to Lesley Dwyer and Chris Thorburn, Subject: “WMHHS and mental health plan”, 26 October 2012, pp 826–827; Transcript, Sharon Kelly, 22 February 2016, p 11–6, lines 30–40.
- 31 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 20 para 11.4(a).

- 32 Transcript, Lesley Dwyer, 23 February 2016, p 12-96 lines 13–35.
- 33 Transcript, Lesley Dwyer, 23 February 2016, p 12-112 lines 21–32.
- 34 Transcript, Lesley Dwyer, 23 February 2016, p 12-122 lines 3–11.
- 35 Exhibit 40, Statement of Michael Cleary, 21 December 2015, p 27 para 110.
- 36 Exhibit 55, Statement of Leanne Geppert, 10 October 2015, pp 2–3 para 2.5.
- 37 Exhibit 55, Statement of Leanne Geppert, 10 October 2015, pp 2–3 para 2.5. Geppert’s evidence is that this unit was responsible for the statewide coordination of projects associated with the QPMH, in collaboration with key stakeholders in the service Districts and other departmental units such as the Health Planning and Infrastructure Branch: Exhibit 55, Statement of Leanne Geppert, 10 October 2015, p 4 para 3.3.
- 38 Exhibit 747, Email from Leanne Geppert to Sharon Kelly, Subject: “Urgent Briefing – Expert Clinical Reference Group for Barrett Adolescent Centre”, 18 March 2013.
- 39 Exhibit 745, Email from Leanne Geppert to Sharon Kelly, Subject: “extra info for BAC and Board Mtg today”, 24 May 2013, attaching Exhibit 746, “Confidential – WM HH Board Meeting”, 24 May 2013.
- 40 Exhibit 55, Statement of Leanne Geppert, 10 October 2015, pp 2–3 para 2.5.
- 41 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment SK-2 to that statement, Job description of Executive Director Mental Health and Specialised Services, West Moreton Hospital and Health Service, p 55.
- 42 Exhibit 740, Email from Sharon Kelly to Lesley Dwyer, Subject: “progression of Barrett Adolescent Centre Expert reference group”, 21 April 2013.
- 43 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, pp 14–15 para 8.4.
- 44 For example, at the meeting of the BAC staff on 9 November 2012: Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, pp 15–16 para 10.1.
- 45 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 16 para 10.3.
- 46 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 38 paras 23.1 and 23.2.
- 47 Exhibit 41, Statement of Mary Corbett, 23 October 2015, pp 15–16 para 11.2.
- 48 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-18 to that statement, West Moreton Hospital and Health Board Meeting Minutes of 26 April 2013, pp 138, 140.
- 49 The agenda paper for the 28 June 2013 West Moreton Board meeting states this at para 3 referring back to the 24 May 2013 meeting of the Board: Exhibit 308, West Moreton Board Committee Agenda Papers and Meeting Minutes, 23 November 2012 to 28 February 2014 as provided by Timothy Eltham, p 117.
- 50 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-24 to that statement, West Moreton Hospital and Health Board Meeting Minutes of 27 September 2013, pp 198, 202.
- 51 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 16 para 10.5(a); Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 7 para 8.2.
- 52 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 16 para 10.5(b); Exhibit 41, Statement of Mary Corbett, 23 October 2015, pp 7–8 para 8.3.
- 53 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, pp 16–17 para 10.5(c); Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 9 para 8.4.
- 54 Transcript, Anthony O’Connell, 23 February 2016, p 12-13 lines 36–38.
- 55 Transcript, Lawrence Springborg, 26 February 2016, p 15-27 lines 8–9.
- 56 Transcript, Jeannette Young, 7 March 2016, p 21-96 lines 1–8.
- 57 Transcript, Jeannette Young, 7 March 2016, p 21-96 lines 1–8.
- 58 Transcript, Anthony O’Connell, 23 February 2016, p 12-13 lines 39–42.
- 59 Transcript, Anthony O’Connell, 23 February 2016, p 12-13 lines 42–46.
- 60 Transcript, Anthony O’Connell, 23 February 2016, p 12-13 line 46 – p 12-14 line 2.
- 61 Transcript, Lawrence Springborg, 26 February 2016, p 15-41 lines 1–13.
- 62 The legal process required an agreement by West Moreton HHS and Queensland Health to amend the service agreement (See chapter 12.) On 1 November 2012 Cleary received a briefing note from the Mental Health Alcohol and Other Drugs Branch seeking the closure of the BAC: Exhibit 40, Statement of Michael Cleary, 21 December 2015, Attachment MC-14 to that statement, Draft Briefing Note for Approval to Director-General Queensland Health, Subject: “Approval to close Barrett Adolescent Centre, The Park Centre for Mental Health”, 1 November 2012, pp 459–462. He did not approve the briefing note because he was concerned that, under the new (post 1 July 2012) structure, West Moreton HHS should be involved in the process: Transcript, Michael Cleary, 25 February 2016, p 14-25 lines 11–37.
- 63 Submissions on behalf of the State of Queensland, 23 March 2016, p 14 para 36.
- 64 Submissions on behalf of the State of Queensland, 23 March 2016, pp 14–15 para 37.

- 65 *Health Services Act 1991* (Qld) ss 7(2), 22(2), 24(2).
- 66 *Carers (Recognition) Act 2008* (Qld), ss 7–9 and Schedule 1, clauses 3–5.
- 67 Department of Health, *National Standards for Mental Health Services 2010*, Canberra: Department of Health, Australian Government, pp 4, 9, 15, 20–21, 34 (Standards 3 and 7).
- 68 Exhibit 208, *Queensland Plan for Mental Health 2007–2017*, pp 14–15 (principles 1, 4) and p 21 (priority 2).
- 69 Exhibit 1076, *Consumer, Carer and Family Participation Framework*, Queensland Mental Health Services, 2010, pp 7, 9, 13–14 (principles 2–4, 8–9).
- 70 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, pp 9–10 para 10.7, and Attachment SK-10 to that statement, p 779.
- 71 Transcript, Anthony O’Connell, 23 February 2016, p 12-54 lines 13–22.
- 72 See the discussion of this issue later in this chapter.
- 73 O’Connell gave evidence that the decision to cease the Redlands replacement of the BAC was “a big decision” and he agreed with counsel that it was a “very serious decision” even though it was not a decision to close the BAC: Transcript, Anthony O’Connell, 23 February 2016, p 12-50 line 32 – p 12-51 line 10.
- 74 Paragraph 3(g) of the Commission’s terms of reference require it to make full and careful inquiry into any alternative for the replacement of BAC that was considered, the bases for the alternative not having been adopted, and any other alternatives that ought to have been considered. The discussion of alternatives is part of a number of chapters, including chapter 14.
- 75 Transcript, Philip Hazell, 17 February 2016, p 8-33 line 43.
- 76 Exhibit 216, *Barrett Adolescent Strategy, Expert Clinical Reference Group Report: “Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)”, Version 5, Endorsed by ECRG 8 May 2016*, pp 1–2.
- 77 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, attachment LJS-7 to that statement, Media Statement by West Moreton Hospital and Health Service and Children’s Health Queensland, Subject: “Statewide focus on adolescent mental health”, dated 6 August 2013, p 57.
- 78 Transcript, Lawrence Springborg, 26 February 2016, p 15-32 lines 30–37.
- 79 Those two meetings are examined in chapters 9 and 12.
- 80 O’Connell seemed taken aback by the suggestion that the information in briefing notes might be misstated, overstated or invented. At one point he seemed to say that a fact would only appear in a briefing note if indeed it was a fact otherwise it would not so appear: Transcript, Anthony O’Connell, 23 February 2016, p 12-14 lines 4–12.
- 81 Closing submissions of Counsel Assisting, 17 March 2016, pp 75–76 para 268. It was suggested that, with respect to important decisions such as a decision to cease a capital program or close a facility, relevant Directors-General or Ministers should have been provided with much more extensive reports: Submissions on behalf of the State of Queensland, 23 March 2016, p 10 paras 21–22. Further, Counsel Assisting submitted that briefing notes often lacked supporting reports or information: Closing submissions of Counsel Assisting, 17 March 2016, p 56 para 184.
- 82 Submissions on behalf of Lawrence Springborg, 23 March 2016, p 53 para 6.17.
- 83 Transcript, Anthony O’Connell, 23 February 2016, p 12-14 lines 11–12.
- 84 Transcript, Anthony O’Connell, 23 February 2016, p 12-14 lines 23–24.
- 85 Transcript, Anthony O’Connell, 23 February 2016, p 12-14 lines 28–32.
- 86 Transcript, Anthony O’Connell, 23 February 2016, p 12-14 lines 34–41.
- 87 Submissions on behalf of Anthony O’Connell, 23 March 2016, p 22 para 71.

16 6 August 2013 to 10 September 2013

The Minister's closure announcement

The lead up to the announcement

The decision to close the BAC was announced on 6 August 2013 by the Minister for Health, Lawrence Springborg, during a radio interview with Rebecca Levingston on ABC 612.¹

Prior to the Minister's announcement, West Moreton Hospital and Health Service (HHS) and Children's Health Queensland HHS (CHQ) planned to make a joint announcement to the media on 5 August 2013.² On 4 August 2013 Naomi Ford, Manager of Communication and Community Engagement for West Moreton HHS, was advised by the Minister's Media Adviser, Cameron Thompson, that the joint announcement between West Moreton HHS and CHQ would not proceed and that the Minister's office would manage the announcement.³ After that, West Moreton HHS did not have any further involvement with the announcement.⁴

Sharon Kelly⁵ gave evidence that she was advised on 5 August 2013 that the Minister would make the announcement.⁶ As a result, she convened a meeting with BAC staff on 6 August 2013 at 3.00 pm, ahead of the Minister's announcement.⁷ Her speaking notes for that meeting record that staff were to be told that West Moreton HHS was exploring "new, state-wide options for long-term adolescent mental health treatment". Notably, the speaking notes state, "Until new options of care become available, young people requiring longer term mental health treatment will continue to be provided that care at Barrett Adolescent Centre by yourselves [BAC staff] ... [T]he complete model at this point in time is not known however we know that work will take place to phase it in by 2014".⁸ It appears that at this stage, staff were not provided with any further information about the future of their employment. Kelly gave evidence that she arranged for two senior staff to telephone staff members who were not present at the meeting.⁹

Similarly, prior to the Minister's announcement, Kelly, Trevor Sadler and Terry Stedman¹⁰ attempted to telephone the parent/carer contact for each current BAC patient to advise them of the Minister's announcement.¹¹ One parent said that Sadler and Kelly told them that "the BAC would not close until an alternative was in place" (emphasis added).¹²

On the day of the Minister's announcement, patients were informed of the decision to close the BAC by BAC staff.¹³ According to one patient, staff sat the patients down in the living room and told them "in a gentle way" that the BAC would close.¹⁴ Another patient recalled being told by Sadler that the BAC would close.¹⁵

Minister's announcement on ABC 612

On the evening of 6 August 2013, Minister Springborg gave an interview on ABC 612 radio station, during which he announced the closure of the BAC.¹⁶

An extract of the transcript of this interview is set out below:

MINISTER SPRINGBORG: So it is true that some time **by early 2014 that centre will be closing as we actually come up with a range of new options** to actually deliver those services to people closer to their own home ... but we do understand that there will need to be acute, um, inpatient type options for youth. At the moment you've only got one and that's at the Barrett and they've done an exceptionally good job. It's an ageing facility, won't be able to function much beyond this year because it's in the middle of an adult mental health facility which is going to be expanded and, of course, that carries with it some risks.

... **we expect to have the options available to people in early 2014 and the transition will start sometime in the early part of 2014 as we build up services in other areas around the State.**

...

REBECCA LEVINGSTON: So – so just – sorry, to be clear, **will you guarantee that there will be services operating that offer inpatient care for teenagers in Queensland before Barrett shuts?**

MINISTER SPRINGBORG: **That's the whole point of this is to actually leave no one who is currently a patient or resident there, and those that are hopefully on, you know, that are waiting on the list so that they can have services closer to their own home and we're allocating an additional two million dollars for that.** ...

...

... We needed to look at the whole issue **whether we should have one facility or whether we should look at having those services broken down across Queensland so that we could deliver services across the State**, not just in one consolidated area. ... And the final details to the way that's going to be worked out just – it's going through now; as I indicated we've got probably around about another 7 to 8 months before it's completely formalized, and that's been done in consultation with this expert panel. ...

... we'll have a much clearer picture by the latter stage of this year and the finer details around it will be the early part of next year.¹⁷

(emphasis added)

West Moreton HHS and its Board submitted that the Minister's announcement was consistent with the proposition that the BAC would continue to provide services until the new model for adolescent services was operational.¹⁸ The Commission accepts this submission. Notably, the Minister's announcement is consistent with what Kelly and Sadler told a parent during a telephone call on 6 August 2013 (discussed above), that the BAC would not close until an alternative was in place.¹⁹

Messages between 6 and 9 August 2013

In the days following the Minister's announcement on 6 August 2013, West Moreton HHS issued a flurry of communication to BAC staff and parents and carers of BAC patients and waitlist patients, among others. Unfortunately, these communications contained unclear, confusing and misleading messages. These communications and their messages are discussed below.

Media statement, FAQ and ECRG Recommendations sent to stakeholders

On 6 August 2013, after the Minister's announcement, Leanne Geppert sent an email to staff who were not present at the meeting with Kelly earlier that day. The following three documents were attached to the email:²⁰

- a joint media statement from West Moreton HHS and CHQ dated 6 August 2013 bearing the Queensland Government coat of arms (the media statement)
- a two page sheet of frequently asked questions (FAQ) co-authored by West Moreton HHS and CHQ released on Queensland Government letterhead
- a copy of what is described as the ECRG Recommendations Barrett Adolescent Strategy July 2013 [produced by West Moreton HHS] ("ECRG Recommendations").

These three documents are discussed in detail below. On 9 August 2013, Susan Daniel, a registered nurse at the BAC, sent the same three attachments to Sadler and BAC registered nurse Vanessa Clayworth.²¹ It is unclear whether all staff members received these documents.

On 7 August 2013, Kelly sent the same three attachments to the parents and carers of BAC patients²² and Alison Earls, founder of the Save the Barrett website and campaign (copying the Mental Health Commissioner, Lesley van Schoubroeck, into the email).²³ She also sent the three attachments to Bill Kingswell, Michael Cleary, Geppert and Lesley Dwyer, among others, on 7 August 2013.²⁴ On 9 August 2013, Daniel sent the three attachments to families and carers of waitlist patients.²⁵

The media statement

Relevantly, the media statement included the following passage:

West Moreton Hospital and Health Service Chief Executive Lesley Dwyer and Children's Health Queensland Chief Executive Dr Peter Steer today said **adolescents requiring extended mental health treatment and rehabilitation will receive services through a new range of contemporary service options from early 2014.**

Ms Dwyer said the **young people who were receiving care from Barrett Adolescent Centre at that time**, would be supported to **transition to other contemporary care options** that best meet their **individual needs**.²⁶

(emphasis added)

The first thing to note about this statement is that Steer and Dwyer did not make an announcement on 6 August 2013. Because of a last minute change of plans, it was Minister Springborg who made the announcement. This may have caused confusion for some readers.

Secondly, the media statement makes an important distinction, one that Minister Springborg did not make in his announcement on the same day. It distinguishes between "adolescents requiring extended mental health treatment" and "young people who were receiving care from the BAC at that time". Adolescents requiring extended mental health treatment were to receive "services through a new range of contemporary **service options from early 2014**", and BAC patients were to be "supported to transition to **other contemporary service options** that best meet their **individual needs**". This distinction is repeated throughout a number of West Moreton HHS's communications, including Fast Facts 6 and 7.

It is unclear whether by making this distinction, West Moreton HHS intended to communicate to readers that BAC patients were not going to receive the new services. Counsel for the State of Queensland submitted that emphasis should be placed on the words “other” and “individual” in relation to BAC patients.²⁷ Presumably this submission was made to rebuff criticism that the media statement was misleading by suggesting that the development of the new services was linked to the transition of BAC patients and the closure of the BAC. The State of Queensland’s submissions refer to evidence Kelly gave that she did not intend the media statement to convey that the existing patients would all remain at the BAC until early 2014.²⁸ However, it would have been difficult for readers to appreciate the subtle distinction between the services BAC patients were to receive and the services “adolescents requiring extended mental health treatment” were to receive. The Commission finds that the media statement was misleading because, objectively, it was open to the interpretation that young people who were receiving care from the BAC in early 2014, when new services were to become available, would be supported to transition to those new services. In other words, readers were led to believe that the development of new services and the transition of BAC patients were linked. This interpretation is consistent with the Minister’s announcement.

The FAQ

An extract of the FAQ is set out below:

What is happening to BAC?

Barrett Adolescent Centre will **continue to provide care to young people until suitable service options have been determined**. We anticipate adolescents requiring extended mental health treatment and rehabilitation will receive services through a new range of contemporary service options from early 2014.

...

What will happen to the consumers currently being treated at BAC?

West Moreton Hospital and Health Service is committed to ensuring no adolescent goes without the expert mental health care they require. The goal is to ensure our youth are cared for in an environment that is best suited for them. It is in the best interests of young people that they are not cared for in the same environment as adult mental health consumers who require high secure care.

Care coordinators and clinicians will work closely with the consumers, families and services to ensure that the appropriate care and support is provided for them.

...

What will happen to the young people currently waiting for a place in BAC?

Each individual adolescent that has been referred to the BAC and is currently on the waiting list for care will be considered on an individual basis. Clinicians will work with local and statewide services to determine how their needs can be best met in a timely manner.

...

What is the process, and how long will it take, to transfer the existing consumers to other services or facilities?

The governance of the adolescent mental health service has been handed to the Children’s Health Queensland Hospital and Health Service and an implementation group will progress

the next step. This group will use the expert clinical reference group recommendations, and broader consultation, to identify and develop the service options.

We anticipate that **some of those options will be available by early 2014.**²⁹

(emphasis added)

The messages in this FAQ were unclear and confusing. Like the Minister's announcement and the media statement, an objective reading of the FAQ was that the process of transferring existing BAC patients to other services or facilities was linked to the development of new services by Children's Health Queensland HHS. However, the FAQ uses different terminology from the media statement by stating that the BAC would "continue to provide care to young people until suitable service options have been determined". It is unclear whether "suitable service options" was a reference to existing or new services.

The FAQ states that only *some* options would be available by early 2014. This was the first time it was made clear that not all services would be available in early 2014. In contrast, the Minister stated, "we expect to have the options available to people in early 2014". These mixed messages would likely have created confusion for staff and parents and carers.

Further, the terminology used to describe the services waitlist patients were to receive ("local and statewide services"), was different from that used to describe the "new range of contemporary service options" that were being developed by CHQ. If this was an attempt to distinguish between the services waitlist patients and adolescents requiring extended mental health treatment were to receive, it is unlikely that this distinction would have been clear to readers.

The ECRG Recommendations

The "ECRG Recommendations" document attached to Geppert's email was the ECRG and Planning Group recommendations.³⁰ Like previous versions of the Planning Group recommendations, the ECRG Recommendations did not include or refer to the ECRG preamble, which is discussed in detail in chapter 10. The ECRG preamble discusses a number of important findings made by the ECRG, including, that "a design-specific and clinically staffed bed-based service is essential for adolescents who require medium-term extended care and rehabilitation".³¹ The fact that the document provided as the "ECRG Recommendations" was not a complete copy of its recommendations was misleading.

Lesley Dwyer interviewed on radio

On 8 August 2013, Chief Executive of the West Moreton HHS, Lesley Dwyer, was interviewed about the BAC by Daniel Dixon on 4ZZZ Radio.³² In the interview, Dwyer stated that West Moreton HHS had "been talking about early 2014" to close the BAC and said, "but what I will say is we will **continue to operate Barrett until, at such time, there is an agreed model and those models are up and running ...**" (emphasis added).³³

Objectively, this suggested that the development of the new services and the closure of the BAC were linked – that closure would not occur until there were new services available. What Dwyer subjectively intended to convey is not the point. The point is, objectively, *was there a basis for linking the two?* Objectively, at this point in time, there was a basis for saying that Y-PARC could be operational by early 2014, but there was no basis for saying that *models* or a combination of services would be up and running by early 2014. As to Y-PARC see Chapter 14.

In the interview, Dwyer was asked about the new services being developed:

INTERVIEWER, DANIEL DIXON: So the Expert Panel suggested that a Tier 3 service should be established to provide extended treatment and rehabilitation for adolescents with severe and persistent mental illness but the Planning Group said such models involving ‘statewide clinical bed-based service’ – I believe is the terminology they used – are essentially outmoded and not contemporary ... what kind of alternatives to that clinical bed-based service are superseding it and why is Barrett not worthwhile in that sense?

LESLEY DWYER: Look, you know, sort of, this is now really the role of the Implementation Group which will come up under the, you know, auspice of Children’s Health Queensland and, although we’re not aiming to replicate exactly the existing Barrett model of care, through the recommendations from that group, we’re looking at developing **alternate contemporary models of care and it does include a bed-based model of extended treatment and rehabilitation**. At the moment, the Barrett Centre is a 15 bed unit which offers a statewide model. We’re actually looking – and I think the Minister said this the other night – at whether or not elements of that model, which may include inpatient rehabilitation, can be replicated in other parts of the state. So what has been represented to us from that particular group – the Expert Group – is that we really need a combination and not only just from Queensland Health but working with our non-government organisations as well ... around, you know, sort of early intervention, ‘step up’ models, being able to think about which adolescents do require that intensive, you know, **sort of rehabilitation bed-based models but also then to be starting to think about what a ‘step down’ model would be as well. So it will be a combination of inpatient beds, community residential facilities** but particularly working in partnerships with other organisations.³⁴

Ultimately, the BAC closed without any new services having commenced. West Moreton HHS and its Board submitted that Dwyer’s statements were not misleading because, at the time of the interview, West Moreton HHS understood that the new models of service would be developed and implemented over the period up to and around early 2014.³⁵ Further, they submitted that Dwyer’s statements were based on her understanding (from Kingswell) that a Y-PARC model could be up and running by then.³⁶ However, Dwyer did not specifically refer to a Y-PARC in the interview, and she was plainly speaking of a wider range of facilities than just one.³⁷

Letter to a parent from Mary Corbett

On 9 August 2013, Mary Corbett (Chair of the West Moreton Board) sent a letter to a parent of a BAC patient, responding to letters the parent had sent to Kelly and Dwyer on 6 August 2013.³⁸ The parent had expressed a number of concerns, including that the ECRG report had not been provided to parents and carers.³⁹ Unfortunately Corbett’s letter in reply was not responsive to the parent’s letter. For example, she did not deal with the parent’s concern that a copy of the ECRG report had not been provided.

Corbett’s letter (on West Moreton HHS letterhead) informed the parent that CHQ would lead the development of a new model for adolescent services. The letter stated, “in the meantime the Barrett Adolescent Centre will continue to provide services until this model is **operational**” (emphasis added).⁴⁰ A similar assurance was made by the Minister during his announcement on 6 August 2013⁴¹ and Dwyer’s statements in her interview with Dixon on 8 August 2013.⁴²

Counsel for West Moreton HHS and its Board made five submissions about this letter:

1. that the letter was part of continuing correspondence and the parent was made “very clear” about what was being done for their child⁴³
2. that at the time Dwyer sent the letter “it was thought” that there would be a Y-PARC facility functioning by January 2014 and this was recorded in the July SWAETRI meeting minutes⁴⁴
3. that a number of interpretations of the letter were open⁴⁵
4. that the language of Mary Corbett’s letter borrows heavily from the Minister’s own language and that “given that the Minister for Health sits at the apex of the Queensland Public Health System, the question must be asked: How can Mary Corbett be criticised for adopting language publically broadcast by the Minister of State only three (3) days before?”⁴⁶
5. that in any event, the parent gave evidence that they realised some point in August / September 2013, that the BAC [cohort] were not going to receive services from any of the new services.⁴⁷

Counsel for the State of Queensland observed that Corbett was not questioned about the letter.⁴⁸

Viewed objectively, in the eyes of a reasonable parent reading this letter at the time, the words “in the meantime the Barrett Adolescent Centre will continue to provide services until this model is operational” meant that the development of the new services and the closure of the BAC were linked. Even if correct, West Moreton HHS’s submission that the letter was open to interpretation would be a ground for criticism, because communications to stakeholders should have been clear.

The parent who received this letter gave evidence of not receiving further correspondence from Corbett to inform them that circumstances had changed or that the information Corbett provided in the letter was no longer accurate.⁴⁹

The parent gave evidence of forwarding the letter to other parents and members of the BAC community, to reassure them that “the BAC would not be closing until the new services were available”.⁵⁰ As a result, the misleading messages in this letter were amplified.

Analysis of communications between 6 and 9 August 2013

The messages communicated to BAC staff and parents and carers of BAC patients and waitlist patients between 6 and 9 August 2013 were at times vague, unclear, inconsistent, confusing and lacking in transparency.

First, none of the communications during this period made it clear to readers or listeners that at this point in time, the development of the new services and the transition of BAC patients were being treated differently and that the timeframes for the closure of the BAC and the availability of new services were not linked. In contrast, the Minister’s announcement, Dwyer’s radio interview and Corbett’s letter to a parent, included assurances that the BAC would not close until new services were operational⁵¹ or “up and running”.⁵² These assurances would have led readers and listeners to believe that the transition of BAC patients would occur when the new services were ready. The Minister stated, “transition will start sometime in the early part of 2014”.⁵³ However, as discussed in chapter 19, transition of BAC patients commenced a short time after Anne Brennan’s appointment as acting Clinical Director of the BAC on 11 September 2013. It took place independently of the development of the new services.

Second, there were mixed messages about when the new services would be ready. In his announcement, the Minister stated “we expect to have **the options available** to people in **early 2014**” (emphasis added).⁵⁴ The media statement said the service options would be available “**from early 2014**” (emphasis added), while the FAQ informed readers that “**some**” of the options would be available “**by early 2014**” (emphasis added).

Third, the messages about the types of services being developed were confusing and inconsistent. The Minister said CHQ and West Moreton HHS were looking at “whether we should have one facility or whether we should look at having those services broken down across Queensland”. When interviewed on radio, Dwyer said “it will be a combination of inpatient beds, community residential facilities”.⁵⁵ Both the media statement and the FAQ referred to the new services as “a new range of contemporary service options”.⁵⁶

Fourth, the communications about the services BAC waitlist patients were to receive were confusing and unclear. The Minister’s announcement gave the impression that the waitlist patients would access the new services being developed by CHQ. In relation to waitlist patients, the FAQ stated, “Clinicians will work with local and statewide services to determine how their needs can be best met in a timely manner”. It is unclear whether “local and statewide services” was a reference to new or existing services.

Fifth, the communications between 6 and 9 August 2013 lacked transparency because they failed to include the following:

- findings by the ECRG contained in the ECRG preamble, including that “a design-specific and clinically staffed bed-based service is essential for adolescents who require medium-term extended care and rehabilitation”⁵⁷ and the closure of the BAC without a Tier 3 service was “associated with risk”;⁵⁸
- information about EFTRU, including that it opened on 29 July 2013⁵⁹ and details about how the risks posed by EFTRU were being managed at The Park, despite the fact that Kelly gave evidence that EFTRU posed an “unacceptable” risk to BAC patients.⁶⁰

The Commission does not criticise these communications on the basis that they were deliberately dishonest or that those responsible for issuing them intentionally excluded certain information. However, the point is that the communications did not include all the information they reasonably ought to, having regard for the circumstances at the time.

Impact of the closure announcement – atmosphere of crisis, uncertainty, turmoil and distress

Impact on patients

According to Trevor Sadler, the Minister’s closure announcement “destabilised many of the adolescents and staff”.⁶¹ A number of BAC staff have evidence that there was an increase in anxiety experienced by BAC patients after the Minister’s announcement.⁶² BAC registered nurse Brenton Page said the impact of the closure decision varied from patient to patient, according to their acuity, age and home circumstances.⁶³ This is reflected in the evidence from BAC patients. One patient said [redacted] ⁶⁴ while another said, [redacted]

[redacted] ⁶⁵

There is evidence from staff that patients expressed feelings of abandonment⁶⁶ and concerns about their future⁶⁷ and “where they would be placed”.⁶⁸ BAC registered nurse Peta-Louise Yorke recalled that [REDACTED]

[REDACTED]⁶⁹ Page said generally, outpatients (and their families and friends) appeared to handle the closure decision better than inpatients, because they had partially integrated back into their communities, and had support networks other than BAC.⁷⁰

Increased incidents reported at the BAC

BAC registered nurses Matthew Beswick, Mara Kochardy, Peta-Louise Yorke and Moira Macleod, psychiatric registrar Thomas Pettet and Sadler gave evidence that the number of incidents on the ward increased following the closure announcement. They gave examples [REDACTED]

[REDACTED].⁷¹ This meant that staff had to focus on stabilising the adolescents and managing those incidents.⁷² Pettet said in the five weeks following the closure announcement, there “were consistently patients [REDACTED]

[REDACTED].⁷³ Kochardy recalled that “when the decision to close the BAC was made the mood changed overnight. The patients [REDACTED].⁷⁴ Macleod said the increase in the [REDACTED] during this period could be verified by reviewing the PRIME clinical incident reports logged from the date of the closure announcement.⁷⁵ Sadler gave similar evidence.⁷⁶

The PRIME reports are part of the Queensland Health clinical incident reporting system. The PRIME system allows incidents to be logged centrally under an incident category and type.⁷⁷ Raw incident data from BAC PRIME reports between 1 January 2005 and 8 January 2014⁷⁸ were produced to the Commission.⁷⁹ The raw incident data demonstrate that from 2010 onwards, the majority of incidents were recorded in the ‘behavioural’ incident category.⁸⁰ A draft *Prime Clinical Incident Dictionary and Guide for Use*, which appears to have been updated in August 2014, notes that the ‘behavioural’ category refers to actions to/by the patient and incidents logged within this category are usually ones that end up in restraint or seclusion.⁸¹

The raw incident data from BAC PRIME reports between 1 January 2005 and 8 January 2014⁸² are depicted in Figure 16A. The impact of the closure announcement on the number of reported incidents at the BAC needs to be examined in the context of long term reported incidents. From Figure 16A it is clear that there was a downward trend in reported incidents at the BAC between 1 January 2005 and January 2014. Although Figure 16A shows that during the period of July 2013 to September 2013 (immediately before and after the Minister’s announcement) there was an increase in reported incidents, it is clear that this period was no different from the long term trend, particularly considering the variability in the number of reported incidents over time.

Unfortunately, not much can be gleaned from the raw incident data from the PRIME reports because the number of PRIME reported incidents is dependent on reporting practices. The Commission does not have sufficient evidence to draw conclusions about whether there were any changes to reporting practices around the time of the closure announcement or whether there was actually an increase in incidents at the BAC.

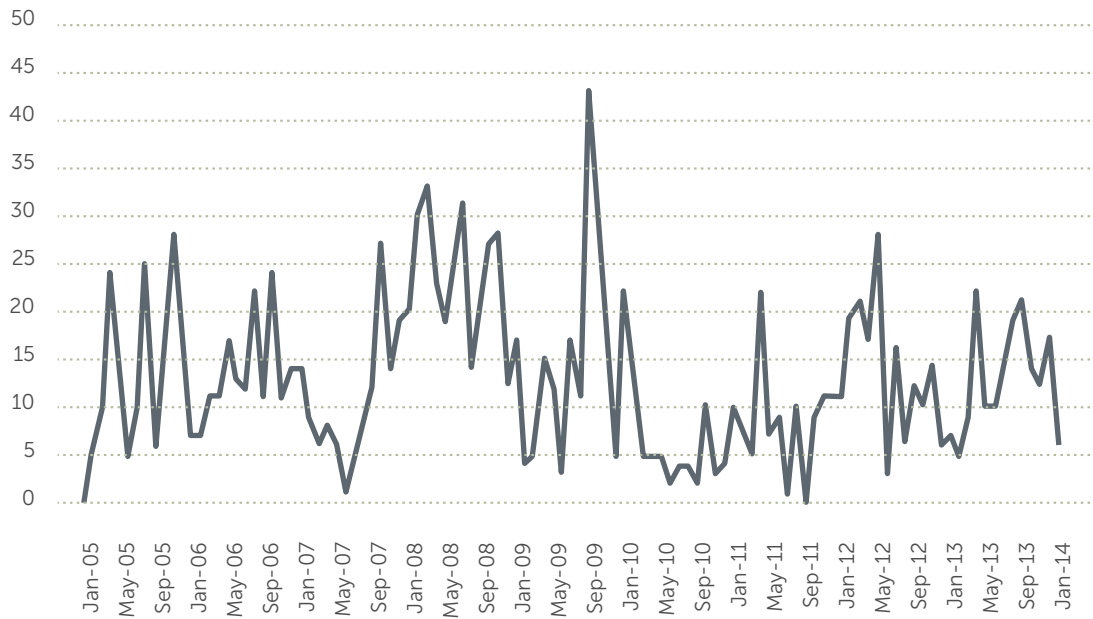


Figure 16A: Number of reported PRIME clinical incidents at the BAC by month between 1 January 2005 and 8 January 2014

Impact on families

A number of BAC parents and carers gave evidence that they were concerned about their children's future following the closure announcement.⁸³ One parent said, "There was confusion about the closure, what the plan was for the children and what was going to happen to them. In the last few weeks, the BAC went from being a very structured environment to a mess". The parent said it was "traumatising for the children and this transferred to the staff and families".⁸⁴ Another parent gave evidence of being concerned that they "couldn't see a model that would cater for all aspects of youth mental health that didn't involve a facility like BAC".⁸⁵

A number of BAC staff members observed that the closure announcement had an impact on families.⁸⁶ Rosangela Richardson (BAC registered nurse) recalled that following the closure announcement, nursing staff needed to provide support to patients' families as they were "very concerned about the future for their children".⁸⁷

Impact on staff

Nearly all staff who provided statements to the Commission gave evidence of experiencing increased levels of stress, anxiety or confusion after the closure announcement.⁸⁸ Many BAC staff said they were torn between two immediate concerns: their future employment and the future of the patients.⁸⁹ Kochardy recalled seeing staff "upset for the distress caused to the patients" and believed that there was an increase in sick leave taken by staff following the closure announcement.⁹⁰ BAC registered nurse, Lourdes Wong said, "I still cared a lot about the well-being of the patients and their future well-being but the job insecurity affected me psychologically".⁹¹

Following the announcement, some staff held hope that the BAC would not close. For example, registered nurse at the BAC, Peter Kop, sent an email to Minister Springborg on 19 August 2013 urging him to "Save the Barrett".⁹² Lorraine Dowell, Team Leader of Allied Health Non-Secure

Services, said, "For some staff, the announcement was probably a confirmation of what they already expected or thought may happen". She said other staff believed that the BAC might not close because previous attempts to close it had been unsuccessful.⁹³ BAC registered nurse Kimberley Sadler gave evidence that many staff members believed the "BAC would be 'saved'". She said "As a result ... there seemed to be no motivation to prepare clients in the practical skills needed in the community as part of comprehensive transition arrangements".⁹⁴ This is consistent with the Commission's finding that prior to Anne Brennan's appointment on 11 September 2013, very little by way of transitioning BAC patients was done, which is discussed below.

Dowell gave evidence that some staff said the decision to close the BAC without a replacement facility reflected that the "BAC and the model of care was not valued and/or adolescent complex care needs were not important to relevant decision makers or the clinical community".⁹⁵

Loss of staff expertise

Prior to the closure announcement on 6 August 2013, there had been staff losses for some time and the closure announcement added to these problems. In 2003, a review of the BAC found the "ongoing funding uncertainty hampered the capacity of the BAC to recruit and retain high quality staff".⁹⁶ The proposed Redlands relocation (which staff became aware of in 2009)⁹⁷ created uncertainty for staff as it was not clear who would be transferred to the new site.⁹⁸ Described by Beswick as "the start of the 'brain drain'", experienced staff started to leave and were replaced by less experienced nurses.⁹⁹

The subsequent cancellation of the Redlands Project in August 2012 and Brett McDermott's disclosure in November 2012, created more uncertainty for BAC staff.¹⁰⁰ In 2012, another review of the BAC found that the "current staffing mix is not the most appropriate for provision of [extended treatment] adolescent services"¹⁰¹ and there was an "over reliance upon casual staff as a result of uncertainty" regarding relocation to Redlands.¹⁰² There is evidence that a number of staff left the BAC between November 2012 and August 2013.¹⁰³

Several witnesses gave evidence that the closure announcement added to the staffing problems at the BAC.¹⁰⁴ Beswick described the closure announcement as a "final blow" and said experienced staff members began to leave and were replaced with contract staff, agency and nursing pool staff.¹⁰⁵ According to Sadler, "by September 2013, there was a lot of instability in relation to nursing staff". He said, "there were many casual nurses and nurses on short term contracts of between three and six months. Many of those staff had little experience with adolescents".¹⁰⁶ Despite this evidence, the Commission was unable to find any specific examples of permanent staff members resigning, accepting voluntary redundancies or being redeployed in the time period directly following the closure announcement.¹⁰⁷ Rather, there are numerous examples of staff members resigning or taking voluntary redundancies in the first half of 2013,¹⁰⁸ or staff being redeployed, transferred or taking voluntary redundancies in very late 2013 or early 2014.¹⁰⁹ The impacts of the staffing issues during the transition process are discussed in chapter 20.

Messages between 23 and 30 August 2013

After the period 6 to 9 August 2013, there were no communications issued by West Moreton HHS or Children's Health Queensland HHS to BAC staff and parents and carers of BAC patients and waitlist patients until Fast Facts 6 was issued on 23 August 2013.¹¹⁰ Fast Facts 6 was issued a little over three months after Fast Facts 5 was issued on 21 May 2013.

Fast Facts 6

Like the media statement sent to staff and parents/carers of BAC patients and waitlist patients after the closure announcement, Fast Facts 6 makes the distinction between “adolescents requiring extended mental health treatment and rehabilitation” who would receive “services through a range of new contemporary service options” and “young people receiving care from the BAC at that time” who would be transitioned to “other contemporary care options”.¹¹¹

Fast Facts 6 further explained that “This is about implementing the work already done by the ECRG, and focusing our efforts on the final stages of the strategy so we are **ready to deliver new service options by early 2014**” (emphasis added). Readers were assured that “there will be no gap to service provision to young people currently receiving care from BAC”.¹¹² This statement was misleading for two reasons.

First, West Moreton HHS was not responsible for the development and implementation of the new service options. It is uncontroversial that it was CHQ that had that responsibility.

Second, Fast Facts 6 did not make it clear that, as at this point in time, there was no expectation on the part of CHQ (those responsible for the new services), or West Moreton HHS, that the *whole suite* of services would be available by early 2014. Fast Facts 6 conveyed mixed messages about when the new services would be ready. At one point it said, “adolescents requiring extended mental health treatment and rehabilitation will receive services through a new range of contemporary service options **from early 2014**”. It later said, “this is about implementing the work already done by the ECRG ... so we are ready to deliver new service options **by early 2014**”.

The State of Queensland submitted that from an early version of CHQ’s revised draft SWAETRI Project Plan dated 16 August 2013¹¹³ (“draft August project plan”) and the oral evidence of Peter Steer, Chief Executive of CHQ, it was clear that the comprehensive nature of the new service model meant that it would not be ready within six months.¹¹⁴ The Commission accepts this submission.

The draft August project plan stated, “not **all** alternative service options will necessarily be available in early 2014” (emphasis added).¹¹⁵ It further noted “sites for delivery of any potential bed based service option eg YPARC will be identified and negotiations regarding governance will be held as a priority”. The draft August plan is discussed further in Chapter 26. Under cross examination, in response to questions about a 12 November 2013 email between Kingswell and Michael Cleary, Steer said:

STEER: ... right from August [he is referring to the August draft Project Plan] we’ve made it very clear that the comprehensive nature – the five elements of the new service model would not be ready within the six months. **That was made very clear both within the project scope, business case and in fact in communication with parents.**

FREEBURN: Well, at this time, wasn’t Children’s Health Queensland saying to West Moreton that some of the future service options won’t be fully operational for possibly 12 months?

STEER: **We were clear about that particular issue, as I’ve said to you, from documentation as early as August 2013 so that should not have been news to Lesley Dwyer and I’m sure it wasn’t news to Lesley Dwyer or anybody as – as late as November 2013.**¹¹⁶

(emphasis added)

Letter to a parent from Steer

On or about 28 August 2013, Steer responded to a letter from a parent dated 19 August 2013, in which the parent began by outlining concerns as follows:

My distinct concerns are for the gap in services for a specific group of youth that will be created by the closure of Barrett, and the short time frame that the Government states it will have a network of services in place, to which the current patients of the centre can transition. The process by which this is to be achieved also seems at odds with the government's legislated process involving the Mental Health Commission and Mental Health Drug and Alcohol Advisory Council.¹¹⁷

In response, Steer borrowed from the language used in the first paragraph of Fast Facts 6, which is discussed above:

As identified in the Health Minister's announcement adolescents requiring extended mental health treatment and rehabilitation **will receive services through a new range of contemporary service options from early 2014**. Young people receiving care from Barrett Adolescent Centre **at that time** will be supported to transition to **other contemporary care options** that best meet their individual needs.¹¹⁸

(emphasis added)

Meeting of a parent and Earls with Dwyer, Kelly and Stathis

On 30 August 2013, there was a meeting attended by a parent, Alison Earls, Dwyer, Kelly and Stephen Stathis, Clinical Director of Child and Youth Mental Health Services, CHQ.¹¹⁹

The parent gave evidence that at the meeting, Earls and the parent raised the "poor communication" and "lack of consultation with parents/carers/community"¹²⁰ and "the tight time frame for the development and delivery of the new services".¹²¹ The parent said:

All of the discussions at this meeting were about the new services in the context of the closure of the BAC. There was no distinction made at this time by Ms Dwyer, Ms Kelly or Dr Stathis that any of the new services in the model would not be available for BAC patients being transitioned out of the BAC upon its closure. I left this meeting thinking that the plan was that the BAC would not be closing before the new services were up and running.¹²²

The parent also said that the mixed messages in relation to the "kinds of services that would be available in the future" were discussed.¹²³ The parent said that in the meeting, particular focus was given to the need for a Tier 3 extended inpatient service in a future model, which the parent "understood ... to be a facility".¹²⁴

Trevor Sadler's absence

Late in the afternoon of Monday 2 September 2013 Sadler underwent surgery to his left elbow for an injury he had sustained in a bike accident.¹²⁵ Sadler called the BAC that night and spoke to Kochardy, who informed him of an incident [REDACTED]

[REDACTED]¹²⁶ Sadler was discharged from hospital the next day, and attended at the BAC that afternoon.¹²⁷ He gave evidence that during that following week he was recovering from the surgery and was at work for "limited periods".¹²⁸

The incident was [REDACTED]

[REDACTED]¹²⁹

On [REDACTED] the incident was [REDACTED]

[REDACTED]¹³⁰

Standing down of Trevor Sadler

Sadler was stood down on 10 September 2013. The decision was made by Dwyer on the advice of Kelly.¹³¹ Dwyer said she considered it necessary to stand Sadler down while external investigations into the alleged incident were conducted. She said:

... Dr Sadler's failure to take any action in response to [the] complaints, if proven, represented a very significant failure of governance and would reflect a gross lack of insight into his responsibilities in the unit.¹³²

Communication to staff

The day after Sadler was stood down, Kelly met with BAC staff.¹³³ There is conflicting evidence about what staff were told during this meeting. A number of staff said they were told that Sadler was taking leave or was on holidays, and were not aware that he had been stood down until much later.¹³⁴ In contrast, Pettet recalled that all staff were told that Sadler had been stood down.¹³⁵ Kelly could not recall the meeting described by staff, nor whether a decision was made to tell staff or patients that Sadler was on leave.¹³⁶ Dwyer gave evidence that she neither gave any directive, nor was aware of any directive being given by another West Moreton HHS staff member, that the BAC staff and patients were to be told Sadler was on leave.¹³⁷

Clayworth and Megan Hayes recalled being told by either Dwyer or Kelly that other staff members were not to communicate with Sadler.¹³⁸ Sadler said he was told by Kelly that staff had been instructed not to have contact with him.¹³⁹

Impact on staff

Sadler's standing down was not well received by many BAC staff members. Beswick described it as an "overwhelmingly negative experience for everyone involved".¹⁴⁰ He said most or all staff "held Dr Sadler in high regard" and felt that he was [REDACTED]¹⁴¹ He felt that Sadler's departure "left a great hole in the unit".¹⁴²

A number of staff have evidence that the timing of Sadler's departure had a negative impact on the staff and patients at the BAC.¹⁴³ Daniel gave evidence Sadler's departure was "at a most critical time" because staff had recently learned that [the BAC] was to close and the person who was most central in the multi-disciplinary team and had been at the BAC for a long time was removed".¹⁴⁴ She said his leaving at this time was "a significant blow to staff and patient morale".¹⁴⁵ Similarly, Macleod said Sadler's departure was "at a time when he was really needed".¹⁴⁶ Macleod explained that Sadler "had always been available to provide guidance to all the BAC staff"¹⁴⁷ and:

... was the heart of the BAC service. He cared deeply for the young people in our care and had a wonderful rapport with all of them. His patience made them all feel that they mattered. Because of this and the uncertainty created by the closure announcement, his presence and involvement in the transitioning of the young adults would have been reassuring for them at a vulnerable time.¹⁴⁸

Communication to parents

Geppert gave evidence that she, Kelly and Neillie jointly called the parent or carer contact for each BAC patient to inform them of Sadler's standing down. She recalled that not all calls were answered during their first attempt. It is unclear whether further attempts were made. Geppert said the following messages were communicated to the parents and carers:

- a. An incident of a serious nature had been reported.
- b. WMHHS would need to consider the allegations which had been made and investigate the matter.
- c. WMHHS considered it was appropriate to have Dr Sadler not involved during the course of the investigation.
- d. This would not affect the care of their adolescent. Clinical and other care would continue to be provided as usual and an acting Clinical Director would be appointed.¹⁴⁹

The evidence from parents and carers reveals that they were informed of Sadler's standing down through a variety of means. Three parents recalled being told by their child at the BAC,¹⁵⁰ one parent received a telephone call from a journalist,¹⁵¹ another was told by a BAC nurse,¹⁵² and another received telephone call from the "head psychiatrist at the BAC".¹⁵³ It is unclear who the parent meant by "the head psychiatrist at the BAC". There is limited evidence from families about what they were told about the circumstances surrounding Sadler's standing down.

On 25 September 2013, Kelly sent an email to BAC parents and carers which stated, "You are aware there have been a number of changes in the BAC from both a clinical and operational governance perspective recently, in response to alleged incidents [redacted]. An investigation has commenced, and a range of actions have been swiftly initiated to ensure the safety and continuity of care for BAC consumers while the investigation is being undertaken".¹⁵⁴ There is no evidence to explain the delay between Sadler's standing down on 10 September 2013 and this email on 25 September 2013.

Notably, none of the Fast Facts mentioned the removal of Sadler. Fast Facts 7, which was issued on 26 September 2013, merely informed readers that Anne Brennan had commenced as acting Clinical Director of the BAC.¹⁵⁵

Impact on parents and carers

One parent said, following advice that Sadler had been stood down, they contacted clinical staff at the BAC to ask for information. The parent said, "I was very frustrated and getting worried at not knowing what was happening".¹⁵⁶

It appears that media reports about Sadler's standing down caused some parents distress. One parent said on 12 September 2012 they read a news article about statements made by Minister Springborg in Parliament about Sadler's standing down. The article misreported that Minister Springborg had implied that Sadler was involved in the incident.¹⁵⁷ Another parent was provided with the same information when they were contacted by a journalist.¹⁵⁸ Both parents said the news was distressing.¹⁵⁹ One of the parents sent an email to Dwyer on 12 September 2013 "asking why parents were not informed of the circumstances surrounding Dr Sadler's removal".¹⁶⁰ The other parent contacted Kelly about "the way it had been conveyed to the public as it was very upsetting for the young people at the BAC".¹⁶¹

Communication to patients

It is unclear how patients were informed about Sadler's departure and what details were provided to them. Beswick said there was a meeting with Anne Brennan and Elisabeth Hoehn during which the patients were told "there had been an incident which was under investigation and that Dr Sadler would not be working at the BAC until the investigation was finished".¹⁶² It is unclear when this meeting was held.

Impact on patients

There is evidence from patients,¹⁶³ parents¹⁶⁴ and staff¹⁶⁵ that Sadler's standing down had an impact on many of the BAC patients. One patient gave evidence that "There was a lot of anger around Sadler's dismissal and fear that once he was gone, the government could do what they wanted". The patient said, "I do not believe the government's reason for suspending him".¹⁶⁶

A number of parents gave evidence that the standing down of Sadler was upsetting for their child.¹⁶⁷ One parent said their child "was concerned about starting with a new doctor and thought it would [redacted]".¹⁶⁸ Another parent said [redacted] after Sadler's standing down. They said their child "was very worried about ... friends at the BAC because they all adored Sadler, and took it really hard".¹⁶⁹ Another parent said their child told them that "all the young people were extremely upset and angry and crying" when they were told that Sadler had been stood down.¹⁷⁰

A number of staff recalled that Sadler's departure impacted on the care of patients.¹⁷¹ Beswick said despite Anne Brennan, who was appointed acting Clinical Director of the BAC on 11 September 2013, being a "competent, honest and hardworking clinician", Sadler's "absence was disruptive in the extreme".¹⁷² He explained that "The patients had to establish a rapport with a new consultant who did not know them and would be making major decisions about their future care".¹⁷³ Clayworth gave similar evidence. She said, following Sadler's departure, BAC patients were having "difficulty with Dr Sadler leaving, Dr Brennan coming in [and] they were having trouble identifying with somebody that they could trust".¹⁷⁴

In her evidence, Hayes made the point that Sadler had "comprehensive knowledge of each adolescent's clinical presentation and had developed a therapeutic rapport which would have been invaluable to the transition process".¹⁷⁵ Sadler himself gave evidence that he was "shocked" by the decision to stand him down and that his standing down would have had

“adverse implications for many of the adolescents, where a sense of stability was essential to their progress”.¹⁷⁶

In cross examination, Kelly was questioned about whether she considered the potential impact on BAC patients of standing down Sadler:

- FREEBURN: [D]id it cross your mind that it might affect the transition process to stand down Dr Sadler?
- KELLY: Standing down Dr Sadler was part of the process around good clinical governance. And – however, we had certainly identified within – at that period of time that we could find someone from within the children’s cohort to replace him at that particular point in time.
- FREEBURN: But that was always going to be beset by difficulties, wasn’t it, bringing in somebody new into the transition process?
- KELLY: It – it created an extra challenge that we didn’t necessarily need, but it was an appropriate response for us in regards to what had occurred.¹⁷⁷

Timothy Eltham, Deputy Chair of the West Moreton Board, was asked the same question. He was of the view that Dwyer’s quick action in replacing Sadler with Anne Brennan minimised any disruption to the patients’ transition process.¹⁷⁸

In the 2014 health services investigation, Beth Kotzé and Tania Skippen were provided with raw incident data from BAC PRIME reports after the closure announcement.¹⁷⁹ Kotzé said:

The PRIME reports have not been cross-matched with the individual clinical files to establish that all incidents recorded in the clinical files had been captured in the formal incident reporting system. It is superficially understood that the standing down of Dr Sadler had some relationship to incident reporting practices on the Unit. It is not known if this was significant in changing incident reporting practices on the Unit before and after the standing down of Dr Sadler. **Nevertheless, it is apparent on review of the clinical files that increased incidents can be gleaned in consumers for whom [REDACTED]. This is a predictable clinical scenario and was dealt with in an expert manner by staff.**¹⁸⁰

(emphasis added)

They made a finding that:

The process of transitional planning occurred in an atmosphere of crisis consequent to the announcement of the closure and the standing-down of the senior leader of the service in the context of an unrelated matter, with escalation of distress in a number of the adolescents and staff of BAC. There appears to have been a contagion effect of distress and anxiety amongst the adolescents and an increase in incidents on the unit.¹⁸¹

In her statement to the Commission, Kotzé elaborated on this finding. She said while it was “not surprising that the standing down of Dr Sadler, the announcement of the closure and the general reaction of staff, patients and families gave rise to distress and anxiety and that some individuals would [REDACTED] ... “it was not possible to quantify the relative contribution of the closure or the standing down of Dr Sadler to the atmosphere of crisis”.¹⁸²

Nothing started by way of transition arrangements other than business as usual treatment

Counsel for the State of Queensland submitted that prior to the standing down of Sadler on 10 September 2013, no closure related transition planning had taken place.¹⁸³ The evidence supports this submission.

Clayworth gave evidence that when she joined the Clinical Care Transitional Panel on 30 September 2013, transitional arrangements had only been considered in the course of normal discharge planning.¹⁸⁴ She said, "... Dr Sadler had great hope that Barrett would continue as a service in another location, so no transition plans had yet been actioned at that time".¹⁸⁵

Anne Brennan also said that when she took on the role of acting Clinical Director of the BAC, she understood that she would be assuming responsibility for the clinical care of patients, and, given that the BAC would be closing, the implementation of existing transition plans.¹⁸⁶ In response to questioning from Counsel Assisting the Commission, Anne Brennan said:

MUIR: So without any handover, am I correct in understanding your evidence that it became pretty clear to you when you started on the job that, in fact, you had to devise transition plans, implement those plans and see to the clinical care of the patients more generally?

BRENNAN: That's correct.¹⁸⁷

The following chapter discusses the appointment of Anne Brennan as acting Clinical Director of the BAC.

(Endnotes)

- 1 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, p 12 para 62; Exhibit 307, Transcript of ABC 612 interview with Lawrence Springborg, 6 August 2013.
- 2 Exhibit 51, Statement of Naomi Ford, 1 December 2015, p 5 para 20; Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 13 para 11.14.
- 3 Exhibit 51, Statement of Naomi Ford, 1 December 2015, p 5 para 21.
- 4 Exhibit 51, Statement of Naomi Ford, 1 December 2015, p 5 para 21.
- 5 Executive Director, Mental Health and Specialised Services, West Moreton HHS.
- 6 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 13 para 11.14; p 31 para 20.1(a).
- 7 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 31 para 20.1(a).
- 8 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment SK-30 to that statement, Speaking Notes, Sharon Kelly, 5 August 2013, p 1061.
- 9 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 31 para 20.1(a).
- 10 Director of Clinical Services, The Park Centre for Mental Health.
- 11 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 28 para 19.4; Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 50 para 238.
- 12 Confidential exhibit.
- 13 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 50 para 237.
- 14 Confidential exhibit.
- 15 Confidential exhibit.
- 16 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, p 12 para 62; Exhibit 307, Transcript of ABC 612 interview with Lawrence Springborg, 6 August 2013, pp 1–3.
- 17 Exhibit 307, Transcript of ABC 612 interview with Lawrence Springborg, 6 August 2013.
- 18 Further submissions on behalf of West Moreton HHS and Board on Corbett's letter and Fast Facts, 14 April 2016, p 2 para 5.

- 19 Confidential exhibit.
- 20 Exhibit 129, Statement of Ashleigh Trinder, 30 October 2015, Attachment AT-4 to that statement, Email from Leanne Geppert to Ashleigh Trinder, Subject: "Barrett Adolescent Strategy Update", 6 August 2013, p 49; Exhibit 1501, Email from Leanne Geppert to Danielle Corbett, Subject: "Barrett Adolescent Strategy Update", 6 August 2013; Statement of Angela Clarke, 20 November 2015, Attachment AC-11 to that statement, Email from Leanne Geppert to Angela Clarke, Subject: "Barrett Adolescent Strategy Update", 6 August 2013, p 75; see in particular Exhibit 62, Statement of Megan Hayes, 19 November 2015, Attachment MH-03 to that statement, Email from Leanne Geppert to Megan Hayes, Subject: "Barrett Adolescent Strategy Update", 6 August 2013, p 38.
- 21 Exhibit 959, Email from Susan Daniel to Laura Fay, Subject: "Future of the Barrett Adolescent Centre", 9 August 2013.
- 22 Exhibit 66, Statement of Sharon Kelly, 19 October 2015, p 29 para 19.5, Attachment SK-25 to that statement, Email from Sharon Kelly to parents/carers of BAC patients, Subject: "announcement regarding Barrett Adolescent Centre", 6 August 2013, p 951.
- 23 Exhibit 130, Statement of Lesley van Schoubroeck, 3 December 2015, Attachment L to that statement, Email from Sharon Kelly to Alison Earls, Subject: "TRIM: announcement regarding Barrett Adolescent Strategy", 7 August 2013, p 115.
- 24 Exhibit 223, Email from Sharon Kelly to Bill Kingswell, Leanne Geppert, Marie Kelly, Michael Cleary, and Lesley Dwyer, Subject: "progression of the Barrett Adolescent Strategy", 7 August 2013.
- 25 Exhibit 960, Letter from Sue Daniel to parents regarding the future of the Barrett Adolescent Centre, 9 August 2013.
- 26 Exhibit 62, Statement of Megan Hayes, 20 November 2015, p 17, Attachment MH-03 to that statement, Media Statement "Statewide focus on adolescent mental health", dated 6 August 2013, p 48.
- 27 Supplementary submissions on behalf of the State of Queensland, 14 April 2016, p 18 para 64(b) (with respect to the same language used in a letter from Sharon Kelly on 7 August 2013).
- 28 Supplementary submissions on behalf of the State of Queensland 14 April 2016, p 18 para 63; Transcript, Sharon Kelly, 22 February 2016, p 11-65 lines 29–45.
- 29 Exhibit 1236, BAC FAQ sent to families following the closure announcement, undated.
- 30 The only difference between this document and the ECRG Planning Group recommendations was that references to "accept with caveats" in the Planning Group recommendations were replaced with "accept with considerations".
- 31 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG 8 May 2016, p 2.
- 32 Exhibit 1371, Lesley Dwyer interview on 4ZZZ Radio, 8 August 2013, p 1.
- 33 Exhibit 1371, Lesley Dwyer interview on 4ZZZ Radio, 8 August 2013, p 2.
- 34 Exhibit 1371, Lesley Dwyer interview on 4ZZZ Radio, 8 August 2013, p 2.
- 35 Submissions on behalf of West Moreton HHS, in response to further submissions of [confidential], 12 May 2016, p 2 with reference to evidence of Lesley Dwyer (Transcript, Lesley Dwyer, 23 February 2016, p 12-103 lines 25–36) that her understanding as at August 2013 was that the YPARC model could be tendered for and put in place by January 2014.
- 36 Submissions on behalf of West Moreton HHS, in response to further submissions of [confidential], 12 May 2016, p 2.
- 37 See for example: the expressions "alternate contemporary models of care" and "a combination of inpatient beds, community residential facilities".
- 38 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment 32 to that statement, pp 275–280; Confidential exhibit.
- 39 Confidential exhibit.
- 40 Confidential exhibit; Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment 32 to that statement, p 280.
- 41 The Minister said "that's the whole point" when he was asked if he could guarantee that, before the BAC closed, a range of new options would be available to BAC patients and the BAC waitlist patients who required extended treatment and rehabilitation; see Exhibit 307, Transcript of ABC 612 interview with Lawrence Springborg, 6 August 2013.
- 42 Lesley Dwyer said, "we will continue to operate Barrett until, at such time, there is an agreed model and those models are up and running ..."; see: Exhibit 1371, Lesley Dwyer interview on 4ZZZ Radio, 8 August 2013, p 2.
- 43 Transcript, Kathryn McMillan QC, Closing submissions on behalf of West Moreton HHS and Board, 15 April 2016, pp 28-61 lines 29–32.
- 44 Transcript, Kathryn McMillan QC, Closing submissions on behalf of West Moreton HHS and Board, 15 April 2016, p 28-61 lines 29–32.
- 45 Transcript, Kathryn McMillan QC, Closing submissions on behalf of West Moreton HHS and Board, 15 April 2016, p 28-61 line 44.
- 46 Further submissions on behalf of West Moreton HHS and Board on Corbett's letter and Fast Facts, 14 April 2016, p 2 para 5.
- 47 Transcript, Kathryn McMillan QC, Closing submissions on behalf of West Moreton HHS and Board, 15 April 2016, p 28-62 lines 36–40.
- 48 Supplementary submissions on behalf of the State of Queensland, 14 April 2016, p 18 para 67.

- 49 Transcript, closed hearing.
- 50 Confidential exhibit.
- 51 The Minister's announcement and Corbett's letter to a parent on 9 August 2013. See: Exhibit 307, Transcript of ABC 612 interview with Lawrence Springborg, 6 August 2013; and Exhibit 1371, Lesley Dwyer interview on 4ZZZ Radio, 8 August 2013, p 2.
- 52 Exhibit 1371, Lesley Dwyer interview on 4ZZZ Radio, 8 August 2013, p 2.
- 53 Exhibit 307, Transcript of ABC 612 interview with Lawrence Springborg, 6 August 2013.
- 54 Exhibit 307, Transcript of ABC 612 interview with Lawrence Springborg, 6 August 2013.
- 55 Exhibit 1371, Lesley Dwyer interview on 4ZZZ Radio, 8 August 2013, p 2.
- 56 Exhibit 62, Statement of Megan Hayes, 20 November 2015, p 17, Attachment MH-03 to that statement, Media Statement "Statewide focus on adolescent mental health", 6 August 2013, p 48; Exhibit 1236, BAC FAQ sent to families following the closure announcement, undated.
- 57 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG 8 May 2016, p 2.
- 58 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG 8 May 2016, p 4.
- 59 Exhibit 986, Second supplementary statement of Mary Corbett, 22 March 2016, Attachment MC-1 to that statement, West Moreton HHB Meeting Agenda Paper, 23 August 2013, p 7.
- 60 Exhibit 66, Statement of Sharon Kelly, 19 October 2015, p 12 para 11.11(b).
- 61 Exhibit 254, Third supplementary statement of Trevor Sadler, 26 February 2016, p 2 para 7; p 4 para 15.
- 62 Exhibit 254, Third supplementary statement of Trevor Sadler, 26 February 2016, p 2 para 7; Exhibit 69, Statement of Mara Kochardy, 29 October 2015, p 15 para 30(b) and (c); Exhibit 77, Statement of Moira Macleod, 5 November 2015, p 12 para 30(b); Exhibit 109, Statement of Rosangela Richardson, 30 October 2015, p 13 para 30(a); Exhibit 142, Statement of Peta-Louise Yorke, 2 November 2015, p 13 para 30(a)–(c); Exhibit 728, Statement of Liam Huxter, undated, p 8 para 17(a).
- 63 Exhibit 97, Statement of Brenton Page, 16 December 2015, p 8 para 15.1.
- 64 Confidential exhibit.
- 65 Confidential exhibit.
- 66 Exhibit 143, Statement of Victoria Young, 30 October 2015, p 11 para 30(c); Exhibit 142, Statement of Peta-Louise Yorke, 2 November 2015, p 13 para 30(a).
- 67 Exhibit 142, Statement of Peta-Louise Yorke, 2 November 2015, p 13 para 30(a).
- 68 Exhibit 23, Statement of Matthew Beswick, 30 October 2015, p 15 para 30(d).
- 69 Exhibit 142, Statement of Peta-Louise Yorke, 2 November 2015, p 13 para 30(c).
- 70 Exhibit 97, Statement of Brenton Page, 16 December 2015, p 8 para 15.2.
- 71 Exhibit 69, Statement of Mara Kochardy, 29 October 2015, [redacted] Exhibit 23, Statement of Matthew Beswick, 30 October 2015, [redacted]; Exhibit 142, Statement of Peta-Louise Yorke, 2 November 2015, [redacted] Exhibit 103, Statement of Thomas Pettet, 4 December 2015, p 5 para 35.
- 72 Transcript, Trevor Sadler, 9 March 2016, p 23–63 lines 31–32; Exhibit 103, Statement of Thomas Pettet, 4 December 2015, p 5 para 35; Exhibit 69, Statement of Mara Kochardy, 29 October 2015, p 15 para 30(e).
- 73 Exhibit 103, Statement of Thomas Pettet, 4 December 2015, p 5 para 35.
- 74 Exhibit 69, Statement of Mara Kochardy, 29 October 2015, [redacted]
- 75 Exhibit 77, Statement of Moira Macleod, 5 November 2015, [redacted]
- 76 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 50 para 239.
- 77 Exhibit 1125, Patient Safety and Quality Improvement Service, Training Script – How to report a clinical incident in PRIME CI, Centre for Healthcare Improvement, 3 March 2011, p 9. Sharon Kelly described the PRIME system as follows: "... if an issue occurs that has an outcome for a consumer or a patient it is reported in the PRIME system as something that occurs at the time, and then it creates a feedback loop. So we can address any issues, whether they be individual issues or becoming more system issues if – we look at PRIME on a – so that's what the PRIME system is; it's a state-wide-led system", see: Transcript, Sharon Kelly, 22 February 2016, p 11–35 lines 28–33.
- 78 Exhibit 684, Spreadsheet of data exported from PRIME relating to Barrett Adolescent Centre, from 2005 to 2013.
- 79 It does not appear that any PRIME incidents were logged after 8 January 2014.
- 80 Exhibit 684, Spreadsheet of data exported from PRIME relating to Barrett Adolescent Centre, from 2005 to 2013. There was a dearth of evidence on why reporting practices changed in 2010.
- 81 Exhibit 1126, Draft Prime Clinical Incident Dictionary and Guide for Use, Version 6.6, Queensland Health, August 2014, p 26.
- 82 Exhibit 684, Spreadsheet of data exported from PRIME relating to Barrett Adolescent Centre, from 2005 to 2013.

- 83 Confidential exhibits.
- 84 Confidential exhibit.
- 85 Confidential exhibit.
- 86 Exhibit 142, Statement of Peta-Louise Yorke, 2 November 2015, p 13 para 30(d); Exhibit 77, Statement of Moira Macleod, 5 November 2015, p 12 para 30(c); Exhibit 109, Statement of Rosangela Richardson, 30 October 2015, pp 13–14 para 30(f)–(g); Exhibit 69, Statement of Mara Kochardy, 29 October 2015, p 15 para 30(c); Exhibit 728, Statement of Liam Huxter, undated, p 8 para 17(a).
- 87 Exhibit 109, Statement of Rosangela Richardson, 30 October 2015, pp 13–14 para 30(f)–(g).
- 88 See Exhibit 971, Supplementary statement of Megan Hayes, 2 March 2016, p 3 para 2.2; Exhibit 36, Statement of Angela Clarke, 20 November 2015, p 38 paras 18.1–18.2; Exhibit 113, Statement of Stephen Sault, 15 December 2015, p 14 para 14(b) and p 24 para 26(c); Exhibit 728, Statement of Liam Huxter, undated, p 8 para 17(a); Exhibit 140, Statement of Lourdes Wong, 22 December 2015, p 6 para 9(h); Exhibit 97, Statement of Brenton Page, 16 December 2015, p 9 para 15.6; Exhibit 77, Statement of Moira Macleod, 5 November 2015, p 12 para 30(d); Exhibit 69, Statement of Mara Kochardy, 29 October 2015, p 15 para 30(d)–(f); Exhibit 45, Statement of Susan Daniel, 29 October 2015, p 16 para 30(b).
- 89 For example, Exhibit 69, Statement of Mara Kochardy, 29 October 2015, p 15 para 30(f), Exhibit 140; Statement of Lourdes Wong, 22 December 2015, p 6 para 9(h); Exhibit 45, Statement of Susan Daniel, 29 October 2015, p 11 para 16(a)–(b).
- 90 Exhibit 69, Statement of Mara Kochardy, 29 October 2015, pp 15–16 para 30(f).
- 91 Exhibit 140, Statement of Lourdes Wong, 22 December 2015, p 6 para 9(h).
- 92 In his email to Minister Springborg, Kop said the closure of the BAC had “devastated many”. He referred to the ECRG’s recommendation to retain an extended inpatient treatment model of care with on-site schooling, and asked the Minister to “announce publicly that your government will ensure the provision of exactly such a service”. See Exhibit 1275, Email from Peter Kop to Lawrence Springborg, Subject: “Save the Barrett Centre”, 19 August 2013, p 4.
- 93 Exhibit 48, Supplementary statement of Lorraine Dowell, 2 February 2016, p 9 paras 7.4–7.5.
- 94 Exhibit 111, Statement of Kimberley Sadler, 14 December 2015, p 14 para 89.
- 95 Exhibit 47, Statement of Lorraine Dowell, 27 November 2015, p 17 para 10.3(e).
- 96 McDermott, Gullic, Powell, Kyte, Barrett Adolescent Centre, Consultation on aggression and violence at the BAC, South Brisbane, Kids in Mind Consulting, 2003, p 32.
- 97 Exhibit 129, Statement of Ashleigh Trinder, 30 October 2015, p 2 para 5.2.
- 98 Exhibit 23, Statement of Matthew Beswick, 30 October 2015, p 8 para 11(c)–(d); Exhibit 260, Chettleburgh, K & Doyle H, Review of The Park Centre for Mental Health, Undertaken March/April 2012, p 5; Exhibit 45, Statement of Susan Daniel, 30 October 2015, p 8 para 11 (f).
- 99 Exhibit 23, Statement of Matthew Beswick, 30 October 2015, p 9 para 11(i).
- 100 Transcript, Cary Breakey, 15 February 2016, p 6–46 lines 7–10.
- 101 Exhibit 260, Chettleburgh, K & Doyle H, Review of The Park Centre for Mental Health, Undertaken March/April 2012, p 5.
- 102 Exhibit 260, Chettleburgh, K & Doyle H, Review of The Park Centre for Mental Health, Undertaken March/April 2012, p 6.
- 103 For example, the permanent BAC Nurse Unit Manager (NUM) retired and the vacancy was not permanently filled. Instead, four different nurses temporarily acted in the position until the BAC’s closure, see Exhibit 23, Statement of Matthew Beswick, 30 October 2015, p 9 para 11(f); and Exhibit 113, Statement of Stephen Sault, 15 December 2015, p 9 para 9(f); Social Worker David Ward resigned in January 2013 and was not replaced, see Exhibit 137, Statement of Georgia Watkins-Allen, 26 November 2015, p 7 para 25(a); The role of Clinical Supervisor, filled by Danielle Corbett, was abolished, see Exhibit 137, Statement of Georgia Watkins-Allen, 26 November 2015, p 8 para 25(c); A contractual BAC Senior Psychologist role, held by Watkins-Allen, was not renewed in April 2013 and this role was not replaced, see Exhibit 113, Statement of Stephen Sault, 15 December 2015, p 9 para 9(f); The occupational therapist and diversional therapist/life skills therapist roles which had been filled by 1.5 FTE staffing were reduced to one full-time position: Exhibit 137, Statement of Georgia Watkins-Allen, 26 November 2015, pp 7–8 para 25(b).
- 104 See Exhibit 23, Statement of Matthew Beswick, 30 October 2015, p 9 para 11(h); Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 23 para 16.1(c); Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 50 para 240; Exhibit 87, Statement of Padraig McGrath, 16 November 2015, p 23 para 20.2.
- 105 Exhibit 23, Statement of Matthew Beswick, 30 October 2015, p 9 para 11(h).
- 106 Exhibit 254, Third supplementary statement of Trevor Sadler, 26 February 2016, p 3 para 9.
- 107 Particularly the period 6 August 2013 to 10 September 2013.
- 108 For example, the permanent BAC Nurse Unit Manager (NUM) retired and the vacancy was not permanently filled. Instead, four different nurses temporarily acted in the position until the BAC’s closure, see Exhibit 23, Statement of Matthew Beswick, 30 October 2015, p 9 para 11(f); and Exhibit 113, Statement of Stephen Sault, 15 December 2015, p 9 para 9(f); Social Worker David Ward resigned in January 2013 and was not replaced, see Exhibit 137, Statement of Georgia Watkins-Allen, 26 November 2015, p 7 para 25(a); The role of Clinical Supervisor, filled by Danielle Corbett, was abolished, see Exhibit 137, Statement of Georgia Watkins-Allen, 26 November 2015, p 8 para 25(c); A contractual BAC Senior Psychologist role, held by Watkins-Allen, was not renewed in April 2013 and this role was not replaced, see Exhibit 113, Statement of Stephen Sault, 15 December 2015, p 9 para 9(f); The occupational therapist and diversional therapist/life skills therapist

- roles which had been filled by 1.5 FTE staffing were reduced to one full-time position: Exhibit 137, Statement of Georgia Watkins-Allen, 26 November 2015, pp 7–8 para 25(b).
- 109 See chapter 23 Support to staff for a discussion about staff movements in late 2013 and early 2014. Exhibit
- 110 51, Statement of Naomi Ford, 1 December 2015, Appendix K to that statement, Fast Facts 6, p 124. Exhibit 51,
- 111 Statement of Naomi Ford, 1 December 2015, Appendix K to that statement, Fast Facts 6, p 124. Exhibit 51,
- 112 Statement of Naomi Ford, 1 December 2015, Appendix K to that statement, Fast Facts 5, p 124. Exhibit 14,
- 113 Statement of Ingrid Adamson, 24 November 2015, Attachment E to that statement, pp 104–117.
- 114 Supplementary submissions of The State of Queensland, 14 April 2016, pp 19–20 paras 69–71.
- 115 Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment E to that statement, p 104–117.
- 116 Transcript, Peter Steer, 10 March 2016, p 24-116 lines 5–10.
- 117 Confidential exhibit.
- 118 Confidential exhibit.
- 119 Confidential exhibit.
- 120 Confidential exhibit.
- 121 Confidential exhibit.
- 122 Confidential exhibit.
- 123 Confidential exhibit.
- 124 Confidential exhibit.
- 125 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 54 para 253; Transcript, closed hearing.
- 126 Transcript, closed hearing.
- 127 Transcript, closed hearing.
- 128 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 54 para 253.
- 129 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment SK-35 to that statement, Briefing Note for Noting to Director-General Queensland Health, Subject: [confidential], dated 9 September 2013, p 1151.
- 130 Exhibit 30, Statement of William Brennan, 16 November 2015, p 4 para 4.9.
- 131 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 32 para 18.1; Transcript, Sharon Kelly, 22 February 2016, p 11-44 lines 29–44.
- 132 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 32 para 18.4.
- 133 See Exhibit 142, Statement of Peta-Louise Yorke, 2 November 2015, p 10 para 13(c); Exhibit 45, Statement of Susan Daniel, 29 October 2015, p 12 para 17(b); Transcript, Vanessa Clayworth, 8 March 2016, p 22-49 lines 13–16.
- 134 Exhibit 45, Statement of Susan Daniel, 29 October 2015, p 12 para 17(b); Exhibit 62, Statement of Megan Hayes, 20 November 2015, p 2 paras 3.1 and 3.2; Exhibit 728, Statement of Liam Huxter, undated, p 9 para 19; Transcript, Vanessa Clayworth, 8 March 2016, p 22-48 lines 30–34; Exhibit 38, Statement of Vanessa Clayworth, 27 October 2015, p 3 para 6.1(a); Exhibit 97, Statement of Brenton Page, 16 December 2015, p 10 paras 17–18; Exhibit 142, Statement of Peta-Louise Yorke, 2 November 2015, p 10 para 13(c).
- 135 Exhibit 103, Statement of Thomas Pettet, 4 December 2015, p 5 para 29.
- 136 Transcript, Sharon Kelly, 22 February 2016, p 11-95 lines 22–34.
- 137 Transcript, Lesley Dwyer, 23 February 2016, p 12-119 lines 32–45.
- 138 Transcript, Vanessa Clayworth, 8 March 2016, p 22-49 lines 10-16; Exhibit 62, Statement of Megan Hayes, 20 November 2015, p 2 para 3.1.
- 139 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 54 para 257.
- 140 Transcript, Matthew Beswick, 29 February 2016, p 16-41 line 25.
- 141 Exhibit 178, Supplementary statement of Matthew Beswick, 12 February 2016, pp 13–14 para 15(c).
- 142 Exhibit 178, Supplementary statement of Matthew Beswick, 12 February 2016, p 13 para 15(a).
- 143 Exhibit 46, Supplementary statement of Susan Daniel, 10 February 2016, p 16 para 13(a)(i); Exhibit 77, Statement of Moira Macleod, 5 November 2015, p 7 para 11(f); Exhibit 178, Supplementary statement of Matthew Beswick, 12 February 2016, p 13 para 15(a)–(c).
- 144 Exhibit 46, Supplementary statement of Susan Daniel, 10 February 2016, p 16 para 13(a)(i).
- 145 Exhibit 46, Supplementary statement of Susan Daniel, 10 February 2016, p 16 para 13(a)(i).
- 146 Exhibit 77, Statement of Moira Macleod, 5 November 2015, p 7 para 11(f).

- 147 Exhibit 77, Statement of Moira Macleod, 5 November 2015, p 7 para 11(f).
- 148 Exhibit 726, Supplementary statement of Moira Macleod, 2 March 2016, p 6 para 5(a)(i).
- 149 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, p 38 para 22.8.
- 150 Confidential exhibits.
- 151 Confidential exhibit.
- 152 Confidential exhibit.
- 153 Confidential exhibit.
- 154 Exhibit 615, Email from Sharon Kelly to Sharon Kelly, Subject: "Consumer Advocate Barrett Adolescent Centre", 25 September 2013.
- 155 Exhibit 51, Statement of Naomi Ford, 1 December 2015, Appendix K of that statement, p 125.
- 156 Confidential exhibit.
- 157 Confidential exhibit.
- 158 Confidential exhibit.
- 159 Confidential exhibit.
- 160 Confidential exhibit.
- 161 Confidential exhibit.
- 162 Exhibit 23, Statement of Matthew Beswick, 30 October 2015, p 10 para 17(a).
- 163 Confidential exhibit.
- 164 Confidential exhibits.
- 165 Exhibit 178, Supplementary statement of Matthew Beswick, 12 February 2016, pp 13–14 para 15(a)–(f).
- 166 Confidential exhibit.
- 167 Confidential exhibits.
- 168 Confidential exhibit.
- 169 Confidential exhibit.
- 170 Confidential exhibit.
- 171 Exhibit 178, Supplementary statement of Matthew Beswick, 12 February 2016, pp 13–14 para 15(a)–(f); Transcript, Vanessa Clayworth, 8 March 2016, p 22-52 line 40–43; Exhibit 971, Supplementary statement of Megan Hayes, 2 March 2016, p 10 para 15.5.
- 172 Exhibit 178, Supplementary statement of Matthew Beswick, 12 February 2016, p 13 para 15(b).
- 173 Exhibit 178, Supplementary statement of Matthew Beswick, 12 February 2016, p 14 para 15(e).
- 174 Transcript, Vanessa Clayworth, 8 March 2016, p 22-52 lines 38–40.
- 175 Exhibit 971, Supplementary statement of Megan Hayes, 2 March 2016, p 10 para 15.4.
- 176 Exhibit 179, Supplementary statement of Trevor Sadler, 12 February 2016, p 15 para 68.
- 177 Transcript, Sharon Kelly, 22 February 2016, p 11-46 lines 5–18.
- 178 Transcript, Timothy Eltham, 18 February 2016, p 9-37 lines 15–23.
- 179 Kotzé said she and Skippen identified that "a time-trended report that graphed reported incidents over time" particularly, "before and after the standing down of Dr Sadler and the announcement of the closure of the BAC" would have been "potentially useful". However, she said she and Skippen were only provided with the raw incident data for the period after the announcement, despite the fact that such a report "should be expected to be routinely available because reports of that nature are part of the standing clinical governance processes of mental health services and are routinely required for accreditation purposes"; See Exhibit 71, Statement of Beth Kotzé, 18 December 2015, pp 23-24 paras 102 and 103.
- 180 Exhibit 71, Statement of Beth Kotzé, 18 December 2015, p 24 para 103.
- 181 Exhibit 71, Statement of Beth Kotzé, 18 December 2015, Attachment F to that statement, Report: Transitional Care for Adolescent patients of the Barrett Adolescent Centre, p 72.
- 182 Exhibit 71, Statement of Beth Kotzé, 18 December 2015, p 22 paras 95–96.
- 183 Submission of the State of Queensland, 23 March 2016, p 37 para 110.
- 184 Transcript, Vanessa Clayworth, 8 March 2016, p 22-66 lines 32–35.
- 185 Transcript, Vanessa Clayworth, 8 March 2016, p 22-66 lines 41–43.
- 186 Transcript, Anne Brennan, 4 March 2016, p 20-6 lines 15–17.
- 187 Transcript, Anne Brennan, 4 March 2016, p 20-8 lines 38–41.

17 Appointment of Anne Brennan as A/Clinical Director

The arrival of Anne Brennan

On 10 September 2013 Peter Steer (Chief Executive, Children's Health Queensland HHS) telephoned Anne Brennan and asked her to take over the clinical care of inpatients and day patients at the BAC as of the following day, and to act as Clinical Director of the unit in the transition process.¹

Trevor Sadler also telephoned Brennan that day. Brennan's evidence was that Sadler told her "he expected it [meaning the investigation into his conduct] would all be sorted out in a matter of weeks".² Brennan told the Commission that, consequently, she was not expecting to still be acting in Sadler's position when the BAC closed.³

On 10 September 2013, Brennan was formally appointed to the position of acting Clinical Director on a temporary full-time basis, with a commencement date of 11 September 2013 and an end date of 9 March 2014.⁴ She commenced duty on that date.

What was Anne Brennan's task?

Role to devise individual care packages

Before taking up the position, Brennan had assumed that a transition process had commenced, when it had not:⁵

It was clear that there was no process in place, nothing was happening ... it was clear I not only had to start it, I had to finish it. And it was a matter of then working out how we were going to do that.⁶

In fact she had not only to assume responsibility for the ongoing clinical care of the 17 BAC patients, but also to devise individual care packages for them, with a view to their discharge to alternative services within three to four months.

In closing submissions, Brennan's Counsel described what she faced on arrival at the BAC:

Dr Brennan walked into a situation where: Dr Sadler had been suspended; she was not given a "handover" from Dr Sadler; she did not know that she had been engaged to undertake transitioning having been advised that an urgent replacement was required for Dr Sadler and that the BAC was closing; she assumed a transition process had commenced but it had not; people were confused as to when BAC was closing; partly as a result of confusing information about closure being provided by WMHHS; staff morale was low, staff were feeling insecure about their employment, had a heavy workload due to resignations and the lack of skills of casual staff and they were anxious for the future care of their patients; patients were distressed; there was no adequate database or list of services to which patients might transition; education staff at the BAC actively supported the Save the Barrett campaign.⁷

Not a 'business as usual transition', but the closing down of an entire centre

The challenge Brennan faced in matching the patients to services was two-fold – getting to know the patients to ascertain their mental health needs and identifying what services were available. She told the Commission that in a different setting these two phases could have been sequential, but here they needed to run concurrently.⁸

Brennan agreed with Counsel Assisting that, in this context, one would expect detailed, careful and lengthy consultation and communication with families, staff and patients, skilled and consistent staff, enough lead time to prepare staff and to work with families and patients, and liaison and consultation with receiving services.⁹

To whom Anne Brennan reported

Brennan had broad and multilayered reporting obligations,¹⁰ with a lack of clarity around levels of governance and the support which was to be provided to her and by whom.

Under the West Moreton HHS governance structure, the Clinical Director of the BAC formally reported to the Director of Clinical Services West Moreton HHS. This position was held initially by Darren Neillie, and later (from 16 November 2013)¹¹ by Terry Stedman.¹² As Brennan's line manager, Neillie required her to notify him of any "serious matters".¹³

Brennan was also required to report to the West Moreton HHS executive (that is, Lesley Dwyer, Sharon Kelly and Leanne Geppert) at least weekly¹⁴, and she was "asked by the executive to perform certain tasks".¹⁵

Until October 2013, Brennan was supervised by Elisabeth Hoehn¹⁶ who was relieving in Stephen Stathis' position in his absence.¹⁷ After Stathis resumed his position as acting Clinical Director, Child and Youth Mental Health Service, Children's Health Queensland HHS (CHQ) Brennan had regular phone contact with him and she spoke with Steer when necessary.¹⁸

During her interview as part of the health services investigation by Kotzé and Skippen, Brennan spoke of the lack of clarity in her reporting lines; in particular there was no central point of authority to which she could appeal to put transition plans into effect:

There were times when at the next level of governance, and I know I was an Indian not a chief, but I felt like there were two things. One was, I've got a lot of responsibility here, where is the next person up in terms of medically or anything else. There didn't seem to be an expert you could turn to. Stephen Stathis, who was the director of Children's Health Queensland and now my boss. He would ring me up and say 'What's going on with such and such?' and I would tell him and he'd make some suggestions or, but he wasn't in charge. He didn't have power ... But it just didn't seem to me that there was a central point of authority and maybe there isn't anywhere! But that's a hole.¹⁹

Contact between Anne Brennan and Trevor Sadler prohibited

There was never a handover by Sadler to Brennan.

Brennan gave evidence that Sadler told her in their phone conversation on 10 September 2013 that he would provide a written handover for each patient to Neillie, but she never received any written handover.²⁰

On Brennan's first morning at the BAC, Kelly handed her a document and told her she was prohibited from contacting Sadler.²¹

Sadler gave evidence that when he was stood down Kelly told him he was to have no further input into the care of the adolescents at the BAC, and the staff of BAC were instructed not to have contact with him. He said that was why he did not provide any formal handover.²²

In her statement, Brennan said that a major impediment to a handover was that "staff received a written direction to not contact Dr Sadler".²³

When cross-examined by Counsel for Sadler, Kelly said she did not recall telling Sadler that he was not to have any contact with the BAC.²⁴

Dwyer's evidence was that from the time Sadler was stood down, she expected he would have no ongoing contact with BAC staff, adolescents, or their families.²⁵ She denied issuing any formal directive to staff. She did not recall whether she instructed Kelly to tell Sadler he was to have no ongoing contact with any BAC patients, their families or staff members, but said that it would be usual to ask someone in Sadler's position not to have such contact.²⁶

Vanessa Clayworth's evidence was that she was told at an executive meeting with either Dwyer or Kelly that "other staff members were not to communicate with Dr Sadler".²⁷

BAC occupational therapist Megan Hayes gave evidence that as far as she was aware, the instruction not to contact Sadler still applied when the transition planning was under way. She said: "Dr Sadler had a comprehensive knowledge of each adolescent's clinical presentation and had developed a therapeutic rapport which would have been invaluable to the transition process".²⁸

Although Brennan understood she was not to have contact with Sadler,²⁹ she did contact him on a couple of occasions, both in person and by email.³⁰

(Endnotes)

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- 1 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 2 para 5(a).
 - 2 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 7 para 27.
 - 3 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 7 para 27.
 - 4 Exhibit 28, Statement of Anne Brennan, 23 October 2015, Attachment AB-3 to that statement, pp 63–65.
 - 5 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, pp 6–7 para 6.
 - 6 Exhibit 53, Statement of Kristi Geddes, 22 October 2015, Attachment KG-60 to that statement, Transcript of Health Services Investigation interview with Anne Brennan, 13 October 2014, p 851.
 - 7 Submissions on behalf of Anne Brennan, 23 March 2016, p 5 para 13 (citations omitted).
 - 8 Transcript, Anne Brennan, 4 March 2016, p 20-18 lines 31–46.
 - 9 Transcript, Anne Brennan, 4 March 2016, p 20-17 lines 19–44.
 - 10 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, p 12 para 14.
 - 11 Exhibit 89, Statement of Darren Neillie, 23 October 2015, pp 2–3 para 3.2(a).
 - 12 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 4 para 12; Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, pp 7–8 para 8.
 - 13 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 4 para 13; Brennan provided the example of an assault on a patient: Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, p 12 para 14.
 - 14 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 4 paras 12–13.
 - 15 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 4 para 13.
 - 16 Exhibit 64, Statement of Elisabeth Hoehn, 18 November 2015, pp 1–2 para 4 and p 8 para 29.
 - 17 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 4 para 12; At the time, Hoehn’s substantive position was Program Director and Consultant Child Psychiatrist, Future Families, Children of Parents with a Mental Illness Program, Queensland Centre for Perinatal and Infant Mental Health and Parent Aide Unit, Nundah: Exhibit 64, Statement of Elisabeth Hoehn, 18 November 2015, pp 1–2 para 4.
 - 18 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 4 para 12.
 - 19 Exhibit 53, Statement of Kristi Geddes, 22 October 2015, Attachment KG-60 to that statement, Transcript of Health Services Investigation interview with Anne Brennan, 13 October 2014, p 862.
 - 20 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 7 paras 29–30.
 - 21 Transcript, closed hearing.
 - 22 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 54 para 257.
 - 23 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, p 8 para 9(e).
 - 24 Transcript, closed hearing.
 - 25 Transcript, Lesley Dwyer, 23 February 2016, p 12-114 line 1–4.
 - 26 Transcript, Lesley Dwyer, 23 February 2016, p 12-113 line 42–43.
 - 27 Transcript, Vanessa Clayworth, 8 March 2016, p 22-49 lines 10–11.
 - 28 Exhibit 971, Supplementary statement of Megan Hayes, 2 March 2016, p 10 para 15.4.
 - 29 Transcript, closed hearing.
 - 30 Transcript, closed hearing.

18 The meaning of transition

Transition

In making the closure announcement on 6 August 2013, Minister Lawrence Springborg referred to “early 2014” as the likely date for closure. He anticipated a range of new services closer to patients’ homes, and said that “the transition will start sometime in the early part of 2014 as we build up services in other areas around the State”.¹

The concept of “transition” is introduced in term of reference 3(d), which calls for inquiry into the alternative care arrangements for the “transition clients” – “BAC patients transitioned to alternative care arrangements in association with the closure or anticipated closure, whether before or after the closure announcement”.² That term of reference, and later terms of reference which also incorporate the concept raise the issue: what is “transition”?

The process of transition

In ordinary usage, “transition” is a noun, and its meanings include the process or period of changing from one condition or stage of development to another.³ It has acquired technical meanings in various spheres including in medicine.

In psychiatry, “transition” is usually used to describe the planned, purposeful movement of a patient from one form of management to another – (a) for clinical reasons, such as a chronically ill patient from inpatient to family/community care, or a patient whose condition has improved from adolescent inpatient care to less restrictive adolescent care; or (b) for developmental reasons, such as from an adolescent care system to an adult care system.⁴ It is a gradual process born out of a particular patient’s needs, a process that is bespoke and focused upon the satisfaction of those needs.⁵

By contrast, the “transfer” of a patient is an act or event which occurs at a point in time, such as when the patient is moved from one care facility to another or from one care system to another.⁶

This distinction between “transition” and “transfer” appears in the ‘Guideline for the transition of care for young people receiving mental health services’ published by the Queensland Government in 2015.⁷ The guideline relates to young people moving from one CYMHS to another part of the mental health system, including those moving from CYMHS to Adult Mental Health Services. “Transition” is defined as “[t]he process and period of changing care arrangements for a young person”, while “transfer” is defined as “[t]he act of moving the young person from one care facility to another, to another care arrangement”.⁸

The Metro South Mental Health Services had procedures in place for the transition of patients within South Queensland Health Services District.⁹ These were effective from July 2012 and reviewed in July 2013. They set out some principles including the following:

- Mental health services will work collaboratively to ensure a consumer focused transition of care.
- The transfer process, including the time it takes to complete, will be consistent with the consumer’s recovery/care/treatment plans, e.g. efforts made to support the consumer’s ongoing access to their care network if they are from a rural and remote area and are transferred out of the area.
- Some transfers of consumer care may require a shared care arrangement for a period of time.
- If a clinical difference of opinion occurs regarding the ongoing management of a consumer transferring between districts, the consultant of the receiving service has the final decision and responsibility for ongoing care.¹⁰

Transition is a core function of an extended treatment and rehabilitation unit. Trevor Sadler acknowledged this when he said that “[f]rom the time of admission, the objective was to transition BAC adolescents back into the community if possible”.¹¹ In principle, transition planning should commence at the time of admission: admission to a sub-acute or extended care unit should include a prospective discharge plan and an estimated date of discharge.¹²

The time necessary for a transition varies according to the needs of the patient.¹³ In Sadler’s experience at the BAC, “at times transition would occur at a relatively rapid pace (eg over a month) whereas at other times it would take several months”.¹⁴

While clinical responsibility for a patient changes upon discharge from one service and admission to another,¹⁵ some overlap of care (either cross-tapered care or parallel care) may be appropriate for a particular patient. A patient’s involvement in Service A may gradually “taper off” while Service B, the new service, has increasing involvement and carriage of the patient’s needs. There may be a period of parallel care, when various services work at the same time. Cross-tapering of care and parallel care are illustrated in Figures 18A and 18B.¹⁶

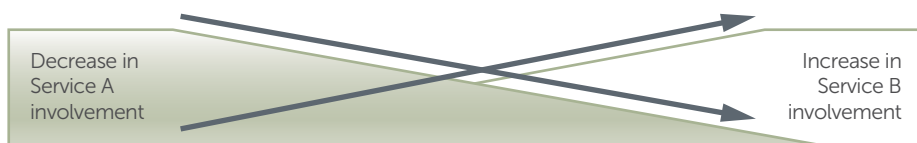


Figure 18A : Cross-tapering of care

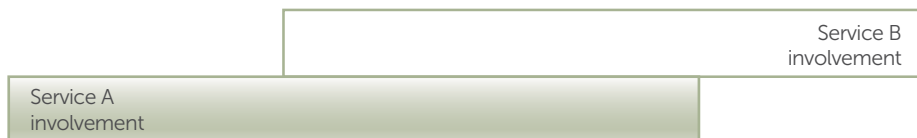


Figure 18B : Parallel care

The literature contains little discussion about when a transition should be regarded as having ended. The process does not come to an abrupt end at the point of discharge from Service A and admission to Service B. Rather, the period over which it gradually reaches its conclusion varies from patient to patient, and may be affected by the duration of cross-tapering of care or parallel care.

Transition from adolescent service to adult service

Transition from an adolescent mental health service to an adult mental health service can be particularly fraught. It is often necessitated by arbitrarily imposed age limits, as in Queensland where adolescent services are usually available only for patients aged between 13 and 17 years.¹⁷ However, as Stephen Stathis said in oral evidence, “[y]ou don’t suddenly become an adult when you’re 18”.¹⁸ Young people mature at different rates, with the consequence that chronological ages and developmental ages can differ. Mental illness can detrimentally affect every aspect of a patient’s being, including slowing the rate of maturation. The negative effects of institutionalisation resulting from an unduly long stay in a mental health facility can add to the difficulties of transition from adolescent to adult mental health services.

Generally, adolescent and adult services care for patient cohorts markedly different in age, diagnosis and chronicity. While both services promote recovery and rehabilitation, they are based on different principles: the adolescent service on a biopsychosocial model and the adult service on individual treatment, including medication and other therapies. Education and vocational training are integral to the adolescent model, but not part of the adult model.¹⁹

Anne Brennan described the alignment of adolescent and adult mental health services in these terms:

There are no specific disorders/behaviours treated only by child and adolescent mental health services or only by adult mental health services. Approximately half of all adult disorders are evident by age 14 years and three quarters by 25 years. There is a much higher incidence of psychoses in the adult population.

Transition is not the same as transfer.

Transition needs to be tailored to the young person’s needs, be gradual, involve good communication and if possible parallel streams of care. Transition in mental health care at this stage of life, when there is the peak incidence of emerging mental disorders and the highest rate of discontinuity of care in early onset disorders, needs to take into account the myriad of extraneous forces involved, including transition from school to higher education and/or employment, transition from a child role within the family unit, and the development of relationships with other autonomous young adults. It is particularly challenging for those already in the care of the state or who are unable to reside with their families. This group is at higher risk of self-harm, suicide, homelessness, incarceration, unemployment and ongoing mental health and physical health disorders. The particular mental health label given is necessary but not sufficient to inform this process.

In recent years it has been shown that there is very high rate of continuity of childhood psychopathology into adult years as well as the development of comorbidities. Child and adolescent mental health has developed from an understanding of the individual in context of relationships with family and community whereas Adult mental health has focused more on individual psychopathology, biology and diagnosis-informed interventions. That is an

oversimplification but this question seeks to understand the different paradigms and why there are barriers to transition.

Patients with psychoses such as schizophrenia may transition more readily than [those with] neurodevelopmental disorders. Personality Disorders may fluctuate in presentation as they may not be fully developed. Fluctuations in behaviour at time of transition may mean that a young person at a particular point in time (referral or assessment or intake) may not meet eligibility criteria.

Adult mental health services and Child and adolescent mental health services are structured differently. There are issues re consent and confidentiality and responsibility for clinical care and there are differing priorities regarding funding and allocation of resources which are scarce across all ages, services and disorders.²⁰

It is uncontroversial that young people are at increased risk of service disengagement during this critical time period, and it is imperative that the process be managed as well as possible.²¹ Optimal transition has been described as fulfilling four inter-related criteria: continuity of care, at least one transition planning meeting, good information transfer, and parallel care.²² According to the research literature, transition from child to adult mental health services is optimal when it is a “coordinated, purposeful, planned and patient-centred process that ensures continuity of care, optimizes health, minimises adverse events, and ensures that the young person attains his/her maximum potential”.²³

Transition in the terms of reference

Under terms of reference 3(d), (e) and (f) the Commission must make these inquiries:

- (d) for BAC patients transitioned to alternative care arrangements in association with the closure or anticipated closure, whether before or after the closure announcement (**transition clients**):
 - i. how care, support, service quality and safety risks were identified, assessed, planned for, managed and implemented before and after the closure (**transition arrangements**); and
 - ii. the adequacy of the transition arrangements;
- (di) the adequacy of the care, support and services that were provided to transition clients and their families;
- (dii) the adequacy of support to BAC staff in relation to the closure and transitioning arrangements for transition clients.²⁴

The inquiries required by these paragraphs focus on matters pertaining to “transition clients”, their families and BAC staff involved in their care.

“Transition clients” are defined as “BAC patients transitioned to alternative care arrangements in association with the closure or anticipated closure, whether before or after the closure announcement”.²⁵ The Commission has interpreted the phrase “in association with” as “in connection with” or “at the same time as”.

The circumstances surrounding the discharge of patients from the BAC in the lead up to its closure were very different from those associated with the discharge of patients from an ongoing mental health facility in the usual course.

Although the terms of reference use “transition” (or some form of that word) to describe the process by which patients were moved to alternative care services in association with the closure or anticipated closure, the Commission considers that it was not a “transition” in the sense that term is ordinarily used in psychiatry.

Transition and the BAC

The BAC was the only unit of its type in Queensland.²⁶ The decision to close it was announced by the Minister on 6 August 2013 when he said in a radio interview that “by early 2014 the Centre will be closing”.²⁷ Instead of announcing a precise date when this would occur, he said in effect that all of the patients would be discharged from the BAC within the next four to five months, and that the BAC would cease to operate. And that is what happened.²⁸

Of course the closure of the BAC had been anticipated for some months prior to the decision being made in mid-2013.²⁹ Its likelihood was made public by Brett McDermott on 8 November 2012.³⁰ Then the Barrett Adolescent Strategy was tabled at a West Moreton Board meeting on 23 November 2012. Although the minutes of that meeting record only that the strategy was discussed, in fact the HHS proceeded largely in accordance with it.³¹

The strategy was based on the assumption that services then provided by the BAC would not remain on the campus of The Park after June 2013. As proposed in the strategy, an Expert Clinical Reference Group (ECRG) was formed, and it held its first meeting in December 2012. Its remit was to recommend new models of care to replace the existing statewide services provided by the BAC. The option of rebuilding on another site was expressly excluded in the Barrett Adolescent Strategy, and this was conveyed to the ECRG at least orally.³²

At the time of the closure announcement there were [redacted] inpatients [redacted]
[redacted]
[redacted]³³

After the closure announcement, [redacted]
[redacted]³⁴ [redacted] for reasons not directly related to the closure.³⁵

The closure necessitated alternative care arrangements for the others. In other words, the impetus for their “transition” within the terms of reference and the broad timeframe within which “transition” had to be effected was administrative need rather than individual patient need. An entire unit was to be emptied out in the absence of any similar unit.³⁶

As Brennan’s counsel said in their closing submissions, “The BAC closure presented a situation where ‘transition’ or transfer to a different service or services was necessary rather than being a process in the usual course”.³⁷

Beth Kotzé described it this way:

As I understood it, the date for closure was set as an administrative decision and in expectation of the process of transition being completed over five months or so. It was ‘artificial’ in the sense that it was arbitrary across a cohort rather than personal to the individuals.³⁸

Patient transition/discharge from October 2012

What happened in relation to patient transition and discharge from October 2012, just prior to McDermott's announcement? On the evidence, Sadler did not accelerate or otherwise alter transition work before the closure announcement. At least until the announcement, it was business as usual.³⁹ The transition processes for some patients were on foot, and those patients were well advanced on their trajectories towards discharge. Some were discharged prior to the announcement, and [REDACTED]

[REDACTED] It is unlikely that those patients were oblivious to the uncertainty about the BAC's future or that they were unaffected by the concerns and negative emotions of some staff, parents and members of the public. However, that is an insufficient connection with the closure for them to have been transitioned to alternative care arrangements "in association with" the closure or anticipated closure. In fact, it was only after Brennan's arrival that transition in association with the closure, or anticipated closure, commenced.

Transition under Brennan

There were young people on the waitlist and others on the assessment list when the closure was announced. Apart from [REDACTED]

[REDACTED]
[REDACTED] Apart from [REDACTED]
[REDACTED] within the terms of reference.

According to Brennan, some of the transition clients were or became well enough and far enough advanced on their transition trajectories for their movement from the BAC to alternative care to be classed as "transition" in the usual sense; for others, there was insufficient time for full transition.⁴⁰ Nevertheless, it is uncontroversial that whether a particular transition client's move from the BAC was in the course of a "transition" or a "transfer", it is within the Commission's remit.

The Commission considered that some temporal limitation on the duration of the transitions for the purposes of terms of reference 3(d) and (e) is implied by the words "in association with the closure or anticipated closure".

As with transitions in the usual sense, the time when the transitions in association with the closure concluded may have varied from patient to patient.

An important aspect in which transitions in association with the closure differed from transitions in the usual sense was that the service from which the patients were discharged ceased to exist. After 24 January 2014 there were few staff left at the BAC to provide any monitoring post discharge. On 29 January 2014 Brennan compiled information about all the young people who had been under her care and was satisfied they were all doing well at that stage. She provided this to the West Moreton HHS executive who gave a de-identified version to the Board. She repeated this exercise on 3 March 2014.⁴¹

After receiving submissions on the duration of these transitions, the Commission concluded that generally a transition in association with the closure ended about a month after the patient's discharge from the BAC, although some flexibility must be applied in determining the end point of any particular transition.

Transition arrangements

Under term of reference 3(d)(i), the Commission is required to make a factual inquiry as to the transition arrangements for each of the transition clients. This means examining *how* the care, *how* the support, *how* the service quality and *how* the safety risks were identified, assessed, planned for, managed and implemented for each of the transition clients before and after the closure. This inquiry focuses on the process underlying each transition client's movement to alternative care. It includes consideration of the transition plan prepared for that transition client and how a receiving service was identified, both as the type of service and as having the capacity required for that transition client. It does not extend to the clinical outcomes, quality or efficacy of the treatment at the alternative care service once the transition process was complete.

Adequacy of transition arrangements

Then the Commission must inquire into the "adequacy" of those transition arrangements: term of reference 3(d)(ii). Several counsel made submissions which the Commission found helpful in considering what is required by this term of reference.

Counsel for West Moreton submitted⁴² that in ordinary usage, "adequate" means "equal to the requirement or occasion, fully sufficient, suitable, or fit"⁴³ or "sufficient, satisfactory."⁴⁴ They continued:

[T]he Macquarie [Dictionary] definition is noteworthy because it requires an evaluation by reference to the "requirement" or "occasion". This focuses the assessment not only with reference to the transition client requirements, but also (with reference to the "occasion") by considering contemporary service availability, and the contemporary factual mix.⁴⁵

Brennan's counsel submitted:

The Commission is not asked by the terms of reference as to whether some particular standard was met by the transition process. Rather it is asked whether the transition arrangements for the transition clients were "adequate". That conveys a focus on what was achieved rather than whether a process was textbook. It also makes it clear that it is not whether it was ideal or as desired. By "adequate" it means "sufficient" for the needs of the "client".⁴⁶

Counsel for Metro South made this submission about the assessment of adequacy: "[T]here must be shown in the evidence a benchmark against which adequacy is to be assessed and then it must be demonstrated that there was a departure or departures from that benchmark".⁴⁷

The Commission has concluded that "adequate" in this term of reference means "sufficient" or "satisfactory" in the circumstances of the impending closure. Case by case, the Commission must make an objective assessment of whether the process by which a transition client was moved to alternative care was sufficient or satisfactory in that context. Matters relevant to that factual inquiry include:

- What were the young person's developmental and illness-specific needs?
- Where was the young person on their transition trajectory at the time of the transition?
- What were the available services necessary to meet those needs?
- What were the communications with the young person and or their family about the process?
- What were the number and training of the carers proposed for the patients at the receiving service?

- What was the breadth of service available to the patient either directly through the receiving service or otherwise?
- How was the receiving service managed? Were there arrangements for the patient to visit the receiving service premises or facilities? Did the patient meet the new treating team before transfer? How often and how was that managed?
- What were the patient's and the family's views of and responses to the receiving service?
- When (if at all) did the patient engage with the receiving service? Was this a gradual process?

Adequacy of care, support and services

By term of reference 3(e) the Commission must inquire into the care, support and services provided to the transition clients and their families. It has interpreted this as requiring an objective evaluation, on a case by case basis, of the care, support and services actually provided. Case by case, the Commission must assess whether they were sufficient or satisfactory in the context of the closure. The assessment is limited temporally to the period of the transition process.

Transition clients

The inquiry into the care, support and services provided to a transition client is an inquiry into the adequacy of the care, support and the services provided by West Moreton HHS and the receiving service.

The Commission considers that assessing adequacy objectively should begin with an assessment of what actually happened against general guidelines for a transition process "in the usual course". The most important factors and considerations, as described by a number of witnesses, and set out in the written submissions of the relevant parties, include:

- The process should start early.⁴⁸ It should be individualised, patient-centred, involve the young person and their family,⁴⁹ and be gradual.⁵⁰
- Transition needs to be tailored to the young person's needs, involve good communication and, if possible, parallel streams of care.⁵¹
- Transition should take into account both the developmental and the illness-specific needs of the young person.⁵²
- A transition plan needs to incorporate a holistic approach that takes into account the medical and psychosocial needs of the individual.⁵³
- Timing should be appropriate. (Transition should not be attempted during a stressful period.)⁵⁴
- The process should be systematic and formal.
- Individual transition plans should be developed.
- Transition should be co-ordinated and continuous involving a team approach.
- The young person should be empowered, encouraged, and enabled to self-manage. (Where the young person has complex needs, their family/carers need to be involved).
- Managerial and administrative support should be available.
- Follow up and evaluation should be undertaken.

The relevance of each of these factors and the weight to be given to them vary from case to case. The objective importance of some factors may depend on the individual transition client's needs at the time.

One key developmental need which had to be considered in relation to each transition client was ongoing education/vocational training. Where this need was identified, appropriate arrangements had to be made.⁵⁵

While the “transition” processes were undertaken in the context of the closure of the BAC, they are to be assessed objectively, having regard to the transition clients’ individual needs. There is no reason to confine the assessment on account of difficulties encountered in finding suitable services or the unavailability or non-existence of suitable services.

Families

The Commission must also inquire into the adequacy of the care, support and services provided to the families of the transition clients. This issue has two aspects – how the care, support and services provided to families bore on the welfare of the transition clients, and how they catered for needs of the families that were distinct from those of the transition clients.

There has been increasing acknowledgement of the role played by families and carers in the mental health system, for example, in the principles which underlie the Queensland Plan for Mental Health 2007–2017,⁵⁶ in the *Carers (Recognition) Act 2008* (Qld)⁵⁷ and in the National Standards for Mental Health Services 2010.⁵⁸ In that context, the Commission has approached the adequacy of the care, support and services provided to the families of transition clients from the perspective of good practice, rather than legal obligation.

Some of the transition clients told their clinicians

[REDACTED]

⁵⁹

[REDACTED]⁶⁰ Their wishes were properly respected where they had capacity to give those instructions to their clinicians. Otherwise the BAC and the receiving services ought to have given their families consistently clear and reasonably accurate and timely information about their mental health, transition arrangements and ongoing management and care.

Staff

By term of reference 3(f) the Commission must inquire into the adequacy of support to BAC staff “in relation to the closure and transitioning arrangements for transition clients”.

Term of reference 3(d) focuses on “the transition arrangements” for transition clients, who are defined as “BAC patients transitioned to alternative care arrangements in association with the closure or anticipated closure, whether before or after the closure announcement”. By contrast, term of reference 3(f), which focuses on support to BAC staff, is concerned with the adequacy of that support “in relation to the closure and transitioning arrangements for transition clients”.

The Commission has interpreted the phrase “in relation to” as having a similar meaning to “in association with” – that is, “in connection with” or “at the same time as”. And it has interpreted “transitioning arrangements” as having the same meaning as “transition arrangements”.

It considered whether there is a temporal limitation on the inquiry into support to staff. Because this term of reference refers to support in relation to “the closure” rather than in relation to “the closure or anticipated closure”, the Commission has interpreted the period in question as commencing with the decision to close the BAC made by the Minister and the West Moreton

Board on 15 July 2013.⁶¹ And because the inquiry is in relation to “transitioning arrangements”, it has interpreted the period as ending when the transitions of the BAC patients had all concluded.

The Commission has interpreted “BAC staff” as including all clinical, allied health and teaching staff who worked at the BAC during this period.

It considers that the categories of “support” are not closed, and that they are not confined to legal obligations owed by an employer to an employee. They include matters affecting the health, safety and welfare of staff, but do not extend to the availability of physical amenities such as clean toilets.

(Endnotes

- 1 Exhibit 307, Transcript of ABC 612 interview with Lawrence Springborg, 6 August 2013, p 1.
- 2 *Commissions of Inquiry Order (No. 4) 2015*, 16 July 2015, Term of Reference 3(d).
- 3 Exhibit 117, Statement of Tania Skippen, 13 November 2015, pp 16–18 para 19; Exhibit 309, Ipsos-Eureka Social Research Institute Review of Transition of Young Adult Clinics Final Report Attachment 6: Literature review, 28 October 2008, p 2; Closing submissions of Counsel Assisting, 17 March 2016, p 89 para 315.
- 4 Blum, R, Garell, D, Hodgman, C, Jorissen, T, Okinow, N, Orr, D, Slap, G 1993, ‘Transition from child-centered to adult health-care systems for adolescents with chronic conditions’, *Journal of Adolescent Health*, volume 14, pp 570–576 (p 570); McNamara, N, McNicholas, F, Ford, T, Paul, M, Gavin, B, Coyne, I, Cullen, W, O’Connor, K, Ramperti, N, Dooley, B, Barry, S, & Singh, S 2013, ‘Transition from child and adolescent to adult mental health services in the Republic of Ireland: an investigation of process and operational practice’, *Early Intervention in Psychiatry*, volume 8 issue 3, pp 291–297, DOI: 10.1111/eip.12073.
- 5 Transcript, Anne Brennan, 4 March 2016, p 20–16 lines 20–41; Exhibit 118, Supplementary statement of Tania Skippen, 15 January 2016, pp 24–25 para 30; McNamara, N, McNicholas, F, Ford, T, Paul, M, Gavin, B, Coyne, I, Cullen, W, O’Connor, K, Ramperti, N, Dooley, B, Barry, S, & Singh, S 2013, ‘Transition from child and adolescent to adult mental health services in the Republic of Ireland: an investigation of process and operational practice’, *Early Intervention in Psychiatry*, volume 8 issue 3, pp 291–297, DOI: 10.1111/eip.12073.
- 6 Paul, M, Ford, T, Kramer, T, Islam, Z, Harley, K & Singh, S 2013, ‘Transfers and transitions between child and adult mental health services’, *The British Journal of Psychiatry*, volume 202, s36–s40 (s36), DOI: 10.1192/bjp.bp.112.119198; McNamara, N, McNicholas, F, Ford, T, Paul, M, Gavin, B, Coyne, I, Cullen, W, O’Connor, K, Ramperti, N, Dooley, B, Barry, S, & Singh, S 2013, ‘Transition from child and adolescent to adult mental health services in the Republic of Ireland: an investigation of process and operational practice’, *Early Intervention in Psychiatry*, volume 8 issue 3, pp 291–297, DOI: 10.1111/eip.12073; Transcript, Anne Brennan, 4 March 2016, p 20–16 lines 20–21; Exhibit 71, Statement of Beth Kotzé, 18 December 2015, pp 3–4 para 13.
- 7 Exhibit 681, Department of Health, Guideline for the transition of care for young people receiving mental health services, Document Number: QH-GDL-365-5:2015, 21 September 2015.
- 8 Exhibit 681, Department of Health, Guideline for the transition of care for young people receiving mental health services, Document Number: QH-GDL-365-5:2015, 21 September 2015, p 7.
- 9 Exhibit 43, Statement of David Crompton, 19 October 2015, Attachment to that statement, Metro South Mental Health Services Procedure, July 2012, p 449.
- 10 Exhibit 43, Statement of David Crompton, 19 October 2015, Attachment to that statement, Metro South Mental Health Services Procedure, July 2012, pp 449–450.
- 11 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 27 para 139; Transcript, Cary Breakey, 15 February 2016, p 6–44 lines 5–21.
- 12 Transcript, Brett McDermott, 16 February 2016, p 7–59 lines 29–45; Transcript, Anne Brennan, 4 March 2016, p 20–16 lines 34–41; Transcript, Philip Hazell, 17 February 2016, p 8–42 lines 35–38.
- 13 Exhibit 43, Statement of David Crompton, 19 October 2015, p 2 para G.
- 14 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 25 para 130; Murcott, W 2014, ‘Transitions between child and adult mental health services: service design, philosophy, and meaning in uncertain times’, *Journal of Psychiatric and Mental Health Nursing*, volume 21, issue 7, pp 628–634, DOI: 10.1111/jpm.12150; Transcript, closed hearing.
- 15 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, p 28 para 28(a).
- 16 Hovish, K, Weaver, T, Islam, Z, Moil, p & Singh, S 2012, ‘Transition experiences of mental health service users, parents and professionals in the United Kingdom: a qualitative study’, *Psychiatric Rehabilitation Journal*, volume 35, issue 3, pp 251–257; Exhibit 117, Statement of Tania Skippen, 13 November 2015, p 21 para 25; Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, p 28 para 28(a).

- 17 Although in recent times some services have offered flexibility, particularly with respect to the upper age limit. The BAC day program included adolescents from the ages of 13–18 years old. Youth Resi and Step-up/Step-down units are offered to adolescents ages 16–21 years old.
- 18 Transcript, Stephen Stathis, 10 March 2016, p 24–51 lines 29–30.
- 19 Transcript, Beth Kotzé, 9 March 2016, p 23–7 lines 25–35; Exhibit 172, Supplementary statement of Cary Breakey, 9 February 2016, p 9 paras 38–40; Exhibit 63, Statement of Philip Hazell, 5 November 2015, p 17 para 97; Transcript, Patrick McGorry, 2 March 2016, p 18–5 lines 25–40.
- 20 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, pp 36–37 para 35.
- 21 Schraeder, K & Reid, G 2016, 'Who should transition? Defining a target population of youth with depression and anxiety that will require adult mental health care', *The Journal of Behavioural Health Services and Research*, pp 1–15, DOI: 10.1007/s11414-015-9495-2.
- 22 Paul, M, Ford, T, Kramer, T, Islam, Z, Harley, K & Singh, S 2013, 'Transfers and transitions between child and adult mental health services', *The British Journal of Psychiatry*, volume 202, s36-s40 (s36), DOI: 10.1192/bjp.bp.112.119198.
- 23 Singh, S, & Tuomainen, H 2015, 'Transition from child to adult mental health services: needs, barriers, experiences and new models of care', *World Psychiatry*, volume 14 issue 3, pp 358–361 (p 358), DOI: 10.1002/wps.20266.
- 24 *Commissions of Inquiry Order (No. 4) 2015*, 16 July 2015, Terms of Reference 3(d)–(f) (emphasis in original).
- 25 *Commissions of Inquiry Order (No. 4) 2015*, 16 July 2015, Term of Reference 3(d); Closing submissions of Counsel Assisting, 17 March 2016, p 89 para 316.
- 26 Exhibit 27, Statement of Cary Breakey, 29 September 2015, p 8 para 42(a).
- 27 Exhibit 307, Transcript of ABC 612 interview with Lawrence Springborg, 6 August 2013, p 1.
- 28 Exhibit 113, Statement of Stephen Sault, 15 December 2015, p 15 para 16(d).
- 29 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 46 para 226; Exhibit 449, Batch of emails collated by Trevor Sadler to child psychiatrists, Subject: "Learning of closure", 15 November 2012, pp 1–2.
- 30 Exhibit 84, Statement of Brett McDermott, 10 November 2015, p 18 para 100; Transcript, Brett McDermott, 8 November 2012, Queensland Child Protection Commission of Inquiry, p 33–58 lines 2–19. Available from: <<http://www.childprotectioninquiry.qld.gov.au/hearings/transcripts/>>. [18 December 2015].
- 31 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-13 to that statement, p 68.
- 32 Transcript, Leanne Geppert, 19 February 2016, p 10–13 lines 16–30.
- 33 Exhibit 1369, West Moreton Hospital and Health Service, 'Current Inpatients, Current Day Patients, Waiting List, Assessment Enquiries', 1 September 2013.
- 34 Confidential details removed.
- 35 Confidential details removed; Exhibit 39, Supplementary statement of Vanessa Clayworth, 20 November 2015, p 2 para 10.4(b) and (c).
- 36 Exhibit 71, Statement of Beth Kotzé, 18 December 2015, p 23 para 100.
- 37 Submissions on behalf of Anne Brennan, 23 March 2016, p 2 para 5.
- 38 Exhibit 71, Statement of Beth Kotzé, 18 December 2015, p 23 para 100.
- 39 Closing submissions of Counsel Assisting, 17 March 2016, p 94 para 326; Exhibit 319, Independent Health Service Investigation report commissioned by Qld Health folder 31, Letter from Sharon Kelly to Kristi Geddes, Subject: "Health Service Investigation – Barrett Adolescent Centre (Your Ref: SGE KXMM I084936)", 19 September 2014, pp 2–5.
- 40 Transcript, Anne Brennan, 4 March 2016, p 20–16 lines 19–41; Transcript, Vanessa Clayworth, 8 March 2016, p 22–58 lines 44–47.
- 41 Submissions on behalf of Anne Brennan, 23 March 2016, p 10 paras 20(cc), (dd).
- 42 Submissions on behalf of West Moreton HHS and Board, 23 March 2016, p 40 para 20.
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- 45 Submissions on behalf of West Moreton HHS and Board, 23 March 2016, p 40 para 22.
- 46 Submissions on behalf of Anne Brennan, 23 March 2016, p 4 para 10.
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- 48 Transcript, Anne Brennan, 4 March 2016, p 20–16 line 22.
- 49 Transcript, Anne Brennan, 4 March 2016, p 20–16 line 23.
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- 51 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, p 36 para 35.
- 52 Exhibit 118, Supplementary statement of Tania Skippen, 15 January 2016, p 24 para 30.
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- 54 Submissions on behalf of Anne Brennan, 23 March 2016, p 3 para 7(d); Exhibit 309, Ipsos-Eureka Social Research Institute Review of Transition of Young Adult Clinics Final Report Attachment 6: Literature review, 28 October 2008; Agency for Clinical Innovation and Trapeze, 2014, 'Key principles for transition of young people from paediatric to adult health care', Sydney: Agency for Clinical Innovation and Trapeze, The Sydney Children's Hospitals Network. Available from: <http://www.aci.health.nsw.gov.au/_data/assets/pdf_file/0011/251696/Key_Principles_for_Transition.pdf>. [15 April 2016].
- 55 Confidential details removed.
- 56 Exhibit 208, *Queensland Plan for Mental Health 2007–2017*, pp 14–15.
- 57 *Carers (Recognition) Act 2008* (Qld) Schedule, in particular Item 3 and Item 6.
- 58 Department of Health, National Standards for Mental Health Services 2010, Canberra: Department of Health, Australian Government, Foreword at p 5, Standard 7 at 7.2, 7.13–14.
- 59 Confidential details removed.
- 60 Confidential details removed.
- 61 See chapter 12 for discussion of the decision.

19 Transition under Anne Brennan

Introduction

When Anne Brennan commenced as the acting Clinical Director of the BAC, she walked into uncharted territory, in challenging circumstances.

This chapter examines what Brennan inherited when she arrived at the BAC and how she and dedicated BAC staff went about identifying, assessing, planning for, managing and implementing the necessary care, support, service quality and safety risks for the BAC patients (transition arrangements).

Brennan described the extent of the task she faced in the statement she provided to the health services investigators:¹

The amount of work involved in keeping the patients safe, identifying possible services in the local community, getting agreement from the proposed receiving service to taking individual patients and if necessary to modify their service provision, getting support from the family and other stakeholders and dealing with all the challenges referred to above was extraordinary.²

When she met with West Moreton HHS executives on 11 September 2013, she was told that “the closure target date was the end of January 2014 but this was with the proviso that BAC would remain open until adequate and appropriate care was in place for each young person”.³ She also gave evidence of Bill Kingswell (MHAODB) discussing with Elisabeth Hoehn (then Children’s Health Queensland HHS (CHQ)) and her, the need to transition all patients from the BAC “as soon as possible”.⁴

What Anne Brennan inherited

Disillusionment, discontent and uncertainty

Brennan described an atmosphere of “intense distress and uncertainty” on her arrival at the BAC.⁵

She told the health service investigators:

Such was the level of concern on my first day at BAC as to what the patients might do in response, there was serious consideration given to closing the BAC that day and just transferring all inpatients to acute adolescent wards. However, the decision was made to keep the BAC open and to try and engage the patients, their families and staff in the transition process which it felt would give the best chance of the patients accepting and engaging with their new treating services.⁶

Hoehn told the Commission that when she attended the BAC on the afternoon of 11 September 2013, she observed that a number of young people were agitated and required the use of psychiatric nursing and visual observation categories.⁷

As a consequence of the intense levels of distress, Brennan's first weeks at the BAC involved diffusing crises and stabilising the young people:⁸

[REDACTED]

In her interview with the health services investigators, Brennan said:

So, it was getting to know them while managing for a few of them [REDACTED] [REDACTED] and just intense distress over the fact that it wasn't that they were moving on, at that point, it wasn't they were moving onto something good, it was they were being abandoned and they were having everything taken away from them.¹⁰

Brennan inherited a cohort of staff who had become disillusioned and unsettled by a number of recent events, including the announcement of the closure of the BAC, the loss of Clinical Director Trevor Sadler, the loss of qualified staff whose positions had not been filled, and concerns about patient welfare and safety.¹¹ She was also faced with an unfortunate breakdown in the relationship between some of the education staff and the clinical and allied health staff.¹² She summarised her perception of the views held by the education, allied health, and nursing staff as follows:¹³

- The education staff were almost unanimously of the view that closing the BAC school was wrong. They actively supported the Save the Barrett campaign. Their attitude was that no other school or facility would be able to support the patients as they did.¹⁴
- The allied health staff were split on the issue of whether the BAC should close.
- The nursing staff were also split on the decision to close but, generally they worked together with the transition planning group to find the best possible alternative services for each patient.
- Staff morale was affected by the distress of the patients, the suspension of Sadler, insecurity regarding employment prospects,¹⁵ heavy workload due to staff resignations and the lack of relevant skills displayed by the casual or agency staff.¹⁶

Effect of the lack of handover

Brennan did not receive any handover from Sadler – a procedure she and Sadler both considered would have been especially helpful.

Sadler told the Commission that a verbal handover provides an important opportunity for discussion and clarification:

I think if you can provide direct verbal handovers – my feeling is that you can communicate in written form but having the opportunity for a verbal handover was important because then you can clarify questions. You might have different perceptions about what is meant by different terms or different interventions, and having the opportunity to actually discuss things so that there's clarity would have been really quite important.¹⁷

Brennan said that a patient's diagnosis or demographic details do not, in themselves, convey much about the patient. She said she would have been assisted by insight from a psychiatrist's perspective, as opposed to that of a skilled nurse.¹⁸ In particular she explained:

... to have an insight into what the young person's ... psychopathology is or what their defence mechanisms are like ... or their usual patterns of behaviour ... [are] clinical gems of how to manage somebody. It's those kinds of things that, really, only, I think, psychiatrists can give you.¹⁹

Brennan also said that, had she received a handover from Sadler, she would have asked him for a nuanced synopsis of each patient, detailing their presentation and needs.²⁰ She would have also appreciated his view of the staff, their skills, whom to rely on, and any advice regarding potential "traps for new players".²¹ Brennan said that it would have "made it perhaps a little bit easier" had she "understood that there was already some existing tension between education and health [staff at the BAC]".²²

Brennan said she was unsure, retrospectively, if a handover from Sadler would have had any material impact on the patients' transition. She added, "It might have made my work easier at the time".²³ The Commission agrees with that assessment.

Few up to date resources

According to Sadler, the resources available to assist Brennan included:

- a green folder which contained details of referring agencies and alternative services that was kept at the nurses' station
- a list of services maintained electronically in a sub-directory on the West Moreton G: Drive
- comprehensive notes for each patient that had been prepared for by the care planning workshops (which he said occurred every two to three months),²⁴ summarising interventions and progress over the previous three months.²⁵

However, the contents of the green folder and the electronic list of services were limited and out of date.²⁶

Brennan expressed concern about the quality of the transition resources that were available. Her evidence was that the BAC did not have a database or list of services to which patients might transition.²⁷ There were "some documents of resources", however they were outdated and "far from comprehensive".²⁸ Brennan's evidence was that she "would have expected a folder or data base to be kept in which ... details [about what services would be available for each of the young people she was required to transition] were easily available".²⁹ And there were no resources relating to adult services.³⁰

Staff had to resort to searching White or Yellow Pages of the phone book to find contact details for local services.³¹ A great deal of time was spent telephoning government departments and health services to find out what was available and if a particular patient could access a particular service in a particular area.³² Brennan said that on some days, BAC occupational therapist Megan Hayes and Clayworth would send out 32 emails and make 50 phone calls between them.³³

The Commission accepts Brennan's evidence that the transition planning was an enormous task and "not helped by an absence of resources on available services".³⁴

Lack of any transition policies or procedures

Sharon Kelly, Executive Director Mental Health and Specialised Services of West Moreton HHS gave evidence that staff at the BAC were expected to employ “business as usual” transition practice, policies and procedures.³⁵

However, Brennan’s evidence was that no transition literature was available at the BAC or provided to her by West Moreton HHS or CHQ, and that she had to search for such literature and ask colleagues herself.³⁶

Beth Kotzé told the Commission that, to the best of her recollection, none of the BAC clinicians or staff who were interviewed during the health services investigation mentioned the West Moreton HHS Inter-district Transfer Procedure.³⁷ This evidence is consistent with that of Hayes and Carol Hughes, neither of whom were aware of the procedure,³⁸ as well as that of Padraig McGrath who did not recall seeing the Inter-district Transfer Procedure before being shown it during the Commission’s oral hearings. McGrath said that he did not refer Clayworth to any official policies or processes when he gave her guidance in relation to her responsibilities.³⁹

The Commission is satisfied that the transition work was not underpinned by formal guidelines, as there were none.⁴⁰

IT issues

The computer support provided to Brennan was inadequate in two respects.

First, it took several weeks for her to obtain an employee login so that she might access a computer.⁴¹

Second, some of the staff had not been trained to use Queensland Health’s Consumer Integrated Mental Health Application (CIMHA) to record data, and Brennan was not provided with training in its use.⁴² For example, Brennan said that “[r]ecord keeping of dates of transfer from inpatient to day-patient or outpatient status and discharge dates did not seem accurate when I started at BAC”.⁴³

No new services available

As counsel for the State of Queensland submitted, in September 2013, Brennan ‘appreciated’ that the new services being developed by CHQ would not be an option for the transition of the BAC patients.⁴⁴

Brennan said in oral evidence that “[she] was aware they were being developed and that they were not ready for this cohort”.⁴⁵

Availability of beds at the Mater

There was some conflict in the evidence about the availability of beds at the Mater Hospital.

The Commission accepts that Brett McDermott, who was then the Executive Director, CYMHS Mater Health Service, was at all times willing to provide what assistance he could to Stephen Stathis (Clinical Director of Child and Youth Mental Health Services, CHQ) and Brennan.⁴⁶

Sometime after the BAC closed in January 2014, the Mater formally agreed to make two beds in its adolescent acute mental health unit available as needed for sub-acute patients in need of extended inpatient care.⁴⁷

The contentious issues were whether those beds were available before the closure and whether Brennan was aware of their availability.

The Commission is satisfied that it was not until about November 2013 that there was discussion about those beds and that Brennan was unaware of them.⁴⁸ There was some tension in the evidence and submissions about whether these sub-acute beds would have been taken up in any event, which is not necessary to resolve.

How Anne Brennan went about the task

Finding her bearings

Brennan was not given any specific instructions on how to carry out the task of developing and implementing the transition plans for the BAC patients.⁴⁹

Brennan and Hoehn agreed that Hoehn should take the lead in engaging with SWAETRI about new services, to allow Brennan to focus on what services were currently available for the BAC cohort.⁵⁰ Brennan thought that as she was the clinician for the BAC cohort, from a clinical perspective it would be best for her to be seen as independent from the process of developing the new services:

[T]here was significant distress on the part of several people connected with the Barrett and of some of the patients and their families about the provision of new services, the delay in providing them ... I thought it best not [to] align myself in any way with a process that was causing [the patients and their families] distress.⁵¹

The Commission accepts that this was a sound approach.

Brennan later described Hoehn as “supportive, strategic and always available by phone day or night and on weekends”,⁵² and a “sounding board” in relation to her approach to the transition and development of transition plans.⁵³

The meaning of transition and the principles which should inform it are discussed in chapter 18. Brennan fully appreciated those principles. She quickly appreciated, too, that what she had been asked to undertake was far more than “transition” in the usual sense.

On Brennan’s first day, psychiatry registrar Thomas Pettet, Clayworth and other clinical staff provided her with an oral handover about each patient’s current presentation, a brief synopsis of their history, and information focused on patients considered to be at acute risk that day.⁵⁴ Either Clayworth or Susan Daniel (BAC Community Liaison Nurse) provided her with a folder of information about inpatients and day patients.⁵⁵

At the outset and in line with her transition principles, Brennan recognised that in order to get to know each patient and ascertain their transition requirements, she had to familiarise herself with their family situations, understand which therapeutic approaches had worked (or not) thus far, and identify the current service providers.⁵⁶ Brennan explained the importance of consultation with families in the following way:

Consultations with patients and family were carried out in person or by telephone to understand the family dynamics, the needs and aspirations and concerns of the patient and making suggestions about services so as to develop a recommendation which met the needs of the patient and was acceptable to all parties.⁵⁷

Within two days of her commencement Brennan had spoken to all but two families.⁵⁸ She subsequently held meetings with eleven families, meeting with some of them more than once.⁵⁹

On 16 September 2013, Brennan convened a case conference with a large panel which “went for a very long time, perhaps all day”.⁶⁰ During this conference there was detailed discussion about each patient, with input from each care coordinator and individual therapist.⁶¹

The Clinical Care Transition Panel

In late September 2013, Brennan formed and chaired the BAC Clinical Care Transition Panel (the transition panel).⁶² Brennan retained overall responsibility for the plans that the transition panel developed.⁶³

Brennan chose members of the transition panel according to their skills and the needs of the patients.⁶⁴ Daniel also nominated staff to sit on the panel (nominees being determined by their responsibilities and availability).⁶⁵ The members of the transition panel included:⁶⁶

- Vanessa Clayworth – acting Clinical Nurse Consultant
- Megan Hayes – Occupational Therapist
- Carol Hughes – Social Worker
- Laura Johnson – administrative support⁶⁷
- Justine Oxenham – Teacher at the BAC School
- Kevin Rodgers – Principal BAC School⁶⁸
- Deborah Rankin – Teacher at the BAC School
- Susan Daniel – Clinical Nurse
- Angela Clarke – Speech Pathologist
- carers, family members and community service providers (on a case by case basis)⁶⁹
- other BAC staff members and non-BAC professionals, on a case by case basis (subject to individual patient needs).⁷⁰

Clayworth was the acting Nurse Unit Manager from 5 August 2013 until 13 October 2013 when she was formally appointed to the position of acting Clinical Nurse Consultant at the BAC.⁷¹ This was a new position created to support the transition work.⁷²

Brennan explained that the transition panel was small because of confidentiality issues⁷³ and also because “it was clear from the initial case conference that took approximately 7 hours that we would be unable to progress if the meetings were as large as case conferences with all available staff there on the particular day, but coming and going depending on other duties”.⁷⁴

Separation of staff into two groups – transition panel members and case coordinators

Case coordinators played an important role in the day-to-day therapeutic care of the patients.⁷⁵ After Brennan’s appointment, the transition panel was responsible for the planning and management of transitional arrangements for transition clients, and the case coordinators were no longer directly involved in the transition planning.⁷⁶ Brennan considered it was important to maintain a separation between them.⁷⁷

Case coordinators and other nursing staff were charged with the day-to-day care of the BAC patients. It was the role of the case coordinators to implement the transition arrangements and carry out delegated transition-related tasks.⁷⁸ Brennan stated that this “necessitated phone calls, emails, home and service visits as well as the most important component which was one to one, day to day emotional support at BAC”.⁷⁹ The case coordinators “perform[ed] a role in terms of a conduit before, say, the transition panel and, the young person and their family”.⁸⁰ As Clayworth said:

It took much consideration and many discussions... when there was heightened anxiety and the young people... were having trouble identifying with somebody they could trust. So in order to keep the therapeutic relationship and the therapeutic trust there was a decision initially that the case co-ordinators would be there to support and be an advocate for the young people and the young people’s families.⁸¹

When asked whether the case coordinators were invited to join the transition panel, Clayworth responded:

[The case coordinators] ... were welcome to join the panel,⁸² but we wanted to make it known to the young people should it be somewhere that the young people found it difficult to consider or comprehend the placement that they still had somebody to identify with and feel safe with, and that was the CCs or associate CCs.⁸³

The transition panel’s role

The transition panel had to draw together a number of services that addressed the individual patient’s needs – in other words, what Kelly described as “wrap-around care”, namely “an individualised service plan” which involved “identifying the needs” and “an appropriate package of care or wrap-around service”.⁸⁴

According to Brennan, the function of the transition panel was to:

- explore the full range of possible care options for each individual young person
- develop a list of options for each young person, and then assist the case coordinator, young person, and their family to choose what suited them best. This involved hours of work, including calling government and non-government agencies, attending meetings on and off-site, and preparing referral documents
- make referrals, and communicate relevant matters to receiving services
- where time permitted, trial services and monitor the transition
- keep West Moreton HHS updated as to the progress of transition plans and transition care.⁸⁵

Similarly, Hayes described the role of the transition panel and other BAC staff to:

- identify other needs and appropriate service providers for the adolescents
- discuss possible options (where options existed) with the adolescents and their families/carers
- facilitate the referral of adolescents to those services.⁸⁶

Brennan would present each adolescent’s case at the transition panel meetings, and then the panel would discuss the patient’s community reintegration needs.⁸⁷ Hayes described the focus of the panel as to utilise a holistic approach to addressing each adolescents needs for transition.⁸⁸

The transition panel met on a regular basis between October and November 2013.⁸⁹ Clayworth explained that panel meetings were scheduled over a series of weeks from 15 October 2013 until 25 November 2013 on Tuesdays, Wednesdays and Thursdays, and that over the course of each two-hour session, usually three BAC patients were reviewed one by one.⁹⁰

Clayworth went on to explain that, in the absence of any like facility to BAC, unless a patient required acute (inpatient) care, they needed to be transitioned back into their community. The transition panel's focus was to identify each adolescent's community reintegration needs and the skills which they would need to develop to achieve reintegration. This was done by:

- a. Dr Brennan summarising the patient's case with reference to their CIMHA record and if possible, identifying a tentative discharge date.
- b. The panel, as a group, discussing the adolescent's community reintegration needs and skill needs with reference to a guide which was projected onto a screen that the adolescent would require to successfully reintegrate.⁹¹

Brennan explained that the transition panel had to consider and balance a number of factors before they could create a transition plan:

In order to develop a transitional care plan for each individual patient, it was necessary to first get to know and understand them, their history, their family, their strengths, difficulties and hopes for the future. It was also important to understand their previous involvement with services and therapists in order to identify services that were developmentally appropriate and accessible both physically and financially, that could deliver good quality care in the least restrictive environment, while providing an appropriate level of security and addressing any risk of harm. Such care should promote recovery and growth; protect, restore and develop relationships with family, friends and community; and engage each adolescent in educational and /or vocational activities commensurate with their capabilities and interests.⁹²

Brennan understood that the transition arrangements needed to take into account higher education, employment, living arrangements and the development of relationships with other young adults.⁹³ For example, in addition to looking at health care providers, the transition panel identified broader community supports and accommodation providers. They obtained information from community service databases, NGOs, and even the Yellow Pages. They convened a large stakeholder meeting with many NGOs, service providers and agencies.⁹⁴ She explained that:

... apart from acute inpatient mental health units in child, adolescent and adult sectors, community adult health clinics, CYMHS clinic and mental health day programs in Brisbane, [redacted] we tried to identify broader community supports, and accommodation providers.⁹⁵

Hughes took on the role of gathering information and carrying out research on the internet with a view to informing decision-making regarding appropriate placement and referral sources. She also made contact with a number of families, and housing and support agencies.⁹⁶

For some patients, special requirements, such as 24-hour support and additional nurses, were negotiated and provided.⁹⁷

The Commission understands that the task was a difficult one, and notes that Daniel's role on the transition panel consisted of "... making desperate internet searches for possible community support services and numerous telephone calls to make referrals to other agencies or facilities with the hope of being able to jump wait lists".⁹⁸

Transition planning documentation

The transition panel's goal was also to develop a discharge plan for each patient and to ensure that a well-informed handover to each receiving service occurred.⁹⁹

Before and after panel meetings, Brennan and Clayworth compiled "Community Contacts" for each patient.¹⁰⁰

The transition panel attempted to create 'transition guides' to capture the needs of patients to assist the transition panel in identifying relevant services. Hayes said:

These needs included for example:

- a. psychiatric, psychological and medical needs; community mental health service support
- b. accommodation including family homes; supported accommodation; youth and community housing; community care units
- c. vocational
- d. educational including school and TAFE studies
- e. living skills/self-care including healthy eating habits, dieting, cooking, household chores and budgeting
- f. leisure/recreational including social clubs
- g. community linkage (that is, Open Minds, Headspace) and specific youth services
- h. family support and psycho-education
- i. service handover documents such as discharge summaries (including those for GPs), crisis management plans and clinical hand over documents including those for psychology, occupational therapy, speech pathology and dietetics.¹⁰¹

The transition guides were not intended to reflect the actual transition plan for each patient. Clayworth said they were "not complete and were not intended to be representative of a comprehensive plan for each adolescent".¹⁰²

The general approaches taken for specific elements of transition planning, including accommodation, clinical care, and education, are described in further detail below.

Counsel for West Moreton HHS submitted that:

[T]he original intent was that the new services would be operational coincident with the closure of BAC to ensure that current BAC patients did not experience a gap in services. As assessment and implementation of discharge/transition of existing BAC patients progressed, as outlined above, it became apparent that those patients could be safely and appropriately discharged to the services operational at the time of individual discharges/transitions or with wrap around care.¹⁰³

There is a tension between this submission and the evidence from Brennan about her experiences at the time.

Item 5 of the minutes of the Barrett Centre Allied Health Operational Meeting dated 16 December 2013 suggested that all was not going well during the transition process. These minutes state that "feedback has been received that some of the adolescents already transitioned are not managing well ... [and that] [i]ntensive service requirements may be difficult for community based services to provide".¹⁰⁴

Further, in [redacted] Brennan was desperate to find appropriate and sufficient

[redacted]¹⁰⁵

[REDACTED] Panel

[REDACTED] Brennan convened [REDACTED] Panel [REDACTED].¹⁰⁶ This panel was comprised of a multidisciplinary group of mental health practitioners. [REDACTED]¹⁰⁷ The details of this statewide panel, [REDACTED], are discussed in the confidential volume of this report.¹⁰⁸

Consequences of lack of new services

Brennan and her team faced many difficulties in identifying existing services for the BAC patients.¹⁰⁹ The Commission accepts her evidence about this.

She told the health services investigators that, while a number of services could provide some of the treatment, accommodation, allied health or educational requirements of the BAC cohort, “there was no service which was tailored to provide all the services in a single location, let alone which would allow the patients to connect with and maintain close contact with families, friends and community”.¹¹⁰

In her oral evidence Brennan said that the options available for an individual with a mental illness requiring supported accommodation were extremely limited, and that the accommodation that was available was, in her opinion, extremely poor.¹¹¹ Further, some of the patients simply did not fit neatly into any alternative service, and so she had to try to persuade services to “change their rules” to accommodate BAC patients.¹¹² She also said that some young people were not ready for transition from the BAC, at least not in the usual sense.¹¹³

Brennan’s frustration in trying to identify services in the absence of any new alternatives resonated in her interview with the health service investigators in October 2014:

... the Board was often trying to look like they’re saying the right things and there was always this bit that would come up, Barrett will not close until there are [wrap] around services available. Well, to my simple way of thinking, we are now more than 12 months on from when they said that they would be provided and that was the new services under [SWAETRI] ... those services included things like a residential in [REDACTED]. That new service must be up and running before Barrett closes. I think they took their first patient ... So I guess you could say they were up and running! But the residential wasn’t and still isn’t.¹¹⁴

The idea is I think that you have more community-based care, that you live in a community and access other services. They are going to have [Y-PARC] model care and step up step down models. At this stage, they are not in existence. They’ve got the pilot residential at Greenslopes but that’s all.¹¹⁵

When Counsel Assisting put to Brennan that SWAETRI did not assist her by identifying any new services to which BAC patients might transition,¹¹⁶ she responded that they did not identify any services other than the residential facility at Greenslopes, for which they started recruiting towards the end of December 2013.¹¹⁷

Accommodation

Hayes explained that she made preliminary contact with many housing and support agencies to identify those with potential to meet the BAC patients’ community reintegration needs. If an adolescent was unable to return home to live with family, the location of accommodation arrangements with other clinical or support networks needed to be identified in advance.¹¹⁸

Many BAC patients accessed these services, for example:

- six of [redacted] ¹²⁸
- four patients [redacted] ¹²⁹
- three patients [redacted] ¹³⁰
- seven patients [redacted] ¹³¹
- three patients [redacted] ¹³²
- three patients [redacted] ¹³³
- some patients were [redacted] ¹³⁴

Education

Addressing the educational needs of the individual BAC patients was an important part of transition planning. This was left in the experienced hands of the education staff at the Barrett Adolescent Centre Special School (BACSS), which operated the on-site integrated education program at the BAC.¹³⁵ Specifically, Brennan asked the education staff to “write up an individual education plan for each young person”.¹³⁶

Practically speaking, the determination of education services for the individual BAC student was very much dependent on the clinical care arrangements that were made for the individual BAC patient.¹³⁷ Deborah Rankin who was the acting Principal of the BACSS from 21 October 2013 to 3 December 2013,¹³⁸ said that staff at the school and the health professionals at the BAC attended regular meetings to discuss the transition plans.¹³⁹ Despite the tensions between some education and some health staff referred to earlier in this chapter, Rankin and Brennan enjoyed a good working relationship.¹⁴⁰

Peter Blatch, the Assistant Regional Director, School Performance, Special and Specific Purpose Schools said that there was no change in the curriculum or education planning content during the transition period, but there was a focus on assessing the social and emotional issues of the students, associated with their transfer to other services.¹⁴¹

Rankin explained that “the education transition arrangements were managed and administered by each class teacher, Kevin Rodgers as Principal and [her] as Acting Principal”.¹⁴² In particular Rankin said that “the transition arrangements were monitored closely through weekly meetings. In addition to this, communication with parents and health care professionals was frequent and included regular emails, phone calls and visits”.¹⁴³

Education staff at the BACSS remained constant throughout the transition process, although Rodgers found he was unable to continue in his role as principal due to health issues.¹⁴⁴ He returned from sick leave on 4 December 2013 for 10 days to assist the education staff with the move to the new site for the BACSS on the grounds of the Yeronga State High School.¹⁴⁵

The BACSS also employed teachers Justine Oxenham and Susan Cassidy to work an extra day each week until the end of the school year, to meet with parents/carers so that they could best represent parents’ views at the transition panel meetings.¹⁴⁶

Blatch gave evidence of a “simple tracking tool” that was developed by him and the school principal¹⁴⁷ to monitor student transitions.¹⁴⁸

The educational transition plan developed by the education staff recognised the student's health, accommodation and family/carer arrangements¹⁴⁹ and included:

- the student's educational history before and during their admission to the BAC
- the student's achievements across different subjects and vocational areas
- information about earlier unsuccessful educational plans
- information to encourage further learning, strengths and interests
- areas of concern regarding educational outcomes
- the student's forward plan.¹⁵⁰

Other arrangements, such as assisting with transport arrangements, training on how to access public transport, variation in food provision and variation of timetable were also included.¹⁵¹

Rankin said that:

These transition arrangements included but were not limited to supporting students at the new school site in Yeronga (including making preparatory visits to the site with the students) and developing outreach programs for students who, due to the severity of their mental illnesses and/or their distance from the new School site, prevented them from attending School in 2014.¹⁵²

A general overview and assessment of the educational component of the transition arrangements is set out in chapter 21. An individual overview and assessment of the adequacy of the education component of the transition arrangements for each BAC patient considered to be a transition client¹⁵³ is contained in the confidential volume of the report.

Families

As Brennan accepted, detailed, careful and lengthy consultation and communication with families is an element of a good transition.¹⁵⁴

The Commission accepts her evidence that from the perspective of patients and their families, there was uncertainty about why the BAC was closing and what new services would be online when it closed, and that this made the transition process more complex. Relevantly she said:

I think if there had been a shared narrative about why Barrett [was] closing it may have helped. It may have allayed some anxiety for some if there had been a clear understanding of when new services would come online and what would they be. And in particular, I think – as I understood it from the concerned consumers and their supporters, I think the perception that services weren't available was highly relevant... the fact that some, particularly tier 3, were seen not to be available, I think, contributed to the perception of abandonment and I think that made the transition process very complex in this particular case. So it certainly wasn't business as usual.¹⁵⁵

Families received various Fast Facts and other communications from the West Moreton HHS, which are discussed in chapter 24.

No one person was solely responsible for ensuring that families and carers were regularly updated on and involved in their children's transition planning. Instead, they received communications from a number of BAC staff members, including Hughes, Hayes, Clayworth and sometimes Brennan.

As noted above, the transition panel's functions included maintaining contact with patients and their families, developing a list of options for each patient and then assisting the care coordinator and the patient and their family choose what best suited them.¹⁵⁶

There was limited evidence as to the precise information each family received about their child's transition plan. Some transition plans were relatively straightforward given the transition clients' ages and clinical trajectories,¹⁵⁷ while others were more complex and may have necessitated more communication with families. The families did not receive written transition plans as such, but were informed of the transition arrangements on an ad hoc basis.¹⁵⁸

Sometimes patients expressed preferences contrary to those of their families. For example, [redacted]

[redacted]¹⁵⁹ [redacted]¹⁶⁰ Another patient's parent [redacted]¹⁶¹

[redacted]¹⁶² Where Brennan assessed a patient as [redacted]¹⁶³

[redacted]¹⁶⁴ [redacted]

[redacted]. Even apart from ethical and legal obligations to maintain confidentiality, it was important for the clinicians to maintain confidentiality in order to build trust and rapport with the patient.¹⁶⁵

Timing issues

Brennan gave evidence of a "sense of time pressure" and mixed messages about timing – that on the one hand there were clear indications that the BAC would remain open as long as was necessary to ensure the best result for patients while on the other hand there were statements that the BAC needed to close as soon as possible".¹⁶⁶

Hayes said that "there was a general sense of urgency to transition the adolescents from BAC during September 2013 – January 2014 which gained momentum once the closure date was announced".¹⁶⁷

Darren Neillie (then Clinical Director, High Secure Inpatient Services at The Park) said he did not believe the "target closure date of January 2014 ... was ever fixed as a definite closure date, however, it was clear to [him] that this was the timing towards which the transition team was working".¹⁶⁸

The Commission accepts Brennan's evidence that "...as the numbers of patients decreased, the unit did not function well. There were increasing risks for some still resident at BAC".¹⁶⁹ Issues such as the mix of the remaining patients and a lack of appropriate staff, made indefinite or further extended care under the guise of a "flexible closure date" difficult.¹⁷⁰

Indeed, the transitions of [redacted]

[redacted]¹⁷¹ The

Commission accepts that once the transition process commenced, the ever decreasing number of patients remaining at the BAC made the flexibility of the closure date increasingly illusory.

Working with staff

When Brennan arrived, a number of staff were very unhappy with the decision to close and made their views clear.¹⁷² She told the Commission that the active and vocal opposition to the closure of some staff made transition more difficult for some patients who were influenced by those views.¹⁷³

Amongst the staff, there was an atmosphere of intense distress and uncertainty about the wellbeing of patients and their own future employment.¹⁷⁴

The Commission accepts that Sadler's standing down was "... an overwhelmingly negative experience for all staff involved".¹⁷⁵

In late September 2013, West Moreton Chief Executive Lesley Dwyer appointed an external investigator to review the circumstances which led to his being stood down. The investigator inspected facilities at the BAC and took photographs of areas of interest. Between mid-October and early November 2013, he conducted a series of interviews with staff.¹⁷⁶

Some staff were very distressed by the ongoing investigation.¹⁷⁷ Some were concerned that there might be negative repercussions for them professionally.¹⁷⁸ Brennan observed that the nurses were "traumatised" as a result of their involvement in the investigation.¹⁷⁹ Her evidence was that:

[T]he nursing staff felt that their competence and commitment was under question and yet at the same time they were expected to continue to provide care for these adolescents who were dealing with a lot of anxiety and whose behaviour at times was very difficult to manage in a nursing setting. I – as I say, I don't know what more could have been done but I was aware that the nurses expressed a sense of being abandoned by the executive in terms of caring for their needs at that time.¹⁸⁰

Brennan recalled a complaint by staff that the individual who was escorting the investigator around The Park was the human resources representative staff were expecting to turn to for support.¹⁸¹

Unsurprisingly, Brennan said that at times some staff were more of a hindrance than help.¹⁸²

Brennan said that the vagueness of the closure date was frustrating for staff and made it difficult for them to make decisions about their futures.¹⁸³ She gave evidence that "As the number of staff reduced and the level of anxiety increased I recall emailing Leanne Geppert advising that a specific date should be circulated to avoid the uncertainty affecting everyone".¹⁸⁴

In Brennan's view, there should have been "consistent clear advice from the executive and HR re closure date".¹⁸⁵

One consequence of Brennan's having to work with an unsettled staff cohort was that a significant amount of her time was spent supporting staff by listening and encouraging them.¹⁸⁶ Allied health staff, nurses, and teachers frequently called her and expressed their concerns.¹⁸⁷ Brennan said that "To maintain a functional unit, I took the view that it was imperative to support staff as best I could within the time constraints of a heavy work load where the focus needed to be on patient care and development of comprehensive transitional care plans".¹⁸⁸

Another consequence was that some staff took exception to changes Brennan implemented, such as not allowing the patients ground leave.¹⁸⁹ One staff member disregarded instruction.¹⁹⁰

Brennan also had to deal with the unfortunate breakdown in the relationship between some education staff, and allied health and clinical staff.¹⁹¹ According to Margaret Nightingale, this had

been “festering” since late 2012, and became difficult to manage.¹⁹² It deteriorated to the point where education staff were no longer welcome at discussions about the BAC closure led by West Moreton HHS.¹⁹³ Ashleigh Trinder (a psychologist at the BAC) said Sadler had been a “containing” figure who had brought the teams together, and that with his departure there was a loss of staff cohesion.¹⁹⁴

In Brennan’s assessment, staff discontent did not ultimately have any direct impact on the implementation of the transition plans, although their hostility was sensed by the patients and may have been an added stress for them, at a time when they needed a sense of confidence and trust.¹⁹⁵ The Commission accepts and adopts that assessment.

The adequacy of support to staff is discussed in chapter 23.

Clerical matters

Brennan received administrative assistance from the West Moreton HHS project officer, Laura Johnson.¹⁹⁶ Brennan’s written evidence was that she understood it to be Johnson’s role to document the transition process and to maintain a summary of plans, including any changes made.¹⁹⁷ Brennan thought Johnson’s knowledge and ability to assist in identifying necessary services were limited.¹⁹⁸

Brennan also thought that the documentation of the transition process was not sufficiently maintained¹⁹⁹ and that the process of arriving at the decisions that were ultimately incorporated into those plans was not sufficiently documented. For example, she felt that each service that was approached and its response should have been captured. This meant that there was no one-page document encapsulating the entire transition plan for a patient that could have been handed on to a receiving service.²⁰⁰

There is a tension in this evidence, and the evidence in Johnson’s statement, that Brennan did not provide her with day-to-day direction. Johnson’s written evidence was that her day-to-day direction was provided by Geppert, and that she understood her role with respect to the transition panel to be the provision of high level administrative support.²⁰¹

Ultimately, Brennan considered that the absence of this documentation did not impact adversely on the transition planning.²⁰² The Commission agrees.

Brennan said that following closure there was inadequate administrative assistance.²⁰³ She was left to complete the discharge summaries without support and hampered by inability to access a dictaphone or to have Winscribe software installed on her computer. However, the Commission notes Brennan’s further evidence that after a few days of working alone in the BAC, she moved to an administration building where she shared an office with two administration officers who were of assistance.²⁰⁴

The role of the West Moreton HHS executive

As noted in chapter 17 (The appointment of Anne Brennan), Brennan reported at least weekly to the West Moreton HHS executive (Dwyer, Kelly and Geppert). Although Brennan agreed in cross-examination that they were responsive to matters she raised,²⁰⁵ she said that the support she received was not always ideal.²⁰⁶ For example, there was “... inadequate nursing staff in terms of the numbers or skills on some shifts”.²⁰⁷ And there was no central point of authority to which she could appeal to put transition plans into effect.²⁰⁸

Geppert (now the Director of Strategy at West Moreton HHS)²⁰⁹ gave evidence of providing Brennan with strategic advice about the most appropriate contacts in various services associated with transition, and either suggesting processes to engage these contacts or making contact on behalf of Brennan.²¹⁰ Geppert described her role in the transition process in the following terms.

She was:

- "... a key contact for internal and external stakeholders to WMHHS regarding the progression of transition plans, and was specifically involved in supporting the development of and then referring funding requests to the appropriate decision-maker regarding transition packages"²¹¹
- "engaged in the development of solutions and negotiations with key stakeholders when barriers were identified with the implementation of transition plans"²¹²
- "... the person to whom matters were escalated if Dr Brennan was experiencing barriers to progressing a particular transition plan through normal referral processes, and transition plans that required additional funding (in addition to care already provided through the public system)".²¹³

Summation

In a little over four months, Brennan and her dedicated team completed their task with unflinching commitment and professionalism. The adequacy of the transition arrangements and the adequacy of the care, support and services provided to transition clients and their families are discussed in chapter 21.

(Endnotes)

- 1 Exhibit 71, Statement of Beth Kotzé, 18 December 2015, Attachment F to that statement, "Transitional Care for Adolescent Patients of the Barrett Adolescents", p 67.
- 2 Exhibit 53, Statement of Kristi Geddes, 22 October 2015, Attachment KG-50 to that statement, Pre-interview statement of Anne Brennan, Part 9 Investigation into Statewide Transition and Care Planning Measures Following Closure of the Barrett Adolescent Centre, p 753 para 14.
- 3 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 19 para 77; Transcript, closed hearing.
- 4 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 4 para 14. In his statement Kingswell said that the intention was to finalise the closure [of BAC] prior to the start of the new school year in 2014, Exhibit 68, Statement of William Kingswell, 21 October 2015, p 11 para 22(iv).
- 5 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 51 para 129; Exhibit 53, Statement of Kristi Geddes, 22 October 2015, Attachment KG-60 to that statement, Transcript of Health Services Investigation interview with Anne Brennan, 13 October 2014, p 850 lines 92–93.
- 6 Exhibit 53, Statement of Kristi Geddes, 22 October 2015, Attachment KG-50 to that statement, Pre-interview statement of Anne Brennan, Part 9 Investigation into Statewide Transition and Care Planning Measures Following Closure of the Barrett Adolescent Centre, 13 October 2014, p 743 para 10(a).
- 7 Exhibit 64, Statement of Elisabeth Hoehn, 18 November 2015, p 4 para 17.
- 8 Transcript, Anne Brennan, 4 March 2016, p 20-90 lines 1–3.
- 9 Exhibit 53, Statement of Kristi Geddes, 22 October 2015, Attachment KG-60 to that statement, Transcript of Health Services Investigation interview with Anne Brennan, 13 October 2014 [REDACTED]
- 10 Exhibit 53, Statement of Kristi Geddes, 22 October 2015, Transcript of Health Services Investigation interview with Anne Brennan, 13 October 2014, p 851 lines 143–147.
- 11 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, p 4 para 3(f); Transcript, Anne Brennan, 4 March 2016, p 20-11 lines 27–31.
- 12 Exhibit 177, Supplementary statement of Margaret Nightingale, 25 January 2016, pp 9–10.
- 13 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, p 24 para 24.

- 14 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, p 24 para 24, [confidential].
- 15 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 51 para 129.
- 16 Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 4–5 paras 15(a), (b), (e), (f).
- 17 Transcript, Trevor Sadler, 9 March 2016, p 23–95 lines 5–10.
- 18 Transcript, Anne Brennan, 4 March 2016, p 20–89 lines 17–21.
- 19 Transcript, Anne Brennan, 4 March 2016, p 20–89 lines 14–18.
- 20 Transcript, Anne Brennan, 4 March 2016, p 20–8 lines 20–23.
- 21 Transcript, Anne Brennan, 4 March 2016, p 20–8 lines 24–26, p 20–89 lines 25–40.
- 22 Transcript, Anne Brennan, 4 March 2016, p 20–89 lines 33–38.
- 23 Transcript, Anne Brennan, 4 March 2016, p 20–89 lines 39–40.
- 24 Exhibit 254, Third supplementary statement of Trevor Sadler, 26 February 2016, p 3 para 11.
- 25 Exhibit 254, Third supplementary statement of Trevor Sadler, 26 February 2016, p 3 para 11.
- 26 Clayworth said that the telephone numbers of some of the services contained in the green folder were out of date and some places had closed; Transcript, Vanessa Clayworth, 8 March 2016, p 22–50 lines 36–37.
- 27 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, p 17 para 19(a); Transcript, Anne Brennan, 4 March 2016, p 20–8 lines 43–46.
- 28 Transcript, Anne Brennan, 4 March 2016, p 20–9 lines 1–10.
- 29 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, p 4 para 3(e).
- 30 Transcript, Anne Brennan, 4 March 2016, p 20–9 lines 8–10.
- 31 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, p 4 para 3(e); Exhibit 53, Statement of Kristi Geddes, 22 October 2015, Attachment KG-60 to that statement, Transcript of Health Services Investigation interview with Anne Brennan, 13 October 2014, p 853 lines 213–216.
- 32 Exhibit 53, Statement of Kristi Geddes, 22 October 2015, Attachment KG-50 to that statement, Pre-interview statement of Anne Brennan, Part 9 Investigation into Statewide Transition and Care Planning Measures Following Closure of the Barrett Adolescent Centre, 13 October 2014, p 745 para 10(n).
- 33 Exhibit 53, Statement of Kristi Geddes, 22 October 2015, Attachment KG-60 to that statement, Transcript of Health Services Investigation interview with Anne Brennan, 13 October 2014, p 853 lines 213–216.
- 34 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, p 33 para 32(b)(iii).
- 35 Exhibit 319, Independent Health Service Investigation report commissioned by QLD Health folder 31, p 3.
- 36 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, p 17 para 18.
- 37 Transcript, Beth Kotzé, 9 March 2016, p 23–19 lines 10–36.
- 38 Exhibit 971, Supplementary statement of Megan Hayes, 2 March 2016, p 7 para 10.1; Transcript, Carol Hughes, 3 March 2016, p 19–72 lines 8–28.
- 39 Transcript, Pdraig McGrath, 3 March 2016, p 19–2 line 25 – p 19–3 line 15.
- 40 Submissions on behalf of Anne Brennan, 23 March 2016, p 11 para 23. The Commission notes that subsequently a guideline was compiled, Exhibit 681, Guideline for the transition of care for young people receiving mental health services, 21 September 2015.
- 41 Transcript, Anne Brennan, 4 March 2016, p 20–9 lines 32–40.
- 42 Exhibit 53, Statement of Kristi Geddes, 22 October 2015, Attachment KG-50 to that statement, Pre-interview statement of Anne Brennan, Part 9 Investigation into Statewide Transition and Care Planning Measures Following Closure of the Barrett Adolescent Centre, 13 October 2014, p 744 para 10(g).
- 43 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, p 19 para 19(d).
- 44 Supplementary Submissions on behalf of the State of Queensland, 14 April 2016, p 26 para 96.
- 45 Transcript, Anne Brennan, 4 March 2016, p 20–21 lines 1–3
- 46 Transcript, closed hearing; Transcript, Stephen Stathis, 10 March 2016, p 24–48 lines 33–37; Transcript, Brett McDermott, 16 February 2016, p 7–43 lines 4–22; Transcript, Brett McDermott, 16 February 2016, p 7–60 lines 11–18; Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, p 9 para 30, Attachment L to that statement, Memo from Ms Kelly dated 22 October 2013, p 620; Transcript, Brett McDermott, p 7–43 lines 17–19; Transcript, Stephen Stathis, 10 March 2016, p 24–50 lines 7–15, p 24–92 line 32, p 24–94 lines 5–6, p 24–97 lines 44–47.
- 47 Exhibit 1312, Letter from Sean Hubbard to Commission, Subject: "Notice to Produce", 18 February 2016.
- 48 Transcript, Anne Brennan, 4 March 2016, p 20–20 lines 1–10; Exhibit 359, Second supplementary statement of Anne Brennan, 22 February 2016, p 6 para 11; Transcript, closed hearing; Transcript, Stephen Stathis, 10 March 2016, p 24–48 lines 33–37.

- 49 Exhibit 28, Statement of Anne Brennan, 23 October 2015, [confidential].
- 50 Transcript, Anne Brennan, 4 March 2016, p 20-21 lines 14–16; Exhibit 1257, Email from Anne Brennan to Stephen Stathis, Elisabeth Hoehn and Ingrid Adamson, Subject: "Memo to Executive and Clinical Directors, Mental Health Services", 17 October 2013.
- 51 Transcript, Anne Brennan, 4 March 2016, p 20-21 lines 8–12.
- 52 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 51 para 131.
- 53 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, p 10 para 10(d).
- 54 Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 7–8 para 31.
- 55 Transcript, closed hearing; Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 8 para 32. This folder did not include young people on the wait list or the assessment list; Transcript, Vanessa Clayworth, 8 March 2016, p 22-49 lines 41–44.
- 56 Exhibit 53, Statement of Kristi Geddes, 22 October 2015, Attachment KG-60 to that statement, Transcript of Health Services Investigation interview with Anne Brennan, dated 13 October 2014, p 851 lines 152–154.
- 57 Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 24–25 para 97.
- 58 Exhibit 28, Statement of Anne Brennan, 23 October 2015, [confidential].
- 59 Exhibit 28, Statement of Anne Brennan, 23 October 2015, [confidential].
- 60 Transcript, closed hearing. In her statement Brennan said it took approximately 7 hours; Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 8 paras 33, 35.
- 61 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 8 para 33.
- 62 Closing submissions of Counsel Assisting, 17 March 2016, p 107 paras 375–376.
- 63 Exhibit 62, Statement of Megan Hayes, 20 November 2015, p 8 para 9.1.
- 64 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 8 para 34; Closing submissions of Counsel Assisting, 17 March 2016, p 107 para 376.
- 65 Exhibit 45, Statement of Susan Daniel, 30 October 2015, p 13 para 19.
- 66 Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 9–11 para 39(a)–(h).
- 67 Laura Johnson now Laura Tooley.
- 68 Rodgers participated in the transition panel until 16 October 2016: Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 8 para 34.
- 69 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 11 para 39(i).
- 70 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 8 para 34.
- 71 Exhibit 38, Statement of Vanessa Clayworth, 27 October 2015, p 2 para 4.1. She held the new position from 14 October 2013 until 21 January 2014.
- 72 Exhibit 87, Statement of Pdraig McGrath, 16 November 2015, p 16 para 14.6; There was evidence that this position was planned for the transition process as Kelly's notes from the 24 May 2013 West Moreton Board meeting state 'Bring in senior clinician to support transition and closure'. Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 11 para 11.2(d), Attachment SK-13 to that statement, p 884.
- 73 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 8, p9 para 38.
- 74 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 8, para 35.
- 75 Transcript, Matthew Beswick, 29 February 2016, p 16-45 line 44.
- 76 Transcript, Matthew Beswick, 29 February 2016, p 16-40 lines 24–28.
- 77 Transcript, Vanessa Clayworth, 8 March 2016, p 22-52 lines 36–43.
- 78 Exhibit 97, Statement of Brenton Page, 16 December 2015 p 10–11, paras 19.1–19.3.
- 79 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 10 para 39(g)(i).
- 80 Transcript, Vanessa Clayworth, p 22-80 lines 33–35; Also see chapter 23 regarding staff support.
- 81 Transcript, Vanessa Clayworth p 22-52 lines 37–43; Submissions on behalf of West Moreton HHS and Board, 23 March 2016, p 54 para 50(a).
- 82 The Commission notes there is some tension between the comment that case coordinators were welcome and the other evidence that it was decided that case coordinators would be there to support and advocate for the young people and their families, and not ordinarily be transition panellists.
- 83 Transcript, Vanessa Clayworth, 8 March 2016, p 22-52 lines 45–47 – p 22-53 lines 1–2.
- 84 Transcript, Sharon Kelly, 22 February 2016, p 11-18 lines 1–12; Closing submissions of Counsel Assisting, 17 March 2016, p 79 para 273; For more information about "wraparound care" see section 17 of report.

- 85 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 11 para 40; Closing submissions of Counsel Assisting, 17 March 2016, p 108 para 378.
- 86 Exhibit 62, Statement of Megan Hayes, 20 November 2015, p 6 para 7.10.
- 87 Exhibit 62, Statement of Megan Hayes, 20 November 2015, p 6 para 7.7.
- 88 Exhibit 65, Statement of Carol Hughes, 27 November 2015, p 6 para 7.7.
- 89 Exhibit 62, Statement of Megan Hayes, 20 November 2015, p 6 para 7.7.
- 90 Exhibit 39, Supplementary statement of Vanessa Clayworth, 20 November 2015, p 3 para 10.6.
- 91 Exhibit 39, Supplementary statement of Vanessa Clayworth, 20 November 2015, p 3 para 10.7.
- 92 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 12 para 45.
- 93 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, p 36 para 35.
- 94 Exhibit 28, Statement of Anne Brennan, 23 October 2015, [confidential].
- 95 Exhibit 28, Statement of Anne Brennan, 23 October 2015, [confidential].
- 96 Exhibit 65, Statement of Carol Hughes, 27 November 2015, p 10 para 8.4
- 97 Exhibit 39, Supplementary statement of Vanessa Clayworth, 20 November 2015, [confidential].
- 98 Exhibit 45, Statement of Susan Daniel, 30 October 2015, pp 13-14 para 19(e).
- 99 Exhibit 65, Statement of Carol Hughes, 27 November 2015, p 11 para 9.3.
- 100 Exhibit 39, Supplementary statement of Vanessa Clayworth, 20 November 2015, p 3 para 10.9.
- 101 Exhibit 65, Statement of Carol Hughes, 27 November 2015, pp 6-7 para 7.7; Exhibit 16, Statement of Holly Ahern, 23 December 2015, pp 8-9 para 7.1.
- 102 Exhibit 39, Supplementary statement of Vanessa Clayworth, 20 November 2015, p 3 para 10.8.
- 103 Submissions on behalf of West Moreton HHS relating to further submissions of [confidential], 12 May 2016, p 6.
- 104 Transcript, Ashleigh Trinder, 2 March 2016, p 18-22, lines 18-35; Exhibit 830, Minutes of Barrett Adolescent Centre Operational meeting, 16 December 2013, p 1.
- 105 Transcript, closed hearing.
- 106 Exhibit 359, Second supplementary statement of Anne Brennan, 22 February 2016; Exhibit 66 Statement of Sharon Kelly, 16 October 2015, p27 para 18.19, [confidential details removed].
- 107 Exhibit 39, Supplementary statement of Vanessa Clayworth, 20 November 2015, [confidential details removed]; Exhibit 29 Statement of Anne Brennan, 23 October 2015, [confidential].
- 108 Confidential details removed.
- 109 Transcript, Anne Brennan, 4 March 2016, p 20-23 lines 40-47.
- 110 Exhibit 53, Statement of Kristi Geddes, 22 October 2015, Attachment KG-50 to that statement, Pre-interview statement of Anne Brennan, Part 9 Investigation into Statewide Transition and Care Planning Measures Following Closure of the Barrett Adolescent Centre, p 745 para 10(n).
- 111 Transcript, Anne Brennan, 4 March 2016, p 20-24 lines 1-5.
- 112 Transcript, Anne Brennan, 4 March 2016, p 20-88 lines 39-43.
- 113 Transcript, Anne Brennan, 4 March 2016, p 20-23 lines 32-41.
- 114 Exhibit 53, Statement of Kristi Geddes, 22 October 2015, Attachment KG-60 to that statement, Transcript of Health Services Investigation interview with Anne Brennan, [confidential].
- 115 Exhibit 53, Statement of Kristi Geddes, 22 October 2015, Attachment KG-60 to that statement, Transcript of Health Services Investigation interview with Anne Brennan, p 864.
- 116 Transcript, Anne Brennan, 4 March 2016, p 20-21 lines 14-16.
- 117 Transcript, Anne Brennan, 4 March 2016, p 20-21 lines 16-20
- 118 Exhibit 62, Statement of Megan Hayes, 20 November 2015, p 7 para 8.6.
- 119 Transcript, Anne Brennan, 4 March 2016, p 20-23 line 43 - p 20-24 line 12.
- 120 Closing submissions of Counsel Assisting, 17 March 2016, p 141 para 478.
- 121 Exhibit 39, Supplementary statement of Vanessa Clayworth, 20 November 2015, [confidential].
- 122 Exhibit 39, Supplementary statement of Vanessa Clayworth, 20 November 2015, [confidential].
- 123 Exhibit 53, Statement of Kristi Geddes, 22 October 2015, Attachment KG-50 to that statement, Pre-interview statement of Anne Brennan, Part 9 Investigation into Statewide Transition and Care Planning Measures Following Closure of the Barrett Adolescent Centre, p 745 para 10(o).

- 124 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, p 37 para 36.
- 125 Personal Helpers and Mentors Service (Department of Social Services).
- 126 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, [confidential].
- 127 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 25 para 99(i).
- 128 Closing submissions of Counsel Assisting, 17 March 2016, [confidential].
- 129 Closing submissions of Counsel Assisting, 17 March 2016, [confidential].
- 130 Closing submissions of Counsel Assisting, 17 March 2016, [confidential].
- 131 Closing submissions of Counsel Assisting, 17 March 2016, [confidential].
- 132 Closing submissions of Counsel Assisting, 17 March 2016, [confidential].
- 133 Closing submissions of Counsel Assisting, 17 March 2016, [confidential].
- 134 Closing submissions of Counsel Assisting, 17 March 2016, [confidential].
- 135 The decision to cease the on-site integrated education program and transfer the BACSS to another location is discussed in chapter 13. The operation of the BACSS at two other locations after it ceased operation at Wacol is set out in chapter 29.
- 136 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 13 para 49.
- 137 Exhibit 78, Statement of Stephan Marriott, 11 January 2016, pp 5–7 para 7(f).
- 138 Exhibit 106, Statement of Deborah Rankin, 11 October 2015, p 2 para 10.
- 139 Exhibit 106, Statement of Deborah Rankin, 11 October 2015, p 25 para 97.
- 140 Exhibit 107, Supplementary statement of Deborah Rankin, 5 February 2016, p 25 paras 123–127; Exhibit 359, Statement of Anne Brennan 22 February 2016, p 3 para 7.
- 141 Exhibit 25, Statement of Peter Blatch, 20 November 2015, p 25 para 84.
- 142 Exhibit 106, Statement of Deborah Rankin, 11 October 2015, p 24 para 95.
- 143 Exhibit 106, Statement of Deborah Rankin, 11 October 2015, p 28 para 108.
- 144 Exhibit 110, Statement of Kevin Rodgers, 10 December 2015, p 11 para 45. He worked up until the September school holidays and for eight days following his return to work after the school holidays before commencing sick leave on 21 October 2013.
- 145 Exhibit 110, Statement of Kevin Rodgers, 10 December 2015, p 11 para 45.
- 146 Exhibit 106, Statement of Deborah Rankin, 11 October 2015, p 25 para 96.
- 147 It is not clear on the evidence if this was Rodgers, or Rankin as acting Principal.
- 148 Exhibit 25, Statement of Peter Blatch, 20 November 2015, p 26 paras 87–89.
- 149 Exhibit 106, Statement of Deborah Rankin, 11 October 2015, p 23 para 90.
- 150 Exhibit 106, Statement of Deborah Rankin, 11 October 2015, p 24 para 93.
- 151 Exhibit 106, Statement of Deborah Rankin, 11 October 2015, p 24 para 94, pp 30–31 paras 116–118.
- 152 Exhibit 106, Statement of Deborah Rankin, 11 October 2015, p 24 para 92.
- 153 See chapter 18 for an interpretation of the meaning of transition clients as the expression is used in term of reference 3(d) (that is BAC patients transitioned to alternative care arrangements in association with the closure or anticipated closure, whether before or after the closure decision).
- 154 Transcript, Anne Brennan, 4 March 2016, p 20-17 lines 19–25.
- 155 Transcript, Anne Brennan, 4 March 2016, p 20-18 lines 2–12.
- 156 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 11 paras 40(b), (d).
- 157 Exhibit 28, Statement of Anne Brennan, 23 October 2015, [confidential].
- 158 Confidential details removed.
- 159 Confidential details removed.
- 160 Confidential exhibit; Transcript, closed hearing.
- 161 Confidential exhibit.
- 162 Transcript, closed hearing.
- 163 Transcript, closed hearing.
- 164 Confidential details removed.
- 165 Confidential exhibit.

- 166 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, p 33 para 32(b)(ii); Exhibit 68, Statement of William Kingswell, 21 October 2015, p 11 para 22(iv); Exhibit 971, Supplementary statement of Megan Hayes, 2 March 2016, p 5 para 5.7.
- 167 Exhibit 971, Supplementary statement of Megan Hayes, 2 March 2016, p 5 para 5.7; Closing Submissions of Counsel Assisting, 17 March 2016, p 109 para 382.
- 168 Exhibit 89, Statement of Darren Neillie, 23 October 2015, p 8 para 8.2.
- 169 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 51 para 127.
- 170 Transcript, Anne Brennan, 4 March 2016, p 20-12 lines 33–43.
- 171 Closing Submissions of Counsel Assisting, 17 March 2016, p 109 para 380.
- 172 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, p 23 para 23(a).
- 173 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, pp 24–25 para 24.
- 174 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 51 para 129.
- 175 Transcript, Matthew Beswick, 29 February 2016, p 16-41 line 25.
- 176 Exhibit 66, Statement of Sharon Kelly 16 October 2015, Attachment SK5 to that statement, p 66.
- 177 Exhibit 53, Statement of Kristi Geddes, 22 October 2015, Attachment KG-50 to that statement, Pre-interview statement of Anne Brennan, Part 9 Investigation into Statewide Transition and Care Planning Measures Following Closure of the Barrett Adolescent Centre, p 744 para 10(d).
- 178 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 51 para 129.
- 179 Transcript, Anne Brennan, 4 March 2016, p 20-14 line 10.
- 180 Transcript, Anne Brennan, 4 March 2016, p 20-14 lines 19–25.
- 181 Transcript, Anne Brennan, 4 March 2016, p 20-14 lines 12–14.
- 182 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, pp 22–24 para 23(a).
- 183 Exhibit 99, Statement of Kerrie Parkin, 18 December 2015, p 7 para 5.6.
- 184 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 19 para 77.
- 185 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, [confidential].
- 186 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, [confidential].
- 187 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 54 para 146; Exhibit 91, Statement of Margaret Nightingale, 24 November 2015, p 22 para 87.
- 188 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 6 para 21.
- 189 Exhibit 53, Statement of Kristi Geddes, 22 October 2015, Attachment KG-50 to that statement, Pre-interview statement of Anne Brennan, Part 9 Investigation into Statewide Transition and Care Planning Measures Following Closure of the Barrett Adolescent Centre, 13 October 2014, p 744 para 10(i).
- 190 Exhibit 53, Statement of Kristi Geddes, 22 October 2015, Pre-interview statement of Anne Brennan, Part 9 Investigation into Statewide Transition and Care Planning Measures Following Closure of the Barrett Adolescent Centre, 13 October 2014, [confidential].
- 191 Exhibit 91, Statement of Margaret Nightingale, 24 November 2015, p 13 para 59(b).
- 192 Exhibit 91, Statement of Margaret Nightingale, 24 November 2015, p13 para 59(b).
- 193 Exhibit 91, Statement of Margaret Nightingale, 24 November 2015, p 13 para 59(b). The continuation of this breakdown throughout 2013 contributed to the burden under which the transition panel carried on their role of transitioning the patients from the BAC. For example, Margaret Nightingale stated that (in her view) education staff were viewed as being obstructionist during the transition period and as a result, the nursing staff stopped communicating with them which in turn led to a feeling of isolation; Exhibit 177, Supplementary statement of Margaret Nightingale, 9 February 2016, p 9 para 42.
- 194 Transcript, Ashleigh Trinder, 2 March 2016, p 18-25 lines 33–42.
- 195 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, p 24 para 24.
- 196 Laura Johnson now Laura Tooley.
- 197 Transcript, Anne Brennan, 4 March 2016, p 20-14 lines 43–47, p 20-15 lines 1–4; Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, p 16 para 17.
- 198 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, p 16 para 17.
- 199 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, p 16 para 17.
- 200 Transcript, Anne Brennan, 4 March 2016, p 20-16 lines 1–7.
- 201 Exhibit 127, Statement of Laura Tooley, 22 October 2015, pp 2-3 paras 2-3.
- 202 Transcript, Anne Brennan, 4 March 2016, p 20-15 lines 38–40.

- 203 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, p 16 para 17.
- 204 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 52 para 138; Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, pp 16–17 para 17.
- 205 Transcript, closed hearing.
- 206 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 52 para 136.
- 207 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 52 para 136.
- 208 Exhibit 53, Statement of Kristi Geddes, 22 October 2015, Attachment KG-60 to that statement, Transcript of Health Services Investigation interview with Anne Brennan, 13 October 2014, p 862.
- 209 From June 2011 to May 2013, Leanne Geppert had held the role of Director, Planning and Partnerships at the MHAODB and reported to Bill Kingswell. From this experience, Geppert had detailed knowledge of the funding system and how to make a funding request. Geppert used her knowledge to assist with the preparation of funding submissions to MHAODB.
- 210 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, p 23 para 12.1.
- 211 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, p 21 para 11.4(a).
- 212 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, p 21 para 11.4(b).
- 213 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, p 21 para 11.4(c).

20 Funding for transition arrangements

How were the transition arrangements funded?

Sourcing funding for transition patients

Beth Kotzé described funding to support the transition of patients as “brokerage funding” in her written evidence. In particular, she stated:

It provides a higher degree of flexibility in responding to the changing needs of an individual than more routine methods of funding allocation, and is in addition to the routine or recurrent funding. It is an extremely useful tool in responding to the care issues of young people with highly complex needs who require coordinated inter-agency responses and who may benefit from the purchase of an additional care service for a period of time that they would not otherwise be able to access. Access may be unavailable for a variety of reasons, for example, if the service is not provided in the public system but can be purchased from the private system, or there is not identified recurrent funding available for the required purpose.¹

The Clinical Care Transition Panel (the Transition Panel) arranged funding to support the transition of a number of the BAC patients. Laura Johnson² (Project Officer, Mental Health and Specialised Services, West Moreton Hospital and Health Service (West Moreton HHS)) gave evidence that she made enquiries with relevant external stakeholders about the proper process for securing funding and support, undertook preliminary tasks to facilitate provision of that funding and support and escalated needs for funding and support to Leanne Geppert as required.³

In her statement, Anne Brennan recalled that:

Requests for additional funding and interventions to secure placements were escalated to Dr Leanne Geppert and the WMHHS executive when the Transitional Care Panel were unable to procure appropriate placements and funding. This involved several government departments but details would best be provided by those directly involved. I understood that the executive of WMHHS worked to secure funding to other Hospital and Health Services in order that they could provide extra services or fund external service providers to do so, in order that BAC patients could be transitioned safely to services that would otherwise have been inadequate to meet their individual clinical needs.⁴

Geppert provided an overview of the rationale, mechanisms and governance of funding for transition arrangements in her statement.⁵ Some key points were that:

- Funding was provided through the Mental Health Alcohol and Other Drugs Branch (MHAODB) for requests associated with the provision of care through to the end of the 2013/14 financial year.
- MHAODB was ultimately responsible for deciding whether or not to grant requests for additional funding as it held the funds for that purpose in 2013/14.

- MHAODB indicated that the operational funding previously allocated to the ceased Redlands capital project (approximately \$2 million) would be redirected to the transition packages.
- Funding packages were required for patients because it was agreed by MHAODB and West Moreton HHS that the two entities would take responsibility for the financial implications of transferring a BAC patient to another facility in the context of BAC closing.
- This was the process for funding for transition arrangements. Brennan and the clinical team identified whether the patient required care over and above what the patient could expect to receive in the public system or, in some cases, the receiving services themselves identified this need. If additional care was considered necessary, Geppert would request that the receiving service liaise with Brennan about clinical needs, and that it submit a request for funding for any additional services to Geppert. MHAODB did not question the clinical assessment of the patients' needs, but on some occasions MHAODB and/or Children's Health Queensland HHS (CHQ) and/or West Moreton HHS questioned whether there were alternative ways of providing the same care under a different costing structure or funding source (for example, application for a Housing and Support Package for a patient).

Who received funding for transition arrangements?

An analysis of the evidence shows that [redacted] former BAC patients received funding to support their transition arrangements. [redacted] received funding from [redacted] to provide services through to the end of the 2013/14 financial year. This occurred through an amendment to the service agreement between Queensland Health and the receiving HHS. [redacted] patients received funding from the Department of [redacted]

A request for funding to support transition was made on behalf of [redacted] former BAC [redacted] by the receiving HHS. This request was refused, although [redacted] funding was later provided.

Patient one

During this patient's transition period, significant work was undertaken by members of the Transition Panel to source funding for wrap around care. On transition from the BAC, [redacted] [redacted] and [redacted] was provided, funded by the [redacted] via an amendment to the service agreement between Queensland Health and the receiving service.⁶ The intensity of the [redacted] [redacted]⁷

The total amount of funding approved by the [redacted] for 2013–2014 was [redacted], which was consistent with the funding required to [redacted]. However, the receiving service considered it [redacted] and this allocation of funds would [redacted]⁸

Patient two

provided [redacted] and a [redacted] package to support this patient. The aim of support for [redacted] is to assist [redacted] into [redacted] by strengthening [redacted], assisting them [redacted] and to develop [redacted].⁹ [redacted] is reserved for people who receive [redacted] to reduce their level of risk where they are in [redacted].¹⁰ In order to access [redacted] a person must be eligible for [redacted] be in [redacted] and have no access to other supports that can reduce or remove harm.¹¹

An analysis of the evidence suggests that [redacted] after discharge, a total [redacted] was provided to [redacted] to assist the patient [redacted]. At least initially, the service was for [redacted]. Further, funding [redacted] for this patient to [redacted] appears to have been approved [redacted].

Patient three

On discharge from the BAC, this patient was initially transferred to and supported by [redacted]. Although the patient [redacted], they continued to receive ongoing support from [redacted].

The [redacted] requested funding for the additional [redacted] required to provide appropriate and sufficient care for this patient. This request was approved by [redacted]. An initial funding package was provided to support transition [redacted].¹² [redacted] provided [redacted] to fund the transition package, through an amendment to the HHS's service agreement with Queensland Health.¹³

Patient four

This patient's transition involved [redacted].¹⁴ The duties of [redacted] as outlined in the service agreement [redacted] were to:

Provide [redacted] during the transition period.

Provide services based on [the patient's] needs. It had been agreed upon with the clinical team that [redacted] service provision would be flexible [redacted] developed by the clinical support team [redacted].

...

Provide [redacted].¹⁵

The budget for services for [redacted]¹⁶

There was a [redacted]. The term of the agreement was until [redacted]. Non-recurrent funding [redacted] (GST exclusive) for 2013–14 was provided by [redacted] to [redacted] via service agreement amendment window 3 on 28 February 2014.¹⁷ Prior to [redacted] it was understood that [redacted] would be providing funding for the transition.¹⁸

A [redacted] was lodged,¹⁹ but funding was not provided for the transition.

Patient five

[redacted] approved an [redacted] package for this patient and their family through [redacted]²⁰ The service included [redacted]

[redacted]²¹

This service was for [redacted]

The budget was [redacted] (GST exclusive).²² There is an indication that this [redacted]²³

The issue of funding [redacted]. [redacted]

[redacted] Vanessa Clayworth (acting Clinical Nurse Consultant BAC) [redacted]

[redacted] discussed [redacted] by email.²⁴ Clayworth noted that [redacted]

[redacted]. Clayworth's concern was the [redacted]

[redacted]

[redacted] She queried whether [redacted] There

is no information available to the Commission in respect of funding being sought beyond [redacted]

[redacted]. Ultimately, the patient [redacted]

Patient six

The director of this patient's [redacted] wrote to Geppert of West Moreton HHS seeking [redacted]²⁵ The

director outlined that the patient required [redacted]

[redacted].

This funding was not provided. A response by Geppert was drafted,²⁶ detailing that [redacted]

[redacted] had considered the request and a collective decision had been made

to deny the request due to there being no additional funds available.²⁷ Geppert's evidence was

that the [redacted] submission was considered by [redacted]

but not supported because the decision by the HHS to discharge the patient from one of their

[redacted] was not as a result of closure of the BAC [redacted]

[redacted]

[redacted]²⁸

Post-transition funding

Funding provided by CHQ

At a BAC Clinical Oversight Meeting on 12 December 2013, it was agreed that following the closure of the BAC, its operational funds would be transferred to CHQ.²⁹ Once transferred, the funds were used for the first stage of the Adolescent Mental Health Extended Treatment Initiative (AMHETI), but were also available for ongoing support of former BAC patients.³⁰ Judith Krause (Divisional Director (CHQ), Stephen Stathis (Medical Director, CHQ Child and Youth Mental Health Service) and Ingrid Adamson (Project Manager, Adolescent Mental Health Extended Treatment Initiative) had oversight of requests for funding.³¹ Krause gave evidence that decision making regarding requests for funding was undertaken jointly by West Moreton HHS and CHQ via email and memorandums from West Moreton HHS and/or other HHSs.³²

The evidence demonstrated that both Krause and Stathis felt a certain level of discomfort and concern about the use of these funds for ongoing provision of wrap around care for former BAC patients. The concerns were around past refusal to engage with CYMHS,³³ that the funding was not budgeted for in the AMHETI Business Case,³⁴ and the uncertainty of the amounts and unspecified end date of funding requests.³⁵

There was also evidence of a certain amount of tension between CHQ and MHAODB in relation to funding requests for wrap around care for former BAC patients.³⁶

Funding provided by the MHAODB

The MHAODB provided funding for wrap around care for at least two former BAC patients following their transition from the BAC. The evidence is that this funding was responsible and considered. In an email to Stathis on 9 December 2014, Kingswell stated:

In the event that the [Department of Health] needs to fund some support for either the patients or their parents, I will do that. It will be controlled. I have no intention of funding long term interventions with no end date or treatment outcomes specified.³⁷

The Housing and Support Program

Funding for some BAC patients was provided through the HASP. The 'Queensland Plan for Mental Health 2007–2017' provides an overview of HASP as a:

collaborative service initiative between the Department of Housing, Queensland Health, Disability Services Queensland and the Department of Communities. This program provides coordinated social housing, clinical treatment and non-clinical support to enable people with moderate to severe mental illness and psychiatric disability to live successfully in the community.³⁸

HASP appears to have first been contemplated by West Moreton HHS as a possible funding source in November 2013 when Laura Johnson queried whether there may have been "benefit in looking into the feasibility of a HASP type of package for the more complex cases at BAC" because "transition funding will not be sustainable in terms of managing the risk of these young people in the longer term".³⁹

Kingswell recalled that HASP was previously called 'Project 300'.⁴⁰ The Queensland Health website provides an overview of the eligibility and application process for HASP.⁴¹ To be eligible, the applicant must meet **all** of the following criteria:

- have a psychiatric disability
- be an Australian citizen or permanent resident
- reside in Queensland
- be an inpatient of a Queensland Health mental health facility who is unable to be discharged due to homelessness or risk of homelessness, or reside in the community and is homeless or at risk of homelessness and have a history of frequent mental health inpatient admissions
- be committed to maintaining stable housing
- be eligible for and meet social housing requirements
- require non-clinical supports to assist them to live in the community
- accept the provision of non-clinical supports
- be ready and willing to transition to the community with supports within three months
- provide consent.

The HASP application process⁴² begins with the local HHS identifying, nominating, prioritising and verifying the eligibility of people who are residing in extended treatment or acute mental health facilities and are homeless or at risk of homelessness, or who are living in the community and who are homeless or at risk of homelessness, and who frequently require admission to an acute inpatient facility. The HHS case manager assists the individual to select a suitable non-government provider and together they work to develop a support plan. The Department of Housing and Public Works (DHPW) assesses the person's housing and tenancy management needs and identifies a suitable property to meet those needs. Then, Queensland Health allocates funding to the person's selected NGO which then commences providing support to the person.

Who received funding post-transition?

An analysis of the evidence shows that [redacted] former BAC patients received funding to support their wrap around care after their transition to their receiving service was completed. The [redacted] [redacted] requested funding to support transition from the BAC, but did not appear to receive a response.

Of the [redacted] patients who received funding, [redacted] received funding from [redacted] [redacted] received funding from [redacted], [redacted] received [redacted] and the source of [redacted] [redacted] funding is unclear.

Patient [redacted]

From [redacted] provided [redacted] (excluding GST) in funding for additional wrap around care for the patient [redacted].⁴³ The contract for this funding appears to have been managed by the [redacted] with the funds paid by [redacted].⁴⁴ It was Krause's evidence that this package was funded from the service underspend carried forward for the subacute beds being provided by the Mater Children's Hospital, as there had been no consumers in the subacute beds and so nil expense had been incurred.⁴⁵ The service underspend was in turn part of the pool of funds which was intended for the AMHETI, which came from recurrent operational funding from the BAC (\$3.8 million) and the ceased Redlands project (\$2 million).⁴⁶

The evidence suggests that extended discussions occurred about continuing the funding for wrap around care for the patient after [redacted] [redacted] [redacted] received a quote for additional wrap around care to be [redacted] between 1 January 2015 and 30 June 2015. The quote was \$35 981.88 (including GST) and included [redacted].⁴⁷

On [redacted], Stathis and Krause discussed the continuation of wrap around care for the patient [redacted]

[redacted].⁴⁸ What eventuated was the provision of an additional [redacted] from AMHETI underspend to fund wrap around care from [redacted].⁴⁹ By [redacted], it appeared that [redacted].⁵⁰

Further negotiations were entered into with [redacted] for funding [redacted] [redacted]. On [redacted] whether there was any possibility for further financial assistance [redacted]. The request for additional funding was passed on to [redacted] was committed to funding wrap around care through [redacted] it had no capacity to fund [redacted] because the AMHETI underspend must be directed to keeping the subacute beds open for as long as possible.⁵¹

[redacted] agreed to fund [redacted] for an [redacted] with any longer term funding being subject to the provision of a progress report.⁵² However, there is conflicting evidence about whether [redacted].⁵³

Patient [redacted]

An amended service agreement between [redacted] and [redacted] was entered into for services [redacted].⁵⁴ All service requirements from the first service agreement remained, save for the provision [redacted]. The cost of services was forecast to be [redacted]. This was funded through the underspend of the previous service agreement, and no further funds were provided by [redacted].

[redacted] funded [redacted] for this patient between [redacted].⁵⁵ This totalled [redacted].⁵⁶

Patient [redacted]

A [redacted] was lodged on [redacted].⁵⁷ [redacted] did not endorse the patient for [redacted] funding of [redacted] was approved however.⁵⁸ This was to provide [redacted].

The Commission does not have access to the service agreement negotiated with [redacted] or a list of responsibilities/tasks within its remit. However, clinical notes indicate generally the type of support [redacted].⁵⁹ Specific supports included: [redacted]

[redacted]; being involved in [redacted]

[redacted] such as [redacted] assisting in [redacted]; and support with [redacted]

On [redacted] approved the continuation of services for the patient (amongst others) from [redacted]. The patient was to be supported through [redacted] at a cost of [redacted].⁶⁰

Patient [redacted]

This patient participated [redacted]. This service was provided by [redacted] which [redacted].⁶¹ [redacted]⁶² Leanne Geppert's evidence was that a funding allocation was required for [redacted].⁶³ Information regarding the amount of money that was allocated, whether the amount was approved, and the mechanism for transferring the money is not before the Commission.

Patient [redacted]

[redacted] after discharge from the BAC, this patient moved [redacted].⁶⁴ The patient's [redacted] to ensure adequate support [redacted]. After [redacted] and after [redacted], the patient [redacted]. They assisted with [redacted].⁶⁵ These [redacted].

Patient [redacted] – funding not received

There was evidence that [redacted] requested that [redacted] pay [redacted] to maintain wrap around care [redacted].⁶⁶ There is no evidence that any funding was provided for this purpose, and the parent's evidence was that [redacted] did not hear anything from [redacted] about possible funding options for the patient.⁶⁷

[redacted] also gave evidence that [redacted], the patient had an assessment [redacted] which [redacted] for funding packages. The [redacted] evidence was that [redacted] regarding funding for [redacted].⁶⁸ [redacted] there was no funding.⁶⁸

Funding for transition arrangements and beyond

A balanced and responsible approach was taken to the funding of transition arrangements, support services, and wrap around care for the BAC transition clients. [redacted] transition clients received funding. The governmental sources of the funding included the Mental Health Alcohol and Other Drugs Branch of Queensland Health, Children's Health Queensland HHS, West Moreton HHS, the Department of Communities, Child Safety and Disability Services, as well as a collaborative service between the Department of Housing, Queensland Health, Disability Services Queensland and the Department of Communities. Indeed, there was a collaborative, inter-departmental effort in financing these transition arrangements.

There was a logical and considered connection between the patient and the funding they received. The needs, services available to address those needs, and funding avenues to finance those services, were on occasion considered by panels comprised of clinical and executive staff from multiple government agencies. The funding provided was for specific, defined services addressing the individual needs of the recipient once transitioned into the community. Services included family therapy, psychotherapy, day programs, holiday activities and 24-hour clinical and non-clinical support workers provided by non-government organisations.

There was also responsible, hierarchical oversight of the financial arrangements. There is evidence of service agreements with delineated duties being entered into between the relevant government agency, signed by the chief executive of that service, and the entity providing the service. Costings and quotes were sought for services before funding approval was sought. On at least one occasion Michael Cleary, Deputy Director-General of Queensland Health, approved the allocation of funding for support services.

The funding and provision of additional services, after transition, has been controlled and measured. Although there was some reservation voiced by Queensland Health executives about the ongoing provision of wrap around care, there is evidence of some transition clients receiving funded services in 2015 and 2016.

(Endnotes)

- 1 Exhibit 71, Statement of Beth Kotzé, 18 December 2015, p 25 para 111.
- 2 Laura Johnson now Laura Tooley.
- 3 Exhibit 127, Statement of Laura Tooley, 22 October 2015, p 14 para 11.2. (Laura Johnson now Laura Tooley.)
- 4 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, pp 15–16 para 15(c).
- 5 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, pp 28–32 para 16–17.
- 6 Exhibit 318, Health services investigation material, 30 October 2014, pp 159–160.
- 7 Exhibit 318, Health services investigation material, 30 October 2014, p 150.
- 8 Exhibit 71, Statement of Beth Kotzé, 18 December 2015, pp 25–26 para 112; Exhibit 53, Statement of Kristi Geddes, 22 October 2015, (confidential exhibit).
- 9 Department of Communities, Child Safety and Disability Services, Support for school leavers, 6 April 2016, <<https://www.communities.qld.gov.au/disability/support-and-services/our-services/support-for-school-leavers>>. [28 April 2016].
- 10 Department of Communities, Child Safety and Disability Services, Time-limited response policy, July 2011, <<https://www.communities.qld.gov.au/resources/disability/support-services/accessing/policies/documents/time-limited-response-policy.pdf>>. [28 April 2016].
- 11 Department of Communities, Child Safety and Disability Services, Time-limited response policy, July 2011, <<https://www.communities.qld.gov.au/resources/disability/support-services/accessing/policies/documents/time-limited-response-policy.pdf>>. [28 April 2016].
- 12 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, p 29 para 16.2(c); Exhibit 72, Statement of Judith Krause, 26 November 2015, Attachment U to that statement, pp 348–352.
- 13 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, p 29 para 16.2(c).
- 14 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, pp 31–32 para 30.
- 15 Confidential exhibit.
- 16 Confidential exhibit.
- 17 Confidential exhibit.
- 18 Confidential exhibit.
- 19 Confidential exhibit.
- 20 Exhibit 39, Supplementary statement of Vanessa Clayworth, 20 November 2015, p 8 para 15.3; [confidential exhibit removed].
- 21 Exhibit 39, Supplementary statement of Vanessa Clayworth, 20 November 2015, p 8 para 15.3.

- 22 Confidential exhibit.
- 23 Confidential exhibit.
- 24 Confidential exhibit.
- 25 Confidential exhibit.
- 26 It is not clear whether this particular response was sent to the Director, but the general decision certainly was conveyed.
- 27 Exhibit 127, Statement of Laura Tooley, 22 October 2015, Attachment LT-38 to that statement, pp 583–588, Email from Laura Johnson to Leanne Geppert dated 21 January 2014.
- 28 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, p 29 para 16(2)(e).
- 29 Exhibit 72, Statement of Judith Krause, 26 November 2015, p 13 para 53, Attachment T to that statement, p 341.
- 30 Exhibit 72, Statement of Judith Krause, 26 November 2015, p 13 para 53; Exhibit 618, Children’s Health Queensland Hospital and Health Service, 2014, Business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation model of care, version 4.0, July 2014, p 17.
- 31 Exhibit 72, Statement of Judith Krause, 26 November 2015, p 13 para 53.
- 32 Exhibit 73, Supplementary statement of Judith Krause, 19 January 2016, pp 25–26 para 19.
- 33 Exhibit 72, Statement of Judith Krause, 26 November 2015, Attachment U to that statement, p 390; Exhibit 1333, Draft letter from Bill Kingswell to parents of former BAC patients, December 2014.
- 34 Exhibit 72, Statement of Judith Krause, 26 November 2015, Attachment U to that statement, p 390.
- 35 Exhibit 72, Statement of Judith Krause, 26 November 2015, Attachment U to that statement, pp 390–391.
- 36 Exhibit 72, Statement of Judith Krause, 26 November 2015, Attachment U to that statement, pp 426–427.
- 37 Exhibit 72, Statement of Judith Krause, 26 November 2015, Attachment U to that statement, p 390.
- 38 Exhibit 208, *Queensland Plan for Mental Health 2007–2017*, p 9.
- 39 Exhibit 318, Independent Health Service Investigation report commissioned by Queensland Health folder 24, p 340.
- 40 Transcript, William Kingswell, 24 February 2016, p 13–80 lines 31–32.
- 41 Queensland Health, Housing and Support Program, available at <<https://www.health.qld.gov.au/townsville/IMHS/imhs-sic-housing-support.asp>>. [27 April 2016].
- 42 Queensland Health, Housing and Support Program, available at <<https://www.health.qld.gov.au/townsville/IMHS/imhs-sic-housing-support.asp>>. [27 April 2016].
- 43 Exhibit 72, Statement of Judith Krause, 26 November 2015, Attachment U to that statement, pp 351–352. It appears that the wrap around care was initially to be 15 hours per week for three months, decreasing to eight hours per week but as at December 2014 the wrap around care provided by the NGO was still 15 hours per week.
- 44 Exhibit 72, Statement of Judith Krause, 26 November 2015, Attachment U to that statement, p 353.
- 45 Exhibit 73, Supplementary statement of Judith Krause, 19 January 2016, Attachment U to that statement, pp 345–352. The evidence is that on 15 July 2014 an email attaching the funding request was sent by Ingrid Adamson to Judith Krause. It requested funding be used from the sub-acute underspend.
- 46 Exhibit 72, Statement of Judith Krause, 26 November 2015, p 13 para 53; Exhibit 618, Children’s Health Queensland Hospital and Health Service, 2014, Business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation model of care, version 4.0, July 2014, p 17.
- 47 Exhibit 72, Statement of Judith Krause, 26 November 2015, Attachment U to that statement, p 378.
- 48 Exhibit 73, Supplementary statement of Judith Krause, 19 January 2016, p 26 para 20.
- 49 Exhibit 72, Statement of Judith Krause, 26 November 2015, Attachment U to that statement, pp 359, 393–394, 398–399, 402 and 406.
- 50 Exhibit 72, Statement of Judith Krause, 26 November 2015, Attachment U to that statement, p 450.
- 51 Exhibit 72, Statement of Judith Krause, 26 November 2015, Attachment U to that statement, p 420.
- 52 Exhibit 82, Statement of Janet Martin, 22 January 2016, p 4 para 17.
- 53 Exhibit 82, Statement of Janet Martin, 22 January 2016, p 4 paras 18, 19; Exhibit 72, Statement of Judith Krause, 26 November 2015, Attachment U to that statement, p 444; [confidential exhibit removed].
- 54 Confidential exhibit.
- 55 Exhibit 82, Statement of Janet Martin, 22 January 2016, p 6 para 26 and Attachments G and H to that statement, pp 61–69.
- 56 Exhibit 82, Statement of Janet Martin, 22 January 2016, p 6 para 27 and Attachments G and H to that statement, pp 61–69.
- 57 Confidential exhibit.
- 58 Exhibit 675, Proposed HASP funding allocations dated 26 March 2014; Exhibit 1352, Brief for approval signed by Michael Cleary on 12 May 2014.

- 59 Confidential exhibit.
- 60 Exhibit 680, Proposed HASP allocations, 14 May 2014.
- 61 Exhibit 294, Email from Myfanwy Pitcher to Ivan Frkovic, Subject: "Aftercare", 12 December 2013; [confidential exhibit removed].
- 62 Confidential exhibit.
- 63 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, p 30 para 16.2(f).
- 64 Confidential exhibit.
- 65 Confidential exhibit.
- 66 Confidential exhibit.
- 67 Confidential exhibit.
- 68 Confidential exhibit.

21 Overview and assessment of transition

How the Commission identified the 17 transition clients

To help it identify the “transition clients” the Commission asked the Department of Health and West Moreton HHS to produce a list of the BAC patients between 31 October 2012 and January 2014. The list produced to the Commission contained the names of 41 young people who were inpatients, outpatients and day patients, those who had been assessed and were on the waiting list for admission (waitlist patients), and those who were on the list for assessment of eligibility to be placed on the waiting list for admission (assessment list patients). The Commission analysed all 41 of these potential transition clients in detail.

Anne Brennan, acting Clinical Director of the BAC, gave detailed evidence in relation to the transition arrangements for 16 patients.¹ Brennan’s list of relevant patients was consistent with a list of potential transition clients circulated by Counsel Assisting to legally represented parties on 29 February 2016. Counsel Assisting subsequently added a seventeenth patient to the list.²

Generally, the 17 patients the Commission has identified as “transition clients” were inpatients, day patients and outpatients during the period from the closure announcement on 6 August 2013 to closure of the BAC in late January 2014. The list excludes [redacted] [redacted]³ and [redacted]⁴ transferred from the BAC in [redacted] for reasons not directly related to its closure.⁵ The Commission has considered the transition arrangements and the care, support and services provided to each of these patients and their families in the confidential volume.

The waitlist patients and assessment list patients are discussed in general in chapter 25 and individually in chapter 39 of the confidential volume.

Limit on factual inquiry

As discussed in chapter 18, the Commission determined that generally a transition in association with the closure ended about a month after the transition client’s discharge from the BAC.

This temporal limitation meant that the Commission’s factual inquiry started at the beginning of the transition and ended around one month after the transition client’s discharge from the BAC.

The Commission’s terms of reference, and its factual inquiry, do not extend to a consideration of the following matters:

- the immediate cause or root causes of the deaths of the three young people who died in 2014 who had formerly been patients of the BAC
- whether those deaths were caused by or contributed to or affected by the closure of the BAC in early 2014
- whether those deaths were caused by or contributed to or affected by the transition arrangements or the adequacy of care provided by the various receiving services.⁶

Those are matters for the Coroner.

Evidence from patients and family members

Of the 17 "transition clients" identified by the Commission, four transition clients⁷ and a total of 12 family members of transition clients⁸ gave statements. The Commission took a draft statement from another person⁹ who was a member of a transition client's family, but who, for personal reasons, was unable to finalise the statement. Two families of transition clients¹⁰ chose not to engage with the Commission, and staff were unable to contact the families of two further transition clients.¹¹ The Commission received statements from three of the four families¹² of the transition clients it identified as having particular problems with their transition arrangements.

Of the [redacted] patients discharged prior to the closure announcement on 6 August 2013, the Commission received statements from all of the families with whom its staff made contact, including statements from two former BAC patients.¹³ The Commission attempted to contact all the families of the [redacted] whom the Commission determined were not "transition clients"; however, it received only limited evidence from [redacted] [redacted]¹⁴ and the [redacted].¹⁵ Of [redacted] waitlist patients, the Commission contacted [redacted] families; [redacted] families were not contacted because of family issues.¹⁶

The Commission received 28 statements from former patients and their family members comprising:

- six statements from former BAC patients
- 22 statements from family members of former BAC patients.¹⁷

The transition arrangements

Brennan was required to identify, assess, plan for, manage and implement the necessary care, support, service quality and safety risks for each of the transition clients. Transition under Brennan is discussed in chapter 19.

A clinical care transition panel formed and chaired by Brennan had to draw together a number of services addressing each patient's individual needs.¹⁸

Overall Brennan and the transition panel had to:

- identify needs and appropriate services for the patients
- discuss possible options (where options existed) with the adolescents and their families/carers
- facilitate the referral of patients to those services.¹⁹

The types of individual needs that were addressed in the transition arrangements are discussed in chapter 19.

Specific elements of the transition planning, including accommodation, clinical care, and education are described below.

Trajectory of the transition clients

Brennan's evidence was that for 11 of the 16 transition clients,²⁰ there was sufficient time to approach the transition in a gradual way.²¹ She considered that [redacted]

[redacted]²²

Brennan's evidence was that the transition arrangements for those patients²³ were affected [redacted]²⁴ [redacted]²⁵ [redacted] that Brennan characterised the

arrangements as a [redacted]²⁶ Later in her evidence, Brennan identified [redacted]²⁷

For most patients, the closure was one of a number of factors considered in their transition planning. Although they may have had similar clinical trajectories notwithstanding the closure of the BAC, the closure accelerated the transition process for a number of them.²⁸ The impending closure also affected the BAC's capacity to offer ongoing services during the transition as often occurred in a "business-as-usual transition".²⁹ For example, a patient may have been transitioning to the community but then have needed re-admission to the BAC. Because the BAC was unable to offer to resume services after the closure announcement, the transition client had to be admitted to another service such as an acute inpatient unit at a hospital.³⁰ On the other hand, the trajectories of some patients were not affected by the closure of the BAC. For example, one transition client gave evidence that [redacted]

[redacted]³¹ Another transition client gave evidence of [redacted]
[redacted]³² A parent of one transition client said [redacted]
[redacted]³³

Clinical care

Generally, the transition clients whom Brennan identified as being ready for transition were referred to a combination of community services including CYMHS, community mental health organisations, private psychologists or psychiatrists, and general practitioners. Overall:

- There were six referrals to [redacted]³⁴
- There were four referrals to [redacted]³⁵ and three referrals to [redacted]³⁶
- Eight patients were referred to [redacted]
[redacted] and/or [redacted]³⁷
- Four patients had [redacted]³⁸
- Some patients were referred to services [redacted]³⁹

Some of the clinical care arrangements ensured continuity of care with clinicians familiar to the transition clients. For example, a few transition clients [redacted]
[redacted] to the BAC.⁴⁰

Of the [redacted] Brennan identified [redacted]
[redacted]
[redacted]⁴² and [redacted]
support.⁴³

[redacted] of the [redacted] transition clients were [redacted]⁴⁴ and [redacted] were [redacted]
[redacted]⁴⁵ at the time of their discharge from the BAC.⁴⁶ While a number of patients were [redacted]
[redacted] there was evidence that these patients were [redacted]
[redacted], either [redacted] or [redacted]
[redacted]⁴⁷

The Commission considers that the clinical needs of the respective transition clients were identified and planned for adequately in the circumstances.

Education

Brennan asked the teaching staff at the Barrett Adolescent Centre Special School to develop an educational transition plan for each student recognising their health, accommodation and family/carer arrangements.⁴⁸

Of the [redacted] transition clients whom Brennan identified as ready to transition from the BAC, [redacted] planned to continue their education and [redacted] pursued employment [redacted] [redacted]⁴⁹ [redacted] focused on [redacted]⁵⁰

Of the [redacted] patients who planned to continue their education, [redacted] were enrolled [redacted] [redacted]⁵¹ and [redacted] enrolled [redacted] [redacted]⁵²

Of the [redacted] transition clients [redacted] receive educational/vocational support from [redacted]⁵³ [redacted] received [redacted] [redacted]⁵⁴ and [redacted] to continue [redacted] [redacted]⁵⁵

The educational/vocational needs of each transition client were considered on an individual basis, and adequate arrangements were made to address those needs.

Accommodation

Brennan's evidence was that they had great difficulty arranging accommodation for [redacted] [redacted]⁵⁶ Her evidence was that "[m]ost accommodation providers we contacted were unable to help [redacted] for a variety of reasons such as safety and eligibility criteria".⁵⁷ Like Brennan, Sadler considered a lack of suitable accommodation as a key issue for the most complex transitions.⁵⁸

In one case,⁵⁹ a [redacted] but this was not possible according to both Brennan and Vanessa Clayworth.⁶⁰ For another transition client,⁶¹ Brennan anticipated that [redacted] supported accommodation [redacted]⁶² however, there was [redacted] [redacted] and the [redacted] rather than to failing/s on the part of anyone involved in the process.⁶³

For another transition client,⁶⁴ the search for accommodation [redacted] [redacted] particularly in [redacted] [redacted]. First, Brennan considered that this transition client required [redacted] [redacted]⁶⁵ [redacted] Needless to say, [redacted] are designed to [redacted]. Second, despite the efforts of both the BAC and the receiving service, [redacted] [redacted]⁶⁶ One accommodation provider rejected a request to provide accommodation on the basis that the transition client was [redacted]. Another option was [redacted] [redacted] The [redacted] regarded this as unacceptable.⁶⁷

Finding accommodation for some of the transition clients proved to be difficult. Despite the difficulties, the Commission is satisfied that the accommodation arrangements for the transition clients, while not ideal, were adequate.

Adequacy of transition arrangements

The former Clinical Director of the BAC, Trevor Sadler said that “[i]f I had been given a similarly short time frame to work towards for the closure, I may well have come up with very similar transition plans. Having said this, I would have felt compromised”.⁶⁸ Brennan said that she had frank discussions with patients about transition, addressing their particular difficulties, and that it became possible to transition some she had initially thought would be difficult to transition given the timeframe.⁶⁹

Health services investigation report

On 30 October 2014, Beth Kotzé and Tania Skippen, as health service investigators, delivered a report entitled “Transitional Care for Adolescent Patients of the Barrett Adolescent Centre” to the Department of Health (health services investigation report).⁷⁰

The health services investigation report concluded that:

- the health care transition plans developed for individual patients were adequate to meet the needs of the patients and their families
- the transition plans for individual patients were appropriate and took into consideration patient needs.

There were limitations on the Health services investigation report including that:

- under the *Hospital and Health Boards Act 2011* (Qld) the investigators could not compel evidence from outside Queensland Health
- the terms of reference for the investigation focused upon the appropriateness of the transition planning
- families and carers of BAC patients were not contacted
- there was concern not to affect pending coronial investigations.

The following distinguishing features of the present inquiry are worth noting:

- the provisions of the *Commissions of Inquiry Act 1950* (Qld) enabled the Commission to compel evidence from any person⁷¹
- the Commission’s terms of reference were much broader than those of the Health Services Investigation
- the three coronial investigations were adjourned pending finalisation of the present inquiry.

In any event, the Commission was not bound by the conclusions of the health services investigation report.

The conclusions reached by the Commission are based on its objective assessment of all the evidence received during the course of its inquiry, including a consideration of medical records, written and oral evidence from BAC patients and their families, and the expert opinions of relevant child and adolescent psychiatrists, allied health workers, nurses and teachers who gave evidence by way of statement and/or oral evidence during the hearings.

Conclusion

Detailed confidential information about the individual transition arrangements and assessment of their adequacy is contained in the confidential volume.

Brennan and her team carried out their tasks at all times focused on the best interests of the BAC patients.

Overall, the Commission has determined that the transition arrangements for the 17 transition clients were adequate.

Care, support and services provided to the transition clients

The Commission was also required to make an objective assessment, on a case by case basis, of the adequacy of the care, support and services actually provided to the transition clients. Important factors to be considered in making this assessment are set out in chapter 19.

The relevance of each of these factors and the relative weight to be given to each of them vary from case to case.

A general overview of the outcomes of the care, support and services such as accommodation, cross-tapering of care and services, clinical care, and education is provided below.

Cross-tapering of care and services Brennan explained that:

depending on the particular person, their particular, if you like, disorder and their range of family or community supports, that transitioning into a new service may need to be gradual in terms of a kind of cross-tapering of care or it may be different. There may be some in-reach into the new service.⁷²

The evidence before the Commission revealed that parallel care or cross-tapering of services was achieved for a number of patients, but not for all. A number of patients attended appointments with receiving services and other community services prior to being discharged.⁷³ BAC school staff provided ongoing support to some patients after they left the BAC.⁷⁴

However, the cross-tapering of services was limited or less than ideal for other patients. One transition client,⁷⁵

[redacted], gave evidence that “[k]nowing the whole thing was there for you was important ... Knowing there were certain people there solely for you was important [redacted]”.⁷⁶

In another case,⁷⁷ although there was some parallel care, the transition client [redacted] and the BAC [redacted].⁷⁸

Sadler’s evidence was that usually “[i]f a local service was unable to meet the needs of the adolescent at any particular stage in the transition process, BAC would resume providing the service while the situation was rectified or an alternative service provider was arranged”.⁷⁹ He also said that:

... there are a number of young people for whom I think social disconnection is a potential risk for suicide, and so from that perspective I just thought when the unit closes there won’t be that connection with Barrett. And so it – you know, as I said, we would offer some connections when they have confronting crises with how to deal with that. So that was my concern with [a particular transition client].⁸⁰

Brennan's evidence was that for those patients for whom the transition process was always going to be difficult,⁸¹ the fact that the BAC existed was quite important:

For these young people, they went to a new place. And in their mind either immediately or very shortly after arriving there, Barrett didn't exist anymore. And for them, they had lived there, that had been their world for sometimes a matter of years.⁸²

Brennan thought longer timeframes would have assisted in providing some in-reach, and that returning to the BAC, or at least knowing that it still existed, was important for these patients.⁸³

Overall the Commission accepts that some cross-tapering was achieved for a majority of the transition clients, and where it was limited, there was a reasonable basis for this. For [redacted] BAC patients,⁸⁴ clinical decisions were made to limit cross-tapering [redacted] [redacted]⁸⁵ [redacted]⁸⁶ cross-tapering was limited [redacted] [redacted]⁸⁷ and [redacted] cross-tapering was limited [redacted]⁸⁸

Clinical care

Sadler's evidence was that "[a]dolescents were often referred to BAC by community clinicians because they did not have access to the necessary range of interventions, or the number of interventions required were difficult to implement in the community or acute inpatient setting".⁸⁹

It emerged during the Commission's inquiry that many of the transition clients were referred back to the services that had initially referred them to the BAC. A discussion of the transition clients before their admission to the BAC is contained in chapter 32 of the confidential volume.

One possible inference is that the BAC was able to bring these patients to a level of wellness where they could be referred to services which previously had been unable to assist them because of their levels of acuity, chronicity and complexity. Another possible inference is that Brennan had no choice because those services were all that were available to transition clients.⁹⁰

Despite Brennan's assessment of the readiness of 11 patients to transition from the BAC, a number of patients struggled to engage with the services to which they were referred.⁹¹ In some cases, difficulties in engagement may not have been attributable to any inadequacy in the capacity of the receiving services or to the care actually provided, but to circumstances outside the control of the receiving services.⁹²

Education / Employment

After discharge from the BAC, transition clients requiring intensive clinical support during school hours because of high acuity were transferred to mental health services with the capacity to facilitate their educational/vocational transition. For example, the receiving service assisted [redacted] [redacted] to [redacted] and [redacted]⁹³ The BAC Special School [redacted] to encourage [redacted]⁹⁴ Another transition client [redacted] but [redacted] was instructed [redacted] [redacted] to [redacted] with that transition client.⁹⁵ For transition clients with lower acuity, educational transition arrangements were generally made and facilitated by the BAC, or instructions were provided to the receiving services.

Education staff worked tirelessly to accommodate the individual educational needs of the transition clients.

It was submitted on behalf of Justine Oxenham, one of the BAC teachers, that at a systemic level (and specifically from an education perspective), the “uncoupling” of education from healthcare meant that transition clients lost the immediate benefit of “close quarter” clinical support during school hours.⁹⁶ As a general proposition, this submission is correct, as the decision to close the BAC meant that the on-site education program had to be transferred to another site. The decision to cease the on-site education program is discussed in more detail in chapter 13.

A discussion of future educational models of care for adolescents with severe and complex mental health needs is contained in chapter 29.

Accommodation

[redacted] transition clients [redacted] and [redacted]. Of those who [redacted]:

- three were [redacted]⁹⁷ who were [redacted] during their admission while they attended the [redacted]
- two were [redacted]⁹⁸ who were [redacted] and attending [redacted]
- three [redacted] while attending the BAC [redacted]⁹⁹
- two [redacted]¹⁰⁰

For some transition clients their home environment was not optimal.¹⁰¹ In one case [redacted]
[redacted]
[redacted]¹⁰² While returning home was not ideal for some transition clients, it was, nevertheless, adequate.

The BAC arranged [redacted]¹⁰³ [redacted]¹⁰⁴
Brennan’s evidence was that accommodation was a key issue for [redacted]
[redacted]¹⁰⁵ Of these [redacted]
[redacted]¹⁰⁶ [redacted]¹⁰⁷
[redacted]¹⁰⁸

The evidence was that in some cases the receiving services deviated from the transition plans and did not implement the recommendations of the BAC. The Commission accepts those decisions were made by qualified clinical staff based on their assessments at the time.¹⁰⁹ In another instance, the plan to [redacted]
[redacted] needs were met through [redacted]
[redacted]¹¹⁰.

Conclusion

The Commission finds that the care, support and services provided to several transition clients were not ideal. Nevertheless in all cases they were adequate.

Systemic issues

The Commission found that systemic problems affected the transition arrangements for and the care, support and services available to some of the transition clients.

Services for patients with complex developmental needs

A number of the transition clients were chronologically adults but developmentally adolescents. They had extremely high treatment needs, high acuity and high complexity.

The focus of an adult mental health service on self-management and self-empowerment necessitated Brennan's customising the transition plan of a transition client to take account of developmental and personal needs. What emerged from the evidence, particularly in relation to the management and implementation of safety risks, was the stark difference between the framework of an adolescent inpatient mental health service and that of an adult community mental health service.

A number of experts have provided evidence to the Commission about the lack of alignment in adolescent and adult mental health services.¹¹¹

Services for patients with dual diagnosis

Evidence before the Commission highlighted how few services are available for young people with both intellectual disability and mental illness.

The level of unmet need is significant.¹¹²

The Commission considers that co-operation and collaboration between relevant government departments in addressing the needs of young people with dual diagnosis should be improved. It appreciates that not all individuals with dual diagnosis require a cross-departmental response.

Care, support and services provided to families of transition clients

The Commission was required to assess the adequacy of the care, support and services provided to the families of the transition clients. Its inquiry was limited to the transition period for each of the transition clients.

As discussed in chapter 22, there are two aspects to the provision of care, support and services to the families of transition clients. The *first* is the care, support and services provided to families or carers as partners in the delivery of care to the transition clients. In other words, the purpose of the care, support and services is to assist the families and carers to care for the transition client. The *second* is the care, support and services required by the families and carers in relation to their own needs discrete from those of the transition clients.

The individual assessments of the care, support and services provided to each family are set out in the confidential volume.

Families and carers as “partners in the delivery of care”

Two questions arise:

- Were families and carers adequately informed of, and given adequate opportunity to participate in the development of, their children’s transition arrangements?
- Where the transition arrangements involved transition clients returning to the care of families or carers, were those families and carers adequately supported to resume primary carer responsibilities?

These questions are addressed in turn below.

Communication about, and involvement in, transition arrangements

Brennan agreed that detailed, careful and lengthy consultation and communication with families was an element of a good transition.¹¹³

There was no evidence that any person was solely responsible for ensuring that all families were regularly updated on and involved in their children’s transition planning. Instead, there was evidence of families receiving communications from a number of BAC staff members. In her supplementary statement, BAC occupational therapist Megan Hayes said that “responsibility for contacting families was a responsibility shared amongst clinical staff”.¹¹⁴ Even so, BAC social worker Carol Hughes gave evidence that “there was a sense” that her role on the transition panel, along with others, was to communicate with families.¹¹⁵ Hughes explained that she “responded as needed,”¹¹⁶ for example, if care coordinators needed assistance with communicating with families.¹¹⁷ Having regard to her background in social work and family therapy, her role extended to providing support “at any opportunity”.¹¹⁸

Brennan explained that the functions of the transition panel included maintaining contact with transition clients and their families, developing a list of options for each transition client and then assisting the care coordinator and the transition client (and their family) to choose what best suited them. She said that families and carers were invited to meet with the transition panel on a case by case basis.¹¹⁹

Brennan gave evidence that within two days of commencing at the BAC, she had spoken to all but two families.¹²⁰ She had meetings with eleven families and met with some of those families on more than one occasion.¹²¹ Brennan said that:

Consultations with patients and family were carried out in person or by telephone to understand the family dynamics, the needs and aspirations and concerns of the patient and making suggestions about services so as to develop a recommendation which met the needs of the patient and was acceptable to all parties.¹²²

A number of parents gave evidence about their contact with Brennan.¹²³ While one parent¹²⁴ said they were never invited to comment or contribute to the transition plan,¹²⁵ Brennan’s evidence was that this transition client [REDACTED]

[REDACTED]¹²⁶ The parent acknowledged this, recalling that Brennan had said [REDACTED] due to [REDACTED] the transition client would [REDACTED] and that [REDACTED].¹²⁷ Although a number of parents could not recall the exact details of contact with Brennan, they generally acknowledged that her recollection of contact was correct.¹²⁸

Clayworth said that her responsibilities included communication with families.¹²⁹ She gave evidence of communicating with families about the patients' transition arrangements in meetings and by telephone and email.¹³⁰

Brennan and Hughes both said that generally care coordinators were very involved in communicating with families.¹³¹ Brennan said care coordinators "were often the person who knew the young person and their family best".¹³² Hughes said care coordinators had "quite a strong involvement with the young person and would have contact with the families".¹³³

There was limited evidence about the precise information each family received about their child's transition plan, probably because of the likelihood that each family received a different level of information. Some patients' transition plans were more complex and necessitated more communication than others, which were relatively straightforward.¹³⁴ The evidence revealed that the families did not receive written transition plans, but they were informed of the transition arrangements on an ad hoc basis.¹³⁵

The communication with, and involvement of, families in the transition arrangements became complicated where transition clients expressed preferences contrary to those of their families.

For example, as mentioned above, one transition client's parent¹³⁶ [REDACTED]

[REDACTED]¹³⁷ Another transition client's parent recommended [REDACTED]

[REDACTED]¹³⁸, [REDACTED]¹³⁹

Difficulties also arose where a transition client¹⁴⁰ [REDACTED]

[REDACTED] Even apart from ethical and legal duties to maintain confidentiality, in order to build trust and rapport, it was important that the treating team not discuss the transition client's case with their parent.¹⁴¹ While it is understandable that this parent wanted to be involved in their child's treatment, it was also clear that [REDACTED]

[REDACTED].

Practical support for resuming primary carer responsibilities

Details of the additional support through funding, provided to a number of transition clients and their families, is discussed in chapter 20.

Where a family did not receive practical support to care for their child, generally their child's acuity was not high, and there was apparently no particular issue about the family's capacity to support their child.¹⁴²

Discrete needs of families and carers

The Commission has found some evidence of arrangements directed towards supporting family members in relation to their own discrete needs.

On 25 September 2013, Sharon Kelly sent an email to families informing them of the following offer:

the option of a regular phone call from our Consumer Advocate (Ms Nadia Beer) to discuss any general concerns or questions you may have, who will escalate issues as is necessary. Nadia will not provide any specific clinical information regarding the care of your adolescent (this will continue to be the role of the treating clinical team). Nadia will be someone who can listen to your general concerns regarding the care of your adolescent at BAC, and ensure that any issues are escalated appropriately for consideration by the right people.¹⁴³

Kelly asked families to respond if they were interested in being contacted by Nadia Beer.¹⁴⁴ One parent¹⁴⁵ reacted negatively to the requirement to register their interest. The Commission acknowledges that Kelly may have intended no more than to be in a position to pass on the names of only those parents wishing contact rather than all parents.¹⁴⁶

At least three possibly five family members made contact with Nadia Beer.¹⁴⁷

Adequacy of care, support and services provided to families of transition clients

The health services investigators did not interview any families of transition clients. Even so, they found that:

The process of communication and negotiation between the clinical team and the young person and their family/carers was careful, respectful, timely and maintained. As would be expected during a time of heightened emotions and anxiety about the future, there appears to have been some misunderstandings at times along the way but these appear to have been in each case dealt with promptly and appropriately. The misunderstandings arose, for example, in circumstances of unopened emails by parents/carers or unexpected emerging clinical need requiring immediate action by the BAC clinical team, with communication following as time permitted.¹⁴⁸

Kotzé said in her statement that:

After reviewing the documentation and interviewing clinical staff, we concluded that there was evidence that the biopsychosocial needs of the consumers and parents/families were identified comprehensively by the clinicians and comprehensively planned for.¹⁴⁹

The evidence before the Commission revealed that on the whole, the care, support and services provided to families of transition clients were adequate. Brennan and her team made considerable efforts to communicate with, and involve, families and carers in relation to the transition arrangements. Where families required extra support to resume primary carer responsibilities for their children, arrangements were made.

(Endnotes)

- 1 Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 28–51 paras 114–126.
- 2 Confidential; Transcript, Anne Brennan, 4 March 2016, p 20-60 lines 20-45; see also Transcript, Vanessa Clayworth, 8 March 2016, p 22-63 lines 15–20.
- 3 Confidential; see Exhibit 39, Supplementary statement of Vanessa Clayworth, 20 November 2015, p 2 para 10.4(a); Transcript, Vanessa Clayworth, 8 March 2016, p 22-51 lines 25–40.
- 4 Confidential.
- 5 Exhibit 39, Supplementary statement of Vanessa Clayworth, 20 November 2015, p 2 para 10.4(b)-(d).
- 6 Transcript, Commissioner, 1 March 2016, p 17-101 line 40 – p 17-102 line 5.
- 7 Confidential.
- 8 Confidential.
- 9 Confidential.
- 10 Confidential.
- 11 Confidential.
- 12 Confidential.
- 13 Confidential.

- 14 Confidential.
- 15 Confidential.
- 16 Confidential.
- 17 The Commission took 17 statements from family members and received statements from three family members who were given leave to be legally represented and two statements from families who were not legally represented.
- 18 Exhibit 62, Statement of Megan Hayes, 20 November 2015, p 8 para 9.1; Transcript, Sharon Kelly, 22 February 2016, p 11-18 lines 1–12.
- 19 Exhibit 62, Statement of Megan Hayes, 20 November 2015, p 6 para 7.10.
- 20 As discussed earlier the Commission has determined as a matter of fact that there were 17 transition clients.
- 21 Confidential details removed; Transcript, Anne Brennan, 4 March 2016, p 20-36 lines 35-48.
- 22 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, p 41 para 42(e).
- 23 Confidential details removed.
- 24 Transcript, Anne Brennan, 4 March 2016, p 20-23 line 40 – p 20-24 line 12, p 20-37 line 30 – p 20-38 line 15.
- 25 Confidential.
- 26 Transcript, Anne Brennan, 4 March 2016, p 20-58 lines 9–15.
- 27 Transcript, Anne Brennan, 4 March 2016, p 20-62 lines 20–25.
- 28 Confidential details and exhibits removed.
- 29 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 29 para 146; Transcript, Anne Brennan, 4 March 2016, p 20-37 line 39 – p 20-38 line 2.
- 30 Confidential; Transcript, Trevor Sadler, 1 March 2016, p 17-82 lines 1–15; Transcript, Trevor Sadler, 9 March 2016, p 23-79 lines 40 – p 23-80 line 15. See also Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 53 para 250(d); and Exhibit 179, Supplementary statement of Trevor Sadler, 12 February 2016, p 10 para 42.
- 31 Confidential details removed.
- 32 Confidential details removed; Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 45–46 para 122.
- 33 Confidential details removed.
- 34 Confidential details and exhibits removed; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 46–47 para 123; Exhibit 465, Appendix 4 "Summary of Mater Involvement of [confidential]", 22 October 2015; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 37-38 para 117; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 44–45 para 121; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 35-36 para 115; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 41–44 para 120; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 39–40 para 118; Exhibit 62, Statement of Megan Hayes, 19 November 2015, pp 13–14 para 13.2.
- 35 Confidential details and exhibits removed Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 37–38 para 117; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 47–48 para 124; Exhibit 293, Email from Amelia Callaghan to Ellen Heathwood, Subject: "Barrett Centre files as requested for the Commission of Inquiry", 8 December 2015; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 49–51 para 126; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 40–41 para 119.
- 36 Confidential details and exhibits removed Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 35–36 para 122; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 49–51 para 126.
- 37 Confidential details and exhibits removed; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 45–46 para 122; Exhibit 129, Statement of Ashleigh Trinder, 30 October 2015, p 8 para 7.19; Transcript, Ashleigh Trinder, 2 March 2016, p 18-32 line 31 – p 18-33 line 15. Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 48–49 para 125; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 37–38 para 117; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 35–36 para 115(f); Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 47–48 para 124. Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 41–44 para 120; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 40–41 para 119; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 32–34 para 115(d).
- 38 Confidential details and exhibits removed; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 48-49 para 125; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 44–45 para 121; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 49–51 para 126; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 32–34 para 115(d).
- 39 Confidential details removed; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 32–34 para 115(d); Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 40-41 para 119.
- 40 Confidential details removed; Transcript, Ashleigh Trinder, 2 March 2016, p 18-32 line 31 – p 18-33 line 15; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 45–46 para 122; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 47–48 para 124.
- 41 Confidential.
- 42 Confidential.
- 43 Confidential.

- 44 Confidential.
- 45 Confidential.
- 46 Confidential details removed.
- 47 Confidential details removed; Exhibit 59, Statement of Charlotte Hambly, 15 January 2016, p 8 para 22.
- 48 Exhibit 106, Statement of Deborah Rankin, 11 October 2015, p 23 para 90.
- 49 Confidential details removed; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 37–38 para 117.
- 50 Confidential details removed.
- 51 Confidential details and exhibit removed; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 46–47 para 123; Exhibit 617, Emails between Judi Krause and Tasneem Hasan, Subject; "Ex-BAC patient (for your information)", 11 August 2014; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 41–44 para 120; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 39–40 para 118; Exhibit 489, Emails between David Crompton, Richard Ashby and others, Subject; "Struggling Students Barrett", 17 October 2014; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 40–41 para 119.
- 52 Confidential details removed; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 35–36 para 115; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 35–36 para 115; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 47–48 para 124; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 49–51 para 126.
- 53 Confidential details removed; Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 31 para 115(c); Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 31 para 115(b).
- 54 Confidential; Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 35 para 115(e).
- 55 Confidential; Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 30 para 115(b).
- 56 Transcript, Anne Brennan, 4 March 2016, p 20–38 lines 29–32.
- 57 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 16 para 62; Confidential details removed; Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 16 para 101; Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 27 para 105; Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 27 para 108.
- 58 Exhibit 254, Third supplementary statement of Trevor Sadler, 26 February 2016, p 3 para 10; But, in relation to [confidential], see Exhibit 80, Statement of Alicia Martin, 3 November 2015, pp 5–6 paras 22–25.
- 59 Confidential.
- 60 Confidential exhibits; Transcript, Vanessa Clayworth, 8 March 2016, p 22–60 line 4 – p 22–61 line 25.
- 61 Confidential.
- 62 Transcript, Anne Brennan, 4 March 2016, p 20–61 lines 36–39.
- 63 Transcript, Kerri Mellifont QC, Closing submissions on behalf of Metro South HHS, 12 April 2016, p 27–24 lines 13–16 and p 27–26 lines 7–10.
- 64 Confidential.
- 65 Confidential.
- 66 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 27 para 105.
- 67 Confidential; Transcript, closed hearing; Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 27 para 106.
- 68 Exhibit 179, Supplementary statement of Trevor Sadler, 12 February 2016, p 16 para 70.
- 69 Transcript, Anne Brennan, 4 March 2016, p 20–23 lines 21–25.
- 70 Exhibit 53, Statement of Kristi Geddes, 22 October 2015, Attachment KG-80 to that statement, Report: Transitional Care for Adolescent Patients of the Barrett Adolescent Centre, 30 October 2014, p 1054. Having been appointed on 14 August 2014 by the then Director-General of the Department of Health, Ian Maynard, to investigate and report on a number of matters arising from the closure of the BAC in 2014.
- 71 *Commissions of Inquiry Act 1950* (Qld) s 5.
- 72 Transcript, Anne Brennan, 4 March 2016, p 20–16 lines 30–33.
- 73 Confidential details and exhibit removed; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 39–40 para 118; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 39–40 para 118.
- 74 Confidential details and exhibits removed.
- 75 Confidential.
- 76 Confidential exhibit.
- 77 Confidential.
- 78 Exhibit 129, Statement of Ashleigh Trinder, 30 October 2015, Attachment AT-47 to this statement, "Clinical Psychology Summary", p 200.
- 79 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 29 para 146.

- 80 Transcript, Trevor Sadler, 9 March 2016, p 23-80 lines 1-5 See also Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 53 para 250(d); and Exhibit 179, Supplementary statement of Trevor Sadler, 12 February 2016, p 10 para 42.
- 81 Confidential details removed.
- 82 Transcript, Anne Brennan, 4 March 2016, p 20-37 line 30 – p 20-38 line 9.
- 83 Transcript, Anne Brennan, 4 March 2016, p 20-37 line 30 – p 20-38 line 9.
- 84 Confidential details removed.
- 85 Confidential details removed; Exhibit 26, Statement of Janelle Bowra, 3 February 2016, p 55; Exhibit 139, Statement of Una Window, 29 October 2015, p 20 para 147; see Transcript, Anne Brennan, 4 March 2016, p 20-72 lines 15-39; and Transcript, Anne Brennan, 7 March 2016, p 21-5 lines 11-47 and p 21-6 lines 20-29; Transcript, Anne Brennan, 4 March 2016, p 20-72 lines 34-39.
- 86 Confidential.
- 87 Confidential details removed; Exhibit 61, Statement of Emma Hart, 25 January 2016, p 3 para 12.
- 88 Confidential.
- 89 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 55 para 262.
- 90 Confidential details removed.
- 91 Confidential details removed.
- 92 Confidential details removed.
- 93 Confidential.
- 94 Confidential; Exhibit 126, Statement of Robert Stewart, 16 October 2015, p 7 para 21(b).
- 95 Confidential; Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 31 para 115(b).
- 96 Submissions on behalf of Justine Oxenham, 23 March 2016, p 10 para 14.1.
- 97 Confidential exhibit and details removed; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 46-47 para 123; Confidential; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 47-48 para 124; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 45-46 para 122.
- 98 Confidential exhibit and details removed; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 47-49 para 125. Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 49-51 para 126.
- 99 Confidential exhibits and details removed; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 39-40 para 118; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 41-44 para 120; Confidential exhibit and details removed; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 40-41 para 119.
- 100 Confidential; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 37-38 para 117; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 37-38 para 115.
- 101 Confidential exhibit and details removed.
- 102 Confidential details removed; Transcript, Anne Brennan, 4 March 2016, p 20-60 lines 13-15; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 46-47 para 123 Confidential details removed; Exhibit 39, Supplementary statement of Vanessa Clayworth, 20 November 2015, p 8 para 15.3.
- 103 Confidential; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 44-45 para 121.
- 104 Confidential; Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 32-34 para 115(d).
- 105 Transcript, Anne Brennan, 4 March 2016, p 20-37 line 30 – p 20-38 line 15.
- 106 Confidential.
- 107 Confidential.
- 108 Confidential.
- 109 Confidential.
- 110 Confidential.
- 111 See, for example, Transcript, Patrick McGorry, 2 March 2016, p 18-5, lines 25-40; Transcript, Beth Kotzé, 9 March 2016, p 23-7 lines 25-35, Transcript, Beth Kotzé, 9 March 2016, p 23-20 lines 10-35.
- 112 Transcript, Beth Kotzé, 9 March 2016, p 23-44 lines 5-15; Transcript, Stephen Stathis, 11 March 2016, p 25-7 lines 35-40; see also Exhibit 295; Transcript, Anne Brennan, 4 March 2016, p 20-63 lines 5-10.
- 113 Transcript, Anne Brennan, 4 March 2016, p 20-17 lines 19-25.
- 114 Exhibit 971, Supplementary statement of Megan Hayes, 2 March 2016, p 16 para 28.1.
- 115 Transcript, Carol Hughes, 3 March 2016, p 19-73 line 45 – p 19-74 line 2.
- 116 Transcript, Carol Hughes, 3 March 2016, p 19-77 line 41.

- 117 Transcript, Carol Hughes, 3 March 2016, p 19-74 lines 33–35.
- 118 Transcript, Carol Hughes, 3 March 2016, p 19-78 line 5.
- 119 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 11 paras 39(i), 40(b) and (d); Confidential exhibit and details removed.
- 120 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 22 para 87(d).
- 121 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 23 para 88; Confidential details removed; Exhibit 359, Second supplementary statement of Anne Brennan, 22 February 2016, p 26 para 78(a); Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 23 para 87(g).
- 122 Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 24–25 para 97.
- 123 Confidential exhibits and details removed.
- 124 Confidential details removed.
- 125 Confidential exhibit removed.
- 126 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 23 para 87(e).
- 127 Confidential exhibit removed.
- 128 Confidential exhibits removed.
- 129 Exhibit 38, Statement of Vanessa Clayworth, 27 October 2015, p 3 para 5.1(g).
- 130 Exhibit 39, Supplementary statement of Vanessa Clayworth, 20 November 2015, Attachment VC-20 to that statement, Summary table of communication with transition clients.
- 131 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 10 para 39(g)(i); Transcript, Carol Hughes, 3 March 2016, p 19-74 lines 25–29.
- 132 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 10 para 39(g)(i).
- 133 Transcript, Carol Hughes, 3 March 2016, p 19-74 lines 25–29; Confidential exhibits and details removed.
- 134 For example, see Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 22 para 87(c).
- 135 Confidential exhibits and details removed.
- 136 Confidential.
- 137 Confidential exhibits; Transcript, closed hearing.
- 138 Confidential exhibit.
- 139 Transcript, closed hearing.
- 140 Confidential.
- 141 Exhibit 138, Statement of Emma White, 21 October 2015, pp 317 and 651.
- 142 Confidential exhibits and details removed.
- 143 Exhibit 615, Email from Sharon Kelly to Sharon Kelly, Subject; “Consumer Advocate Barrett Adolescent Centre”, 25 September 2013.
- 144 Confidential exhibit.
- 145 Confidential.
- 146 Further submissions on behalf of West Moreton HHS and Board, in response to submissions from [confidential], 12 May 2016, p 7.
- 147 Exhibit 706, Email from [confidential] to Sharon Kelly and others, Subject; “Consumer Advocate Barrett Adolescent Centre”, 26 September 2013; Exhibit 707, Email from [confidential] to Sharon Kelly and others, Subject; “Consumer Advocate Barrett Adolescent Centre”, 1 October 2013; Exhibit 708, Email from Leanne Geppert to Sharon Kelly and Nadia Beer, Subject; “BAU”, 9 October 2013; Exhibit 709, Email from [confidential] to Nadia Beer, Subject: [confidential], 10 October 2013; Exhibit 712, Email from Sharon Kelly to [confidential] , Subject; “Consumer Advocate Barrett Adolescent Centre”, 5 November 2013.
- 148 Exhibit 71, Statement of Beth Kotzé, 18 December 2015, Attachment BK-F to that statement, Transitional Care for Adolescent Patients of the Barrett Adolescents, p 73 (references omitted).
- 149 Exhibit 71, Statement of Beth Kotzé, 18 December 2015, pp 9–10 para 34.

22 Families of the transition clients

Care, support and services provided to the families of transition clients

By term of reference 3(e), the Commission is required to assess the adequacy of the care, support and services provided to the families of the transition clients.

Two main themes can be drawn from the National Standards for Mental Health Services 2010, the *Carers (Recognition) Act 2003* (Qld) and the Queensland Plan for Mental Health (QPMH). First, consumers have a right to have their nominated carer(s) involved in all aspects of their care as “partners in the delivery of care”.¹ Second, carers have their own discrete needs.²

In relation to the first point, Philip Hazell and James Scott³ gave evidence about the importance of family engagement, particularly in adolescent mental health services,⁴ and Brennan⁵ gave evidence that transition needs to involve good communication.⁶ This engagement is vital to the success of families’ assuming or resuming carer responsibilities, particularly where patients are transitioned into the care of their families. Family engagement remains necessary in cases where patients cannot transition to family care. Regardless of the strength of the partnership in the delivery of care, transition clients were (subject to their wishes where they were competent to give instructions), entitled to have their families and carers involved in all aspects of it.

In relation to the second point, the adequacy of the care, support and services provided to the families of transition clients cannot be assessed solely by reference to the needs of the transition clients. It must take into account the discrete needs of the families of those transition clients and the duties imposed by the National Standards for Mental Health Services 2010, the *Carers (Recognition) Act 2003* (Qld) and the QPMH.

The inquiry into the adequacy of the care, support and services provided to the families cannot be undertaken in isolation from the inquiry into the adequacy of the care, support and services provided to transition clients: there must be some nexus between the needs of the transition client and the needs of the family member. Any inconsistency between those needs must be resolved in favour of the needs of the transition client, recognising the primary responsibility of a hospital and health service is to its patients.

Individual assessments of the care, support and services to the families of each transition client are contained in the confidential volume.

As set out in chapter 21, the Commission determined that this inquiry was limited to the transition period for each transition client.

A general discussion of the overall assessment of the adequacy of the care, support and services provided to the families of transition clients is in chapter 21.

Relevance of evidence to other issues

Families and carers experienced considerable distress and anxiety attributable in no small measure to uncertainty about if and when the BAC was to close, and what services would be available for their children and other young people who suffered from severe and complex mental health issues, and all the information they were given about those matters.

The evidence from families about the broader issue of closure of the BAC and the development of services was not relevant to the inquiry into the care, support and services provided to them under term of reference 3(e).

This evidence was however relevant to the information and processes that related to:

- the making of the closure decision under term of reference 3(c)
- the transition arrangements and the care, support and services provided to transition clients and their families within term of reference 3(h).

The communications patients and their families received about the BAC's closure and the development and implementation of new services are discussed in chapter 24.

(Endnotes)

- 1 Department of Health, National Standards for Mental Health Services 2010, Canberra; Department of Health, Australian Government, Foreword at p 5, Standard 7 at 7.2.
- 2 Department of Health, National Standards for Mental Health Services 2010, Canberra; Department of Health, Australian Government, Foreword at p 5, Standard 7 at 7.13-4; *Carers (Recognition) Act 2003* (Qld) Schedule Item 6.
- 3 Philip Hazell and James Scott are both child and adolescent psychiatrists and both were on the ECRG. Hazell is (amongst other positions) the Director of the Thomas Walker Hospital (Rivendell). Scott is, amongst other positions, Consultant Psychiatrist at the Royal Brisbane Women's Hospital.
- 4 Transcript, Philip Hazell, 17 February 2016, p 8-39 lines 5-10; Transcript, James Scott, 17 February 2016, p 8-9 lines 16-20.
- 5 Anne Brennan was appointed the acting Clinical Director of the BAC on 10 September 2013. She is a child and adolescent psychiatrist.
- 6 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, p 36, para 35.

23 The adequacy of support provided to BAC staff

Introduction: What is required by term of reference 3(f)?

By term of reference 3(f) the Commission must inquire into “the adequacy of support to BAC staff in relation to the closure and transitioning arrangements for transition clients”.

Assessment of the adequacy of support to BAC staff requires consideration of:

- whether support was given to staff
- if so, what support was given
- the adequacy of the support that was given.

The Commission has interpreted “BAC staff” as including all clinical and allied health staff, and also education staff.

‘Adequacy’ in term of reference 3(f) relates to the adequacy of support. The Commission must assess objectively whether the support was sufficient or satisfactory¹ in the context of the closure and the transitioning arrangements for transition clients.

“Transition clients” are defined in the terms of reference as “BAC patients transitioned to alternative care arrangements in association with the closure or anticipated closure, whether before or after the closure announcement”. The Commission considers that “transitioning arrangements” in term of reference 3(f) has the same meaning as “transition arrangements” elsewhere in the terms of reference – that is, “how care, support, service quality and safety risks were identified, assessed, planned for, managed and implemented before and after the closure”. It has interpreted the phrase “in relation to” as having a similar meaning to “in association with” – that is, “in connection with” or “at the same time as”.²

Because this term of reference refers to support in relation to “the closure” rather than in relation to “the closure or anticipated closure”, the Commission has interpreted the period in question as commencing with the decision to close the BAC (made on 15 July 2013). And because the inquiry is in relation to “transitioning arrangements”, it has interpreted the period as ending when the transitions had all concluded.

Term of reference 3(f) does not extend to the availability of physical amenities, such as clean toilets, cool and clean drinking water and hygienic eating areas.

Who had responsibility to provide support to staff?

The Queensland Plan for Mental Health, the ECRG and the Planning Group

The Queensland Plan for Mental Health 2007–2017 (QPMH) is underpinned by six principles that “guide and support reform”.³ Relevantly, one principle is:

High quality services will be accessible and responsive, informed by research and evidence of best practice, **provided by a suitably skilled and supported workforce**, and deliver improved outcomes to people living with mental illness, their families and carers, and the wider community.⁴

(emphasis added)

The QPMH provided for \$70.82 million over four years to:

[E]xpand and develop the mental health workforce to ensure the provision of high quality, safe public mental health services, and to continue developing mental health research and information management capacity.⁵

That funding included \$3.06 million to provide “a range of ongoing support to assist with retaining mental health staff”.⁶

The ECRG expressed concern about “the dissipation and loss of specialist staff skills and expertise in the area of adolescent extended care in Queensland if BAC closes and a Tier 3 is not established in a timely manner. This includes both clinical staff and education staff”.⁷ Its recommendation 3(c), which was strongly supported by the Planning Group, was: “BAC staff (clinical and educational) must receive individual care and case management if BAC closes, and their specialist skill and knowledge must be recognised and maintained”.⁸

Transition to Hospital and Health Services

The legal relationship between Queensland Health and West Moreton Hospital and Health Service (HHS) is outlined in chapter 4.

As discussed in that chapter, on 28 June 2012 a Service Agreement was entered into between West Moreton HHS and Queensland Health for the period 1 July 2012 to 30 June 2013.⁹ The Service Agreement, (and the subsequent agreement, entered into on 28 June 2013)¹⁰ detailed West Moreton HHS’s responsibilities in relation to workforce management.¹¹

Pursuant to section 45 of the *Hospital and Health Boards Act 2011* (Qld) (HHB Act), and the service agreements, the Chief Executive of Queensland Health retained the power to employ health service employees (including BAC employees), but many of Queensland Health’s workforce-related functions, including workplace health and safety compliance, were delegated to the Chief Executive of West Moreton HHS.¹²

The result was that from 1 July 2012 until the BAC closed, its clinical staff were employed by Queensland Health, but their “day-to-day management”¹³ was handled by West Moreton HHS. From July 2014, West Moreton HHS had power to employ staff but, by then, the BAC had closed. On 1 July 2014, amendments to regulations under the HHB Act prescribed West Moreton HHS as a HHS with the power to employ health service employees.¹⁴

What was done to provide support to staff?

The support to staff falls into the following six categories:

1. Communication
2. Appointment of Personnel and Consultants
3. Leadership and Support
4. Future employment opportunities
5. Personal and emotional support
6. Support to staff in arranging and implementing transitions.

Each type of support is considered below.

Support type 1: Communication with staff

As discussed in chapter 8, many staff first became aware of the anticipated closure of the BAC through media reports following Brett McDermott's¹⁵ public announcement on 8 November 2012.¹⁶ The following day, Sharon Kelly (Executive Director Mental Health and Specialised Services, West Moreton HHS) sent an email to BAC staff. She gave a commitment that staff would be kept up-to-date as soon as information became available.¹⁷ Kelly assured staff that "[o]nce any decision is made I am committed to consultation about the implementation of any organisational change, particularly in regard to minimising the impact of any change on staff. As always staff are welcome at any time to bring forward all suggestions and ask questions".¹⁸

In November 2012, Naomi Ford (Media and Communications Consultant, West Moreton HHS) developed a communication strategy which was annexed to the Barrett Adolescent Strategy Project Plan dated 16 November 2012.¹⁹ The Barrett Adolescent Strategy (including the communication strategy) is discussed in chapter 9.

Relevantly, one of the communication strategy's objectives was to "[c]reate ownership of, and support for, the BAC project within WMHHS staff".²⁰ It described a number of challenges facing West Moreton HHS and Queensland Health including "[w]orkforce shortages across health professions", "[r]ecruiting and retaining clinical staff given overall shortages, competition from other states and countries and the private sector" and "recruiting skilled, professional staff".²¹

In relation to BAC staff, the communication plan recommended the dissemination of fact sheets and internal stakeholder briefings.²² Consistent with this, staff received a series of 'Fast Facts' bulletins and staff communiques. There were also a number of staff briefings with West Moreton HHS executive and Human Resources. The following section discusses these three forms of communication.

Fast Facts

Between 30 November 2012 and 20 December 2013, West Moreton HHS issued a series of 11 Fast Facts bulletins to patients, families, staff and other child and youth mental health services in Queensland.²³ The Fast Facts bulletins were drafted by Ford using information she gained from Barrett Adolescent Strategy Planning Group meetings and information provided by Kelly, Lesley Dwyer (Health Service Chief Executive, West Moreton HHS), Leanne Geppert (Director Planning and Partnerships MHAODB and, from May 2013, Director of Strategy, Mental Health and Specialised Services, West Moreton HHS) and Chris Thorburn (Director Service Redesign, West Moreton HHS).²⁴

Although intended for patients and their families, the Fast Facts bulletins were also available to staff and were placed on the West Moreton HHS website.

Fast Facts 1 to 5, issued between 30 November 2012 and 21 May 2013 are discussed in detail in chapter 9. A consistent theme throughout Fast Facts 1 to 5 was that no decision about the future of the BAC had been made, and no decision would be made until all of the ECRG recommendations had been considered by the Planning Group. There was then a gap in communication until the closure announcement on 6 August 2013. Communications with staff following the announcement are discussed in chapter 16, as is Fast Facts 6 which was issued on 23 August 2013.²⁵ Fast Facts 9 to 11 (which were issued in November and December 2013) are discussed in chapter 24.

Staff communiques

Between 3 October 2013 and 21 January 2014, staff received four communiques which were intended to keep them “informed about what [was] happening and how it will impact [them]”.²⁶ They are discussed in turn below.

Staff Communique 1

The first communique was issued on 3 October 2013 and was virtually identical to Fast Facts 8. Staff were provided with the following updates on the BAC:

- “We continue to work toward the end of January 2014 to cease services from the BAC building” but it was a “flexible date”.
- “Clinical Care Transition Panels have been planned for each individual young person at BAC”.
- “There will be no more admissions to BAC services from this date forward. For adolescents currently on the waiting list, we will work closely with their receiving service to identify their options for care”.
- “As part of the [SWAETRI – discussed in chapter 26], two Working Groups have been defined to deliver on various aspects of this initiative...Working Group two will focus on the financial and staffing requirements of any future service options that are developed”. ‘Working Group two’ was later named the ‘Financial and Workforce Planning Transition Working Group’.

It seems that the “flexible” closure date caused confusion for at least one staff member Stephen Sault (BAC registered nurse) said he interpreted this to mean the BAC might remain open past January 2014.²⁷

Staff Communique 1 also provided staff with some information about employment issues:

- They were informed that discussions had commenced with Human Resources regarding “processes, options and issues” for BAC staff. Human Resources and senior clinical staff were to commence working with BAC staff individually to identify their “individual employment options”.
- Staff were also provided with information about the Employee Assistance Service (EAS)²⁸ and were reminded that their line managers were available to discuss their concerns or queries.²⁹

Staff Communique 2

The second communique was issued on 4 November 2013.³⁰ It was similar to Fast Facts 9. It provided staff with an update on the SWAETRI process:

- Staff were told that “We continue to engage regularly with our key stakeholders including the parents/carers and staff of BAC and other service providers”. However, there is no evidence that staff were consulted during this process.
- Staff were given further information about the Financial and Workforce Planning Transition Working Group. They were told that “West Moreton HHS was well represented at [the Group’s first meeting on 22 October 2013] with both senior allied health and nursing representatives, in addition to workforce and finance representatives”. However, apart from the statement that “[w]ith regard to current workforce needs of BAC staff, this will continue to be a high priority for West Moreton HHS”, no further information was provided to staff about how this Group’s work might affect them.

The communique informed staff that Human Resources had “been on-site at BAC at various times across the last couple of weeks, to provide information and support to all interested staff about their future employment options”.³¹ It noted that there were on-going discussions between line managers and staff regarding each staff member’s “particular preferences”. Staff were again encouraged to contact their line managers if they required additional methods of support or information.

Staff Communique 3

On 4 December 2013, shortly before the third staff communique was issued, Geppert sent an email³² to Kerrie Parkin (Acting Director, Human Resource Services, West Moreton HHS) and a number of other staff acknowledging that there had been problems with communications to staff.

Hi Kerrie and everyone

It has been fed back in a recent [meeting] with lead clinical staff at BAC that they would appreciate meeting Kerrie face to face at the earliest possible opportunity, given Kathryn White has gone on leave. **It was also noted that the HR information to date has not been consistent in content across staff, and that there is still a lack of clarity about the options and the process.**

...

It is likely our **BAC Staff Communique #3** will go out today or tomorrow, but it was agreed **it wouldn’t go into this detail. The detail needs to be delivered one on one to staff**, by line managers and discipline leaders, in conjunction with HR.

Kerrie, can I suggest we go ahead and arrange the times for BAC staff to meet with you personally, with our MHSS line managers/discipline leaders supporting these meetings?³³

(emphasis added)

The third staff communique was issued on 5 December 2013.³⁴ It was much shorter than previous issues. Consistent with Geppert’s email, this communique did not provide staff with information about future employment options. Instead, it informed staff that Parkin was the new contact for Human Resources issues for BAC staff. Staff were assured that West Moreton HHS was “working with Kerrie [Parkin] now in order to provide more details around [their] individual

employment options and will arrange times for each of you to meet Kerrie personally". Staff were provided with Parkin's contact details.³⁵

The third communique included information about the BAC holiday program, which was to run between 16 December 2013 and 23 January 2014. However, it was noted that those dates were flexible and were to be "based on the needs of the adolescents".

Staff were also informed that an information session was to be held by Sandra Radovini (Child and Adolescent Psychiatrist, Director of Mindful, Centre for Training and Research in Developmental Health, the University of Melbourne, and Clinical Director of Headspace) on 10 December 2013. It was described as a "professional development session" and an opportunity for West Moreton HHS child and youth mental health staff to hear about service delivery models from Victoria.³⁶ There is evidence that Megan Hayes (BAC occupational therapist), Carol Hughes (BAC social worker), Matthew Beswick (BAC acting clinical nurse), Mara Kochardy (BAC acting clinical nurse) and Anne Brennan (BAC acting Clinical Director) attended this session.³⁷

Staff Communique 4

The fourth and final staff Communique was issued on 20 January 2014.³⁸ Its primary focus was to provide information to staff about human resources issues, namely voluntary redundancies and job matching.

The communique confirmed that job matching had been completed for the majority of BAC permanent staff. It emphasised that staff who had not been job matched would have to choose between accepting a voluntary redundancy or pursuing transfer or redeployment. With regard to staff support, the communique (from Kelly) stated:

I am very keen to ensure that all staff feel supported during the implementation of this change. It is important that you approach your supervisor or a more senior manager if you have any questions or concerns about the changes or how they may affect you. This is particularly important if you feel you need further detail about decisions taken or their impact. If your supervisor or manager does not know the answer to your question, they will escalate the issue and get back you as quickly as possible.³⁹

Staff were again encouraged to contact EAS for support including face-to-face and telephone counselling.

The fourth communique did not provide staff with any information as to the type of alternative service options being considered, when they would be available, or whether any BAC patients would transition to these services. Despite being dated 21 January 2014 [REDACTED], it was silent on when the BAC would close.

Briefings with staff

Kelly said she "had extensive meetings with staff around closure" between 9 November 2012 and when BAC closed in January 2014.⁴⁰ There is evidence that at 3.00 pm on 6 August 2013, Kelly held a meeting with BAC staff ahead of the Minister's announcement.⁴¹ That evening Geppert sent an email to staff who were not present at this meeting.⁴² Kelly's meeting and Geppert's email are discussed in chapter 16.

Finding as to adequacy

The Commission accepts that no level of communication could have relieved staff from what was an inevitably a difficult situation. But, in the Commission's view, the vague and intermittent nature of the communication from the point of the closure announcement until the ultimate closure of the BAC was unacceptable and inadequate.

First, like the Fast Facts discussed in chapters 9 and 24, the communiques did not contain any detailed information about the new services being developed, when those services would be ready, whether the BAC patients would be transitioned to those services, and whether BAC staff would have any involvement in the future services.

The staff Communiques also failed to advise staff about the progress of transition arrangements, or the alternative service options available. Given that many staff members held concerns for the patients' futures (as well as their own,⁴³ the provision of decisive information in relation to patient transitions and alternative services would have been of assistance to the general wellbeing of staff during this time of uncertainty.

Second, the communiques (and Fast Facts) failed to provide staff with a clear idea of when the BAC would close. Several different dates for the actual closure of BAC were given to staff members, which caused confusion. For example, the first staff communique dated 3 October 2013, listed January 2014 as the closure date.⁴⁴ A letter sent by Kelly to all BAC staff on 16 December 2013 stated the services would cease as of 2 February 2014.⁴⁵ Other staff members said they were never given a specific date for closure and had assumed this meant the BAC would remain open for as long as it took to find appropriate transition services for all patients.⁴⁶ Accordingly, the communiques did not relieve many staff of their concerns or stressors during this time.

There is evidence that even by January 2014, communication about the final closure date was not extended to some staff members. Sault was rostered for an afternoon shift on 24 January 2014. When he arrived at the BAC for his shift he was met by Alex Bryce who told him the BAC was now closed and requested his keys. Sault noticed a locksmith changing the BAC locks.⁴⁷ Similarly, Richardson returned to the BAC after a few days off at the end of January, to find the doors locked and that her keys no longer worked. She called the acting nurse unit manager and was told the BAC was closed.⁴⁸ Those were unfortunate breakdowns in communication.

The inconclusiveness of the closure date was very frustrating for staff members and made it difficult to make decisions about their futures.⁴⁹ It is true that the date for closure of the BAC depended on the progress of each patient's transition arrangements. Even with that uncertainty, the situation called for transparent communication of target dates, or regular updates on the proposed closure date, or even some assurances about employment to a particular date.

Third, it is unfortunate that the communiques did not provide more detailed information to staff about their employment options, an issue discussed further in the context of future employment opportunities, below.

Fourth, as explained in chapters 16, 17 and 19, Sadler's standing down was very unsettling for staff (as well as for patients and families). The loss of the most senior employee of the BAC at a crucial time, coupled with the fact that many staff were given incorrect information about his absence, was a setback to staff morale. Staff involved in the investigation of the incident that led to the standing down were distressed, and some were concerned that there may be negative repercussions for them professionally.

Adequate communication required specific and definite decisions, communicated regularly, both orally and in writing, to all staff members. There was little point in holding the regular meetings Kelly describes, if staff left the meeting with no less uncertainty or confusion as to their future, and the future of the patients. The staff had extremely difficult jobs, made more difficult by the increased acuity of the patients. In the Commission's view, for health staff to also have to deal with uncertainty about their own livelihood was regrettable.

The Commission finds that support to staff, in terms of communication, was inadequate.

Support type 2: Appointment of personnel and consultants

Following the announcement of the closure, Kelly asked William Brennan (Director of Nursing) to act as a liaison and support for nursing staff at the BAC.⁵⁰ Kelly asked that Lorraine Dowell (Allied Health Team Leader Non Secure Services and Senior Occupational Therapist)⁵¹ provide a similar support for allied health staff.⁵²

William Brennan gave oral evidence that in his role as liaison/support, he "visited the [BAC] on a regular basis" and made himself available to nurses who wanted to discuss specific requests about their employment options after the closure.⁵³

According to Dowell, her role was to "support allied health staff through the organisational change process and to support positive engagement with the transition planning process to secure the best possible outcome for the patients".⁵⁴

With respect to organisational change, Dowell explained that she acted as a liaison "between allied health staff at BAC and the Human Resources team in investigating redeployment and other future options for staff".⁵⁵ From 23 September 2013 until the BAC closed, Dowell met weekly with allied health staff,⁵⁶ and did so in order to "develop an appreciation of [staff] circumstances and to identify the best way to support them as individuals".⁵⁷ Dowell offered "advice to staff on strategies to cope with the challenges and stressors" associated with BAC's closure.⁵⁸

Finding as to adequacy

In all of the circumstances, the Commission is satisfied that appropriate personnel and consultants were appointed by West Moreton HHS to provide support to BAC staff.

Support type 3: Leadership and support

Loss of employment is inevitably an emotional and unpleasant experience. That was perhaps amplified in the case of long-term and dedicated staff caring for a highly vulnerable group of young people. It is unlikely that any level of support could have completely alleviated the distress staff felt. There is, however, a noticeable theme in the evidence of the BAC staff that direct line managers, leaders and senior clinicians did the best they could to support staff during these challenging circumstances, and the staff were able to rely on each other for collegial support.

Nursing, medical and allied health staff

There is significant evidence of support having been provided to nursing and allied health staff by senior staff and clinicians, such as Anne Brennan, Vanessa Clayworth and Dowell.

As outlined in chapter 20, when Anne Brennan arrived, staff were exhibiting intense distress and uncertainty about the wellbeing of patients and their own future employment.⁵⁹ Anne Brennan took steps to address the concerns of staff. She explained that:⁶⁰

WMHHS (Leanne Geppert) proposed a suggestion box for staff but instead I offered to all staff that they could come to me at any time with their concerns and they could leave me anonymous notes. Many called in including all allied health staff, many nurses and two teachers on frequent occasions. I do not have dates for the calls which occurred over the duration of the transition process. No one left notes. I used the matters raised to guide the plans which were developed for individual patients.

Clayworth gave evidence that following the announcement of the closure, she facilitated a debriefing for nursing staff and stayed back until 9:30 pm to be available to provide support.⁶¹ Clayworth explained that she “also provided staff with opportunities on the roster should they need time off to debrief or access clinical supervision”⁶² and held clinical nurse meetings, designed to support the clinical nurses in leading the nurses and supporting case coordinators.⁶³ Clayworth noted that had she been advised of the circumstances surrounding Sadler’s absence from the BAC, she could have provided “more sensitive support” to staff.⁶⁴

Thomas Pettet’s evidence was that he always felt “entirely supported” by Trevor Sadler (and, later Brennan in his role as psychiatric registrar).⁶⁵

Education staff

Justine Oxenham (a teacher at the BAC school) gave evidence that no real support for BAC education staff was forthcoming, and that the only support they received was support they organised themselves.⁶⁶

Deborah Rankin (acting principal, BAC school) gave evidence that, together with Kevin Rodgers (principal, BAC school) she encouraged Peter Blatch (Assistant Regional Director, School Performance, Special and Specific Purpose Schools) to visit the BAC school as regularly as he could, and that Rodgers also encouraged the Teachers Union to support staff.⁶⁷

There is evidence of an increase in the level of communication between education staff and the Department of Education, Training and Employment (DETE (as it was then known), following the announcement of the BAC’s closure. Blatch’s evidence was that he met personally with the BAC school principal and acting principal “on a frequent basis and received email correspondence from education staff”.⁶⁸ The support from Blatch was commended by a number of education staff who felt that Blatch went above and beyond his professional duties.⁶⁹

Support was also provided to education staff by Rankin, Rodgers and Dianne Wallace (guidance officer, BACSS). Rankin gave evidence that they took steps to support education staff by offering an open door policy, encouraging open and honest sharing of information, and creating a collegial environment.⁷⁰ Rankin recalled that self-care was spoken about, and that staff were encouraged (it is unclear, by whom) to reflect on how they were responding to the constantly changing environment.⁷¹

Margaret Nightingale (a teacher at the school) commended Rankin for the support she provided to education staff.⁷²

Finding as to adequacy

The Commission finds that adequate leadership and support was made available to health and education staff, following the announcement of BAC’s closure.

Support type 4: Future employment opportunities

There is significant evidence that following the closure announcement, BAC staff were greatly concerned about their ongoing employment. According to McDermott, by the time Anne Brennan commenced in September 2013, staff were “chronically concerned about their jobs”.⁷³ Brennan gave a similar recount, saying that staff were “very concerned about their own futures in terms of employment” and “[t]here was constant discussion about [the] date of closure as this was highly relevant to their seeking new employment or holding out for redundancies”.⁷⁴

Management of the redeployment/redundancy process

On 27 September 2013, Kelly prepared a board meeting agenda paper which noted that human resources processes had not yet started, but foreshadowed the plan to come:⁷⁵

Once a date is confirmed for staff there are a range of HR processes that will be instigated, including the offering of voluntary redundancies if no alternate commensurate roles are available. It is acknowledged that some staff are already seeking alternate positions and as such we are appointing long term casual contract staff to maintain the service.

Ashleigh Trinder recalls that from around 30 September 2013 there were “regular meetings”, during which there was a general discussion about staff issues and, in particular, “employment movements and the options for staff in terms of redeployment or redundancy”.⁷⁶

Initially, management of the redeployment and redundancy process was undertaken by the West Moreton HHS Workplace Relations team, under the leadership of Kathryn White (Director of Workplace Relations).

On 28 October 2013, White met with a number of BAC allied health staff.⁷⁷ A note of the meeting, circulated by Dowell the following afternoon, records that White presented information about the early retirement, redundancy and retrenchment processes, the Employee Requiring Placement process, and the procedures for transferring within and between classification levels and systems.⁷⁸

In mid-November 2013, responsibility for the redeployment/redundancy of BAC staff transferred to the West Moreton HHS Human Resource Services Team, under the leadership of Parkin.⁷⁹ According to Parkin, with the transfer of leadership, she assumed responsibility for identifying and actioning individual “work options” for the BAC staff. In the context of the BAC’s closure, she explained these options included redeployment, redundancy or resignation.⁸⁰ Parkin gave evidence that she “dealt with individual staff members in relation [to] their individual options”⁸¹ and “provided assistance and support to line managers in the staff redeployment process”.⁸²

Organisation change meeting

On 28 November 2013, Parkin attended a ‘Barrett Adolescent Centre Organisation Change’ meeting, chaired by Geppert. Also in attendance were Alan Milward, William Brennan, Michelle Giles, Laura Tooley (nee Johnson) (Project Officer, West Moreton HHS) and Terry Stedman (Clinical Director, Division of Mental Health & Specialised Services, West Moreton HHS).⁸³ Giles described the meeting as a “one-off” meeting,⁸⁴ the purpose of which was “to discuss, with HR, staff issues including voluntary redundancies, communicating with staff and communicating with unions”.⁸⁵

The meeting minutes record some uncertainty about the options to be made available to BAC staff and, specifically, whether voluntary redundancies (“VRs”) could be offered and under what funding arrangement. Relevant extracts of the minutes are as follows:

Voluntary Redundancies

- Funding for VR ceased 1 July 2013
- VRs do not need to be offered as part of change process. Concern over staff expecting/ assuming that VRs are going to be offered.
- Resolve VR funding – confirm with Lesley Dwyer. Who funds? How many – 12 staff have indicated that they want a VR...

Communication with Staff

- [Johnson, Geppert and Parkin] to work out key messages / key statement for inclusion in letters etc.
- Dates have been announced for closure of facility not staffing positions. Staff can continue to be utilised in other areas.
- All possible arrangements for staff are being looked at.
- Change process is the same as always.
- Advertising positions – ERP.
Temp v perm.
Suitability assessment...

Other Business

- VRs to possibly be funded from BAC funding service level agreements
 - [Johnson] to link with [Parkin] in weekly meetings
 - Staffing profile
 - Permanent night shift (nursing) not consulted
- ...
- Communique for assessing staff impact, processes, investigating availability of VRs post 1 July to be sent to [Milward] for review.

Soon after this meeting, on 4 December 2013, Geppert sent an email to Parkin, Tooley, Giles, Kelly, Brennan, Dowell, Pdraig McGrath, William Brennan and Stedman, in which she confirmed that voluntary redundancy offers could be made. That email stated, in part:

In our BAC Org Change mtg [sic] last week, we mapped out a way forward to seek clarity/ approval re option of VRs. This is progressing, however, it is clear we need to update BAC staff on the process and what we are doing to seek approval. I believe MHSS EXEC and HR are now clear and on the same page about the process but we need to cascade this info down.⁸⁶

(emphasis added)

Options communicated to staff

On 16 December 2013, Kelly sent a letter to all BAC staff, outlining the options available to staff depending on their employment type. The letter stated, relevantly:

Staff who occupy permanent substantive positions

In line with Public Service Commission 06/13: *Employees Requiring Placement*, each staff member who currently occupies a substantive position in [BAC] has now been declared an employee requiring placement. I have attached a copy of the Directive ...

A process is underway to identify suitable alternative positions for permanent staff. If a suitable alternative substantive position is not identified for any permanent staff member

before close of business 10 January 2014... [s]taff not placed will then have the opportunity to decide between two courses of action:

- Accept a voluntary redundancy ...; or
- Pursue transfer (and/or redeployment) opportunities...

Where the outcome for individual staff is that they will separate through voluntary redundancy, and redundancy processes are not finalised before 2 February 2014, arrangements will be made for alternative work between that date and the final date of separation.⁸⁷

The letter outlined alternative arrangements in respect of staff in temporary engagements and staff currently on secondments or higher duties.⁸⁸ Temporary fixed term contracts were not to be renewed.⁸⁹ The letter noted that arrangements would be made for “follow up communication” with staff to work through in more detail the impact on them, and any individual issues or concerns.⁹⁰

Sault gave evidence that he found this letter “extremely distressing as it created great uncertainty” as to how he would be able to provide for his family as the sole breadwinner.⁹¹ He discussed these concerns several times with Bryce and the Human Resources section.⁹²

Discussions with staff about their options

According to Parkin, Des Suttle (Senior Human Resources Advisor) was appointed as employee contact in the Human Resources Services team (it is unclear when), and was responsible for providing staff support via email, telephone and one-on-one meetings. Parkin said that Suttle provided information to staff about options, and obtained information about a staff member’s particular wishes, circumstances and preferences in order to help them identify potential alternative roles.⁹³

Between 16 and 19 December 2013, Suzanna Perkins (Associate Advisor Workplace Relations, West Moreton) convened seven one-on-one follow-up meetings with BAC staff.⁹⁴ The purpose of each meeting was “to discuss the closure of the BAC and its impact” on the staff member concerned.⁹⁵ Perkins was accompanied at each meeting by Alex Bryce (acting nurse unit manager, BAC). When staff asked an employment-related question, Perkins directed that question via email to Parkin.⁹⁶

Employee Requiring Placement process

On 16 January 2014, West Moreton HHS conducted interviews with permanent BAC nursing and allied health staff to determine suitability for alternative substantive positions.⁹⁷ Both Beswick and Sault gave evidence that the interviews were conducted by a panel, similar to job interviews.⁹⁸ Beswick said that during his interview he was told that:

...there were 5 jobs for 10 people and that potentially 5 redundancies would be offered. However, if a prison job [that is, a vacancy in a medical unit of a correctional facility] was taken it would reduce the number of redundancies offered.⁹⁹

In the event a staff member was matched to an available position, McGrath facilitated their transition in terms of “timing, orientation to the new unit, the provision of training to successfully transition to the new role and support to ensure success of the transition”.¹⁰⁰

Richardson’s evidence is similar. She was told that five positions were available which included two positions at The Park, two in the Mental Health Unit at Ipswich Hospital and one in the

medical unit of a correctional facility. However, it was Richardson's recollection that there were 12 or 13 permanent nursing staff vying for those five positions.¹⁰¹

The minutes of a meeting of the Chief Executive and Department of Health Oversight Committee, held on 22 January 2014, record the conclusion of the process:¹⁰²

HR processes have been completed for all BAC staff with many being placed in vacancies within WM HHS, and the remaining becoming Employees Requiring Placement...[Dwyer] raised that funding is required for redundancies; however, these redundancies have been delayed until an existing investigation process has concluded.

It appears that by 29 January 2014, funding for the voluntary redundancies for BAC staff had been arranged, and steps were being taken to progress the redundancy process. In an email from Ian Wright (Executive Director of Finance and Business Services) to Dwyer, Kelly and Helen Ceron (Senior Director, System Policy and Performance Division) dated 29 January 2014, Wright stated that a submission sheet for employees to receive voluntary redundancies had been processed in order to ensure that the redundancies were processed in "an appropriate time frame".¹⁰³

The email stated that Kelly had spoken to Bill Kingswell, and that it was understood that the MHAODB would fund the redundancies.¹⁰⁴

Education staff

The experience of education staff was quite different. According to Rankin, from the decision to close the BAC up until its closure, education staff were advised by DETE that their employment would be secure and that they were regarded as "an expert team that would be kept together while a future model of education for adolescents with mental health issues was developed".¹⁰⁵

Blatch and Patrea Walton (former acting Deputy Director General, State Schools, DETE) gave evidence that there was no reduction in education staff numbers following the announcement of the closure.¹⁰⁶ According to Rankin, staff members who were not permanent at the time of BAC's announcement were advised to apply for permanency.¹⁰⁷

There is evidence of at least one casual staff member's employment being terminated at the end of 2013, but that staff member was subsequently re-employed by DETE as a permanent teacher's aide in 2014.¹⁰⁸ The Commission has no evidence of any difficulties with the re-deployment of education staff upon the BAC's closure.

Outcomes for BAC staff

Out of the 20 permanent health staff employed at the time of the closure, nine accepted voluntary redundancies.¹⁰⁹ Of those nine staff members:

- five gained employment in areas of mental health, but only two in roles related to children's mental health. One of those roles was in the private sector, and the other in the public sector, but not Queensland Health¹¹⁰
- one gained employment at a national non-government organisation¹¹¹
- one undertook mental health nursing work through a private nursing agency¹¹²
- one commenced work at an interstate detention centre¹¹³
- one has not returned to work in the medical field.¹¹⁴

The remaining 11 employees were offered a direct transfer or redeployment to alternative positions:

- six staff members were transferred or redeployed to roles within The Park¹¹⁵
- two staff members transferred to Ipswich Hospital Mental Health Unit¹¹⁶
- one staff member transferred to Lady Cilento Children's Hospital¹¹⁷
- one staff member transferred to the Brisbane Correctional Centre¹¹⁸
- one employee was matched to a position at CYMHS, but elected to resign from Queensland Health instead.¹¹⁹

A management debriefing session was held on 6 February 2014, with a view to examining the closure and applying lessons learnt to future processes. It was attended by Elisabeth Hoehn (acting Clinical Director, Child Youth Mental Health Service), Giles, Geppert, Kelly, Anne Brennan, McGrath, William Brennan and Stedman.¹²⁰ The debriefing checklist, prepared during the session, lists a number of "implications on staff" including "insecurity amongst affected staff transferred to workplace behaviours", "no firm agreement to HR process", "collateral damage by HR – mopped up leadership".¹²¹ Several of the attendees were asked questions about this session during oral evidence, however were unable to recall the discussion.¹²²

According to McGrath, no actions arose from this session. He said "[t]he purpose of the session was to enable those attending to express views about the process and their experience of it rather than to identify action items".¹²³

Retention of staff expertise

Despite the specific observations contained in the QPMH and ECRG report, there is evidence of a failure to retain the BAC staff skills and expertise. Notably, out of the 17 permanent health staff members whose subsequent employment paths are known to the Commission, 14 staff members continued practising in areas of mental health, but only three continued employment in child and adolescent mental health.¹²⁴ For staff members who pursued transfer or redeployment opportunities, only two were offered roles in areas involving children or adolescents – a position at CYMHS, and another at the Lady Cilento Children's Hospital.¹²⁵ One of these roles was ultimately not accepted by the staff member.¹²⁶ Thus, upon the BAC's closure there was certainly a loss of specialist staff skills and expertise in the area of adolescent extended mental health care in Queensland.

It may be argued that it was such a specialised area that there were simply very limited options for transfer into adolescent extended care, especially considering that a replacement facility was not ultimately established. Transfer options may have been limited further still when considering the evidence of the steps taken by West Moreton HHS to accommodate staff members' location preferences.¹²⁷

It is also notable that the majority of the permanent health staff members were able to be transferred to employment within public mental health services.¹²⁸ Therefore, while their specialist skills and knowledge within child and adolescent mental health services may not have been specifically retained, there was certainly a retention of the cohort's skill in Queensland's mental health services generally. This effectively recognises the QPMH's more general provision for supporting the retention of mental health staff.¹²⁹

Finding as to adequacy

In terms of future employment opportunities, it is clear that education staff received a higher level of support than clinical staff. Education staff were promptly reassured that their employment would be secure after the closure, and that their 'expert team' would be kept together and found roles in a new service model. Those assurances are likely to have assisted them greatly. Staff members who were not permanent were offered permanency.

The situation was quite different for health staff. Health staff were not formally advised of their options for transfer or voluntary redundancy until late 2013, and interviews for those staff members seeking transfer opportunities were not held until January 2014.

Faced with an uncertain future, a number of permanent clinical staff members left to seek employment elsewhere and were replaced with less experienced clinical staff. McGrath said that West Moreton HHS attempted to assist those staff seeking alternative employment by allowing them flexibility with respect to finish dates and by assisting them with identifying redeployment opportunities.¹³⁰ Parkin gave similar evidence.¹³¹ Many clinical staff described a reduction in the average skill level at this time which placed extra pressure on the remaining staff members. This, according to some staff, was exacerbated by the increase in acuity of the ward as a consequence of the closure announcement.

Not all health staff were satisfied with the redeployment/redundancy process. On 23 January 2014, Adrian Walder (BAC clinical nurse) sent an email to Parkin, noting the following concerns:

Please note that at no stage in this whole process, did anyone either from HR or Nursing initiate contact with me. All contacts were instigated by myself. The prolonged uncertainty about my future and lack of communication throughout has been stressful and demoralising. Final outcomes have been left to the very last minute and in the event no attempt has been made to discuss my preferences or professional development goals before deciding on an alternative placement. I feel that the process has been poorly managed throughout and – in my own personal experience at least – has fallen well short of the standards as outlined in communications by the Executive Director.¹³²

McGrath gave evidence that some health staff seemed to take the view that they only wanted to work at BAC and therefore no other option was acceptable". He said that some staff refused to participate in redeployment processes, and some had an expectation that it was up to West Moreton HHS to find them another job.¹³³

There is evidence that clinical staff members' redeployment and location preferences were sought and considered during the redeployment/redundancy process, and that individual one-on-one meetings were made available to staff to discuss their employment options. As noted above, of the 20 permanent health staff employed at the BAC, nine staff members accepted a voluntary redundancy, eight of whom subsequently gained alternative employment. The remaining 11 staff were matched with a suitable alternative position.

While confirmation in respect of the availability of voluntary redundancies might possibly have been made earlier to health staff, the Commission finds that on balance there was adequate support to staff in respect of their future employment options.

Support type 5: Personal and emotional support

Nursing, medical and allied health staff

There is evidence of four sources of personal and emotional support being made available to BAC nursing, medical and allied health staff in relation to the closure and the transition arrangements – the Employee Assistance Scheme (EAS), collegial support, line management and a peer support team. Each of these is discussed below.

Parkin described the EAS as “the primary mechanism through which Human Resource Services provides for the emotional and psychological support to staff”.¹³⁴ Two of the staff communiques (discussed above), expressly encouraged BAC staff to access the EAS. Clayworth said that she “made it known to staff that EAS would come onsite should they want that in a group setting as well”.¹³⁵ Kelly encouraged staff requiring assistance to access the EAS.¹³⁶

In circumstances where EAS provides counselling and support always on a strictly confidential basis, it is not known how many BAC staff members approached it. While some staff members recalled being told they could access EAS support if they wished,¹³⁷ Richardson,¹³⁸ Kochardy,¹³⁹ Huxter,¹⁴⁰ Beswick,¹⁴¹ Macleod,¹⁴² Yorke¹⁴³ and Victoria Young (BAC registered nurse)¹⁴⁴ all said they were not offered, or did not recall being offered, any support between August 2013 and their last day at the BAC.

Collegial support was a common theme in the evidence of nurses and allied health staff. Many said the most effective support mechanism was a ‘coming together’ of BAC colleagues to support each other.¹⁴⁵ Beswick’s evidence was that “the effect on staff was significant” but that the staff were very professional and supported each other as best they could in the circumstances.¹⁴⁶ Hayes said colleagues provided “peer support and a collaborative working environment during a difficult time”.¹⁴⁷ Nursing and allied health staff also drew on the support offered by senior staff and clinicians. As noted above, it was apparent that Dowell was a valuable addition to allied health staff support. Parkin gave evidence that she “observed Dowell provide very substantial emotional support to BAC staff” in response to their concerns.¹⁴⁸ Clayworth also provided individual counselling for some staff.¹⁴⁹

As noted above, a number of staff have evidence of individual support provided by line managers/staff leaders, including Brennan, Clayworth and Dowell. There is evidence that Dowell offered allied health staff weekly individual meetings, intended to assess their personal requirements for support during the closure process.

Parkin, who was acting Director of Human Resource Services at The Park from November 2013, described the line management reporting system as follows: Each group of employees had a line manager and a professional lead to whom they reported;¹⁵⁰ nursing staff reported to the Nurse Unit Manager (line manager) and the Nursing Director (professional lead); allied health staff reported to Dowell (line manager) and the Director of Allied Health (professional lead); and the line managers themselves reported to the BAC Clinical Director.¹⁵¹ While some staff have evidence of using the line management reporting system as a source of support,¹⁵² there was no evidence about the type of support it provided and the extent to which it was relied on by all staff.

McGrath gave evidence that staff’s emotional needs were also met through a “peer support team”,¹⁵³ which he said operated within The Park for nursing and allied health staff.¹⁵⁴ There is limited evidence suggesting that staff were specifically informed about the availability of this team. Victoria Young said she was aware that there was “a general ‘peer support’ program

available upon request within the hospital that nurses could access".¹⁵⁵ The Commission does not have evidence as to whether any BAC staff accessed the peer support mechanism. It is likely that this support, in so far as it was provided, was informal or ad hoc support which was not documented.

Some staff members said that they did not know what support was offered because they did not seek it out.¹⁵⁶

Education staff

There is some evidence of Rodgers, Rankin and Blatch providing personal support to the education staff. This included providing an open door policy and a collegial atmosphere¹⁵⁷ and encouraging staff to reflect individually on the changes.¹⁵⁸ Nightingale gave evidence that the "teaching staff had a great deal of support from Deborah Rankin". Although the period she refers to is unclear,¹⁵⁹ she went on to note that teaching staff had "very little support" during the relocation of the school.¹⁶⁰

Blatch gave evidence that he met frequently with the BAC school principal and staff, explaining that he would "drop in" on the way to or from work, and would also meet with the principal off-site as required for a cup of coffee to provide support or supervision.¹⁶¹ Rodgers confirmed this, stating that after the closure announcement, Blatch gave "a lot of support to education staff which was above and beyond his professional duty".¹⁶²

Lasting impacts

For some BAC staff members, the closure of the BAC had a personal ongoing effect. One staff member said that, after the deaths of the three former BAC patients, they became depressed, had to stop working and went on workers' compensation.¹⁶³ According to that staff member, as a result of the closure of the BAC they have become a more antisocial and introverted person with depression and anxiety, which has affected their marriage.¹⁶⁴

Another staff member took stress leave in November 2013.¹⁶⁵ In an interview with health service investigators Beth Kotzé and Tania Skippen on 14 October 2014, the staff member described "getting burnt out towards the end" and considered the deaths to be "the last straw".¹⁶⁶ They took leave due to the "stress and concerns" they held for the safety and well-being of the patients, and described feeling "emotionally drained" and unable to perform their role.¹⁶⁷ The staff member has received treatment for these stress symptoms, though specific details were not provided to the Commission.¹⁶⁸ In the October interview, the staff member said they were "giving up nursing for a little while" and was "[j]ust taking it easy for a little bit".¹⁶⁹ At the time of providing their statement to the Commission, the former BAC employee had not returned to nursing practice, explaining that they were "presently not well enough to return".¹⁷⁰

Another staff member gave evidence of consulting a General Practitioner for treatment of stress-related symptoms in late 2013. That staff member described this period as a "difficult time" in their personal life¹⁷¹ and said the "stressful time working in the BAC in 2013" coupled with the death of a former BAC patient, added to their own personal trauma. The Commission was provided with no further evidence in relation to this staff member's stress-related symptoms.¹⁷²

Finding as to adequacy

Some staff have evidence that better support could have been provided by offering debriefing sessions, at which they could reflect and let go of a significant part of their professional lives.¹⁷³ Sault gave evidence that:

[O]nce the BAC closed, there was no acknowledgement given to the staff of the BAC of the efforts they made to care for the patients of the BAC. There was no debrief. The doors closed and that was the end of the BAC.¹⁷⁴

Kochardy gave similar evidence. She said that a weekly debriefing update about the patient transition progress and an “opportunity ascertain how the staff were coping” would have helped her deal with the stress.¹⁷⁵ In response to a question about whether better support could have been given, Hayes stated:

Yes. In a time of uncertainty and change, it may have been valuable to offer staff the opportunity to reflect upon their experience of the service and letting go of what had been a significant part of their professional lives (i.e. a supportive debrief process).¹⁷⁶

While staff may well have benefitted from a debriefing session (or sessions), there is evidence that at least four avenues were made available to health staff to provide them with personal and emotional support. There is evidence that education staff received support from Rankin, Rodgers and Blatch.

Without minimising the health problems suffered by a number of former BAC staff members the Commission finds that on balance, the personal and emotional support provided to staff was adequate.

Support type 6: Support provided to BAC staff in arranging and implementing transitions

The development and implementation of transitions for the BAC patients was a challenging. Beswick described the patient transitions as totally different from previous transitions.¹⁷⁷ Sault similarly explained that:¹⁷⁸

Prior to the closure decision, when a patient was being transitioned out of the BAC it was discussed by the multi-disciplinary team who had input into the transition planning and guided the transition process. The allocated care coordinator would usually have a greater role in the transition process. This did not occur after the closure decision was made.

The process of transitioning patients was made more difficult for staff by their concern about the future wellbeing of their patients. Beswick gave evidence that the “closure decision caused anxiety and uncertainty for patients”¹⁷⁹ and that “increasing acuity placed even more strain on the already stressed staff”.¹⁸⁰ Some patients told Beswick “that their transitional plans were inappropriate and inadequate for them” and that “[t]hey felt it would not work and was not enough to keep them safe”.¹⁸¹ Beswick delayed holidays to look after patients during their transition.

Clinical and allied health

Dowell provided support to allied health staff in respect of the patient transitions, “guiding and directing the staff as to executing quality clinical handover”.¹⁸² Dowell explained that she “assisted [allied health] staff to understand their role in the transition of patients, understand how to provide the best possible support to patients by enabling quality handover or care, and provided staff with a structure for what some staff may have seen as an uncertain or unfamiliar process”.¹⁸³

There is evidence of Brennan and Clayworth giving similar support to BAC clinical staff in respect of the transitions. Kochardy recalled that she received support from Brennan and Clayworth in relation to her concerns about patient welfare.¹⁸⁴

As discussed in chapter 19, Brennan made a considered decision to keep the function of the case coordinators separate from the function of the clinical care transition panel. While the health staff on transition panels were offered some support from West Moreton HHS executives, there was a general lack of clarity about the specific transition procedures, practices and resources. However, given the nature of these particular transitions, and the need for individual plans for each patient, it is difficult to see how a written procedures manual or guide could or would have provided much assistance.

Some staff members took issue with their limited involvement in the planning and management of transition arrangements. For example, Richardson described feeling demeaned by the lack of consultation and support in relation to the future plans for patients, and as a result, “questioned [her] decision to stay to the end”.¹⁸⁵ She said there was “little formal information provided to staff about the closure date and what would be happening for the patients”¹⁸⁶ and that this made it difficult for nursing staff to provide support to the patients and their families, many of whom kept coming back for advice after their children’s transitions were complete.¹⁸⁷

Some resistance to changed work practices is not an unusual phenomenon. But in the context of the impending closure of the BAC, sensitivities and emotions were heightened, and all of the staff at the BAC, including Brennan and Clayworth, were working under tremendous pressure. Some of the difficulties Brennan had in working with the staff are discussed in chapter 19.

Pettet recalled that after Sadler’s departure, Darren Neillie and Kelly both made time to call or meet with him to “listen about the concerns and distress” he or others were experiencing.¹⁸⁸ His evidence however was that, unfortunately, those discussions did not lead to any additional support being provided on the ground.¹⁸⁹ He explained that he did not recall being provided with any additional resources or personnel during his time at the BAC “to help alleviate the additional stress” associated with Sadler’s “sudden departure” or the increasing levels of distress among the BAC cohort.¹⁹⁰ Pettet does not clarify what those additional resources could have been, or how those resources might have supported him better.

Education staff

Nightingale gave evidence that “prior to the relocation [of the BAC school], there was very limited support given to the education staff”¹⁹¹ and that “Mr Rodgers or Ms Rankin gave very limited feedback to the education staff” in relation to the transitional arrangements.¹⁹²

Megan Vizzard (teacher aide, BAC school) gave evidence that education staff commenced packing up and moving the school on 2 December 2013.¹⁹³ She said the patients became upset that too much was changing.¹⁹⁴ Vizzard recalled that the education staff had sole responsibility of packing up the school, and then unpacking at Yeronga.¹⁹⁵

Nightingale said she could not recall being given a time frame for the school's relocation. She said:

I recall that there were concerns about packing [up] the school while the students were still there because the packing caused them anxiety so we would try to do packing when there were no students around. I do, however, recall that there was pressure for the school to be packed up over the holidays and for it to move out of the building.¹⁹⁶

She added that "packing was also difficult because we did not know what space we would have at the next location, so we did not know what we needed to pack for".¹⁹⁷ She said the building was claimed back by Queensland Health quickly, but that "the building then remained vacant for quite some time".¹⁹⁸ Nightingale thought that a gradual move would have been of much more assistance.¹⁹⁹

Michelle Bond (Principal, Royal Children's Hospital School), provided support to education staff in relation to developing the educational components of the transitional arrangements for transition clients. These arrangements required consideration of each transition client's educational history, achievements and vocational activities, and the collating of information to encourage further learning, such as strengths and areas of interest.²⁰⁰

Finding as to adequacy

Dowell told the Commission that she considered the "support [provided to the allied health staff] was adequate for a professional workforce".²⁰¹ She said that in her view, there was "sufficient communication, support and assistance given to allied health staff in relation to the closure of the BAC". She said that she is unaware of any additional communication, support or assistance options that could have been given.²⁰²

On balance, the Commission is satisfied that there is no basis for criticism of the support provided to health staff in relation to the transition arrangements. The support was adequate. Notwithstanding the concerns raised by education staff in respect of the relocation of the BAC school to Yeronga, the Commission finds that the support to education staff in respect of the transition arrangements for transition clients, was adequate also.

(Endnotes

- 1 See discussion of "adequacy" in chapter 18.
- 2 See chapter 18.
- 3 Exhibit 208, Queensland Plan for Mental Health 2007–2017, p 10.
- 4 Exhibit 208, Queensland Plan for Mental Health 2007–2017, p 11.
- 5 Exhibit 208, Queensland Plan for Mental Health 2007–2017, p 28.
- 6 Exhibit 208, Queensland Plan for Mental Health 2007–2017, p 28.
- 7 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG 8 May 2015, p 4 para 3.
- 8 Exhibit 216, Barrett Adolescent Strategy, Expert Clinical Reference Group Report: "Proposed Service Model Elements, Adolescent Extended Treatment and Rehabilitation Services (AETRS)", Version 5, Endorsed by ECRG 8 May 2015, p 4 para 3.
- 9 Exhibit 228, West Moreton 2012–13 Service Agreement, p 6; Transcript, Tony O'Connell, 23 February 2016, p 12–32 lines 3147. See also chapter 4.
- 10 Exhibit 182, West Moreton Hospital and Health Service 2013/14 – 2015/16 Service Agreement.
- 11 Exhibit 228, West Moreton 2012–13 Service Agreement, p 66.
- 12 Exhibit 228, West Moreton 2012–13 Service Agreement, p 11.

- 13 Exhibit 228, West Moreton 2012–13 Service Agreement, p 67.
- 14 *Hospital and Health Boards Act 2011* (Qld) s 20(4); *Hospital and Health Boards Regulation 2012* (Qld) sch 1AA, 3AA.
- 15 Executive Director, Child and Youth Mental Health Services
- 16 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 49 para 230; Exhibit 91, Statement of Margaret Nightingale, 24 November 2015, p 15 para 62; Exhibit 106, Statement of Deborah Rankin, 11 October 2015, p 17 para 63; Exhibit 110, Statement of Kevin Rodgers, 10 December 2015, pp 6–7 para 26.
- 17 Exhibit 45, Statement of Susan Daniel, 30 October 2015, Attachment to that statement, Email from Sharon Kelly to BAC staff, 9 November 2012, p 28.
- 18 Exhibit 45, Statement of Susan Daniel, 30 October 2015, Attachment to that statement, Email from Sharon Kelly to BAC staff, 9 November 2012, p 28.
- 19 Exhibit 51, Statement of Naomi Ford, 1 December 2015, p 3 para 9.
- 20 Exhibit 51, Statement of Naomi Ford, 1 December 2015, Attachment E to that statement, Communication Plan, p 74.
- 21 Exhibit 51, Statement of Naomi Ford, 1 December 2015, Attachment E to that statement, Communication Plan, p 74.
- 22 Exhibit 51, Statement of Naomi Ford, 1 December 2015, Attachment E to that statement, Project Plan, pp 79–80.
- 23 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 22 para 14.17(a).
- 24 Exhibit 51, Statement of Naomi Ford, 1 December 2015, p 4 para 13.
- 25 Closing submissions of Counsel Assisting, 17 March 2016, p 83 para 288.
- 26 Exhibit 100, Supplementary Statement of Kerrie Parkin, 19 January 2016, Attachment KP-2 to that statement, BAC Staff Communique 1, p 12; Closing submissions of Counsel Assisting, 17 March 2016, p 224 para 782.
- 27 Exhibit 113, Statement of Stephen Sault, 15 December 2015, p 11 para 11(e); Closing submissions of Counsel Assisting, 17 March 2016, p 224 para 784.
- 28 EAS is a free, voluntary, confidential and time-limited counselling and advisory services provided to Queensland Government employees and their immediate family members. The EAS is sometimes referred to as the Employee Assistance Program (EAP).
- 29 Exhibit 100, Supplementary Statement of Kerrie Parkin, 19 January 2016, Attachment KP-2 to that statement, BAC Staff Communique 1, pp 12–13.
- 30 Exhibit 100, Supplementary Statement of Kerrie Parkin, 19 January 2016, Attachment KP-2 to that statement, BAC Staff Communique 2, p 15; Closing submissions of Counsel Assisting, 17 March 2016, p 224 para 786.
- 31 Exhibit 100, Supplementary Statement of Kerrie Parkin, 19 January 2016, Attachment KP-2 to that statement, BAC Staff Communique 2, p 14; Closing submissions of Counsel Assisting, 17 March 2016, p 225 para 786.
- 32 This email is discussed further later in this chapter.
- 33 Exhibit 1411, Email from Leanne Geppert to Laura Johnson, Michelle Giles, Kerrie Parkin, Sharon Kelly, Anne Brennan, Lorraine Dowell, Padraig McGrath, Terry Stedman and William Brennan, 4 December 2013.
- 34 Exhibit 100, Supplementary Statement of Kerrie Parkin, 19 January 2016, Attachment KP-2 to that statement, BAC Staff Communique 3, p 16; Closing submissions of Counsel Assisting, 17 March 2016, p 225 para 788.
- 35 Exhibit 100, Supplementary Statement of Kerrie Parkin, 19 January 2016, Attachment KP-2 to that statement, BAC Staff Communique 3, p 16.
- 36 Exhibit 100, Supplementary Statement of Kerrie Parkin, 19 January 2016, Attachment KP-2 to that statement, BAC Staff Communique 3, p 16; Closing submissions of Counsel Assisting, 17 March 2016, p 225 para 788.
- 37 Exhibit 127, Statement of Laura Tooley, 22 October 2015, Attachment LT-11 to that statement, RSVP list for Sandra Radovini Staff session, p 250; Closing submissions of Counsel Assisting, 17 March 2016, p 225 para 788.
- 38 Exhibit 127, Statement of Laura Tooley, 22 October 2015, Attachment LT-07 to that statement, BAC Staff Communique 4, p 176; Closing submissions of Counsel Assisting, 17 March 2016, p 225 para 788.
- 39 Exhibit 127, Statement of Laura Tooley, 22 October 2015, p 176, Attachment LT-07 to that statement, BAC Staff Communique 4, p 125; Closing submissions of Counsel Assisting, 17 March 2016, p 225 para 790.
- 40 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 24 para 17.2.
- 41 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 31 para 20.1(a).
- 42 Exhibit 129, Statement of Ashleigh Trinder, 30 October 2015, Attachment AT-4 to that statement, p 49; Exhibit 36, Statement of Angela Clarke, 20 November 2015, Attachment AC-11 to that statement, p 75; Exhibit 62, Statement of Megan Hayes, 20 November 2015, Attachment MH-03 to that statement, p 38–50; Exhibit 1501, Email from Leanne Geppert to Danielle Corbett, 6 August 2013.
- 43 See for example, Exhibit 36, Statement of Angela Clarke, 20 November 2015, p 38 para 18.1; Exhibit 69, Statement of Mara Kochardy, 29 October 2015, p 15 para 30(f); Exhibit 23, Statement of Matthew Beswick, 30 October 2015, p 16 para 30(m); Exhibit 103, Statement of Thomas Pettet, 4 December 2015, pp 5–6 para 35; Exhibit 140, Statement of Lourdes Wong, 22 December 2015, p 6 para 9(h). See also chapter 16.

- 44 Exhibit 100, Supplementary Statement of Kerrie Parkin, 19 January 2016, Attachment KP-2 to that statement, BAC Staff Communique 1, p 12.
- 45 Exhibit 1545, Letter from Sharon Kelly to all staff of the Barrett Adolescent Unit, 16 December 2013.
- 46 Exhibit 23, Statement of Matthew Beswick, 30 October 2015, p 14 para 25(a); Exhibit 113, Statement of Stephen Sault, 15 December 2015, p 15 para 18(a). See also Exhibit 87, Statement of Padraig McGrath, 16 November 2015, p 12 para 12.2; Closing submissions of Counsel Assisting, 17 March 2016, p 212 para 728.
- 47 Exhibit 113, Statement of Stephen Sault, 15 December 2015, p 15 para 16(d); Closing submissions of Counsel Assisting, 17 March 2016, p 212 para 730.
- 48 Exhibit 109, Statement of Rosangela Richardson, 30 October 2015, p 16 para 36(c).
- 49 Exhibit 99, Statement of Kerrie Parkin, 18 December 2015, p 7 para 5.6(d); Closing submissions of Counsel Assisting, 17 March 2016, p 212 para 729.
- 50 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 31 para 20.2.
- 51 Exhibit 47, Statement of Lorraine Dowell, 27 November 2015, Attachment A, Curriculum Vitae, p 2.
- 52 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 31 para 20.2.
- 53 Transcript, William Brennan, p 16-55 lines 28-31; Closing submissions of Counsel Assisting, 17 March 2016, p 220 para 764.
- 54 Exhibit 47, Statement of Lorraine Dowell, 27 November 2015, p 16 para 10.1; Closing submissions of Counsel Assisting, 17 March 2016, p 219 para 762.
- 55 Exhibit 47, Statement of Lorraine Dowell, 27 November 2015, p 16 para 10.2(d).
- 56 Exhibit 47, Statement of Lorraine Dowell, 27 November 2015, p 16 para 10.2(a).
- 57 Exhibit 47, Statement of Lorraine Dowell, 27 November 2015, p 4 para 3.4; Closing submissions of Counsel Assisting, 17 March 2016, p 219 para 762.
- 58 Exhibit 47, Statement of Lorraine Dowell, 27 November 2015, p 6 para 10.2(c).
- 59 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 51 para 129.
- 60 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 54 para 146.
- 61 Transcript, Vanessa Clayworth, 8 March 2016, p 22-47 lines 44-47 – p 22-48 lines 1-3; p 22-49 lines 2-6.
- 62 Transcript, Vanessa Clayworth, 8 March 2016, p 22-48 lines 12-14.
- 63 Transcript, Vanessa Clayworth, 8 March 2016, p 22-78 line 30.
- 64 Transcript, Vanessa Clayworth, 8 March 2016, p 22-48 lines 30-34.
- 65 Exhibit 103, Statement of Thomas Pettet, 4 December 2015, p 6 para 38.
- 66 Exhibit 96, Statement of Justine Oxenham, 24 November 2015, p 5 para 10(a).
- 67 Exhibit 107, Supplementary Statement of Deborah Rankin, 5 February 2016, p 10 para 35.
- 68 Exhibit 25, Statement of Peter Blatch, 22 October 2015, p 16 para 42.
- 69 Exhibit 110, Statement of Kevin Rodgers, 10 December 2015, p 9 para 36; Exhibit 19, Statement of Janine Armitage, 14 December 2015, p 9 para 33.
- 70 Exhibit 107, Supplementary Statement of Deborah Rankin, 5 February 2016, p 10 para 32-33; Closing submissions of Counsel Assisting, 17 March 2016, p 220 para 765.
- 71 Exhibit 107, Supplementary Statement of Deborah Rankin, 5 February 2016, p 10 para 34; Closing submissions of Counsel Assisting, 17 March 2016, p 220 para 765.
- 72 Exhibit 91, Statement of Margaret Nightingale, 24 November 2015, p 19 para 75.
- 73 Transcript, Brett McDermott, 16 February 2016, p 7-33 line 1.
- 74 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 51 para 129.
- 75 Exhibit 308, Exhibit 308, West Moreton Board Committee Agenda Papers and Meeting Minutes, 23 November 2012 to 28 February 2014 as provided by Timothy Eltham, p 157.
- 76 Exhibit 129, Statement of Ashleigh Trinder, 30 October 2015, p 26 paras 14.5-14.6.
- 77 Exhibit 1476, Email from Lorraine Dowell to Michelle Giles, Subject: "AH meeting notes - 28/10/13", 29 October 2013, p 1.
- 78 Exhibit 1476, Email from Lorraine Dowell to Michelle Giles, Subject: "AH meeting notes - 28/10/13", 29 October 2013, p 1.
- 79 Exhibit 99, Statement of Kerrie Parkin, 18 December 2015, p 6 para 5.1.
- 80 Exhibit 99, Statement of Kerrie Parkin, 18 December 2015, p 3 para 4.3(b).
- 81 Exhibit 99, Statement of Kerrie Parkin, 18 December 2015, pp 3-4 para 4.3.
- 82 Exhibit 99, Statement of Kerrie Parkin, 18 December 2015, p 8 para 5.10.

- 83 Exhibit 56, Statement of Michelle Giles, 19 January 2016, Attachment G to that statement, BAC Organisation Change Meeting Minutes, dated 28 November 2013, p 45.
- 84 Exhibit 56, Statement of Michelle Giles, 19 January 2016, p 8 para 47.
- 85 Exhibit 56, Statement of Michelle Giles, 19 January 2016, p 9 para 52.
- 86 Exhibit 1411, Email from Leanne Geppert to Laura Johnson, Michelle Giles, Kerrie Parkin, Sharon Kelly, Anne Brennan, Lorraine Dowell, Pdraig McGrath, Terry Stedman and William Brennan, 4 December 2013.
- 87 Exhibit 1545, Letter from Sharon Kelly to all staff of the Barrett Adolescent Unit, 16 December 2013.
- 88 Exhibit 1545, Letter from Sharon Kelly to all staff of the Barrett Adolescent Unit, 16 December 2013.
- 89 Exhibit 99, Statement of Kerrie Parkin, 18 December 2015, p 5 para 4.11(a); Closing submissions of Counsel Assisting, 17 March 2016, p 226 para 793.
- 90 Exhibit 1545, Letter from Sharon Kelly to all staff of the Barrett Adolescent Unit, 16 December 2013.
- 91 Exhibit 113, Statement of Stephen Sault, 15 December 2015, p 14 para 14(b).
- 92 Exhibit 113, Statement of Stephen Sault, 15 December 2015, p 14 para 14(c).
- 93 Exhibit 99, Statement of Kerrie Parkin, 18 December 2015, p 9 para 5.13(a).
- 94 Exhibit 99, Statement of Kerrie Parkin, 18 December 2015, Attachment KP-6 to that statement, Emails from Suzanna Perkins to Kerrie Parkin, 16-19 December 2013, pp 51–57.
- 95 Exhibit 99, Statement of Kerrie Parkin, 18 December 2015, p 9 para 5.13(b).
- 96 Exhibit 99, Statement of Kerrie Parkin, 18 December 2015, Attachment KP-6 to that statement, Emails from Suzanna Perkins to Kerrie Parkin, 16-19 December 2013, pp 51–57.
- 97 Exhibit 99, Statement of Kerrie Parkin, 18 December 2015, p 9 para 5.13(c); Closing submissions of Counsel Assisting, 17 March 2016, p 227 para 795.
- 98 Exhibit 727, Supplementary Statement of Stephen Sault, 25 February 2016, p 22 para 25; Exhibit 22, Statement of Matthew Beswick, 30 October 2015, p 18 para 32(a); Closing submissions of Counsel Assisting, 17 March 2016, p 227 para 795.
- 99 Exhibit 23, Statement of Matthew Beswick, 30 October 2015, pp 17–18 para 32.
- 100 Exhibit 87, Statement of Pdraig McGrath, 16 November 2015, p 25 para 22.2.
- 101 Exhibit 109, Statement of Rosangela Richardson, 30 October 2015, p 14 para 32(d).
- 102 Exhibit 122, Statement of Stephen Stathis, 30 October 2015, Attachment M to that statement, SWAETRI Oversight Committee Meeting Minutes, p 354.
- 103 Exhibit 1415, Email from Ian Wright to Helen Ceron, Lesley Dwyer and Sharon Kelly, 29 January 2014.
- 104 Exhibit 1415, Email from Ian Wright to Helen Ceron, Lesley Dwyer and Sharon Kelly, 29 January 2014.
- 105 Exhibit 106, Statement of Deborah Rankin, 11 October 2015, p 23 para 88.
- 106 Exhibit 25, Statement of Peter Blatch, 22 October 2015, p 22 para 64; Exhibit 134, Statement of Patrea Walton, 31 October 2015, p 9 para 41.
- 107 Exhibit 106, Statement of Deborah Rankin, 11 October 2015, pp 21–22 para 85; Submissions on behalf of the State of Queensland, 23 March 2016, p 31 para 85.
- 108 Exhibit 1265, Statement of Megan Vizzard, 13 April 2016, p 2 paras 6(c), (e).
- 109 Exhibit 1488, Extract from Kerrie Armstrong Human Resources file; Exhibit 1492, Extract from Trevor Sadler Human Resources file; Exhibit 1493, Extract from Vanessa Clayworth Human Resources file; Exhibit 1490, Extract from Maree Sheraton Human Resources file; Exhibit 1486, Extract from Danielle Corbett Human Resources file; Exhibit 111, Statement of Kimberley Sadler, 14 December 2015, p 16 para 106; Exhibit 109, Statement of Rosangela Richardson, 30 October 2015, p 14 para 32(f); Exhibit 46, Supplementary statement of Susan Daniel, 10 February 2016, p 4 para 4(iii); Exhibit 728, Statement of Liam Huxter, undated, p 7 para 12(b). It should be noted, that pursuant to *Public Service Commission Directive 11/12*, for staff who accepted voluntary redundancy packages to receive the entirety of their severance payment, they were excluded from working within a Queensland Government entity for a total cumulative period of more than 20 full-time working days: Directive No 11/12: Minister Assisting the Premier Directive: Early Retirement, Redundancy and Retrenchment, Available from: <<http://www.psc.qld.gov.au/publications/directives/assets/2012-11-Early-Retirement-Redundancy-and-Retrenchment.pdf>>. [4 May 2016].
- 110 Exhibit 728, Statement of Liam Huxter, undated, p 15 para 30(a)-(c); Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 1 para 1 and Exhibit A to that statement, Curriculum Vitae of Trevor Sadler, p 57.
- 111 Exhibit 38, Statement of Vanessa Clayworth, 27 October 2015, Exhibit VC-1 to that statement, Curriculum Vitae of Vanessa Clayworth, p 8.
- 112 Exhibit 109, Statement of Rosangela Richardson, 30 October 2015, p 1 para 1(d).
- 113 Exhibit 111, Statement of Kimberley Sadler, 14 December 2015, Exhibit KS-1 to that statement, Curriculum Vitae of Kimberley Sadler, pp 19 and 22.
- 114 Exhibit 46, Supplementary statement of Susan Daniel, 10 February 2016, p 20 para 18(a).

- 115 Exhibit 1485, Extract from Adrian Walder Human Resources file; Exhibit 1484, Extract from Angela Clarke Human Resources file; Exhibit 1487, Extract from Elaine Ramsey Human Resources file; Exhibit 142, Statement of Peta-Louise Yorke, 2 November 2015, p 16 para 32(d), Exhibit 113, Statement of Stephen Sault, 15 December 2015, p 23 para 24(f)-(g); Exhibit 1491, Extract from Peter Kop Human Resources file.
- 116 Exhibit 23, Statement of Matthew Beswick, 30 October 2015, p 17 para 32(d); Exhibit 140, Statement of Lourdes Wong, 22 December 2015, p 12 para 24.
- 117 Exhibit 1494, Megan Hayes Employee Movement Form.
- 118 Exhibit 77, Statement of Moira Macleod, 5 November 2015, p 2 para 1(e).
- 119 Exhibit 1489, Extract from Kim Hoang Human Resources file.
- 120 Exhibit 1416, Email from Leanne Geppert to Sharon Kelly, Anne Brennan and others, Subject: "Date Claimer: Debrief Session", 29 January 2014; Exhibit 1417, Email from Leanne Geppert to Elisabeth Hoehn, Anne Brennan and others, Subject: "BAC debrief session - confirmation details", 31 January 2014; Exhibit 87, Statement of Padraig McGrath, 16 November 2015, Attachment PM-8 to that statement, Barrett Closure Debriefing Checklist, pp 62–63.
- 121 Exhibit 87, Statement of Padraig McGrath, 16 November 2015, Attachment PM-8 to that statement, Barrett Closure Debriefing Checklist, pp 62–63.
- 122 Transcript, Padraig McGrath, 3 March 2016, p 19-10 line 41 – p 19-11 line 9; Transcript, William Brennan, 29 February 2016, p 16-54 lines 3-4 and lines 39-46 – p 16-55 lines 1-10;
- 123 Exhibit 87, Statement of Padraig McGrath, 16 November 2015, p 29 para 25.11.
- 124 See analysis in Future employment opportunities above.
- 125 Exhibit 1494, Megan Hayes Employee Movement Form; Exhibit 1489, Extract from Kim Hoang Human Resources file.
- 126 Exhibit 1489, Extract from Kim Hoang Human Resources file.
- 127 Exhibit 99, Statement of Kerrie Parkin, 18 December 2015, p 8 para 5.11; Submission of Counsel Assisting the Commission, p 227 para 794.
- 128 See analysis in Future employment opportunities above.
- 129 Exhibit 208, Queensland Plan for Mental Health 2007–2017, p 28.
- 130 Exhibit 87, Statement of Padraig McGrath, 16 November 2015, p 23 para 20.2.
- 131 Exhibit 99, Statement of Kerrie Parkin, 18 December 2015, p 8 para 5.11.
- 132 Exhibit 1414, Emails between Adrian Walder and Kerrie Parkin, 23 January 2014, p 2.
- 133 Exhibit 87, Statement of Padraig McGrath, 16 November 2015, p 24 para 20.4.
- 134 Exhibit 100, Supplementary statement of Kerrie Parkin, 19 January 2016, p 3 para 4.2(a).
- 135 Transcript, Vanessa Clayworth, 8 March 2016, p 22-48 lines 21-23; Closing submissions of Counsel Assisting, 17 March 2016, p 228 para 802.
- 136 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 31 para 20.4. See also discussion of the Staff Communiques (which were published under Sharon Kelly's name) above.
- 137 Exhibit 111, Statement of Kimberley Sadler, 4 December 2015, p 11 para 69; Exhibit 46; Supplementary statement of Susan Daniel, 10 February 2016, p 19 para 16; Exhibit 113, Statement of Stephen Sault, 15 December 2015, p 23 para 25; Closing submissions of Counsel Assisting, 17 March 2016, p 228 para 802.
- 138 Exhibit 109, Statement of Rosangela Richardson, 30 October 2015, p 16 para 33.
- 139 Exhibit 69, Statement of Mara Kochardy, 29 October 2015, p 17 para 33(b); Exhibit 70, Supplementary Statement of Mara Kochardy, 8 February 2016, p 30 para 5(b).
- 140 Exhibit 728, Statement of Liam Huxter, undated, p 24 para 46.
- 141 Exhibit 23, Statement of Matthew Beswick, 30 October 2015, p 19 para 33.
- 142 Exhibit 77, Statement of Moira Macleod, 5 November 2015, p 15 para 33.
- 143 Exhibit 142, Statement of Peta-Louise Yorke, 3 November 2015, p 16 para 33.
- 144 Exhibit 143, Statement of Victoria Young, 30 October 2015, p 13 para 33.
- 145 Exhibit 109, Statement of Rosangela Richardson, 30 October 2015, p 15 para 33; Exhibit 70, Supplementary Statement of Mara Kochardy, 8 February 2016, p 8 para 5(a)(iii)-(iv); Exhibit 22, Statement of Matthew Beswick, 30 October 2015, p 19 para 33(a); Exhibit 971, Supplementary Statement of Megan Hayes, 2 March 2016, p 17 para 28.8(iii); Exhibit 77, Statement of Moira Macleod, 5 November 2015, p 15 para 33(a); Closing submissions of Counsel Assisting, 17 March 2016, p 229 para 806.
- 146 Transcript, Matthew Beswick, 29 February 2016, p 16-39 lines 33-36; Closing submissions of Counsel Assisting, 17 March 2016, p 229 para 806.
- 147 Exhibit 971, Supplementary Statement of Megan Hayes, 2 March 2016, p 17 para 28.8(iii); Closing submissions of Counsel Assisting, 17 March 2016, p 229 para 806.

- 148 Exhibit 100, Supplementary Statement of Kerrie Parkin, 19 January 2016, p 3 para 4.2(b)(i); Closing submissions of Counsel Assisting, 17 March 2016, p 228 para 800.
- 149 Transcript, Vanessa Clayworth, 8 March 2016, p 22-47 lines 44-45 – p 22-48 lines 1-3; Closing submissions of Counsel Assisting, 17 March 2016, p 228 para 801.
- 150 Exhibit 99, Statement of Kerrie Parkin, 18 December 2015, pp 4–5 para 4.8.
- 151 Exhibit 99, Statement of Kerrie Parkin, 18 December 2015, pp 4–5 para 4.8.
- 152 See Exhibit 971, Supplementary statement of Megan Hayes, 2 March 2016, p 17 para 28.8(a); Exhibit 70, Supplementary Statement of Mara Kochardy, 8 February 2016, p 8 para 5(b)(iv); Exhibit 141, Supplementary statement of Lourdes Wong, 9 February 2016, p 7 paras 8(c)(iii)-(iv); Exhibit 129, Statement of Ashleigh Trinder, 30 October 2015, p 26 para 14.5 and p 27 para 14.8(f).
- 153 Exhibit 87, Statement of Pdraig McGrath, 16 November 2015, p 26 para 22.5(b).
- 154 Exhibit 87, Statement of Pdraig McGrath, 16 November 2015, p 26 para 22.5(b).
- 155 Exhibit 143, Statement of Victoria Young, 30 October 2015, p 13 para 33(b).
- 156 Exhibit 97, Statement of Brenton Page, 16 December 2015, p 24 para 30.1; Exhibit 141, Supplementary Statement of Lourdes Wong, 9 February 2016, p 8 para 8(c)(iv)(1); Closing submissions of Counsel Assisting, 17 March 2016, p 229 para 805.
- 157 Exhibit 107, Supplementary Statement of Deborah Rankin, 5 February 2016, p 10 para 32-33; Closing submissions of Counsel Assisting, 17 March 2016, p 220 para 765.
- 158 Exhibit 107, Supplementary Statement of Deborah Rankin, 5 February 2016, p 10 para 34; Closing submissions of Counsel Assisting, 17 March 2016, p 220 para 765.
- 159 Exhibit 91, Statement of Margaret Nightingale, 24 November 2015, p 19 para 75.
- 160 Exhibit 91, Statement of Margaret Nightingale, 24 November 2015, p 19 para 75-76.
- 161 Exhibit 25, Statement of Peter Blatch, 20 November 2015, p 2 para 8.
- 162 Exhibit 110, Statement of Kevin Rodgers, 10 December 2015, p 9 para 36
- 163 Confidential; Closing submissions of Counsel Assisting, 17 March 2016, p 230 para 809.
- 164 Confidential; Closing submissions of Counsel Assisting, 17 March 2016, p 230 para 809.
- 165 Confidential; Closing submissions of Counsel Assisting, 17 March 2016, p 230 para 810.
- 166 Confidential; Closing submissions of Counsel Assisting, 17 March 2016, p 230 para 810.
- 167 Confidential; Closing submissions of Counsel Assisting, 17 March 2016, p 230 para 811.
- 168 Confidential; Closing submissions of Counsel Assisting, 17 March 2016, p 230 para 811.
- 169 Confidential; Closing submissions of Counsel Assisting, 17 March 2016, p 230 para 811.
- 170 Confidential; Closing submissions of Counsel Assisting, 17 March 2016, p 230 para 811.
- 171 Confidential; Closing submissions of Counsel Assisting, 17 March 2016, p 231 para 813.
- 172 Confidential; Closing submissions of Counsel Assisting, 17 March 2016, p 231 para 813.
- 173 Exhibit 971, Supplementary statement of Megan Hayes, 2 March 2016, p 17 para 28.9; Exhibit 70, Supplementary Statement of Mara Kochardy, 8 February 2016, p 8 para 5(b)(v); Closing submissions of Counsel Assisting, 17 March 2016, p 229 para 807.
- 174 Exhibit 113, Statement of Stephen Sault, 15 December 2015, p 24 para 26(f).
- 175 Exhibit 70, Supplementary statement of Mara Kochardy, 8 February 2016, p 8 para 5(b)(v).
- 176 Exhibit 971, Supplementary statement of Megan Hayes, 2 March 2016, p 17 para 28.9.
- 177 Exhibit 71, Statement of Beth Kotzé, 18 December 2015, Attachment N to that statement, , Health Service Investigation interview with Matthew Beswick, dated 13 October 2014, p 355.
- 178 Exhibit 727, Supplementary statement of Stephen Sault, 25 February 2016, p 20 para 21(e)(iii).
- 179 Exhibit 23, Statement of Matthew Beswick, 30 October 2015, p 15 para 30(c).
- 180 Exhibit 23, Statement of Matthew Beswick, 30 October 2015, p 16 para 30(m).
- 181 Exhibit 23, Statement of Matthew Beswick, 30 October 2015, p 15 para 30(d).
- 182 Exhibit 47, Statement of Lorraine Dowell, 27 November 2015, p 15 para 9.3.
- 183 Exhibit 47, Statement of Lorraine Dowell, 27 November 2015, p 16, para 10.2(b).
- 184 Exhibit 69, Statement of Mara Kochardy, 29 October 2015, p 16 para 33(a); Exhibit 70, Supplementary statement of Mara Kochardy, 8 February 2016, p 8 para 5(b)(iv).
- 185 Exhibit 109, Statement of Rosangela Richardson, 30 October 2015, p 15 para 36.
- 186 Exhibit 109, Statement of Rosangela Richardson, 30 October 2015, p 13 para 30(e).

- 187 Exhibit 109, Statement of Rosangela Richardson, 30 October 2015, p 13 para 30(e)-(f).
- 188 Exhibit 103, Statement of Thomas Pettet, 4 December 2015, p 6 para 39.
- 189 Exhibit 103, Statement of Thomas Pettet, 4 December 2015, p 6 para 39.
- 190 Exhibit 103, Statement of Thomas Pettet, 4 December 2015, p 6 para 38.
- 191 Exhibit 91, Statement of Margaret Nightingale, 24 November 2015, p 19 para 75.
- 192 Exhibit 91, Statement of Margaret Nightingale, 24 November 2015, p 17 para 71.
- 193 Exhibit 1265, Statement of Megan Vizzard, 13 April 2016, p 12 para 62.
- 194 Exhibit 1265, Statement of Megan Vizzard, 13 April 2016, p 12 para 63.
- 195 Exhibit 1265, Statement of Megan Vizzard, 13 April 2016, p 12 para 65.
- 196 Exhibit 177, Supplementary statement of Margaret Nightingale, 25 January 2016, p 16-17 para 83.
- 197 Exhibit 177, Supplementary statement of Margaret Nightingale, 25 January 2016, p 17 para 84.
- 198 Exhibit 177, Supplementary statement of Margaret Nightingale, 25 January 2016, p 17 para 85-86.
- 199 Exhibit 177, Supplementary statement of Margaret Nightingale, 25 January 2016, p 17 para 86.
- 200 Exhibit 106, Statement of Deborah Rankin, 11 October 2015, p 24 para 93; Exhibit 25, Statement of Peter Blatch, 20 November 2015, p 25 para 84.
- 201 Exhibit 48, Supplementary statement of Lorraine Dowell, 2 February 2016, p 5 para 3.3.
- 202 Exhibit 48, Supplementary statement of Lorraine Dowell, 2 February 2016, p 15 para 15.1.

24 Mixed messages

Relevance of communications

Without limiting terms of reference 3(a) and (b), term of reference 3(c) requires the Commission to inquire into the information and processes that “related to” the closure decision. Such information and processes include the planning for and the communications with staff, patients, families and the public about the proposed closure of the BAC and the development of the new services.

Without limiting terms of reference 3(d) – (g), term of reference 3(h) requires the Commission to inquire into the information and processes that related to the transition arrangements and the adequacy of the care, support and services that were provided to transition clients and their families. Such information and processes include the communications with transition clients and their families about the transition arrangements. The Commission has limited this inquiry to the transition period for each transition client.

As discussed in chapters 18 and 21, a good transition includes good communication. West Moreton HHS appointed Anne Brennan to make the transition arrangements and implement them. How Brennan went about this task is discussed in chapter 19. Her communications with the transition clients and their families are discussed in general in chapter 21 and individually in the confidential volume.

This chapter discusses communications with staff, patients, families and the public about the proposed closure of the BAC and the development of the new services. Overall these communications fall within term of reference 3(c) although some relate to the transition arrangements and the care, support and services provided to transition clients and their families and so are within term of reference 3(h).

The analysis of the communications has been divided into the following time periods:

- communications between 8 November 2012 and 21 May 2013
- communications between 22 May 2013 and 5 August 2013
- communications between 6 August 2013 and 10 September 2013
- communications between 11 September 2013 and 24 January 2014.

Some of these communications have been discussed in earlier chapters.

Guiding principles

The guiding principles of the *Hospital and Health Boards Act 2011* (Qld) (HHB Act) include the principle that “information about the delivery of public sector health services should be provided to the community in an open and transparent way”.¹

Communication strategies and plans

Barrett Adolescent Strategy Communication Plan

Quite properly and in keeping with their obligation under the HHB Act, West Moreton HHS and Children's Health Queensland HHS (CHQ) developed processes and plans for communication with relevant stakeholders about the closure of the BAC and the development of new services.

As a part of the Barrett Adolescent Strategy Project Plan dated 16 November 2012 (Project Plan) (discussed in chapter 9), a communication plan was developed on 20 November 2012 (Communication Plan).²

Under the Project Plan,³ West Moreton HHS undertook the responsibility for communicating with staff, patients, families and the public about the closure of the BAC.⁴

By the Communication Plan, West Moreton HHS was responsible for communicating with staff, families, patients and the general public, including issuing facts sheets and responses to correspondence.⁵ The Communication Plan listed a number of communication objectives, including:

- Ensure stakeholders understand the vision and objectives of the BAC project.
- Encourage effective communication and feedback from stakeholders.⁶

It also included the following communication principles:

- Communication with all stakeholders is based on honesty and transparency.
- Information is easily accessed by all stakeholders.
- Communication is responsive and flexible to stakeholder feedback.
- Communication speaks with 'one voice' to stakeholders.⁷

SWAETRI Project Plan and Communication Plan

As discussed in chapter 26, later, on 30 July 2013, Leanne Geppert (Director of Strategy, Mental Health and Specialised Services, West Moreton HHS) prepared a draft Project Plan for the State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy (SWAETRI). The draft SWAETRI Project Plan was revised on 1 August 2013 and 16 August 2013.⁸ All three drafts specified that West Moreton HHS and CHQ were to have "joint responsibility for communications".⁹

The final SWAETRI¹⁰ Project Plan was endorsed by the Steering Committee and Oversight Committee on 21 October 2013,¹¹ and by the CHQ Board on 18 November 2013.¹² The endorsed version no longer stated that West Moreton HHS and CHQ were to have joint responsibility for communications. However, its stated objectives included, "Develop a consistent and transparent Communication Plan regarding the implementation of the new service options" and it attached a SWAETRI Communication Plan. Under the SWAETRI Communication Plan, CHQ and West Moreton HHS held responsibility for different communications,¹³ including:

- Fact sheets/FAQs – West Moreton HHS and SWAETRI Project Team (the SWAETRI Project Team was supervised by CHQ)
- Meetings with current BAC families/carers to educate them about their "options" – West Moreton HHS
- Contact with current BAC families to introduce CHQ and the role they would play in the future care of their child – SWAETRI Project Team

- Contact with current BAC families to inform/educate (e.g. aim of the project, timeline, updates, outcomes, next steps, promote benefits of enhanced model) – SWAETRI Project Team
- Meetings with BAC staff to inform/educate – West Moreton HHS.¹⁴

The SWAETRI communication plan listed a number of objectives, including:

- Ensure stakeholders are aware of the implementation of an enhanced model of service for adolescent mental health extended treatment and rehabilitation and understand the key impacts, benefits and outcomes of the project.
- Increase awareness of the timeframes, processes and milestones of the implementation.
- Implement effective communication processes and resources to encourage consultation with and support for stakeholders throughout the implementation of the project.¹⁵

Communications between 8 November 2012 and 21 May 2013

As discussed in chapter 7, on 8 November 2012, Brett McDermott (Executive Director, Mater Child and Youth Mental Health Services) gave evidence to the Queensland Child Protection Commission of Inquiry that the BAC would close by Christmas 2012.¹⁶ Until then, West Moreton HHS had not issued any external communications about the proposed closure of the BAC. This changed after McDermott's disclosure and, in the days following, West Moreton HHS issued a series of communications to BAC staff and families and carers of BAC patients. These communications are discussed in chapter 8.

On 30 November 2012, West Moreton HHS commenced issuing a series of 'Fast Facts' bulletins, which were distributed to staff, patients, families and other child and youth mental health services in Queensland from November 2012 to December 2013. They were also posted to the West Moreton HHS website for public access.¹⁷ Fast Facts 1 to 5, issued between 30 November 2012 and 21 May 2013, are discussed in chapter 9.

No communication between 22 May 2013 and 6 August 2013

After Fast Facts 5 on 21 May 2013, no further external communications about the BAC closure were issued by West Moreton HHS until the Minister's announcement on 6 August 2013.¹⁸ For about two and a half months, BAC staff, patients, families and the public (including waitlist patients and their families) were left in a state of flux. Fast Facts 1 to 5 told readers that no decision about the BAC would be made until the ECRG recommendations had been considered. Fast Facts 5 informed readers that the ECRG had submitted its recommendations to the overarching Planning Group and that West Moreton HHS appreciated that a decision was needed as soon as possible. However, then, for approximately two and a half months, they waited for information about the decision.

The lack of communication during this period created an atmosphere of uncertainty within the BAC community. A parent gave the following evidence:

I remember that prior to the public announcement, there had been talk about the BAC closing and there was lobbying to keep it open ... It was a time of great confusion for all involved and there was no clear pathway forward. Information was transmitted to the children but it was never confirmed. There was confusion about the closure, what the plan was for the children and what was going to happen to them ... It was traumatising for the children and this transferred to the staff and families. Staff were upfront but they could not give clear answers because they did not know themselves.¹⁹

Another parent recalled that there were "general conversations" at the BAC about its closure. The parent said although no one knew that it was definitely closing, "there were strong rumours that the BAC was closing".²⁰

Counsel for West Moreton HHS submitted that there was a gap in communication between Fast Facts 5 and the Minister's announcement because until Minister Springborg publically announced the closure, neither the West Moreton HHS nor its Board could "say much else".²¹ They submitted that communication by West Moreton HHS and its Board during that time "would have caused greater angst, because it was certainly their view that it was ultimately the Minister's decision. They would not go about disseminating information that no doubt would cause a lot of distress".²²

However, this submission is inconsistent with the evidence. The evidence of Sharon Kelly²³ (Executive Director, Mental Health and Specialised Services, West Moreton HHS) and Naomi Ford²⁴ (Manager of Communication and Community Engagement for West Moreton HHS) was that until a day or so before the Minister's announcement, West Moreton HHS had planned to hold a joint media conference with CHQ. Kelly said the plan changed on 5 August 2013 when she was advised that the Minister would handle the announcement.²⁵ This is discussed further in chapter 16.

The submission also disregards the fact that staff, patients, families and the public were given assurances (without qualification) in a number of communications, including Fast Facts, that updates would be regular. The last Fast Facts actually noted that a decision was needed as soon as possible.

Communications between 6 August 2013 and 10 September 2013

Following the Minister's announcement on 6 August 2013,²⁶ West Moreton HHS and CHQ issued a flurry of communications to staff, patients, families and the public. These are discussed in chapter 16.

On 10 September 2013, Trevor Sadler was stood down as Clinical Director of the BAC.²⁷ The communications surrounding his standing down are also discussed in chapter 16. Anne Brennan was appointed acting Clinical Director of the BAC the next day.²⁸

The focus of the balance of this chapter is the communications with the staff, patients, families and the public between 11 September 2013 and the closure of the BAC on 24 January 2014.

Communications between 11 September 2013 and 24 January 2014

Parents' meeting with the Mental Health Commissioner – 11 September 2013

On 11 September 2013, there was a meeting between a parent, a carer, Alison Earls (founder of the Save the Barrett campaign) and Lesley van Schoubroeck (Queensland Mental Health Commissioner). The parent, carer and Earls presented van Schoubroeck with a document entitled "Concerns of consumers, carers & community in response to the closure of the Barrett Adolescent Centre and the future of adolescent mental healthcare in Queensland".²⁹ The parent recalled that van Schoubroeck was unable to assist because the process was "too far along and could not be changed".³⁰ Van Schoubroeck's recollection was that she said it was not the remit of the Queensland Mental Health Commissioner to comment "on the implementation of an operational matter relating to clinical services".³¹

The parent gave evidence of being "so disappointed – devastated would be a better description with the discussion with van Schoubroeck – we were essentially dismissed ... I didn't understand where we were supposed to turn for help and support". The following demonstrates the parent's frustration:

I didn't understand that – the closure had barely been announced, there was no model decided – the Implementation Committee for the SW AETRS had only just had its first meeting on 26 August, no contracts had been signed for future services, and there was no idea as to where any of the young people would go, and the person most qualified to advise [on] that process, Dr Sadler, had been removed the day before.³²

It is not within this Commission's terms of reference to consider the role of the Queensland Mental Health Commission (QMHC). Its broad functions include to "review, evaluate, report and advise on issues affecting people with mental health issues, and their families, carers and support persons".³³ The QMHC was entitled to decide what issues it would review, and as Mental Health Commissioner, van Schoubroeck plainly decided that she would not engage with the parent, carer and Earls on this issue.

Fast Facts 7 – 26 September 2013

On 26 September 2013 a bulletin Fast Facts 7 was issued by West Moreton HHS.³⁴ As with the earlier Fast Facts, the document was distributed to staff, patients, families and the public. Copies were available on West Moreton HHS's website.

The message in Fast Facts 7 was essentially the same as that in Fast Facts 6, which had been issued on 23 August 2013.

For the same reasons as explained in relation to Fast Facts 6 (chapter 16), West Moreton HHS omitted to make it clear in Fast Facts 7 that not all of the service options would be available by or from early 2014.

The State of Queensland submitted that in September 2013, Brennan appreciated that the new services being developed by CHQ would not be an option for the transition of BAC patients.³⁵ The evidence of Brennan and BAC occupational therapist, Megan Hayes, who was on the Consumer Care Transition Panel with Brennan, was that they were aware the new services

were not going to be ready for this cohort.³⁶ The Commission accepts the State's submission. However, at the same time, West Moreton HHS was saying, in Fast Facts 7, that a new range of contemporary service options would be ready from early 2014.

Another problem with the messages in Fast Facts 7 was that Brennan gave evidence of "a general guideline that BAC was expected to [be] closed by the end of January [2014]"³⁷ and told the Commission that the West Moreton HHS executives advised her, in a meeting on 11 September 2013, that "the closure target date was the end of January 2014 but this was with the proviso that BAC would remain open until adequate and appropriate care was in place for each young person".³⁸ However, at this time, the public (and in particular the families and carers) were not told that there was a target closure date of the end of January 2014, or that Brennan was carrying out the transition of the BAC patients without reference to new service options, or that there was some urgency in the transition of patients.

Fast Facts 8 – 3 October 2013

Fast Facts 8 was issued by West Moreton HHS on 3 October 2013 and told readers:

- "We continue to work towards the end of January 2014 to cease services from the Barrett Adolescent Centre (BAC) building"
- that a "Clinical Care Transition Panel" was being planned for each BAC patient to "review their individual care needs and support transition to alternative service options when they are available and when the time is right"
- that a forum of the Service Options Implementation Working Group had taken place on 1 October 2013 and that "all current families and carers of Barrett have been emailed an invitation to provide written submissions on the development of the new service options moving forward (for the consideration of the working group)".³⁹

There are a number of problems with Fast Facts 8.

First, this was the first time the public, including families and carers, were told that West Moreton HHS was continuing to work toward the end of January 2014 to cease services from the BAC building.

Second, the concept of ceasing services from the BAC "building" was introduced. That concept, in the context of the previous messages, suggested the possibility that the BAC services might be continued elsewhere.

Third, the use of the expression "alternative service options when they are available and when the time is right" was a shift from the expressions "new range of contemporary service options from early 2014" and "other contemporary care options that best meet their individual needs", which had been used in earlier Fast Facts. This change in terminology was not explained and it unclear whether it was intended to be of any significance to readers. Further, no clear explanation was given of the services which would be available for the BAC patients, the BAC waitlist patients, and other adolescents requiring extended mental health treatment and rehabilitation. In oral evidence, Lesley Dwyer (Chief Executive, West Moreton HHS) confirmed that in September 2013 she was aware that planning of the new suite of statewide services was still progressing and that no new services had yet started.⁴⁰

Fourth, save for the statement that "feedback from the forum has suggested it was a very successful day", no detail was provided about what was discussed at the Service Options Implementation Working Group forum on 1 October 2013, or what types of services were being

considered. Ingrid Adamson (Project Manager, CYMHS) gave evidence that the Service Options Implementation Working Group met once on 1 October 2013 for a workshop and was then disbanded (discussed in chapter 26).⁴¹

Fifth, there was no mention of the management of risks associated with EFTRU opening.

Sixth, there was no mention that there would be no more admissions and that waitlist patients were to be referred back to their receiving services. However, Staff communique 1 (also issued on 3 October 2013) informed staff that there would be no more admissions to the BAC from that date forward and that West Moreton HHS would work closely with receiving services of adolescents on the waitlist.⁴²

Staff Communiques

On 3 October 2013, West Moreton HHS commenced issuing a series of four Staff Communiques for BAC staff. These are discussed further in chapter 23.

Three letters to a parent

One parent was particularly active in contacting members of Queensland Health, West Moreton HHS and CHQ, amongst others, about issues surrounding the closure of the BAC. The following section discusses three letters that parent received in reply.

Letter to the parent from Dwyer – 4 October 2013

On 4 October 2013 in response to a letter from the parent, Dwyer introduced the concept of “wrap around” services. She referred to the first service options group being convened to hear about services required and said that she had a great deal of confidence in being able to deliver these “wraparound” services. She said, “We continue to work towards early 2014”.⁴³

The concept of “wrap around” services had not appeared in any of the Fast Facts up to this point. The concept was not explained and the difference between this type of service and the new contemporary service options was not explained. For these reasons, this letter was confusing and unclear.

Letter to the parent from Maynard – 8 October 2013

On a date after 8 October 2013, the parent received a letter in response to emails the parent had sent to the then Director-General of Queensland Health, Ian Maynard, on 16 September 2013 and 8 October 2013.⁴⁴ The letter was on Queensland Health letterhead and was expressed to be from Ian Maynard, but appears to have been signed by the Deputy Director-General of Queensland Health, Michael Cleary ‘for’ Maynard. The letter directed enquiries to Kelly as the Executive Director of West Moreton HHS. Counsel for Maynard submitted that the letter was not signed by Maynard and that there is no evidence that Maynard knew of its existence or its contents.⁴⁵ The Commission accepts this submission, but notes that, importantly, there is evidence that Queensland Health sent the letter and the parent received the letter.⁴⁶

In the parent’s email to Maynard on 16 September 2013, the parent expressed a number of concerns, in particular about the time frame imposed on developing and deciding on the model of care to be in place when the BAC closed.⁴⁷ The letter the parent received in reply stated, “progress is being made regarding the development and implementation of new and expanded adolescent mental health service options for the future”. It said West Moreton HHS “are focused on ensuring each current patient is provided with appropriate services and support as they move

into a new phase of their rehabilitation and reintegration back to their families and community".⁴⁸ The letter to the parent was not responsive to the parent's concerns. It was vague, particularly in relation to the time frame for the development of the new services.⁴⁹

Counsel for Maynard made supplementary submissions in respect of this letter. Those submissions said:

... there was no 'rushing to get the new services up and running' nor was there a 'tight timeframe for the implementation of the new adolescent mental health services'. The evidence before the Commission does not support such assertions. Rather the evidence ... reveals that the new adolescent mental health services were always going to take an extended period of time to properly develop and implement. They were never going to be up and running before the BAC closed. It was for that reason that West Moreton HHS commenced, at an early stage, to plan the provision of interim service options for the BAC patients. That planning ensured that there was no gap in service delivery and that patient care and safety was able to be maintained at all times.⁵⁰

(emphasis added)

This submission is not accepted. As discussed in chapter 26, many witnesses (at least initially) understood that new services would be in place in time for the BAC's closure. For example, during his radio interview on 6 August 2013, the Minister made a number of statements suggesting that a new model of service would be up and running by early 2014 to align with BAC's closure.⁵¹ Both Kelly⁵² and Dwyer⁵³ gave evidence that, as at July 2013, they understood a Y-PARC and/or Youth-Resi would be operational by January 2014. On 9 August 2013, Corbett sent a letter to a BAC parent which said the BAC would continue to provide services until the new model was operational.⁵⁴ In September 2013, William Kingswell (acting Executive Director of the MHAODB) expressed frustration that CHQ were not prioritising replacement services in time for BAC's closure.⁵⁵

Letter to the parent from Steer – 31 October 2013

On 31 October 2013, Peter Steer, Chief Executive of CHQ, sent a letter to the same parent in response to an email the parent had sent him. He told the parent that he had been advised that the clinical team and senior staff of West Moreton HHS were "working closely with the parents and the young people at the [BAC] regarding their rehabilitation and reintegration back to their families and communities".⁵⁶ Again, the parent was not told that the new services were not going to be up and running before the BAC closed. Steer invited the parent to a meeting with him and Stephen Stathis, Clinical Director of Child and Youth Mental Health Services, CHQ.⁵⁷

SWAETRI Steering Committee meeting – 9 October 2013

Communication issues were discussed at the SWAETRI Steering Committee meeting on 9 October 2013. The meeting minutes record a decision that "responsibility for correspondence" remain with West Moreton HHS but that by 21 October 2013, CHQ finalise "a broader communication strategy, including the message that this is an opportunity to do things better".⁵⁸ The SWAETRI Communication Plan is discussed above.

During this meeting, it was formally recognised that the communications surrounding the new services being developed by SWAETRI were problematic. The minutes record that Ingrid Adamson queried whether it was possible to communicate what interim wrap around services would "look like". The carer representative "supported the view that currently it is a little

challenging to draw the dots regarding service care” and the consumer representative noted that “Aside from the BAC [web] site, additional information and communication is needed”.⁵⁹

Fast Facts 9 – 4 November 2013

Fast Facts 9 was circulated on 4 November 2013. This Fast Facts was general and addressed consultation with other stakeholders and families and carers of BAC patients.⁶⁰

It has similar problems to Fast Facts 8. It did not provide any substantive information on when the BAC was to close, or when and what new service options were going to be available.

Fast Facts 9 also failed to mention that there would be no more admissions to the BAC and that no new referrals would be accepted to the waitlist.

Letter to Dwyer from a parent – 5 November 2013

On 5 November 2013, the same parent who received letters from Dwyer, Maynard and Steer in October 2013 (discussed above), wrote to Dwyer thanking her for her time and understanding but expressing difficulty maintaining trust in a process and system where things moved differently from what had been promised. The parent also referred to a year of uncertainty.⁶¹

Meeting with parents, Steer, Stathis and Adamson – 7 November 2013

On 7 November 2013, a meeting was convened involving two parents, Steer, Stathis and Adamson. Steer advised that it would take 12 months before the new model was operational.⁶² This was the first time that the 12 month time-frame was communicated to any of the families or carers. It was subsequently communicated to staff, patients, families, carers and the public in Fast Facts 10, which was issued on 20 November 2013. Fast Facts 10 is discussed below.

Steer’s statement was consistent with other evidence before the Commission. On 12 November 2013, Kingswell emailed Cleary recording that Steer had advised Dwyer that he would not have a model in place to address the closure of the BAC for 12 months.⁶³

On 19 November 2013, one of the parents who attended the meeting wrote to Mary Corbett (Chair, West Moreton Board) advising her that the parent had met with Steer and that an operational service would be 12 months away.⁶⁴

Fast Facts 10 – 20 November 2013

Fast Facts 10 introduced the concept of “transitional services” for current BAC patients while the future services were being finalised. The fact that “some of the future service options” being developed by CHQ would not be ready by early 2014 was formally confirmed by West Moreton HHS on 20 November 2013, through Fast Facts 10 which stated:

Recent information received from CHQ HHS has indicated that **some of the future service options will not be fully operational for possibly 12 months**. Following through with our commitment to ensure there is no gap to service delivery [West Moreton HHS] will work with other service partners to provide transitional services ...while the future services are finalised.⁶⁵

(emphasis added)

As discussed in chapter 26, by September 2013, Kingswell was expressing his frustration that no new services would be available in time for closure.⁶⁶ While it is true that until around November 2013, West Moreton HHS was under the impression that at least one of the new services (Y-PARC and, according to Dwyer, also a Youth Resi) would be ready by early 2014, it would have been clear to West Moreton HHS from at least August 2013 that not *all* of the new services would be ready when the BAC closed in early 2014. For West Moreton HHS to say that “recent information received from CHQ HHS has indicated that *some* of the future service options will not be fully operational for possibly 12 months” was inaccurate. They had known this for at least three months. The “recent information from CHQ” provided to West Moreton HHS was that *none* of the new services being developed by SWAETRI under CHQ would be ready by early 2014. That was not made clear in Fast Facts 10, or in any subsequent communications.

West Moreton HHS and its Board submitted that the first advice that “alternative services” would not be on line by the end of 2013/early 2014 came in or around November 2013.⁶⁷ According to CHQ, however, it was not accurate for West Moreton HHS to have said that recent information indicated that *some* of the future service options would not be fully operational for possibly 12 months. The State of Queensland submitted that, “when developing the planned suites of services”, CHQ and West Moreton HHS both knew (from the 16 August 2013 draft SWAETRI Project Plan) that the preferred services could not be *fully* operationalised in the short-term.⁶⁸ The Commission accepts this submission. As discussed in chapter 26, the 16 August 2013 draft SWAETRI Project Plan made it clear that “not *all* alternative service options will necessarily be available early 2014” (emphasis added).⁶⁹ (However it did seem to envisage that at least some of the new services would be available in time for the BAC’s closure.⁷⁰) This is consistent with the FAQ issued jointly by West Moreton HHS and CHQ in early August 2013, which stated that “We anticipate that *some* of those options will be available by early 2014” (emphasis added).⁷¹

That apparent misunderstanding between West Moreton HHS and CHQ filtered through the messages communicated to the staff, patients, families and the public. At least until Fast Facts 6 on 23 August 2013, staff, patients, families and the public had been expressly told that the BAC would not close until new contemporary service options were available. This is discussed further in chapter 16.

West Moreton HHS’s Counsel submitted that there was a parallel process whereby the BAC’s closure proceeded utilising individual care packages for current BAC consumers independently of the progression of the statewide service model.⁷² If that was the case, it was not communicated:

- in the West Moreton HHS and CHQ media statement dated 6 August 2013⁷³
- in Dwyer’s 8 August 2013 radio interview on 4ZZZ⁷⁴
- in any of the Fast Facts.

Other submissions on behalf of West Moreton HHS were that:

... the original intent was that the new services would be operational coincident with the closure of BAC to ensure that current BAC patients did not experience a gap in services. As assessment and implementation of discharge/transition of existing BAC patients progressed... it became apparent that those patients could be safely and appropriately discharged to the services operational at the time of individual discharges/transitions or with wrap around care.⁷⁵

This submission does not take into account the waitlist patients or other young people with severe and complex mental health issues who, the Minister said,⁷⁶ were to receive the new services. West Moreton HHS repeatedly communicated the message that “adolescents requiring

extended mental health treatment and rehabilitation will receive services through a new range of contemporary service options from early 2014".⁷⁷

If there was a change from West Moreton HHS's original intent, that was not disclosed in the Fast Facts or other communications issued prior to 20 November 2013. The communications from West Moreton HHS until this point consistently communicated the idea that a new range of contemporary service options would be ready from early 2014. Fast Facts 10 was the first to signal a change. It incorrectly stated that recent information received from CHQ had indicated that *some* of the future service options would not be fully operational for possibly 12 months.

Fast Facts 10 also failed to disclose that West Moreton HHS had made a decision to take only a limited liaison role with waitlist patients, who were to be referred to their receiving service or local HHS.⁷⁸ This is discussed in chapter 25.

Parent information session at The Park – 10 December 2013

On 10 December 2013, a parent information session was held at The Park. Five family members attended and one family member sent an apology on the day.⁷⁹ Geppert gave evidence that she hosted the parent information session on behalf of Kelly, who sent an apology.⁸⁰

Geppert gave a presentation on the interim service options that were being developed by SWAETRI.⁸¹ She said the key issues she presented were:

- It was "imperative" to ensure there was "no gap to service delivery for BAC patients".
- SWAETRI was working "within a partnership model" which included West Moreton HHS, CHQ, the Department of Health and Aftercare.
- The interim service options "were to be a pilot for future service options".
- The focus was on "individual recovery oriented packages of care that reconnected young people to their local communities".
- Clinical safety and risk mitigation were key priorities.
- Aligning the models of service delivery of Queensland Health and the Department of Education and Training.⁸²

Stathis also gave a presentation on the proposed SWAETRI models of care.⁸³

Fast Facts 11 – 20 December 2013

The eleventh and last of the Fast Facts was issued on 20 December 2013, approximately one month before the BAC closed. It discussed the parent information session held on 10 December 2013. It said "an update on the interim plan for transitional [interim] service options was presented by West Moreton HHS (see more details below). Additionally CHQ presented an interactive session on elements of the proposed future model of care". Readers were directed to a new website for extended treatment and rehabilitation services for young people. The information provided to families about the "transition service options for 2014" was as follows:

Transitional Service Options for 2014

West Moreton HHS has received approval for Aftercare to be the non-government service provider for the transitional services planned to commence in February 2014. Aftercare has extensive experience in providing similar youth supported accommodation services in Cairns and Sydney, and we will work together to develop a service model around supported residential care as a pilot for the new services being developed at a state-wide level. As

previously advised, the transitional services will be delivered in partnership between West Moreton, CHQ, Aftercare and the Department of Health. The focus will be on recovery oriented treatment for young people with severe and persistent mental health problems. **More information on the transitional services will be in provided in early 2014.**⁸⁴

(emphasis added)

Fast Facts 11 was unclear or otherwise silent in relation to some important and relevant matters. In particular, no information was provided about the:

- actual transitional services to commence in February 2014
- BAC closing its door
- new services being developed by CHQ
- presentation by Geppert and Stathis at the parent information session on 10 December 2013. Only five parents attended that session, and West Moreton HHS could have attached Geppert's and Steer's PowerPoint presentations from the evening
- difficulties Brennan and her team were facing in placing some of the BAC patients.

In addition, there was no suggestion that Fast Facts 11 would be the last Fast Facts. Readers were told that more information on the transitional services would be in provided in early 2014. However, there is no evidence that this occurred.

There is evidence that the uncertainty surrounding the BAC in 2013 had an effect on the staff and patients of the BAC. A patient gave evidence that:

From about the end of 2012 to the end of 2013, there was about one year where we did not know what was happening. Unless you were there every day you cannot comprehend the uncertainty of it and the fear of the unknown. Not knowing for a year was probably the one of the hardest things. During that time I was also doing year 12, which was stressful enough.⁸⁵

A parent said:

During the course of 2013, there was a great deal of uncertainty as to whether the BAC was going to close or not. [My child] was very concerned about the closure. [My child]

[redacted] [My child] [redacted]
[redacted] ...⁸⁶

Conclusions

In analysing the communications relating to the closure of the BAC and the development of new services, the Commission has had the benefit of hindsight. It acknowledges that these matters involved evolving processes. What may have been the position at one point may have later changed.

The Commission has adopted a cautious approach.⁸⁷

In undertaking its task, the Commission has considered the guiding principles of the HHB Act together with the relevant objectives of the communication plans referred to earlier. In doing so it has asked the following questions:

- Were the communications justified and accurate at the time they were issued? (This assessment involved comparing the information communicated with the information that was available to those who issued it at the time.)
- Were the communications consistent with other communications at the same time?
- If circumstances changed, making a previous communication inaccurate, were those changes communicated?

West Moreton HHS

Counsel for West Moreton HHS submitted that West Moreton HHS ought to draw “approbation” from the Commission for the number, consistency, and bona fides of its attempts to communicate highly complex messages.⁸⁸

The Commission rejects this submission.

The communications prior to the Minister’s announcement on 6 August 2013 failed to communicate to staff, patients, families and the public:

- The true state of affairs – that, in practical terms, there was no option but to close the BAC. The communications left open the prospect of the BAC remaining open, or at least there being a replacement of the BAC model, whereas the evidence reveals that West Moreton HHS and Queensland Health had excluded both of those options by this time.
- That a “rebuild” of the BAC was not an option. The Barrett Adolescent Strategy Project Plan dated 16 November 2012 made this clear by stating, “As there is no longer a current capital allocation to rebuild BAC on another site, the model(s) of care to be developed must exclude this as an option”.⁸⁹
- Details of the recommendations included in the ECRG preamble.⁹⁰

In addition, the communications about the closure of the BAC were insufficiently frequent: between 21 May 2013 and the Minister’s announcement on 6 August 2013, West Moreton HHS did not issue any communications at all.

It is true that there was a considerable amount of evidence before the Commission of extensive communications by West Moreton HHS about the potential closure of the BAC. However, contrary to the guiding principles of the HHB Act and the Communication Plan, these communications were not always open and transparent and certainly did not speak with “one voice” to stakeholders. This resulted in confusing and mixed messages being sent about the:

- bases of the decision to close the BAC
- timing and circumstances of the proposed closure of the BAC
- conditions upon which the BAC would close.

Thus, the guiding principles of the HHB Act were not met and, the objectives of the Communication Plan were not attained.

West Moreton HHS and Children's Health Queensland HHS

The communications issued after the Minister's announcement concerning the transition of the BAC patients and the development of new services were not consistent, clear or transparent. This resulted in mixed and confusing messages that:

- did not make it clear that the development of the services and the transition of BAC patients were independent of each other and that the closure of the BAC and the availability of new services were not linked
- failed to include important information, including all of the ECRG recommendations and that EFTRU had opened
- were unclear and confusing about whether the BAC would close without any new services being developed and implemented
- were vague and unclear about what services were being developed, when they would be developed and implemented and who would be accessing them.

Thus, the guiding principles of the HHB were not met and the objectives of the Communication Plan and the SWAETRI Project Plan were not attained.

The State of Queensland submitted that "If the Commission holds any concerns as to failings in the communication plan as drafted or in its effective implementation, Queensland Health is open to the Commission making systemic findings and providing associated recommendations to it concerning any improvements to be made to the communication plan process. Such recommendations would then be considered for inclusion in Service Agreements between the Department and each HHS and HHB".⁹¹

While the Commission does not intend making recommendations about how a HHS should communicate with its staff, patients, their families and the public, it goes without saying that the communications should be open, consistent and transparent. In this case, they were not.

Moving forward

Finally, it is worth emphasising that the communications about the closure of the BAC and the development of the new services were directed principally to very vulnerable and fragile adolescents, their families who were often under stress, and dedicated mental health professionals whose careers and livelihoods were connected to the BAC.

The Commission does not suggest that the deficiencies in the communications were deliberate. It makes no criticism of individuals involved in the drafting and dissemination of the relevant messages. Rather, its criticisms are intended to ensure change at a systemic level, so that in the future, care is taken to avoid confusion and uncertainty among the recipients of relevant communications.

(Endnotes)

- 1 *Hospital and Health Boards Act 2011* (Qld) s 13(1)(e).
- 2 Exhibit 51, Statement of Naomi Ford, 1 December 2015, p 2 para 5, p 3 para 9, Attachment E to that statement, Communication Plan, p 74.
- 3 Exhibit 51, Statement of Naomi Ford, 1 December 2015, Attachment E to that statement, Communication Plan, pp 74, 79.
- 4 Exhibit 51, Statement of Naomi Ford, 1 December 2015, Attachment E to that statement, Communication Plan, p 79.
- 5 Exhibit 51, Statement of Naomi Ford, 1 December 2015, Attachment E to that statement, Communication Plan, pp 79–80.
- 6 Exhibit 51, Statement of Naomi Ford, 1 December 2015, Appendix E, Communication Plan, p 74.
- 7 Exhibit 51, Statement of Naomi Ford, 1 December 2015, Appendix E, Communication Plan, p 74.
- 8 Exhibit 702, Statewide Adolescent Extended Treatment and Rehabilitation Implementation strategy Project Plan, 16 August 2013, p 1. Refers to 'CE teleconference' in the 'revision history' of the project plan. Glossary refers to CE has meaning 'Health Service Executive Officer'.
- 9 Exhibit 392, Barrett Adolescent Strategy Implementation Project Plan, 30 July 2013, p 7.
- 10 SWAETRI was renamed AMHETI.
- 11 Exhibit 122, Statement of Stephen Stathis, 5 November 2015, Attachment J to that statement, State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy meeting minutes, 21 October 2013, p 165; Exhibit 72, Statement of Judith Krause, 26 November 2015, p 508.
- 12 Transcript, Stephen Stathis, 10 March 2016, pp 24–40 lines 11–15.
- 13 The plan explicitly stated that it was for the use of the SWAETRI committee and the Children's Health Queensland Executive Management Team. It listed a number of communications for which West Moreton HHS were responsible, Exhibit 300, Communications Plan Statewide Adolescent Extended Treatment and Rehabilitation Strategy, November 2013, pp 4, 8.
- 14 Exhibit 300, Communications Plan Statewide Adolescent Extended Treatment and Rehabilitation Strategy, November 2013, pp 8–9.
- 15 Exhibit 300, Communications Plan Statewide Adolescent Extended Treatment and Rehabilitation Strategy, November 2013, p 4.
- 16 Transcript, Brett McDermott, 8 November 2012, Queensland Child Protection Commission of Inquiry, p 33–58 lines 2–19. Available from: <<http://www.childprotectioninquiry.qld.gov.au/hearings/transcripts>>. [18 December 2015].
- 17 Exhibit 51, Statement of Naomi Ford, 1 December 2015, p 4 para 13.
- 18 Exhibit 51, Statement of Naomi Ford, 1 December 2015, Appendix K to that statement, p 17.
- 19 Confidential exhibit.
- 20 Confidential exhibit.
- 21 Transcript, Kathryn McMillan QC, Closing submissions on behalf of West Moreton HHS and West Moreton HHB, 15 April 2016, p 28–58 line 35.
- 22 Transcript, Kathryn McMillan QC, Closing submissions on behalf of West Moreton HHS and West Moreton HHB, 15 April 2016, p 28–58 lines 35–38.
- 23 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 13 para 11.14, p 31 para 20.1(a).
- 24 Exhibit 51, Statement of Naomi Ford, 1 December 2015, p 5 para 20.
- 25 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 13 para 11.14.
- 26 See chapter 12 on the decision and announcement.
- 27 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 32 para 18.1; Transcript, Sharon Kelly, 22 February 2016, p 11–44 lines 29–44.
- 28 Exhibit 28, Statement of Anne Brennan, 23 October 2015, Attachment AB-3 to that statement, p 63.
- 29 Exhibit 130, Statement of Lesley van Schoubroeck, 26 October 2015, p 5 para 17.
- 30 Confidential exhibit.
- 31 Exhibit 130, Statement of Lesley van Schoubroeck, 26 October 2015, p 6 para 21.
- 32 Confidential exhibit.
- 33 Section 11(1)(d) of the *Queensland Mental Health Commission Act 2013*.
- 34 Exhibit 51, Statement of Naomi Ford, 1 December 2015, Appendix K of that statement, Fast Facts 7, p 125.
- 35 Transcript, Anne Brennan, 4 March 2016, p 20–21 lines 1–3.
- 36 Transcript, Anne Brennan 20–21 lines 1–4; Exhibit 971, Supplementary statement of Megan Hayes, 2 March 2016, p 5 para 5.7; Closing Submissions of Counsel Assisting, 17 March 2016, p 109 para 382.

- 37 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 51 para 127.
- 38 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 19 para 77; Confidential exhibit.
- 39 Exhibit 51, Statement of Naomi Ford, 1 December 2015, p 127, Attachment K to that Statement, Fast Facts 8, 3 October 2013, p 127.
- 40 Transcript, Lesley Dwyer, 23 February 2016, p 12-103 line 6 – p 12-104 line 2.
- 41 Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, p 23 para 102, Attachment ZD to that statement, List of committees, p 1578.
- 42 Exhibit 100, Supplementary Statement of Kerrie Parkin, 19 January 2016, Attachment KP-2 to that statement, p 12.
- 43 Confidential exhibit.
- 44 Confidential exhibit.
- 45 Response to possible adverse finding – Ian Maynard, 3 June 2016, p 2.
- 46 Confidential exhibit.
- 47 Confidential exhibit.
- 48 Confidential exhibit.
- 49 Confidential exhibit.
- 50 Submissions on behalf of Ian Maynard in response to submissions from [confidential], 10 May 2016, p 5 para 17.
- 51 Exhibit 307, Transcript of ABC 612 interview with Lawrence Springborg, 6 August 2013.
- 52 Transcript, Sharon Kelly, 22 February 2016, p 11-98 lines 27-32.
- 53 Transcript, Lesley Dwyer, 23 February 2016, p 12-103 lines 32-36.
- 54 Confidential exhibit; Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment 32 to that statement, p 280.
- 55 Transcript, William Kingswell, 24 February 2016, p 13-42 line 45 – p 13-43 line 35.
- 56 Confidential exhibit.
- 57 Confidential exhibit.
- 58 Exhibit 122, Statement of Stephen Stathis, 5 November 2015, Attachment J to that statement, SWEATRI meeting minutes of 9 October 2013, p 156.
- 59 Exhibit 122, Statement of Stephen Stathis, 5 November 2015, Attachment J to that statement, SWEATRI meeting minutes of 9 October 2013, p 156.
- 60 Exhibit 51, Statement of Naomi Ford, 1 December 2015, Appendix K of that statement, Fast Facts 9, p 128.
- 61 Confidential exhibit.
- 62 Confidential exhibit.
- 63 Exhibit 439, Email from William Kingswell to Michael Cleary, Subject: "Adolescent Services", 12 November 2013.
- 64 Confidential exhibit.
- 65 Exhibit 127, Statement of Laura Tooley, 22 October 2015, Attachment LT-06 to that statement, p 170.
- 66 Transcript, William Kingswell, 24 February 2016, p 13-42 line 45 – p 13-43 line 35.
- 67 Submissions on behalf of West Moreton HHS and Board, 23 March 2016, p 25 para 7.52.
- 68 Submissions on behalf of the State of Queensland, 23 March 2016, p 50 para 169.
- 69 Exhibit 702, Statewide Adolescent Extended Treatment and Rehabilitation Implementation strategy Project Plan, 16 August 2013, p 3.
- 70 Exhibit 702, Statewide Adolescent Extended Treatment and Rehabilitation Implementation strategy Project Plan, 16 August 2013, p 7.
- 71 Exhibit 1236, BAC FAQ sent to families following the closure announcement, undated, p 2. See chapter 16 for further discussion.
- 72 Further submissions on behalf of West Moreton HHS and Board, 14 April 2016, p 1 para 2.1.
- 73 Exhibit 62, Statement of Megan Hayes, 20 November 2015, p 17, Attachment MH-03 to that statement, Media Statement "Statewide focus on adolescent mental health", p 48. See chapter 16.
- 74 Exhibit 1371, Lesley Dwyer interview on 4ZZZ Radio, 8 August 2013, p 1. See chapter 16.
- 75 Submissions on behalf of West Moreton HHS, in response to further submissions of Jeannine Kimber, 12 May 2016, p 6.
- 76 In his radio interview on 6 August 2013, see Exhibit 307, Transcript of ABC 612 interview with Lawrence Springborg, 6 August 2013, pp 1-3.

- 77 For example, the FAQ and media statement released by West Moreton HHS and CHQ in August 2013 and Fast Facts 6, discussed in chapter 16.
- 78 Exhibit 1361, Emails between Leanne Geppert and Laura Johnson, Subject: "BAC Waitlist Strategy", 15 November 2013.
- 79 Exhibit 127, Statement of Laura Tooley, 22 October 2015, Attachment LT11 to that statement, p 249.
- 80 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, p 16 para 9.1(d).
- 81 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, p 16 para 9.1(b).
- 82 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, p 17 para 9.4; Attachment LG-14 to that Statement, Powerpoint slides for the BAC parent information session, p 80.
- 83 Exhibit 735, Presentation by Stephen Stathis to the Mental Health, Alcohol and Other Drugs Branch Leadership Matters Forum in April 2014.
- 84 Exhibit 51, Statement of Naomi Ford, 1 December 2015, Attachment K to that statement, Fast Facts 11, p 131.
- 85 Confidential exhibit.
- 86 Confidential exhibit.
- 87 This was recognised by counsel for the State of Queensland who said, "The Commission has generally approached the information and communication issue in a balanced way", Response to possible adverse findings - State of Queensland, 3 June 2016, p 4 para 6.
- 88 Further response to possible adverse findings – West Moreton HHS and Board, 6 June 2016, p 6 para 4.2.
- 89 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment SK-10 to that statement, Barrett Adolescent Strategy Project Plan, p 845.
- 90 This is discussed under 'Fast Facts 4' in chapter 9.
- 91 Response to possible adverse findings - State of Queensland, 3 June 2016, p 22 para 79.

25 The waitlist patients

The Commission's terms of reference require it to consider the care, and the adequacy of the care, for "BAC patients transitioned to alternative care arrangements in association with the closure or anticipated closure (transition clients)".

Waitlist patients, who were never admitted to the BAC, fall outside that description. In other words, they were not "transition clients" within the terms of reference.

However, the situations faced by waitlist patients are relevant to some aspects of the Commission's terms of reference, including considerations relevant to the decision to close the BAC (ToR 3(c)), the availability of alternatives to the BAC (ToR 3(g)), and the recommendations the Commission may make (ToR 4).

Operation of the BAC waitlist

Upon referral to the BAC, an adolescent was placed on an assessment list, pending an assessment by a multidisciplinary team of staff. The results of that assessment were then considered by an intake panel, which consisted of clinical and nursing staff, an allied health member, the principal of the BAC school and, at the relevant times, Trevor Sadler as the Clinical Director of the BAC.² If the intake panel decided to accept an adolescent, the adolescent's name would be placed on the BAC's waitlist (as a prospective day-patient or inpatient), awaiting an appropriate vacancy.

According to Sadler, from at least 2006, there were always adolescents on the waitlist and by 2012, they could spend up to six months on that list before being admitted.³

Sadler said that there were times when adolescents got better during the period they were on the waitlist, and the need for admission was averted.⁴ Sometimes adolescents or their parents/carers declined the services of the BAC; their names were removed from the list and they continued to be managed in the community.⁵

The Community Liaison, a registered nurse, was responsible, among other things, for developing and maintaining links with health service providers, and organising all referrals, assessments and admissions to the BAC. She reported to the Nurse Unit Manager. From 2007, this position was held substantively by Susan Daniel.¹

The BAC waitlist as at 2013

West Moreton Hospital and Health Service (West Moreton HHS) provided the Commission with a document dated September 2013 which recorded [] adolescents on the waitlist [] on the assessment list.⁶ No other information about one of the adolescents on the assessment list was produced to the Commission.

In October 2013, the BAC Clinical Care Transition Panel produced a status report which said there were [redacted] patients on the BAC waitlist. There was no reference to the assessment list.⁷

A list, dated 20 November 2013, taken from the BAC CIMHA record management system⁸, identified [redacted] adolescents on the waitlist and [redacted] on the assessment list.⁹

The discrepancies between these lists is partly explicable by [redacted] list [redacted] list [redacted] (the one for whom no other information was produced to the Commission) being removed from the list entirely. The circumstances of this removal are not known to the Commission.

The last admission to the BAC was in [redacted].

On that basis, the Commission considers that the list of 20 November 2013, which includes [redacted] waitlist and [redacted] assessment list adolescents, is most reflective of the waitlist and assessment list patients as at the time of closure.

Overview of the waitlist and assessment list cohort

An analysis and consideration of the medical records, clinical files and relevant witness statements concerning the adolescents identified as being on the BAC waitlist (including the BAC assessment list) is useful in establishing some general characteristics of the adolescents who were referred to the BAC and accepted for future admission.

It is also useful in understanding how long patients remained on the waitlist, what services patients on the waitlist accessed pending admission, and (to the extent this can be ascertained from the available records), what services adolescents received once admission to the BAC was no longer an option.

In general, the [redacted] adolescents on the BAC waitlist were characterised as follows:

- [redacted] of the [redacted] adolescents were under the care of [redacted], at some point in time while on the waitlist, although [redacted], resulting in their cases being closed. [redacted] adolescent was under the care of [redacted].¹⁰
- All [redacted] had [redacted] with [redacted] of the [redacted] at some point having comorbidity.¹¹
- [redacted] of the [redacted] had [redacted].¹² [redacted] had [redacted].
- The group could not easily be categorised as the “same” or “typical”. For example, without taking their comorbidities into account, [redacted].
- While on the waitlist, [redacted] were treated successfully at a less restrictive level of care.¹³
- With the exception of [redacted] adolescents who had been on the waitlist for between one and nine months,¹⁴ the rest had been on the waitlist for one year or more,¹⁵ at the time when Sharon Kelly (Executive Director Mental Health and Specialised Services, West Moreton Hospital and Health Service) issued a memorandum on 22 October 2013,¹⁶ directing that there be no further admissions to the BAC.

The [redacted] adolescents on the BAC assessment list were generally characterised as follows:

- All seven of the adolescents were under the care [redacted] at some point in time, [redacted] resulting in their cases being closed.¹⁷
- [redacted] had [redacted] and [redacted] were [redacted] [redacted] had [redacted]¹⁸ [redacted] had [redacted] [redacted] had [redacted]¹⁹
- Two had [redacted]²⁰
- The group could not easily be categorised as the “same” or “typical”. For example, without taking their comorbidities into account, [redacted]²¹ [redacted] had [redacted] diagnosed with [redacted]²² [redacted] had [redacted]²³ and [redacted] had [redacted]²⁴
- While on the waitlist, [redacted] appear to have been treated successfully at a less restrictive level,²⁵ with [redacted] of those adolescents receiving treatment [redacted]²⁶
- With the exception of [redacted] had been on the assessment list for over one year [redacted] adolescents were on the waitlist for between three and seven months²⁷ at the time when Kelly issued the memorandum of 22 October 2013,²⁸ directing that there be no further admissions.

Admissions from the waitlist pre-closure announcement

On 16 April 2013, Kelly sent an email to Darren Neillie (Clinical Director, High Secure Inpatient Services at The Park), referring to Terry Stedman (Director of Clinical Services at The Park) having been asked to advise Sadler that there were “to be no further admissions to the [BAC] whilst the future was unsure”.²⁹ She told Neillie that it appeared the direction had not been given to Sadler, or he had not adhered to the message. She wanted to discuss with Neillie how to reiterate to Sadler that there be no further admissions to the BAC.³⁰

There is no evidence before the Commission as to who asked Stedman to give the direction to Sadler, when, or under what authority. There is no evidence whether Stedman did so.

The minutes of the West Moreton Hospital and Health Board meeting on 24 May 2013 record, as an action item, that the Minister was to be updated regarding the proposed closure of the BAC, and that the Minister’s approval was to be sought “to not accept any further patients into BAC”.³¹

There is no evidence before the Commission that the Minister’s approval to cease admissions to the BAC was obtained. To the contrary, a West Moreton Board Committee Agenda Paper, dated 28 June 2013, states that the Minister is “to be updated” regarding the proposed closure of the BAC and “the decision not to accept any further patients into the BAC”.³² There is no mention of waitlist patients in the briefing note to the Minister, requested by Lesley Dwyer on 8 July 2013.³³

On 23 July 2013 there was a meeting between various representatives of West Moreton HHS, Children’s Health Queensland HHS (CHQ) and the Mental Health Alcohol and Other Drugs Branch. The topic of the meeting was ‘Barrett Adolescent Strategy’. Meeting minutes record, in part, that the BAC was to “continue to admit [patients] as required, but was to ensure that [the management of] admissions align with criteria suited to the new clinical model (i.e. Y-PARC)”.³⁴

Consistent with this, the available evidence reveals that there were [redacted] further admissions to the BAC, after [redacted]³⁵ Details in respect of these [redacted] admissions are in a confidential chapter of this report.

Admissions following the closure announcement

On 7 August 2013, Kelly emailed Sadler, referring to an earlier telephone conversation and reiterating the need “to let waitlist consumers and families know of the decision [to close the BAC] and what this means to them”.³⁶ Kelly attached to her email a draft letter to be sent to carers on the waitlist. That draft letter, which had presumably been prepared by Kelly or under her instruction, left open the possibility of admission from the waitlist. It said that West Moreton HHS would work with the carer “to enable [them] to access the most appropriate care, **whether that be through Barrett Adolescent Centre** or an alternative option that best meets [their] needs” (emphasis added).³⁷

Sadler forwarded Kelly’s email to Susan Daniel (Community Liaison, BAC) and Vanessa Clayworth (then acting Nurse Unit Manager, BAC).³⁸ In addition to her responsibilities as acting NUM,³⁹ Clayworth also took on some of the responsibilities of Daniel’s Community Liaison role, relevantly, developing and maintaining links with other health service providers.⁴⁰

When forwarding the email to Daniel and Clayworth, Sadler wrote: “This is the letter which can be sent out to those on the waiting list. The option of continuing to admit is clearly identified”.⁴¹

Later that day, Daniel sent a reply on behalf of Sadler, confirming that he was “happy” with the draft letter. Daniel sought clarification from Kelly on the process for issuing the letters. When sending this email, she deleted the words, “The option of continuing to admit is clearly identified” from the email chain.⁴²

The following day, Daniel received a further email from Kelly, this time copied to Sadler, Pdraig McGrath (Nursing Director, Secure Services, The Park), Stedman and Clayworth. The letter attached a signed version of the letter to those on the waitlist, with instructions on how it was to be distributed.⁴³ Kelly’s covering email hinted at the undesirability of admitting new patients to the BAC given the impending closure, but did not go so far as to state that there were to be no further admissions:

I note the challenge over the next few months in regards to those adolescents on the waiting list, and I would be interested to hear from you, Trevor and Vanessa how you believe you will be managing them given we need to support them, but I expect clinically you would not want to commence a treatment plan that may be disruptive to them as we move to the newer models etc.⁴⁴

Daniel responded to Kelly’s email on 8 August 2013, stating:

I note your comments re waitlist and plan to discuss this further with Trevor and Vanessa. Any admissions will be carefully considered in terms of resources. We were in the process of admitting two. Just to reassure you though, we are not prioritising high acuity cases at this stage, given the potential disruption and staffing issues with the transition.⁴⁵

[redacted] admission [redacted] patient
 In [redacted] was offered [redacted] At the same time, Elisabeth Hoehn (then acting Clinical Director of Child and Youth Mental Health Services, CHQ) sent an email to Daniel and William Brennan (Director of Nursing, West Moreton Mental Health and Specialised Services) (copying in Leanne Geppert, Kelly, Neillie, McGrath and Clayworth) asking them not to progress any work in preparation for the admission of any other consumer/family on the waitlist or the assessment list.⁴⁶

Ultimately, [redacted] of Anne Brennan's concern at the high acuity of the ward at that time.⁴⁷ Brennan left open the possibility of future admissions.

Formal decision that there be no further admissions

On 9 October 2013, the Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy (SWAETRS) met. The minutes of that meeting record:

LG [Leanne Geppert] confirmed that there have been no further admissions to BAC and that the waitlist is currently being addressed. It was decided that further admissions would not be in the best interests of current consumers. It was noted that this decision has not been externally communicated at this stage.

JS [Josie Sorban, Director of Psychology, CHQ] asked if it is known across the state that BAC is not taking on more consumers. JK [Judi Krause, Divisional Director CYMHS CHQ] asked whether there should be a communication to the CYMHS sector. [The consumer representative] asked if families on the waitlist know as yet. [Geppert] confirmed this decision has not been communicated more broadly than BAC at this stage. [Krause] recommended a brief be sent to MH Cluster and CEs advising of the current position regarding BAC closure and "no further admissions ..."⁴⁸

On 22 October 2013, Kelly issued a memorandum to Executive Directors and Clinical Directors, Mental Health Services, confirming that no further admissions to the BAC would occur:

As you may be aware the West Moreton Hospital and Health Service (WMHHS) is working towards closing the Barrett Adolescent Centre (BAC) building by the end of January 2014. This is a flexible date that will be responsive to the needs of our consumer group and will be dependent on the availability of ongoing care options for each young person currently at BAC.

WMHHS remains committed to safe, smooth and individually appropriate transitions of care for each young person currently attending BAC. **In order to meet this goal, there will be no further admissions to BAC services. This also means that no new referrals will be accepted to the waitlist.** WMHHS will be working with the referring Hospital and Health Service to ensure no loss of service provision to those young people currently on the BAC waitlist.⁴⁹

(emphasis added)

On 4 November 2013, Kelly issued a BAC Staff communique which referred in part to the decision that there be no further admissions.⁵⁰ It clarified that in addition to no actual admissions, there were to be no new referrals on to the BAC waitlist.⁵¹

Plan for those on the BAC waitlist and assessment list

The report of the Expert Clinical Reference Group (ECRG), dated 8 May 2013, is examined in detail in Chapter 10. Its concern about the closure of the BAC in the absence of Tier 3 extended to adolescents on the BAC waitlist. The relevant extract of the ECRG report, is as follows:

3. Interim service provision if BAC closes and Tier 3 is not available is associated with risk

...

In the case of BAC being closed, and particularly if Tier 3 is not immediately available, a high priority and concern for the ECRG was the 'transitioning' of current BAC consumers, **and those on the waiting list**.

...

Recommendations:

- a) Safe, high quality service provision for adolescents requiring extended treatment and rehabilitation requires a Tier 3 service alternative to be available in a timely manner if BAC is closed.
- b) Interim service provision for current **and 'wait list' consumers** of BAC while Tier 3 service options are established must prioritise the needs of each of these individuals and their families/carers. 'Wrap-around care' for each individual will be essential.

...⁵²

(emphasis added)

In its consideration of the ECRG report, the Planning Group referred to the provision of interim services for those adolescents already admitted to the BAC, but made no mention of those on the waitlist:

While this may be a complex process for some consumers and their individual needs, it was noted that this course of action could start immediately, and that it was feasible. The potential to utilise current BAC operational funds (temporarily) to 'wrap-around' each consumer's return to their local community was noted as a significant benefit.

The relevant local community should play a lead role in the discharge of the consumer from BAC and their return to home. The local services need to be consulted around their ability to provide 'wrap-around' care.

There is evidence of some limited consideration being given to alternative services that might be suitable for waitlist patients, in the course of developing transition plans for patients already admitted to the BAC.

For example, on 9 January 2014 Geppert asked Brennan, Clayworth and Laura Johnson (Project Officer, Mental Health and Specialised Services, West Moreton HHS, who was providing administrative and project support to Geppert in respect of the closure of the BAC)⁵³ whether there was "anyone on the BAC waitlist that still may need extended care and would benefit from admission to Greenslopes residential" in February 2014.⁵⁴

However, most of the relevant evidence is consistent with little active consideration having been given, as part of either the closure or the transition processes, to proactively identify specific alternative services for assessment/waitlist patients, once the BAC was no longer an option.

Instead, as the below narrative demonstrates, the plan was essentially for West Moreton HHS to contact the referring clinician or agency for each assessment list/waitlist adolescent, to notify them of the closure and for the referring clinician or agency to direct the adolescent to alternative care.

The following extract from the minutes of the SWAETRS meeting, dated 9 October 2013, is telling, in respect of the practical consequences of this approach:

LG [Leanne Geppert] advised that waitlist consumers stay with their respective HHS until taken on by BAC; however, they have found that, **in some cases, either the HHS is discharging the consumer as soon as they are placed on the waitlist or that the family has disengaged from services and are assuming a “holding pattern” waiting list for a place in BAC.**⁵⁵

(emphasis added)

Further, the status reports of the BAC Clinical Care Transition Plan for November and December 2013 did not include assessment list or waitlist patients.⁵⁶ The January 2014 status report noted that the waitlist and assessment list “had been updated” and stated, “A review of ongoing care needs has been made. A meeting has been arranged between WM HHS and CHQ HHS to handover”.⁵⁷

West Moreton HHS and the waitlist and assessment list

Soon after the non-clinical review of the assessment list and the waitlist on 20 November 2013,⁵⁸ Kathy Stapley was approached by Geppert and asked to support the progression of the waitlist strategy.⁵⁹ Stapley accepted the role, which she performed alongside her substantive position of Allied Health Professional Practice Lead Social Work, Mental Health, Queensland Health.⁶⁰

Stapley initially understood the plan was for her to contact parents of patients on the BAC waitlist and talk to them about what they as parents might require by way of support, in the context of their children no longer being able to access the BAC.⁶¹ However, following some discussion, Stapley and Geppert decided that because adolescents on the waitlist should be engaged with current care providers, it was preferable that any support to families be provided through the current care provider, rather than the family directly.⁶²

The limited scope of the role to be undertaken by West Moreton HHS with respect to assessment list and waitlist adolescents was made clear in an email sent by Geppert to Brennan, Clayworth and Johnson on 15 November 2013:

Hi Laura

I think we should take a consultation liaison role – service provision should be through current home team/HHS and/or referring team.

We should more enable the current home team, rather than engage directly with the consumers ourselves, but this can be considered on a case by case basis.

Need to prioritise those without ongoing engagement in the home HHS.

thanks Leanne⁶³

Geppert told the Commission that once a representative of West Moreton HHS had made contact with a referring service provider, it was then for the referring provider to determine other avenues of care for the adolescent concerned.⁶⁴ That is, it was not a matter for West Moreton HHS to develop any kind of tailored care plan, as was the case in respect of those adolescents already admitted to the BAC.

Stapley clearly understood the limitations of her role: she appreciated the purpose of her making contact with referring care providers was to ensure they were aware that a referral to the BAC could not proceed, and to obtain their assurance that the adolescent was or would be directed to alternative care.⁶⁵

Similarly, Geppert's evidence was that West Moreton HHS and, specifically, staff of the BAC, were to adopt a "consultation liaison role", whereby contact was to be made with a patient's current home team/HHS and/or referring team.⁶⁶

Discussions with referring care providers

From around 21 November 2013, Stapley (with some occasional assistance from Clayworth and Brennan) attempted to contact the case manager or team leader for each of the adolescents on the assessment list and the waitlist.⁶⁷

In doing so, Stapley (and Clayworth and Brennan)⁶⁸ endeavoured to identify the current status of the adolescent's contact (or lack of contact) with the most recently identified CYMHS (or other referrer) and whether referral to the BAC could be closed.⁶⁹ If an adolescent was still engaged in care, confirmation was sought that the referring provider would continue to provide care and/or was able to manage any alternative referral considered necessary.⁷⁰ If the adolescent had been transferred to another clinical care provider, contact was made with that provider and similar enquiries were made. In the event an adolescent had ceased care, the appropriateness of the referring agency trying to re-engage with the adolescent about any further clinical needs was discussed with the referring provider.⁷¹ As contact was made, Stapley entered the relevant details into a spreadsheet, which was then circulated periodically to Clayworth and Geppert by way of update.⁷²

Reporting on contact with referring providers

On 5 February 2014, Stapley provided an updated spreadsheet to Geppert which she described as a "final" version, in that it recorded contact with all referring providers and the outcome of those contacts.⁷³

Geppert, Brennan and Stephen Stathis (Clinical Director of Child and Youth Mental Health Services, CHQ) subsequently met to discuss the contact that had been made in respect of the waitlist patients.⁷⁴

There do not appear to be any minutes of this meeting, but there is evidence of a plan for Stapley to make direct contact with families of those adolescents on the waitlist and the assessment list identified as having disengaged from CYMHS.⁷⁵ There is no evidence that Stapley did contact families; instead, an email from Brennan on 20 February 2014 refers to a revised plan for Stapley to telephone clinics and for letters to be sent to the families.⁷⁶

Stapley prepared the letters for Brennan to send,⁷⁷ but they were never sent. According to the email sent by Brennan on 20 February 2014, Geppert's preference was for CYMHS to contact the families.⁷⁸

Geppert's evidence was that, based on briefings she received from Stapley and Brennan, she understood that a number of patients on the waitlist had been discharged from care by the referring provider agency since their referral to BAC.

Geppert gave evidence that, to the best of her knowledge, there were no cases where the referring provider expressed the view that, with closure of the BAC, there were no other acceptable options for a waitlisted patient.⁷⁹

adolescents identified to have potentially “slipped through the cracks”

On 14 February 2014, Brennan sent an email to Stathis and Geppert identifying [redacted] waitlist adolescents she considered may have “slipped through the cracks”.⁸⁰ This seems to have been in the context of the identified adolescents having [redacted] [redacted] with the result that it was unknown whether they were receiving appropriate alternative care.

Stathis asked Brennan to attempt to contact the [redacted] families “in her transitional role”, to find out what the reasons for [redacted] were, offer the adolescent a reassessment and, if mental health support were needed, to broker [redacted]. Following further investigations by Brennan, Stathis and Stapley, each of these cases was ultimately closed to the BAC, and the adolescent’s name removed from the assessment list/waitlist.

(Endnotes)

- 1 Exhibit 45, Statement of Susan Daniel, 30 October 2015, pp 3–4 paras 4–6.
- 2 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 20 para 104.
- 3 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 10 para 42; Transcript, Trevor Sadler, 1 March 2016, p 17-14 lines 28–33 and p 17-15 line 6.
- 4 Transcript, Trevor Sadler, 1 March 2016, p 17-15 lines 5–7.
- 5 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, pp 19–20 para 102.
- 6 Exhibit 1369, West Moreton Hospital and Health Service, ‘Current Inpatients, Current Day Patients, Waiting List, Assessment[t] Enquiries September 2013’.
- 7 Exhibit 127, Statement of Laura Tooley, 22 October 2015, Attachment LT-14 to that statement, Status Report – October 2013, p 220. (Laura Johnson now Laura Tooley.)
- 8 The Consumer Integrated Mental Health Application (CIMHA) is a statewide system developed by Queensland Health. The CIMHA program is used by clinical practitioners and administrative personnel to confirm the current position of each consumer, their diagnosis and proposed treatment plans.
- 9 Exhibit 121, Statement of Kathy Stapley, 9 December 2015, Attachment KS-04 to that statement, pp 24–25.
- 10 Evolve Interagency Services provide therapeutic and behaviour support services for children and young people on child protection orders and in out-of-home care who have psychological and behavioural problems: <<https://metrosouth.health.qld.gov.au/evolve-therapeutic-services>>. [11 May 2016]. [Confidential details removed.]
- 11 Confidential details removed.
- 12 Confidential details removed.
- 13 Confidential details removed.
- 14 Confidential details removed.
- 15 Confidential details removed.
- 16 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment SK-19 to that statement, pp 906–907.
- 17 Confidential details removed.
- 18 Confidential details removed.
- 19 Confidential details removed.
- 20 Confidential details removed.
- 21 Confidential details removed.
- 22 Confidential details removed.
- 23 Confidential details removed.
- 24 Confidential details removed.
- 25 Confidential details removed.
- 26 Confidential details removed.
- 27 Confidential details removed.

- 28 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment SK-19 to that statement, Memorandum from Sharon Kelly to Executive Directors and Clinical Directors, Mental Health Services, 22 October 2013, pp 906–907.
- 29 Exhibit 1359, Emails between Sharon Kelly, Kris Antal, Maureen Monaghan and others, Subject: "The Park – Bed Stats Spreadsheet 14.04.2013", 16 April 2013.
- 30 Exhibit 1359, Emails between Sharon Kelly, Kris Antal, Maureen Monaghan and others, Subject: "The Park – Bed Stats Spreadsheet 14.04.2013", 16 April 2013.
- 31 Exhibit 50, Statement of Timothy Eltham, 9 December 2015, Attachment TCE-14 to that statement, West Moreton Board Meeting Minutes dated 24 May 2013, p 130.
- 32 Exhibit 308, Exhibit 308, West Moreton Board Committee Agenda Papers and Meeting Minutes, 23 November 2012 to 28 February 2014 as provided by Timothy Eltham, Board Meeting Agenda Paper, 28 June 2013, p 117.
- 33 Exhibit 671, Briefing Note for Noting to Minister for Health, Subject: "Barrett Adolescent Strategy Meeting" (signed), 8 July 2013.
- 34 Exhibit 207, Minutes of Barrett Adolescent Strategy Planning Group, 23 July 2013, p 2.
- 35 Confidential details and exhibit citations removed.
- 36 Exhibit 1261, Emails between Sharon Kelly, Susan Daniel and Trevor Sadler, Subject: "Fwd: Advising carers of those on the waitlist for BAC", 8 August 2013, p 2.
- 37 Exhibit 1260, Letter from Sharon Kelly to carers regarding consumers on the waitlist, 8 August 2013.
- 38 Exhibit 1261, Emails between Sharon Kelly, Susan Daniel and Trevor Sadler, Subject: "Fwd: Advising carers of those on the waitlist for BAC", 8 August 2013, p 1.
- 39 Exhibit 38, Statement of Vanessa Clayworth, 27 October 2015, p 1 para 2.1.
- 40 Exhibit 38, Statement of Vanessa Clayworth, 27 October 2015, p 1 para 3.2(a).
- 41 Exhibit 1262, Emails between Sharon Kelly, Susan Daniel, Trevor Sadler and Vanessa Clayworth, Subject: "Advising carers of those on the waitlist for BAC", 7 August 2013.
- 42 Exhibit 1360, Emails between Sharon Kelly, Susan Daniel, Trevor Sadler and Vanessa Clayworth, Subject: "Re: Fwd: advising carers of those on the waitlist for BAC", 8 August 2013, p 1–2.
- 43 Exhibit 1261, Emails between Sharon Kelly, Susan Daniel and Trevor Sadler, Subject: "Fwd: Advising carers of those on the waitlist for BAC", 8 August 2013, p 2.
- 44 Exhibit 1261, Emails between Sharon Kelly, Susan Daniel and Trevor Sadler, Subject: "Fwd: Advising carers of those on the waitlist for BAC", 8 August 2013.
- 45 Exhibit 1360, Emails between Susan Daniel, Sharon Kelly and Trevor Sadler, Subject: "Fwd: Advising cares of those on the waitlist for BAC", 8 August 2013.
- 46 Confidential exhibit.
- 47 Exhibit 64, Statement of Elisabeth Hoehn, 18 November 2015, Attachment I to that statement, Email from Anne Brennan to Susan Daniel, Vanessa Clayworth and Elisabeth Hoehn, Subject: "new referrals to BAC and waiting lists", 18 September 2013, p 54.
- 48 Exhibit 125, Statement of Peter Steer, 15 December 2015, Attachment E to that statement, p 214.
- 49 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, Attachment SK-19 to that statement, pp 917–918.
- 50 Exhibit 100, Supplementary statement of Kerrie Parkin, 19 January 2016, Attachment KP-2 to that statement, pp 12–13.
- 51 Exhibit 100, Supplementary statement of Kerrie Parkin, 19 January 2016, Attachment KP-2 to that statement, pp 12–13.
- 52 Exhibit 1465, Report from the ECRG, 'Proposed Service Model Elements AETRS', 8 May 2013, p 4.
- 53 Exhibit 127, Statement of Laura Tooley, 22 October 2015, p 1 para 2 and Attachment LT-2 to that statement, Position Description, p 64. (Laura Johnson now Laura Tooley.)
- 54 Exhibit 39, Supplementary statement of Vanessa Clayworth, 20 November 2015, Attachment VC-14 to that statement, Email from Leanne Geppert to Laura Johnson, Anne Brennan and Vanessa Clayworth, Subject: "BAC waitlist", 9 January 2014, p 121. Laura Johnson (Tooley) responded to Leanne Geppert, advising there may be one adolescent who would benefit from that service, [Confidential details removed]: Exhibit 127, Statement of Laura Tooley, 22 October 2015, Attachment LT-22 to that statement, Email from Laura Johnson to Anne Brennan, Leanne Geppert and Vanessa Clayworth, Subject: "Re: BAC waitlist", 10 January 2014, p 415.
- 55 Exhibit 125, Statement of Peter Steer, 15 December 2015, Attachment E to that statement, p 214.
- 56 Exhibit 127, Statement of Laura Tooley, 22 October 2015, Attachment LT-14 to that statement, Status Report – BAC Clinical Care Transition Panel for November and December 2013, pp 272–274.
- 57 Exhibit 127, Statement of Laura Tooley, 22 October 2015, Attachment LT-14 to that statement, Status Report – BAC Clinical Care Transition Panel for January 2014, pp 276.
- 58 Discussed above.

- 59 Exhibit 121, Statement of Kathy Stapley, 9 December 2015, p 3 paras 3.4, 3.7; Exhibit 39, Supplementary statement of Vanessa Clayworth, 20 November 2015, Attachment VC-09 to that statement, p 112.
- 60 Exhibit 121, Statement of Kathy Stapley, 9 December 2015, p 1 para 1.2.
- 61 Exhibit 121, Statement of Kathy Stapley, 9 December 2015, p 4 para 3.8(f)–(g); Exhibit 55, Statement of Leanne Geppert, 16 October 2015, p 24 para.13.2.
- 62 Exhibit 121, Statement of Kathy Stapley, 9 December 2015, p 4 para 3.8(f)–(g).
- 63 Exhibit 1361, Emails between Leanne Geppert and Laura Johnson, Subject: “BAC Waitlist Strategy”, 15 November 2013.
- 64 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, p 24 para 13.2.
- 65 Exhibit 121, Statement of Kathy Stapley, 9 December 2015, p 3 para 3.4 and 3.6.
- 66 Exhibit 39, Supplementary statement of Vanessa Clayworth, 20 November 2015, Attachment VC-06 to that statement, p 70.
- 67 Exhibit 121, Statement of Kathy Stapley, 9 December 2015, p 4 para 3.8(g) and p 5 para 3.9(a).
- 68 Exhibit 121, Statement of Kathy Stapley, 9 December 2015, p 5 para 3.9(c).
- 69 Exhibit 121, Statement of Kathy Stapley, 9 December 2015, p 5 para 3.9(c).
- 70 Exhibit 121, Statement of Kathy Stapley, 9 December 2015, p 9 par 4.3.
- 71 Exhibit 121, Statement of Kathy Stapley, 9 December 2015, p 9 par 4.3.
- 72 Exhibit 121, Statement of Kathy Stapley, 9 December 2015, p 5 paras 3.9(d) and (e); [confidential exhibit removed].
- 73 Exhibit 121, Statement of Kathy Stapley, 9 December 2015, p 6 para 3.9(h).
- 74 Exhibit 121, Statement of Kathy Stapley, 9 December 2015, p 6 para 3.9(i).
- 75 Exhibit 1362, Email thread involving Anne Brennan, Stephen Stathis, Leanne Geppert and others, Subject: “BAC waitlist”, 20 February 2014.
- 76 Exhibit 1362, Email thread involving Anne Brennan, Stephen Stathis, Leanne Geppert and others, Subject: “BAC waitlist”, 20 February 2014, p 17.
- 77 Exhibit 121, Statement of Kathy Stapley, 9 December 2015, p 6 para 3.9(k), Attachment KS-10 to that statement, Email from Kathy Stapley to Leanne Geppert and Bernice Holland, Subject: “BAC follow up”, 19 February 2014, pp 35–37.
- 78 Exhibit 1362, Emails between Anne Brennan, Stephen Stathis, Leanne Geppert and others, Subject: “BAC waitlist”, 20 February 2014, p 17.
- 79 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, pp 24–25 para 13.3.
- 80 Confidential details removed.

26 Division of responsibility and timing of new services

Introduction

This chapter provides an overview of the division of responsibility between West Moreton Hospital and Health Service (HHS) and Children's Health Queensland HHS (CHQ), with respect to the development of the new suite of services discussed in chapters 27 and 28. Specific points in time, between May and November 2013, will also be examined, in order to understand the extent of knowledge that existed with respect to the new services.

A number of persons and entities involved in either the transitioning of the BAC patients, or the development of the new services, had varying understandings as to the scope of the new services, when they would become available and whether they would be available for BAC patients. These understandings, and the bases for them, are analysed below.

24 May 2013 – Meeting of West Moreton Board

On 24 May 2013, after discussing the Planning Group's recommendations, the West Moreton Board approved the development of a communication and implementation plan, inclusive of a finance strategy, "to support the proposed closure of BAC". The minutes reflect that in doing so, "the Board recognised that the Barrett facility [was] no longer suitable but [was] concerned that there [was] currently no alternative for consumers".¹

An agenda paper, which had been prepared by Sharon Kelly (Executive Director Mental Health and Specialised Services, West Moreton HHS) ahead of the meeting, informed the West Moreton Board that:

[t]he closure of BAC is **not dependent** on the next stages of progressing and consulting on a statewide service model; instead, the closure process is relevant to the needs of the current and wait-list consumer group of BAC, and the capacity for 'wrap-around' care in their local community services. The Planning Group noted this was feasible to commence now.²

(emphasis added)

This position appears not to have been readily accepted by the Board. The minutes of the meeting recommend that West Moreton HHS "engage with Children's Health Services and the Mental Health Alcohol and Other Drugs Branch re planning for future model of care".³ The minutes also note the recommendations of the Planning Group (discussed in chapter 10), and specifically, "the need to move as rapidly as possible to an alternative model based on those recommendations".⁴

In written submissions, Counsel for the State of Queensland referred to the evidence of Mary Corbett (Chair of the West Moreton Board) which they submitted indicated she understood that BAC patients would receive "wraparound services", and that "transition of the transition clients to be to **existing services**" (emphasis added).⁵ In fact, what Corbett said in cross-examination was that she understood transition "**also** meant to existing services" (emphasis added).⁶

A close review the transcript suggests that, as at May 2013, there was some confusion on the part of Corbett (and possibly the West Moreton Board), as to what services were envisaged for BAC patients. In oral evidence, Corbett seemed to oscillate between referring to the West Moreton Board being assured that there would be “no gap” to service because “appropriate ... wrap around services **were available**”,⁷ and referring to the West Moreton Board being assured “of **additional services**” being made available:⁸

So through each monthly reporting cycle the board were continually assured of models of care **being available**. There was also a meeting in December to look at the additional models of care from the statewide adolescent centre that was under the governance of Children’s. So continually from this period the board were assured that **additional** services and appropriate models of care were available.⁹

(emphasis added)

In response to questions from Counsel Assisting as to what those services were, Corbett said, “There was a mobile outreach service. There was a day program. There was a holiday program. There were some acute beds”.¹⁰

As will be discussed further below, the mobile outreach service, day program and holiday program were all services implemented as a “stop gap”, when Kingswell and Dwyer became aware, in November 2013, that none of the services being developed by CHQ would be ready by January 2014. Nevertheless, it would appear that there was to some extent, an expectation on the part of the West Moreton Board (and, specifically, Corbett) as at May 2013, that new services would be established prior to the closure of the BAC.

For further discussion in respect of the 24 May 2013 West Moreton Board meeting, see chapters 11 and 12. It is necessary to now examine the relevant events subsequent to that board meeting.

Plan for a partnership between CHQ and MHAODB (and later, also West Moreton) for the new services

11 June 2013 – Meeting of West Moreton HHS and CHQ

On 11 June 2013, there was a meeting attended by Dwyer, Kelly and Geppert of West Moreton HHS, and Peter Steer (Chief Executive of CHQ), about the new services to replace the BAC. While there are no minutes of this meeting, a subsequent Board Committee Agenda Paper records that it had been agreed that the new service model was to be developed by way of a two-way partnership between CHQ and the Mental Health Alcohol and Other Drugs Branch (MHAODB):¹¹

A meeting was held Tuesday June 11th between Lesley Dwyer, Chief Executive WMHHS, Dr Peter Steer, Chief Executive Children’s Health Services, Leanne Geppert, Acting Director of Strategy MH&SS and Sharon Kelly ED MH&SS WMHHS to agree the following:

- i. **In principle agreement reached that Children’s HHS will partner with The Mental Health Branch to progress a statewide service model.**
- ii. Agreement that the timeliness of the development and implementation service model is a priority for WMHHS as the decision to cease providing services at the Barrett Adolescent Centre is contingent on a viable service model option being available.

(emphasis added)

Steer did not mention the 11 June 2013 meeting in his statement, although he did refer to attending monthly meetings with Dwyer and said that it was probably at one of those meetings that she told him of the decision to close the BAC. He did not refer to any agreement reached, or even any discussion between himself and West Moreton HHS executives about the link between the closure of the BAC and the availability of new services. In his statement, Steer said he understood only that BAC would not close “until the transition plans for every adolescent had been finalised. The priority and commitment was to ensure that transition plans were in place for all patients prior to closure. In that sense, the closure date was flexible”.¹²

17 June 2013 – Meeting of West Moreton HHS and Director-General

On 17 June 2013, Dwyer, Kelly and Geppert met with Anthony O’Connell (Director-General) and Michael Cleary (Deputy Director-General). Although there are no minutes of this meeting, a subsequent Board meeting agenda paper records the following agreements:

- In principle support of the plan for closure of [BAC] with an understanding the new model of service is identified and developed¹³
- Agreement of HSCI [Health Service and Clinical Innovation Division (which fell under Cleary’s area of responsibility)] support for the shared model planning process.¹⁴

The “shared model planning process” was most likely a reference to the two-way partnership between MHAODB and CHQ, which had been devised on 11 June 2013.

According to Cleary, at the meeting on 17 June 2013, “WMHHS briefed the Director-General on the work to date including the proposed new model of care for adolescents with serious mental health issues in Queensland **and as part of this** the proposed discontinuation of the services provided through the BAC” (emphasis added).¹⁵ Thus, at least from Cleary’s point of view, there was a connection between the new models and the closure of the BAC.

In her written statement, Kelly described the purpose of meeting as being “to discuss next steps following the [West Moreton Board] decision to accept the recommendation to close BAC”.¹⁶ Dwyer said that at the meeting, O’Connell and Cleary “confirmed in principle support for the closure of the BAC and development of a new model of service”.¹⁷ Corbett, who did not attend the meeting, said that she was aware of the meeting on 17 June 2013,¹⁸ and attached to her statement a copy of the Board committee agenda paper for the meeting on 28 June 2013.¹⁹

Geppert did not specifically mention the meeting of 17 June 2013 in her statement. Her evidence was that she “attended some meetings with Sharon Kelly and/or Lesley Dwyer in a support and/or information role, and ... provided advice in their preparation for many of these meetings”.²⁰ O’Connell has no specific recollection of the 17 June 2013 meeting. He says that he is “in possession of emails that are meeting requests from the CEO of WMHHS to discuss BAC (scheduled for 14:30 on Jun 17, 2013 and for 15:15 on Jun 14, 2013)” [sic], but he is “unaware of whether these meetings took place, whether one is a rescheduling of the other, or who attended the meetings”.²¹

Having regard to the note of the 17 June 2013 meeting, it seems likely that at this point it was agreed – or at least understood between West Moreton executives, the Board, the Deputy Director-General (and most probably the Director-General) – that the development of the new services and the closure of the BAC were expressly linked.

21 June 2013 – Email Kingswell to Marie Kelly

In that first month, June 2013, there was some confusion as to how the partnership was to work in practice.

On 21 June 2013 there was an email exchange between Kingswell and Marie Kelly, A/Director Planning and Partnerships Unit, about whether a brief to the Director-General (discussed below) regarding the BAC should be led by MHAODB or West Moreton HHS.

In his response to Marie Kelly, Kingswell made it clear that he understood MHAODB to have responsibility for developing a Y-PARC service, and importantly, that the commencement of the Y-PARC service was to coincide with the closure of the BAC:

Marie, Don't care who leads. However, we have been tasked with getting replacement services in place ahead of boards [sic] decision to close. Nick has agreed to release the \$2m to FCMU for Y-PARC and Michael has said the Division will fund also. So maybe it's us. Bill.²²

(emphasis added)

(The Y-PARC model of service is discussed in chapter 14 and appendix C).

8 July 2013 – Meeting of West Moreton HHS and Kingswell

On 8 July 2013 there was a meeting between representatives of West Moreton HHS and Kingswell. A file note of that meeting confirms the agreement that the new services were to be developed under a partnership, but one that was to now include West Moreton HHS. That is, a three-way partnership.

The note records Kingswell as having assured attendees that the focus of the MHAODB was on having a Y-PARC service up and running when the BAC closed:

1. Noted meeting planned with Health Minister 15/7/13.
2. Discussed proposal for **MHAODB, Children's Health Services and WMHHS to jointly progress BAC project regarding statewide service model finalisation.**
3. [Kingswell] indicated limited capacity to engage in BAC project in short term and that **focus of MHAODB is Y-PARC service planning and implementation in Metro South by January 2014.** Tenders to be called 16 July 2013. \$1.8M funding for Y-PARC sourced from QPMH (originally intended for now ceased Redlands Adolescent Extended Treatment Unit). Potentially a second Y-PARC in Cairns into the future.
4. Y-PARC will be supra District, 16-24y target group, NGO and clinical partnership service model. **Accessible to large proportion of adolescent target group of BAC.**
5. [Kelly] noted potential for issues given no formal communications yet re outcome of ECRG process despite Y-PARC tenders being called, however **the development of YPARC would support the board requirement of an alternate service available.**²³

(emphasis added)

Thus, there continued to be a clear understanding of a connection between the roll-out of a replacement service (at this time, Y-PARC) and the closure of the BAC. The comment by Kelly (at point 5) supports the evidence above, namely, that at its meeting on 24 May 2013, the West Moreton Board similarly understood that there was to be a new alternative service available at the time of the BAC's closure.

8 July 2013 – Ministerial and Director-General briefing notes

As detailed in chapter 12, on 8 July 2013, Dwyer requested briefing notes to the Director-General and Health Minister, Lawrence Springborg, with the subject heading 'Barrett Adolescent Strategy Meeting'. The briefing note was prepared by Geppert and cleared by Kelly.

In a briefing note for noting, the Minister was advised of a meeting scheduled for 15 July 2013 and told that "West Moreton Hospital and Health Board considered the recommendations of the Expert Clinical Reference Group on 24 May 2013 ... and approved the closure of BAC dependent on alternative, appropriate care provisions for the adolescent target group and the meeting with the Minister for Health". There are no attachments listed.²⁴

This statement is confusing. The use of the phrase "alternative, appropriate care", conflates existing services and the development of new services. Whilst it may not have been deliberate, or may have simply been an attempt to link development of new contemporary services with closure of the BAC to paint the closure in a positive light, the use of this kind of language possibly contributed to subsequent confusion (discussed below) and a lack of a shared understanding between CHQ, West Moreton HHS, the West Moreton Board and the Department (including MHAODB). (The issue of mixed messages is discussed further in chapter 24.)

The briefing note to the Minister included a briefing note for noting to the Director-General, O'Connell, which O'Connell signed and marked as "approved" on 15 July 2013.²⁵ It was signed by the Minister's Chief of Staff on 31 July 2013.

The briefing note for noting to the Director-General repeated the information in the Minister's briefing note but also gave details of alternative services being planned. Importantly, it stated that "The Department of Health is urgently progressing planning for Youth Prevention and Recovery Care (Y-PARC) services to be established in Queensland by January 2014. This service type would provide an alternative care option for the adolescent target group currently accessing BAC".²⁶

The briefing note advised that "Consultation about the proposed next stages of the Strategy and board decision for closure has been limited to Dr Peter Steer, Children's Health Services; and Dr Tony O'Connell, Director General, Dr Michael Cleary, and Dr Bill Kingswell, Health Services and Clinical Innovation, Department of Health. A short verbal briefing has been provided to the Queensland Commissioner for Mental Health, Dr Lesley van Schoubroeck".

The brief confirmed that "Agreement has been reached that the Strategy will be finalised through a partnership between West Moreton HHS, Children's Health Services, and the Department of Health".²⁷

15 July 2013 – Meeting of West Moreton HHS and Minister

Chapter 12 includes a detailed discussion of a meeting between West Moreton HHS and the Minister, on 15 July 2013. For present purposes, it is relevant to consider the talking points prepared by Kelly for Dwyer, ahead of this meeting, which stated (in part) as follows:²⁸

- Board approval to close BAC is dependent on **alternative**, appropriate service provisions for the adolescent target group.
- The Department of Health is progressing planning for Youth Prevention and Recovery Care (Y-PARC) services to be established in Queensland **by January 2014**. (This has already been announced to the sector through another process.)
- **This service would provide one alternative care option** for the adolescent target group currently accessing BAC.
- Agreement has been reached that the strategy will be finalised through a partnership between West Moreton HHS, Children’s Health Queensland and the Department of Health.

(emphasis added)

Despite the clear reference to the opening of a Y-PARC in the speaking notes, in their written supplementary statements, the Minister, Dwyer and Corbett all gave evidence that they did not recall there being any discussion about the opening of a Y-PARC, at this meeting.²⁹

As discussed in chapter 12, there are no minutes of this meeting which might otherwise have assisted the attendees in refreshing their memories. Nevertheless, the talking points illustrate that as at July 2013, Kelly (and possibly also Dwyer) understood there was a link between the development of a replacement service under the three-way partnership, and the closure of the BAC.

This is significant because it was at this meeting that the decision to close the BAC was made, by Corbett as Chair of the West Moreton Board, and Springborg, as Health Minister. (For further discussion of the decision to close the BAC, see chapter 12).

Change of plan – Transfer of responsibility to CHQ

23 July 2013 – Meeting of West Moreton, CHQ, Department of Health

On 23 July 2013, West Moreton HHS convened a “Barrett Adolescent Strategy” group³⁰ meeting (not to be confused with the strategy that underpinned the project plan adopted in late 2012, discussed in chapter 9, or the Barrett Adolescent Strategy Planning Group discussed in chapter 10.³¹

The meeting was attended by Dwyer, Kelly and Geppert from West Moreton HHS, Kingswell from the MHAODB, and Steer, Stephen Stathis and Judith Krause from CHQ. Naomi Ford and Craig Brown, each in Communications, attended the meeting on behalf of their respective HHS.

The minutes of the 23 July 2013 meeting record a decision that CHQ would take on responsibility for “lead[ing] the implementation phase of the Barrett Adolescent Strategy moving forward” although it was minuted that “WMHHS and DOH [which would include MHAODB] [were to] remain key stakeholders”.³²

Steer explained that “[t]he leadership, clinical expertise and mental health management implications of the planning process for replacement services for the Barrett Centre [was] provided by Stephen Stathis and Judi Krause, senior leaders within Children’s Health Queensland”.³³

Stathis³⁴ referred to the minutes of the 23 July 2013 meeting in his evidence. He said they indicated that CHQ was to lead the implementation stage of the Barrett Adolescent Strategy and that “an implementation steering committee was to be formed for that purpose”.³⁵ Geppert explained that an outcome of the meeting on 23 July 2013 was that “governance for the implementation was shifted from WMHHS and assumed by CHQHHS via the SWAETRI”.³⁶

Further discussion of the SWAETRI is set out below.

Promise of a Y-PARC

The minutes are less clear, however, as to who was given responsibility for progressing the establishment of Y-PARC services, which were at that time being planned by the MHAODB. Responsibility for Y-PARCs seems to have initially remained with the Department or, more specifically, the MHAODB.³⁷

During his oral evidence, Kingswell said that he understood CHQ “had been given by the Minister the responsibility for taking the whole ... adolescent mental health extended treatment program forward”.³⁸

However, Kingswell is minuted as having assured attendees that he “[had] confidence in [a] procurement timeline to open YPARC service by January 2014. Longer term plan will consider a second YPARC site in North Qld – Sector preference is for second site to be Townsville”. Kingswell’s confidence about the January 2014 timeframe, and his reference to longer term plans for Townsville, suggests that his branch was undertaking a role in the development of Y-PARCs.

Kingswell described the Y-PARC model as “16-25yo age group, inpatient beds delivered by NGO with daily in-reach by mental health clinicians, short term admissions, 6-8 beds delivered on hospital campus). While not stated, it seems likely that this proposal eventually became known as the Step-Up/ Step-Down component of AMHETI, as Kingswell is also minuted as having advised of a:

Potential to establish Youth Residential Rehab Service in addition to YPARC. Funding source not identified. Domestic build, service model is residential not therapeutic, extended length of stay for target group. [Kingswell] unable to provide timeline for service establishment – likely to be second priority to YPARC establishment. Potential for this pilot site also in Metro Sth HHS.

Kingswell took notes on his iPad at the 23 July 2013 meeting, which included the following discussion about the Y-PARC service:

Meeting re-BAC 23 July 13

Peter Steer

Lesley Dwyer

et al

Brief to Minister

BAC closure dependant [sic] on replacement services ... Not in public space yet. No date for closure unit aiming at Dec 31

Discussed possibility of establishing Y-PARC model using existing Logan space.

CHQ to oversight the establishment of an implementation group to commence work by early next week. Follow up meeting with Peter Steer, Lesley Dwyer, and Richard Ashby within the month.³⁹

Evidence of West Moreton

The State of Queensland submitted that Corbett recognised the separate roles for West Moreton HHS and CHQ, submitting that Corbett “spoke of the new service development being in ‘a *parallel sense*’ not the focus of West Moreton HHS because the governance of the new State-wide model of care was the responsibility of CHQ” (emphasis in original).⁴⁰ While this may be true, for the reasons discussed above, Corbett’s oral evidence appears to show that there was an expectation on the part of the West Moreton Board that *some* new services (or service) would be established prior to the BAC’s closure.

Kelly annexed the minutes of the 23 July 2013 meeting to her statement. She gave evidence that “[a]t the time of [her] involvement in the closure decision, that is during the period the Planning Group decisions were underway, [she] had received assurances from Dr Bill Kingswell in his role as Executive Director MHAODB that a youth residential extended treatment facility would be established in South East Queensland by around January 2014,” and a “longer term plan would consider a second site in North Queensland”.⁴¹ Kelly confirmed, during oral evidence, that in July 2013, she understood the MHAODB “were meeting with Metro South the following week to progress” planning for the Y-PARC.⁴²

Thus, as at July 2013, Kelly understood that MHAODB was negotiating with Metro South HHS to have a Y-PARC operational in time for the BAC’s closure. She further understood that, in addition to a Y-PARC service, there was also to be a Youth Resi service operational by January 2014.⁴³

Dwyer’s evidence was that the role of West Moreton HHS was to concentrate on the transition plans for the transition clients.⁴⁴ According to Dwyer, based on the advice received from Kingswell, she believed that a Y-PARC would be operational by January 2014, and was aware that assertive outreach models were “starting to emerge and be developed” by CHQ.⁴⁵ However, she accepted that as at July 2013, “nothing had started in so far as there was not a Y-PARC service model ... within Queensland at that time”.⁴⁶

Geppert explained that the transition arrangements and the development of new services did not occur in isolation, and that West Moreton HHS and CHQ “communicated regularly around all relevant issues in both formal and informal forums”.⁴⁷ Geppert told the Commission that she sat on the SWAETRI Steering Committee (discussed below) and contributed in a “two way direction, information from West Moreton and information from that committee back to West Moreton”. She said she was “in regular contact with [Ingrid] Adamson from CHQ” and that Elisabeth Hoehn (program director and consultant child psychiatrist)⁴⁸ was a “conduit ... between the two HHS[s]”.⁴⁹ Thus, as at July 2013, it is clear that West Moreton HHS understood there was to be a replacement developed in time for the closure of the BAC, and that the replacement would most likely be a Y-PARC service.

Evidence of CHQ

The evidence of witnesses for CHQ was quite different.

Steer explained that responsibility for the governance of the BAC closure and transition was split between himself, as Chief Executive of CHQ, and Dwyer, as Chief Executive of West Moreton HHS. According to Steer, he was responsible for the development and provision of replacement services and Dwyer was responsible for closure of the BAC and the management of staff and patients throughout that closure process.⁵⁰

Steer explained that in developing the new services, CHQ was cognisant of the timing of the BAC’s closure, but not driven by it:

[CHQ was] necessarily engaged on a number of levels understanding the process around those transition plans ... because we may have inherited some of those adolescents for ongoing care at transition, but also we did actually have to interface our planning of new services to the timing of the closure of Barrett eventually.⁵¹

Adamson agreed that Geppert was a “connection point” between the responsibilities of West Moreton HHS and those of CHQ,⁵² but said there was a clear division between the responsibilities of the two entities and, specifically, CHQ’s (lack of) responsibility with respect to the BAC patients:

- FREEBURN: Alright. Was there no connection between what you call transition planning and the rolling out of the services as a part of the SWAETRI/AMHETI program?
- ADAMSON: No. There were clear distinctions between what West Moreton was looking after and what Children’s Health Queensland was looking after. The connection point was very much the interactions we would have and the advice that we would give each other at steering committee meetings, which were held on a fortnightly basis and/or informal conversations we might have via the telephone or email ... **In terms of the scope of the work, there was no connection in the sense that transition planning was very much being done by the clinical team at West Moreton and the new service planning was being done by the group that was convened for working group 1.**

- FREEBURN: Wasn't the whole impetus and purpose in this developing services – wasn't that – didn't the impetus come from the idea that the Barrett Adolescent Centre was to close and there needed to be facilities for these – for the young people who were inpatients there to go to?
- ADAMSON: The scope was actually to look at contemporary services for the cohort aged 13 to 18 of similar diagnostic profiles as to those of the young people that were in the Barrett. So, no, **it wasn't that narrow that it was only just looking at what happened to the young people at Barrett but it was also saying how better can we serve these consumers in Queensland. And that certainly was my understanding of the purpose of the project was to look at 13 to 18 year old services and look at how we could best roll those out.** West Moreton was very clear to us particularly at the steering committee that the care and the clinical governance of the young people in the Barrett would remain in their remit.
- FREEBURN: So were West Moreton really restricted to transition plans that involved transitioning these patients to existing services?
- ADAMSON: Not restricted. We certainly explored with them – and hence why Dr Geppert was on working group 1. We explored the different tiers that were provided through ECRG. And then we looked at which of those tiers we could mobilise as quickly as possible and, if appropriate – and that was a clinical decision, if appropriate a consumer from the Barrett could utilise those services if that met with their treatment needs.⁵³

(emphasis added)

While Stathis agreed that there was communication between West Moreton and CHQ,⁵⁴ he was clear that developing services specifically for the type of patients who might access the BAC was not “under the remit” of the Service Options Implementation Working Group (established by CHQ),⁵⁵ whose task was “to build on the Expert Clinical Reference Group recommendations and develop preferred service options for adolescent mental health extended treatment and rehabilitation services”.⁵⁶ During oral evidence he reflected:⁵⁷

[CHQ] is not going to accept the clinical responsibility of ex-Barrett clients or patients that have been transferred out of [our] catchment area.⁵⁸ That's not how the system works ... we did hold funding and we could assist other hospital and health services in terms of further support for young people ... we provided funding for young people in a range of other hospital and health services who required it.⁵⁹

Thus, it was clear by July 2013, that governance for the development of the new services rested with CHQ, and that governance for the transition of the BAC patients rested with West Moreton HHS. Less clear, was the extent to which the new services would be implemented in alignment with the BAC's closure.

Establishment of the SWAETRI Steering Committee

CHQ took steps to establish a State-wide Adolescent Extended Treatment and Rehabilitation Implementation Steering Committee (Steering Committee) and a Chief Executive and Department of Health Oversight Committee (Oversight Committee).

Role of the Steering Committee

According to Geppert, the Steering Committee was established to shift responsibility from West Moreton HHS to CHQ, and to “report to another new body, that being the Chief Executive and Department of Health Oversight Committee”.⁶⁰ In her written statement, Adamson explained that the Steering Committee was not involved in any decisions about BAC’s closure, but “did however provide guidance with respect to mental health service planning, models of care, staffing transitions, financial management, and consumer transition associated with the Project”.⁶¹

The Steering Committee’s terms of reference, endorsed on 23 September 2013,⁶² describe its function as being to provide a “decision-making, guidance and leadership role with respect to mental health service planning, models of care, staffing transition, financial management and consumer transition associated with the project”.⁶³ Practically, they were responsible for overseeing and monitoring the SWAETRI strategy project plan⁶⁴ and three working groups. The three working groups, however, were short lived and were either disbanded or subsumed by other governance arrangements:

- Service Options Implementation Working Group – met once on 1 October 2013 for a workshop and was then disbanded.⁶⁵
- Barrett Adolescent Centre Consumer Transition Working Group⁶⁶ – this working group did not progress and transition of BAC patients was managed by West Moreton HHS.
- Financial and Workforce Planning Working Group – met once on 22 October 2013⁶⁷ and then was disbanded.

The Steering Committee did not meet until 26 August 2013.⁶⁸ It then met a number of times up until 15 December 2014.⁶⁹

The Steering Committee was co-chaired by Stathis and Krause.⁷⁰ Stathis was a member of both the Steering Committee and the Oversight Committee.

SWAETRI Project Plan

On 30 July 2013, Geppert prepared an initial draft of a project plan for the SWAETRI (which later came to be known as AMHETI). That plan was revised on 1 August 2013, and again on 16 August 2013,⁷¹ following meetings with Kelly, Stathis and Krause.⁷²

The following table, extracted (in part) from the 16 August 2013 version, confirmed CHQ's lead role and clarified the nature of the (lesser) roles to be played by the MHAODB and West Moreton HHS with respect to the development of the new services:

West Moreton HHS	<ul style="list-style-type: none"> • Project partner • Responsibility for transition of consumer care and BAC operational funding • Responsibility for support of and information provision to BAC staff • Joint responsibility for communications / media with CHQ • Support timely achievement of Strategy objectives • Support CHQ in project planning and implementation
CHQ	<ul style="list-style-type: none"> • Lead project partner – governance for project including secretariat and chairing responsibilities of steering committee, and project planning and implementation • Drive timely achievement of Strategy objectives • Governance over new statewide service model – governance model to be defined • Lead negotiations with other HHS regarding new service options and support service implementation • Joint responsibility for communications / media with WM HHS
DoH – MHAOD Branch	<ul style="list-style-type: none"> • Project partner • Provide funding and/or identify funding sources (as agreed/negotiated) between key stakeholders) for both the Project and defined service options • Provide advice, information and data on national and state direction regarding policy and service planning as relevant to the Project • Participate in statewide negotiations and decision-making processes

Other than a brief mention of Queensland's early experience in the delivery of some models being proposed "(such as Y-PARC, Intensive Mobile Youth Outreach Service, residential rehabilitation, and other partnership models between the public and non-government sectors)", the August version of the Plan did not include detail about particular services.⁷³

There was no express reference to the proposal that a Y-PARC be in place by January 2014, or who had responsibility for the development and implementation of a Y-PARC service.

Recognition of constraints in timing

Counsel for the State of Queensland submitted that "when developing the planned suite of services, CHQ and West Moreton HHS appreciated that the preferred services could not be fully operationalised in the short-term".⁷⁴

While the project plan is not evidence of what key individuals understood, the plan does seem to envisage that, as at July 2013, it was planned that at least some new services would be available in time for the BAC's closure:

- Beneath the heading 'Objectives', the plan states that "not all alternative service options will necessarily be available early 2014".⁷⁵
- Beneath the heading 'Assumptions', the plan states that not all service options would be available by early 2014, but there was "a commitment to ensuring there is no gap to service delivery for the adolescent target group".
- The plan includes among the list of 'Constraints' that "**alternative service options for BAC consumers must be available by early 2014**, when The Park transitions to an adult forensic and secure mental health facility".⁷⁶

(emphasis added)

Counsel for the State of Queensland submitted that "CHQ communicated the new suite of service options under development and the timelines for each of those across the State".⁷⁷ The State does not pinpoint a specific date when CHQ did this, but rather, broadly references the evidence of Adamson, Steer, Krause and Geppert.

In any event, the evidence below suggests that as at August 2013, it was unclear to a number of individuals (and understandings varied) on the scope of the services to be made available, and by when they were to be available for whom.

Evidence of the witnesses

During examination by Counsel Assisting, Steer said that it was clear from this early version of the project plan, that the comprehensive nature of the new service model meant that it would not be ready by January 2014:

... I think if one looks to the August project statement ... right from August we've made it very clear that the comprehensive nature – the five elements of the new service model would not be ready within the six months. That was made very clear both within in the project scope, business case and in fact in communication with parents as is evidenced in documentation of our meeting with the parents.⁷⁸

Counsel for West Moreton submitted that throughout the second half of 2013, West Moreton embarked on a transition process "in reliance on authoritative, external advice from Queensland Health ... of the availability of new services in January 2014".⁷⁹

Dwyer's oral evidence was unclear as to her understanding of what new services would be in place by December 2013, however her evidence did show that she understood some alternatives would be available at closure:

FREEBURN: What alternate service options were going to become available at the end of December 2013?

DWYER: I'm not too sure that I can talk to specific service options. There were some that were occurring in the north of the state insofar as Townsville Hospital was opening some additional acute beds, but there was also the ability to engage with the non-government organisations. So I think this was – the statement is made predicated that we were still working at a state level as part of a group that were looking at alternate service options following the recommendations of the expert clinical reference group.

FREEBURN: So is it true to say that there were – you had in mind that there were alternate service options that were going to be available at the end of December 2013 but at this point it wasn't fixed or identified what they were going to be?

DWYER: I think that the recommendations talked about a range of options, many of which were community-based, so this was not particularly talking about a bricks and mortar-based solution. And I think that in other documents you will have seen that although we were, you know, working towards an end of 2013 that **we used the term a flexible closure date because we were going to maintain services for as long as possible until there were alternates available.**

FREEBURN: Can I just ask you what alternate service options were available as at August 2013 and then when Dr Brennan came on in September 2013?

DWYER: As I said, there were service developments happening in the north of the state. There were also, I think, services – supportive services that we were looking at with a step-down service that was not in place in July but was recommended to be of value to some particular adolescents. There was also services that were starting to be developed. It was called a Y-PARC model that we were expecting that would occur within Brisbane South, as well. So I think that following the work of that group there were many other models, including – and I'm not going to get the name correctly right, but there was an assertive outreach model which was really based on a much more of a, you know, intensive service that would be caring for adolescents in the community. And so those were the models that were starting to emerge and be developed.⁸⁰

(emphasis added)

Endorsed project plan

The project plan for AMHETI (the renamed SWAETRI) was endorsed by the Steering Committee and Oversight Committee on 21 October 2013,⁸¹ and by the CHQ Board on 18 November 2013.⁸²

As with the earlier versions, the endorsed project plan specified that the lead governing body for the project was to be "CHQ HHS, in partnership with WM HHS and the Department of Health".⁸³

The plan stated that governance of the new service options was to be held by CHQ and governance arrangements were to be defined as a priority.

The endorsed plan continued to include the following assumptions and constraints, which left open the understanding (for some) that at least some alternative services would be available at the time of the BAC's closure:⁸⁴

- An assumption that, "Not **all** service options within the statewide model that will be proposed will be available by early 2014. However, there is a commitment to ensure there is no gap to service delivery for the adolescent target group".
- A constraint that, "Alternative service options for BAC consumers **must be available** by early 2014, when The Park transitions to an adult-only forensic and secure mental health facility".

(emphasis added)

The endorsed project plan specified a number of objectives (outlined below), which did little to clarify matters:⁸⁵

- Develop service options within a statewide mental health model of service for adolescent extended treatment and rehabilitation, within a defined timeline.
- 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 ...
- Oversee the redistribution of BAC operational funds and other identified funding, to adolescent mental health service models to support the identified target group ...
- Consider in all decision-making the key principles and recommendations as defined through the ECRG and Planning Group ...
- Discharge all adolescents from the BAC facility by 31 January 2014, to enable finalisation of The Park campus as an adult-only forensic and secure mental health service facility.

The endorsed plan stated that implementation of the service options was “out of scope” of the project, and was to occur “as a separate project phase”.⁸⁶ At 2.2, the endorsed plan included key milestones/products/activities to be delivered by the project and relevantly set out:⁸⁷

Interim consumer clinical care plans (for current BAC and wait list consumers)	Anne Brennan	31 December 2013
Implementation Plan for SWAETRI Service Model	Ingrid Adamson	31 January 2014
Mobilisation of Phase Two: Service Options Implementation	Stephen Stathis/ Ingrid Adamson	February 2014

Announcement of the closure (and the replacement services)

Returning to the chronology, on 6 August 2013, the Minister publicly announced the closure of the BAC by way of a radio interview with Rebecca Levingston of ABC 612 radio.⁸⁸ Springborg recalls giving the interview. His evidence is that he told listeners that “the [BAC] would close, and that new services would be provided under a new model of care that was being developed”.⁸⁹

A comprehensive discussion of the Minister’s announcement is in chapter 16. The purpose of this section is to focus on those aspects of the announcement which relate specifically to the replacement services.

Radio interview

While some of the Minister’s comments during his radio interview were not completely clear, he did make a number of statements suggesting that a new model of service would be up and running by early 2014, to align with the closure of the BAC.

At the beginning of his interview, Springborg stated that “it is true that sometime in early 2014 ... [the BAC] will be closing as we actually come up with a range of new options to actually deliver those services to people closer to their own home ... in their own home town”.

One interpretation of this statement is that there was a plan for young people transitioning from the BAC to receive care under the new services/care options being developed, and that these services would be available regionally on closure of the BAC.

Springborg's next response more strongly suggested that the new services would be in place before the BAC closed. Springborg expressly linked patient transition to the new services:

LEIVINGSTONE: So just to be clear Minister, come the end of 2013 the Barrett Adolescent Centre will close?

SPRINGBORG: Probably early – well we expect to have the options available to people in early 2014 and the transition will start sometime in the early part of 2014 as we build up services in other areas around the state.

LEIVINGSTONE: And will you guarantee that there will be services in other parts of the State that provide residential care ...

SPRINGBORG: Absolutely.

LEIVINGSTONE: ... this is not about acute care ... this is about the longer term care plan.

SPRINGBORG: Absolutely.

The next exchange was less clear:

LEIVINGSTONE: So – so just – sorry, to be clear, will you guarantee that there will be services operating that offer inpatient care for teenagers in Queensland before Barrett shuts?

SPRINGBORG: That's the whole point of this is to actually leave no one who is currently a patient or resident there, and those that are, hopefully, on the waiting list so that they can have services closer to their own home and we're allocating an additional two million dollars for that.

... [O]bviously it (the BAC) doesn't meet the needs for children with these complex needs around Queensland ... we have to look locally and there has to be inpatient equivalent support for all of them, and hopefully additional young people around Queensland.

LEIVINGSTONE: ... [H]ow many inpatient facilities will exist in Queensland? What's the plan?

SPRINGBORG: Well we'll be taking – we will be taking the advice of the expert panel who's actually indicating to us whether we need to have more inpatient beds or whether these young people can be supported in residential accommodation in their own local community with the experts in a more homely type environment, so that's the sort of thing that's being worked through at the moment.

His next statement also gave an indication that "something new" would be available before the BAC closed (given his earlier comments that the BAC would be closing early 2014 and because this radio interview occurred in early August):

LEIVINGSTONE: All right so 7 to 8 months before you finalise the plan, is that the point at which you'll be able to tell Queenslanders 'look, this is where those centres will be located'?

SPRINGBORG: Absolutely, and where the options are. An additional 2 million dollars has been put into it ... we'll have a much clearer picture by the latter stage of this year and the final details around it will be the early part of next year.

However, what remained unclear was whether the Minister was communicating that a detailed plan would be available to government in seven to eight months, or whether his intention was to explain that the actual services would be in place (as seems to have been suggested by his earlier comments (above)).

West Moreton HHS and CHQ media release

As discussed in chapter 16, Springborg attached to his statement a copy of a media release by West Moreton HHS and CHQ, dated 6 August 2013. He told the Commission that the issues in the release were “familiar to [him]”.⁹⁰ It is worth setting out key sections because they illustrate, to some extent, West Moreton HHS and CHQ’s understanding at that time:

Statewide governance around mental health extended treatment and rehabilitation for adolescents will be moving to Children’s Health Queensland ... adolescents requiring extended mental health treatment and rehabilitation will receive services through a new range of contemporary service options from early 2014. Ms Dwyer [Chief Executive West Moreton HHS] said the **young people who were receiving care from Barrett Adolescent Centre at that time, would be supported to transition to other contemporary care options that best meet their individual needs ...**

Dr Steer [CHQ Chief Executive] said as part of its statewide role to provide healthcare for Queensland’s children, **Children’s Health Queensland would provide the governance for any new model of care.**⁹¹

(emphasis added)

The use of the phrase “other contemporary care options”, alongside the phrase “new range of contemporary service options”, is confusing. The release is worded in a manner that gives the impression new services are to be available for BAC patients at its closure, however it also leaves room for an alternative interpretation that new services would be available “from early 2014”.⁹²

During oral evidence, Trevor Sadler was asked by senior counsel for West Moreton, whether at the time of the announcement, he understood that a Y-PARC “was definitely on the agenda, or a version of it”. Whilst Sadler agreed that a Y-PARC was on the agenda, he told the Commission that he “didn’t consider that YPARC was on track as an option because it required a building and there was no capital works for a building”.⁹³

In any event, it is clear that at this point in time CHQ publicly took over responsibility for developing the new models of care.

Impact of the announcement

Counsel for West Moreton submitted as “as at 8 August 2013, Ms Dwyer believed, on the basis of information provided directly by Dr Kingswell ... that a YPARC would be operational by January 2014 and she was aware that assertive outreach models were being developed by CHQHHS. The timing being targeted for closure of the BAC was January 2014, and the timing for commencement of YPARC as advised to Ms Dwyer at that time, supported that the new service would be operational coincident with the closure of BAC”.⁹⁴ West Moreton submitted that “it became apparent later in 2013 that the YPARC would not proceed in that anticipated timeframe”.⁹⁵

On 9 August 2013, Corbett sent a letter to a parent which summarised the announcement by the Minister in the following terms:

As announced on 6 August 2013 there will be changes to the governance of Mental Health extended treatment and rehabilitation for adolescents. Children’s Health Queensland will provide the leadership for development of a new model for adolescent services. In the meantime the Barrett Adolescent Centre will continue to provide services **until this model is operational**.⁹⁶

Thus, West Moreton’s understanding as at August 2013 was that new services would be up and running by the time the BAC closed. It is unlikely that Corbett would have sent this letter had she then known that new services would not be up and running by the time of the BAC’s closure.

Steering Committee & Oversight Committee Meetings

26 August 2013 –1st Steering Committee meeting

The first Steering Committee meeting was on 26 August 2013.⁹⁷

Attendees included Krause and Stathis (as co-chairs),⁹⁸ Jaimee Keating (secretariat), Geppert (from West Moreton HHS), Trevor Sadler (Clinical Director, BAC), Josie Sorban and Deborah Miller (both from CHQ), and a carer representative.⁹⁹

While there is minimal detail in the minutes about the development of the new service models, the minutes include a recommendation that: “New service options need to consider implications of ABF [activity based funding] and other funding criteria”.¹⁰⁰ Beneath the heading ‘For Information’, there is brief reference to a Y-PARC model and a bed-based facility in Logan. The minutes note a recent site visit to Victoria to review Y-PARC and other contemporary models for adolescent extended treatment and rehabilitation.¹⁰¹

There is some recognition in the minutes of a need for an “interim” replacement for the BAC, pending the development of the new services. Specifically, the minutes record discussion about negotiation by Queensland Health with the Chief Executives of CHQ, West Moreton HHS and Metro South HHS for a bed-based facility at Logan Hospital, to be used as an interim site for the BAC.¹⁰²

However, the minutes make clear that the Steering Committee was “not involved in influencing this interim planning” and that decisions regarding governance and finances still needed to be decided at the chief executive level.¹⁰³ This is further evidence that CHQ (through SWAETRI) considered itself not to have responsibility for the development of new services specifically for the type of patients who might access the BAC.

30 August 2013 – CHQ Site visit to Logan

On 30 August 2013, Stathis, Geppert, Adamson, Trevor Sadler, Kevin Rodgers (principal, BAC school) and Vanessa Clayworth (acting Nurse Unit Manager, BAC) conducted a visit of the proposed interim site at Logan Hospital.¹⁰⁴

In the course of arranging the site visit by email, both Stathis and David Crompton (Executive Director Addiction and Mental Health Services, Metro South HHS) expressed reservations about the appropriateness of the proposed interim site at Logan Hospital for adolescent beds after the BAC closed.¹⁰⁵

At the next Steering Committee meeting, on 9 September 2013, Sadler requested an update in relation to the interim site. The minutes of that meeting record advice from Geppert that this was in the remit of the Queensland Health Chief Executive Oversight Committee to decide¹⁰⁶ (not the Steering Committee).

September 2013 – Consideration of an alternative bed-based service

On 4 September 2013 Stathis sent an email to Dwyer and Steer, setting out four options for a “bed-based service” in South East Queensland.¹⁰⁷ This email, and the correspondence that followed, is worth setting out in some detail as it provides insight into the circumstances in which the new services were being developed, and the realisation that a bed-based alternative might not otherwise be available by January 2014.

The *first* option outlined was the existing site at Logan Hospital as “an interim location” for the service. Stathis noted as disadvantages the fact that the site was still fully occupied as an acute unit and was unlikely to move elsewhere until “sometime in October” which would give only three months to completely refurbish the site. Stathis expressed the view that “with the Christmas/NY break, I just can’t see plans being drawn up, designs [g]oing out to tender, refurbishment completed, and staff relocated by the 26 January ‘deadline’”. He went on to outline a number of further disadvantages including that:

- the proposed Tier 3 service would have significant NGO input and negotiating this in Queensland Health acute hospital setting would be difficult
- refurbishment costs had not been discussed and if Queensland Health spent significant money on a refurbishment they would be unlikely to see the facility as ‘interim’
- using an old ward in a hospital would send a wrong message, given that CHQ was aiming to develop a community, bed-based extended rehabilitation and treatment model.

The *second* option outlined was interim NGO housing, which Stathis noted would be quicker to establish and would support a community, bed-based model. However he identified a number of disadvantages including:

- costs and the difficulty with convincing Queensland Health to spend money on an interim model
- upgrades that would be required to meet hospital standards regarding hanging points and so on
- the difficulty associated with a residential house accommodating ten beds.

The *third* option outlined by Stathis was a new custom built unit, similar to Y-PARCS in Victoria. He noted this would avoid costs for refurbishment of an interim site but that there would be disadvantages including that:

- because the third option would take time to implement, the Barrett would need to stay open longer
- there were different opinions as to sites, with Stathis noting that Kingswell was in favour of establishing the site in Metro South, whilst he considered it preferable for the facility to be established in the CHQ catchment.

Stathis expressed a preference for this third option. However, he outlined a *fourth* option, similar to option three, but with Barrett closing in January and young people being supported by an expansion of Tier 2a and 2b and some mobile outreach. Stathis noted as a specific disadvantage

that “the ECRG had noted significant risks if Barrett closes without the support of another Bed Based Tier 3 service (clinical and political risks)”.

In relation to timing, Stathis noted that Geppert was “committed to have a model written up for a Tier 3 service by the end of September/early October, in time for when [Stathis got] back from leave (8 October). We will also be working on an IMYOS, Day Unit and Resi model as well. I have given an undertaking to the CHQ Board that we will have a model developed (and hopefully costed) to present to their October Board Meeting (last week in Oct, I believe)”.

On 4 September 2013, Kelly replied:

I guess the challenge for us is that we have asked an implementation steering committee to consider the ECRG recommendations and come up with the best options and implementation plan, so I would feel we would need to be cautious in outlining our preferred options at this point in time. I do recognise however that the issues around Logan are time sensitive, so a tricky spot. [T]he big challenge we have is there is a finite amount of funding for all of the options and a new build such as proposed with the appropriate staffing attached etc would potentially find us short to support all of the other modelling and tier options we have put forward. On an alternate note keeping the current facility open for an extended time post January with complete confidence in the safety of the clinical services being delivered will prove a challenge for WMHHS.

September 2013 – Differing understandings as to timing of the new services

Evidence of Kingswell – Frustration at lack of progress

On 14 September 2013, Kingswell sent an email to Scott Harden (a child and adolescent psychiatrist and member of the ECRG), in which he stated there to be “room for concern as to how we effectively provide replacement services” for the BAC.¹⁰⁸

In oral evidence, Kingswell explained that when he sent this email, he was frustrated that no one was prioritising concrete replacement services in time for the BAC’s closure and was instead, focusing only on the new suite of services to be developed by CHQ. His frustrations continued to November 2013 and beyond:

FREEBURN: What was the concern that you had?

KINGSWELL: I think I made those pretty clear, that we had the – **Children’s Health Queensland working on this whole of state model and nobody was focusing their attention on getting, you know, concrete replacement services ... in train in a timely way that would allow these young people to transition out of this – out of this institution which I believed to be failing.**

FREEBURN: So in September, and we see in November you are concerned and frustrated with the transition arrangements; correct?

KINGSWELL: No, I’m not frustrated with the transition arrangements at all. That’s a – **I was frustrated with the speed at which people were getting on with putting in place replacement services.** So I think – we can go around the paddock a million times, if you like. The Aftercare service was envisaged to be in place by 2 or 3 February, and it was not; it didn’t come on board until March. But that was being procured in November. It should have been

procured months earlier. That would have allowed for some of the young people to transition to – into a service like that. That was my issue. It was not with the planning that was going on. The planning I was absolutely confident would – was being done absolutely meticulously.

FREEBURN: Dr Kingswell, the transitioning of these patients was occurring at least from the time Dr Brennan arrived in, I think, 11 September 2013?

KINGSWELL: Yes.

FREEBURN: So the services really needed to be available from then?

KINGSWELL: Absolutely. Couldn't agree more.

FREEBURN: And - -?

KINGSWELL: And why we were still talking about that in November was a source of significant frustration.

FREEBURN: Right. And what is it that you did about that, in summary?

KINGSWELL: Well, once it was put to me that they did not have a concrete plan, they hadn't worked on a concrete plan, they hadn't even started the procurement process, I agreed with Lesley Dwyer that we push that up through – so neither Lesley nor I had sufficient procurement delegation to do that ourselves. I needed to push that up through Michael Cleary; that's what we did. And an agreement was subsequently signed with Aftercare to bring that service on at Greenslopes by 3 February. And then that project, of course, slipped until March.¹⁰⁹

(emphasis added)

During cross-examination by senior counsel for West Moreton, Kingswell gave the example of the "youth resi", which he considered CHQ could have progressed as a matter of urgency, using "a kind of cookie-cutter contract arrangement" to mirror the facility already operating in Cairns.¹¹⁰

Also during cross-examination, Kingswell reiterated "enormous frustration" with people focusing on "building a service for the whole of State rather than attending to the urgent issue, which was what were we going to do with the cohort that was occupying the Barrett Adolescent Centre and those that were on the waiting list".¹¹¹ Kingswell gave evidence that services should have been commissioned earlier:

It wouldn't have been [finding places for these young people] if we'd started commissioning services as early as August when we knew that the decision had been announced by the Minister. So we should not have been in this situation that three months had gone by and nobody had spoken to the non-government sector about the commissioning of the services and nobody had identified the funding or got that moving. That was an enormous frustration.¹¹²

Thus, it is clear that up until September 2013, it was Kingswell's understanding (and presumably that of the MHAODB) that steps were being taken (presumably by CHQ and the SWAETRI) to develop replacement services in time for the BAC's closure.

Evidence of West Moreton

Not all witnesses from West Moreton shared Kelly's understanding.

Dwyer confirmed that, in September 2013, she was aware that planning of the new suite of statewide services was still progressing and that no new services had yet started.¹¹³

At the time of her arrival, in September 2013, Anne Brennan appreciated that the new services being developed by CHQ would not be an option for the BAC patients.¹¹⁴ Counsel for the State of Queensland relied on the following (and other) evidence of Brennan, to submit that there was no misunderstanding, by September 2013, as to the timing for the availability of the new services:

- MUIR: Is it the case that you knew that replacement services were still being developed at the time you were transitioning patients from the Barrett Centre?
- BRENNAN: Yes, I was aware they were being developed and that they were not ready for this cohort.
- ...
- MUIR: What was your understanding of the SWAETRI steering committee's brief? Did you know that – or think that the committee was tasked with developing and implementing new replacement services to support your task of transitioning patients out of the Barrett?
- BRENNAN: ... [M]y understanding was that they were developing the new services which I did not think were going to be available for this cohort. So they weren't really developing services for these people though there were some of this cohort who may use other services in the interim and when new services developed by SWAETRI came online, yes, they may have been appropriate for them.¹¹⁵

An email chain dated 17 October 2013, reflects that in about mid-September 2013, Brennan and Hoehn agreed that it would be best to "keep two separate streams going" and that Brennan would be committed to care of the BAC patients and Hoehn and others would work on strategies for the new models of care and development of such services.¹¹⁶

Thus, whilst earlier West Moreton HHS had understood new services would be available to replace the BAC, it seems that by September 2013 at least Brennan and Hoehn accepted this would not be the case. In contrast, Kingswell's evidence indicates that the MHAODB was of a different view, with Kingswell expressing frustration at the delay in the delivery of the new services and the realisation that they were unlikely to be available in time for the BAC patients.

9 September 2013 – 2nd Steering Committee meeting

The second meeting of the Steering Committee was on 9 September 2013.¹¹⁷ West Moreton HHS was represented by Geppert, who acted as chair.

On 9 September 2013, Ingrid Adamson was appointed by CHQ to a project manager role, and secretariat of the Steering Committee (and Oversight Committee). In this role, Adamson had a range of responsibilities, including being the "interface" between CHQ and West Moreton, service options development, service establishment and service evaluation.¹¹⁸

The minutes record discussion about the membership and roles of the three working groups, as well as a discussion about “recommending models”. There is a decision that the Service Options Implementation Working Group will “determine the best service model for adolescent needs, even if there is no capital to support recommendations at this point in time”.¹¹⁹

23 September 2013 – 3rd Steering Committee meeting

The third meeting of the Steering Committee was held on 23 September 2013.¹²⁰ The minutes record discussion about the committee’s terms of reference and clarification that the role of the committee is to endorse and recommend options to the Oversight Committee for decision-making.

9 October 2013 – 4th Steering Committee meeting

The fourth meeting of the Steering Committee was held on 9 October 2013.¹²¹

At this meeting some concern was expressed about the timing of the replacement services. Adamson recalled that Geppert communicated to the committee, that West Moreton HHS was receiving increasing requests from the parents of BAC patients, to confirm a date that the BAC’s doors would close and their children transitioned.¹²²

The minutes include reference to a discussion between Amanda Tilse (Operational Manager, MHAODB) and Krause about the timing of the announcement of a replacement service for the BAC. Krause gave advice that “there will be no one singular replacement service but rather a range of services, which we are incrementally working toward”. Geppert responded that there “will be additional service options; however, there won’t be a bed based option in the short term – this is not possible to deliver in the next 3 months”.¹²³

Thus, it was clear by October 2013 that not only would all alternative service options not be available, but there would also be no bed-based option available by the time the BAC closed in January 2014.

Despite Geppert’s suggestion at the previous meeting that CHQ undertake responsibility for correspondence about the BAC, the minutes record a decision that West Moreton HHS was to retain “correspondence responsibility” in regard to the BAC.¹²⁴ Thus it was West Moreton HHS’s responsibility to respond to correspondence received from community members about the closure of the BAC. The minutes record that, by 21 October 2013, CHQ was to finalise a “broader communication regarding the statewide service development and approach for the community and consumers/carers”.¹²⁵

17 October 2013 – 1st Oversight Committee meeting

The Chief Executive and Department of Health Oversight Committee (the Oversight Committee) met on only three occasions.¹²⁶ The first meeting was on 17 October 2013.¹²⁷ CHQ members included Steer (as chair), Adamson (as secretariat), Miller and Stathis. Dwyer and Geppert were the West Moreton HHS representatives. Richard Ashby attended for Metro South HHS, Michael Cleary attended on behalf of the Department, and Julia Squire was the member from Townsville HHS.

Role of the Oversight Committee

According to Stathis, the role of the Oversight Committee was to provide strategic leadership and governance for the Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy.¹²⁸ The terms of reference for the Oversight Committee, endorsed on 17 October 2013, describe its functions as follows:

- Provision of executive leadership, strategic advice and advocacy in the implementation of Statewide Adolescent Extended Treatment and Rehabilitation (SW AETR) service options.
- To identify the priorities and objectives associated with the development and implementation of SW AETR services, and to endorse plans and actions to achieve these objectives.
- To oversight the development of a contemporary model of care for SW AETR services within the allocated budget.
- To provide a strategic forum to drive a focus on outcomes and achievements of the transition of SW AETR services to CHQ HHS.
- To facilitate expert discussion from key executive[s] around planning, development, and implementation of SW AETR services.
- To oversee the management of strategic risks.
- To monitor overall financial management of the transition of AETR services from West Moreton HHS to CHQ HHS.
- Provision of guidance and oversight for communication and stakeholder planning.
- Provide an escalation point for the resolution of issues and barriers associated with implementation of the SW AETR services.¹²⁹

According to Stathis, the purpose of the Oversight Committee was to “provide strategic leadership and governance” for the SWAETRI strategy.¹³⁰ In her written statement, Adamson explained that the Oversight Committee would provide guidance to the Steering Committee “around new or enhanced services being developed and would be provided with a status update on the consumer transition process from West Moreton”. According to Adamson, the Steering Committee would “escalate any issues with regard to service planning to the Oversight Committee for resolution”.¹³¹

Ian Maynard (Director-General) gave oral evidence that members of the Oversight Committee were the “key responsible officers for the provision of mental health services and care to adolescents and young people and the actual delivery of that service”.¹³² Kingswell’s oral evidence was that the Oversight Committee meetings “were designed to discuss the replacement services”.¹³³

At the initial meeting on 17 October 2013, the Oversight Committee endorsed the SWAETRI project plan,¹³⁴ and recommended that a “draft model of service be available for review at the next Oversight Committee meeting”.¹³⁵ The minutes clarify that the service model is to be “in line with the National Mental Health Framework”, “developed for consumer need”, and that a “bed-based option [is to form] part of the proposed service model”.¹³⁶

Recognition of transition care needs

According to Hoehn, there was “some urgency” in October 2013 “for Children’s Health Queensland to ensure that new services for patients were up and running where possible prior to their transition from the BAC”. Hoehn explained that Stathis was “significantly involved in this process”, and that she remained “in a consultation liaison role between West Moreton and Children’s Health Queensland”.¹³⁷

Steer is recorded in the 17 October 2013 minutes as asking “how transition care needs could be managed until future service options were available.¹³⁸ The minutes note discussion of an option for an HHS to “set aside 4 to 5 beds specifically for extended treatment and rehabilitation until longer term solutions were established”. There is also mention of the Mater inpatient unit possibly being made available. The minutes reflect agreement that the Logan site was “not a suitable solution to the interim needs of BAC consumers”.¹³⁹

Discussion about a bed-based option

At this meeting there was general discussion about bed-based options, with Stathis advising that it “makes sense to have one bed-based facility in Queensland” in terms of “economies of scale and expertise”.¹⁴⁰ Options discussed included:

- an HHS setting aside four to five beds until longer term solutions established
- use of the Mater inpatient unit in November as a longer term option
- outsourcing beds and in-reach CYMHS services.

The Oversight Committee agreed that further investigation for bed-based options was to be undertaken by Stathis by 1 November 2013.¹⁴¹

The Oversight Committee also discussed the use of acute inpatient units or NGOs as an alternative to a bed-based options. A range of other issues were discussed including the concern that the NGO sector was “not as mature in adolescent services at this stage”, and Stathis’ advice that “Acute Inpatient Units do not provide an appropriate environment for extended treatment and rehabilitation”,¹⁴² and that “there will be a small group of adolescents requiring a bed-based service over and above what Day Program Units can provide”.¹⁴³

The minutes note a suggestion by Geppert that three current complex cases at BAC be used to “test the thinking around the [new] model”.

21 October 2013 – 5th Steering Committee meeting

The fifth meeting of the Steering Committee was on 21 October 2013.¹⁴⁴ The minutes record a brief discussion about an invitation to parents of current BAC patients to present a submission at the following meeting.¹⁴⁵

A “Statewide Adolescent Extended Treatment and Rehabilitation Initiative” was provided to committee members ahead of the meeting, which was set out in three parts. The *first* part gave an update on the status of the BAC patients. It noted that the West Moreton Board was “committed to ensuring that all young people in BAC have alternative service options in place before the closure ...”. The *second* part outlined the service options, and noted that a forum had been convened for 1 October 2013 to explore current service options available and future opportunities. The *third* part dealt with the next steps, which included refinement of service options into a service model, for endorsement by the end of November 2013.¹⁴⁶

22 October 2013 – Memo from Kelly to Chief Executives & Clinical Directors

On 22 October 2013, Kelly sent a memo to all chief executives and clinical directors of services across Queensland which stated, in part:

As you may be aware the West Moreton [HHS] is working towards closing the [BAC] building by the end of January 2014. This is a flexible date that will be responsive to the needs of our consumer group and will be development on the availability of ongoing care options for each young person currently at BAC.

WMHHS remains committed to safe, smooth and individually appropriate transitions of care for each young person currently attending BAC. In order to meet this goal, there will be no further admissions to BAC services ...

[CHQ] has **commenced work** with stakeholders from across the State **to develop** the future model of adolescent extended treatment and rehabilitation services. **Further information about these developments will be provided by CHQ in the near future.**

Until then, please contact Dr Stephen Stathis on [email address] to discuss any clinical issues for patients who may require extended mental health treatment and rehabilitation, and are unable to be managed within your health service.

If you have any other questions regarding BAC, please contact me ...¹⁴⁷

(emphasis added)

31 October 2013 – CHQ Board meeting

On 31 October 2013, there was a meeting of the CHQ Board.

A Hospital and Health Board briefing note, notes (among other matters):¹⁴⁸

- ... Following a site visit to [the Logan Hospital], it was determined that a number of factors will prohibit the use of this area ...
- **It is considered that an interim bed-based residential measure will not be available prior to the closure of the BAC at the end of January 2014.** In the meantime, Clinical Consumer Care Panels have been established to work with current BAC and waitlist consumers and their families regarding their ongoing treatment and care needs.
- Work has commenced on identifying possible future service options ...
- The [Y-PARC] has been previously discussed. A statewide bed-based option, loosely based on the Y-PARC model, will be considered as part of the continuum of service options being considered. ...

Timelines

- The timeframe for closure of the BAC is end of January 2013 [sic, 2014], with no further admissions being accepted.
- A variety of service options are currently under consideration and it is anticipated that a future model of service for adolescent extended treatment and rehabilitation will be developed for endorsement by end November 2013 ...
- Subject to endorsement, **the implementation of new or enhanced service options will commence by end January 2014.**

(emphasis added)

The meeting minutes record a “commitment ... by West Moreton HHS that the BAC will not close if there are delays to providing alternative care arrangements for consumers”.¹⁴⁹ They also note the progress of SWAETRI and a request from the chair (Susan Johnston) for a “fully developed model with costing” to be provided at the November 2013 board meeting.¹⁵⁰ In oral evidence, Stathis confirmed that the CHQ Board had asked SWAETRI to “develop broad costings for the five tiers”, which he said was submitted in November 2013.¹⁵¹

4 November 2013 – 6th Steering Committee meeting

At the Steering Committee meeting on 4 November 2013, two parents gave a presentation (for 30 minutes).¹⁵²

One of the parents gave evidence that they discussed their child’s experiences prior to and at the BAC, the apparent disconnect between the closure of the BAC and the development of new services, their concerns about the time it would take to develop new services and the poor of consultation with BAC patients and stakeholders in relation to the decision to close the BAC and in the development of new services.¹⁵³

Krause recalled that the parents were given time to present to the Committee and “to be informed about the progress towards the re-development of the replacement services”. She said the parents talked about the importance of inpatient longer stay beds, and the importance of on-site schooling opportunities. According to Krause, all issues raised by the parents “are included in the replacement services or were available in existing services at that time”.¹⁵⁴

According to Adamson, the purpose of the presentation was to provide the families with “an opportunity to engage with the Steering Committee and for the Steering Committee to obtain a ‘family perspective’ to assist with the development of improved mental health service options for adolescents”.¹⁵⁵ Adamson’s evidence was the parents’ submission for a Tier 3 facility with on-site schooling was “covered” in the AMHETI by subacute beds at the Mater Hospital and later the Lady Cilento Hospital.¹⁵⁶

The minutes record that after the parents left, Geppert advised:

[C]are planning is underway and ... there is no imperative to have children out by 13th December. This date is the end of the school term ... [I]f at the end of January, they still have consumers then they will keep the BAC doors open to care for them.¹⁵⁷

November 2013 – Planning for interim services

By 12 November 2013, it was abundantly clear that the closure date for the BAC and the start date for the new services were not aligning. Senior executives and staff, including the West Moreton HHS executives, the West Moreton Board and the MHAODB were plainly aware of that non-alignment.

In an email from Kingswell to Cleary on 12 November 2013 (sent relatively soon after BAC patients started transitioning under Anne Brennan) Kingswell wrote:

I met with Lesley [Dwyer] and her team today. She has had advice from Peter Steer that he will not have a model plan in place to address the closure of BAC for 12 months. That is not a solution useful to Lesley.

...

Lesley proposes 1. A 6 month pilot project to deliver a residential support option ... Given this would need to be operational by about Australia Day, it will need to be a type 4 procurement. There will not be time to go to tender ... 2. A 6 month pilot of day program that would use existing West Moreton space in their community MH centre and be staffed jointly HHS and NGO ... If you are happy with this approach, Lesley's and my team will work on a DG brief to go ahead with the type 4 procurement.¹⁵⁸

That day, Kingswell made an iPad note along similar lines:

Meeting with Lesley, Sharon and Leanne re BAC 12/11/13. Flurry of BAC letters as we approach end of school year. What happens with day program from 13 Dec?
Should West Moreton run a day program as a transition?
Peter Steer thinks 12 months to get a replacement program in place propose pilot a therapeutic day program + option of resi program. Some discussion has already occurred with Aftercare who would lease a 4 bed house.¹⁵⁹

When asked by Counsel Assisting about his email, Kingswell said that the advice that a model plan would not be in place for 12 months was a "terrible concern" and "was not an answer that was tolerable". Kingswell explained that he took steps to assist Dwyer with the procurement of various interim services, including the procurement of Aftercare to run a five-bed residential rehabilitation service at Greenslopes.¹⁶⁰

In respect of the iPad note, Kingswell expressed his concern even more strongly:

KINGSWELL: That's just more of the same, really. That, you know, it was very late in the process. And this was some of – you know, kind of – this was some of my frustrations that there was this focus on building a service for the whole of the State rather than attending to the urgent issue, which was what were we going to do with the cohort that was occupying the Barrett Adolescent Centre and those that were on the waiting list. This was an enormous frustration. This went on for some time. It was a group of people that thought they had a job, yeah, and maybe they did, but it wasn't the urgent job. They weren't attending to what was right in front of them.

FREEBURN: Well, wasn't the problem that they had finding places for these young people?

KINGSWELL: It wouldn't have been if we'd started commissioning services as early as August when we knew that the decision had been announced by the Minister. So we should not have been in this situation that three months had gone by and nobody had spoken to the non-government sector about the commissioning of the services and nobody had identified the funding or got that moving. That was an enormous frustration.

FREEBURN: Did you voice that frustration at the time?

KINGSWELL: Well, I think my email to Michael Cleary is pretty clear. And I remember texts exchanged between he and I during these meetings that we just couldn't understand why they didn't get it – why they didn't understand the urgency of the task in front of them.¹⁶¹

When asked about Kingswell's email during cross examination, Steer gave the following evidence:

- STEER: ... [R]ight from August [referring to the August project plan] we've made it very clear that the comprehensive nature – the five elements of the new service model would not be ready within the six months. That was made very clear both within the project scope, business case and in fact in communication with parents ...
- FREEBURN: Well, at this time, wasn't Children's Health Queensland saying to West Moreton that some of the future service options won't be fully operational for possibly 12 months?
- STEER: We were clear about that particular issue, as I've said to you, from documentation as early as August 2013 so that should not have been news to Lesley Dwyer and I'm sure it wasn't news to Lesley Dwyer or anybody as – as late as November 2013.¹⁶²

Thus, it is clear that up until at least November 2013, the MHAODB and CHQ had very different understandings of the urgency within which CHQ was to work in developing the new services, and the link between the services and the BAC's closure.

As will be discussed below (and consistent with the evidence of Kingswell), around the same time as the advice from Steer in November 2013 (that services would not be developed for 12 months), West Moreton took steps to implement an interim solution for the BAC patients.

As discussed in chapter 27, this had implications for the proposed Y-PARC services as, from this point on, AMYOS, the Youth Resi and the Day Program were prioritised as 'phase 2', and Y-PARC became planned for the later 'phase 3'.

Briefing to Director-General

On 20 November 2013 a briefing note for approval by the Director-General was requested by the Director of the Funding and Contract Management Unit, Governance Branch, with action required by 25 November 2013.¹⁶³

The briefing note proposed that the Director-General:

Approve by exercising non-recurrent financial and type 4 procurement delegations, up to \$2,087,776 excluding GST (\$2,296,553 including GST) to commence negotiations with Aftercare to provide extended residential mental health treatment and rehabilitation services for adolescents referred from the West Moreton Hospital and Health Service, from December 2013 to the end of December 2014.

It noted that "Type 4 procurement delegation is sought on the basis of sole source of supply and genuine urgency". The briefing note was marked as "Critical" on the basis that "the Barrett Adolescent Centre (BAC), West Moreton HHS (WMHHS) will close by the end of January 2014 and this transition plan will ensure there are no gaps to service delivery for adolescent consumers while new service options are being developed by Children's Health Queensland Hospital and Health Services (CHQHHS)".

Under 'Headline Issues' the brief included the following:

- The Minister and WMHHS Board gave a public commitment to ongoing provision of safe and comprehensive clinical care for BAC consumers during the transition to the new state-wide adolescent extended treatment and rehabilitation services. CHQHHS has advised that the full range of new state-wide services is not expected to be operational until 2015 ...
- Interim investment in Aftercare will maintain clinical safety for BAC and other state-wide consumers during the transition period. Aftercare is able to meet the time frames expected by the Minister for delivery of the services.

Communication to stakeholders

Fast Facts 10, issued by West Moreton HHS on 20 November 2013 communicated a similar message, stating:

- Recent information received from CHQ HHS has indicated that some of the future service options will not be fully operational for possibly 12 months. Following through with our commitment to ensure there is no gap to service delivery [West Moreton HHS] will work with other service partners to provide transitional services ... while the future services are finalised.¹⁶⁴

This appears to have been the first time the public, patients and families, were told about the lack of alignment between the implementation of the replacement services and the BAC's closure.

15 November 2013 – 2nd Oversight Committee meeting

The Oversight Committee met for the second time on 15 November 2013. Stathis gave an overview of the proposed SWAETRI service model.¹⁶⁵ The minutes include a recommendation that:

- by 29 November 2013, Geppert is to prepare a West Moreton HHS transition plan
- by 20 December 2013, Adamson is to prepare a Service Overview Model and Implementation plan
- by 20 December 2013, Geppert and Adamson are to prepare an overarching document to link the two plans.¹⁶⁶

18 November 2013 – 7th Steering Committee meeting – proposed model of care

The Steering Committee met again on 18 November 2013.¹⁶⁷ Stathis is recorded as taking the committee through the elements of the proposed model of care, which included:

- Assertive Mobile Youth Outreach Service (AMYOS)
- Day Program
- Step Up/Step Down
- Subacute Bed-based Unit
- Residential Rehabilitation Unit

The minutes record observations made in relation to the timing of the proposed model and make a clear distinction between the services being developed by SWAETRI under CHQ, and the interim services being developed by West Moreton HHS:¹⁶⁸

- Due to the time frames regarding new service options, WM HHS is proposing to develop a transition plan of services and retain governance for these services until such time as consumers and new service options are ready for transition to occur.
- The first element is a time-limited, activity-based holiday program at The Park in December 2013/January 2014.
- As of the beginning of February 2014, WM HHS proposes to establish a pilot day program, and pilot community outreach team, and, if feasible, a supported accommodation option. All of which will be located in the WM HHS catchment.
- The intention is to ensure there is no gap in services provided to consumers.
- ...
- The target group will predominantly be current BAC consumers, and it is not intended that these services will interfere with the transition plans under development.

(emphasis added)

18 November 2013 – CHQ Board meeting

The CHQ Board met on 18 November 2013 to endorse the updated project plan. Stathis gave evidence that it was not feasible for CHQ to have progressed the implementation of the new services until the Board's endorsement had been received:

So if I just give you the context of that, the project plan wasn't endorsed – or wasn't given in-principle endorsement by the board of CHQ until November 2013. It would've been reckless to go ahead with un-trialled new services with an unknown workforce until endorsement of that plan was provided by the board. It would've put the board and CHQ at significant clinical and reputational risk.¹⁶⁹

Board paper – proposed model of care

Presumably in preparation for this meeting, in November 2013, Deborah Miller (A/Executive Director, Office of Strategy Management, CHQ) prepared a board paper which comprised an update on the development of the new model of care. The board paper records that, on 15 November 2013, a proposed model of care was presented to the Oversight Committee, which included the following five options for adolescent extended treatment and rehabilitation:

1. **Assertive Community Treatment Service (ACTS)** – a new service option providing mobile interventions in a community or residential setting; resourced with a minimum of two full time employees per ACTS team;
2. **Day Program** – an expansion of existing services with the addition of three day program units in South-East Queensland region; treating up to 15 adolescents per day per unit;
3. **Step Up / Step Down Unit** – a new service option providing short-term residential treatment by mental health specialists in partnership with a non-government organisation (NGO); up to 14 beds per unit located where there is NGO support;
4. **Subacute Bed-based Unit** – a new service providing medium-term, intensive, hospital-based treatment in a secure and safe environment; up to 10 beds on a hospital campus within the [CHQ] catchment area; and

5. **Residential Rehabilitation Unit** – a new service providing long-term accommodation and recovery-oriented treatment in partnership with NGOs together with inreach services provided by mental health specialists; up to 10 beds per unit located where there is NGO support.

The above services are supported by existing Community Child and Youth Mental Health Services and acute inpatient units located throughout Queensland.¹⁷⁰

The board paper confirmed that the Oversight Committee had endorsed the new model “in principle”, subject to further work exploring the implementation requirements of the service options. It stated that, in the interim, West Moreton HHS was developing “a transition service model” for existing BAC patients. It described the transition service model as a “phased process”, commencing with a holiday program at the BAC. It confirmed also that:

- over the school holidays, West Moreton HHS was establishing an Intensive Outreach Team and a Day Program based at Goodna, in preparation for the closure of the BAC at the end of January 2014
- concurrently, West Moreton HHS was exploring “supportive accommodation (comprising three or four beds) in partnership with a non-government organisation”, which would remain in place until the future service options were implemented.

The board paper stated that the next steps were for CHQ to undertake broad consultation on the proposed model of service (including engagement with consumers, families and carers), and to develop a service implementation plan, inclusive of a business case, which would identify funding options for service implementation over a four-year timeframe.¹⁷¹

28 November 2013 – CHQ Board meeting

The CHQ Board met on 28 November 2013. The minutes record the following plan, led by Stathis:

- By 13 December 2013, West Moreton [HHS] will have developed a transitional plan for the BAC, accounting for the six week holiday period over Christmas and New Year;
- By 1 February 2014, all existing day units and acute care units in the state will be participating in the SW AETR initiative ...¹⁷²

29 November 2013 – Advice to the West Moreton Board

In preparation for the 29 November 2013 meeting of the West Moreton Board, Kelly prepared an agenda paper which advised the Board that alternative services would not be on line by the beginning of 2014, and that West Moreton HHS was therefore engaged in interim service planning:

West Moreton HHS has been recently informed that the new state-wide service options may take a further 12 months to be fully established. In order to ensure there is no gap to service delivery, West Moreton HHS has commenced planning interim service options for current BAC patients and other eligible adolescents across the state that would benefit from extended treatment and rehabilitation. Consultation has occurred with the Department of Health and CHQ.¹⁷³

Interim services were listed as follows:

- Activity Based Holiday Program (Phase 1 from mid December 2013 to January 2014)
- West Moreton HHS Transition Service incorporating intensive mobile outreach service, day program and supported accommodation (Phase 2 from February 2014 until December 2014)
- Transition to Statewide Adolescent Extended Treatment and Rehabilitation Services (Phase 3 mid to late 2014).

Evidence of Stathis

In respect of the interim services, Stathis' evidence was that "The Transition Services Plan was a draft of services proposed by WMHHS ... [and] was a very time limited plan that did not evolve or develop".¹⁷⁴ His evidence was that West Moreton HHS developed the Transition Services Plan as:

part of their transitional planning – looking at how they were going to support the Barrett Young People ... But this is something that was evolving over time ... By December 2013 when ... we presented that plan on 11 December to the parents at the Barrett ... CHQ was starting to take ownership of the implementation of further services because the young people in Barrett were slowly being successfully transitioned into existing services within the community.¹⁷⁵

When asked why West Moreton was presenting options, when it was CHQ that had responsibility, Stathis explained:

[T]hat's precisely what happened. You see, West Moreton were so committed at developing transitional plans for their young people that they initially decided to look at the possibility of using a range of services – day programs, resi services within West Moreton HHS. Then they ... And then by November/December 2013, West Moreton recognised that: first, CHQ was taking responsibility of the implementation of a range of new services. Second ... West Moreton were able to transfer a number of young people from Barrett very rapidly out. And, thirdly, the few young people that remained, they were able to develop their own individual transitional plans.¹⁷⁶

Evidence of Corbett and Eltham

Corbett and Eltham were questioned about the agenda paper presented to the West Moreton Board in November 2013.

Counsel for the State of Queensland submitted that during her oral testimony, Corbett "seemed unconcerned about the practical effect of the 'recent' information about the new statewide service options".¹⁷⁷ In making this submission, they relied on the following transcript extract:

- FREEBURN: Now, you'll see there it says at the beginning of the paragraph that: "West Moreton HHS has been recently informed that the new statewide service options may take a further 12 months to be fully established." Did that cause you a concern?
- CORBETT: Well, if you look at the following sentence that says there is no gap to service delivery. We have interim service options that lessened any concern.
- FREEBURN: Well, it doesn't say that, does it? It says that: "The West Moreton HHS has commenced planning interim service options."
- CORBETT: Yes. Well, that was in November. The Barrett Centre was still open at that point.

FREEBURN: But this is in the middle of the process. Some patients had already been transitioned and some were to be transitioned?

CORBETT: So the patients who had been transitioned had been transitioned anyway. They obviously didn't need the service option, otherwise they would not have been transitioned.

Corbett's assumption appears to be that the patients who had been transitioned out to existing service options by this time had no need for the new service options. Of course, the assumption is not logical. Brennan's instructions were to transition the BAC patients and the existing services were all that were available to her.

With respect to the evidence of Eltham, the State of Queensland submitted that he was also "relatively unconcerned" about the practical effect of the information about the new statewide service options. Having regard to Eltham's oral evidence (set out below), this appears to be an overstatement, with Eltham expressing concern and disappointment at the lack of new services available by November 2013:

FREEBURN: So we're in November. The previous [Board] meeting [just discussed in oral evidence] had been in May. Six months has passed and you're effectively being told 12 months to go and may take 12 months. **Did that cause you a concern?**

ELTHAM: **Yes. It caused me some concern there.** But at that stage plans had already been well-advanced for a number of – of patients and there was a lot of activity going on that we were given the impression there was a lot of activity happening for individual patients and that people were working very hard on developing the – the new service – the new system of services.

FREEBURN: But that – wasn't that all the more reason to say as the board with the supervision responsibilities you had to say stop, this is looking open-ended?

ELTHAM: I don't think we felt it was open-ended but we - - -

FREEBURN: Well, you couldn't have got any assurance from the words: The new statewide service options may take a further 12 months to be fully established?

ELTHAM: Yes.

FREEBURN: And see the next the sentence: In order to ensure there is no gap to service delivery West Moreton Hospital and Health Service has commenced planning interim service options for current BAC patients. This is six months later. **Weren't you under the impression that the planning for the interim arrangements was going to start in May?**

ELTHAM: **Very soon thereafter.**

FREEBURN: So the planning process was commenced?

ELTHAM: Yes. Correct. As far as I – we were aware.

FREEBURN: There's a distinction between planning the service options and actually getting them up and operating, isn't there?

ELTHAM: I imagine so but, look, the board are not – well, all of the board were not mental health clinicians and only two of the board members are medical clinicians. So we're not experts in the actual service provision around this particular group of clients. We sought assurances that plans were being made,

that measures were being put into place to support each of the individual patients there and we received those assurances. I think it's fair enough to say that I personally was a bit disappointed that it seemed to be taking so long but it was happening and work was proceeding.

FREEBURN: Well, planning is proceeding. Correct?

ELTHAM: I – I took it to mean that there were more than just plans, that there were actually measures being taken to support individual patients - - -

FREEBURN: And - - -?

ELTHAM: and there had to be if patients were being discharged.

FREEBURN: Well, Mr Eltham, that was what was happening at this time, wasn't it? This was fairly – there were some patients who had already been transitioned by this point?

ELTHAM: Yes. I believe so.

FREEBURN: And some still to be transitioned?

ELTHAM: Yes.¹⁷⁸

And so Eltham was disappointed about the delays in new services becoming available.

2 December 2013 – 8th Steering Committee meeting

On 2 December 2013, the Steering Committee met. The minutes record an update in respect of the development of the new models, and a plan for an interim bed-based service:

- the CHQ Board has endorsed the model of care as well as the immediate transition service planning work underway
- [Steer] and the Chair of the CHQ Board are meeting with the Minister [today], to present the proposed model
- [Stathis] noted the interim subacute inpatient unit being discussed with the Mater. It is hoped that it will be in place until the Mater unit closes in November 2014.¹⁷⁹

There was some discussion about the timing of the new services and, in particular, the appropriate communication approach. There was concern not to mislead the public:

- [Amanda Tilse, Operational Manager, Alcohol other Drugs & Campus, Mater] feels that it should be indicated that the [Step Up/Step Down] won't be implemented until later. There is potential for the model to infer that there are more services available than there really is. This could create false hope amongst consumers and their families.
- ... [The carer representative] cautioned that carers/consumers hold onto anything as hope and there could be massive disappointment if all of the services don't come through. [The carer] agrees that some information needs to be released but finding the right balance will be difficult.
- It was agreed that the model should include a qualifier that the model will be progressively funded and implemented ...

The minutes record a decision to "hold off communicating the model of care to families and staff until further clarification reached" and to "circulate the service elements to the service options working group for review/comment".¹⁸⁰

16 December 2013 – 9th Steering Committee meeting

On 16 December 2012, the Steering Committee met.¹⁸¹ Stathis is recorded as updating the committee on the feedback received on the proposed model of care and service elements.

With respect to the impending closure of the BAC, Geppert noted that West Moreton HHS and CHQ “will have to work very closely to ensure no gap in services, which will be most likely on a daily basis given the speed of change around services and consumers”.¹⁸²

13 January 2014 – 10th Steering Committee meeting

On 13 January 2014, the Steering Committee met.¹⁸³ The YPETRI¹⁸⁴ terms of reference were presented for endorsement at this meeting.

28 January 2014 – 11th Steering Committee meeting

On 28 January 2014, the Steering Committee met. Krause advised attendees of the request from the CHQ Board Chair, to rename the committee to “Adolescent Mental Health Extended Treatment Initiative” (AMHETI). The minutes record that an update is to be given to the Minister “regarding the Barrett closure and new service implementation”.¹⁸⁵

January 2014 – Steering Committee paper

In January 2014, Steer prepared a Steering Committee paper which included the following update in respect of the roll-out of the new services, developed by CHQ:

By February 2014, a 5-bed residential rehabilitation unit at Greenslopes and an Interim subacute bed-based unit at the Mater will be in place. At the same time, recruitment for the Statewide Panel, AMYOS Teams, and Psychiatrists will have commenced with the first appointments being made from March. The AMYOS Teams will be located in Metro North, Metro South, Townsville, Darling Downs, Gold Coast and Redcliffe/Caboolture. And finally, a new Day Program Unit will be established in north Brisbane by June 2014. ...

Successful implementation of the full model of care; [sic] however, is dependent upon new operational and capital funding ...

The closure of the BAC is still on track for the 31st January and CHQ HHS is continuing to support WM HHS throughout the transition process. Any consumer who requires services, previously provided by the BAC, will be supported by wrap around services through their local HHS. These wrap around arrangements are supported and coordinated by the lead psychiatrist from BAC, who will continue to maintain oversight of the consumers under the governance of CHQ, post the January closure.¹⁸⁶

Thus, it appears that CHQ provided some assistance to West Moreton HHS in respect of the interim services, while continuing to progress the development of the full suite of replacement services.

Details as to the actual commencement dates of the new services, is outlined in chapter 27.

January 2014 and July 2014 – Amendments to service agreements

Despite agreement having been reached, as early as July 2013, that CHQ was to have responsibility for the development of the new service models, this was not reflected in the relevant service agreements until some 12 months later.

As noted in chapter 12, the CHQ service agreement was not amended until late January 2014,¹⁸⁷ to include the obligation that CHQ host and deliver the SWAETRI strategy.¹⁸⁸ By means of this amendment, CHQ was given oversight responsibility for the delivery of a number of statewide (or multi-HHS) services, including CYMHS, e-CYMHS, and the Child and Youth Forensic Outreach Mental Health Services.¹⁸⁹

West Moreton HHS's service agreement was subsequently amended, in August 2014, to remove its oversight responsibility over the BAC (Adolescent Extended Treatment and Rehabilitation Centre (state-wide)).¹⁹⁰ The reason for the delay in amending the service agreements is unclear.

Conclusion

Around the time of the meeting of the West Moreton Board on 24 May 2013, there was an understanding that the BAC's closure would align with the commencement of replacement services, to be developed by way of partnership between CHQ and the MHAODB. That partnership was soon extended to include West Moreton HHS.

The MHAODB, under Kingswell's leadership, quickly took steps to explore the viability of a Y-PARC service for Queensland, which it planned to make available in time for the BAC's closure. (As outlined in chapter 27, this did not eventuate).

By July 2013 the governance structure had changed. It was decided that CHQ would take the lead role in respect of the development of the new services, and that West Moreton and the MHAODB were to become "stakeholders". The Steering Committee and Oversight Committee were established by CHQ to lead the development of the services.

From July 2013 until the closure of the BAC in January 2014, there were varying understandings about the scope of the new services, and when they would become available. By August 2013, a draft SWAETRI project plan foreshadowed that not all new services would be available in time for the BAC's closure, but left open the prospect that some services would be available by then.

By September 2013, some witnesses became aware that the new services would not be available for the transitioning of the BAC patients. This was a source of frustration for some witnesses (notably Kingswell). By November 2013, it was unanimously understood that none of the replacement services would be available when the BAC closed. West Moreton, with assistance from CHQ, took steps to implement "interim services" for the BAC patients.

Further discussion in respect of the interim and replacement services is in chapter 26.

(Endnotes)

- 1 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-20 to that statement, West Moreton Hospital and Health Board Meeting Minutes of 24 May 2013, p 173.
- 2 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-19 to that statement, West Moreton Hospital and Health Board Meeting Minutes of 24 May 2013 – Board Committee Agenda Paper, p 147.
- 3 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-20 to that statement, West Moreton Hospital and Health Board Meeting Minutes of 24 May 2013, p 174.
- 4 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-20 to that statement, West Moreton Hospital and Health Board Meeting Minutes of 24 May 2013, p 174.
- 5 Submissions on behalf of the State of Queensland, 23 March 2016, p 67 para 243.
- 6 Transcript, Mary Corbett, 18 February 2016, p 9-79 lines 9–10.
- 7 Transcript, Mary Corbett, 18 February 2016, p 9-50 lines 2–4.
- 8 Transcript, Mary Corbett, 18 February 2016, p 9-50 line 44–45 – p 9–51 lines 1-2.
- 9 Transcript, Mary Corbett, 18 February 2016, p 9-50 line 43 – p 9-51 line 2.
- 10 Transcript, Mary Corbett, 18 February 2016, p 9-51 lines 12–14.
- 11 A record of the 11 June 2013 meeting is referred to in the 28 June 2013 meeting minutes of the West Moreton Hospital and Health Board. Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-6 to that statement, West Moreton Hospital and Health Board Meeting Minutes of 28 June 2013, p 82; Exhibit 308, West Moreton Board Committee Agenda Papers and Meeting Minutes, 23 November 2012 to 28 February 2014 as provided by Timothy Eltham, p 117.
- 12 Exhibit 125, Statement of Peter Steer, 15 December 2015, p 11 para 45.
- 13 A record of the 11 June 2013 meeting is referred to in the 28 June 2013 meeting minutes of the West Moreton Hospital and Health Board. Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-6 to that statement, West Moreton Hospital and Health Board Meeting Minutes of 28 June 2013, p 82; Exhibit 308, West Moreton Board Committee Agenda Papers and Meeting Minutes, 23 November 2012 to 28 February 2014 as provided by Timothy Eltham, p 117.
- 14 A record of the 11 June 2013 meeting is referred to in the 28 June 2013 meeting minutes of the West Moreton Hospital and Health Board. Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-6 to that statement, West Moreton Hospital and Health Board Meeting Minutes of 28 June 2013, p 82; Exhibit 308, West Moreton Board Committee Agenda Papers and Meeting Minutes, 23 November 2012 to 28 February 2014 as provided by Timothy Eltham, p 117.
- 15 Exhibit 40, Statement of Michael Cleary, 21 December 2015, p 21 para 84(viii).
- 16 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 24 para 17.5.
- 17 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 17 para 10.6.
- 18 Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 8 para 8.3(a)(ii).
- 19 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-6 to that statement, Board Committee Agenda Paper – ‘Barrett Adolescent Centre Strategy Update’, 28 June 2013, p 82.
- 20 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, p 13 para 6.3.
- 21 Exhibit 94, Statement of Anthony O’Connell, 6 January 2016, p 19 para 22.
- 22 Exhibit 1279, Emails between Marie Kelly, Bill Kingswell, Adrian Gane and others, Subject: “Barrett Adolescent Centre”, 21 June 2013, p 1.
- 23 Exhibit 868, Minutes of Barrett Adolescent Centre and Extended Treatment & Rehabilitation projects, 8 July 2013, p 1.
- 24 Exhibit 671, Briefing Note for Noting to Minister for Health, Subject: “Barrett Adolescent Strategy Meeting”, 8 July 2013, p 1.
- 25 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, Attachment LJS-5 to that statement, Briefing Note for Noting to Minister for Health, Subject: “Barrett Adolescent Strategy Meeting”, 15 July 2013, pp 44–47.
- 26 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, Attachment LJS-5 to that statement, Briefing Note for Noting to Minister for Health, Subject: “Barrett Adolescent Strategy Meeting”, 15 July 2013, p 45.
- 27 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, Attachment LJS-5 to that statement, Briefing Note for Noting to Minister for Health, Subject: “Barrett Adolescent Strategy Meeting”, 15 July 2013, p 46.
- 28 Exhibit 1280, Document titled ‘Talking Points for Discussion with Health Minister’, dated 12 July 2013, p 2.
- 29 Exhibit 1473, Second supplementary statement of Lesley Dwyer, 17 May 2016, p 2 paras 2.1–2.3; Exhibit 1474, Second supplementary statement of Mary Corbett, 17 May 2016, p 1 para 2.1; Exhibit 1471, Second supplementary statement of Lawrence Springborg, 12 May 2016, p 2 para 4.
- 30 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, p 8 para 4.1; Exhibit 207, Minutes of Barrett Adolescent Strategy Planning Group 23 July 2013, p 1.
- 31 Exhibit 122, Statement of Stephen Stathis, 5 November 2015, Attachment E to that statement, Barrett Adolescent Strategy Planning Group meeting minutes 18 January 2013, p 83.

- 32 Exhibit 207, Minutes of Barrett Adolescent Strategy Planning Group, 23 July 2013, p 2.
- 33 Exhibit 125, Statement of Peter Steer, 15 December 2015, p 4-5 para 15.
- 34 Who was at that time the Clinical Director of the CYMHS.
- 35 Exhibit 122, Statement of Stephen Stathis, 5 November 2015, p 3 para 11; Exhibit 207, Minutes of Barrett Adolescent Strategy Planning Group, 23 July 2013, p 2..
- 36 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, p 8 para 4.3. SWAETRI is the acronym for the State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy Steering Committee chaired by CHQ HHS.
- 37 See the discussion of Y-PARCs in chapter 14.
- 38 Transcript, William Kingswell, 24 February 2016, p 13-29 lines 20–23.
- 39 Exhibit 1128, iPad note as an email from Bill Kingswell, Subject: "Meeting re-BAC-23/07/13", 13 October 2015.
- 40 Submissions on behalf of the State of Queensland, 23 March 2016, p 67 para 243.
- 41 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 17 para 11.24.
- 42 Transcript, Sharon Kelly, 22 February 2016, p 11-98, lines 22–25.
- 43 Transcript, Sharon Kelly, 22 February 2016, p 11-98 lines 27–32.
- 44 Transcript, Lesley Dwyer, 23 February 2016, p 12-99 line 46 – p 12-100 line 4.
- 45 Submissions on behalf of West Moreton HHS, in response to further submissions of [confidential], 12 May 2016, pp 3–4; Transcript, Lesley Dwyer, 23 February 2016, p12–103 lines 32–36.
- 46 Transcript, Lesley Dwyer, 23 February 2016, p 12-103 lines 44–47.
- 47 Transcript, Leanne Geppert, 19 February 2016, p 10-33 lines 12–40.
- 48 Exhibit 64, Statement of Elisabeth Hoehn, 18 November 2015, p 1 para 4.
- 49 Transcript, Leanne Geppert, 19 February 2016, p 10-33 lines 5–40.
- 50 Exhibit 125, Statement of Peter Steer, 15 December 2015, p 2 para 7.
- 51 Transcript, Peter Steer, 10 March 2016, p 24-113 lines 12–16.
- 52 Transcript, Ingrid Adamson, 11 March 2016, p 25-47 lines 45–47.
- 53 Transcript, Ingrid Adamson, 11 March 2016, p 25-47 line 31 – p 25-48 line 23.
- 54 Transcript, Stephen Stathis, 10 March 2016, p 24-38 lines 18–25.
- 55 Transcript, Stephen Stathis, 10 March 2016, p 24-37 lines 5-12, p 24-46 lines 12–20.
- 56 Exhibit 122, Statement of Stephen Stathis, 30 October 2015, p 6 para 22.
- 57 Transcript, Stephen Stathis, 10 March 2016, p 24-31 lines 43–45.
- 58 CHQ HHS had two roles: *First*, the delivery of statewide (or multi-HHS) services, and *second* the delivery of services within a catchment area roughly equivalent to metropolitan Brisbane.
- 59 Transcript, Stephen Stathis, 10 March 2016, p 24-44 lines 31–36.
- 60 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, p 8 para 4.3.
- 61 Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, p 18 para 77.
- 62 Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment F to that statement, Statewide Adolescent Extended Treatment and Rehabilitation Implementation Steering Committee terms of reference, pp 128–131.
- 63 Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment F to that statement, Statewide Adolescent Extended Treatment and Rehabilitation Implementation Steering Committee terms of reference, p 128.
- 64 Exhibit 72, Statement of Judith Krause, 26 November 2015, p 17 para 68(a), Attachment Z to that statement, Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy project plan version 1.1, October 2013, p 507.
- 65 Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, p 23 para 102, Attachment ZD to that statement, List of committees and working group members, pp 1578–1579.
- 66 Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment ZD to that statement, List of committees, p 1579.
- 67 Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, p 22 para 95, Attachment F to that statement, State-wide Adolescent Extended Treatment and Rehabilitation Financial and Workforce Planning Transition Working Group 22 October 2013, pp 723–725.
- 68 Exhibit 1086, Statewide Adolescent Extended Treatment & Rehabilitation Implementation Steering Committee Agendas, Minutes and Documents, 26 August 2013 to 15 December 2014, p 9.
- 69 Exhibit 72, Statement of Judith Krause, 26 November 2015, p 8 para 27. Exhibit 15, Supplementary statement of Ingrid Adamson, 15 January 2016, p 16 para 64.

- 70 Exhibit 72, Statement of Judith Krause, 26 November 2015, p 7 para 22; Exhibit 122, Statement of Stephen Stathis, 30 October 2015, p 4 para 13.
- 71 Exhibit 702, Statewide Adolescent Extended Treatment and Rehabilitation Implementation strategy Project Plan, 16 August 2013, p 1. Refers to 'CE teleconference' in the 'revision history' of the project plan. Glossary refers to CE has meaning 'Health Service Executive Officer'.
- 72 Exhibit 702, Statewide Adolescent Extended Treatment and Rehabilitation Implementation strategy Project Plan, 16 August 2013, p 1.
- 73 Exhibit 702, Statewide Adolescent Extended Treatment and Rehabilitation Implementation strategy Project Plan, 16 August 2013, p 7.
- 74 Submissions on behalf of the State of Queensland, 23 March 2016, p 50 para 169.
- 75 Exhibit 702, Statewide Adolescent Extended Treatment and Rehabilitation Implementation strategy Project Plan, 16 August 2013, p 3.
- 76 Exhibit 702, Statewide Adolescent Extended Treatment and Rehabilitation Implementation strategy Project Plan, 16 August 2013, p 7.
- 77 Submissions on behalf of the State of Queensland, 23 March 2016, p 50 para 171.
- 78 Transcript, Peter Steer, 10 March 2016, p 24-115 lines 29–35.
- 79 Further submissions on behalf of West Moreton HHS and Board on EFTRU, 14 April 2016, p 8 para 4.
- 80 Transcript, Lesley Dwyer, 23 February 2016, p 12-103 lines 6–36.
- 81 Exhibit 122, Statement of Stephen Stathis, 5 November 2015, Attachment J to that statement, State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy meeting minutes, 21 October 2013, p 165; Exhibit 72, Statement of Judith Krause, 26 November 2015, p 508.
- 82 Transcript, Stephen Stathis, p 24-40 lines 11-15.
- 83 Exhibit 300, Communications Plan Statewide Adolescent Extended Treatment and Rehabilitation Strategy, November 2013, pp 17–18.
- 84 Exhibit 300, Communications Plan Statewide Adolescent Extended Treatment and Rehabilitation Strategy, November 2013, pp 17–18.
- 85 Exhibit 300, Communications Plan Statewide Adolescent Extended Treatment and Rehabilitation Strategy, November 2013, p 16.
- 86 Exhibit 300, Communications Plan Statewide Adolescent Extended Treatment and Rehabilitation Strategy, November 2013, p 20.
- 87 Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment C to that statement, p 72.
- 88 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, p 12 para 62; Exhibit 307, Transcript of ABC 612 interview with Lawrence Springborg, 6 August 2013.
- 89 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, p 12 para 62.
- 90 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, p 12 para 61.
- 91 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, Attachment LJS-7 to that statement, Media Statement 6 August 2013, p 57.
- 92 The release states that a "new range of contemporary service options" would be available "from early 2014".
- 93 Transcript, Trevor Sadler, 9 March 2016, p 23-59 line 43 – p 23-60 line 6.
- 94 Submissions on behalf of West Moreton HHS, in response to further submissions of [confidential], 12 May 2016, p 4.
- 95 Submissions on behalf of West Moreton HHS, in response to further submissions of [confidential], 12 May 2016, p 4.
- 96 Confidential exhibit.
- 97 Exhibit 122, Statement of Stephen Stathis, 5 November 2015, Attachment J to that statement, State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy meeting minutes 26 August 2013, p 126.
- 98 Exhibit 122, Statement of Stephen Stathis, 5 November 2015, p 4 para 13; Exhibit 72, Statement of Judith Krause, 26 November 2015, p 7 para 22.
- 99 Exhibit 122, Statement of Stephen Stathis, 5 November 2015, Attachment J to that statement, State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy meeting agenda 26 August 2013, and meeting minutes 26 August 2013, pp 124, 126.
- 100 Exhibit 122, Statement of Stephen Stathis, 5 November 2015, Attachment J to that statement, State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy meeting minutes 26 August 2013, p 128.
- 101 Exhibit 122, Statement of Stephen Stathis, 5 November 2015, Attachment J to that statement, State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy meeting minutes 26 August 2013, p 129.

- 102 Exhibit 122, Statement of Stephen Stathis, 5 November 2015, Attachment J to that statement, State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy meeting minutes 26 August 2013, p 129. Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 54 para 253.
- 103 Exhibit 1127, State-wide Adolescent Extended Treatment and Rehabilitation Implementation Steering Committee, Meeting Minutes, 26 August 2013, p 11.
- 104 Exhibit 1132, Emails between Stephen Stathis and David Crompton, Subject: "Invitation to visit the proposed site at Logan", 30 August 2013; Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 54 para 253.
- 105 Exhibit 1130, Emails between David Crompton and Stephen Stathis, Subject: "Invitation to visit the proposed site at Logan", 27 August 2013. The Senior Leadership Forum was held on 9 August 2013, and the summary report indicates that replacement services for the BAC were discussed, though an interim site at Logan is not specifically mentioned. Exhibit 1131, Mental Health Alcohol and Other Drugs Branch, Leadership Matters: The Fourteenth Forum for Senior Mental Health Leaders, Summary Report, 9 August 2013.
- 106 Exhibit 1127, Statewide Adolescent Extended Treatment & Rehabilitation Implementation Steering Committee Agendas, Minutes and Documents, 26 August 2013 to 10 February 2014, p 63.
- 107 Exhibit 1467, Emails between Sharon Kelly, Stephen Stathis and others, Subject: "Teleconference tomorrow - Summary of the Options. Should we talk beforehand??", 4 September 2013, pp 2-4.
- 108 Exhibit 366, Email from Scott Harden to William Kingswell, Subject: "BAC", 14 September 2013, p 1.
- 109 Transcript, William Kingswell, 24 February 2016, p 13-42 line 45 – p 13-43 line 35.
- 110 Transcript, William Kingswell, 24 February 2016, p 13-53 line 45 – p 13-54 line 3. The facility already operating in Cairns was the "Time Out House Initiative" run by a Non-Government Organisation.
- 111 Transcript, William Kingswell, 24 February 2016, p 13-41 lines 2-5.
- 112 Transcript, William Kingswell, 24 February 2016, p 13-41 lines 9-14.
- 113 Transcript, Lesley Dwyer, 23 February 2016, p 12-103 lines 44-47.
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27 Development and implementation of AMHETI

This chapter provides an overview of the Adolescent Mental Health Extended Treatment Initiative (AMHETI). It examines who was responsible for the development and roll out of AMHETI services, the underlying philosophy of the new continuum of care, and the proposed phases and service funding. The reasons for the identified delays to the roll out of the new continuum are also explained.

Overview of the AMHETI continuum of services

In February 2014, Children's Health Queensland Hospital and Health Service (CHQ) started implementing a new suite of extended treatment and rehabilitation mental health services for adolescents and young people with severe, complex and persistent mental illness. AMHETI is designed as a suite of treatment and rehabilitation services enabling adolescents to move between levels of service according to changes in the acuity, severity and complexity of their mental illness and associated needs at any particular time. CHQ cautions it is "important that each service element is not viewed as a stand-alone component of the model but rather as a necessary integrated element along a continuum".¹

AMHETI includes five service elements:

- Assertive Mobile Youth Outreach Service (AMYOS) – a new outpatient service rolled out since July 2014
- Child and adolescent day program – already established but with new programs
- Youth Residential Rehabilitation Units (Youth Resi) – a new community bed-based service operational since February 2014²
- Step Up/Step Down Units (SUSDU) – another new community bed-based service, with the first unit proposed to be established by mid-2017
- Statewide sub-acute beds – a new service, established on an interim (trial) basis from February 2014 and described by CHQ as "the 'Tier 3' beds that the Expert Clinical Reference Group recommended".³

For a detailed explanation of each AMHETI service and the research evidence-base, refer to chapter 28 and appendix C (research).

The AMHETI was initially known as the Statewide Adolescent Extended Treatment and Rehabilitation Strategy.⁴ In January 2014, the CHQ Board decided to rename the project as the Adolescent Mental Health Extended Treatment Initiative.⁵ To avoid confusion, the term AMHETI has been used throughout this chapter to describe both the initiative and the steering committee that oversaw its development. The exception to this is reference to the Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy project plan (the SWAETRIS project plan).⁶

AMHETI target client group

Evidence from CHQ witnesses emphasised that the role of the AMHETI steering committee was to develop contemporary services for the general population of adolescents in Queensland with severe and complex mental health problems, as opposed to the smaller cohort of adolescents who may have been treated at the BAC.⁷ However, the AMHETI steering committee “[c]ertainly had regard for the diagnostic profiles of those young people and how they presented and how they came to be at the Barrett”.⁸

The SWAETRIS project plan from October 2013 clearly defined the target client group for the AMHETI continuum as adolescents:

- aged 13–17 years, with “flexibility in upper age limit depending on presenting issue and developmental age (as opposed to chronological age)”
- with persistent, severe and complex “mental health problems that may include co-morbid alcohol and other drug problems, which significantly interfere with social, emotional, behavioural and psychological functioning and development”
- whose “mental illness is persistent” presenting a risk to themselves and/or others
- with mental illness of a medium to high level acuity
- requiring extended treatment and rehabilitation.⁹

In February 2014 and July 2014, versions 2 and 4 of the CHQ business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation Model of Care define the target client group as 13 to 18 year olds.¹⁰

The upper age cut off

The AMHETI target client group is for adolescents from 13 to 18 years.¹¹ However, two of the new services — the Youth Resi and the Step Up/Step Down Unit — are for 16–21 year olds. Understandably, CHQ’s focus is on adolescents aged under 18 years. Judith Krause’s evidence was that:

AMHETI was designed for the CYMHS [Child and Youth Mental Health Services] adolescent age range (13 up to 18) but with an awareness of the internationally recognised neuro-developmental literature which identifies the specific needs of the 18–25-year-old population. ... [T]his was acknowledged by extending the age range for resi rehabilitation facilities to 21.

There would need to be a robust funding model to support extending AMHETI services in their entirety up to 21. The risk would be diluting the funds dedicated to the CYMHS sector and reducing the responsiveness of the sector to provide early and targeted interventions for at risk younger adolescents and reduce the impact of emerging mental health issues.¹²

Responsibility for the AMHETI continuum of services

Responsibility for **developing the new continuum of care** was and is being led by CHQ.¹³

Responsibility for implementing **transition arrangements** for Barrett Adolescent Centre (BAC) patients rested with West Moreton Hospital and Health Service (West Moreton HHS). The West Moreton Board provided oversight.¹⁴ Transition of BAC patients is discussed in more detail in chapters 18–21.

The philosophy underpinning the new continuum

Although the philosophy underpinning the new AMHETI continuum is not explicitly stated, Commission witnesses, the SWAETRIS project plan, the CHQ Statewide sub-acute beds discussion paper and the CHQ business case¹⁵ point to a range of issues driving its development.

Value for money

Value for money appears to be one of the key factors in the design of the new continuum. The Statewide sub-acute beds discussion paper emphasised the high cost of inpatient services relative to the small number of adolescents accessing them:

At the extreme end of the continuum, inpatient units are the most expensive setting for managing mental illness in supporting what is a comparatively low number of young people. In an environment of limited resources and many competing priorities for government funds, it is therefore necessary to consider financial costs of inpatient care and balance this with the evidence base and available alternative options for care.¹⁶

CHQ explained why the costs associated with CYMHS services are higher than those associated with adult mental health services. CYMHS services tend to be more family-focussed and educationally based than is typically the case in the more individual-oriented and autonomous adult mental health system, which may make CYMHS more expensive:

The nature of work with children and young people involves longer assessments in the family context, as well as the engagement of more individuals and services. It has been suggested that adopting a systems approach in this way requires up to a three-fold commitment in resources compared with the support provided to adults.¹⁷

Increased reach

The CHQ business case and the evidence of Ingrid Adamson (the AMHETI project manager) confirm CHQ's focus on increasing the reach of services in the new continuum in the context of limited funding:

So we actually considered all of those [ECRG] service elements and said what is the best use of this very limited funding that we can make to reach a larger group of individuals? And as is outlined in the business case, through the combination of AMYOS services, a day program and a youth resi we were actually able to take care of approximately 160 young people versus say, for example, the 15 that were in Barrett or, in fact, the 10 that would've been in a Step Up Step Down.¹⁸

Alignment with national and state strategies

The AMHETI continuum was developed to align with national and state strategic planning, particularly the:

- former Queensland Government's 2013 'Blueprint for better healthcare in Queensland'
- 'Queensland plan for mental health 2007–2017' (QPMH)
- 'National mental health standards 2010'
- 'National framework for recovery-oriented mental health services 2013'
- draft 'National mental health service planning framework' (NMHSPF).¹⁹

Other factors

The SWAETRIS project plan and the business case refer to the following additional factors underpinning the development of the AMHETI continuum of care:

- high quality, effective and evidence-informed services based on contemporary models of care
- treatment and rehabilitation in the least restrictive environment
- providing more local mental health services to ensure that adolescents remain better connected to their families, community and social networks while undergoing treatment and rehabilitation
- recognising the wide geographical spread of Queensland and the complexity of delivering services across a large state
- strengthening partnerships between public mental health services and those delivered by other sectors, such as non-government organisations (NGOs).²⁰

Implementation and funding of AMHETI services

This section explains the proposed phases of AMHETI service implementation and funding as documented in version 2 (February 2014) and version 4 (July 2014) of the CHQ business case.²¹ Version 4 of the business case proposed additional capital and recurrent funding to implement the full continuum of services by the end of 2016–2017.

Implementation of the full AMHETI continuum remains contingent on securing additional funding.

Proposed roll out of AMHETI services

The roll out of the AMHETI services was planned to take place in two phases reflecting the type of funding available at the time of proposed implementation.

Phase 1

Phase 1 depended on the operational funding that was then identified. Recurrent operational funding from the closed Barrett Adolescent Centre (BAC) (\$3.8 million) and funding from the ceased Redlands project (\$2 million) was reallocated to fund the first phase at a total cost of \$5.8 million.²² There was no capital funding available for phase 1.²³

Phase 2

Phase 2 required new recurrent operational funding as well as capital funding for the proposed implementation of the remaining additional services.²⁴ In February 2014, CHQ was advised that no new funding was available in 2014–15 to support the extended continuum (the second phase).²⁵ This was reiterated in the January 2016 CHQ Statewide sub-acute beds discussion paper with “no capital funding currently identified to build new infrastructure”.²⁶

Table 27A shows each proposed phase as documented in version 2 and version 4 of the business case. It also shows the services that required capital funding (for example, construction of a new building or fit out costs) and recurrent funding (for example, staff salaries).²⁷

AMHETI service elements	Proposed phases of implementation				Type of funding required
	Version 2 (February 2014) Business case		Version 4 (July 2014) Business case		
	<i>Phase 1</i>	<i>Phase 2</i>	<i>Phase 1</i>	<i>Phase 2</i>	
AMYOS	March 2014 (6 teams)	From July 2014 (12 teams)	From July 2014 (7 teams)	From July 2014 (12 teams)	No capital funding required Recurrent funding required
New day programs	June 2014 (North Brisbane)	From January 2015 (Logan) From July 2015 (Gold Coast)	From July 2014 (North Brisbane)	From July 2015 (Logan and Gold Coast)	Capital and recurrent funding required
Step Up/ Step Down Unit	Nil	From January 2015 (1 unit) From July 2015 (2 units)	N/A	From July 2015 (Central, North and Southern cluster)	Capital and recurrent funding required
Youth Residential Units	February 2014 (Greenslopes)	From January 2015 (North Cluster) From July 2015 (Central Cluster)	From February 2014 (Greenslopes)	From July 2015 (North and Central cluster)	Recurrent funding required
Statewide sub-acute beds	February 2014 (interim 2 beds)	From January 2015 (4 beds)	From February 2014 (interim 2 beds)	From July 2014 (4 beds)	No capital funding required Recurrent funding required

Table 27A: Proposed phases of AMHETI service implementation

As shown in Table 27A, version 4 of the business case proposed the implementation of three new services to be funded through the identified operational funding (phase 1) – a residential rehabilitation unit, a new day program unit and seven AMYOS teams.²⁸ CHQ also made available, on an interim basis, four sub-acute beds in the acute Adolescent Mental Health Unit at the Lady Cilento Children’s Hospital. These swing beds are funded as acute inpatient beds, but can be used as sub-acute beds on demand. No inpatient sub-acute beds were, or have since been, funded as part of AMHETI.²⁹

Two of the three service elements proposed for phase 2 in version 4 of the business plan – the day program and Step Up/Step Down Unit – required capital funding, despite none being available.³⁰ The capital construction and fi -out costs estimated by CHQ for these two service elements are summarised in Table 27B.³¹ Capital construction costs can be avoided by leasing existing premises, and this is what CHQ did for the North Brisbane day program. The Step Up/Step Down Unit, however, requires a purpose-built facility.

Cost per program or unit	Day program	Step Up/Step Down Unit
Capital construction costs	\$1.6 – \$1.7 million	\$5.5 – \$6 million
Capital fi -out costs	\$0.5 million	\$2.6 million
Total capital cost	\$2.1 – \$2.2 million	\$8.1 – \$8.6 million

Table 27B: CHQ estimated capital costs for the day program and Step Up/Step Down Unit service elements

Note: There were three planned Step Up/Step Down Units and two day programs over the 2015-2016 and 2016-17 period. The estimated expenditure in each financial year was added to arrive at total fit-out or construction cost for each of the two years and then averaged by the number of units.

Other proposed services delivered with additional funding sources

Other services were implemented (or will be implemented) that had not been originally budgeted for as part of the AMHETI business case. Additional sources of funding include the following:

- In April 2015, the Queensland Government announced funding for two new four-bed Youth Resi services and two family accommodation units in Townsville, aligned with its *Rebuilding intensive mental healthcare for young people* election commitment.³² Those services were established in February 2016.
- Two additional AMYOS teams were established in Cairns and Rockhampton as part of the government’s May 2015 *Keriba Omasker Healing Response*.³³
- The Department of Health Mental Health Alcohol and Other Drugs Branch (MHAODB) secured additional separate funding for a second Youth Resi in Cairns, commencing in January 2015.³⁴

Separate to the AMHETI funding, MHAODB has funded a six-bed Step Up/Step Down Unit to be established in Cairns by June 2017 using capital savings from the Health and Hospitals Fund (Regional Priority Round Three) and National Partnership Agreement on Improving Public Hospital Services.³⁵ Once operational, the Step Up/Step Down Unit will replace the second Cairns Youth Resi that opened in January 2015.³⁶

Revised funding priorities

The proposed AMHETI services were again updated in September 2015 to reflect government announcements and additional investment in services. The updated funding priorities were as follows (in priority order):

- four sub-acute swing beds at the Lady Cilento Children’s Hospital (funded by money not spent from the AMHETI budget)
- 10 additional AMYOS teams (for the “rest of Qld”),³⁷ with support from two additional psychiatrists
- a day program in Logan
- a Youth Resi in north Brisbane (Caboolture area)
- a Step Up/Step Down Unit in Brisbane
- a day program on the Gold Coast
- two more Step Up/Step Down Units — one in the northern mental health cluster (north of Mackay) and one in the southern mental health cluster (incorporating the Gold Coast and south-west Queensland).³⁸

Status of AMHETI services

The AMHETI services presently operational are shown in the last row of table B in appendix C.

All services funded under the first phase of AMHETI are now operational, along with the services funded from other sources. These services include:

- the seven AMYOS teams, the Greenslopes Youth Resi and the North Brisbane day program delivered as part of the first phase of funding (from the initial \$5.8 million budget) and
- two additional AMYOS teams (Cairns and Rockhampton), a second Youth Resi (Cairns), two additional Youth Resi services, two family accommodation units (Townsville), and four sub-acute swing beds.

The annual recurrent cost of providing the AMHETI services currently established is \$8 million.³⁹

Value for money and increased reach

Given that value for money and increasing the availability and reach of services across the state was a key driver for CHQ in designing the AMHETI continuum, it is worth noting the comparative cost of each service element.⁴⁰

Table 27C summarises the approximate daily cost per adolescent of providing each AMHETI service. These costs have been estimated by using CHQ feedback on an early Commission working draft tendered at the hearings.⁴¹ The daily cost of an adolescent acute inpatient bed (not part of the AMHETI continuum) has also been included for context. Table 27C shows that as the intensity of care and restrictiveness of the mental health setting increases so does the estimated cost of care.

AMHETI service element	Approximate daily cost per adolescent (\$)
AMYOS	55
Day program	293
Youth Resi	859
Step Up/Step Down Unit	986
Statewide sub-acute swing beds	1659
Adolescent acute inpatient bed	2498

Table 27C: Approximate daily cost per adolescent of the AMHETI services

In July 2014, version 4 of the AMHETI business case identified the need for approximately \$23 million in new recurrent operational funding in order to implement the full AMHETI suite of services.⁴² In September 2015, the revised AMHETI business case sought reduced funding – “from \$22m down to \$20m recurrent”.⁴³ This was to reflect the revised funding required due to the two AMYOS teams (Cairns and Rockhampton) and residential rehabilitation unit (Cairns).⁴⁴

Roll out delays specific to each AMHETI service element

There have been roll out delays specific to each of the AMHETI service elements.

Delays to the roll out of **AMYOS teams** related to:

- the ability to recruit appropriately qualified staff⁴⁵ in the context of a broader issue of the limited number of clinical child and youth mental health staff in Queensland⁴⁶
- the time taken by Queensland Health recruitment processes (for example, preparing role descriptions, advertising and interviewing candidates) and then waiting for newly appointed staff to give the required notice period before commencing in the role⁴⁷
- overall governance issues and negotiation of service agreements funding arrangements.⁴⁸

The delay to the roll out of **day programs** was due to difficulties identifying appropriately zoned premises of a suitable size. Consequently, in January 2015, CHQ established a program at an interim site on the old Royal Children’s Hospital campus until a suitable site for a permanent program was secured and fitted out. The north Brisbane day program will relocate to a standalone building at Chermside by mid-2016.⁴⁹

There were delays in establishing the **Youth Resi**, in part due to procurement processes. Queensland Health used an “urgent procurement”⁵⁰ process to contract Aftercare to establish the Greenslopes Youth Resi, which became operational in March 2014.⁵¹ An open national tender process in late 2015 was used to award service contracts for the other Youth Resi services.

The **Step Up/Step Down Unit** model of service has not yet been finalised and there is evidence that some aspects of the model are the subject of debate within Queensland Health, possibly relating to the complex governance and funding arrangements within the Department. This may explain inconsistencies in the evidence about the model given by key witnesses, including Stephen Stathis (Clinical Director of Child and Youth Mental Health Services, CHQ) and Krause.

Krause's evidence was that CHQ proposed a cluster-based model, rather than integration within a single HHS (as occurs in Victoria):

If only a few SUSDU's [Step Up/Step Down Units] were funded and they relied on being integrated exclusively to a Hospital and Health Service it would exclude people from being admitted if they did not reside in the geographical catchment. The concept of an extended number of SUSDU's was not deemed financially viable as all SUSDUs in Queensland would require new capital and new recurrent funding.⁵²

Insufficient funding for the proposed draft **statewide sub-acute bed model** was part of the reason for the delay in roll out – resulting in interim arrangements of colocation within an acute inpatient unit.⁵³ Krause's evidence was that:

The detailed sub acute model of service delivery was put on hold as there was no indication of whether future sub acute beds would be funded and no understanding of bed numbers, facility design or workforce profile to form the basis of the model.⁵⁴

There have been limited referrals to the sub-acute swing beds. As Stathis explained in oral evidence, a lack of capital build to "put together these swing beds" may be a reason for the limited referrals.⁵⁵ Other reasons for the delay and the low referral rate to the sub-acute swing beds may include:

- the "lack of compelling demand post closure of the BAC" with only six referrals in the period up to March 2016⁵⁶
- the provision of the alternative AMHETI services may have reduced the need for sub-acute admissions for some young people⁵⁷
- lack of support for sub-acute beds (as determined via consultation with the CYMHS sector)
- clinical concerns about locating sub-acute beds within an acute ward.⁵⁸

Overall delays to the development and implementation of AMHETI services

The evidence before the Commission demonstrates that a number of the individuals involved in developing and implementing the new AMHETI services had varying levels of understanding of what was to occur. Between 24 May 2013 (West Moreton Board decision to support closure of the BAC) and 31 January 2014 (the closure of the BAC), there was confusion about:

- the scope of the new services
- when the new services would become available
- whether the new services would be available for BAC patients.

Some Commission witnesses, notably Bill Kingswell (Executive Director of the MHAODB), believed a Y-PARC equivalent model (see appendix C) would be established by January 2014.⁵⁹ Others, in particular Stephen Stathis (Clinical Director of Child and Youth Mental Health Services, CHQ) and Peter Steer (Chief Executive, CHQ), believed that the broader statewide AMHETI service model should be established.⁶⁰

In preparation for writing a briefing note to the Director-General (Tony O'Connell), Kingswell explained in an email on 21 June 2013 that "we have been tasked with getting replacement services in place ahead of the boards [sic] decision to close. Nick has agreed to release the \$2m to FCMU for Y-PARC".⁶¹ The Director-General was then made aware in July 2013 of the intention to establish a Y-PARC equivalent service by January 2014. The Director-General approved the

briefing note dated 15 July 2013. The briefing note provided the Director-General with the following information:

The Department of Health is urgently progressing planning for Youth Prevention and Recovery Care (Y-PARC) services to be established in Queensland by January 2014. This service type would provide an alternative care option for the adolescent target group currently accessing BAC.⁶²

Meeting minutes, emails, and oral evidence from CHQ (notably Steer and Stathis) indicate that at least from August 2013, they were focussed on developing a full suite of services or continuum of care, rather than particular services (such as a Y-PARC).

The issue of communication and mixed messages and how it impacted on certain decisions and the timing of those decisions, is discussed in chapter 24.

(Endnotes)

- 1 Exhibit 618, Children's Health Queensland Hospital and Health Service 2014, 'Business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation model of care', version 4.0, July 2014, p 19.
- 2 Exhibit 255, Statement of Myfanwy Pitcher, 25 February 2015, p 2 para 4.
- 3 Exhibit 122, Statement of Stephen Stathis, 5 November 2015, p 16 para 58(e); See also Exhibit 74, Second supplementary statement of Judith Krause, 4 February 2016, p 17 para Q. 44.
- 4 Exhibit 618, Children's Health Queensland Hospital and Health Service 2014, 'Business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation model of care', version 4.0, July 2014, p 22.
- 5 Exhibit 1086, Batch of meeting minutes and other documents associated with the Statewide Adolescent Extended Treatment and Rehabilitation Steering Committee and subsequent Adolescent Mental Health Extended Treatment Initiative Steering Committee, 26 August 2013 to 15 December 2014, p 2 point 6.5, 'Other business' of minutes of meeting on 28 January 2014.
- 6 Exhibit 300, Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy project plan, Version 1.1 (October 2013), pp 10–36.
- 7 Transcript, Ingrid Adamson, 11 March 2016, p 25-48 lines 4–15.
- 8 Transcript, Ingrid Adamson, 11 March 2016, p 25-49 lines 13–15.
- 9 Exhibit 300, Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy project plan, Version 1.1 (October 2013), p 11 section 1.8.1.
- 10 Exhibit 618, Children's Health Queensland Hospital and Health Service 2014, Business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation model of care, version 4.0, July 2014, p 6; Exhibit 1432, Children's Health Queensland Hospital and Health Service 2014, Business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation model of care, version 2.0, February 2014, p 6.
- 11 Exhibit 618, Children's Health Queensland Hospital and Health Service 2014, Business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation model of care, version 4.0, July 2014, p 29; Exhibit 1235, Overview of the adolescent mental health extended treatment initiative, presented to Queensland Health Youth Mental Health Commitments Committee on 22 September 2015, p 5.
- 12 Exhibit 74, Second supplementary statement of Judith Krause, 4 February 2016, p 35 para Q. 78(b). Judith Krause was Executive Director, Child and Youth Mental Health Service, CHQ from December 2009 to February 2014, when she was appointed Divisional Director, Child and Youth Mental Health Service, CHQ: see Exhibit 72, Statement of Judith Krause, 26 November 2015, p 1 paras 2–3.
- 13 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, p 8 para 4.3; Supplementary submissions on behalf of the State of Queensland, 14 April 2016, p 2 para 1(a)(ii).
- 14 Supplementary submissions on behalf of the State of Queensland, 14 April 2016, p 2 para 1(a)(i).
- 15 There are two versions of the business case referred to – Exhibit 1432, Children's Health Queensland Hospital and Health Service 2014, Business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation model of care, version 2.0, February 2014; Exhibit 618, Children's Health Queensland Hospital and Health Service 2014, Business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation model of care, version 4.0, July 2014.
- 16 Exhibit 280, Statewide Sub-Acute Beds Discussion Paper, January 2016, p 53 para 4.3.
- 17 Exhibit 280, Statewide Sub-Acute Beds Discussion Paper, January 2016, p 14 para 1.3.

- 18 Transcript, Ingrid Adamson, 11 March 2016, p 25-51 lines 27-32.
- 19 Exhibit 300, Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy project plan, Version 1.1 (October 2013), p 9 para 1.6; Exhibit 280, Statewide Sub-Acute Beds Discussion Paper, January 2016, pp 10-13.
- 20 Exhibit 300, Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy project plan, Version 1.1 (October 2013), pp 5-6; Exhibit 618, Children's Health Queensland Hospital and Health Service 2014, Business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation model of care, version 4.0, July 2014, pp 7-8.
- 21 Exhibit 618, Children's Health Queensland Hospital and Health Service 2014, Business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation model of care, version 4.0, July 2014; Exhibit 1432, Children's Health Queensland Hospital and Health Service 2014, Business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation model of care, version 2.0, February 2014.
- 22 Transcript, Ingrid Adamson, 11 March 2016, p 25-53 line 8; Exhibit 618, Children's Health Queensland Hospital and Health Service 2014, Business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation model of care, version 4.0, July 2014, p 17 para 5.1; Exhibit 1235, Overview of the adolescent mental health extended treatment initiative, presented to Queensland Health Youth Mental Health Commitments Committee on 22 September 2015, p 8.
- 23 Transcript, Ingrid Adamson, 11 March 2016, p 25-53 lines 7-8.
- 24 Exhibit 618, Business Case For the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation Model of Care version 4.0, April 2014, p 18.
- 25 Exhibit 618, Children's Health Queensland Hospital and Health Service 2014, Business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation model of care, version 4.0, July 2014, p 18 para 5.1.
- 26 Exhibit 300, Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy project plan, Version 1.1 (October 2013), p 9 para 1.6.
- 27 Queensland Health mental health clusters: North/northern – Cairns and Hinterland, Townsville, Mackay, Torres Strait-Northern Peninsula and Cape York, North West; Central – Metro North, Redcliffe/Caboolture, Sunshine Coast, Central Queensland, Wide Bay, Central West; and South/southern – Gold Coast, Logan/Bayside/Beenleigh, Metro South, Darling Downs, West Moreton and South West. Exhibit 618, Children's Health Queensland Hospital and Health Service 2014, Business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation model of care, version 4.0, July 2014, p 16.
- 28 Exhibit 618, Children's Health Queensland Hospital and Health Service 2014, Business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation model of care, version 4.0, July 2014, p 18 para 5.2.1.
- 29 Exhibit 74, Second supplementary statement of Judith Krause, 4 February 2016, p 8 para Q. 17(a).
- 30 Transcript, Ingrid Adamson, 11 March 2016, p 25-53 lines 7-8; Exhibit 618, Children's Health Queensland Hospital and Health Service 2014, Business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation model of care, version 4.0, July 2014, p 17 para 5.1.
- 31 Exhibit 1235, Overview of the adolescent mental health extended treatment initiative, presented to Queensland Health Youth Mental Health Commitments Committee on 22 September 2015, p 8. CHQ noted that the estimates are indicative only and would need to be verified by an appropriately qualified quantity surveyor; Exhibit 715, [REDACTED] – Adolescent Mental Health Care Costings, [REDACTED]; Exhibit 303, Queensland Health financial data for adolescent mental health services, CHQ Feedback on Financial Data Summary.
- 32 Exhibit 1336, Children's Health Queensland Hospital and Health Service, Financial Overview of AMHETI, 22 July 2015, p 2; Exhibit 664, Mental Health Alcohol and Other Drugs Branch 2015, Discussion paper: Rebuilding intensive mental healthcare for young people, September, Brisbane: Department of Health.
- 33 Exhibit 661, Children's Health Queensland HHS 2015, Adolescent Mental Health Extended Treatment Initiative (AMHETI) update, 18 June 2015, p 1; Exhibit 1336, Children's Health Queensland Hospital and Health Service, Financial Overview of AMHETI, 22 July 2015, p 2.
- 34 Exhibit 661, Children's Health Queensland HHS 2015, Adolescent Mental Health Extended Treatment Initiative (AMHETI) update, 18 June 2015, p 2.
- 35 Exhibit 1088, Brief for approval to Director-General Queensland Health, Subject: "Approval for the development of a Step Up /Step Down Unit, based on the Youth Prevention and Recovery Care model from Victoria, in Cairns and Hinterland Hospital and Health Service", Approved by Director-General Ian Maynard, 21 June 2014.
- 36 Exhibit 664, Mental Health Alcohol and Other Drugs Branch 2015, Discussion paper: Rebuilding intensive mental healthcare for young people, September, Brisbane: Department of Health; Exhibit 304, CHQ feedback on Commission of Inquiry discussion paper 4D: Comparison of AMHETI service elements, 2 March 2016.
- 37 Exhibit 1235, Overview of the adolescent mental health extended treatment initiative, presented to Queensland Health Youth Mental Health Commitments Committee on 22 September 2015, p 8.
- 38 Exhibit 1235, Overview of the adolescent mental health extended treatment initiative, presented to Queensland Health Youth Mental Health Commitments Committee on 22 September 2015, pp 7-8.
- 39 Exhibit 1234, Issues paper, *Rebuilding intensive mental healthcare for young people*, March 2015, p 3 para 8.1.

- 40 Exhibit 1432, Children's Health Queensland Hospital and Health Service 2014, Business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation model of care, version 2.0, February 2014, p 37.
- 41 Exhibit 303, Queensland Health financial data for adolescent mental health services, CHQ Feedback on Financial Data Summary.
- 42 Exhibit 618, Children's Health Queensland Hospital and Health Service 2014, Business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation model of care, version 4.0, July 2014, p 18.
- 43 Exhibit 1235, Overview of the adolescent mental health extended treatment initiative, presented to Queensland Health Youth Mental Health Commitments Committee on 22 September 2015, pp 7–8.
- 44 Exhibit 1235, Overview of the adolescent mental health extended treatment initiative, presented to Queensland Health Youth Mental Health Commitments Committee on 22 September 2015, pp 7–8.
- 45 Transcript, Stephen Stathis, 10 March 2016, p 24-73 lines 7–15.
- 46 Exhibit 618, Children's Health Queensland Hospital and Health Service 2014, Business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation model of care, version 4.0, July 2014, p 14.
- 47 Transcript, Stephen Stathis, 10 March 2016, p 24-47 lines 15–23.
- 48 Exhibit 73, Supplementary statement of Judith Krause, 19 January 2016, p 32 para 25; Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment F to that statement, SWAETRI minutes 2 June 2014.
- 49 Exhibit 73, Supplementary statement of Judith Krause, 19 January 2016, pp 14–15 para 10(h)(iv)(v).
- 50 Transcript, Stephen Stathis, 10 March 2016, pp 24–47 lines 46–47.
- 51 Exhibit 229, Briefing note for approval to Director-General Queensland Health, Subject: "Approval to fund Aftercare for the provision of residential and day program mental health treatment and rehabilitation for adolescents across Queensland requiring extended care in the West Moreton Hospital and Health Service catchment area from December 2013", 20 November 2013.
- 52 Exhibit 74, Second supplementary statement of Judith Krause, 4 February 2016, p 32 para Q. 67(a).
- 53 Exhibit 74, Second supplementary statement of Judith Krause, 4 February 2016, p 18 para Q. 46; Exhibit 1432, Children's Health Queensland Hospital and Health Service 2014, Business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation model of care, version 2.0, February 2014, Appendix 2, p 29. Exhibit 73, Supplementary statement of Judith Krause, 19 January 2016, pp 16, 23 paras 12, 16(d)(2).
- 54 Exhibit 74, Second supplementary statement of Judith Krause, 4 February 2016, p 25 para Q. 60(b).
- 55 Transcript, Stephen Stathis, 10 March 2016, p 24-71 lines 38–39.
- 56 Exhibit 74, Second supplementary statement of Judith Krause, 4 February 2016, p 21 para Q. 58.
- 57 Exhibit 73, Supplementary statement of Judith Krause, 19 January 2016, p 21 para 16(b).
- 58 Exhibit 74, Second supplementary statement of Judith Krause, 4 February 2016, p 21 para Q. 58; Transcript, Cary Breakey, 15 February 2016, p 6-39 lines 42–43 and p 6-53 lines 24–30; Transcript, Aaron Groves, 16 February 2016, p 7-84 lines 41–47; Transcript, Brett McDermott, 16 February 2016, p 7-43 lines 41–47 and p 7-44 lines 1-15; Transcript, James Scott, 17 February 2016, p 8-13 lines 11–16.
- 59 For example, see Exhibit 207, Minutes: Barrett Adolescent Strategy Planning Group, 23 July 2013.
- 60 For example, see Transcript, Peter Steer, 10 March 2016, p 24-115 lines 26–40.
- 61 FCMU is the Funding and Contract Management Unit. Exhibit 1279, Emails between Marie Kelly, Bill Kingswell and Adrian Gane, Subject: "Barrett Adolescent Centre", 21 June 2013.
- 62 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, Attachment LJS-5 to that statement, Briefing note for noting to the Director-General, Subject: "Barrett Adolescent Strategy Meeting", 12 July 2013, p 45.

28 AMHETI suite of services

This chapter describes each of the following five Adolescent Mental Health Extended Treatment Initiative (AMHETI) service elements:

- Assertive Mobile Youth Outreach Service (AMYOS)
- Child and adolescent day program
- Youth Residential Rehabilitation Units (Youth Resi)
- Step Up/Step Down Units (SUSDU)
- Interim statewide sub-acute beds.

The AMHETI continuum of *extended* treatment and rehabilitation services is underpinned by a range of existing child and youth mental health services (CYMHS), including:

- approximately 45 community CYMHS clinics across the state
- early psychosis services in some Hospital and Health Service (HHS) catchment areas
- acute response teams in some HHS catchment areas
- Evolve Therapeutic Services for young people in the child protection system
- the e-CYMHS telepsychiatry service supporting clinicians in rural and regional Queensland.¹

Adolescent acute inpatient units are not designed as an extended treatment and rehabilitation service option and are therefore **excluded** from the AMHETI continuum. Acute units are, however, a crucial element of the overall continuum of mental health services for adolescents. There are currently 57 acute beds in specialist adolescent acute inpatient units across the state.²

Some of the more general features of the five AMHETI service elements are shown in table 28A for ease of comparison. A more detailed description of the features, governance, staffing and client profile of each AMHETI service element is also summarised in table B of appendix C. Table A of appendix C shows the services available pre closure of the BAC to January 2016.

	AMYOS	Day program	Youth Resi	Step Up/Step Down Unit	Interim sub-acute beds
Established	July 2014	Existed before BAC closed	February 2014	Planned for mid-2017	February 2014
Age range	13–18	13–18	16–21	16–21	13–18
Setting	Community	Community	Community	Community	Hospital
Bed-based or outpatient	Ambulatory (outpatient)	Ambulatory (outpatient)	Bed-based	Bed-based	Bed-based
Service provider	Qld Health	Qld Health	NGO	Hybrid – Qld Health & NGO	Qld Health
Unit size	16–20 clients per team	10–15 clients per unit	4–5 beds	Up to 10 beds	4 “swing” beds
Number of services	9 teams; 144–180 clients	4 programs; 45–60 clients	4 units; 18 beds	None (1 planned)	1; up to 4 beds
Hours of operation	8am–8pm weekdays	Business hours weekdays	24hrs / 7days	24hrs / 7days	24hrs / 7days
Length of admission	Case-by-case	Up to 6 months	Up to 12 months	Up to 3 months	3–6 months
Authorised to treat involuntary clients	No	Yes	No	No	Yes
Statewide governance by CHQ	Yes	No	Yes	No	Yes

Table 28A: Summary of general features of AMHETI service elements

Assertive Mobile Youth Outreach Service (AMYOS)

AMYOS is a new mobile and flexible outpatient service providing intensive case management for adolescents aged 13–18 years with severe and complex mental illnesses and who are unwilling or unable to engage in ongoing treatment in a traditional clinical setting.³ The Queensland AMYOS model is based on Victoria's Intensive Mobile Youth Outreach Services (IMYOS) (refer to appendix C research for more information).

Rather than requiring an adolescent to attend a community CYMHS clinic, AMYOS clinicians travel to the adolescent to meet and provide treatment in their home, school or other location in that adolescent's own environment. This is particularly helpful for adolescents with severe agoraphobia or difficulties with transport.⁴

There were some intensive case management services available for adolescents before the closure of the BAC but they focused on specific client groups:

- Evolve Therapeutic Services available only to children and adolescents in the child protection system
- the Child and Youth Forensic Service (CYFOS) targeting only young people on forensic (juvenile justice) orders
- early psychosis teams operated by some HHSs providing early intervention and case management for young people with psychotic disorders or at risk of developing psychosis.

The Queensland adult mental health system also has assertive outreach teams, generally known as a Mobile Intensive Rehabilitation Teams (MIRT).

Features

Features of the AMYOS model include:

- **Small caseloads:** Case workers typically manage 8–10 young people at any one time to allow for more frequent and intensive engagement.⁵
- **Intensive treatment:** Frequency and intensity of interventions are determined on a case-by-case basis but are typically several times per week.
- **"Assertive" follow-up:** Assertive outreach involves continued efforts to initiate contact with an adolescent and engage them in mental health services even if they seem reluctant or resistant. This may include repeated home or school visits, phone calls and notes.⁶
- **Focus on outreach and the adolescent's own environment:** AMYOS clinicians travel to an adolescent's home, school or other "natural" setting (such as a park) "to maximise chances for engagement and to challenge an individual's avoidance strategies".⁷
- **Family-focused:** The flexibility of the AMYOS model enables clinicians to work with the family in their own environment in order to optimise family functioning.⁸ Clinicians can more easily observe the subtleties of family interactions.⁹ Effectiveness of family treatment depends on stable family environments and a willingness of parents/carers to engage in family therapy.

- **Re-engagement in schooling:** AMYOS does not provide a specific schooling option, but does seek to ensure adolescents are engaged in mainstream or specialist schooling or other vocational programs.¹⁰
- **Core interventions:** The core interventions provided by AMYOS are generally the same as those provided by other CYMHS clinical services and include individual psychotherapy, risk management, family therapy and pharmacotherapy. The key difference is in “the level of intensity, flexibility and mobility with which these clinical interventions are delivered”.¹¹ AMYOS clinicians have been trained in a relatively new type of psychodynamic psychotherapy for adolescents – mentalization-based treatment (MBT) – that community CYMHS staff may not yet be trained and experienced in delivering.¹²

Table 28B outlines the features of the AMYOS model compared to CYMHS.

Features	AMYOS	CYMHS
• Case load	8–10 clients	25–30 clients
• Intensive treatment	Several times a week	Weekly or fortnightly
• Assertive follow-up	Continued efforts to initiate contact. Repeated follow-up	Initial follow-up for missed appointments but often not repeated
• Outreach and own environment	Case workers travel to client in their own environment	Clients come into the service, often away from own environment
• Family-focused	Focus on families in own environment to optimise family functioning	Focus on families although not in own environment
• Schooling and vocational programs	Seeks to ensure client engaged in schooling or vocational programs	Seeks to ensure client engaged in schooling or vocational programs
• Core interventions	Greater intensity and flexibility	Less intensity and flexibility

Table 28B: Features of AMYOS compared to CYMHS

Management and operations

Children’s Health Queensland Hospital and Health Service (CHQ) is responsible for the overall governance of AMYOS using service agreements with HHSs to fund local teams and ensure a consistent model of service and reporting.¹³

Three AMYOS teams are operated by CHQ: North Brisbane, South Brisbane and Redcliffe/Caboolture. All other teams are managed by the local HHS under the terms of a service agreement. AMYOS teams are generally co-located with a community CYMHS clinic, and the local CYMHS team leader is operationally responsible for the team.¹⁴

AMYOS teams predominately operate between 8.00 am and 8.00 pm on weekdays, with some flexibility to extend contact with adolescents outside these hours and on weekends if needed. Out-of-hours support is aligned with local community CYMHS service arrangements and may include CMYHS Acute Response Services or adult mental health service Acute Care Teams.¹⁵

Staffing

Each established AMYOS team is currently staffed by two full-time senior mental health practitioners who are the case managers — a mix of psychologists, social workers, nurses and occupational therapists.¹⁶ A part-time speech pathologist is currently working with the three CHQ teams on a trial basis.¹⁷ Ideally, each team has consultant psychiatrist support the equivalent of one day per week (0.2 full-time equivalent).¹⁸ CHQ provides a part-time statewide coordinator and a full-time statewide administration officer to support the AMYOS teams. It also coordinates education and training for AMYOS staff and chairs quarterly discussions with AMYOS teams via videoconference.¹⁹

Locations

Nine AMYOS teams have been established in HHS catchments across the state (see table 28C). Seven were funded under the first stage of the AMHETI business case. Two additional teams were established in Cairns and Rockhampton as part of the Government's *Keriba Omasker Healing Response*.²⁰

The proposed location of another 10 as yet unfunded teams is shown in table 28C.²¹ The AMHETI business case proposes: six full teams with two case managers and four half-teams with one case manager. The proposed full teams are one additional team in each of North Brisbane and South Brisbane, as well as teams in West Moreton, Sunshine Coast, Wide Bay and Mackay. The half-teams would service South West, Central West, North West and Cape York regions.

Current	Date established	Proposed
• North Brisbane	July 2014	<i>Full team (two case managers)</i>
• South Brisbane	July 2014	
• Logan	May 2015	
• Gold Coast	November 2015	
• Redcliffe/Caboolture	July 2014	
• Toowoomba	December 2014	
• Rockhampton	October 2015	<i>Half-team (one case manager)</i>
• Townsville	December 2014	
• Cairns	October 2015	
		• North Brisbane (an additional team)
		• South Brisbane (an additional team)
		• West Moreton
		• Sunshine Coast
		• Wide Bay
		• Mackay
		• South West
		• Central West
		• North West
		• Cape York

Table 28C: Location of existing and proposed AMYOS teams

CHQ has indicated that rural and regional teams may be supported by its e-CYMHS service.²² e-CYMHS was established in 2004 to support clinicians in 12 rural and remote areas of Queensland through telepsychiatry and outreach services. CHQ psychiatrists and other senior CYMHS clinicians provide expert advice to local clinicians, as well as treatment for young people with severe and complex mental health problems. CHQ clinicians also travel to designated clinics on a scheduled basis to conduct face-to-face reviews with young people and their families, as well as training and professional development for local clinicians.²³

Client profile

This AMHETI service element is for adolescents aged 13–18 years who:

- are difficult to engage
- at risk of deterioration or exhibit high risk behaviour
- have a diagnosis of a psychotic illness, severe mood or anxiety disorders
- have complex trauma with significant deficits in psychosocial functioning.²⁴

CHQ profiled adolescents who accessed AMYOS in September 2015, reporting:

- Nearly all were experiencing ongoing [redacted] and were unemployed.
- Three-quarters presented with emerging borderline personality disorder, had disengaged from school, had a history of presenting to hospital emergency departments or had comorbid substance misuse.
- Two-thirds had [redacted]²⁵

In addition, CHQ reported that 38 per cent of AMYOS clients from 2015 had a major psychosocial impairment and 46 per cent had moderate psychosocial impairment.²⁶

Child and adolescent day program

The child and adolescent day program is not a new service within the AMHETI continuum.

The Barrett Adolescent Centre (BAC) commenced as a day program in 1983 and continued to provide day program services until it closed in 2014. The first dedicated child and adolescent day program was established at the Mater Children's Hospital in 1989.²⁷ Additional adolescent day programs were subsequently established in Toowoomba (2012) and Townsville (2013) and, as part of the AMHETI continuum, in North Brisbane (2015). Each program accommodates 10–15 adolescents at a time.²⁸

The Queensland Health 'Child and youth mental health plan 2006–2011' explained that the day programs provide:

- a **step up option**: intensive support without admission to an inpatient unit
- a **component of care**: while an inpatient, the young person sleeps in the acute unit but attends the day program
- a **step down option**: the young person initially attends the day program from hospital some days per week and then gradually increases the number of days attended from home.²⁹

The plan explained the need to design day programs for adolescents "from those requiring short-term step-up or step-down options, to those with treatment-resistant illnesses who may need to use the day program as an alternative education provider over a long term".³⁰

As part of the AMHETI, day programs are available to adolescents who require extended and intensive clinical intervention because of persisting symptoms of mental illness and functional impairment. The home environment must be supportive enough to enable the adolescent to travel to the program on a daily basis and for the adolescent to be safe when not attending the program.³¹ Typical referral pathways include an acute inpatient unit, a community CYMHS clinic and the Evolve Therapeutic Service (see highlight box: The Evolve model).³² Some adolescents transition between being inpatient and community clients (and vice versa), while continuing to be day program clients.³³

Day program participants must be motivated to attend the program on a daily basis and, in some cases, have the capacity to be able to manage public transport to attend.³⁴ As an authorised mental health facility under the *Mental Health Act 2000*, day programs can treat adolescents subject to involuntary treatment orders.

All day programs accept adolescents between the ages of 13 and 18 years. The exception to this is the Lady Cilento Children's Hospital day program, which accepts children from the age of six.

Features

There are five features of the AMHETI child and adolescent day program:

- **Intensive and structured outpatient treatment:** Most patients attend five days per week and participate in timetabled educational, therapeutic, rehabilitation and social activities. Queensland Health describes a typical day for the day program as starting "with a meeting, group walk, and various school subjects, broken up by meals and then therapy or other group activities. All services are generally worked around the school sessions".³⁵
- **Integrated clinical treatment, psychosocial rehabilitation and education:** The child and adolescent day program is the only outpatient AMHETI service element providing integrated clinical treatment, psychosocial rehabilitation and education. Although many day program adolescents are case managed by community CYMHS staff, most of the therapeutic and rehabilitation interventions are provided within the day program environment. These activities are structured around schooling provided by Education Queensland either within the unit itself or on the hospital campus, ensuring the adolescent remains engaged with education.³⁶ In addition to the increased intensity that an integrated program can provide, there are practical benefits for adolescents and their carers by reducing the need for travel to separate locations and appointments.
- **Medium-term support:** Admission is available for two school terms, or around six months.
- **Peer group experience:** Adolescents are a part of a stable peer groups for the one or two school terms and learn how to relate to peers. Belonging to a stable peer group is a critical aspect of patient recovery.
- **Generally co-located with acute inpatient units:** Three of the four day programs (south Brisbane, Toowoomba and Townsville) are co-located with adolescent acute inpatient units. This enables inpatients and adolescents in the community to participate in the same group activities and provides consistency for adolescents who may need to step up to (or down from) an acute inpatient admission during the school term.³⁷

Management and operations

Each day program is governed and delivered by a local HHS. CHQ operates two programs in south Brisbane and north Brisbane. The two other services are operated by the Townsville HHS (Townsville) and the Darling Downs HHS (Toowoomba). CHQ does not have a statewide governance role for the delivery of adolescent day program services.

Although there is a standard model of service for each program, there is significant flexibility for each service to tailor its program to suit the local operating environment and client profile. The programs generally operate five days a week, between 8.00 am and 4.30 pm.³⁸ The Toowoomba program operates from 9.00 am to 3.00 pm.

Day program clients can be case managed in one of three ways:

- **Community CYMHS teams:** for community case managed clients who link with day program services.
- **Day program teams:** typically for adolescents stepping down from an acute inpatient admission into the day program.
- **Acute inpatient units:** for adolescents who are inpatients, but attend day program services and activities.³⁹

Staffing

Day programs are led by a full-time team leader (discipline not specified) and generally supported by a nurse, psychologist, social worker and occupational therapist. Other allied health staff, such as speech pathologists, music therapists or art therapists, may also provide services. A psychiatrist and psychiatric registrar provide clinical governance and treatment (the equivalent of 2.5 days per week each).⁴⁰

Locations

There are currently four day program services in Queensland:

- South Brisbane — Lady Cilento Children's Hospital
- North Brisbane — currently at old Royal Children's Hospital site and relocating to Chermside from mid-2016
- Toowoomba
- Townsville.

Only the north Brisbane program is funded under the AMHETI.

As explained in chapter 27, there were delays in the roll out of some day programs. CHQ established the north Brisbane day program at an interim site on the old Royal Children's Hospital campus until a suitable site for a permanent program was secured and fitted out. This day program will relocate to a standalone building at Chermside by mid-2016.⁴¹

The AMHETI business case proposes to establish two additional day programs at Logan and the Gold Coast over a three year period (2014–15 to 2016–17).⁴²

Client profile

The AMHETI day program service element is for 13 to 18-year-olds with severe and persistent mental illness resulting in severe psychosocial impairment. Adolescents are eligible if they require extended and intensive clinical intervention, but do not need or would not benefit from an inpatient admission. In order to attend the day program, adolescents need a stable family/home life and reliable transportation to and from the day program service.⁴³

Current demographic and diagnostic profile data of day program clients was not available to the Commission. The 2013 Department of Health Child and adolescent day program (CADP) services discussion paper provides the most recent available demographic data. Of the 384 children and adolescents who accessed Mater, Townsville, West Moreton and Darling Downs day program services in 2012–2013:

- fewer than 0.5 per cent were aged 0–5 years
- 6.5 per cent were aged 5–9 years
- 35.2 per cent were aged 10–14 years
- 47.1 per cent were aged 15–17 years
- 10.6 per cent were over the age of 18.⁴⁴

The most common principal diagnostic groups for the 2012–2013 period were:

- anxiety and/or depression (46.1 per cent)
- behavioural and emotional disorders (21.1 per cent)
- “other mental health disorders” (7.8 per cent)
- psychosis (5.7 per cent)
- eating disorders (3.4 per cent)
- self-harm and suicidal ideation (2.9 per cent).⁴⁵

Youth Residential Rehabilitation Units (Youth Resis)

Youth Residential Rehabilitation Units (known also as Youth Resi units or Youth Resis), are a new community-based residential service. The Youth Resi is **not** a clinical service:

The focus of care is rehabilitative not clinical in nature and seeks to foster independence with a lower staff to client ratio. Young people are supported to develop skills of daily living, access their nominated community mental health supports and to re-connect with community based vocational, education and pro-social activities.⁴⁶

Each Youth Resi is operated by a non-government organisation (NGO) in partnership with Queensland Health. The NGO is contracted to provide accommodation and psychosocial rehabilitation for young people aged 16–21 years for up to one year. Youth Resi clients access clinical treatment through Queensland Health community-based services, primarily CYMHS clinics and adult community mental health teams.

There are two NGO service providers for Youth Resi services in Queensland:

- MIND Australia operates the two Townsville units, which opened around the time of the Commission hearings in March 2016.
- Aftercare operates the Brisbane and Cairns units (operational from March 2014 and January 2015 respectively⁴⁷), and the information in this section reflects the operations of those units.⁴⁸

A Youth Resi is not an authorised mental health facility under the *Mental Health Act 2000*. Young people on community category involuntary treatment orders may be voluntarily admitted. Young people on forensic orders may also be voluntarily admitted if assessed as safe for other residents.

Features

Features of the Youth Resi model include:

- **Split model:** The Youth Resi model has two components of recovery – 1) the extended treatment (clinical treatment and support) and 2) rehabilitation (psychosocial rehabilitation). Psychosocial rehabilitation is delivered by the NGO in a residential setting. Clinical treatment is provided by Queensland Health Community Mental Health Services (either CYMHS or adult mental health services), although some adolescents have been case managed by an AMYOS team.⁴⁹ There is also frequent liaison and collaboration between Youth Resi staff and Queensland Health case managers and other external stakeholders.⁵⁰
- **Intensive and long-term support:** Each Youth Resi is staffed by a minimum of two staff 24 hours a day, seven days a week. Each resident has a full-time key worker and an individual service plan identifying the life skills that need developing. The maximum length of stay for adolescents is one year, although additional short-term outreach support is also provided following exit from the residence.⁵¹
- **Focus on psychosocial rehabilitation:** The Aftercare program⁵² generally focuses on developing the skills young people need to live independently and effectively manage their mental illness with appropriate support. This includes:
 - **Psycho-education:** illness and medication management, early detection of relapse and preventing relapse.
 - **Social and communication skills:** social interaction and interpersonal skills, assertiveness, interpersonal problem solving and stress management.
 - **Home management:** cooking, nutrition, shopping, budgeting, housekeeping, personal care, hygiene and presentation.
 - **Other life skills:** managing public transport, engaging appropriate support services and job seeking.
- **Available to older adolescents and young people:** Adolescents must be mature enough to cope with living away from home. The service was designed for 16–21-year-olds. Stephen Stathis (Clinical Director, CHQ) gave oral evidence that CHQ received legal advice there would be “a lot of consent issues” with placing 15-year-olds in Youth Resi services.⁵³

The program also includes a range of individual and group activities. Along with group outings planned as part of the rehabilitation program, residents are encouraged to organise social and recreational activities and outings themselves or in groups. Family support is provided on a case-by-case basis.⁵⁴ Youth Resi residents are required to attend school or other formal education and training, or to be employed, and to get themselves to and from these activities. Engagement in education or employment is prioritised as an early individual service plan goal for those residents who have been disengaged at the time of entry to the program.

Management and operations

CHQ is responsible for the overall governance of the Youth Resi program and for ensuring a generally consistent model of service. A Youth Resi Governance Committee (which meets monthly) oversees the operation of each unit and the program generally. The committee, chaired by Stephen Stathis, includes representatives from:

- each NGO service provider (for example, Aftercare and MIND Australia)
- the Mental Health Alcohol and Other Drugs Branch (MHAODB) of Queensland Health and
- each local HHS that has a Youth Resi in its catchment area.⁵⁵

A separate Youth Resi Referral Panel, including representatives from each NGO service provider and CHQ, also meets monthly to manage referrals.⁵⁶

The contracted NGO is responsible for the day-to-day management and operations of each Youth Resi, governed by a service agreement with CHQ. Despite a standard model of service, each NGO has flexibility in its staffing profile and the development of its own psychosocial rehabilitation model.

Staffing

Youth Resis operated by Aftercare are professionally staffed. Aftercare established its own minimum standards⁵⁷ for the recruitment of staff to ensure they have the skills and experience needed to manage the severity, complexity and acuity of the young people they support.⁵⁸ As Ivan Frkovic (Deputy Chief Executive Officer of Aftercare) said in his written statement: "Our youth residential rehabilitation units have a professional staffing profile even though Aftercare is not required to provide a clinical service".⁵⁹

The service manager is a social worker and former community CYMHS clinic manager, and Aftercare team leaders have allied health qualifications and experience similar to community CYMHS clinic case managers.⁶⁰

Locations

There are currently four Youth Resi units in Queensland — one in Brisbane, two in Townsville and one in Cairns:

- The five-bed Greenslopes unit in Brisbane commenced operations in March 2014.⁶¹ The first adolescent entered the program in late March 2014 and the unit has been at capacity since December 2014.⁶²
- The five-bed Cairns unit commenced operations as a Youth Resi in January 2015. It had previously operated as a Time Out House with a different model of service and different staffing.⁶³
- Two new four-bed units opened in the Townsville suburbs of Aitkenvale and Annandale in February 2016.

The AMHETI business case proposed establishing one Youth Resi unit in each of the three Queensland Health mental health clusters between 2014–15 and 2016–17. The proposed sites included Townsville (northern cluster), north Brisbane (central cluster) and Greenslopes (southern cluster).⁶⁴ The Cairns unit is intended to close once the planned Step Up/Step Down Unit opens in 2017.⁶⁵ A September 2015 Department of Health internal discussion paper noted that an additional service in north Brisbane (Caboolture area) is being considered.⁶⁶

Client profile

The Youth Resi service is available to young people with severe or complex mental health problems and complex psychosocial needs who are socially and functionally impaired, but can manage their basic self-care needs. The service does not accept young people who are:

- acutely unwell, with physical or mental health issues, including those medically compromised by an eating disorder
- significantly intellectually impaired
- withdrawing or detoxing from substance misuse.⁶⁷

Aftercare describes the mental health acuity of residents as “moderate”, although their diagnoses may be complex. Some residents are described as having up to 10 diagnoses “as well as a range of complex social and emotional needs”.⁶⁸ Mental health disorders include a combination of the following: depression, anxiety, chronic self-harm, suicidal ideation, reactive attachment disorder, trauma, bipolar disorder, schizophrenia, eating disorders, obsessive compulsive disorder, emerging personality disorders and gender identity disorder.⁶⁹

Young people with a high level of acuity are not accepted into a Youth Resi. However, a Youth Resi will continue to manage a young person whose condition has deteriorated to the point where they are self-harming on a regular basis, so long as staff assess they can keep the young person safe.⁷⁰ If a resident requires an acute inpatient admission, they can return to the Youth Resi once sufficiently stabilised to continue the rehabilitation program.⁷¹

To date, the average length of stay in the Cairns and Greenslopes units is around nine months.⁷²

Step Up/Step Down Units

The SUSDU model is a new community-based residential service that will provide integrated clinical support and psychosocial rehabilitation for up to three months.

The Step Up/Step Down Unit will provide an early intervention option to reduce the likelihood that a young person at risk of becoming acutely unwell will deteriorate further or relapse and need to be admitted to an acute inpatient unit. The Step Up/Step Down Unit will have two main functions:

- to prevent unnecessary inpatient admissions (“Step up”); and
- to support transition from acute inpatient care to ongoing community-based care (“Step down”).

As part of the AMHETI continuum, CHQ designed the Step Up/Step Down Unit model to be:

- a statewide cluster-based service, with one unit planned for each of the three mental health clinical clusters — each unit would admit patients from any HHS within the northern, central or southern cluster⁷³
- operated by a local HHS, under the statewide governance of CHQ⁷⁴
- for adolescents aged 13–18 years.⁷⁵

The Step Up/Step Down Unit model is based on the Victorian Youth Prevention and Recovery Care (Y-PARC) model established in 2013 (refer to appendix C research).

Like the Youth Resi model, the AMHETI Step Up/Step Down Unit model will be delivered by Queensland Health (which will provide the clinical support) and NGOs (which will provide psychosocial rehabilitation support). Unlike the Youth Resi model, both the clinical and psychosocial components of care will be delivered in the same residential unit as part of an integrated service.

The Step Up/Step Down Unit will not be a gazetted mental health facility and therefore not able to admit adolescents on involuntary treatment orders.⁷⁶

Features

Features of the Step Up/Step Down Unit include:

- **Community-based residential service:** Like the Victorian Y-PARC units, the Step Up/Step Down Unit will be located in a more home-like residential environment than a hospital setting. It will provide 24-hour bed-based care.
- **Integrated clinical treatment and psychosocial rehabilitation support:** The Step Up/Step Down Unit will provide 24-hour care for young people in a “safe, structured, highly supervised and supportive environment”.⁷⁷ The psychosocial rehabilitation component will provide: individual and group support to identify and address personal skills, development needs; maintain and develop natural supports such as family, friends and community groups; and link young people with housing, education or training programs and other social services.
- **No provision for on-site educational support:** Because the Step Up/Step Down Unit is designed as a short-term service there will be no on-site school. However, where appropriate, Education Queensland teachers will provide “in-reach” educational support and help young people’s transition back to mainstream schooling following discharge.⁷⁸ The psychosocial support program seeks to help young people gain employment or enrol in a suitable education or vocational program.⁷⁹
- **Intensive short-term treatment and support:** The Step Up/Step Down Unit model, as initially described in the AMHETI business case and in the draft model of service, had a maximum length of stay of 28 days.⁸⁰ However, CHQ has since decided on a more flexible model with admission available for up to three months, if clinically indicated and subject to monthly review.⁸¹

Management and operations

The management, operational and staffing models of the Step Up/Step Down Unit service element were still being developed when the Commission was considering evidence. Local HHSs will be responsible for governance of Step Up/Step Down Units (refer to table B, appendix C). The available evidence is that a Step Up/Step Down Unit will operate under the direction of:

- a clinical director from the local HHS
- a clinical staff team leader (preferably a nurse) employed by the HHS
- a support staff team leader employed by the contracted NGO.⁸²

The evidence available to the Commission indicates that the Cairns Step Up/Step Down Unit will have differences in its governance arrangements. MHAODB is funding the Cairns Step Up/Step Down (separate to AMHETI funding). There are complex governance and funding arrangements because of this (discussed in chapter 27). It will be operated by the Cairns and Hinterland HHS as a HHS resource. The defined catchment area will not extend to all of the northern mental health clinical cluster, although Judith Krause's evidence is that there is some potential for the unit to admit young people from adjoining HHS catchment areas. MHAODB and the Cairns and Hinterland HHS have decided that the Cairns Step Up/Step Down Unit will admit young people aged 16–21 years, rather than 13–18 years.⁸³

Staffing

A multidisciplinary team will include specialist medical, nursing, allied health, music and art therapists, and mental health support workers from both the local HHS and contracted NGO. The draft model of service does not specify either the staff to patient ratio or the staffing profile for a Step Up/Step Down Unit. It does, however, specify that the proportion of disciplines at each site will be locally determined by the HHS, and that NGO staff will be required to have a certificate 4 in mental health as a minimum qualification.⁸⁴

Each Step Up/Step Down Unit will be staffed by a combination of Queensland Health nursing staff and NGO mental health workers and peer support officers, supported by a consultant psychiatrist and allied health staff and therapists. Nursing staff will be rostered between 8.00 am and 10.00 pm, while NGO mental health workers will staff the unit overnight.⁸⁵ The minimum qualifications of NGO staff on the overnight shift are not specified in the draft model of service.

Locations

There are currently **no** Step Up/Step Down Units in Queensland.

The first Step Up/Step Down Unit is due to open in Cairns by mid-2017, initially as a six-bed unit, with capacity to expand to 12 beds in future.⁸⁶ Queensland Health did not advise the Commission of any current plans beyond that. The AMHETI business case, however, envisaged locating one Step Up/Step Down Unit in each of the three mental health clinical clusters:

- **Northern** — incorporating the HHS catchment areas of Mackay, Townsville, North West, Cairns and Hinterland, and Torres and Cape York.
- **Central** — incorporating the HHS catchment areas of Metro North, Sunshine Coast, Wide Bay, Central Queensland and Central West.
- **Southern** — incorporating the HHS catchment areas of Metro South, Gold Coast, Darling Downs, West Moreton and South West.⁸⁷

Client profile

CHQ describes the Step Up/Step Down Unit client profile in the AMHETI business case:

Young people aged 13–18 who meet the criteria for admission to a mental health service inpatient unit but whose level of risk is such that they can be safely supported in a less restrictive environment than an acute inpatient unit. Primary diagnoses are likely to be psychotic illness, severe mood disorder, or complex trauma with deficits in psychosocial functioning.⁸⁸

The Cairns Step Up/Step Down Unit has a different age profile – 16–21 years.

Krause expressed concern to CHQ colleagues about changes in the model regarding the target client age group, noting it would result in most admissions to the Step Up/Step Down Units being adults aged over 18 years, potentially excluding the adolescent cohort.⁸⁹ Krause's evidence is that:

Children's Health Queensland at all times has advocated strongly for the needs of younger adolescents and see it as potentially discriminatory to exclude the younger age range when we are focussing on the development of the CYMHS extended treatment and rehabilitation continuum of care, which within Queensland is young people under 18.

While we acknowledge the challenges in alignment of service delivery for older youth between 18 and 21 we are also cognizant of the significant needs of a small cohort of young people aged 13–15.

We are currently negotiating with MHAODB to consider a younger cohort for any SUSDU that was funded to be within the Children's Health Queensland local catchment so the younger age range are not inadvertently excluded from a SUSDU model of care. It is my opinion that assuming that young people in the lower adolescent age range do not require access to SUSDU's is a grave risk to the CYMHS continuum of care for adolescent extended treatment and rehabilitation.⁹⁰

Interim statewide sub-acute beds

Four sub-acute beds are nominally available within the 11-bed Adolescent Mental Health Unit at the Lady Cilento Children's Hospital. These statewide sub-acute beds are described by CHQ as "the 'Tier 3' beds that the Expert Clinical Reference Group recommended", providing "extended inpatient care supported by onsite schooling".⁹¹

The Statewide subacute bed referral panel protocol report describes the sub-acute beds as:

medium-term, developmentally-appropriate, hospital-based treatment and rehabilitation services in a safe and structured environment for young people aged 13 to 18 with severe or complex symptoms of mental illness that precludes them receiving treatment in a less restrictive environment.⁹²

Two beds were nominally provided at the Mater Children's Hospital from February 2014 when the BAC closed.⁹³ When the Mater Children's Hospital and Royal Children's Hospital amalgamated to become the Lady Cilento Children's Hospital in November 2014, CHQ increased the nominal allocation of sub-acute beds to four.⁹⁴

The service is considered by CHQ to be an **interim service**. The beds are described as "virtual" or "swing" beds because they are not held exclusively for the use of sub-acute patients. Instead, they are funded as adolescent acute inpatient beds, and used as sub-acute beds only on demand. CHQ has recommended "[m]ost adolescents requiring extended inpatient care be stabilised in their nearest existing acute adolescent unit prior to discharge to less restrictive care".⁹⁵

There are currently no gazetted and funded hospital-based adolescent sub-acute beds within Queensland.⁹⁶

Features

Features of the interim statewide sub-acute beds include:

- **Hospital-based extended-treatment model:** Like the BAC, the statewide sub-acute beds offer a hospital bed-based service providing 24-hour inpatient care. The maximum length of stay is three months, with extension based only on clinical requirements as determined by the Statewide Sub-acute Bed Referral Panel.⁹⁷
- **Co-located within an adolescent acute inpatient unit:** The statewide sub-acute beds are located within the acute adolescent inpatient unit at the Lady Cilento Children's Hospital.
- **Unfunded model with no defined model of service:** There is currently no model of service for the statewide sub-acute beds because "AMHETI does not have any funding for subacute beds".⁹⁸

CHQ notes that the AMHETI statewide sub-acute bed model is "not intended to be a replication of the previous extended treatment approach at BAC"⁹⁹ and identifies four specific differences from the BAC model:

- assessment of referrals by a multidisciplinary statewide assessment panel, rather than a local clinical team
- a maximum three-month stay, although the panel can approve an extension based on clinical requirements
- discharge planning on entry
- "an intensive process of family assessment for integration into the individual treatment plan".¹⁰⁰

Management and operations

Admission to a statewide sub-acute bed is managed by the Statewide Sub-acute Bed Referral Panel established in or about May 2015.¹⁰¹ The panel comprises four child and adolescent psychiatrists and the Nursing Director of Lady Cilento Adolescent Mental Health Unit.¹⁰² It is chaired by the Medical Director, Specialist Services, CYMHS within CHQ (currently Michael Daubney). As at February 2016, the panel had met only twice and considered only three referrals.¹⁰³ An additional three referrals were considered under interim arrangements while the beds were located at the Mater Children's Hospital. Daubney described the types of factors the panel considers in assessing a referral:

The types of variable the panel considers in assessing whether a young person would be likely to benefit from an extended treatment and rehabilitation model in a hospital based subacute bed are complex and multi-faceted, in that the relevant clinician must consider variables such as the: individual patient's medical/psychiatric history and mental state assessment; patient's individual risk assessment; the patient's family involvement in treatment; present systems in place; the current treatment regime and management plan; the available resources to implement alternative treatment; and the available evidence base to support the proposed treatment.¹⁰⁴

At as March 2016 only [redacted] Queensland patients had been admitted as a statewide sub-acute bed patient.¹⁰⁵ The length of stay [redacted]¹⁰⁶ They were “managed through the usual clinical practices of the unit and treatment was tailored to meet their individual client needs”.¹⁰⁷ Despite this, Krause’s evidence is that “their recovery oriented treatment goals reflected their clinical needs which were not acute, but sub-acute (rehabilitative focus)”.¹⁰⁸ For example, [redacted]¹⁰⁹

Staffing

Statewide sub-acute bed patients are managed by Adolescent Mental Health Unit staff through the usual clinical practices of the unit.¹¹⁰

Locations

The statewide sub-acute beds are located in Brisbane, within the Adolescent Mental Health Unit at the Lady Cilento Children’s Hospital.

Client profile

The statewide sub-acute bed referral panel protocol notes that the majority of patients accepted into a statewide sub-acute bed are expected to be current patients of an acute adolescent inpatient unit.¹¹¹ The protocol outlines the following eligibility criteria for the beds:

A young person **may be eligible** for a statewide subacute bed if they:

- Are aged between 13 and 18 years of age, with flexibility in upper age limit depending on presenting issue and developmental age.
- Present with severe or complex mental health problems.
- Are likely to benefit from an extended treatment and rehabilitation model of care in a hospital-based subacute bed.

A young person will **not be eligible** for a statewide subacute bed if they:

- Could be managed in a less restrictive setting.
- Primarily need support with substance misuse issues.
- Their primary problem to be addressed is accommodation.¹¹²

Evidence before the Commission about the difficulties of co-locating sub-acute patients with acute patients in an acute inpatient unit is presented below.

Limitations of interim statewide sub-acute beds

Commission witnesses raised concerns about interim sub-acute beds being collocated with acute beds.¹¹³

Stathis defended the statewide sub-acute bed model on the basis that there was “no capital funding to build another unit” and “no demand for another” unit and therefore “no other option” but to establish the swing beds in the Adolescent Mental Health Unit at the Lady Cilento Children’s Hospital.¹¹⁴ Nonetheless, in his oral evidence he agreed that the current model is a “suboptimal” option and “our view is that sub-acute beds in acute wards are not ideal”.¹¹⁵

The only expert to provide any support for the concept of treating sub-acute patients in an acute ward was Beth Kotzé, who qualified her support by noting that “[i]t really depends on the profile of clinical care need of the young person. It is certainly possible to do that and it is desirable in certain circumstances”.¹¹⁶ She suggested that it may be appropriate to do this in the last stage of an admission where there are established relationships and an “established and positive treatment trajectory in train” and it would cause disruption to send a patient to another setting.¹¹⁷ However she warned that “[i]t does have to be purposefully managed with good operational policies and good clinical leadership to ensure that the clinical care needs of both groups are met in parallel”.¹¹⁸

The evidence of Peter Parry (current Medical Director, CYMHS Campus Services within Lady Cilento Children’s Hospital) is that, given the very limited number of referrals and the limited number of acute inpatient beds, the four ‘swing’ beds are frequently used by acute patients and it is not uncommon for all 11 beds to be occupied.¹¹⁹

While some expert witnesses did not have direct knowledge of the interim statewide sub-acute beds, and had not visited the Adolescent Mental Health Unit at the Lady Cilento Hospital¹²⁰ most expressed concern about locating sub-acute beds within an acute ward. There were three main concerns:

- the different needs of acute and sub-acute patients and competing resource needs
- the ward milieu in an acute unit
- the physical environment.

The different needs of acute and sub-acute patients and competing resource needs

Philip Hazell explained how unwell young people being admitted to an acute ward environment creates an issue of resource allocation:

So inevitably acutely unwell, recently arrived patients tend to soak up most of the clinician time and attention. It’s a reality. It’s unavoidable, because you need to quickly assess a situation and try and resolve the immediate distress. So the first problem is an issue of resource allocation.¹²¹

(emphasis added)

Michelle Fryer had similar views about the different needs of sub-acute and acute patients stating that acutely unwell young people require “stabilisation of mental state”, medication and treatment.¹²² Similarly, Stathis identified differing milieu, clinical and treatment needs of short stay and long stay patients as difficulties with treating sub-acute patients in an acute inpatient ward.¹²³ The Expert Clinical Reference Group (ECRG) noted in the ‘Proposed service model elements’ report that the “risk of institutionalisation is considered greater if the young person receives medium-term care in an acute unit (versus a design-specific extended care unit)”.¹²⁴

Ward milieu

The ward milieu can destabilise a young person. As explained by Hazell, it can occur with acutely unwell patients in the ward:

The experience in an acute unit is that every time you introduce a new acutely unwell patient you destabilise the longer-term patients. So that is going to be the risk of running a subacute service within the confines of an acute unit. Some of those concerns can be mitigated by ensuring that there are adequate resources, but it's not going to alter the milieu issue.¹²⁵

(emphasis added)

The ECRG noted in the 'Proposed service model elements' report that "[c]linical experience shows that prolonged admissions of such young people to acute units can have an adverse impact on other young people admitted for acute treatment".¹²⁶ Trevor Sadler agreed that sub-acute beds located within an acute ward cannot offer the stability that is essential to the treatment of sub-acute patients:

Stability of relationships and stability of environment are essential to the treatment of these adolescents. This stability cannot be found in sub-acute beds located at the Lady Cilento Children's Hospital as these beds are located within the acute inpatient unit and, as such, there would necessarily be a certain level of instability in the cohort of adolescents.¹²⁷

Parry's evidence was that "the combination of this group of extended treatment patients [with chronic complex developmental trauma and borderline personality traits] with acute patients together on an inpatient unit is likely to be deleterious to both groups".¹²⁸ Similarly, Breakey voiced concern about the location of sub-acute beds in an acute ward at the Lady Cilento Hospital. He explained:

The particular cohort of kids that we consistently had at Barrett are ones who are generally seen as not coping well with the acute units because of the – the regular changeover of kids ... many of the Barrett cohort have attachment issues and anxieties and learning – coping with new kids at every step is a big problem for them, as is coping with changes in staff. So acute units generally see the Barrett cohort of patients as ... not settling in well or even being disruptive in the acute services.¹²⁹

Physical environment

McDermott said he had no direct knowledge of the sub-acute beds at the Lady Cilento Hospital,¹³⁰ his view is that acute inpatient wards are not places for rehabilitation, but rather it would be desirable to step someone down from an acute ward to a more "home-like environment".¹³¹ Having visited the sub-acute beds at the Lady Cilento Hospital, James Scott explained that:

The difficulty of subacute beds – I was at the Lady Cilento Hospital a couple of weeks ago, looking at the unit there, and it's certainly not somewhere where I would want a young person housed for any length of time. It's up on a high level. The outdoor areas are small courtyards. There's no cover from the sun. There's a gym with an exercise bike sitting in the corner that looks like it hasn't been used since it's been placed there. I think that it would be an unhealthy environment for any young person to be there for any length of time.¹³²

THE EVOLVE MODEL

Evolve Interagency Services was established in 2006 in response to the Crime and Misconduct Commission's 2004 Inquiry Into the Abuse of Children in Foster Care. Evolve is a formalised partnership of the Department of Communities, Child Safety and Disability Services (DCCSDS), the Department of Health, and the Department of Education and Training to provide coordinated therapeutic and behaviour support services for young people in the child protection system.

Each agency has specific responsibilities:

- Child Safety Services: is the lead agency and is responsible for case planning coordination.
- Disability Services: provides positive behaviour support services and specialist disability assessments through Evolve Behaviour Support Services.
- Department of Education and Training: provides school guidance officers who coordinate educational support.
- Department of Health: provides specialist trauma-informed mental healthcare through Evolve Therapeutic Services.

There are three levels of governance to ensure effective coordination and service delivery:

- Local panels, comprising the partnership agencies and other stakeholders, are responsible for the management of referrals, case management and review and coordination of service delivery to individual clients.
- Local steering committees are responsible for ensuring the engagement of appropriate agencies to support service delivery, local issue resolution and strategic management of the local services.
- Statewide steering committees are responsible for policy and program coordination and strategic management.¹³³

There are 10 multidisciplinary teams operating across 17 sites. Each team is governed by a service agreement between the local HHS and DCCSDS regional office. In 2014–15 there were 134 full-time equivalent positions in the Queensland Health Evolve Therapeutic Services at a cost of \$19.3 million.¹³⁴ In 2013, Evolve Therapeutic Services managed 595 young people for an average service duration of 18 months.

(Endnotes)

- 1 Exhibit 280, Children's Health Queensland 2016, Statewide sub-acute beds discussion paper, January, Brisbane: Children's Health Queensland HHS, p 53; Exhibit 305, Children's Health Queensland, Feedback on Discussion Paper 4E service mapping; Exhibit 618, Children's Health Queensland Hospital and Health Service 2014, 'Business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation model of care', version 4.0, July 2014.
- 2 Exhibit 304, Children's Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, p 7. The child and youth acute inpatient unit at Robina Hospital on the Gold Coast can admit both children and adolescents.
- 3 Exhibit 618, Children's Health Queensland Hospital and Health Service 2014, 'Business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation model of care', version 4.0, July 2014, p 30.
- 4 Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment ZI to that statement, pp 3502–3519; Schley, C, Radovini, A, Halperin, S & Fletcher, K, 2011, 'Intensive outreach in youth mental health: Description of a service model for young people who are difficult-to-engage and high-risk', *Child and Youth Services Review*, volume 33, number 9, pp 1506–1514; Exhibit 435, Statement of Michael Daubney, 22 February 2016, Attachment MD3 to that statement, pp 24–32.

- 5 Exhibit 304, Children's Health Queensland, Feedback on Discussion Paper 4D comparison of service elements; Exhibit 280, Children's Health Queensland 2016, Statewide sub-acute beds discussion paper, January, Brisbane: Children's Health Queensland HHS, p 53.
- 6 Schley, C, Radovini, A, Halperin, S & Fletcher, K, 2011, 'Intensive outreach in youth mental health: Description of a service model for young people who are difficult-to-engage and high-risk', *Child and Youth Services Review*, volume 33, number 9, pp 1506–1514, (p 1511); Exhibit 435, Statement of Michael Daubney, 22 February 2016, Attachment MD3 to that statement, pp 24–32.
- 7 Chia, A, Assan, B, Finch, E, Stargatt, R, Burchell, P, Jones, H, & Heywood-Smith, J 2013, 'Innovations in practice: Effectiveness of specialist adolescent outreach service for at-risk adolescents', *Child and Adolescent Mental Health*, volume 18, number 2, pp 116–119.
- 8 Exhibit 114, Statement of James Scott, 4 February 2016, p 14 paras 80(a) and 81.
- 9 Darwish, A, Salmon, G, Ahuja, A & Steed, L 2006, 'The community intensive therapy team: development and philosophy of a new service', *Clinical Child Psychology and Psychiatry*, volume 11, number 4, pp 591–605.
- 10 Exhibit 74, Second supplementary statement of Judith Krause, 4 February 2016, p 10 para Q. 21.
- 11 Exhibit 435, Statement of Michael Daubney, 22 February 2016, p 3 para 11.
- 12 See Appendix C Research relating to AMHETI services for an explanation of MBT. Exhibit 435, Statement of Michael Daubney, 22 February 2016, p 3 para 11.
- 13 Exhibit 73, Supplementary statement of Judith Krause, 19 January 2016, p 32 para 25.
- 14 Exhibit 435, Statement of Michael Daubney, 22 February 2016, Attachment MD4 to that statement, pp 33–50.
- 15 Exhibit 435, Statement of Michael Daubney, 22 February 2016, Attachment MD4 to that statement, pp 33–50.
- 16 Transcript, Angela Clarke, 29 February 2016, p 16–22 lines 30–42.
- 17 Transcript, Angela Clarke, 29 February 2016, p 16–22 lines 29–34.
- 18 Exhibit 435, Statement of Michael Daubney, 22 February 2016, pp 2–3 para 8.
- 19 Exhibit 435, Statement of Michael Daubney, 22 February 2016, p 1 para 3(b).
- 20 Exhibit 661, Children's Health Queensland HHS 2015, Adolescent Mental Health Extended Treatment Initiative (AMHETI) update, 18 June 2015.
- 21 Exhibit 304, Children's Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, p 6.
- 22 Exhibit 304, Children's Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, p 6.
- 23 Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment ZI to that statement, pp 2536–2544.
- 24 Exhibit 618, Children's Health Queensland Hospital and Health Service 2014, 'Business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation model of care', version 4.0, July 2014, p 30.
- 25 Exhibit 280, Children's Health Queensland 2016, Statewide sub-acute beds discussion paper, January, Brisbane: Children's Health Queensland HHS, p 82.
- 26 This is based on the Children's Global Assessment Scale (CGAS). Exhibit 280, Children's Health Queensland 2016, Statewide sub-acute beds discussion paper, January, Brisbane: Children's Health Queensland HHS, p 82.
- 27 Gahan, K & Kijas, J 2014, *The mental welfare of children: A history of child and adolescent mental health services in Queensland*, University of Queensland Press, Brisbane, p 209.
- 28 Exhibit 304, Children's Health Queensland, Feedback on Discussion Paper 4D comparison of service elements.
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- 31 Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment ZJ to that statement, pp 7193–7221.
- 32 Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment ZJ to that statement, pp 7193–7221.
- 33 Exhibit 988, Mental Health Alcohol and Other Drugs Branch 2013, 'Child and Adolescent Day Program (CADP) services discussion paper', December, Department of Health, p 1.
- 34 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 21 para 106.
- 35 Exhibit 988, Mental Health Alcohol and Other Drugs Branch 2013, 'Child and Adolescent Day Program (CADP) services discussion paper', December, Department of Health, p 1.
- 36 Exhibit 618, Children's Health Queensland Hospital and Health Service 2014, 'Business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation model of care', version 4.0, July 2014; Exhibit 74, Second supplementary statement of Judith Krause, 4 February 2016, pp 10–11 para Q. 21(a)(ii).
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- 39 Exhibit 988, Mental Health Alcohol and Other Drugs Branch 2013, 'Child and Adolescent Day Program (CADP) services discussion paper', December, Department of Health, p 2.
- 40 Exhibit 304, Children's Health Queensland, Feedback on Discussion Paper 4D comparison of service elements.
- 41 Exhibit 73, Supplementary statement of Judith Krause, 19 January 2016, pp 14–15 para 10(h)(iv).
- 42 Exhibit 618, Children's Health Queensland Hospital and Health Service 2014, 'Business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation model of care', version 4.0, July 2014, p 18.
- 43 Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment ZJ to that statement, pp 7193–7221.
- 44 Exhibit 988, Mental Health Alcohol and Other Drugs Branch 2013, 'Child and Adolescent Day Program (CADP) services discussion paper', December, Department of Health, p 5.
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- 46 Exhibit 73, Supplementary statement of Judith Krause, 19 January 2016, p 34 para 27(b)(i).
- 47 Exhibit 255, Statement of Myfanwy Pitcher, 25 February 2016, p 2 para 4.
- 48 Language is considered important in recovery-oriented mental health services. Youth Resi consumers are described as "residents" or "young people". The young people "enter" and "exit" the program, rather being "admitted" and "discharged". Exhibit 255, Statement of Myfanwy Pitcher, 25 February 2016, p 3 para 13.
- 49 Exhibit 255, Statement of Myfanwy Pitcher, 25 February 2016, p 2 para 5.
- 50 Exhibit 255, Statement of Myfanwy Pitcher, 25 February 2016, p 2 para 4, p 9 para 52 (b).
- 51 Exhibit 255, Statement of Myfanwy Pitcher, 25 February 2016, p 2 para 8.
- 52 The specific components of the Aftercare Living Skills program were afforded confidentiality as "commercial-in-confidence" and therefore cannot be described in detail. Exhibit 255, Statement of Myfanwy Pitcher, 25 February 2016, p 4 para 17.
- 53 Transcript, Stephen Stathis, 10 March 2016, p 24-51, lines 25–29.
- 54 Exhibit 255, Statement of Myfanwy Pitcher, 25 February 2016, p 4 para 17.
- 55 Exhibit 256, Statement of Ivan Frkovic, 25 February 2016, p 7 para 31.
- 56 Exhibit 256, Statement of Ivan Frkovic, 25 February 2016, p 7 paras 31–32.
- 57 The specific staffing profile of the Youth Resi services operated by Aftercare in Brisbane and Cairns was afforded confidentiality as "commercial-in-confidence" and therefore cannot be described in detail.
- 58 Exhibit 255, Statement of Myfanwy Pitcher, 25 February 2016, p 10 para 55.
- 59 Exhibit 256, Statement of Ivan Frkovic, 25 February 2016, pp 5–6 para 20.
- 60 Exhibit 256, Statement of Ivan Frkovic, 25 February 2016, pp 5–6 para 20.
- 61 Exhibit 255, Statement of Myfanwy Pitcher, 25 February 2015, p 2 para 4; Exhibit 256, Statement of Ivan Frkovic, 25 February 2016, p 10 para 53; Transcript, William Kingswell, 24 February 2016, p 13-40 lines 41–44.
- 62 Exhibit 255, Statement of Myfanwy Pitcher, 25 February 2015, p 15 para 93; Exhibit 256, Statement of Ivan Frkovic, 25 February 2016, p 6 para 26.
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- 66 Exhibit 648, Department of Health 2015, 'Discussion paper: rebuilding intensive mental healthcare for young people', prepared by the Mental Health Alcohol and Other Drugs Branch, September, p 9.
- 67 Exhibit 255, Statement of Myfanwy Pitcher, 25 February 2016, p 7 paras 37–38.
- 68 Exhibit 255, Statement of Myfanwy Pitcher, 25 February 2015, p 12 para 68.
- 69 Exhibit 255, Statement of Myfanwy Pitcher, 25 February 2015, p 12 para 67.
- 70 Exhibit 255, Statement of Myfanwy Pitcher, 25 February 2015, p 12 para 69.
- 71 Exhibit 255, Statement of Myfanwy Pitcher, 25 February 2015, p 6 para 30.
- 72 Exhibit 255, Statement of Myfanwy Pitcher, 25 February 2016, p 11 paras 62–63.

- 73 Exhibit 74, Second supplementary statement of Judith Krause, 4 February 2016, pp 29, 32 paras Q. 63(c), Q. 67(a); Exhibit 30, Children's Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, p 6.
- 74 Exhibit 618, Children's Health Queensland Hospital and Health Service 2014, 'Business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation model of care', version 4.0, July 2014, pp 29, 61.
- 75 Exhibit 618, Children's Health Queensland Hospital and Health Service 2014, 'Business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation model of care', version 4.0, July 2014, p 29; Exhibit 74, Second supplementary statement of Judith Krause, 4 February 2016, p 29 para Q. 63(c); Exhibit 304, Children's Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, p 2.
- 76 Exhibit 123, Statement of Stephen Stathis, 15 February 2016, Attachment D to that statement, pp 109–157.
- 77 Exhibit 123, Statement of Stephen Stathis, 15 February 2016, Attachment D to that statement, pp 109–157.
- 78 Exhibit 123, Statement of Stephen Stathis, 15 February 2016, Attachment D to that statement, pp 109–157; Exhibit 74, Second supplementary statement of Judith Krause, 4 February 2016, p 32 para Q.67(a).
- 79 Exhibit 123, Statement of Stephen Stathis, 15 February 2016, Attachment D to that statement, pp 109–157; Exhibit 989, Bendigo Health (undated) 'Excerpt from – Youth PARC interim functional guidelines.
- 80 Exhibit 618, Children's Health Queensland Hospital and Health Service 2014, 'Business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation model of care', version 4.0, July 2014, p 60.
- 81 Exhibit 123, Statement of Stephen Stathis, 15 January 2016, p 9 para 27; Exhibit 304, Children's Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, p 4.
- 82 Exhibit 123, Statement of Stephen Stathis, 15 February 2016, Attachment D to that statement, pp 109–157.
- 83 Exhibit 74, Second supplementary statement of Judith Krause, 4 February 2016, pp 29–30 paras Q. 63(c) and Q65(b); Exhibit 304, Children's Health Queensland, Feedback on Discussion Paper 4D comparison of service elements.
- 84 Exhibit 123, Statement of Stephen Stathis, 15 February 2016, Attachment D to that statement, pp 109–157.
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- 86 Exhibit 648, Mental Health Alcohol and Other Drugs Branch 2015, 'Discussion paper: Rebuilding intensive mental healthcare for young people', September, Brisbane: Department of Health,
- 87 Exhibit 618, Children's Health Queensland Hospital and Health Service 2014, 'Business case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation model of care', version 4.0, July 2014.
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- 90 Exhibit 74, Second supplementary statement of Judith Krause, 4 February 2016, p 30 para Q. 65(b).
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- 92 Statewide subacute bed referral panel protocol, p 1, Attachment MD2 to Exhibit 435, Statement of Michael Daubney, 22 February 2016, pp 13–23.
- 93 Exhibit 1312, Correspondence from Sean Hubbard, Chief Operating Officer, Mater Health to the Commission on 18 February 2016.
- 94 Exhibit 280, Children's Health Queensland 2016, Statewide sub-acute beds discussion paper, January, Brisbane: Children's Health Queensland HHS, p 7.
- 95 Exhibit 280, Children's Health Queensland 2016, Statewide sub-acute beds discussion paper, January, Brisbane: Children's Health Queensland HHS, p 88.
- 96 Exhibit 74, Second supplementary statement of Judith Krause, 4 February 2016, pp 24–25 para Q. 60(a).
- 97 Exhibit 280, Children's Health Queensland 2016, Statewide sub-acute beds discussion paper, January, Brisbane: Children's Health Queensland HHS, p 25; Statewide subacute bed referral panel protocol, p 1, Attachment MD2 to Exhibit 435, Statement of Michael Daubney, 22 February 2016, pp 13–23.
- 98 Exhibit 74, Second supplementary statement of Judith Krause, 4 February 2016, p 15 para Q. 33(c).
- 99 Exhibit 280, Children's Health Queensland 2016, Statewide sub-acute beds discussion paper, January, Brisbane: Children's Health Queensland HHS, p 24.
- 100 Exhibit 280, Children's Health Queensland 2016, Statewide sub-acute beds discussion paper, January, Brisbane: Children's Health Queensland HHS, pp 24–25.
- 101 Exhibit 435, Statement of Michael Daubney, 22 February 2016, p 5 para 22(a).
- 102 Exhibit 435, Statement of Michael Daubney, 22 February 2016, p 5 para 21, Attachment MD2 to that statement, pp 13–23.
- 103 Exhibit 435, Statement of Michael Daubney, 22 February 2016, p 5 22(b) and p 6 para 28.

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- 105 Exhibit 176, Statement of Peter Parry, 4 February 2016, p 3 para 11; Exhibit 280, Children's Health Queensland 2016, Statewide sub-acute beds discussion paper, January, Brisbane: Children's Health Queensland HHS, p 25.
- 106 Exhibit 278, Email from Judith Krause to Fionnagh Dougan regarding progress of the sub-acute discussion paper, 10 September 2015; 'Consumer summary report: subacute beds', Attachment E to Exhibit 176, Statement of Peter Parry, 4 February 2016, p 52.
- 107 Exhibit 280, Children's Health Queensland 2016, Statewide sub-acute beds discussion paper, January, Brisbane: Children's Health Queensland HHS, p 25.
- 108 Exhibit 74, Statement of Judith Krause, 4 February 2016, p 20 para Q. 53(d).
- 109 Exhibit 278, Email from Judith Krause to Fionnagh Dougan regarding progress of the sub-acute discussion paper, 10 September 2015.
- 110 Exhibit 280, Children's Health Queensland 2016, Statewide sub-acute beds discussion paper, January, Brisbane: Children's Health Queensland HHS, p 25.
- 111 Exhibit 435, Statement of Michael Daubney, 22 February 2016, Attachment MD2 to that statement, pp 13–23.
- 112 Exhibit 435, Statement of Michael Daubney, 22 February 2016, Attachment MD2 to that statement, pp 13–23 (para 2.1).
- 113 See for example, Transcript, Cary Breakey, 15 February 2016, p 6-39 lines 42–43 and p 6-53 lines 24–30; Transcript, Aaron Groves, 16 February 2016, p 7-84 lines 41–47; Transcript, Brett McDermott, 16 February 2016, p 7-43 line 41 – p 7-44 line 15; Transcript, James Scott, 17 February 2016, p 8-13 lines 11–16.
- 114 Transcript, Stephen Stathis, 10 March 2016, p 24-49 lines 34–37.
- 115 Transcript, Stephen Stathis, 10 March 2016, p 24-49 line 36.
- 116 Transcript, Beth Kotzé, 9 March 2016, p 23-9 lines 41–45.
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- 119 Exhibit 176, Statement of Peter Parry, 4 February 2016, pp 4–5 paras 13–14.
- 120 Transcript, Cary Breakey, 15 February 2016, p 6-41 lines 30–40; Transcript, Brett McDermott, 16 February 2016, p 7-43 lines 30–35; Transcript, Beth Kotzé, 9 March 2016, p 23-9 lines 25–35; Transcript, Graham Martin, 11 March 2013, p 25-44 lines 1–15.
- 121 Transcript, Philip Hazell, 17 February 2016, p 8-37, lines 38–41.
- 122 Transcript, Michelle Fryer, 11 March 2016, p 25-13, line 13.
- 123 Exhibit 123, Supplementary statement of Stephen Stathis, 15 January 2016, p 15 para 49.
- 124 Exhibit 216, Proposed Service Model Elements: Adolescent Extended Treatment and Rehabilitation Services (AETRS), endorsed by ECRG on 8 May 2013, p 3.
- 125 Transcript, Philip Hazell, 17 February 2016, p 8-37 lines 45–47 – p 8-38 lines 1–3.
- 126 Exhibit 216, Proposed Service Model Elements: Adolescent Extended Treatment and Rehabilitation Services (AETRS), endorsed by ECRG on 8 May 2013, p 3.
- 127 Exhibit 179, Supplementary statement Sadler, 12 February 2016, p 42 para 175.
- 128 Exhibit 176, Statement of Peter Parry, 4 February 2016, p 7, para 21.
- 129 Transcript, Cary Breakey, 15 February 2016, p 6-53 lines 24–30.
- 130 Transcript, Brett McDermott, 16 February 2016, p 7-43 lines 30–35.
- 131 Transcript, Brett McDermott, 16 February 2016, p 7-44 lines 5–9.
- 132 Transcript, James Scott, 17 February 2016, p 8-13 lines 11–18.
- 133 Exhibit 1087, Queensland Health 2015, Evolve Therapeutic Services performance review, Brisbane: Queensland Health, March 2015.
- 134 Exhibit 1087, Queensland Health 2015, Evolve Therapeutic Services performance review, Brisbane: Queensland Health, March 2015.

29 Education – Since the cessation of the on-site program

The Barrett Adolescent Centre Special School at Yeronga

The relocation of the BACSS from Wacol to the Yeronga State High School campus in January 2014 was expected to be temporary, for a period of 12 months. This was because Yeronga SHS would require the classrooms that were to be used by the BACSS for its first cohort of year seven students, who were to arrive in 2015.¹

The BACSS opened at the new site at Yeronga in January 2014 with [] students.² [] of them required outreach services because they were unable to attend school physically on account of their complex mental illnesses or living too far away.³

All the permanent teaching staff at the BACSS at Wacol moved to the new site, including the principal Kevin Rodgers, who returned from leave for the start of the first term. A junior registered nurse was also employed for the first six months to assist with student health and well-being.⁴

Deborah Rankin, who was the acting principal at the BACSS at Yeronga from April 2014 until December 2014, gave evidence that once the students had transitioned from the BACSS at Wacol to Yeronga, the procedures developed at the Wacol site were followed.⁵ This meant that all students (including outreach students) had personal education plans and a class teacher who assessed their educational needs and ability to access their chosen educational outcomes, in consultation with their health care providers and their families or carers. Education staff discussed each student's progress daily, and in more detail at a weekly meeting, as they had done at Wacol. Families and carers were also kept up to date by email and phone.⁶

For those outreach students requiring more assistance, the BACSS education staff at Yeronga provided outreach visits and, at least once a week, contact by phone and email. Rankin described these outreach services as not easy to set up and limited because of the distances to be travelled and the difficulty of providing educational support in an outreach environment.⁷

Brett McDermott (Executive Director, Child and Youth Mental Health Services) was alarmed when he found out that the BACSS was operating at Yeronga. In an email to Stephen Stathis (Clinical Director, Children's Health Queensland HHS (CHQ)) on 3 April 2014, he expressed particular concern that the school was running a "BAC-like service with minimal mental health resources".⁸ In his oral evidence he said relevantly:

McDERMOTT: This is actually a very unusual situation where before you had a school geographically intimately located to [sic] a mental health unit. There were mental health staff within minutes of that school. There were lots of staff from a high level of seniority, you know, right through the continuum of staff.

McMILLAN: Yes?

McDERMOTT: Looking after a group of individuals who had complex needs. This scenario is similar, if you like, patients – similar young people with similar school staff with, from what I was told, was .5 FTE [full-time equivalent] of a mental health nurse – totally different scenario. I was extremely worried when I heard of this - that these were a group of young people who, if they become aroused or acutely agitated or disturbed, they ha[d] none of the scaffolding that was there at the Barrett Adolescent Centre. Hence my email.⁹

McDermott's concerns about the uncoupling of Education and Health were well made and reflected in evidence the Commission received from a number of teachers.

Rodgers described the issue as follows:

When things got particularly desperate, education staff could call Patient A's mental health service providers. I recall there were often problems contacting the mental health service providers or we received the response that they could not respond to our concerns and Patient A would need to contact them personally. When Patient A was in crisis they refused to contact Queensland Health staff.

When based at Wacol, education staff could call for assistance from clinical staff of a student was having problems relating to [their] mental health. Those resources were no longer available to the education staff after the transition to the Yeronga site.¹⁰

Rodgers went on to say that the way patients at the BAC often engaged with clinical staff, education staff and other students helped promote regular attendance at the on-site school. However, after the BAC closed and the BACSS relocated to Yeronga, some students returned home and retreated to the confines of their bedrooms. In one student's case, [REDACTED]

[REDACTED]

.¹¹

Peter Blatch, the Assistant Regional Director, School Performance, Metropolitan Region, gave evidence that the BACSS encountered a number of operational issues at the Yeronga site, including information technology and facility issues.¹² He also gave evidence that throughout the 2014 school year, education staff told him they were concerned about the lack of mental health care being provided to the students at Yeronga.¹³

Darren Bate, a teacher's aide who worked at the BACSS at Wacol, Yeronga and Tennyson, said that at the Wacol site there was open communication and constant engagement with health staff, allowing all staff to be aware of the students' current conditions and states of mind, and that allied health officers were in the school building facilitating appointments taking place during school hours.¹⁴ At Yeronga, where there were no medical staff on site, education staff had to ascertain that information by speaking to families or carers when they dropped the students off at school; this was not always possible, as a number of the students arrived by taxi.¹⁵

The Barrett Adolescent Centre Special School at Tennyson

The BACSS relocated from Yeronga to the Tennyson Special School site at Tennyson at the end of 2014.¹⁶ The Tennyson Special School was described as a Band 6 special school catering specifically for primary aged children with severe behavioural issues including mental health conditions, who were difficult to support successfully in mainstream primary school settings.¹⁷

There was evidence of a ministerial plan for the BACSS to be amalgamated with the Tennyson Special School.¹⁸ This plan was put on hold “until such time as Queensland Health’s plan to build a new facility for young people with serious mental health conditions, including an integrated specific-purpose school, is known”.¹⁹

By the time it relocated from Yeronga to Tennyson, the BACSS bore little resemblance to the on-site school at Wacol.

The BACSS at Tennyson is in an area variously described as industrial, confined and congested. It is close to a grain mill, and consequently exposed to associated heavy vehicle traffic.²⁰ It is currently housed in a demountable building consisting of one open plan teaching room with a small side room which is used both for teaching and as a staffroom. There is a small room for the principal. The administration officer sits in the hallway. The only toilet doubles as a storeroom. There was evidence that the BACSS staff negotiated the use of the Tennyson Special School classrooms and kitchen, but these proved unsuitable for the students, as the benches and desks were too low, and the chairs too small.²¹

Rankin contrasted the school at Tennyson with “our School” [the BACSS at Wacol]:

[The] culture and philosophies of the two schools were very different. Tennyson Special School was [a] very behavioural-based model and dealt with young people who acted-out and required regular time-out and restraint. Our School was a relational model that used a supportive strengths based approach.²²

Another witness described the BACSS at Tennyson as “just a transition school”: young people who attended there had previously refused to attend school, and the purpose of the school at Tennyson was to transition them back to their base schools.²³

The BACSS at Wacol catered exclusively for adolescents who were inpatients or day patients of the BAC. By contrast, students are referred to the school at Tennyson by Guidance Officers, CYMHS, Department of Education and Training Youth Support Coordinators and mental health service providers such as psychologists and psychiatrists in private practice.²⁴ Only students enrolled at state schools are eligible for admission to the BACSS at Tennyson.²⁵

The students enrolled at the BACSS at Tennyson either attend school there physically or receive support at their base school. There was evidence that as at late November 2015 [redacted] attending school at the BACSS at Tennyson and 17 other students²⁶ were being supported (through outreach and their base schools).²⁷ The ages of the students ranged between 14 and 18 years of age, with one 20-year-old ex-student visiting occasionally.²⁸ Attendance varies from student to student in terms of both the number of hours per day and the number of days per week.

At Tennyson, each student has a Negotiated Education Plan (NEP) drafted by their base school.²⁹ Students are assessed using the 'Compass Test', which is a diagnostic test that forms part of the Online Assessment and Reporting System run by the Australian Council for Educational Research. Students undertake the test online and the system generates a report identifies gaps in literacy and numeracy.³⁰

The BACSS at Tennyson does not employ a psychologist or social worker, although it has a teacher's aide who is trained in social welfare.³¹ Communication with the students' clinicians is not on an "as needed" basis, with access to clinicians varying, and students having to wait for appointments with them.³²

Education staff do not have the advantages of "immediacy and constancy" in being able to access clinical and allied health care assistance quickly whenever the need emerges in the classroom.³³

According to Walton, the current plan is for the BACSS to continue operating at Tennyson pending the outcome of this Commission of Inquiry.³⁴

The Lady Cilento Children's Hospital School

Patients of the Adolescent Mental Health Unit at the Lady Cilento Children's Hospital (whether admitted as acute patients or subacute patients) have access to the Lady Cilento Children's Hospital School (LCCHS).³⁵ It has been in operation since about November 2014 and has two campuses (at the LCCH and at Herston).

The education services provided by the LCCHS are available to a broad range of patients and their families. They are not restricted to patients with mental illness. Every child/adolescent receiving treatment in any inpatient unit of the LCCH is eligible to attend the school, as are patients admitted to the Mater Private Hospital. A patient's sibling may attend the school if the family has had to move to Brisbane for an extended period. Similarly, LCCHS accepts students who have travelled from regional areas because their parents are receiving treatment.³⁶ It also receives referrals from CYMHS for day patient education. Unlike the BACSS, the LCCHS does not provide outreach services to young people with mental illness.

Possible future models of care

The decision to close the BAC resulted in the cessation of the on-site integrated education program and led to the BACSS continuing as a stand-alone education service at two other locations without the integration and "scaffolding" which had characterised it at Wacol.

Deborah Rankin described an education model suited to treating adolescents with complex mental health needs as one where health and education staff work together as an integrated team, assisting each other and providing input from an experienced group of professionals.³⁷ She spoke of a combination of the educational model at Wacol with new services like the outreach work currently being undertaken, and of a statewide model of care to provide services in regional areas outside Brisbane.³⁸

The Commission accepts the submissions on the behalf of the State of Queensland that:

- it is preferable, wherever possible, for young people with significant mental health needs to be kept connected to their local community and their local school
- support should be provided using cross-agency models of care and planning
- in some instances this will not be possible, as the student will need to be in a health facility under medical care and supervision. In these instances, it is important that any models of schooling provide an integrated approach by education and health that promotes the wellbeing of the student
- it is imperative that medical support be readily available within the education setting, for example, a child and youth psychiatrist and other mental health clinical staff
- if a student is in a facility under medical care, it is important to establish links with the student's base school to assist with connection to local community and the transition back to school when the student is discharged from the facility.³⁹

A 'Students with Complex Mental Health Conditions Advisory Group' has recently been established to provide the Department of Education with advice in relation to the statewide coordination and delivery of educational services to young people with severe and complex mental health issues.⁴⁰ Its membership includes Michelle Bond (Principal of the LCCHS) and Rankin, and representatives from the Mental Health Commission, Mental Health Alcohol and Other Drugs Branch (MHAODB) and child and youth mental health specialists.⁴¹

(Endnotes)

- 1 Exhibit 106, Statement of Deborah Rankin, 11 October 2015, p 31 para 120.
- 2 Exhibit 106, Statement of Deborah Rankin, 11 October 2015, p 33 para 126.
- 3 Exhibit 19, Statement of Janine Armitage, 14 December 2015, p 10 para 39.
- 4 Exhibit 173, Email from Brett McDermott to Stephen Stathis, Subject: "Current risk of ex-BAC patients", 3 April 2014.
- 5 Exhibit 106, Statement of Deborah Rankin, 11 October 2015, pp 28–29 para 109.
- 6 Exhibit 106, Statement of Deborah Rankin, 11 October 2015, p 29 para 109.
- 7 Exhibit 106, Statement of Deborah Rankin, 11 October 2015, p 35 para 131.
- 8 Exhibit 173, Email from Brett McDermott to Stephen Stathis, Subject: "Current risk of ex-BAC patients", 3 April 2014.
- 9 Transcript, Brett McDermott, 16 February 2016, p 7–62 lines 16–28, with reference to Exhibit 173, Email from Brett McDermott to Stephen Stathis, Subject: "Current risk of ex-BAC patients", 3 April 2014.
- 10 Exhibit 110, Statement of Kevin Rodgers, 10 December 2015, pp 17–18 paras 73–74.
- 11 Exhibit 110, Statement of Kevin Rodgers, 10 December 2015, p 18 paras 74–79.
- 12 Exhibit 25, Statement of Peter Blatch, 20 November 2015, p 24 para 76.
- 13 Exhibit 25, Statement of Peter Blatch, 20 November 2015, p 24 paras 76–77.
- 14 Exhibit 20 Statement of Darren Bate, 13 November 2015, p 4 para 12.
- 15 Exhibit 20 Statement of Darren Bate, 13 November 2015, p 5 para 13.
- 16 Exhibit 25, Statement of Peter Blatch, 20 November 2015, p 27 para 90.
- 17 Exhibit 33, Statement of Mark Campling, 10 February 2016, Attachments G and H to that statement, pp 37, 41, 48.
- 18 Exhibit 33, Statement of Mark Campling, 10 February 2016, p 14 paras 58 and 60, Attachments G and H to that statement, pp 35–53.
- 19 Exhibit 33, Statement of Mark Campling, 10 February 2016, p 14 para 61, Attachment H to that statement, p 49.
- 20 Exhibit 19, Statement of Janine Armitage, 14 December 2015, p 12 para 44, Exhibit 20 Statement of Darren Bate, 13 November 2015, p 12 para 50.
- 21 Exhibit 19, Statement of Janine Armitage, 14 December 2015, p 12 para 43.
- 22 Exhibit 106, Statement of Deborah Rankin, 11 October 2015, p 36 para 134.

- 23 Confidential exhibit.
- 24 Exhibit 20 Statement of Darren Bate, 13 November 2015, p 12 para 49. 25 Exhibit 107, Supplementary statement of
Deborah Rankin, 5 February 2016, p 18 para 79.
- 26 Including the one enrolled.
- 27 Exhibit 33, Statement of Mark Camping, 10 February 2016, Attachment H to that statement, p 49.
- 28 Exhibit 20 Statement of Darren Bate, 13 November 2015, p 12 para 49.
- 29 Exhibit 19, Statement of Janine Armitage, 14 December 2015, p 3 para 11.
- 30 Exhibit 19, Statement of Janine Armitage, 14 December 2015, p 3 para 11.
- 31 Exhibit 19, Statement of Janine Armitage, 14 December 2015, p 5 para 17.
- 32 Exhibit 19, Statement of Janine Armitage, 14 December 2015, p 6 para 22.
- 33 Final submissions on behalf of Justine Oxenham, 23 March 2016, p 10 para 14.3.
- 34 Exhibit 134, Statement of Patrea Walton, 21 October 2015, p 13 para 61.
- 35 Exhibit 433, Statement of Michelle Bond, 29 February 2016, p 3 para 12.
- 36 Exhibit 433, Statement of Michelle Bond, 29 February 2016, p 5 para 19.
- 37 Exhibit 106, Statement of Deborah Rankin, 11 October 2015, p 40 para 150.
- 38 Exhibit 106, Statement of Deborah Rankin, 11 October 2015, p 40 para 152.
- 39 Submissions on behalf of State of Queensland, 23 March 2016, pp 34–35 paras 97–99.
- 40 Exhibit 434, Supplementary statement of Patrea Walton, 24 February 2016, p 1 para 2, p 3 para 7.
- 41 Exhibit 980, Supplementary statement of Michelle Bond, 18 March 2016, pp 7–8 para 12(c).

30 Contraventions

By term of reference 3(i) the Commission must inquire whether any contraventions of the *Mental Health Act 2000* (Qld) or other Acts, regulations or directives occurred with regard to patient safety and confidentiality.

The Commission interpreted this term of reference to mean that it must inquire whether any such contraventions occurred in relation to the closure decision, the closure, the transition arrangements, or the patients' transition to alternative services.

The Commission did not find evidence of any such contravention.

31 Recommendations

Review of operation of HHS system

1. The National Health Reform Agreement 2011 and the *Hospital and Health Boards Act 2011* (Qld) wrought fundamental changes to the delivery of public hospital and health services in Queensland and the way they were funded. Newly established Hospital and Health Services (HHS) were made responsible for the operational management of hospitals and other services in defined geographical areas, and sometimes also given oversight responsibility for statewide services.
2. The last two years of the BAC's life straddled the old system and the new. It was a statewide service for which the West Moreton HHS had oversight responsibility. The unsatisfactory character of the decision-making process which led to its closure is at least in part a reflection of key players' unfamiliarity with the new system, some uncertainty about their respective roles, and an evolving appreciation of the respective authorities of Queensland Health as the System Manager and West Moreton HHS.
3. Four years have passed since the changes took effect. This seems an opportune time to review the legislation and how the devolution of responsibility is working in practice, especially in relation to state-wide services.
4. The Commission recommends:
 - that a review of the devolution of responsibilities to Hospital and Health Services under the *Hospital and Health Boards Act 2011* (Qld) be undertaken by a party independent of Queensland Health, the HHSs and the Queensland Mental Health Commission
 - that the review be commenced by 30 September 2016
 - that the review be completed within six months of its commencement.

Service agreements

5. Some of the AMHETI services are to be delivered by non-government organisations (NGOs). Ultimate responsibility for their delivery is to be shared by Queensland Health (through Mental Health Alcohol and Other Drugs Branch), Children's Health Queensland HHS, and the local HHS. A detailed analysis of the relationships between these different entities (including the NGOs) was outside this Commission's terms of reference. Nevertheless, the Commission observes that these relationships are potentially complex.
6. The Commission recommends that service agreements be carefully drawn to ensure they deal explicitly and sufficiently with matters such as:
 - minimum standards for staff employed to work in a particular facility
 - which entity may prescribe and monitor compliance with those standards
 - which entity may prescribe the extent and quality of the services to be provided by the NGO
 - which entity may monitor the quality of service delivery and give ongoing directions about it
 - termination of the service agreement, whether by effluxion of time, for breach of contract, because of policy changes, or for any other reason.

Evaluation and outcomes based research

7. Some former BAC patients and families of patients gave anecdotal evidence in praise of the care, treatment and rehabilitation the BAC provided. Other witnesses were critical in one or more respects. However, apart from an early paper written by Trevor Sadler, there was no evidence of evaluation of the clinical effectiveness of its interventions having been conducted.
8. Brett McDermott and Graham Martin commented on the relative paucity of clinical evaluation of mental health interventions generally in Australia. There are Queensland Health systems for recording mental health data, such as CIMHA,¹ but there is little published analysis of outcomes for young people with mental illness.
9. Reliable evaluation of the clinical effectiveness of interventions would assist policy makers and administrators when they allocate resources. Change and reform should be an iterative process that is informed by evaluation of what has gone before.
10. The Commission recommends:
 - that the Queensland Centre for Mental Health Research investigate the extent of the clinical evaluation of mental health interventions
 - that the extent of clinical evaluation of mental health interventions be referred to the Council of Australian Governments (COAG) for possible development of a co-ordinated nationwide approach
 - the provision of funding to undertake ongoing, and where practicable, independent evaluation and research
 - that services and/or independent evaluators be well resourced to enable research results to be published in a timely manner
 - that service agreements relating to the delivery of AMHETI services include a requirement to conduct ongoing evaluation and that this expectation be matched by targeted ongoing funding.

A bed-based service

11. The principle of caring for the mentally ill in the least restrictive environment possible cannot be gainsaid. Nor can it be denied that there will always be some people who are so mentally ill that they cannot be cared for in the community.
12. Over the years the BAC operated, services for adolescents requiring acute mental health services expanded steadily, and some less restrictive forms of community-based care began to appear. However, there was a small number of vulnerable adolescents with severe and complex mental illness who did not require hospitalisation in acute units and who were resistant to the forms of treatment at less restrictive levels that were then available. In this chapter the Commission refers to adolescents with those features generically as “the Barrett cohort” (whether or not they were patients of the BAC). They often have very high levels of acuity; they present with very high levels of suicidality, self-harm, uncontrolled aggression and incapacity to cope with common dangers. They include adolescents with complex post-traumatic stress disorder and emerging borderline personality disorder.
13. The AMHETI suite has been designed as a continuum of services which can be accessed sequentially or in combination. It has been designed for a much broader cohort than the Barrett cohort, and there is reason to be optimistic that it will provide appropriate and effective care for some of the Barrett cohort.
14. Nevertheless, the goal of treating mentally ill young people in their communities, close to family and social networks, is unlikely to be attainable in every case.
15. Two and a half years since the BAC closed, the full suite of AMHETI services has still not been rolled out, despite dedicated and meticulous attention to the development of the new services and their implementation. The roll-out has been beset sometimes by funding and procurement delays and sometimes by difficulties in recruiting appropriately qualified and experienced clinicians.
16. Queensland is geographically large and dispersed. It is about the size of Germany, France, Spain and Italy combined. The tip of Cape York is approximately 2400 kilometres from Brisbane. Cairns and Brisbane are separated by 1700 kilometres, which is about the same distance as Brisbane from Melbourne. Cairns is almost 700 kilometres from the tip of Cape York and about 1250 kilometres from Mt Isa. Approximately three-quarters of the State’s population² is resident in the south-east corner (from the Sunshine Coast to the New South Wales border). Otherwise, the population base is fairly decentralised. There are provincial cities along the eastern seaboard and in a small number of locations west of the Great Dividing Range. In some regions, the population is scattered. Resources and demand will probably always be too limited for the various services to be provided in numerous communities, with the consequence that a service needed by a particular young person may not be available in their local community.
17. Moreover, the Commission is satisfied that, even when the AMHETI suite is fully rolled out, there will be a residual need for a unit for young people with severe and complex mental illness that is bed-based and multi-disciplinary and that has an integrated educational/ vocational training program. It respectfully adopts the summation in the State-wide Sub-Acute Beds Discussion Paper:
 - ... a small sub-group of young people may benefit from an extended admission, especially if compounded by significant comorbidity, including intellectual/ developmental impairment. The small sub-group of young people that may benefit

from a longer admission with a rehabilitative focus are likely to comprise those experiencing severe psychosis and/or eating disorders compounded by significant risk factors and a lack of protective factors, or those young people with severe and/or complex mental illness that have failed to respond to the less restrictive form of care.³

Queensland would not be unique in providing such a unit. Philip Hazell gave evidence about the Walker Unit in New South Wales, and the WA Mental Health Commissioner has told the Commission about a proposal to re-scope the Bentley Unit in Western Australia for this purpose.

18. That need cannot be satisfied by making beds in an acute unit available to sub-acute patients as "virtual" or "swing" beds. The Commission is satisfied that doing so is inconsistent with the best care and welfare of both the sub-acute patients and the acute patients in the unit.
19. Step up/Step down units designed largely on the Victorian Y-PARC model are a component of the AMHETI suite of services still to be implemented. The Commission accepts that there is a need for such a facility on the continuum. However, it should not be regarded as satisfying the residual need for a bed-based extended treatment and rehabilitation service for young people with severe and complex mental illness. As the Commission understands them, the Y-PARC model and the Step up/Step down units proposed for Queensland are intended for patients with lower levels of acuity and complexity than the Barrett cohort, have short lengths of stay (Y-PARC 28 days, Queensland three months), and have no on-site integrated education/vocational training program.
20. The Commission does not suggest that the BAC should be replicated. It was geographically and clinically isolated. Some of its interventions and the lack of other interventions have been criticised. The periods some patients remained there were too long. It has been criticised for paying less than optimal attention to early discharge planning (even allowing for the limited range of community-based services then available, including the lack of supported accommodation). Its accommodation was not purpose-built, and was old and run-down. Its co-location with adult secure and forensic mental health facilities, especially EFTRU, was inappropriate and fraught.
21. The Commission appreciates that the allocation of available funding and other resources across a large, multi-faceted public health system is a matter for policy makers and administrators. Faced with competing claims to share in a limited pool of resources, they have to make difficult decisions that take account of matters such as:
 - illnesses and disabilities that are infinitely variable in their incidence, presentation, severity, complexity and responsiveness to different forms of intervention
 - cost/benefit analyses of competing claims
 - assessment and balancing of risks
 - geographic and demographic considerations
 - provision for vulnerable members of society that is practical, effective, fair and compassionate.
22. The Commission recommends that consideration be given to the establishment of a bed-based extended treatment and rehabilitation unit for young people with severe and complex mental illness as part of an adolescent non-acute mental health facility on, or adjacent to, the campus of a general hospital in south-east Queensland.

23. The Commission envisages that such a facility might encompass:

- a bed-based extended treatment and rehabilitation unit for 10–15 inpatients
- the local day treatment centre (for another 10 patients)
- supported accommodation (for day patients)
- the base for the local AMYOS service.

The bed-based extended treatment and rehabilitation unit should have the following features:

- a non-medicalised environment, at ground level
- a multi-disciplinary approach
- careful and early discharge planning, from the time of admission
- a six month target length of stay
- a contemporary suite of interventions
- an integrated education/vocational training program
- flexibility with upper age limits
- admission of young people from all over Queensland.

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

Non-alignment of adolescent and adult services

25. In Australia, as well as in the United Kingdom and North America, there has long been a structural divide between child and adolescent health services on the one hand and adult health services on the other.⁴

26. For these purposes, in Queensland an “adolescent” has been defined as someone aged between 13 and 17 years – that is, someone at least 13 and under 18 years old.

27. However, definitions of adolescence and related terms vary: for example, the World Health Organisation (WHO) has defined “adolescence” as between 10 and 19 years, while referring to the 15 – 24-year-old age group as “youth” and “adolescents and young adults”.⁵

28. It is widely accepted that psychological and emotional development may not keep pace with chronological development. In other words, an individual’s chronological age may be 18 years, but their developmental age may be less. Adopting the WHO age categories, the Lancet Commission on Adolescent Health and Wellbeing has referred to three phases in psychological and emotional development through adolescence:

- i. early adolescence: 10 – 14 years
- ii. late adolescence: 15 – 19 years
- iii. young adulthood: typically 20 – 24 years.⁶

But across the Australian jurisdictions, and within jurisdictions, there are varying views on the age brackets which should be adopted for the purposes of health service planning, and in particular mental health service planning.

29. As discussed in chapter 18, transition from an adolescent mental health service to an adult mental health service can be fraught. The two systems are based on different principles, and generally care for cohorts markedly different in age, diagnosis and chronicity.
30. Patients at the BAC were not necessarily discharged as soon as they reached the age of 18 years. Some were allowed to stay on for a time, because no appropriate alternative service was available. However, allowing them to stay contributed to “bed block”. There was usually a waitlist of vulnerable and fragile young people who had been referred to the BAC. See chapter 25.
31. In the AMHETI suite, the Youth Residential Rehabilitation Units (“Youth Resis”) cater for young people aged between 16 and 21 years. The Step up/Step down unit in Cairns is intended to do likewise. Eligibility for the other services in the suite depends on the patient’s being under 18 years, with some flexibility.
32. The Commission received evidence of the lived experiences of several former BAC patients who had attended adult mental health facilities after turning 18. For some of them, their interactions with the adult mental health system and adult mental health patients were confronting and negative.
33. Counsel for the State submitted that a service-mapping exercise should be undertaken as a preliminary step in addressing this systemic issue. Such an exercise may be useful in identifying any lack in services, but lack of services is a different issue from lack of alignment.
34. The Commission recommends:
 - that a review of the lack of alignment of adolescent and adult mental health services be undertaken by a party independent of Queensland Health, the HHSs and the Queensland Mental Health Commission
 - that lack of alignment of adolescent and adult mental health services be referred also to COAG for possible development of a coordinated nationwide approach.

Services for dual diagnosis patients

35. Services addressing the needs of individuals with both mental illness and intellectual disability are extremely limited. The levels of unmet need in the adult and adolescent populations are significant.
36. These cases can be beset both by unavailability of appropriate services and by a comparatively low level of cooperation and collaboration among government departments and agencies.
37. In the confidential volume of the report, the Commission discusses the case of a transition client who had such a dual diagnosis.
38. The Commission endorses the recommendations of the Process Review Report into that case which was undertaken by the Centre of Excellence for Clinical Innovation and Behaviour Support, Department of Communities, Child Safety and Disability Services, namely:
 - that the Guidelines for Collaboration between Queensland Health – Mental Health Services, Disability Services Queensland and Funded Disability Service Providers be reviewed and revised
 - that the need for joint transition planning be addressed
 - that comprehensive risk assessment and post-discharge follow up responsibilities of the discharging organisation be included in the joint transition planning.
39. The Commission recommends also:
 - that those Guidelines deal expressly with the respective responsibilities of Queensland Health, Children’s Health Queensland HHS and local Hospital and Health Services in collaborating with Disability Services Queensland and Funded Disability Service Providers
 - that a service-mapping exercise be undertaken to identify what services are needed.

(Endnotes)

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- 1 Consumer Integrated Mental Health Application
 - 2 The estimated resident population of Queensland was approximately 4.7 million in 2014. See chapter 1.
 - 3 Exhibit 280, Statewide Sub-Acute Beds Discussion Paper, January 2016, p 6.
 - 4 Bennett, D, Towns, S & Steinbeck, K 2005, 'Smoothing the transition to adult care', *Medical Journal of Australia*, volume 182 number 8, pp 373–374.
 - 5 Patton, G, Sawyer, S, Santelli, J, Ross, D, Afifi, R, Allen, N and others 2016, 'Our future: a Lancet commission on adolescent health and wellbeing', *The Lancet*, 9 May, DOI: <[http://dx.doi.org/10.1016/S0140-6736\(16\)00579-1](http://dx.doi.org/10.1016/S0140-6736(16)00579-1)>, pp 1–58 (p 3).
 - 6 Patton, G, Sawyer, S, Santelli, J, Ross, D, Afifi, R, Allen, N and others 2016, 'Our future: a Lancet commission on adolescent health and wellbeing', *The Lancet*, 9 May, DOI: <[http://dx.doi.org/10.1016/S0140-6736\(16\)00579-1](http://dx.doi.org/10.1016/S0140-6736(16)00579-1)>, pp 1–58 (p 3).

Appendix A – Terms of Reference

Order in Council containing terms of reference

Commissions of Inquiry Order (No. 4) 2015

Short title

1. THIS Order in Council may be cited as the *Commissions of Inquiry Order (No. 4) 2015*.

Commencement

2. THIS Order in Council commences on 14 September 2015.

Appointment of Commission

3. UNDER the provisions of the *Commissions of Inquiry Act 1950* the Governor in Council hereby appoints the Honourable Margaret Wilson QC from 14 September 2015 to make full and careful inquiry in an open and independent manner with respect to the following matters:
 - (a) the decision to close the Barrett Adolescent Centre (*BAC*) announced on 6 August 2013 by the then Minister for Health, including with respect to the cessation of the on-site integrated education program (the *closure decision*);
 - (b) the bases for the closure decision;
 - (c) without limiting paragraphs (a) and (b) above—the information, material, advice, processes, considerations and recommendations that related to or informed the closure decision and the decision-making process related to the closure decision;
 - (d) for *BAC* patients transitioned to alternative care arrangements in association with the closure or anticipated closure, whether before or after the closure announcement (*transition clients*):
 - i. how care, support, service quality and safety risks were identified, assessed, planned for, managed and implemented before and after the closure (*transition arrangements*); and
 - ii. the adequacy of the transition arrangements;
 - (e) the adequacy of the care, support and services that were provided to transition clients and their families;
 - (f) the adequacy of support to *BAC* staff in relation to the closure and transitioning arrangements for transition clients;
 - (g) any alternative for the replacement of *BAC* that was considered, the bases for the alternative not having been adopted, and any other alternatives that ought to have been considered;

- (h) without limiting paragraphs (d)-(g) above—the information, material, advice, processes, considerations and recommendations that related to or informed the transition arrangements and other matters mentioned in paragraphs (d)-(g) above;
 - (i) whether any contraventions of the *Mental Health Act 2000* or other Acts, regulations or directives have occurred with regard to patient safety and confidentiality.
4. THE Commissioner may make any other recommendations arising out of the evidence, considerations or findings of the inquiry in relation to the matters set out in paragraphs 3(a) to (i) above that the Commissioner considers appropriate, including for clinically appropriate models of care for intensive mental health services to young people with severe and complex mental illness.

Commission to report

5. AND directs that the Commissioner make full and faithful report and recommendations on the aforesaid subject matter of inquiry, and transmit the same to the Honourable the Premier by 14 January 2016.

Application of Act

6. THE provisions of the *Commissions of Inquiry Act 1950* shall be applicable for the purposes of this inquiry except for section 19C – Authority to use listening devices.

Conduct of Inquiry

7. THE Commissioner may hold public and private hearings in such a manner and in such locations as may be necessary and convenient.

(Endnotes)

- 1 Made by the Governor in Council on 16 July 2015.
- 2 Notified in the Gazette on 17 July 2015.
- 3 Not required to be laid before the Legislative Assembly.
- 4 The administering agency is the Department of Justice and Attorney-General.

Commission of Inquiry Amendment Order (No. 3) 2015

Short Title

1. This Order in Council may be cited as the *Commissions of Inquiry Amendment Order (No. 3) 2015*.

Amended Order

2. The *Commissions of Inquiry Order (No. 4) 2015* is amended as set out in this Order.

Amendment of Order

3. At paragraph 5, '14 January 2016' —
omit, insert—
'24 June 2016'.

(Endnotes)

1. Made by the Governor in Council on 10 December 2015.
2. Notified in the Gazette on 11 December 2015.
3. Not required to be laid before the Legislative Assembly.
4. The administering agency is the Department of Justice and Attorney-General.

Appendix B – Background and history

History of child and adolescent psychiatry: an international perspective

The history of child and adolescent psychiatry is linked to greater understanding of child-rearing practices, children's place in society and their educational needs.¹ Little was published before the 1900s in regard to psychiatric disorders of children and adolescents. What was published spoke mainly to the belief that a child's mind was not yet stable enough to show signs of psychopathology. As explained by Henry Maudsley in his 1895 book *The Pathology of Mind*, "How soon can a child go mad? Obviously not before it has got some mind to go wrong, and then only in proportion to the quantity and quality of mind which it has".²

In the early 20th century, psychiatrists, social workers, psychologists and educators began to accept the view that "childhood was a period of psychological and emotional vulnerability and that modern scientific approaches to parenting were urgently needed".³ Although child psychiatry evolved from adult psychiatry, "its close relationship to paediatrics and the patients it treats have led to marked differences between the two disciplines".⁴

Adult psychiatry, associated with "biological and pharmacological concepts",⁵ continued to be heavily influenced by drug therapies available during the early to mid-20th century. For example, during deinstitutionalisation of adult mental health facilities in the United States in the 1950s, developments in adult psychiatry were connected to developments in drug treatment and new types of psychosocial rehabilitation in community settings.⁶

Child and adolescent psychiatry emerged after adult psychiatry and was initially concerned with "vagrant, traumatised or delinquent youth".⁷ Initially, child psychiatry focused more on the young person's sociological context. For example, Chicago's Juvenile Psychopathic Institute (subsequently renamed the Institute for Juvenile Research) was set up in 1909 to explore the root causes of juvenile delinquency. Many disciplines were incorporated into the institute's work, including psychology, social work, psychiatry and law. Attracting research funding and support from the judiciary, the institute quickly made significant contributions to child and adolescent psychiatry.⁸ These major developments in child psychiatry occurred prior to the United States' policy shift from institutionalisation to deinstitutionalisation of adult mental health patients.⁹

Child guidance movement

The child guidance movement, led by neurologist William Healy, began in Chicago in 1906 and was formally established in the 1920s.¹⁰ Described by Truitt (1926) as a "practical step in the evolution of the modern health movement",¹¹ the child guidance model aimed to shift the focus from the juvenile justice system to the young person's family, peer networks, schools and community.¹² With a strong multidisciplinary focus, psychiatrists, clinical psychologists and psychiatric social workers worked together in child guidance clinics throughout the United States.¹³ Developmental factors and the importance of family were emphasised,¹⁴ with assessments concentrating on the "interactions between developmental and emotional processes, family relations and social experiences, with treatments geared primarily towards psychological and systems interventions".¹⁵ The child guidance movement was soon adopted in other countries. Australia adopted the model in the 1930s.¹⁶

Child psychiatry as a specialisation

In the 1950s, the profession of child psychiatry became more pronounced and separated from adult psychiatry.¹⁷ The specialisation of child psychiatry was formalised in the United States in 1959 when the American Board of Psychiatry and Neurology created a new board-certified specialisation.¹⁸ In Australia, the Royal Australian and New Zealand College of Psychiatrists established the Section of Child Psychiatry in 1964, renaming it in 1992 as the Faculty of Child and Adolescent Psychiatry.¹⁹ This specialisation emerged relatively recently,²⁰ and in some countries child psychiatry is “not yet formally recognised as a subspecialty, not taught in medical schools and no formal training is available”.²¹ McGorry (2007) describes child psychiatry as a “relatively recent feature of service provision in mental health”.²²

Adolescent psychiatry as a specialisation

Adolescent psychiatry “is an even newer concern”.²³ Patel and colleagues (2007) argue that adolescent mental health services and the specialised care required for adolescents:

have emerged only fairly recently from an exclusive focus on younger children, and typically still struggle to manage young people in the middle and later stages of adolescence, when adult patterns of disorders generally emerge, whereas adult services are mainly focused on older and more chronic patients, and exclude and neglect younger patients.²⁴

There have been attempts in recent years to create an adolescent subspecialty of psychiatry. The “broader labels of ‘child and adolescent psychiatry’” have in some ways tried to create this distinction, at least further distinguishing it from adult psychiatry.²⁵ McGorry (2007) argues the distinction is also qualitative in that the clinical approach of adolescent psychiatrists, contrasted to child psychiatrists, “tends to look forward into their future life rather than backward into childhood”.²⁶

Understanding the differences between child and adult psychiatry

Child and adult psychiatry “differ in their theoretical and conceptual views of diagnosis, cause and treatment focus and have quite different service organization and professional training”.²⁷ Child psychiatry is “uniquely concerned with the interplay” between emotional, cognitive, social and physical dimensions of a child’s development.²⁸ The rapid developmental changes for children and adolescents are more pronounced than those of adults, hence the focus on developmental issues.²⁹

Understanding the historical development of and differences between adult and child psychiatry is important for several reasons. First, it helps to explain why some care cultures have become entrenched and “difficult to reshape due to long-standing traditions and habitual ways of practice”.³⁰ Second, it provides background as to why there is sometimes a collision of perspectives during a young person’s transition to different care in the adult system.³¹ It is important to appreciate the challenges young people face in this context, especially if services do not align or do not meet their individual needs.³² Third, it may help to explain why some experts from one age group (for example, adult psychiatry) may not have the required expertise for another age group (for example, child psychiatry). Last, understanding the differences can also help to improve the cost efficiencies between the two types of services and explain the various

payment models and other funding structures associated with each area of expertise and service.³³

Researchers argue that child psychiatry “deals more comprehensively with the person in his or her environment than almost any other profession”.³⁴ From a research perspective, Steinhauser et al. argue that child psychiatrists “have much to learn from their colleagues in adult psychiatry in the area of research design and methodology even though child psychiatrists in research face different challenges”.³⁵ Given the complexity of the issues children and adolescents face such as familial and developmental factors, child psychiatrists often have more to grapple with than adult psychiatrists (for example, not just consent from the young person but their parents/care givers as well). Steinhauser et al. suggest child and adult psychiatry ought each to be “evaluated on its own terms” as “each area has adapted to the needs of its patients and the basic sciences it adheres to”.³⁶

The following provides an overview of the development of Queensland mental health services for children and adolescents in the context of these international developments in child and adolescent psychiatry.

History of child and adolescent mental health services in Queensland

Queensland children in adult facilities

In the 19th century and well into the 20th century, there was little if any differentiation between children and adults with mental health issues, and children were typically treated in adult mental health facilities.³⁷ This continued until the late 1970s.³⁸

Queensland government policy in the 19th century was to separate people with mental health issues from the wider public. This separation was regarded as in the interests of both patients and the general public.³⁹ From 1859, Queenslanders diagnosed as insane were housed at the Brisbane Gaol until 1865, when the Woogaroo Asylum (the asylum) was opened at Wacol.⁴⁰ Over the years the asylum was renamed multiple times, eventually becoming The Park – Centre for Mental Health Treatment, Research and Education in 1996.⁴¹

In its early years, the asylum was subject to several Government inquiries into its operations, and the Royal Commission on the Management of the Woogaroo Lunatic Asylum and the Lunatic Reception Houses of the Colony was established in 1877.⁴² The first of those inquiries was prompted by reports of mistreatment of a young female patient at the asylum, including a complaint of an ‘improper connection’ between her and a warder.⁴³ In 1915, another Royal Commission was established to inquire into the management of the Goodna Hospital for the Insane, as it was then named, following reports that children were being bedded in wards with adults, and allegations that warders often had to remove adult male patients from young boys’ beds, and vice versa.⁴⁴ In response to the 1915 Royal Commission, the superintendent of the Hospital, H Bryam Ellerton, championed a plan to establish a separate ward for thirty boys.⁴⁵

Specialised treatment for children and adolescents in Queensland

Child guidance clinics in Queensland

In Queensland, the push for specialised psychiatric services for children began in earnest in the late 1920s. This was about the time the child guidance movement in the United States began to build momentum.⁴⁶ John Bostock was a key figure in establishing clinical child psychiatric services in Queensland and was a strong advocate of mental hygiene and child guidance.⁴⁷ Bostock was a proponent of preventive mental health treatment, and emphasised the need for early intervention in the mental health of children. He established his first clinical services for children at the Brisbane Clinic, a private medical centre where medical practitioners of various specialities practised.⁴⁸ In 1940, Bostock was appointed to the Brisbane General Hospital, where he chose to focus on child psychiatry.⁴⁹ He established a child guidance clinic to conduct further research into child guidance.⁵⁰

At around the same time, Ruth Griffiths⁵¹ was engaged in a similar endeavour. In 1932, she established a private Psychological Clinic for Child Guidance in Elizabeth Street, Brisbane, “to advise parents and teachers in regard to the mental development of children in their care, to give vocational advice for those about to leave school, to assist parents with difficult children, and also in the education of backward children”.⁵² Two years later, in 1934, Minister for Health Ned Hanlon appointed Raphael Cilento as Director-General of Health and Medical Services to assist in the reorganisation of Queensland health services.⁵³ With the assistance of Basil Stafford (the Superintendent at Goodna Hospital), Cilento reviewed Queensland mental health services.

The ‘mental hygiene’ of children and adolescents in Queensland

After travelling to the United States and Europe and attending the 1937 International Conference on Mental Hygiene in Paris, Stafford drafted the Mental Hygiene Bill, which was enacted in 1938. This abolished the use of the terms ‘insanity’, ‘lunacy’ and ‘asylum’ and created the Division of Mental Hygiene, of which he was the first director.⁵⁴

Significantly, the “*Mental Hygiene Act of 1938*” made provision for voluntary and temporary patients for the first time. Under this Act, a mental hospital could not receive a person under the age of 18 years on their own application, but that child’s parent or guardian could make an application on their behalf.⁵⁵ One of the Division’s objectives in introducing the Act was to reduce the stigma of mental illness amongst the general community, thereby alleviating the reluctance of sufferers of mental illness (or, in the case of children, their guardians) to seek treatment voluntarily.⁵⁶

Prior to World War II, psychologically disturbed children were often treated by general practitioners, paediatricians and adult psychiatrists. In 1945, the Division of Mental Hygiene formed the Brisbane Psychiatric Clinic.⁵⁷ Sometime after World War II, Stafford enunciated four principles for the progress of the Division of Mental Hygiene. One of these was preventive treatment with a focus on children and adolescents.⁵⁸ He had previously noted in 1944 that, due to the prevalence of mental illness amongst children, the “provision of a separate hospital for mentally sick children is desirable”.⁵⁹ This suggested plan never eventuated post-World War II.

Institutional and community-based treatment approaches

During the 1950s in Queensland, with the emergence of new ideas about psychiatric treatment, there was a shift in emphasis from separation and institutionalisation to community-based treatment.⁶⁰ In 1957, the new Coalition Government established the Committee on Youth Problems, led by Alexander T Dewar. The committee's report was handed down in 1959.⁶¹ In his introduction to the report, Dewar noted that while the press and the public seemed to assume that the committee was investigating juvenile delinquency, its focus was on all young people with problems, not just delinquents.⁶²

Youth policy historian Terry Irving suggests that there were two schools of thought within the Dewar committee. The first favoured a traditional, 'reactionary' approach, under which strict discipline, punishment and fear were advocated as a deterrent to reoffending. The second was a 'progressive' approach, under which maladjusted and delinquent children⁶³ would be treated by medical professionals. The latter became the leading view in the committee's report.⁶⁴ The committee made a number of recommendations in its report, including the establishment of child guidance clinics, increased funding for the kindergarten system, the establishment of a Juvenile Court Clinic, and the establishment of a second correctional institution for young offenders with a focus on treatment rather than punishment.⁶⁵

In 1959, the Division of Welfare and Guidance was established by the Health and Home Affairs Department by Health Minister Winston Noble.⁶⁶ Its objective was to provide a service to children under the age of 18 with an "emotional and behaviour disorder which was sufficient to cause social, physical or mental disability".⁶⁷ Bert Phillips served as the Senior Medical Director of the Division from 1959–1978. He considered 'child psychiatry' and 'child guidance' to be interchangeable, and advocated child psychiatry as a medical profession distinct from adult psychiatry and paediatrics.⁶⁸ This advocacy reflected similar developments internationally.⁶⁹

The Division of Welfare and Guidance opened the Wilson Youth Rehabilitation Hospital in 1961 to treat "as both outpatients and inpatients delinquent children with mental, nervous and personality disorders".⁷⁰ Initially, the hospital catered only for boys, with inpatient care for girls provided by three church-run homes. It was not until 11 years later that a section for girls was opened at the hospital.⁷¹

In 1966, responsibility for inpatient (child) services at the Wilson Youth Rehabilitation Hospital was transferred to the Children's Services Department although responsibility for clinical treatment remained with the Division of Welfare and Guidance. Dual responsibility for the hospital's services was administratively highly complex and, not surprisingly, in the early 1970s a comprehensive review of its operations was conducted. Partly as a result of the review, the Division of Youth Welfare and Guidance's professional staff withdrew from the hospital in 1983.⁷² In the same year, the division opened the Institute of Child Guidance to supply child psychiatric services, initially on an outpatient and day hospital basis, in association with the Children's Hospital. It also offered a consultancy service to the Royal Brisbane Hospital and the Children's Hospital.⁷³

Between 1960 and 1980 the Division of Welfare and Guidance opened 12 child guidance clinics.⁷⁴ Each of these clinics employed the traditional child guidance interdisciplinary team of a psychiatrist, psychologist, social worker and nurse-receptionist, as well as a speech pathologist and child guidance therapist. Other clinics were staffed with additional professionals, including remedial teachers and physiotherapists. Later, paediatricians and neurologists also became involved.⁷⁵

Throughout the 1960s and 1970s, different categories of children and young people were treated by separate services within the Division of Welfare and Guidance. Older 'troubled' children were detained in the Wilson Youth Hospital (as it was then named), the Farm Home for Boys at Westbrook, child welfare training homes or Karrala House, with the child guidance staff visiting these facilities. Younger, school-aged children were seen by the community clinics.⁷⁶ Maladjusted and delinquent children were seen at different sites, with differences in diagnoses and treatment, but under the same overarching medical framework.⁷⁷

In 1972, the Division of Welfare and Guidance, in partnership with the Education Department, founded a special school to treat 'emotionally and behaviourally disturbed children'. The school was located at Tennyson and staffed by both psychiatrists from the Division of Welfare and Guidance and teachers from the Education Department.⁷⁸ The 1972–3 annual report of the Division of Welfare and Guidance explained that the school was to cater for "maladjusted children, who are not disturbed enough to need full-time psychiatric service, such as a day hospital, but are too disturbed to adjust to their own class in their school".⁷⁹

In 1976, the Courier Ward at the Royal Children's Hospital was launched as the first inpatient children's psychiatric service in Queensland, under Helen McConnell.⁸⁰ Previously, children with psychiatric disorders had been treated in various medical wards within the hospital.⁸¹ The Courier Ward had six beds and provided both inpatient and outpatient service for children up to 14 years old.⁸²

It soon became apparent that the ward was too small to meet growing demand. In 1981 planning began for the Child and Family Therapy Unit, which opened in 1983.⁸³ This was funded by the Golden Casket. The unit was located in a three-storey building within the Royal Brisbane Hospital campus and included a new child psychiatric unit. Upon completion, the inpatient service had a maximum capacity of 12 beds and the unit also provided outpatient and day hospital services for children under the age of 14.⁸⁴ The inpatient service was limited to patients with 'clear cut psychiatric disorders', while children with social disorders were referred elsewhere.⁸⁵

The Mater Children's Hospital had also been providing child psychiatry service since 1966. Initially, the Mater employed one part-time child psychiatrist, who was joined by a clinical psychologist in the early 1970s. It was not until 1981 that a full-time child psychiatrist was appointed.⁸⁶ Inpatient and outpatient psychiatric care was able to be provided in the early 1980s as nursing and allied staff were 'lent' by other areas of the hospital, and a psychiatric registrar was provided by the Division of Youth Welfare and Guidance.⁸⁷ Child psychiatry inpatients were separated from other patients in 1983, but this separation was abandoned the following year due to a lack of staff.⁸⁸ Staffing remained at this level until the 1990s, despite increasing demand for child psychiatric services.⁸⁹

Opening in 1987, the John Oxley Youth Detention Centre was closed in 2001. It was replaced by the Brisbane Youth Detention Centre, with adolescent mental health consultation provided by Child and Youth Mental Health Services.

In the early 1990s, the Faculty of Child and Adolescent Psychiatrists wrote to the Mental Health Branch of Queensland Health expressing concern about young people being admitted to adult inpatient facilities.⁹⁰ In 1996, there were only 12 adolescent psychiatric inpatient beds in Queensland. A submission to Cabinet in 1996 noted that on the basis of population-based planning guidelines for the provision of specific mental health components, Queensland required 53 beds.⁹¹ Between 1996 and 2001, adolescent acute inpatient units opened at the Royal Brisbane, Logan, Robina, Mater and Toowoomba hospitals. A unit was planned for Cairns Hospital, but failed to open because of difficulties attracting staff.⁹² The acute unit at the Mater

was relocated to Lady Cilento Children's Hospital when it opened in 2014, and a further acute unit has since opened at the Townsville Hospital. There are now seven acute units in Queensland at the Lady Cilento Children's Hospital, Royal Brisbane and Women's Hospital, Logan Hospital, Robina Hospital, Toowoomba Hospital and Townsville Hospital.⁹³

The first day program for adolescents commenced at the Mater Children's Hospital in 1989,⁹⁴ and day programs are now offered at Lady Cilento Children's Hospital (south Brisbane), Chermside (north Brisbane), Toowoomba and Townsville.⁹⁵

Establishment of the Barrett Adolescent Centre

Prior to 1983, there was no designated adolescent inpatient unit in Queensland. The inpatient services available at the child mental health units at the Royal Children's Hospital and the Mater Children's Hospital catered for adolescents up to 13 or 14 years old, but did not accept older adolescents. Nor did the older adolescents fit into the adult service.

Cary Breakey of the Division of Youth Welfare and Guidance identified a gap in inpatient psychiatric services for adolescents. From approximately 1981, he and Alex Shearer, the Deputy Director of the Division, began establishing a specialised psychiatric inpatient unit for adolescents, by securing approval and funding and finding a suitable location.¹⁰⁰

Fortuitously, there was an empty building at Wolston Park Hospital following the decentralisation of some services – the Barrett Psychiatric Unit.¹⁰¹ This was available as the site for adolescent mental health services, offering therapeutically useful space and facilities not available to the Division of Youth Welfare and Guidance elsewhere.¹⁰²

On 20 December 1982, Cabinet gave approval "for the establishment of an adolescent psychiatric service to be called the Barrett Adolescent Centre, Gailes".¹⁰³

The Barrett Adolescent Centre (BAC) was opened on 1 June 1983.¹⁰⁴ It was established as a joint venture between the Division of Youth Welfare and Guidance and the Division of Psychiatric Services.¹⁰⁵

Initially, the Centre operated as a day centre and outpatient facility, but it aimed to offer an inpatient service once sufficient staff could be employed and trained. The Division of Youth Welfare and Guidance explained that "though most adolescent problems can be handled at outpatient level, a small proportion of young people have such a degree of disturbance that more intensive treatment is indicated. Sometimes this can be done on a daily attendance basis during week days, but more severe problems will need residential treatment".¹⁰⁶

Following the withdrawal of the Division of Youth Welfare and Guidance from the Wilson Youth Hospital, the Division anticipated that adolescents who would have been admitted there with primarily psychiatric problems could be treated at the BAC.¹⁰⁷

The day program was provided by a multidisciplinary team with training in psychiatry, general medicine, psychiatric nursing, psychology, child guidance therapy, occupational therapy and communication therapy. It included group and individual therapy and recreational activities.¹⁰⁸ At that stage, the BAC provided services to a wide range of patients, including those with depression and behavioural and anxiety disorders. However, it could not treat those with suicidal depression or acute schizophrenia without an inpatient service.¹⁰⁹ The inpatient service was launched in October 1984¹¹⁰ with the provision of 16 beds for adolescents between 13 and 17 years of age.¹¹¹

An education program was made available to patients from the outset, with four teachers and a guidance officer provided by the Department of Education.¹¹² By the time the inpatient service was launched, parallel educational programs had been developed: a school program for patients requiring formal education and a 'living skills' program for those who had left the formal education system.¹¹³ The Barrett Adolescent Centre Special School was formally established with an acting principal from the beginning of the 1985 school year.¹¹⁴

In 1991, the BAC became a unit of Wolston Park Hospital, which reported to the West Moreton Health Services Region.

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Appendix C – Research relating to AMHETI services

This appendix documents the research relating to the five service elements of the Adolescent Mental Health Extended Treatment and Rehabilitation Initiative (AMHETI) services:

- Assertive Mobile Youth Outreach Service (AMYOS)
- Child and adolescent day program
- Youth Residential Rehabilitation Units (Youth Resi)
- Step up/Step down Units (SUSDU)
- Statewide sub-acute beds.

For a detailed description of the service elements, refer to chapter 27.

Assertive Mobile Youth Outreach Service (AMYOS)

The Assertive Mobile Youth Outreach Service (AMYOS) is based on assertive community treatment (ACT). Assertive community treatment was developed in the United States in the 1970s by Leonard Stein and Mary Ann Test as an alternative to hospitalisation.¹ The original service, known as “training in community living”, was designed as a specific and complex form of psycho-social education.²

British researchers have identified features of people who might benefit from ACT. Agreed indicators include:

- psychotic illness
- fluctuating mental state
- fluctuating social functioning
- poor adherence to medication regimes
- poor engagement
- relapse would have severe consequences.³

Core practice features

A number of core practice features were integral to the original ACT model, including:

- delivering treatment and psychosocial rehabilitation within a person’s own environment, rather than expecting them to attend a clinical environment
- individualised care
- treatment by a multidisciplinary team (with a case manager)
- small caseloads
- frequent team meetings to review treatment plans and services
- 24-hour crisis support
- greater frequency and intensity of service involvement as needed
- commitment to long term and continuous care
- careful monitoring of medication
- integration of mental healthcare and social care, with the treating team taking responsibility for helping a person to meet all their needs, including housing, employment and educational/vocational support.⁴

Not all features have endured because of the evolving evidence base and because some features, such as the original commitment to time-unlimited support, are neither practical nor cost-effective.⁵ Around the clock crisis support has become less important as an intrinsic component of the ACT model with the establishment of other community-based mental health crisis support, such as crisis assessment and treatment teams (known as CAT or CATT).

In practice, ACT models also differ in how closely they replicate the features of the original model, as measured by various fidelity scales, such as the Dartmouth ACT Scale.⁶ Despite this, the ACT emphasis remains on “helping individuals to function as independently as possible, by teaching and enhancing skills in the environment where they will be needed, rather than in day hospitals and sheltered workshops”.⁷

The Queensland AMYOS model is based on the Victorian Intensive Mobile Youth Outreach Services (IMYOS) model. The Victorian IMYOS philosophy:

explicitly holds that any intervention which is thoughtfully planned and is aimed at supporting the client can be reparative and therefore ‘therapeutic’. Hence therapy, as understood and provided by the IMYOS team, occurs on a ‘continuum of care’, and ranges from basic practical support (e.g. assistance with housing issues) to evidence based interventions (psychological and psychiatric therapy).⁸

The AMYOS model of service notes that teams will “coordinate and establish collaborative links with other community service providers”, such as education, child safety, housing and police.⁹

Empirical evidence

The ACT model has generally been regarded as one of the most empirically supported of all community mental health treatment approaches.¹⁰

A 1979 Australian study at Sydney’s Macquarie Hospital was the first major study outside North America to demonstrate better clinical outcomes and higher patient satisfaction associated with intensive community treatment and 24-hour crisis support.¹¹ Early North American and Australian randomised controlled studies on the effectiveness of the original Stein and Test ACT model produced impressive results. Not only did clients improve clinically and in social functioning, but they were more likely to live independently in the community, be employed, adhere to medication regimes, and report a better quality of life.¹² There were also significant reductions in the number of hospital admissions.¹³

In 2000, the United Kingdom (UK) National Health Service Plan identified assertive outreach as a mandatory component of community mental health provision, resulting in the proliferation of ACT teams in that jurisdiction.¹⁴ ACT was rolled out nationally in the UK, with over 300 “assertive outreach teams” established by the mid-2000s.¹⁵ However, while the evidence base has remained relatively strong in the United States, long-term and robust UK studies have failed to demonstrate any advantage of ACT care teams over standard community mental health care teams, as measured by the rate of hospital admission, resulting in significant disinvestment in ACT in the UK.¹⁶ Researchers have suggested that reasons for the variance in the evidence base for ACT may include:

- comparative studies about the fidelity of the ACT model are complicated by the lack of consistent reporting about service models and treatment interventions¹⁷
- differences in the types of care used as the ‘standard’ or ‘comparison’ make it difficult to evaluate the effectiveness of the ACT model reliably
- differences in jurisdictions and health care requirements (for example, staff to patient ratios, measures of program performance and levels of hospitalisation).¹⁸

British child and adolescent psychiatrists Jonathan Green and Anne Worrall-Davies found that while most of the comparative studies suggest that intensive outreach *does not* replace the need for the inpatient option, the studies show that intensive outreach can certainly reduce the usage of this option.¹⁹ However, it is not clear whether Green and Worrall-Davies' reference to an "inpatient option" includes sub-acute inpatient services.

Improvements in the quality of "standard" community care options over time may also partly explain why more recent studies have failed to replicate the results of the earlier studies.²⁰ In the UK, for example, standard community health teams have assimilated many of the features of ACT into standard practice.²¹ Consequently, more recent research has focused on identifying and testing individual features of the ACT.

*Research from the Netherlands also indicates that the ACT model is not well suited to rural settings because of the lower number of clients with severe mental illness, increased travel times and the costs of sustaining an experienced multidisciplinary clinical team in these areas.*²²

A 2004 systematic review of 91 studies of home treatment services identified a core group of six service components associated with clinical effectiveness:

- smaller caseloads
- regular visiting at home
- a high proportion of contacts at home
- a psychiatrist integrated into the team
- a multidisciplinary team
- responsibility for both healthcare and practical social support.²³

A Melbourne-based adolescent assertive community outreach program (not IMYOS) reported improvements in functioning and full-time educational participation across a heterogeneous group with anxiety, mood, psychotic or emerging personality disorders, indicating the service may be effective in managing young people with a fairly broad range of clinical profiles.²⁴ A 2012 study of an intensive management team delivering mental health interventions for adolescents who are at-risk and/or difficult to engage in Victoria (not IMYOS), cited by Children's Health Queensland (CHQ) in support of this model,²⁵ found that as well as significantly reducing rates of admission in the client sample, assertive outreach intervention to at-risk adolescents led to significant increases in participation in full-time education and improvement in clinician-rated levels of functioning. Like the Queensland model, this service focused on optimising family functioning, offered a range of interventions to be delivered in optimal settings for clients and provided for contact as frequently as several times a week. Even so, this study highlighted that further research is needed to clarify specifically which aspects of assertive outreach assist in producing these outcomes.²⁶

A 2008 study of the Victorian IMYOS services found that of 49 cases examined, the majority had "traumatic upbringings characterized by early family breakdown, exposure to violence and childhood abuse. The audit revealed very strong family histories of mental illness, suicide, crime and substance abuse".²⁷ Even so, this study found that the prevalence rates for all measured risk variables, including suicidal ideation and deliberate self-harm, were significantly reduced following IMYOS involvement.²⁸

A relatively new psychodynamic psychotherapy for adolescents — mentalization-based treatment (MBT) — is being used by AMYOS teams.²⁹ MBT was first developed by British clinicians Anthony Bateman and Peter Fonagy in the late 1990s for reducing suicidal behaviour and self-harm in adult patients with borderline personality disorder in an outpatient setting.³⁰ More recently it has been adapted for use with adolescents (MBT-A) and families (MBT-F) by Trudie Rossouw and Peter Fonagy.³¹ Mentalization is the capacity to understand one's own state of mind, the minds of others and how this affects the emotions, thoughts and actions of ourselves and others.³² MBT is grounded in attachment theory and focuses on affect, in contrast to the more established cognitive behaviour therapy (CBT) models that focus on understanding how a person's thought processes (cognition) affect their mood and behaviour. MBT-A is a 12-month outpatient intervention involving weekly individual sessions and monthly family therapy focusing on impulsivity and affect regulation. Initial randomised controlled studies by Fonagy and Rossouw indicate that MBT-A may be effective in reducing self-harm and depression in adolescents with borderline personality features.³³

Child and adolescent day program

Day programs, also known as day hospitalisation or partial hospitalisation programs, have been an established component of the child and adolescent continuum of care in the United States since the 1960s.³⁴

A range of models exist in Australian and overseas jurisdictions providing either generalist or specialist mental health assessment and treatment for young people and their families. Some function as a step up or step down service to support transition from or to a more general community service or from or to acute inpatient treatment. The model generally includes an intensive five day a week program providing a range of individual and group therapies and other activities, scheduled around a specialised on-site schooling program or external mainstream schooling.³⁵

Most Australian adolescent day programs are delivered over at least four hours per day on three days per week and provide:

- a range of intensive multi-disciplinary individual and group psychotherapies
- group-based psychoeducational programs
- group-based psychosocial rehabilitation programs and activities, such as daily living skills, cooking and healthy eating, mindfulness, creative expression, communication skills, social skills and job readiness
- individual pharmacotherapies
- milieu/process therapy
- schooling or vocational activities
- recreational activities.³⁶

The level of family therapy provided varies across programs.

Empirical evidence

A 2004 study of 16 Australian adolescent day programs found two types of programs:

- fixed programs that adolescents attended each day over a school term
- flexible individualised programs that were available for periods of four months to two years.³⁷

Research confirms that the peer group within a group program can provide an environment where young people can share experiences, improve personal strengths and coping skills, develop an optimistic outlook for the future and master appropriate developmental tasks.³⁸

However, British child and adolescent psychiatrist Anne Worrall-Davies notes that robust research evaluating day unit programs is scarce because the varying programs and treatment models make it difficult to extrapolate findings both within and across jurisdictions.³⁹

A 2011 study of an integrated therapeutic and vocational Melbourne day program for six to eight adolescents with a range of severe emotional, behavioural, social and psychiatric disorders, cited by CHQ in support of the day program model,⁴⁰ compared day program treatment to standard treatment in an outpatient clinic. Although both groups of adolescents experienced significant improvements in peer relationships, school attendance and overall mental health functioning, the magnitude of improvement was significantly greater for adolescents attending the day program. Further, only the day program clients improved in scholastic/language skills and family relationships post-treatment.⁴¹ The Melbourne program provided a structured timetable of daily sessions ranging from skill-based work to more flexible psychotherapy groups and outings, and emphasis on group work to learn how to relate to peers. It ran for three days per week, for four to five hours per day and for eight to nine weeks.⁴²

Green and Worrall-Davies argue that for the most severe problems, day unit care may not offer sufficient containment for safety or sufficient intensive outreach for effectiveness, and that it is unrealistic therefore to believe that the day unit can be a substitute for other intensive treatment modalities.⁴³

Youth residential rehabilitation units

Residential rehabilitation has a long history in adult mental health services both in Australia and internationally. Half-way houses and hostels were established in the 1950s and 1960s. More sophisticated models have developed over the past 25 years or so.

Residential rehabilitation units specifically designed for young people are a more recent development, but have been available in other Australian jurisdictions since the 1990s. For example, there are 17 youth residential rehabilitation sites across Victoria providing 166 beds for young people aged 16–25 years with mental illness.⁴⁴ Thirteen of the services are provided by a single major non-government organisation (NGO) service provider (Mind Australia). The remaining four services are each provided by a different NGO.

In Queensland, a range of NGO services provide accommodation and support for young people with mental illness. These include supported accommodation services such as Brisbane Youth Service's Centre for Young Women, Carina Youth Agency's Phoenix House program, and Budaroo House Youth Shelter in Rockhampton. The Time Out House Initiative (TOHI), previously operating in Logan and Cairns, provided short-term accommodation, employment support and other services to young people aged 15–25 years experiencing the early signs of mental illness.⁴⁵ These types of supported accommodation services may also provide some psychosocial rehabilitation services, although the quality and intensity of the services vary considerably.

Empirical evidence

There is little, if any, useful empirical evidence about the effectiveness of residential rehabilitation services for improving mental health outcomes in young people because:

- the definition of what constitutes a residential treatment and/or rehabilitation service varies considerably across jurisdictions and studies
- much of the available evidence base comes from the US, where there was significant variation in the types of residential services for adolescents — many had a juvenile justice emphasis and many have now closed⁴⁶
- the available studies lack rigorous experimental design, such as across-program and between treatment comparisons. Many focus instead on the lived experience of people with mental illness, rather than on clinical outcomes.⁴⁷

A 2011 report into Youth Residential Rehabilitation Services in Victoria found that the Department of Health's performance framework for youth residential services meant that providers were not accountable to deliver recovery outcomes for young people.⁴⁸

Step Up/Step Down units (SUSDU)

The Step Up/Step Down Unit can allow early discharge from acute inpatient care by providing intensive and integrated clinical and psychosocial rehabilitation support in a safe and stable environment to consolidate gains made as an inpatient.⁴⁹ Step up units aim to prevent inpatient admissions and step down units aim to support transition from acute inpatient care to ongoing community-based care.

The CHQ Step Up/Step Down Unit model is based on the Victorian Youth Prevention and Recovery Care (Y-PARC) model established in 2013. Y-PARCs are adapted from the Prevention and Recovery Care (PARC) model established in Victoria for adults ten years earlier. There are currently 14 adult PARCs in Victoria.⁵⁰

The Victorian Y-PARCs are purpose-built 10-bed facilities located in residential areas. There are four Y-PARC facilities operating in Victoria. Three of the facilities are operated by MIND Australia.⁵¹ The staff to patient ratio varies from facility to facility.⁵² The Y-PARCs cater for young people aged 16–25 years and provide short term step up (from community) or step down (from hospital) treatment.⁵³ They provide young people "short-term intensive residential support to prevent deterioration or relapse of mental illness".⁵⁴ The Y-PARC length of stay is up to 28 days.⁵⁵

Young people who are a low to moderate risk, are safe to treat in the community and who typically have psychosis, a mood disorder or borderline personality disorder are eligible to live in a Y-PARC facility. Young people who are assessed as being at too high a risk (for example, actively suicidal), using illegal substances, or with no capacity to engage and comply with treatment are excluded from the service.⁵⁶

Empirical evidence

There is a dearth of published research specifically evaluating the outcomes of children and adolescents who have progressed as step up or step down clients in mental health services. The available research tends to be about the perspectives of clients, rather than evaluating readmission rates, lengths of stay and longer-term outcomes. For example, an Australian study assessed clients' perspectives on their mental health after admission to a sub-acute service either

as a step up client (from community) or step down client (from inpatient unit). Thomas, Rickwood and Brown determined from the interviews conducted with clients over a 30-month period that clients perceived:

- improvement in their symptoms and functioning post admission
- a reduction in hospital admission
- that the service assisted them with transition to independent living.⁵⁷

Neither the Commission nor Queensland Health was able to identify any formal evaluations of the Victorian Y-PARC model on which the Step Up/Step Down Unit model is heavily based.⁵⁸

Formal evaluations of the adult PARC services are also limited and rely largely on the design, implementation and cost-effectiveness of the model, as well as staff and client perceptions of the service.⁵⁹ Only one study appears to have assessed changes in clinical measures of symptom, social and behavioural difficulty (for example, issues with daily living and functioning, and depression and anxiety).⁶⁰

Interviews with clients identified a range of positive aspects of the PARC program. Clients reported the program helped them to “gain strength and stability before returning home”⁶¹ and particularly valued the:

- sense of normality and the fact that the program promoted independence
- diversity of therapeutic activities
- range of psychoeducational programs to help them better manage their illness
- ability to seek one-on-one help from staff then distressed
- assistance with practical issues, such as accessing housing programs and meal support.⁶²

The STEPS program in the Australian Capital Territory is a seven-bed residential facility for young people aged 14–18 years with moderate to severe mental illness. It provides step up and step down clinical and psychosocial rehabilitation care for up to 12 weeks using a model similar to Y-PARC. A pilot study of the program found that while a “stepped-care approach” is likely to be beneficial for some young people, more research is needed.⁶³ It did not examine clinical outcomes, focusing only on people’s experiences of the program.

Statewide sub-acute beds

The term ‘sub-acute’ describes the type of health care that is “driven predominantly by ... functional status rather than principal diagnosis”.⁶⁴

There are four sub-acute beds nominally available at the Lady Cilento Children’s Hospital. Children’s Health Queensland describe these beds as an “interim arrangement” as they are not held exclusively for the use of sub-acute patients (refer to chapter 27).⁶⁵

Empirical evidence

There is limited published research about sub-acute patients being co-located with acute inpatient beds.⁶⁶ Several Commission witnesses expressed concern about sub-acute beds being co-located with acute beds. This is discussed in more detail in chapter 27.⁶⁷

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Table A – Service mapping: Before and after closure of Barrett Adolescent Centre (BAC)

Public Adolescent Mental Health Services in Queensland		Pre-BAC Closure	
		Extended treatment and rehabilitation services	
MH Clinical Cluster	Hospital and Health Service (HSS) Catchment	Sub-acute service	Day program
Southern	Children's Health Queensland (CHQ) and Mater Children's Health (merged 24 Nov 2014)		1 unit <i>Mater</i>
	Metro South HSS (includes Logan)		
	Gold Coast HHS		
	Darling Downs HHS		1 unit <i>Toowoomba</i>
	West Moreton HHS		BAC
	South West HHS		
Central	CHQ services located in Central clinical cluster		
	Metro North HHS (includes RBWH and Redcliffe-Caboolture)		
	Sunshine Coast HHS		
	Wide Bay HHS		
	Central Queensland HHS		
	Central West HHS		
Northern	Mackay HHS		
	Townsville HHS		1 unit <i>(from late 2013)</i>
	North West HHS		
	Cairns and Hinterland HHS		
	Torres and Cape HHS		
	Statewide services	BAC 15 beds (13-17 yrs)	

Pre-BAC Closure		
Other Qld Health adolescent MH services		Non-Qld Health services <i>(not comprehensive)</i>
Acute inpatient unit	CYMHS / Other	
12 beds (0-17 yrs) <i>Mater</i>		Time Out House Initiative (TOHI) <i>Logan</i>
		Headspace
		Headspace
8 beds (13-17 yrs) <i>Toowoomba</i>		Headspace
		Headspace Therapeutic Residential (DoCS)
CFTU (see statewide services)	Extended Hours Team ⁸ Consultation-Liaison Service for RCH	
12 beds (14-17 yrs) <i>RBWH</i>	Early Psychosis Teams (RBWH & TPCH)	Headspace Therapeutic Residential (DoCS)
		Headspace
		Headspace
		Headspace
		Headspace
	Young Peoples Early Intervention Team (yPEIT) ³	Headspace Therapeutic Residential (DoCS)
		Headspace
		TOHI Therapeutic Residential (DoCS) Headspace
Child and Family Therapy Unit (CFTU) 10 beds (0-13 yrs) (based at RCH)	* Evolve Therapeutic Services * e-CYMHS (tele-psychiatry & outreach) * Child & Youth Forensic Outreach Service (CYFOS) ⁶	Kids Helpline Medicare Local ATAPS ⁷

Public Adolescent Mental Health Services in Queensland		End of January 2014 (Closure of BAC) and immediately post-closure (February/March 2014)			
		Extended treatment and rehabilitation services			
MH Clinical Cluster	Hospital and Health Service (HSS) Catchment	AMYOS	Day program	Youth Resi	Sub-acute beds
Southern	Children's Health Queensland (CHQ) and Mater Children's Health (merged 24 Nov 2014)		1 unit <i>Mater</i>		2 x sub-acute swing beds <i>Mater</i>
	Metro South HSS (includes Logan)			5 beds ¹ <i>Greenslopes</i>	
	Gold Coast HHS				
	Darling Downs HHS		1 unit <i>Toowoomba</i>		
	West Moreton HHS				
	South West HHS				
	Central	CHQ services located in Central clinical cluster			
	Metro North HHS (includes RBWH and Redcliffe-Caboolture)				
	Sunshine Coast HHS				
	Wide Bay HHS				
	Central Queensland HHS				
	Central West HHS				
Northern	Mackay HHS				
	Townsville HHS		1 unit		
	North West HHS				
	Cairns and Hinterland HHS				
	Torres and Cape HHS				
	Statewide services				2 x sub-acute swing beds <i>Mater</i>

End of January 2014 (Closure of BAC)
and immediately post-closure (February/March 2014)

Other Qld Health adolescent MH services		Non-Qld Health services (not comprehensive)
Acute inpatient unit	CYMHS / Other	
12 beds (13-17 yrs) incl. 2 x sub-acute swing beds		
10 beds (13-17 yrs) <i>Logan</i>		Time Out House Initiative (TOHI) <i>Logan</i> Headspace
8 beds (0-17 yrs) <i>Robina</i>		Headspace & hYEPP ²
8 beds (13-17 yrs) <i>Toowoomba</i>		Headspace Headspace Therapeutic Residential (DoCS)
CFTU (see statewide services)	Acute Response Team ⁹ Consultation-Liaison Service for RCH	
12 beds (14-17 yrs) <i>RBWH</i>	Early Psychosis Teams <i>RBWH & TPCH</i>	Headspace Therapeutic Residential (DoCS) Headspace Headspace Headspace
8 beds (12-17 yrs) <i>from 20 Jan 2014</i>	Young People Early Intervention Team (yPEIT)	Headspace Headspace Therapeutic Residential (DoCS) Headspace TOHI Therapeutic Residential (DoCS) Headspace
CFTU 10 beds (0-13 yrs) (based at RCH)	Evolve Therapeutic Services eCYMHS CYFOS	Kids Helpline Medicare Local ATAPS

Public Adolescent Mental Health Services in Queensland		31 December 2014			
		Extended treatment and rehabilitation services			
MH Clinical Cluster	Hospital and Health Service (HSS) Catchment	AMYOS	Day program	Youth Resi	Sub-acute beds
Southern	Children's Health Queensland (CHQ) and Mater Children's Health (merged 24 Nov 2014)		1 unit LCCH	5 beds Greenslopes	
	Metro South HSS (includes Logan)	South Brisbane (July 2014)			
	Gold Coast HHS				
	Darling Downs HHS	Toowoomba (Dec 2014)	1 unit Toowoomba		
	West Moreton HHS				
	South West HHS				
Central	CHQ services located in Central clinical cluster	North Brisbane (July 2014)			
	Metro North HHS (includes RBWH and Redcliffe-Caboolture)	Redcliff - Caboolture (July 2014)			
	Sunshine Coast HHS				
	Wide Bay HHS				
	Central Queensland HHS				
	Central West HHS				
Northern	Mackay HHS				
	Townsville HHS	Townsville (Dec 2014)	1 unit		
	North West HHS				
	Cairns and Hinterland HHS				
	Torres and Cape HHS				
	Statewide services				4 x sub-acute swing beds LCCH

31 December 2014

Other Qld Health adolescent MH services		Non-Qld Health services (not comprehensive)
Acute inpatient unit	CYMHS / Other	
11 beds (14-17 yrs) incl. 4 x sub-acute swing beds LCCH AMHU LCCH CMHU (see statewide services)	Acute Response Team ⁹ Consultation-Liaison Service for LCCH	
10 beds (13-17 yrs) <i>Logan</i>		Headspace
8 beds (0-17 yrs) <i>Robina</i>		Headspace & hYEPP ⁴
8 beds (13-17 yrs) <i>Toowoomba</i>		Headspace
		Headspace Therapeutic Residential (DoCS)
12 beds (14-17 yrs) <i>RBWH</i>	Early Psychosis Teams <i>RBWH & TPCH</i>	Headspace Therapeutic Residential (DoCS)
		Headspace
		Headspace
		Headspace
		Headspace
8 beds (12-17 yrs)	Young People Early Intervention Team (yPEIT)	Headspace Therapeutic Residential (DoCS)
		Headspace
		TOHI Therapeutic Residential (DoCS) Headspace
Child Mental Health Unit (CMHU) 9 beds (0-13 yrs) (based at LCCH)	Evolve Therapeutic Services eCYMHS CYFOS	Kids Helpline Medicare Local ATAPS

Public Adolescent Mental Health Services in Queensland		Current (End of Jan 2016)				
		Extended treatment and rehabilitation services				
MH Clinical Cluster	Hospital and Health Service (HSS) Catchment	AMYOS	Day program	Youth Resi	Step-up / Step-down Unit (SUSDU)	Sub-acute beds
Southern	Children's Health Queensland (CHQ) and Mater Children's Health (merged 24 Nov 2014)		1 unit <i>LCCH</i>	5 beds <i>Greenslopes</i>		
	Metro South HSS (includes Logan)	<i>South Brisbane</i> (July 2014) <i>Logan</i> (May 2015)				
	Gold Coast HHS	<i>Gold Coast</i> (Nov 2015)				
	Darling Downs HHS	<i>Toowoomba</i> (Dec 2014)	1 unit <i>Toowoomba</i>			
	West Moreton HHS					
	South West HHS					
Central	CHQ services located in Central clinical cluster	<i>North Brisbane</i> (July 2014)	1 unit (Jan 2015) <i>North Brisbane</i>			
	Metro North HHS (includes RBWH and Redcliff - Caboolture)	<i>Redcliff - Caboolture</i> (July 2014)				
	Sunshine Coast HHS					
	Wide Bay HHS					
	Central Queensland HHS	<i>Rockhampton</i> (Oct 2015)				
	Central West HHS					
Northern	Mackay HHS					
	Townsville HHS	<i>Townsville</i> (Dec 2014)	1 unit	2 x 4-bed units ⁴ <i>(March 2016)</i>		
	North West HHS					
	Cairns and Hinterland HHS	<i>Cairns</i> ⁵ (October 2015)		5 beds <i>Cairns</i>	Funded - Due to open by mid-2017	
	Torres and Cape HHS					
	Statewide services					4 x sub-acute swing beds <i>LCCH</i>

Current (End of Jan 2016)		
Other Qld Health adolescent MH services		Non-Qld Health services <i>(not comprehensive)</i>
Acute inpatient unit	CYMHS / Other	
11 beds (14-17 yrs) incl. 4 x sub-acute swing beds LCCH AMHU LCCH CMHU (see statewide services)	Acute Response Team ⁹ Consultation-Liaison Service for LCCH	
10 beds (13-17 yrs) <i>Logan</i>	Headspace & hYEPP ²	
8 beds (0-17 yrs) <i>Robina</i>		
8 beds (13-17 yrs) <i>Toowoomba</i>		
		Headspace Therapeutic Residential (DoCS)
12 beds (14-17 yrs) <i>RBWH</i>	Early Psychosis Teams <i>RBWH & TPCH</i>	Headspace Therapeutic Residential (DoCS)
		Headspace
		Headspace
		Headspace
		Headspace
8 beds (12-17 yrs)	Young People Early Intervention Team (yPEIT)	Headspace Therapeutic Residential (DoCS)
		Headspace
		Therapeutic Residential (DoCS)
		Headspace
CMHU 9 beds (0-13 yrs) (based at LCCH)	Evolve Therapeutic Services eCYMHS CYFOS	Kids Helpline Medicare Local ATAPS

(Acronyms)

AMHETI - Adolescent Mental Health Extended Treatment Initiative

AMHU - Adolescent Mental Health Unit (Lady Cilento Children's Hospital)

AMYOS – Assertive Mobile Youth Outreach Service

ATAPS – Access to Allied Psychological Services

BAC – Barrett Adolescent Centre

CFTU - Child and Family Therapy Unit (Royal Children's Hospital)

CHQ – Children's Health Queensland HHS

CCYMHS – Community Children and Youth Mental Health Service

CMHU – Child Mental Health Unit (Lady Cilento Children's Hospital)

CYFOS – Child and Youth Forensic Outreach Service

CYMHS – Children and Youth Mental Health Service

DoCS – Child Safety Services (Department of Communities, Child Safety and Disability Services)

eCYMHS – Child and Youth Forensic Outreach Service (tele-psychiatry support)

HHS – Hospital and Health Service

hYEPP – headspace Youth Early Psychosis Program

LCCH – Lady Cilento Children's Hospital

MH – mental health

RCH – Royal Children's Hospital

RBWH – Royal Brisbane and Women's Hospital

TPCH – The Prince Charles Hospital

TOHI – Time Out House Initiative

yPEIT – Young Peoples Early Intervention Team

YRRU – Youth Residential Rehabilitation Unit

(Notes)

1. Although the Greenslopes Youth Residential Rehabilitation Unit (YRRU) is shown against Metro South HHS, it is managed by Children's Health Queensland HHS (contracted to Aftercare).
2. The headspace Youth Early Psychosis Program (hYEPP) provides early intervention services for young people aged 12-25 years who are experiencing a first episode of psychosis or at very high risk of psychosis.
3. Young Peoples Early Intervention Team (yPEIT) provides a specialised mental health service to young people aged 15-24 years who reside in the Townsville HHS catchment area. yPEIT has a focus of reducing the duration and impact of psychological disturbance by providing timely recognition and treatment of young people experiencing Early Psychosis, emerging severe and complex non psychotic disorders.
4. Mind Australia has been contracted to operate two 4-bed Youth Resi services in Townsville (consistent with the Labor Government's *Rebuilding intensive mental healthcare for young people* election commitment).
5. The establishment of the Cairns and Rockhampton AMYOS teams was not funded through the Adolescent Mental Health Extended Treatment Initiative (AMHETI). The services were funded under the Keriba Omasker Healing Response following the deaths in December 2014 of eight Torres Strait Islander children in Cairns. Recurrent funding for both services has, however, been provided to Children's Health Queensland HHS.
6. Child and Youth Forensic Outreach Service (CYFOS) provide services to young people in the Central and Southern Health zones of Queensland. Services include training, specialised assessment, advice, and assistance with intervention planning.
7. The Commonwealth Government's Access to Allied Psychological Services (ATAPS) provides a maximum of 12 sessions per calendar year upon referral by a General Practitioner. Primary Health Networks act as fundholders.
8. The Extended Hours Team provided after hours support to the Royal Children's Hospital, and limited support to the Royal Brisbane and Women's Hospital and The Prince Charles Hospital.
9. The Extended Hours Team became the Acute Response Team and provided limited after hours support to the Royal Children's Hospital, and limited support to the Royal Brisbane and Women's Hospital.

(Sources)

Exhibit 255, Statement of Myfanwy Pitcher, 25 February 2016, p 2 para 6.

Exhibit 618, Children's Health Queensland Hospital and Health Service, July 2014, *Business Case for the development of the Statewide Adolescent Mental Health Extended Treatment and Rehabilitation Model of Care (v 4)*.

Exhibit 1086, Batch of meeting minutes and other documents associated with the Statewide Adolescent Extended Treatment and Rehabilitation Steering Committee and subsequent Adolescent Mental Health Extended Treatment Initiative Steering Committee, 26 August 2013 to 15 December 2014.

Exhibit 73, Supplementary affidavit of Judith Krause, 19 January 2016, p 14 para 9(h)(iv).

Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment ZJ to that statement, in particular, "AMHETI service mapping – current and proposed service by HHS catchment", p 6910.

Exhibit 305, CHQ Feedback on Discussion Paper 4(e) – Service mapping, 2 March 2016.

Table B – AMHETI

Service Element	Assertive Mobile Youth Outreach Service (AMYOS) (new)	Child and Adolescent Day Program (CADP) (expanded)	Youth Residential Rehabilitation Unit (Youth Resi) (new)
ECRG Tier ²	· Tier 2a ³	· Tier 2a ⁴	· Tier 2b ⁵
Clinical Services Capability Framework (CSCF) Level and Category ⁹	· <i>Level:</i> 6 · <i>Service sub-section:</i> Ambulatory services	· <i>Level:</i> 5 · <i>Service sub-section:</i> Ambulatory services	· Because it does not provide clinical services the Youth Resi is not classified under the CSCF. ¹⁰
National Mental Health Service Planning Framework (NMHSPF) service mapping ¹³	· <i>Stream:</i> Primary and specialised clinical ambulatory · <i>Category:</i> Intensive community treatment service · <i>Element:</i> 2.1.5.1 Intensive community treatment team – child and adolescent ¹⁴	· <i>Stream:</i> Primary and specialised clinical ambulatory · <i>Category:</i> Day program · <i>Element:</i> 2.1.6.1 Day program team – child and adolescent ¹⁵	· Youth residential rehabilitation units are not included in the current draft NMHSPF. · The Youth Resi includes services under two categories: – 2.2.2 Individual support and rehabilitation services – 2.3.3 Non-acute extended treatment services (residential and hospital or nursing home based) ¹⁶
Age range	· 13 and up to 18 years (flexible) ²¹	· 13 and up to 18 years (flexible) ²²	· 16–21 years
Features	<ul style="list-style-type: none"> · High frequency and high intensity individual support as needed · Treatment in the consumer’s own environment (usually home) rather than in a clinical setting · Repeated efforts to engage consumers who are reluctant or resistant (“assertive” outreach) · Medium to long-term support · Intensive case management by a multidisciplinary team · Small caseloads (8-10 consumers per case manager) · Interventions in individual and family settings · Emphasis on working with the adolescent’s family · Emphasis on mentalization-based treatment (MBT)²⁴ · Emphasis on, recovery, rehabilitation and community integration²⁵ 	<ul style="list-style-type: none"> · Intensive and structured outpatient treatment · Interventions in individual, group family settings · Medium-term time-limited support (1–2 school terms) · Intensive case management by multidisciplinary team · Clinical treatment and psychosocial rehabilitation integrated with schooling · Rehabilitation-oriented · Generally co-located with an acute inpatient unit²⁶ 	<ul style="list-style-type: none"> · Sub-acute residential (bed-based) facility · Intensive and long-term psychosocial <u>rehabilitation</u> service delivered by NGO · Not a <u>clinical</u> service – the extended <u>treatment</u> component is provided separately by community CYMHS clinic case managers (or sometimes AMYOS case managers)²⁷ · Emphasis on: <ul style="list-style-type: none"> – building daily living skills to support transition to independent living – education or employment · Interventions in individual and group settings, and in family settings where appropriate · Suitable for consumers with low-moderate acuity, but with complex psychosocial needs²⁸ · Emphasis on recovery, rehabilitation and community integration²⁹

Step-Up / Step-Down Unit (SUSDU) (proposed)	Statewide Sub-acute Beds (SSB) (QH classifies as new, but amended is more accurate)	Adolescent Acute Inpatient Units ¹ (existing) (Not an extended treatment and rehabilitation service element)
<ul style="list-style-type: none"> · Tier 2b⁶ 	<ul style="list-style-type: none"> · Tier 3⁷ 	<ul style="list-style-type: none"> · Tier: 3⁸
<ul style="list-style-type: none"> · <i>Level:</i> Not yet classified. Although, Level 5 is the highest classification for a non-acute bed-based service, CHQ believes Level 6 accurately reflects the type of care provided.¹¹ · <i>Service sub-section:</i> Non-Acute Inpatient Service — subject to QH service mapping¹² 	<ul style="list-style-type: none"> · <i>Level:</i> 6 · <i>Service sub-section:</i> Acute inpatient 	<ul style="list-style-type: none"> · <i>Level:</i> 6 · <i>Service sub-section:</i> Acute inpatient
<ul style="list-style-type: none"> · <i>Stream:</i> Specialised bed-based · <i>Category:</i> Sub-acute (Residential and hospital or nursing home based) · <i>Element:</i> 2.3.2.1 Step Up/Step Down — Youth (Residential)¹⁷ 	<ul style="list-style-type: none"> · <i>Stream:</i> Specialised bed-based · <i>Category:</i> Sub-acute (Residential, hospital or nursing based care)¹⁸ · <i>Element:</i> 2.3.2.5 Sub-acute intensive care (hospital)¹⁹ 	<ul style="list-style-type: none"> · <i>Stream:</i> Specialised bed-based · <i>Category:</i> Acute inpatient (hospital) · <i>Element:</i> 2.3.1.2 Acute — Child and youth²⁰
<ul style="list-style-type: none"> · CHQ developed a model for 13–18 year-olds consistent with AMHETI scope. · Cairns and Hinterland HHS has locally adapted the planned Cairns Step Up/ Step Down Unit for 16–21 year-olds.²³ 	<ul style="list-style-type: none"> · 13 and up to 18 years (flexible) 	<ul style="list-style-type: none"> · 13 and up to 18 years (flexible) – most units · 0–17 years (Gold Coast unit), but most patients are adolescents · Separate Child Mental Health Unit at Lady Cilento Children’s Hospital (LCCH) for children up to 13 years.
<ul style="list-style-type: none"> · Sub-acute residential (bed-based) facility · Intensive clinical and psychosocial rehabilitation support for up to 3 months (1 month + 1 month + 1 month if clinically indicated)³⁰ · Interventions in individual and group settings, and in family settings where appropriate · Service delivery partnership between HHS and NGO — Queensland Health clinical staff and NGO staff providing psychosocial rehabilitation. · Initially designed to accept referrals from across a clinical cluster. The planned SUSDU for Cairns HHS has deviated from this model, but will have “some potential” to accept consumers from adjoining HHS catchment areas, such as the Cape and Torres HHS.³¹ · Clinically staffed by Queensland Health nurses 8am–10pm; overnight by NGO mental health workers 	<ul style="list-style-type: none"> · Hospital-based extended treatment · Unfunded interim service with no defined model of service · Four “swing” beds located in the Lady Cilento Children’s Hospital (LCCH) adolescent acute inpatient unit — the beds are funded as acute adolescent beds and used as sub-acute beds on demand.³² · Medium-term intensive inpatient care (3–6 months) · Clinical treatment and psychosocial rehabilitation integrated with schooling — access to LCCH onsite schooling and day program · Interventions in individual and group settings · Statewide service — referrals managed by state-wide sub-acute bed referral panel (chaired by CHQ) · Allows for involuntary detention 	<ul style="list-style-type: none"> · Short-term 24-hour inpatient assessment and treatment services i.e. short-term targeted treatment programs³³ · Focus on providing a safe, containing and low stimulus environment in which to rapidly stabilise an adolescent’s symptoms and reduce their level of acuity before discharge to continued community-based treatment — may also be needed for diagnostic clarification and review of psychopharmacology³⁴ · Focus on “immediate acute symptom reduction, providing safety and containment, diagnostic clarification and review of psychopharmacology if appropriate”³⁵ · Generally unplanned “crisis” admissions, but may include planned admissions (including regular planned admissions) as part of a treatment plan.

Service Element	Assertive Mobile Youth Outreach Service (AMYOS) (new)	Child and Adolescent Day Program (CADP) (expanded)	Youth Residential Rehabilitation Unit (Youth Resi) (new)
<p>Service aims and functions</p>	<ul style="list-style-type: none"> · Reduce barriers to treatment · Improve engagement of high risk adolescents in ongoing mental healthcare · Reduce the need for inpatient hospital admissions · Reduce the length of stay when hospitalisation is required · Help adolescents to develop their personal support systems and live successfully within their community · Facilitate and support the safe transition to more functional and independent living³⁶ 	<ul style="list-style-type: none"> · Reduce the severity of mental health symptoms · Provide an alternative to acute hospital admission · Improve functioning in key areas of development, including educational or vocational programs, involvement in social networks, leisure and recreational pursuits³⁷ 	<ul style="list-style-type: none"> · Improve social and daily living skills · Develop and maintain independence, rather than reliance · Improve young people’s ability to manage their illness, with the available support, and live independently in the community · Help young people develop their personal support systems, including community, family and social networks, and live successfully within their community · Decrease self-harming behaviour · Reduce the need for inpatient admissions · Improve engagement with education and vocational opportunities and employment · Provide short-term accommodation for young people with mental health issues to build independence to return to the family home or other accommodation options³⁸
<p>Interventions</p>	<ul style="list-style-type: none"> · Core interventions are generally the same as those provided through other CYMHS clinical services and include individual psychotherapy, risk management, family therapy and pharmacotherapy. The key difference is in “the level of intensity, flexibility and mobility with which these clinical interventions are delivered”.⁴⁵ · AMYOS clinicians have been trained in a relatively new type of psychodynamic psychotherapy for adolescents – mentalization-based treatment (MBT) – that community CYMHS staff may not yet be trained and experienced in delivering.⁴⁶ · Crisis/safety planning and management⁴⁷ 	<ul style="list-style-type: none"> · Individual and group psychotherapies · Group-based psycho-educational programs · Family therapies · Group-based psychosocial rehabilitation programs and activities, such as daily living skills, cooking and healthy eating, mindfulness, creative expression, communication skills, social skills and job readiness · Individual pharmacotherapies · Schooling and vocational activities · Recreational activities⁴⁸ 	<ul style="list-style-type: none"> · Clinical interventions are managed by CYMHS or Adult Mental Health Service case workers. · Residential interventions target psychosocial rehabilitation through: <ul style="list-style-type: none"> – daily living skills – engagement in education and/or employment – family interventions, including family therapy where appropriate – pharmacological supervision and education – distress management when needed – Re-engagement with community of origin⁴⁹
<p>Educational and vocational options</p>	<ul style="list-style-type: none"> · No specific schooling option – seeks to ensure adolescents are engaged in mainstream or specialist schooling or other vocational programs⁶⁰ 	<ul style="list-style-type: none"> · Integrated schooling provided by Education Queensland teachers within either the day program unit itself or on the hospital campus⁶¹ 	<ul style="list-style-type: none"> · Residential staff support residents to engage or re-engage with local schooling, other educational options and/or employment within 4 weeks of entry (although there needs to be flexibility for individual circumstances)⁶² · Consistent with the Youth Resi focus on rehabilitation and transition to independent living, residents are required to travel to and from schooling or employment themselves, usually on public transport.⁶³

Step-Up / Step-Down Unit (SUSDU) (proposed)	Statewide Sub-acute Beds (SSB) (QH classifies as new, but amended is more accurate)	Adolescent Acute Inpatient Units ¹ (existing) (Not an extended treatment and rehabilitation service element)
<ul style="list-style-type: none"> · Step up (prevent unnecessary inpatient admissions): <ul style="list-style-type: none"> – “prevent further deterioration of a person’s mental state and associated disability...to reduce the likelihood of an acute inpatient admission”³⁹ – early intervention alternative for those at increased risk of further deterioration or relapse · Step down (early discharge option): <ul style="list-style-type: none"> – no longer needing acute-level intervention, but need further stabilisation and recovery before returning to the community – strengthen and consolidate gains made as acute inpatient – minimise trauma and disruption of acute episode for consumers and carers⁴⁰ 	<ul style="list-style-type: none"> · As there is currently no model of service for the statewide sub-acute beds, the service aims and functions have not yet been clearly defined. · Improve functioning in key areas of development that may be arrested secondary to the mental illness (rehabilitative focus)⁴¹ · In contrast to an acute inpatient stay, the focus of sub-acute inpatient treatment is on stabilising and reducing psychiatric symptoms, restoring independent functioning (rehabilitation) and enabling the adolescent to re-engage with an educational or vocational program consistent with their developmental trajectory. This requires a more active, stimulating and motivating therapeutic program than is available in a short-term acute inpatient unit⁴² 	<ul style="list-style-type: none"> · Provide a safe, containing and low stimulus environment in which to rapidly stabilise a person’s psychiatric symptoms and reduce their level of acuity and risk before discharge to continued community-based treatment⁴³ · “Acute presentations focus more on immediate acute symptom reduction, providing safety and containment, diagnostic clarification and review of psychopharmacology if appropriate.”⁴⁴
<ul style="list-style-type: none"> · Behavioural and psychotherapeutic (individual and group based) · Family interventions (short-term intervention and psychoeducation, and referral to follow-up therapy)^{50,51} · Pharmacological (administration, supervision and education) · Multidisciplinary case review, including a consultant psychiatrist or appropriate medical delegate, at least weekly⁵² · Psychosocial rehabilitation including personal care, daily living skills, parenting (if relevant), community access, and social skills⁵³ · Acute mental health or medical assessment requires transport to most appropriate hospital. 	<ul style="list-style-type: none"> · Individualised treatment program · As there is currently no model of service for the statewide sub-acute beds, the range of interventions provided is unclear. · SSB consumers are managed by LCCH Adolescent Mental Health Unit staff through the usual clinical practices of that unit although their treatment goals reflect a sub-acute (rehabilitative) focus rather than the clinical needs of acute patients.⁵⁴ · One of the SSB consumers attended a day program as part of their treatment plan.⁵⁵ 	<ul style="list-style-type: none"> · Multidisciplinary and intensive specialist assessment, particularly where there are difficulties with diagnosis⁵⁶ · Review and adjust pharmacological treatments in a safe environment under clinical observation · Crisis intervention and brief family interventions to stabilise the adolescent so that psychological treatments can continue in the community⁵⁷ · Sensory room, time out and continuous observations are used to modulate distress.⁵⁸ · No rehabilitative focus — impairments in developmental tasks are not addressed⁵⁹
<ul style="list-style-type: none"> · There is will be no on-site school in the Step Up/Step Down Unit. There will be facilities to support “in-reach” educational support by Education Queensland teachers, or distance education⁶⁴ · The psychosocial support program seeks to help young people gain employment or enrol in a suitable education or vocational program.⁶⁵ 	<ul style="list-style-type: none"> · On-site schooling through the LCCH school⁶⁶ 	<ul style="list-style-type: none"> · On-site schooling

Service Element	Assertive Mobile Youth Outreach Service (AMYOS) (new)	Child and Adolescent Day Program (CADP) (expanded)	Youth Residential Rehabilitation Unit (Youth Resi) (new)
Consumer profile	<ul style="list-style-type: none"> Complex and severe mental disorder, often with high acuity – most have ongoing suicidal ideation⁶⁷ Exhibit high risk behaviour or risk of deterioration – most have a history of emergency department presentations and psychiatric admissions, and have previously attempted suicide⁶⁸ Moderate to major psychosocial impairment as measured by the Children’s Global Assessment Scale⁶⁹ Difficult to engage in ongoing mental healthcare through mainstream clinic-based CYMHS services⁷⁰ Majority of consumers are unemployed and disengaged from any type of education⁷¹ 	<ul style="list-style-type: none"> Severe and persistent mental illness resulting in severe psychosocial impairment, despite a range of less restrictive interventions⁷² Require extended and intensive clinical intervention, but do not need or would not benefit from an inpatient admission.⁷³ In a living environment supportive enough to ensure safety overnight and on weekends, and facilitate attendance at the day program on a daily basis⁷⁴ 	<ul style="list-style-type: none"> Severe and complex mental health conditions and complex psychosocial needs⁷⁵ Moderate mental health acuity – some residents continue to self-harm⁷⁶ Must be a consumer of a Child and Youth Mental Health Services (CYMHS) or Adult Mental Health Service⁷⁷ Willing/voluntary participant⁷⁸
Service exclusions	<ul style="list-style-type: none"> None specified⁸⁵ 	<ul style="list-style-type: none"> Consumers who are: <ul style="list-style-type: none"> Substance-dependent Assessed as being at an unacceptably high risk to self or others⁸⁶ 	<ul style="list-style-type: none"> Consumers who are: <ul style="list-style-type: none"> acutely unwell (physically or mentally), including those medically compromised by an eating disorder considered to be at high risk of suicide are actively engaging in threatening, aggressive, destructive or antisocial behaviours significantly intellectually impaired withdrawing or detoxing from substance misuse⁸⁷ The primary problem to be addressed is accommodation.⁸⁸
Hours of operation	<ul style="list-style-type: none"> Monday to Friday, 8am – 8pm Flexibility to extend contact to weekends or after hours if needed⁹⁴ 	<ul style="list-style-type: none"> Monday to Friday, business hours – specific hours vary across programs, but typically 8am–4.30pm⁹⁵ Some flexibility to accommodate extracurricular and recreational activities⁹⁶ 	<ul style="list-style-type: none"> Residential: 24/7 including 2 staff overnight⁹⁷ Clinical treatment (CYMHS): Generally business hours, with capacity for extended hours to meet particular needs
Length of stay	<ul style="list-style-type: none"> Determined on a case by case basis 	<ul style="list-style-type: none"> 120 days average stay (one school term), with maximum stay of 180 days (two school terms)⁹⁹ 	<ul style="list-style-type: none"> Up to 365 days Short-term outreach service following exit from the residence¹⁰⁰
Unit size	<ul style="list-style-type: none"> 16–20 adolescents per team at any one time 	<ul style="list-style-type: none"> 10–15 adolescents per day, per program 	<ul style="list-style-type: none"> Up to 5 beds¹⁰⁵ Greenslopes and Cairns units each have 5 beds. The two Townsville units have 4 beds each.

Step-Up / Step-Down Unit (SUSDU) (proposed)	Statewide Sub-acute Beds (SSB) (QH classifies as new, but amended is more accurate)	Adolescent Acute Inpatient Units ¹ (existing) (Not an extended treatment and rehabilitation service element)
<ul style="list-style-type: none"> · Moderate to severe mental health problems and/or disorders · Have recently experienced, or are at increased risk of experiencing, an acute episode of mental illness⁷⁹ · Living in the community, but at risk of relapse or further clinical deterioration without short-term intensive clinical treatment and intervention⁸⁰ · Need a level of monitoring and clinical care that does not require admission to an acute inpatient unit, but will benefit from more intensive clinical care and psychosocial support than can be provided through the usual continuum of care⁸¹ 	<ul style="list-style-type: none"> · Severe or complex symptoms of mental illness and associated with significant disturbance in behaviour precluding treatment in a less restrictive environment safely · Improvement in mental health not expected to occur within short term; measured in weeks/months⁸² 	<ul style="list-style-type: none"> · Young people experiencing “severe episodes of mental illness, who cannot be adequately treated in a less restrictive environment”⁸³ · Young people with “acute episodes of mental illness” with the episodes characterised by a recent onset of severe clinical symptoms that have the potential to result in prolonged functional impairment or emotional distress, or risk to self and/or others⁸⁴
<ul style="list-style-type: none"> · Secure forensic patients · Level of acuity or risk too high to be safely managed · SUSDU is not a drug and alcohol withdrawal service⁸⁹ 	<ul style="list-style-type: none"> · Consumers who: <ul style="list-style-type: none"> – could be managed in a less restrictive setting – primarily need support with substance misuse issues⁹⁰ · The primary problem to be addressed is accommodation.⁹¹ · Secure forensic patients · “It is not anticipated that young people with a primary diagnosis of an eating disorder will be accepted into the SSB.”⁹² 	<ul style="list-style-type: none"> · Secure forensic patients⁹³
<ul style="list-style-type: none"> · 24 hours, 7 days including Queensland Health nursing staff for two of the three daily shifts (8am–10pm) · NGO service provider to staff the overnight shift⁹⁸ 	<ul style="list-style-type: none"> · 24 hours, 7 days 	<ul style="list-style-type: none"> · 24 hours, 7 days
<ul style="list-style-type: none"> · Expected stay of up to 28 days with a maximum length of stay of 3 months (1 month + 1 month + 1 month if clinically indicated)¹⁰¹ 	<ul style="list-style-type: none"> · Maximum length of stay of 3 months, with extension based only on clinical requirements, as determined by the Statewide Sub-acute Bed Referral Panel¹⁰² 	<ul style="list-style-type: none"> · 14 days¹⁰³ · Most recent public data indicates an average length of stay of 10.3 days¹⁰⁴
<ul style="list-style-type: none"> · Up to 10 beds per Step Up/Step Down Unit¹⁰⁶ · 6 beds planned for Cairns, with potential to increase to 10 beds¹⁰⁷ 	<ul style="list-style-type: none"> · 4 “swing” beds available on demand 	<ul style="list-style-type: none"> · Varies – see “Locations”

Service Element	Assertive Mobile Youth Outreach Service (AMYOS) (new)	Child and Adolescent Day Program (CADP) (expanded)	Youth Residential Rehabilitation Unit (Youth Resi) (new)
Primary referral / Referral pathway	<ul style="list-style-type: none"> Referral via a community CYMHS clinic or acute inpatient unit¹⁰⁸ 	<ul style="list-style-type: none"> Referral via CYMHS service, generally a community CYMHS clinic or acute inpatient unit¹⁰⁹ 	<ul style="list-style-type: none"> Child and Youth Mental Health Services (CYMHS) or Adult Mental Health Services Via a multidisciplinary statewide Youth Resi Referral Panel, which is chaired by CHQ and includes representatives from each NGO service provider¹¹⁰
Gazetted Mental Health facility (authorised under the Mental Health Act to treat involuntary patients)	<ul style="list-style-type: none"> Not gazetted 	<ul style="list-style-type: none"> Gazetted Some clients may be subject to Involuntary Treatment Order (community category) or forensic order 	<ul style="list-style-type: none"> Not gazetted Young people on an Involuntary Treatment Order (community category) may be voluntarily admitted Young people on a forensic order may be voluntarily admitted if assessed as safe for other residents¹¹⁵
Staffing profile and case load (where applicable)	<ul style="list-style-type: none"> Typical caseload: <ul style="list-style-type: none"> 8–10 consumers per full-time AMYOS clinician¹¹⁷ equates to 16–20 consumers per standard AMYOS team Standard AMYOS teams to be staffed by two full-time senior clinicians (NG7 or HP4 level) Single clinician services are planned for four HHS catchment areas with a smaller population – South West, Central West, North West and Cape York.¹¹⁸ Current AMYOS teams are staffed by a combination of clinical nurses, psychologists, occupational therapists, social workers¹¹⁹ Each standard AMYOS team is supported by a psychiatrist the equivalent of one day per week (0.2 full-time equivalent FTE).¹²⁰ CHQ-operated teams in Brisbane and Redcliffe/Caboolture have additional psychiatric, team leader and administrative support.¹²¹ 	<ul style="list-style-type: none"> Typical caseload: <ul style="list-style-type: none"> 12–15 consumers per team 1 clinician per 5 consumers in group work¹²² CHQ-operated day programs (per team): <ul style="list-style-type: none"> Psychiatrist (0.5 FTE) Registrar (0.5 FTE) Nursing (1.0 FTE) Team leader (1.0 FTE) Psychologist (1.0 FTE) Social Worker (1.0 FTE) Occupational Therapist (1.0 FTE) Other CYMHS therapists (speech pathology, music, art etc.) (0.9 FTE) Administration Officer (1.0 FTE)¹²³ 	<ul style="list-style-type: none"> Staffed 24/7 at a ratio of 2 staff for 5 residents across all shifts NGOs have significant flexibility in staffing outside this requirement Qld Health does not mandate minimum qualifications and experience for NGO staff. This is at the discretion of the NGO service provider. Aftercare staffing per residential (Greenslopes and Cairns): <ul style="list-style-type: none"> Team Leader: professionally qualified allied health clinician and experienced youth mental health worker Senior support workers: professionally qualified allied health professionals Support workers: at least vocationally qualified in mental health and youth support work¹²⁴ Community CYMHS clinic case managers
Service provider	<ul style="list-style-type: none"> Queensland Health – local HHS 	<ul style="list-style-type: none"> Queensland Health – local HHS 	<ul style="list-style-type: none"> NGO service provider Youth Resi model is “provider agnostic”, meaning it can be delivered by an NGO or Queensland Health.¹²⁸

Step-Up / Step-Down Unit (SUSDU) (proposed)	Statewide Sub-acute Beds (SSB) (QH classifies as new, but amended is more accurate)	Adolescent Acute Inpatient Units ¹ (existing) (Not an extended treatment and rehabilitation service element)
<ul style="list-style-type: none"> · Step up: from community CYMHS, enrolment in day program, other less-restrictive CYMHS services, admission to nearest hospital for rural and remote locations¹¹¹ · Step down: from acute inpatient unit¹¹² · Via a designated referral process – Hospital and Health Service (HHS)-chaired assessment panel including representatives from the SUSDU and other local CYMHS services, and at least one CYMHS consultant psychiatry representative¹¹³ 	<ul style="list-style-type: none"> · Statewide Sub-acute Bed Referral Panel chaired by CHQ¹¹⁴ 	<ul style="list-style-type: none"> · Community CYMHS · Department of Emergency Medicine · Hospital inpatient services · Private psychiatrists · Other specialist services · Via a designated intake process
<ul style="list-style-type: none"> · Not gazetted · Young people on an Involuntary Treatment Order (community category) may be voluntarily admitted¹¹⁶ 	<ul style="list-style-type: none"> · Gazetted · Seclusion room 	<ul style="list-style-type: none"> · Gazetted · Seclusion room
<ul style="list-style-type: none"> · Proportion of disciplines at each SUSDU to be determined by local HHS · Every SUSDU to have: <ul style="list-style-type: none"> – a clinical team leader from the local HHS – a support staff team leader from the NGO service provider – a consultant psychiatrist.¹²⁵ · Clinical staff preferably led by a nurse) may include doctors, nurses, allied health staff, and music and art therapists. · Non-clinical staff may include ATSI mental health workers, community care staff and Department of Education and Training (DET) staff. · All NGO support staff must be vocationally qualified in mental health (Certificate 4).¹²⁶ 	<ul style="list-style-type: none"> · There are no specific staff members allocated to SSB patients. They are cared for by the staff in the LCCH Adolescent Mental Health Unit alongside acute patients. The LCCH : <ul style="list-style-type: none"> – Psychiatrist (0.2 FTE) – Psychiatric registrar (0.4 FTE) – Nursing (5.1 FTE) – Psychologist (0.2 FTE) – Social work (0.2 FTE) – Occupational therapist (0.2 FTE) – Speech therapist (0.2 (FTE) – Recreational officer (2.2 FTE) – Administration officer (0.2 FTE)¹²⁷ 	<ul style="list-style-type: none"> · Nursing staff rostered to cover shifts 24 hours, 7 days a week · On-call child and adolescent psychiatrist (with Registrar support) available 24 hours, 7 days a week · Supported by multidisciplinary team of psychologists, social workers, occupational therapists, speech therapists, recreational officers and administration officers
<ul style="list-style-type: none"> · Queensland Health – local HHS, in partnership with NGO service provider · Technically “provider agnostic” model, meaning the service can be delivered by an NGO or Queensland Health.¹²⁹ 	<ul style="list-style-type: none"> · Queensland Health – CHQ HHS 	<ul style="list-style-type: none"> · Queensland Health – local HHS

Service Element	Assertive Mobile Youth Outreach Service (AMYOS) (new)	Child and Adolescent Day Program (CADP) (expanded)	Youth Residential Rehabilitation Unit (Youth Resi) (new)
Governance	<ul style="list-style-type: none"> Local HHS under service agreement with CHQ CHQ provides statewide coordination under the service level agreements – provides training and hold funds.¹³⁰ 	<ul style="list-style-type: none"> Local HHS 	<ul style="list-style-type: none"> Children’s Health Queensland (CHQ) provides statewide coordination and governance. NGO service provider responsible for day-to-day operations of each Resi under a service agreement with CHQ Local HHS provides clinical governance for each consumer Statewide governance panel (CHQ, local HHSs and NGOs) – provides strategic and operational governance, and holds funding.¹³¹
Location – General	<ul style="list-style-type: none"> Mobile working from local CYMHS service (usually community CYMHS clinic) – delivery at residences and/or in community settings Regional and Rural AMYOS may be supported by eCYMHS 	<ul style="list-style-type: none"> Hospital campus or in a gazetted community mental health facility that has access to onsite educational services¹³⁴ Located close to public transport to provide access to consumers who need to travel to the unit daily Three of the current four day programs are co-located with adolescent acute inpatient units.¹³⁵ The North Brisbane day program is located in separate standalone premises. 	<ul style="list-style-type: none"> Leased domestic residence in a residential area, in proximity to a hospital with an established CYMHS service, including after-hours teams¹³⁶ Clinical case managers based in local community CYMHS clinic (or local AMYOS)¹³⁷
Locations pre-AMHETI (and pre-Barrett Adolescent Centre closure)	<ul style="list-style-type: none"> Nil 	<ul style="list-style-type: none"> Mater Toowoomba Townsville BAC¹³⁹ 	<ul style="list-style-type: none"> Nil

Step-Up / Step-Down Unit (SUSDU) (proposed)	Statewide Sub-acute Beds (SSB) (QH classifies as new, but amended is more accurate)	Adolescent Acute Inpatient Units ¹ (existing) (Not an extended treatment and rehabilitation service element)
<ul style="list-style-type: none"> · Local HHS · Model was developed as a cluster-based service, operated by a local HHS under the statewide oversight of CHQ.¹³² · The planned Cairns SUSDU is being developed by the Mental Health Alcohol and Other Drugs Branch with the Cairns and Hinterland HHS. CHQ has not been involved in decision making about the project.¹³³ 	<ul style="list-style-type: none"> · CHQ HHS 	<ul style="list-style-type: none"> · Local HHS
<ul style="list-style-type: none"> · Purpose-built facility in a residential area close to an acute adolescent inpatient unit¹³⁸ 	<ul style="list-style-type: none"> · Hospital campus 	<ul style="list-style-type: none"> · Hospital campus
<ul style="list-style-type: none"> · Nil 	<ul style="list-style-type: none"> · There were 15 gazetted and funded specialist sub-acute beds at the Barrett Adolescent Centre (15 beds; 13–18 years). · There were no sub-acute "swing" beds located in an adolescent acute inpatient unit before the BAC closed. 	<ul style="list-style-type: none"> · Mater (12 beds; 13–17 years) · Royal Brisbane and Women's Hospital (RBWH) 12 beds (14–17 years) · Logan (10 beds; 13–17 years) · Gold Coast (8 beds; 0–17 years) · Toowoomba (8 beds; 13–17 years) · Child and Family Therapy Unit (CFTU) of Children's Health Queensland (10 beds; 0–13 years) · Total = 50 beds available to adolescents (excludes CFTU beds)

Service Element	Assertive Mobile Youth Outreach Service (AMYOS) (new)	Child and Adolescent Day Program (CADP) (expanded)	Youth Residential Rehabilitation Unit (Youth Resi) (new)
Locations proposed in AMHETI business case (Exhibit 618) and Rebuilding intensive mental healthcare for young people discussion paper (Exhibit 664)	<ul style="list-style-type: none"> · North Brisbane (x 2) · South Brisbane (x 2) · Gold Coast · Logan · West Moreton · Ipswich · Toowoomba · Redcliffe/Caboolture · Sunshine Coast · Wide Bay · Rockhampton · Mackay · Townsville · Cairns¹⁴⁰ <p>Single-clinician teams proposed for:</p> <ul style="list-style-type: none"> · South West HHS · Central West HHS · North West HHS · Cape York HHS¹⁴¹ 	<ul style="list-style-type: none"> · Mater / LCCH · Toowoomba · Townsville · North Brisbane · South Brisbane (Logan) · Gold Coast 	<ul style="list-style-type: none"> · AMHETI business plan proposed a cluster-based service, with one Youth Resi located in each of the three mental health clinical clusters: · Northern — Townsville¹⁴² · Central — north Brisbane (in or around Caboolture¹⁴³) <ul style="list-style-type: none"> – Southern — south Brisbane (Greenslopes). – See explanation of mental health clinical clusters under the proposed SUSDU locations. · Following the establishment of additional services in Cairns and Townsville, the current CHQ priority is for one additional service in the Central clinical cluster (in or around Caboolture)¹⁴⁴
Current locations (as at March 2016)	<p><i>Since July 2014</i></p> <ul style="list-style-type: none"> · North Brisbane · South Brisbane · Redcliffe/Caboolture <p><i>Since December 2014</i></p> <ul style="list-style-type: none"> · Toowoomba · Townsville <p><i>Since May 2015</i></p> <ul style="list-style-type: none"> · Logan <p><i>Since October 2015</i></p> <ul style="list-style-type: none"> · Rockhampton · Cairns <p><i>Since November 2015</i></p> <ul style="list-style-type: none"> · Gold Coast¹⁴⁷ 	<ul style="list-style-type: none"> · Brisbane South (LCCH) · Brisbane North (since January 2015) — currently at old Royal Children’s Hospital site — to relocate to Chermside (close to the Prince Charles Hospital) by mid-2016¹⁴⁸ · Toowoomba · Townsville 	<ul style="list-style-type: none"> · Brisbane (Greenslopes) — 5 beds · Cairns — 5 beds (converted from Time Out House Initiative service) · Townsville x 2 — 4 beds each from March 2016. These units were delivered separate to the AMHETI plan under the Labor Government’s <i>Rebuilding intensive mental healthcare for young people</i> election commitment.¹⁴⁹

Underpinned by Community CYMHS (Tier 1) — out of scope for AMHETI

Step-Up / Step-Down Unit (SUSDU) (proposed)	Statewide Sub-acute Beds (SSB) (QH classifies as new, but amended is more accurate)	Adolescent Acute Inpatient Units ¹ (existing) (Not an extended treatment and rehabilitation service element)
<ul style="list-style-type: none"> · Cluster-based. One SUSDU proposed for each of the three mental health clinical clusters: <ul style="list-style-type: none"> – Northern: incorporating the HHS catchment areas of Mackay, Townsville, North West, Cairns and Hinterland, and Torres and Cape York – Central: incorporating the HHS catchment areas of Metro North, Sunshine Coast, Wide Bay, Central Queensland and Central West – Southern: incorporating the HHS catchment areas of Metro South, Gold Coast, Darling Downs, West Moreton and South West.¹⁴⁵ 	<ul style="list-style-type: none"> · One statewide SSB “unit” within CHQ HHS catchment (Brisbane) 	<ul style="list-style-type: none"> · AMHETI out of scope, but 2 mental health beds are proposed for a new adolescent unit in Cairns¹⁴⁶
<ul style="list-style-type: none"> · Nil · Planning underway to establish the first SUSDU in Cairns by end of 2016–17¹⁵⁰ 	<ul style="list-style-type: none"> · 4 x “swing” beds within the Adolescent Mental Health Unit (acute inpatient unit) at the Lady Cilento Children’s Hospital 	<ul style="list-style-type: none"> · Lady Cilento Children’s Hospital <ul style="list-style-type: none"> – Adolescent Mental Health Unit (AMHU): 11 beds for 14–17 years (includes 4 sub-acute swing beds) – Child Mental Health Unit (CMHU) 9 beds for 0–13 years · Royal Brisbane and Women’s Hospital Adolescent Mental Health Inpatient Unit (12 beds; 14–17 years) · Logan (10 beds; 13–17 years) · Gold Coast (Robina) (8 beds; 0–17 years) · Toowoomba (8 beds; 13–17 years) · Townsville (8 beds; 12–17 years) (opened 20 Jan 2014) · Total = 57 beds available to adolescents (excludes CMHU beds)

(Endnotes)

- 1 Acute inpatient units fall outside the definition of mental health extended treatment and rehabilitation services. They have been included in this summary table because they are a crucial element of the continuum of mental health services for adolescents.
- 2 Relevant Tier according to the Queensland Health Expert Clinical Reference Group (ECRG). The ECRG proposed four tiers of service provision – Tiers 1, 2a, 2b and 3. No witness was able to identify the classification system on which the ECRG based its recommendations.
- 3 Exhibit 735, Presentation by Stephen Stathis to the Department of Health Mental Health Alcohol and Other Drugs Branch Leadership Matters forum on 29 April 2014.
- 4 Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, p 1.
- 5 Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, p 1.
- 6 Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, p 1.
- 7 Exhibit 735, Presentation by Stephen Stathis to the Department of Health Mental Health Alcohol and Other Drugs Branch Leadership Matters forum, April 2014.
- 8 Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, p 1.
- 9 Relevant CSCF level according to the Queensland Health Clinical Services Capability Framework version 3.1; Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment ZI to that statement, pp 3041–3172. CSCF level refers to the minimum capability requirements for a particular service by capability level. A description of the CSCF is available on the Queensland Health website: <<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/service-delivery/cscf/default.asp>>.
- 10 Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016.
- 11 Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, p 1.
- 12 Department of Health 2015, Draft Adolescent step up step down unit model of service, October, p 81; Exhibit 123, Statement of Stephen Stathis, 15 January 2016, Attachment D to that statement, pp 74–122. A note at page 81 of the draft MOSD indicates that the CSCF level will be “reviewed and clarified following service mapping”.
- 13 Exhibit 233, National Mental Health Service Planning Framework “Service Elements and Activity Descriptions”, October 2013. The NMHSPF aims to provide a tool “that can be adapted for use within each Australian jurisdiction that will provide transparency and consistency across all jurisdictions for estimating the need and demand for mental health services – across the continuum of care from prevention and early intervention to the most intensive treatment” (p 10, Version 1.03, January 2012 of the NMHSPF project charter). See also Exhibit 73, Supplementary statement of Judith Krause, 19 January 2016, pp 16–17 para 12.
- 14 Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, p 1; Exhibit 73, Supplementary statement of Judith Krause, 19 January 2016, pp 19–17 para 12.
- 15 Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, p 1; Exhibit 73, Supplementary statement of Judith Krause, 19 January 2016, pp 19–17 para 12.
- 16 Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, p 1; Exhibit 73, Supplementary statement of Judith Krause, 19 January 2016, pp 19–17 para 12.
- 17 Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, p 1; Exhibit 73, Supplementary statement of Judith Krause, 19 January 2016, pp 19–17 para 12.
- 18 Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, p 1; Exhibit 73, Supplementary statement of Judith Krause, 19 January 2016, pp 19–17 para 12.
- 19 Counsel Assisting the Commission submits that an extended inpatient sub-acute unit for adolescents, consistent with the attributes of the Tier 3 model proposed by the ECRG, is also consistent with the following NMHSPF category: 2.3.3 Non-acute extended treatment services (residential and hospital or nursing home based); and associated element: 2.3.3.1: Non-acute intensive care service (hospital). The main difference between the different service elements is the average and expected length of stay. Element 2.3.2.5 has an average length of stay of 120 days with an expected maximum stay of less than 180 days (6 months). Element 2.3.3.1 has an average length of stay of 365 days. Submission 30, Counsel Assisting on the draft NMHSPF, 14 April 2016, pp 11–13, 24 paras 34–35, 93.
- 20 Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, p 1; Exhibit 73, Supplementary statement of Judith Krause, 19 January 2016, pp 19–17 para 12.
- 21 AMYOS model of service; Exhibit 435, Statement of Michael Daubney, 22 February 2016, Attachment MD4 to that statement, pp 33–50.
- 22 Child and adolescent day program model of service; Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment ZJ to that statement, pp 7193–7221.

- 23 Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016; Exhibit 74, Second supplementary statement of Judith Krause, 4 February 2016, pp 29–30 paras Q. 63(c) and Q65(b).
- 24 Exhibit 435, Statement of Michael Daubney, 22 February 2016, p 3 para 11.
- 25 Exhibit 618, AMHETI Business Case, Children’s Health Queensland Hospital and Health Service, V. 4.0, 16 July 2014, Appendix 3, p 39.
- 26 Exhibit 618, AMHETI Business Case, Children’s Health Queensland Hospital and Health Service, V. 4.0, 16 July 2014, Appendix 3, p 39; Exhibit 974, Mental Health Alcohol and Other Drugs Branch 2013, ‘Child and Adolescent Day Program (CADP) services discussion paper’, December, Department of Health.
- 27 Exhibit 255, Statement of Myfanwy Pitcher, 25 February 2016, p 3 para 12.
- 28 Exhibit 255, Statement of Myfanwy Pitcher, 25 February 2016, p 12 paras 67–69.
- 29 Youth Residential Rehabilitation Unit model of service, pp 2–3, Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment ZJ to that statement, pp 7691–7705.
- 30 Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016.
- 31 Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016; Exhibit 74, Second supplementary statement of Judith Krause, 4 February 2016, p 29 para Q.63(c).
- 32 Exhibit 280, Statewide Sub-Acute Beds Discussion Paper, January 2016, p 25.
- 33 Children’s Health Queensland 2013, Model of service for an acute adolescent inpatient unit; Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment ZJ to that statement, pp 5881–5817.
- 34 Cotgrove, A 2014, ‘Inpatient services’, in McDougall T and Cotgrove A (eds), *Specialist mental healthcare for children and adolescents: hospital, intensive community and home based services*, Routledge, London, pp 34–53; Royal College of Psychiatrists (RCP) 2013, *Building and sustaining specialist CAMHS to improve outcomes for young children: update guidance on workforce, capacity and functions of CAMHS in the UK*, College Report CR182, RCP, London; Exhibit 73, Supplementary Statement of Judith Krause, 19 January 2016, p 22, para 16(d)(i).
- 35 Exhibit 73, Supplementary statement of Judith Krause, 19 January 2016, p 22 para 16(d)(i).
- 36 AMYOS model of service, p 1; Exhibit 435, Statement of Michael Daubney, 22 February 2016, Attachment MD4 to that statement, pp 33–50.
- 37 Child and adolescent day program model of service, p 2–3; Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment ZJ to that statement, pp 7193–7221
- 38 Youth Residential Rehabilitation Unit model of service, pp 2–3; Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment ZJ to that statement, pp 7691–7705; Exhibit 255, Statement of Myfanwy Pitcher, 25 February 2016, p 3 para 15; Exhibit 256, Statement of Ivan Frkovic, 25 February 2016, p 4, paras 13–14.
- 39 Department of Health 2015, Draft Adolescent step up step down unit model of service, October, p 9; Exhibit 123, Supplementary Statement of Stephen Stathis, 15 January 2016, Attachment D to that statement, pp 74–122.
- 40 Department of Health 2015, Draft Adolescent step up step down unit model of service, October, p 9; Exhibit 123, Supplementary Statement of Stephen Stathis, 15 January 2016, Attachment D to that statement, pp 74–122.
- 41 Exhibit 618, AMHETI Business Case, Children’s Health Queensland Hospital and Health Service, V. 4.0, 16 July 2014, Appendix 3, p 64.
- 42 Cotgrove, A 2013 ‘Inpatient services’, in McDougall, T & Cotgrove, A (eds), *Specialist mental healthcare for children and adolescents: hospital, intensive community and home based services*, Routledge, London, pp 34–53.
- 43 Cotgrove, A 2013 ‘Inpatient services’, in McDougall, T & Cotgrove, A (eds), *Specialist mental healthcare for children and adolescents: hospital, intensive community and home based services*, Routledge, London, pp 34–53; Royal College of Psychiatrists (United Kingdom) 2013, *Building and sustaining specialist CAMHS to improve outcomes for young children: update guidance on workforce, capacity and functions of CAMHS in the UK*, College Report CR182, Royal College of Psychiatrists, London.
- 44 Exhibit 73, Supplementary statement of Judith Krause, 19 January 2016, p 22 para 16(d)(i).
- 45 Exhibit 435, Statement of Michael Daubney, 22 February 2016, p 3 para 11.
- 46 Exhibit 435, Statement of Michael Daubney, 22 February 2016, p 3 para 11.
- 47 AMYOS model of service, p 1; Exhibit 435, Statement of Michael Daubney, 22 February 2016, Attachment MD4 to that statement, pp 33–50.
- 48 Exhibit 988, Mental Health Alcohol and Other Drugs Branch 2013, ‘Child and Adolescent Day Program (CADP) services discussion paper’, December, Department of Health; Fothergill, J 2005, ‘An evaluation of mental health gains in adolescents who participate in a structured day treatment program’, PhD thesis, Bond University, Gold Coast, p 33, Available from: <<http://epublications.bond.edu.au/theses/fothergill/>>.
- 49 Exhibit 255, Statement of Myfanwy Pitcher, 25 February 2016, p 4 para 17.
- 50 Exhibit 73, Supplementary statement of Judith Krause, 19 January 2016, p 31 para 24(b). Judith Krause’s evidence is that, compared with the Victorian Y-PARC model, the SUSDU model has “an increased focus on family visiting spaces and an increased therapeutic focus on family therapy interventions”.

- 51 Department of Health 2015, Draft Adolescent step up step down unit model of service, October, section 4.9.2; Exhibit 123, Supplementary Statement of Stephen Stathis, 15 January 2016, Attachment D to that statement, pp 74–122.
- 52 Department of Health 2015, Draft Adolescent step up step down unit model of service, October, section 4.4.1; Exhibit 123, Supplementary Statement of Stephen Stathis, 15 January 2016, Attachment D to that statement, pp 74–122.
- 53 Department of Health 2015, Draft Adolescent step up step down unit model of service, October, section 4.10; Exhibit 123, Supplementary Statement of Stephen Stathis, 15 January 2016, Attachment D to that statement, pp 74–122.
- 54 Exhibit 280, Statewide Sub-Acute Beds Discussion Paper, January 2016, p 25.
- 55 Exhibit 278, Emails between Judi Krause and others, Subject: “Progress of Sub Acute Discussion Paper”, 10 September 2015.
- 56 Cotgrove, A 2013 ‘Inpatient services’, in McDougall, T & Cotgrove, A (eds), *Specialist mental healthcare for children and adolescents: hospital, intensive community and home based services*, Routledge, London, pp 34–53.
- 57 Exhibit 179, Supplementary statement of Trevor Sadler, 12 February 2016, pp 35–36 para 151.
- 58 Exhibit 179, Supplementary statement of Trevor Sadler, 12 February 2016, pp 36–37 para 154
- 59 Exhibit 179, Supplementary statement of Trevor Sadler, 12 February 2016, pp 35–36 para 151.
- 60 Exhibit 618, AMHETI Business Case, Children’s Health Queensland Hospital and Health Service, V. 4.0, 16 July 2014, Appendix 2, p 29.
- 61 Exhibit 618, AMHETI Business Case, Children’s Health Queensland Hospital and Health Service, V. 4.0, 16 July 2014; Exhibit 74, Second supplementary statement of Judith Krause, 4 February 2016, pp 10–11 para Q. 21(a)(ii).
- 62 Exhibit 618, AMHETI Business Case, Children’s Health Queensland Hospital and Health Service, V. 4.0, 16 July 2014, Appendix 2. p 29.
- 63 Exhibit 255, Statement of Myfanwy Pitcher dated 25 February 2016, p 3 para 15.
- 64 Department of Health 2015, Draft Adolescent step up step down unit model of service, October, p 26; Exhibit 123, Supplementary Statement of Stephen Stathis, 15 January 2016, Attachment D to that statement, pp 74–122.
- 65 Department of Health 2015, Draft Adolescent step up step down unit model of service, October, section 4.9.2; Exhibit 123, Supplementary Statement of Stephen Stathis, 15 January 2016, Attachment D to that statement, pp 74–122.
- 66 Exhibit 280, Statewide Sub-Acute Beds Discussion Paper, January 2016, p 24; Exhibit 618, AMHETI Business Case, Children’s Health Queensland Hospital and Health Service, V. 4.0, 16 July 2014, Appendix 2. p 29.
- 67 Exhibit 618, AMHETI Business Case, Children’s Health Queensland Hospital and Health Service, V. 4.0, 16 July 2014, Appendix 3, p 30; Exhibit 280, Children’s Health Queensland HHS 2016, ‘Statewide sub-acute beds discussion paper’, January, Brisbane: CHQ HHS, p 82.
- 68 Exhibit 618, AMHETI Business Case, Children’s Health Queensland Hospital and Health Service, V. 4.0, 16 July 2014, Appendix 3, p 30; Exhibit 280, Statewide Sub-Acute Beds Discussion Paper, January 2016, p 82.
- 69 CGAS: Children’s Global Assessment Scale rates general functioning independent of the diagnosis of mental illness. Exhibit 280, Statewide Sub-Acute Beds Discussion Paper, January 2016, p 82.
- 70 AMYOS model of service, p 2; Exhibit 435, Statement of Michael Daubney, 22 February 2016, Attachment MD4 to that statement, pp 33–50.
- 71 Exhibit 280, Statewide Sub-Acute Beds Discussion Paper, January 2016, p 82.
- 72 Child and adolescent day program model of service, pp 2–4; Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment ZJ to that statement, pp 7193–7221.
- 73 Child and adolescent day program model of service, pp 3; Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment ZJ to that statement, pp 7193–7221.
- 74 Child and adolescent day program model of service, p 4; Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment ZJ to that statement, pp 7193–7221.
- 75 Exhibit 255, Statement of Myfanwy Pitcher, 25 February 2016, p 12 para 67.
- 76 Exhibit 255, Statement of Myfanwy Pitcher, 25 February 2016, p 12 paras 68–70.
- 77 Exhibit 255, Statement of Myfanwy Pitcher, 25 February 2016, p 16 paras 31.
- 78 Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, p 2.
- 79 Department of Health 2015, Draft Adolescent step up step down unit model of service, October, pp 6, 9; Exhibit 123, Supplementary Statement of Stephen Stathis, 15 January 2016, Attachment D to that statement, pp 74–122.
- 80 Department of Health 2015, Draft Adolescent step up step down unit model of service, October, p 6; Exhibit 123, Supplementary Statement of Stephen Stathis, 15 January 2016, Attachment D to that statement, pp 74–122.
- 81 Department of Health 2015, Draft Adolescent step up step down unit model of service, October, p 6; Exhibit 123, Supplementary Statement of Stephen Stathis, 15 January 2016, Attachment D to that statement, pp 74–122.
- 82 Exhibit 618, AMHETI Business Case, Children’s Health Queensland Hospital and Health Service, V. 4.0, 16 July 2014, Appendix 3, p 42.

- 83 Children’s Health Queensland 2013, Model of service for an acute adolescent inpatient unit, p 1; Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment ZJ to that statement, pp 5881–5817.
- 84 Children’s Health Queensland 2013, Model of service for an acute adolescent inpatient unit, p 2; Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment ZJ to that statement, pp 5881–5817.
- 85 AMYOS model of service, pp 2, 4–5; Exhibit 435, Statement of Michael Daubney, 22 February 2016, Attachment MD4 to that statement, pp 33–50.
- 86 Exhibit 618, AMHETI Business Case, Children’s Health Queensland Hospital and Health Service, V. 4.0, 16 July 2014, Appendix 3, p 42.
- 87 Exhibit 255, Statement of Myfanwy Pitcher, 25 February 2016, p 7 paras 37–38; Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, pp 3–4.
- 88 Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, p 4.
- 89 Department of Health 2015, Draft Adolescent step up step down unit model of service, October, p 19; Exhibit 123, Supplementary Statement of Stephen Stathis, 15 January 2016, Attachment D to that statement, pp 74–122.
- 90 Statewide subacute bed referral panel protocol, p 5; Exhibit 435, Statement of Michael Daubney, 22 February 2016, Attachment MD2 to that statement, pp 13–23.
- 91 Statewide subacute bed referral panel protocol, p 5; Exhibit 435, Statement of Michael Daubney, 22 February 2016, Attachment MD2 to that statement, pp 13–23.
- 92 Exhibit 618, AMHETI Business Case, Children’s Health Queensland Hospital and Health Service, V. 4.0, 16 July 2014, Appendix 3, p 67; Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, p 3.
- 93 Children’s Health Queensland 2013, Draft model of service for an acute adolescent inpatient unit, p 5884; Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment ZJ to that statement, pp 5881–5817.
- 94 AMYOS model of service, p 16; Exhibit 435, Statement of Michael Daubney, 22 February 2016, Attachment MD4 to that statement, pp 33–50.
- 95 Exhibit 988, Mental Health Alcohol and Other Drugs Branch 2013, ‘Child and Adolescent Day Program (CADP) services discussion paper’, December, Department of Health, p 2.
- 96 Exhibit 618, AMHETI Business Case, Children’s Health Queensland Hospital and Health Service, V. 4.0, 16 July 2014, Appendix 3, p 43.
- 97 Exhibit 255, Statement of Myfanwy Pitcher, 25 February 2016, p 3 para 11.
- 98 Department of Health 2015, Draft Adolescent step up step down unit model of service, October, p 43; Exhibit 123, Supplementary Statement of Stephen Stathis, 15 January 2016, Attachment D to that statement, pp 74–122; Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, p 4.
- 99 Exhibit 618, AMHETI Business Case, Children’s Health Queensland Hospital and Health Service, V. 4.0, 16 July 2014, Appendix 3, p 43; Child and adolescent day program model of service, p 7194; Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment ZJ to that statement, pp 7193–7221.
- 100 Youth Residential Rehabilitation Unit model of service, pp 2–3; Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment ZJ to that statement, pp 7691–7705; Exhibit 256, Statement of Ivan Frkovic, 25 February 2016, p 8 para 39; Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, p 4.
- 101 Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, p 4; Exhibit 123, Supplementary statement of Stephen Stathis, 15 January 2016, p 9 para 27.
- 102 Exhibit 280, Statewide Sub-Acute Beds Discussion Paper, January 2016, p 25; Statewide subacute bed referral panel protocol, p 1; Exhibit 435, Statement of Michael Daubney, 22 February 2016, Attachment MD2 to that statement, pp 13–23.
- 103 Children’s Health Queensland 2013, Draft model of service for an acute adolescent inpatient unit, p 5884; Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment ZJ to that statement, pp 5881–5817.
- 104 Productivity Commission 2016, *Report on Government services*, Volume E (Health), Chapter 12A (Mental health management), Table 12A.61 Average length of stay, public hospitals acute units, by target population (no. of days), 2013–14.
- 105 Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, p 4; Youth Residential Rehabilitation Unit model of service, p 13; Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment ZJ to that statement, pp 7691–7705.
- 106 Exhibit 618, AMHETI Business Case, Children’s Health Queensland Hospital and Health Service, V. 4.0, 16 July 2014, p 60.
- 107 Exhibit 664, Discussion Paper: Rebuilding intensive mental healthcare for young people, September 2015, Appendix 9, p 27.
- 108 AMYOS model of service, p 4; Exhibit 435, Statement of Michael Daubney, 22 February 2016, Attachment MD4 to that statement, pp 33–50.
- 109 Child and adolescent day program model of service, p 5–6; Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment ZJ to that statement, pp 7193–7221.
- 110 Exhibit 256, Statement of Ivan Frkovic, 25 February 2016, p 7 paras 31–32.

- 111 Department of Health 2015, Draft Adolescent step up step down unit model of service, October; Exhibit 123, Supplementary Statement of Stephen Stathis, 15 January 2016, Attachment D to that statement, pp 74–122.
- 112 Department of Health 2015, Draft Adolescent step up step down unit model of service, October, section 4.2.6; Exhibit 123, Supplementary Statement of Stephen Stathis, 15 January 2016, Attachment D to that statement, pp 74–122.
- 113 Department of Health 2015, Draft Adolescent step up step down unit model of service, October, section 4.2.1; Exhibit 123, Supplementary Statement of Stephen Stathis, 15 January 2016, pp 74–122.
- 114 Exhibit 435, Statement of Michael Daubney, 22 February 2016, p 5 para 22(a).
- 115 Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, p 1.
- 116 Department of Health 2015, Draft Adolescent step up step down unit model of service, October, p 80 Exhibit 123, Supplementary Statement of Stephen Stathis, 15 January 2016, Attachment D to that statement, pp 74–122.
- 117 AMYOS model of service, p 16; Exhibit 435, Statement of Michael Daubney, 22 February 2016, Attachment MD4 to that statement, pp 33–50.
- 118 Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, p 6.
- 119 Exhibit 435, Statement of Michael Daubney, 22 February 2016, pp 2–3 para 8.
- 120 AMYOS model of service, p 16; Exhibit 435, Statement of Michael Daubney, 22 February 2016, Attachment MD4 to that statement, pp 33–50.
- 121 Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016.
- 122 Exhibit 618, AMHETI Business Case, Children’s Health Queensland Hospital and Health Service, V. 4.0, 16 July 2014, p 43.
- 123 Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, p 6.
- 124 Exhibit 256, Statement of Ivan Frkovic, 25 February 2016, pp 6–7 para 20.
- 125 Department of Health 2015, Draft Adolescent step up step down unit model of service, October, p 43; Exhibit 123, Supplementary Statement of Stephen Stathis, 15 January 2016, Attachment D to that statement, pp 74–122; Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, p 6.
- 126 Department of Health 2015, Draft Adolescent step up step down unit model of service, October, pp 42–43; Exhibit 123, Supplementary Statement of Stephen Stathis, 15 January 2016, Attachment D to that statement, pp 74–122.
- 127 Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, p 5.
- 128 Exhibit 618, AMHETI Business Case, Children’s Health Queensland Hospital and Health Service, V. 4.0, 16 July 2014, Appendix 2, p 29.
- 129 Exhibit 618, AMHETI Business Case, Children’s Health Queensland Hospital and Health Service, V. 4.0, 16 July 2014, Appendix 2, p 29.
- 130 AMYOS model of service, p 16; Exhibit 435, Statement of Michael Daubney, 22 February 2016, Attachment MD4 to that statement, pp 33–50; Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, p 6.
- 131 Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, p 6.
- 132 Exhibit 618, AMHETI Business Case, Children’s Health Queensland Hospital and Health Service, V. 4.0, 16 July 2014, pp 29, 61.
- 133 Exhibit 73, Supplementary statement of Judith Krause, 19 January 2016, p 12 para 10(g); Exhibit 74, Second supplementary statement of Judith Krause, 4 February 2016, p 8 para Q. 17.
- 134 Exhibit 618, AMHETI Business Case, Children’s Health Queensland Hospital and Health Service, V. 4.0, 16 July 2014, Appendix 2, p 29.
- 135 Exhibit 988, Mental Health Alcohol and Other Drugs Branch 2013, ‘Child and Adolescent Day Program (CADP) services discussion paper’, December, Department of Health, p 1.
- 136 Youth Residential Rehabilitation Unit model of service, p 14; Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment ZJ to that statement, pp 7691–7705;
- 137 Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, p 1.
- 138 Exhibit 618, AMHETI Business Case, Children’s Health Queensland Hospital and Health Service, V. 4.0, 16 July 2014, Appendix 2, p 29.
- 139 Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, p 6; Exhibit 305, Children’s Health Queensland, Feedback on Discussion Paper 4E service mapping, 2 March 2016;

- Children’s Health Queensland HHS 2014, AMHETI service mapping: current and proposed services by HHS catchment; Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, Attachment ZJ to that statement, p 5879.
- 140 Exhibit 661, Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy Steering Committee Update, June 2015. In May 2015 the Government announced funding for an additional two AMYOS teams in Cairns and Rockhampton as part of the Keriba Omasker Healing Response.
- 141 Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, p 7.
- 142 Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, p 6.
- 143 Exhibit 618, AMHETI Business Case, Children’s Health Queensland Hospital and Health Service, V. 4.0, 16 July 2014, Appendix 2, p 29.
- 144 Exhibit 1235, Overview of the adolescent mental health extended treatment initiative, presented to Queensland Health Youth Mental Health Commitments Committee on 22 September 2015, p 8.
- 145 Exhibit 1235, Overview of the adolescent mental health extended treatment initiative, presented to Queensland Health Youth Mental Health Commitments Committee on 22 September 2015, p 8; Exhibit 618, AMHETI Business Case, Children’s Health Queensland Hospital and Health Service, V. 4.0, 16 July 2014, p 12.
- 146 Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, p 6.
- 147 Exhibit 73, Supplementary statement of Judith Krause, 19 January 2016, p 15 para 10(h)(v); Exhibit 123, Supplementary statement of Stephen Stathis, 15 January 2016, p 21–22 para 69; Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, p 7.
- 148 Exhibit 73, Supplementary statement of Judith Krause, 19 January 2016, p 15 para 10(h)(v); Exhibit 123, Supplementary statement of Stephen Stathis, 15 January 2016, p 21–22 para 69; Exhibit 304, Children’s Health Queensland, Feedback on Discussion Paper 4D comparison of service elements, 2 March 2016, p 7.
- 149 Exhibit 661, Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy Steering Committee Update, June 2015.
- 150 Exhibit 664, Discussion Paper: Rebuilding intensive mental healthcare for young people, September 2015. Discussion paper notes that once the purpose-built step-up/step-down unit is operational in Cairns from 2017–18, operational funding for the Cairns Youth Residential Unit will be reallocated to contribute to the recurrent operational funding for the SUSDU (p 10).

Appendix D – Key personnel

Ingrid Adamson (CHQ)

Since September 2013, Adamson has held the position of Project Manager, Child and Youth Mental Health Service, CHQ HHS.¹

Adamson sat on a number of committees, including:² Member and Secretariat of the Chief Executive and Department of Health Oversight Committee,³ Member of the Adolescent Mental Health Treatment Initiative (AMHETI) Steering Committee (formerly the SWAETRI Steering Committee), Secretariat of the Service Options Working Group, Secretariat of the Youth Resilience Governance Panel, Member (and later, Secretariat) of the Young Person's Extended Treatment and Rehabilitation Initiative Governance Committee (formerly the Young Person's Extended Treatment and Rehabilitation Initiative Governance Committee),⁴ and Member of the SWAETR Financial and Workforce Planning Working Group.⁵

As Secretariat, Adamson's responsibilities included taking minutes of meetings and reporting to the committee on the status of the relevant group's activities in terms of risks, issues and timeframes.⁶ Adamson has a number of accreditations. Her formal qualifications include Bachelor of Business Banking and Finance/Accountancy, Master of Business Administration, Diploma in Project Management, Advanced Diploma in Project Management. She has undertaken the Australian Institute of Company Director's Course.⁷

John Allan (QH)

Since 4 August 2014, Allan has held the position of Chief Psychiatrist, with the Mental Health Alcohol and Other Drugs Branch.⁸ As Chief Psychiatrist, Allan is responsible for exercising the powers of the Director of Mental Health under *Mental Health Act 2000* (Qld).⁹ Since 1 July 2015, Allan has formally held the statutory role of Director of Mental Health.¹⁰

From February 2009 until July 2014, Allan was the Chief Psychiatrist, Mental Health and Drug and Alcohol Office, NSW Ministry of Health.¹¹ Allan currently holds the academic role of Associate Professor, School of Psychiatry, University of Queensland.¹² Allan has a Doctor of Philosophy,¹³ a Bachelor of Medicine and a Bachelor of Surgery.¹⁴ Allan is a Fellow of the Royal Australian and New Zealand College of Psychiatrists.¹⁵

Janine Armitage (BACSS)

Between 1999 and 2001, Armitage was employed as a casual and temporary teacher at the Barrett Adolescent Centre Special School (BACSS). In 2008, Armitage became a permanent teacher at the BAC School.¹⁶ She taught English and Home Economics/Life Skills.¹⁷ Armitage has a Bachelor of Arts and a Post-Graduate Diploma in Education, majoring in special education.¹⁸

Matthew Beswick (BAC)

Beswick first commenced work as a Registered Nurse in the area of mental health nursing at The Park on 4 July 1999. In mid-2001, he undertook an 18 month rotation at the BAC. He returned to work at the BAC in 2005, where he remained employed as a Registered Nurse until it closed in January 2014.¹⁹ Beswick acted as Clinical Nurse for 18–24 months prior to BAC closing.²⁰

Beswick holds a Bachelor of Nursing and registration with the Nursing and Midwifery Board of Australia.

Darren Bate (BACSS)

From 11 February 2000, Bate has worked as a teacher's aide at the Barrett Adolescent Centre Special School (BACSS).²¹ Bate continues to work as a teacher's aide at the BACSS, now located at Tennyson. Prior to his appointment at the BACSS, he worked as a disability support officer for 2 ½ years.²²

Peter Blatch (DETE)

From 2012 until 2014, Blatch held the position of Assistant Regional Director, School Performance, Special and Specific Purpose Schools.²³ In that role he was responsible for the supervision of 25 principals of special and specific purpose schools in the Brisbane Metropolitan Region, which included the BACSS.²⁴ Blatch was also responsible for delivering special education services across the 256 government schools in the Brisbane Metropolitan Region.²⁵ Blatch retired in January 2015.²⁶

Blatch has a Diploma of Teaching, Primary and Secondary Schools, a Master of Educational Studies, and a Master of Educational Administration.²⁷

Cary Breakey (BAC)

Breakey was the founding Medical Director of the BAC.²⁸ Since 1980, he has practised as a child, adolescent and family psychiatrist, both as a government employee and as a private consultant. Although currently semi-retired, Breakey has maintained his current registration and works as a locum on a semi-regular basis in Queensland Health Services.²⁹

Breakey holds a Bachelor of Medicine and Surgery (MBBS) and a Diploma of Psychological Medicine (DPM). He is a Fellow of the Royal Australian and New Zealand College of General Practitioners.³⁰

Anne Brennan (BAC)

Until July 2013 Brennan was in private practice as a child and adolescent psychiatrist.³¹ On 10 September 2013 West Moreton HHS formally appointed her to the position of acting Clinical Director of the BAC, with an end date of 9 March 2014.³² Brennan commenced in that role on 11 September 2013, following the standing down of Sadler as Clinical Director.³³ Brennan continued in that role until the closure of the BAC in late January 2014. Thereafter Brennan remained employed by West Moreton HHS until her contract expired on 9 March 2014.³⁴

Brennan's role as acting Clinical Director was not defined.³⁵ However, she was asked to take over the clinical care of the patients at the BAC,³⁶ and William Kingswell asked her and her

supervisor (Elisabeth Hoehn) to transition patients from the BAC as soon as possible.³⁷ Brennan subsequently attended to both the care and transition of the BAC patients. After the BAC closure Brennan was retained as a consultant psychiatrist at Ipswich CYMHS and assisted with assessing the progress of the young people who had been on the BAC waiting list.³⁸

Until October 2013, Brennan was supervised by Elisabeth Hoehn³⁹ who was relieving in Stephen Stathis' position in his absence.⁴⁰ After Stathis resumed his position as acting Clinical Director, Child and Youth Mental Health Service, Children's Health Queensland HHS (CHQ) Brennan had regular phone contact with him and she spoke with Steer when necessary.⁴¹

Brennan holds the qualifications of Bachelor of Medicine and a Bachelor of Surgery from the University of Queensland (1978) and is a Fellow of the Royal Australian and New Zealand College of Psychiatrists. She obtained a Certificate in Child and Adolescent Psychiatry in 2004.⁴² After the expiry of her contract with West Moreton HHS, Brennan worked as a consultant psychiatrist at the Mater Children's Hospital and the Royal Children's Hospital with eCYMHS. Following the Queensland Health (Kotzé) Inquiry she took six months leave. In February 2015 Brennan resigned.⁴³

William Brennan (WM HHS)

From October 2010 until November 2012, Brennan held the position of Director of Nursing at The Park. From November 2012 until December 2014, he became the Director of Nursing for West Moreton Mental Health and Specialised Services (which included the units within The Park, as well as Offender Health and Clinical Support, Community Integration and Service Improvement and Evaluation).⁴⁴

Nurse Unit managers within the units at The Park (including the BAC) reported to a Nursing Director, who in turn reported to Brennan. Brennan reported to the Executive Director Mental Health and Specialised Services (who at all relevant times was Sharon Kelly).⁴⁵

As Director of Nursing, Brennan was responsible for the strategic and operational management of nursing services.⁴⁶ This included managing the nursing workforce and ensuring that nursing resources matched needs as advised to him by the Nursing Director or clinical team.⁴⁷ During the transition period, Brennan was appointed by Kelly to act as a liaison and support for nursing staff at the BAC.⁴⁸

Amelia Callaghan (headspace)

From June 2011 until June 2015, Callaghan was the State Manager for Queensland and Northern Territory for Headspace National Youth Mental Health Foundation Ltd.⁴⁹ Callaghan is currently the Regional Manager for Headspace Centres for Aftercare.⁵⁰

Callaghan represented the views of the headspace National Office and headspace centres, as a member of the Expert Clinical Reference Group (ECRG),⁵¹ which considered contemporary models of care for subacute mental health treatment and rehabilitation for adolescents in Queensland. She was also a member of the State-wide Adolescent Extended Treatment and Rehabilitation Implementation Steering Committee (SWAETRI)⁵² and the SWAETR Service Options Implementation Working Group.⁵³

Callaghan has a Bachelor in Social Science (Psychology), a Graduate Diploma in Psychology, and a Masters in Social Administration.⁵⁴

Paul Casos (WMB)

From 29 June 2012 until 17 May 2014, Casos was a member of the West Moreton Board.⁵⁵ Casos is a dental technician by trade with prior involvement in the development of local businesses, community organisations and service clubs. Between 1969 and 2001, Casos had been employed by Queensland Health in various roles, including developing Ipswich Health Plaza as a Community Health Centre.⁵⁶

Angela Clarke (BAC)

From 10 October 2000 until 28 January 2014, Clarke worked as a Speech Pathologist at the BAC.⁵⁷ Her formal qualifications include a Bachelor of Speech Pathology.⁵⁸

Vanessa Clayworth (BAC)

In April 2009, Clayworth was appointed to the position of acting Clinical Nurse, at the BAC.⁵⁹ From 5 August 2013 until 13 October 2013, she acted in the higher duties position of Nurse Unit Manager, BAC.⁶⁰ From 14 October 2013 until 21 January 2014, Clayworth acted in the position of Clinical Nurse Consultant.⁶¹ As acting Clinical Nurse Consultant, Clayworth's responsibilities included supporting the clinical needs of BAC patients and progressing their transition to alternative service providers.

Clayworth holds a Bachelor of Nursing, majoring in Infant and Child Mental Health, and a Masters of Mental Health Nursing.

Michael Cleary (QH)

From July 2012 until July 2015, Cleary held the position of Deputy Director-General, Health Services and Clinical Innovation Division (HSCIDD), Queensland Health.⁶² Cleary held the position of acting Director-General, Queensland Health for several periods between 4 February 2013 and 5 July 2015.⁶³

As Deputy-Director General HSCIDD, Cleary was responsible for overseeing statewide clinical support and coordination functions to assist Hospital and Health Services, and to provide leadership and direction to the Department and the broader Queensland Health system. Cleary reported to the Director-General (who was initially Anthony O'Connell and then, from 23 September 2013, was Ian Maynard).

Cleary was a member of the Budget Review Committee.⁶⁴ Cleary attended two meetings in respect of the closure of the BAC (6 May 2013 and 17 June 2013).

Cleary's extensive qualifications and memberships included a Bachelor of Medicine, Bachelor of Surgery, Master of Health Administration, Fellow of the Royal Australasian College of Medical Administrators, Board Member of the Australasian Council on Healthcare Standards and President of Royal Australasian College of Medical Administrators.⁶⁵

Mary Corbett (WMB)

On 18 May 2012, Corbett was appointed to the position of Chair of the West Moreton Board.⁶⁶ She still holds that position. As Chair, Corbett's responsibilities include presiding at all meetings of the Board and signing the Service Agreement between West Moreton HHS and the Department of Health.⁶⁷

Corbett has extensive Board and sub-committee experience, including as a Company Director in the scientific research and development area, and in education.⁶⁸ Since 2012, Corbett has sat on a number of West Moreton committees, including its Executive Committee, Finance Committee and Nominations Committee.

Corbett holds a Bachelor of Applied Biology (Hons Biochemistry) and a PhD in Clinical Physiology.⁶⁹ She is a Fellow of the Australian Institute of Company Directors, an Associate Fellow of the Australian Institute of Management and has over 20 years experience as a company director, predominantly in scientific research and development, primary industries and commercialisation.⁷⁰

Julie Cotter (WMB)

From 7 September 2012 until 1 April 2015, Cotter was a member of the West Moreton Board.⁷¹ Cotter is an accomplished researcher who has published and presented extensively in the areas of corporate reporting, finance and investor relations. Cotter has sat on numerous committees and boards.⁷²

David Crompton (MS HHS)

Since June 2012, Crompton has held the position of Executive Director of Addiction and Mental Health Services, Metro South HHS.⁷³ Crompton has held a number of other positions in the area of mental health, including: Executive Director, Clinical Services, Princess Alexandra Hospital; Executive Director, Mental Health, Hunter New England Area Health Service; Director of Mental Health, Queensland Health; Director Acute and Community Mental Health, Toowoomba & District Mental Health Service.⁷⁴

In 2009, Crompton was chairperson of a Capital Works User Group, formed to guide the redesign and development of the Redlands project.⁷⁵ In 2010, he formed a second group to review the Redlands model of service delivery.

Crompton is a Professor in the School of Health Services and Social Work at Griffith University.⁷⁶ He has a Bachelor of Medicine and a Bachelor of Surgery and a Post Graduate Diploma of Social Science (Psych).⁷⁷ He is a Fellow of the Australasian Chapter of Addiction Medicine and a Fellow of the Royal Australian and New Zealand College of Psychiatrists.⁷⁸ He has been awarded a Medal of the Order of Australia for development of community based mental health services for veterans, development of community post-traumatic stress disorder and anxiety and substance abuse treatment services.⁷⁹

Susan Daniel (BAC)

From October 1996 until November 2007, Daniel was employed as a Registered Nurse at the BAC.⁸⁰ From November 2007 until 2014, Daniel was appointed as Community Liaison at the BAC. The Community Liaison role was the interface for referral enquiries and admission wait list decisions.⁸¹ From May 2012 until 4 May 2013, Daniel acted in the position of Nurse Unit Manager, BAC.⁸² Daniel was a member of the multidisciplinary Clinical Care Transition Panel.

Daniel holds a Bachelor of Nursing and registration with the Nursing and Midwifery Board of Australia.

Lorraine Dowell (BAC)

From May 2002 until February 2013, Dowell worked as an Occupational Therapist at the BAC.⁸³ She held the position of Team Leader, Allied Health Non-Secure Services/Discipline Senior-Occupational Therapy.⁸⁴ From around September 2013, Dowell provided a support role for BAC allied health staff, assisting them through the organisational change and transition planning processes. Dowell holds a Bachelor of Occupational Therapy.⁸⁵

Lesley Dwyer (WM HHS)

From 30 July 2012, Dwyer was the Health Service Chief Executive of West Moreton HHS.⁸⁶ In managing West Moreton HHS, Dwyer was subject to direction by the West Moreton Board. At the commencement of her appointment, one of Dwyer's priorities was to bring the newly created West Moreton HHS back into budget.⁸⁷

Prior to joining West Moreton, Dwyer had had numerous executive and director positions within the public health system.⁸⁸ Most recently, these had included the position of acting Chief Executive/Chief Operating Officer at Adelaide Health Service (June 2010 – August 2011), acting Chief Executive Officer Southern Adelaide Health Service (April – July 2010) and Executive Director – Operations, Acute and Specialist Services, Central Northern Adelaide Health Service (May 2008 – April 2010).⁸⁹ Dwyer has a Diploma in General Nursing and a Diploma of Midwifery.⁹⁰

As Chief Executive, Dwyer was responsible for providing updates to the West Moreton Board. Dwyer attended the meeting with Anthony O'Connell (Director-General) on 17 June 2013. There is evidence that, at this meeting, Dwyer briefed O'Connell on the proposed new model of care for adolescents and the proposed discontinuation of services through the BAC.

Timothy Eltham (WMB)

From 29 June 2012 until 17 May 2014, Eltham was appointed to the position of Member and Deputy Chair of the West Moreton Board.⁹¹ As Deputy Chair, Eltham was required to act as Chair during all periods when the Chair (Mary Corbett) was absent from duty. Eltham was acting Chair for periods 29 June – 14 July 2013, 27 August – 22 September 2013 and 16 February – 23 February 2014.⁹²

Eltham's professional experience is primarily in the areas of social planning, community development, social research and education.⁹³ Between 1996 and 1998, Eltham had been employed by Queensland Health as a program manager for the deinstitutionalisation of Wolston

Park. Eltham was responsible for arranging individual transition plans and resettling up to 300 long stay adult psychiatric patients into community care.⁹⁴

Alan Fry (WMB)

From 7 September 2012 until 17 May 2014, Fry was a member of the West Moreton Board. Fry is a former Deputy Assistant Commissioner of the London Metropolitan Police Service and former Head of the Anti-Terrorist Branch in London. When former Director of Surrey Oaklands NHS Trust, Fry chaired *Mental Health Act 1983 (UK)* hearings and was responsible for reviewing unresolved complaints.⁹⁵

Michelle Fryer (RANZCP)

Fryer is the current Chair of the Queensland Branch of the Faculty of Child and Adolescent Psychiatry of The Royal Australian & New Zealand College of Psychiatrists. Fryer was a member of the Expert Clinical Reference Group (ECRG) which considered contemporary models of care for subacute mental health treatment and rehabilitation for adolescents in Queensland.

Fryer's qualifications include a Bachelor of Medicine, Bachelor of Surgery and RANZCP Certificate of Advanced Training in Child and Adolescent Psychiatry. She is a Fellow of the Royal Australian and New Zealand College of Psychiatrists.

Kristi Geddes

Geddes is a lawyer employed at Minter Ellison, Brisbane where she works as a Senior Associate in the Health Team. Geddes was appointed, along with Beth Kotzé and Tania Skippen, as a health service investigator to review the transitional care arrangements for adolescent patients of the recently closed BAC. Geddes holds a Bachelor of Laws and a Bachelor of Psychological Science.

Leanne Geppert (QH/WM HHS)

From June 2011 until May 2013, Geppert was the Director of Planning and Partnerships, Mental Health and Other Drugs Branch (MHAODB), Queensland Health.⁹⁶ As part of this role, Geppert was responsible for leading the implementation of projects and initiatives of the Queensland Plan for Mental Health, one of which was "services redesign" at The Park Centre for Mental Health. In this role, Geppert also advised the Executive Director of MHAODB on emerging and critical issues in mental health service delivery.

As Director of Planning and Partnerships with MHAODB, Geppert chaired the Expert Clinical Reference Group (ECRG) which considered contemporary models of care for subacute mental health treatment and rehabilitation for adolescents in Queensland. She was a member of the Planning Group which considered the recommendations of the ECRG, and made recommendations to West Moreton HHS regarding future service delivery.

In May 2013, Geppert was seconded to West Moreton HHS in the role of Director of Strategy, Mental Health and Specialised Services.⁹⁷ She was appointed to the position permanently, in January 2015.⁹⁸ As Director of Strategy, Geppert advises the West Moreton HHS executive regarding high level change, policy, performance and planning for Mental Health and Specialised Services. She is also responsible for aligning the performance and development of West Moreton HHS's mental health services with statewide agendas and negotiations. In this role, she was a

member of the Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy Steering Committee (SWAETRI), which was later renamed the Adolescent Mental Health Extended Treatment Initiative (AMHETI) Steering Committee.

Geppert is a clinical psychologist, with a Doctor of Philosophy in Psychology, a Masters of Clinical Psychology, a Bachelor of Behavioural Science in Psychology, and a Bachelor of Behavioural Science. Geppert is registered with the Psychology Board of Australia, a Member of the Australian Psychological Society and a Member of the Australian College of Clinical Psychologists.⁹⁹

Aaron Groves (QH)

From September 2005 until April 2012, Groves was appointed to the position of Director of Mental Health (Qld) (DMH).¹⁰⁰ Between 2005 and 2012, Groves was also appointed to a concurrent role, responsible for state mental health planning. This position had various titles during this period, including “Director” or “Executive Director” of the “Mental Health Unit, Branch or Directorate”, including the “Mental Health Alcohol and Other Drugs Directorate”.

The key responsibilities of the DMH role are defined in Chapter 3 of the *Mental Health Act 2000* (Qld). They include facilitating the proper and efficient administration of the Act and advising and reporting to the Minister on any matter relating to the administration of the Act, the declaration of high secure units and authorised mental health services and overseeing compliance with legislative requirements relating to involuntary treatment – both involuntary treatment orders and forensic orders – for mental health patients.

From October 2011-March 2012, Groves was appointed to the position of the Executive Director of the Queensland Mental Health Commission Transition Team, Queensland Health. He retained the statutory role as DMH, but Mohan Gilhotra assumed most of the statutory responsibilities as a Delegate of the DMH.

Between September 2012 and December 2015, Groves held a number of positions in the Western Australian Department of Health and Western Australian Mental Health Commission. These positions included Consultant Psychiatrist, Principal Clinical Planner, State Clinical Planner for the WA Ten-Year Mental Health Service Plan and Clinical Director Adult Program. Since February 2015, Groves has been appointed as the Chief Psychiatrist, South Australia.

Groves’ formal qualifications include a Bachelor of Medicine and Bachelor of Surgery. He is a member of the Royal Australian New Zealand College of Psychiatrists.¹⁰¹ He has General and Specialist (Psychiatry) Registration with the Australian Health Practitioners Registration Authority.

Megan Hayes (BAC)

From January 2007 to June 2009, and from September 2013 to February 2014, Hayes held the position of Occupational Therapist – Life Skills Focus, at the BAC.¹⁰² Hayes was a member of the multidisciplinary Clinical Care Transition Panel.¹⁰³ Hayes has a Bachelor of Occupational Therapy.

Philip Hazell

Since July 2006, Hazell has held the position of Director of Thomas Walker Hospital (Rivendell) Child Adolescent and Family Mental Health Services, in New South Wales. In this position, Hazell is responsible for the leadership and clinical management of Area Child and Adolescent Mental Health Services, which includes Rivendell Child and Adolescent and Family Service.¹⁰⁴

Hazell was a member of the Expert Clinical Reference Group (ECRG) which considered contemporary models of care for subacute mental health treatment and rehabilitation for adolescents in Queensland. Hazell provided the ECRG with evidence concerning the models of care for the Rivendell and Walker units.¹⁰⁵

Hazell is Conjoint Professor of Child and Adolescent Psychiatry, University of Sydney (Concord Clinical School). His qualifications include Bachelor of Medical Science, MB ChB and Certificate of Accreditation in Child Psychiatry. He is a Fellow of the Royal Australian and New Zealand College of Psychiatrists and has a PhD (Medicine).

Elisabeth Hoehn (CHQ)

From 2006 until 2014, Hoehn was Program Director and Consultant Child Psychiatrist, Future Families, Children of Parents with a Mental Illness Program, Queensland Centre for Perinatal and Infant Mental Health and Parent Aide Unit.¹⁰⁶

From 9 September 2013 until around mid-October 2013, Hoehn acted as Clinical Director, Child and Youth Mental Health Services, CHQ, while Stephen Stathis was on leave. During this period, Hoehn played a consultation role between West Moreton and Children's Health Queensland, and provided support to Anne Brennan with respect to the development and implementation of transition plans.¹⁰⁷

Between 9 September 2013 and December 2013, Hoehn attended Barrett Adolescent Centre Update meetings.¹⁰⁸ From 21 October 2013 until the end of December 2013, Hoehn held a "liaison position" on the Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy Steering Committee (SWAETRI).¹⁰⁹

Hoehn has been employed by Queensland Health since 1984 and has been employed in the area of child and youth mental health since 1990. Since 1991, Hoehn has provided consultant child psychiatry services to child and youth mental health services across North Brisbane, as well as providing leadership to service development in perinatal and infant mental health across Queensland.¹¹⁰

Hoehn has a Bachelor of Medicine and a Bachelor of Surgery (MBBS) and a Certificate of Child and Adolescent Psychiatry. She is a member of the Faculty of Child and Adolescent Psychiatry of The Royal Australian and New Zealand College of Psychiatrists and a Fellow of The Royal Australian and New Zealand College of Psychiatrists.¹¹¹

Carol Hughes (BAC)

From 3 June 2013 until December 2013, Hughes was employed as part of the BAC allied health team, as a Social Worker.¹¹² Hughes was a member of the multidisciplinary Clinical Care Transition Panel.¹¹³ Among other qualifications, she holds a Bachelor of Social Work and Bachelor of Business Administration.¹¹⁴

Sharon Kelly (WM HHS)

From 17 September 2012 until 31 December 2014, Kelly held the position of Executive Director Mental Health and Specialised Services, West Moreton HHS (save for 13 November to 29 November 2013 when she was acting Health Service Chief Executive Torres–Strait–Northern Peninsula HHS, and 29 September to 9 November 2014 when she was acting Health Service Chief Executive – West Moreton HHS).¹¹⁵ Kelly reported to Dwyer.

Prior to this position, from 4 June 2012 until 3 August 2012, Kelly held the position of acting Health Service Chief Executive West Moreton HHS. From 1 January 2012 until 4 June 2012, she was appointed as Executive Director Primary and Community Health, West Moreton District (with her title changing on 1 July 2012 to Executive Director Primary and Community Health, West Moreton HHS).¹¹⁶

As Executive Director Mental Health and Specialised Services, Kelly's responsibilities in respect of the BAC included the provision of executive level leadership, governance and management, ensuring safety and quality at the BAC, service delivery, and budget and workforce accountability.¹¹⁷ Kelly was a member of the Planning Group which considered the ECRG report and other information and made recommendations to the West Moreton HHS regarding service delivery.

Kelly has a background in nursing and midwifery and has a Master of Health Administration. She is an Associate Fellow of the Australian College Health Service Executives.

William Kingswell (QH)

Kingswell is a Forensic Psychiatrist. Since 1 January 2012, Kingswell has held the position of Executive Director of the Mental Health Alcohol and Other Drugs Branch, Queensland Health.¹¹⁸ Initially this was in an acting capacity, with Kingswell being permanently appointed to the position on 6 June 2014.

Between 28 September 2013 and 30 June 2015, Kingswell was concurrently appointed to the statutory role of Director of Mental Health.¹¹⁹

Prior to 1 July 2012, Kingswell reported to the Chief Health Officer, Jeannette Young.¹²⁰ From 1 July 2012 onwards, Kingswell reported to the newly created position of Deputy Director-General, Health Service and Clinical Innovation (which, at the relevant times, was held by Michael Cleary).¹²¹

As Executive Director, Kingswell is responsible for leading and influencing policy development and legislative reform to ensure contemporary clinical practice and mental health service delivery in Queensland, and supporting clinical governance activities to promote high quality and safe mental health alcohol and other drugs services.¹²² Kingswell was a member of the Planning Group which considered the ECRG report and other information and made recommendations to the West Moreton HHS regarding service delivery.

Between January 1994 and May 1997, Kingswell worked as a Senior Medical Officer at Wolston Park Hospital Complex (what is now The Park Centre for Mental Health).¹²³

Kingswell has been a Chair and Board member of multiple medical and psychiatry committees and institutes including RANZCP Committee for Examinations, Bi-National Forensic Section RANZCP and Griffith University Innocence Project. He is a Member of the Education Committee RANZCP. Kingswell completed a Masters of Public Health in 2012 and became a Fellow of

the Royal Australasian College of Medical Administrators in 2014. Kingswell has a Bachelor of Medicine, Bachelor of Surgery and is a Fellow of the Royal Australian and New Zealand College of Psychiatrists. Kingswell was awarded the RANZCP inaugural Medicott Award for research in forensic psychiatry.¹²⁴

Mara Kochardy (BAC)

In early 2012, Kochardy commenced a three month contract of employment to work as a Registered Nurse at the BAC. Kochardy's contract was reviewed and extended every three months, until 5 January 2014.¹²⁵ Kochardy holds a Bachelor of Nursing and a Master of Mental Health Nursing, and holds registration with the Nursing and Midwifery Board of Australia.

Beth Kotzé

On 28 August 2014, Kotzé was appointed along with Tania Skippen and Kirsti Geddes as a health service investigator to review the transitional care arrangements for adolescent patients of the recently closed BAC. Kotzé was Skippen's manager. Kotzé was the co-author (with Skippen) of the health service investigation report released on 30 October 2014, 'Transition Care for Adolescent Patients of the Barrett Adolescent Centre'.

From 4 November 2013 until 19 December 2014, Kotzé was seconded to the New South Wales Ministry of Health into the position of Associate Director – Health Systems Management, Mental Health and Drug and Alcohol Office.¹²⁶

Kotzé has subspecialty qualifications in child and adolescent psychiatry obtained in 1990, and throughout her career she has worked in a number of senior clinical, management and leadership positions.¹²⁷ Her formal qualifications include a Bachelor of Medicine and Bachelor of Surgery, a Master of Medicine (Psychotherapy), Master of Health Administration and Certificate in Child Psychiatry (RANZCP). She is a Fellow of the Royal Australasian College of Medical Administrators.¹²⁸

Judith Krause (CHQ)

From December 2009, Krause acted in the role of Executive Director, Child and Youth Mental Health Service, Children's Health Queensland. She was formally appointed to the position in October 2011 and remained in the role until February 2014.¹²⁹

Krause was a member of the group formed by David Crompton in 2010 to review the Redlands model of service delivery.¹³⁰ Krause was co-chair of the State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy Steering Committee (SWAETRI). The Steering Committee was tasked with the development of new services.¹³¹ Krause provided updates to both the Central Cluster Mental Health Committee (of which she is a member) and the State-wide Child and Youth Mental Health, Alcohol and Other Drugs Clinical Group (of which she is Chair) primarily in relation to the progress towards the replacement services and the closure of the BAC.¹³² She was a member of the Young People's Extended Treatment and Rehabilitation Initiative Governance Committee.¹³³

On 12 December 2013, Krause attended the Barrett Adolescent Centre Clinical Oversight meeting at which the allocation of additional transition funding for a client was discussed and endorsed by West Moreton. Upon closure, the operational funds of the BAC were transferred to

Children’s Health Queensland, and Krause (together with Stephen Stathis and Ingrid Adamson) was given oversight responsibility for these funds.

Krause is a Registered Nurse and Midwife. She has 25 years’ experience as a health practitioner, including in general and midwifery nursing. Kraus has 14 years’ experience in mental health middle and senior management roles. She has a Masters in Community Mental Health and graduate certificates in Health Management and Family Therapy.

Moira Macleod (BAC)

From February 2007 until January 2014, Macleod worked as a Registered Nurse at the BAC.¹³⁴ On occasion during 2012-2014, she provided holiday relief in the substantive position of Clinical Nurse.¹³⁵ Macleod holds a Bachelor of Nursing and registration with the Nursing and Midwifery Board of Australia.¹³⁶

Graham Martin

From September 2001 until August 2014, Martin was employed by The University of Queensland, as Professor and Director of Child and Adolescent Psychiatry. From 2001 to 2014, Martin also held the position of Clinical Director of the Royal Children’s Hospital and Brisbane North Health Service District Child & Youth Mental Health Service (CYMHS), Queensland Health.¹³⁷ He described this as a “nominal and advisory” appointment, in the sense that it did not involve direct management or authority over services.¹³⁸

Prior to that, from 1986 to 2001, Martin was Clinical Director of Southern Child and Adolescent Mental Health Service in Adelaide.¹³⁹ Since August 2014, Martin has been in part-time private clinical practice as a Child and Family Psychiatrist.¹⁴⁰

Martin’s qualifications include Doctorate of Medicine, Certificate of Accreditation in Child Psychiatry, Diploma in Family Therapy, Diploma in Psychological Medicine, Diploma in Obstetrics, MBBS. Martin is a Fellow of the Royal Australian and New Zealand College of Psychiatrists and a member of International Association Suicide Prevention, International Association for Suicide Research and Ex-chairperson/life member of Suicide Prevention Australia.

Martin has received numerous awards for his work in the area of suicide prevention, including the Medal of the Order of Australia in 2009 for his contributions to youth suicide prevention and child psychiatry.¹⁴¹

Ian Maynard (QH)

From 23 September 2013 until 23 March 2015, Maynard was appointed to the position of Director-General of Queensland Health.¹⁴² As Director-General, Maynard’s key responsibility was to oversee the Queensland public health system, including advising the Minister for Health, leading the government’s reforms to Queensland’s public health system and providing leadership and strategic direction to the staff and delivery of public health services.¹⁴³

In 2013, Michael Cleary, who was then the Deputy Director-General of the Health Service and Clinical Innovation Division, reported to Maynard.¹⁴⁴ The Chief Executive Officer of each of CHQ (Peter Steer) and West Moreton (Lesley Dwyer) reported to Maynard as required.¹⁴⁵ For day-to-day operations, Maynard reported to the Minister for Health.¹⁴⁶

Prior to his appointment as Director-General, Maynard held a number of prior executive positions. These included Chief Executive of the Public Service Commission, Chief Executive Officer of Queensland Urban Utilities, and Chief Operating Officer, Divisional Manager, Executive Manager – Brisbane City Council.

Maynard holds a Bachelor of Science and has completed an Advanced Management Residential Programme and Australian Institute of Company Directors course.¹⁴⁷ He is a graduate member of the Australian Institute of Company Directors.

Brett McDermott

From May 2002 to November 2014, McDermott was appointed as Executive Director, CYMHS, Mater Health Service.¹⁴⁸ In this role, McDermott had responsibility for the overall strategic direction of the Mater CYMHS service and research initiatives. In addition to significant on-call responsibilities, he also covered consultant leave and provided second opinions around areas of personal clinical experience.¹⁴⁹

From around June 2013 until December 2014, McDermott was appointed as Director of the Mater Adolescent and Young Adult Centre, and responsible for the development of the service and its new model of care.¹⁵⁰

McDermott has published several papers in international peer reviewed journals that relate to child and adolescent mental health models of care.¹⁵¹ McDermott's qualifications include a Bachelor of Medical Science, Bachelor of Medicine, Bachelor of Surgery, Doctorate in Medicine, and a Certificate of Training in Child and Adolescent Psychiatry. McDermott is a Fellow of the Royal Australian and New Zealand College of Psychiatrists.

Patrick McGorry

McGorry holds, and has held, numerous positions in the area of mental health including: Professor of Youth Mental Health at the University of Melbourne (1996-present); Executive Director, Orygen, the National Centre of Excellence in Youth Mental Health (2014 to present); Executive Director, Orygen Youth Health Research Centre (2002-2014); Editor in Chief, Early Intervention in Psychiatry Journal (2007-present); Director, Board, National Youth Mental Health Foundation (headspace) (2009-present); Treasurer, International Early Psychosis Association (2007-present); Visiting Professor, University of Stavanger and Rogaland Psychiatric Services (2007-present); Founding Board of Directors, the Schizophrenia International Research Society (2007-present); Honorary Professional Fellow, Department of Psychiatry, University of Melbourne (2011-present); Chair, Psychosis Australia Trust Research Advisory Council (2013-present); President Elect, Schizophrenia International Research Society (2014, to take full office in 2016).¹⁵²

McGorry holds the following qualifications: Bachelor of Medicine; Bachelor of Surgery; PhD, Doctor of Philosophy (Diagnosis and Classification of Psychotic Disorders); Doctor of Laws (Honoris Causa) Monash University; Doctor of Medicine (Honoris Causa) University of Newcastle; and Doctor of Philosophy (Honoris Causa) University of Haifa, Israel. McGorry is a Member of the Royal College of Physicians, Member and Fellow of the Royal Australian and New Zealand College of Psychiatrists, and a Fellow of the Royal College of Physicians.¹⁵³

In 2009 and 2010, McGorry was made Australian of the Year in recognition of his contributions to the field of Youth Mental Health.¹⁵⁴

Padraig McGrath (WM HHS)

In March 2012, McGrath was appointed to act in the position of Nursing Director, Secure Inpatient Services for The Park.¹⁵⁵ In April 2013 he was permanently appointed to the position, and continued to hold the position until 30 June 2015, when the position was upgraded to the role of Operational Director/Nursing Director of The Park. McGrath continues to hold that position.¹⁵⁶

As Nursing Director, McGrath had responsibility for the management of nursing staff and nursing services in certain units at The Park, one of which was the BAC.¹⁵⁷ This included managing nursing staff and nursing services, ensuring the BAC was adequately staffed, ensuring the staff allocated to the BAC were qualified, and ensuring the effectiveness of the nursing budget for BAC.¹⁵⁸ McGrath reported to William Brennan, Director of Nursing.¹⁵⁹

McGrath has a Masters of Mental Health Nursing, Graduate Diploma of Business (Health Services Management), Certificate Effective Management for Health Professionals. He is registered as a General Nurse and Psychiatric Nurse with the Irish Nursing Board.

Robert McGregor (WMB)

McGregor has been a member of the West Moreton Board since 29 June 2012. He is a senior visiting consultant paediatrician at Ipswich Hospital, a Board member of the Ipswich Hospital Foundation and a former Board member of the West Moreton Regional Health Authority. McGregor has held various executive positions in community organisations within the West Moreton community.¹⁶⁰

Darren Neillie (WM HHS)

From November 2007 until July 2014, Neillie held the position of Clinical Director, High Secure Inpatient Services (HSIS) at The Park, West Moreton HHS.¹⁶¹ The position of Clinical Director did not normally involve any role or direct involvement with BAC. As Clinical Director, Neillie was heavily involved in the planning and development of the Extended Forensic Treatment and Rehabilitation Unit (EFTRU) at The Park.¹⁶²

For the period 20 August 2013 – 15 November 2013, Neillie acted in the role of Director of Medical Services, The Park, while Terry Stedman was on scheduled leave. Neillie attended weekly update meetings in relation to the transition of patients from the BAC into alternative services ahead of the anticipated closure of BAC. He had involvement in engaging other service providers in the transition arrangements for some of the BAC patients.¹⁶³

Neillie is a Forensic Psychiatrist. His qualifications include a Bachelor of Medicine and Bachelor of Surgery, a Bachelor of Science in Parasitology, Diploma of the Royal College of Obstetricians and Gynaecologists, Certificate of Completion of Higher Specialist Training in Forensic Psychiatry, Masters of Science Degree in Clinical Criminology. He is a member of the Royal College of Psychiatrists (UK) and a Fellow of the Royal Australian and New Zealand College of Psychiatrists.¹⁶⁴

Margaret Nightingale (BACSS)

From 2010 until 2015, Nightingale was employed as a teacher aide at the Barrett Adolescent Centre Special School (BACSS).¹⁶⁵ Nightingale had previously worked as a student nurse and, later, as a registered nurse at the BAC (1992-1998). Between 1998 and 2000, she worked as Clinical Liaison Person and acting Clinical Nurse at the BAC.¹⁶⁶

Justine Oxenham (BACSS)

In 2010 Oxenham commenced work as a Physical Education Teacher at the Barrett Adolescent Centre Special School (BACSS).¹⁶⁷ She was permanently appointed on 8 July 2013.¹⁶⁸

Prior to that, from 1996 to 2010, Oxenham held various other teaching appointments at primary, secondary and special schools throughout Queensland.¹⁶⁹ Oxenham had worked as a teacher's aide at the BAC in the early 1990s.¹⁷⁰ Oxenham holds a Graduate Diploma of Education (Primary) and a Bachelor of Modern Asian Studies.

Anthony O'Connell (QH)

From June 2011 until 15 August 2013, O'Connell held the position of Director-General of Queensland Health.¹⁷¹ O'Connell reported to the Minister for Health and to the Premier of Queensland. Prior to that, O'Connell held the positions of Chief Executive Officer, Centre for Healthcare Improvement, Queensland Health; and A/Deputy Director-General, NSW Health.¹⁷²

Prior to 1 July 2012, all Deputy Directors-General and the Chief Executive Officers of the Health Districts reported to the Director-General, and all Divisions including the Health Districts were within the Director-General's responsibility.¹⁷³ After 1 July 2012, only the Deputy Directors-General reported directly to the Director-General, who had responsibility for the overall management of the Queensland public health system.¹⁷⁴

In May 2012, O'Connell signed the briefing note, as Director-General, which approved the cessation of the Redlands Adolescent Extended Treatment Unit (RAETU) capital program (the Redlands project).

O'Connell holds a Bachelor of Medicine and Bachelor of Surgery (1977), he is a Fellow of the Australian New Zealand College of Anaesthetists and a Fellow of the College of Intensive Care Medicine of Australasia. He is a Graduate of the Australian Institute of Company Directors 2010 and an Honorary Fellow of the Australasian College of Health Service Management. He has attended two residential business courses, including Harvard Business School Massachusetts, Leading Excellence in Healthcare Delivery (2007) and the Australian Graduate School of Management, Senior Management Course (2005).¹⁷⁵

Melinda Parcell (WMB)

Since 29 June 2012, Parcell has been a member of the West Moreton Board.¹⁷⁶ She is a registered nurse/midwife with broad nursing experience including community nursing. Parcell has worked in various nursing director roles and has been involved in developing a nursing education training program.¹⁷⁷

Thomas Pettet (WM HHS)

Pettet was the Psychiatric Registrar at the BAC for six months, from 5 August 2013 until November 2013.¹⁷⁸ He holds a Bachelor of Medicine and Bachelor of Surgery¹⁷⁹ and has completed a Graduate Medical Course. Pettet has a Masters Degree of Health Science, a Graduate Diploma of Occupational Health and Safety and a Bachelor of Science.¹⁸⁰

Deborah Rankin (BACSS)

Rankin acted in the position of Principal of the Barrett Adolescent Centre Special School (BACSS) for the following periods, while Kevin Rodgers was on leave: 21 October 2013 to 3 December 2013, 22 April 2014 to 12 December 2014, and finally from 21 January 2015 to present.¹⁸¹

Rankin first commenced work at the BAC in 1998, in the position of a part-time teacher. Her roles and responsibilities gradually developed over time, and her hours were increased.¹⁸² In 2002, she commenced as BAC's curriculum coordinator.¹⁸³ In 2012, she held the position of Specialist Teacher/Curriculum coordinator at the BACSS.¹⁸⁴ From February 2013 until October 2013, she was appointed as the BACSS Senior Teacher/Curriculum coordinator.

Rankin holds a Graduate Diploma in teaching, a Bachelor of Arts and a Masters of Mental Health (Art Therapy).¹⁸⁵

Rosangela Richardson (BAC)

From August 2008 until January 2014, Richardson worked a Registered Nurse at the BAC.¹⁸⁶ On one occasion, Richardson acted in the role of Community Liaison for two weeks and very occasionally she acted in the role of Clinical Nurse.¹⁸⁷ Richardson holds a Bachelor of Nursing, Graduate Certificate in Drug and Alcohol Studies, Certificate in Sandplay Therapy and Symbol Work with Children Adolescents and Adults, and registration with the Nursing and Midwifery Board of Australia.¹⁸⁸

Kevin Rodgers (BACSS)

From 1987 until his retirement on 9 October 2015, Rodgers held the position of School Principal of the Barrett Adolescent Centre Special School (BACSS). Rodgers was on leave for extended periods between 2013-2015, including from 21 October 2013 to 3 December 2013.¹⁸⁹

Rodgers was a member of the Expert Clinical Reference Group (ECRG) which considered contemporary models of care for subacute mental health treatment and rehabilitation for adolescents in Queensland.

Rodgers holds a Certificate in Teaching, a Graduate Diploma in Special Education, a Bachelor of Arts, a Bachelor of Education and a Masters of Education Studies.¹⁹⁰ In 2006, Rodgers received a Public Service Medal for outstanding public service and contribution to disadvantaged and disabled youth.¹⁹¹

Kimberley Sadler (BAC)

From August/September 2009 until 27 January 2014, Sadler worked as a Registered Nurse at the BAC.¹⁹² Initially Sadler was rostered to work a variety of day and night shifts, however from the beginning of 2012, she worked night shifts only.¹⁹³ Sadler holds an Honours degree in Psychology, a Bachelor of Nursing and a Masters of Mental Health Nursing.¹⁹⁴

Trevor Sadler (BAC)

From December 1986 until September 2013, Sadler worked as a registrar and then as a consultant psychiatrist at the BAC.¹⁹⁵ During this period, he was given a number of additional titles. Between 1986 and 1995 he was the acting Medical Director and, from 1995 until September 2013, his position was that of the Medical Director or Clinical Director.¹⁹⁶

As Medical/Clinical Director, Sadler had the ultimate responsibility for clinical decision-making and was accountable for these decisions. He had overall responsibility for the decision to discharge adolescents from the BAC, as well as assessing, reviewing and providing treatments to the adolescents directly. Sadler chaired weekly Case Conference meetings, which were multidisciplinary team meetings that reviewed a particular adolescent's response to interventions and participation in activities. He oversaw the Care Planning Workshop held every two to three months. From the early 1990s, Sadler was permanently on call for the BAC unless on leave.¹⁹⁷ Sadler estimates that when he left the BAC in September 2013, he had assessed and treated approximately 1000 adolescents in various outpatient settings (community clinics, private practice and hospital-based outpatient services).¹⁹⁸

Between April 1989 and March 2015, Sadler also worked as a psychiatrist consulting and assessing inpatient and outpatient adolescents at the Mater Children's Hospital.¹⁹⁹ Between July and November 2014, he worked as a locum psychiatrist in the Mater Acute Mental Health Inpatient Unit, where his work was focused on providing psychiatric care to adolescents.²⁰⁰

Sadler was a member of the Expert Clinical Reference Group (ECRG) which considered contemporary models of care for subacute mental health treatment and rehabilitation for adolescents in Queensland.

Sadler's qualifications include a Bachelor of Medicine, a Bachelor of Surgery and a Certificate of Child Psychiatry, Royal Australian and New Zealand College of Psychiatrists. Sadler is a Fellow of the Royal Australian and New Zealand College of Psychiatrists and is registered with the Medical Board of Queensland and subsequently the Medical Board of Australia to practise as a specialist in psychiatry.²⁰¹

Stephen Sault (BAC)

From 14 July 2008 until 24 January 2014, Sault was employed to work as a Registered Nurse at the BAC.²⁰² Sault performed higher duties, as a Clinical Nurse, approximately 1-2 shifts every 6-8 weeks.²⁰³

Sault holds a Bachelor of Nursing, a Graduate Diploma in Mental Health Nursing, a Master of Mental Health Nursing and registration to practise as a Registered Nurse with the Nursing and Midwifery Board of Australia.²⁰⁴

James Scott

Since 2010, Scott has been a Consultant Psychiatrist at the Royal Brisbane and Women's Hospital. Prior to that, from 2007 until 2010, he was a Consultant Psychiatrist at the Royal Children's Hospital Child and Youth Mental Health Service. From 2003 to 2006, he was the Director of Hospital Services for Child and Youth Mental Health Services at the Mater Children's Hospital.²⁰⁵ Scott gave evidence of having referred patients to the BAC.²⁰⁶

Scott was a member of the Expert Clinical Reference Group (ECRG) which considered contemporary models of care for subacute mental health treatment and rehabilitation for adolescents in Queensland.

Since 2010, Scott has been a Senior Lecturer (2010-2013) and Associate Professor (2014 to date) in psychiatry at The University of Queensland. He has developed a programme of research which is broadly in the area of child and adolescent mental health and early psychosis.²⁰⁷ Scott's formal qualifications include a Bachelor of Medicine, Bachelor of Surgery (MBBS), a PhD and a Fellowship of the Royal Australian and New Zealand College of Psychiatrists (FRANZCP).²⁰⁸

Tania Skippen

Since 2012, Skippen has held the position of Associate Director of Specialist Programs for Mental Health – Children and Young People for the New South Wales Ministry of Health.²⁰⁹ On 28 August 2014, Skippen was appointed, along with Beth Kotzé and Kristi Geddes, as a health service investigator to review the transitional care arrangements for adolescent patients of the recently closed BAC.²¹⁰ Kotzé was Skippen's line manager.²¹¹ Skippen was the co-author (with Kotzé) of the health service investigation report released on 30 October 2014, 'Transition Care for Adolescent Patients of the Barrett Adolescent Centre'.

Skippen's qualifications include a Graduate Certificate in Health Services Planning and a Bachelor of Applied Science in Occupational Therapy.²¹²

Lawrence Springborg

On 3 April 2012 Springborg was appointed as Minister for Health. He ceased being the Minister on 14 February 2015, after the change in State government.²¹³ Springborg's office was headed by a Chief of Staff, Jake Smith. His Principal Policy adviser was Mark Wood (although Neil Hamilton-Smith was also a Principal Policy Adviser until March 2013). There were about 11 to 12 people in the Health Minister's office at any one time.²¹⁴

As Minister for Health, Springborg was responsible for leading the policy direction of the Department of Health, and for implementing the Government's election manifesto in relation to health. Springborg gave evidence that he was also responsible for ensuring that there were appropriate resources to run the health system, and ensuring taxpayer's money was being spent to get the best value outcomes.²¹⁵

During Springborg's term as Minister, there were two Directors-General (Anthony O'Connell from June 2011 to 15 August 2013 and Ian Maynard from 23 September 2013 to 23 March 2015). Of the Deputy Directors-Generals, Springborg dealt principally with Michael Cleary, who was responsible for the Health Services and Clinical Innovation Division from July 2012 to July 2015, in relation to matters concerning the BAC.²¹⁶

Stephen Stathis (CHQ)

From 2009 until February 2014, Stathis held the position of Clinical Director of Child and Youth Mental Health Services (CYMHS), Children’s Health Queensland Hospital and Health Service.²¹⁷

Prior to this, from 2002 to 2009, he was a Consultant Child and Adolescent Psychiatrist, Royal Children’s Hospital.²¹⁸ Since 3 February 2014, Stathis has held the position of Medical Director, Child and Youth Mental Health Services, Children’s Health Queensland Hospital and Health Service.

Stathis was a member of the Planning Group which considered the ECRG report and other information and made recommendations to the West Moreton HHS regarding service delivery. He was the co-chair of the State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy Steering Committee (SWAETRI), a member of the Chief Executive and Department of Health Oversight Committee, a member of the Service Option Implementation Working Group, a member of the Barrett Adolescent Centre Consumer Transition Working Group, and co-chair of the Young People’s Extended Treatment and Rehabilitation Initiative Governance Committee (YPETRI).

Stathis holds a Bachelor of Medicine and a Bachelor of Surgery (MBBS), a Masters in Epidemiology and Biostatistics (MSc), and a Certificate in Child & Adolescent Psychiatry (Cert. Child Adol. Psych). He is a Fellow of the Royal Australasian College of Physicians (FRACP), a Fellow of the Royal Australian and New Zealand College of Psychiatrists (FRANZCP) and a foundation member of the Faculty of Forensic Psychiatry (RANZCP). In 2007, Stathis was appointed Associate Professor at The University of Queensland.

Terry Stedman (WM HHS)

Since June 1997, Stedman has been the Director of Clinical Services at The Park Centre for Mental Health (although his title was changed in June 2013 to that of Clinical Director, Division of Mental Health and Specialised Services, West Moreton HHS,²¹⁹ and again in 2015 to Director of Clinical Services, Strategy and Performance, The Park Centre for Mental Health, West Moreton HHS).

As Director of Clinical Services, Stedman was involved in discussing complex transition arrangements with colleagues at receiving Hospital and Health Services.²²⁰ Stedman was on leave between 20 August 2013 and 15 November 2013.²²¹

Prior to his current position, from 1987 until 1997, Stedman was employed as a Psychiatrist at (the then) Wolston Park Hospital (now The Park Centre for Mental Health).²²²

Peter Steer (CHQ)

From July 2012 until December 2014, Steer was appointed as Chief Executive of Children’s Health Queensland Hospital and Health Service.²²³

Steer was “Project Sponsor” for the State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy (SWAETRI). As Chief Executive of Children’s Health Queensland, he was accountable for the development and provision of services to replace the BAC.²²⁴

Steer was the Chair of the Chief Executive and Department of Health Oversight Committee,²²⁵ the role of which was to provide strategic leadership and governance for the SWAETRI. Steer has been and is a member of numerous Queensland Health committees and medical colleges and organisations.

Steer's qualifications include a Bachelor of Medicine, Bachelor of Surgery, FRACP (Paediatrics) with the Royal Australasian College of Physicians, FRCPC (Paediatrics) with the Royal College of Physicians & Surgeons of Canada, FAAP American Academy of Paediatrics and GAICD with the Australian Institute of Company Directors.²²⁶ Steer is, and has been, a member of a large number of medical colleges and organisations, Queensland Health committees, and Hospital/University Committees.²²⁷

Lesley van Schoubroeck (QH)

On 23 May 2013, van Schoubroeck was appointed by the Governor-in-Council as the Mental Health Commissioner, for a three year term commencing 1 July 2013.²²⁸ Van Schoubroeck proceeded on previously planned leave for the period 1 August 2013 to 1 September 2013.²²⁹

The Mental Health Commissioner is the Chief Executive Officer of the Queensland Mental Health Commission under *Queensland Mental Health Commission Act 2013* (Qld). The functions of the Commission include the preparation of a whole-of-government strategic plan for the improvement of mental health and limiting the harm associated with substance misuse in Queensland, and to review, evaluate, report and advise on the mental health and substance misuse system in Queensland.²³⁰

Prior to assuming the role of Mental Health Commissioner, van Schoubroeck was the Director of Organisation Change in the Mental Health Commission in Western Australia (2012-2013). From 2010 to 2011 she was seconded to the Mental Health Commission in Western Australia to lead the reform agenda. Between 2007-2009, van Schoubroeck was a member of the WA Government's Economic Audit Committee Secretariat, and also undertook short term assignments providing strategic management advice to government agencies in Western Australia.²³¹

Van Schoubroeck's qualifications include Doctor of Philosophy in Governance and Public Policy, Graduate Diploma in Governance and Public Affairs, Master of Education, Bachelor of Applied Science (Mathematics), Bachelor of Education, Secondary Teaching Certificate.²³² She is a member of the Institute of Public Administration Australia (WA Branch).

Ashleigh Trinder (BAC)

From 2009 until 30 December 2013, Trinder held the position of locum Clinical Psychologist at the BAC.²³³ Trinder holds a Bachelor of Psychology and a Doctorate of Clinical Psychology. She is a member of the APS Clinical College.²³⁴

Patrea Walton (DETE)

Walton is currently the Deputy Director General, State Schools, Department of Education and Training. From July 2013, she was acting Deputy Director-General, State Schools, Department of Education and Training²³⁵. This position was made permanent on 30 August 2013. Walton holds a Bachelor of Education and Diploma of Teaching, Commerce, Secondary.

David Ward (BAC)

From October 2004 until January 2013, Ward was employed as a full-time social worker at the BAC.²³⁶ Prior to this position, Ward worked as a private practitioner at Headspace Meadowbrook.²³⁷

In November 2014, Ward submitted a research thesis for his Doctor of Philosophy, entitled 'The long sleep-over: the lived experience of teenagers, parents and staff in an adolescent psychiatric unit'. The thesis was an exploration of the subjective experiences of inpatient life from the perspectives of adolescents, parents and staff at the BAC.²³⁸

Ward is an Accredited Mental Health Social Worker. His qualifications include a Bachelor of Social Work, Bachelor of Arts, Graduate Diploma (Couple Therapy), Master of Counselling, Master of Philosophy and Doctor of Philosophy (2015).²³⁹

Georgia Watkins-Allen (BAC)

From November 2004 until April 2013 Watkins-Allen worked part time as a Clinical Psychologist at the BAC.²⁴⁰ From 4 March 2013 to 31 March 2013, Watkins-Allen held the position of Senior Psychologist (Specialist Clinical Supervisor) at the BAC on a part time basis.²⁴¹

Watkins-Allen holds a Bachelor of Arts (Psychology) and a Masters Degree in Clinical Psychology. She is a member of the Australian Psychological Society.²⁴²

Lourdes Wong (BAC)

From April 2007 until January 2014, Wong was employed as a Registered Nurse to work night duty in the BAC.²⁴³ Prior to that, from July 2005 to March 2007, she worked as a Registered Nurse in the casual pool for all areas of The Park.²⁴⁴ Wong was first registered to practise psychiatric nursing in 1985, after completing psychiatric nurse training at Wolston Park Hospital. She holds registration to practise as a Registered Nurse with the Nursing and Midwifery Board of Australia.²⁴⁵

Peta-Louise Yorke (BAC)

From December 2012 until January 2014, Yorke worked as a Registered Nurse at the BAC.²⁴⁶ Yorke was first employed as a Registered Nurse at The Park in early 2011, when she commenced a 12 month Transition to Mental Health Nursing Program, which she completed in early 2012. During the program, she undertook two, three month rotations at the BAC.²⁴⁷ Yorke's qualifications include a Bachelor of Nursing and registration with the Nursing and Midwifery Board of Australia. She also has an Associate Diploma of Business.²⁴⁸

Jeannette Young (QH)

Since 2005 Young has been appointed as the Chief Health Officer for Queensland. In July 2015 she was appointed Deputy Director-General, Prevention Division.²⁴⁹

The role of Chief Health Officer is a statutory role.²⁵⁰ Its functions include the provision of high level medical advice to the chief executive and the Minister on health issues, including policy and legislative matters associated with the health and safety of the Queensland public.²⁵¹ Prior to July 2012 Kingswell as the Executive Director of MHAODB reported to Young. From July 2012 Kingswell reported to Cleary as the Deputy Director-General, Health Services and Clinical Innovation Division.²⁵² Thus, from July 2012 Young had no oversight responsibilities with respect to Mental Health,²⁵³ although she signed the August 2012 briefing note as acting Director-General.²⁵⁴

Prior to her position as Chief Health Officer, Young held the position of Executive Director, Medical Services at the Princess Alexandra Hospital (from 1999 to 2005).²⁵⁵

Young's qualifications include a Bachelor of Medicine and Bachelor of Surgery, Master of Business Administration, AFCHSM, FRACMA, FFPH, FCHSM and DUniv.²⁵⁶ She is a Fellow of the Royal Australian College of Medical Administrators, an Associate Fellow of the Australasian College of Health Service Management, and a Fellow through Distinction of the Faculty of Public Health of the Royal College of Physicians (UK). Young was made an Honorary Fellow of the Australasian College of Health Service Management in 2013, received a Pride of Australia Medal in 2014 for Care and Compassion. In 2015 she received an Australia Day Achievement Medallion for Outstanding contribution to the management of public health issues in the State of Queensland and a Public Service Medal for outstanding public service.²⁵⁷

Victoria Young (BAC)

From 10 June 2013 until 23 January 2014, Young was employed to work on a full-time basis as a Registered Nurse at the BAC.²⁵⁸ Prior to that, from March 2012-March 2013, Young worked as a Registered Nurse at The Park in its Transition to Practice Nurse Education Program. From March 2013-July 2013, she worked as a Registered Nurse in The Park casual nursing pool.²⁵⁹ Young holds a Bachelor of Nursing and registration with the Nursing and Midwifery Board of Australia.

(Endnotes)

- 1 Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, pp 1–2 paras 1 and 4.
- 2 Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, pp 2–4 para 6.
- 3 Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, p 22 para 97.
- 4 Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, p 18 para 83.
- 5 Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, p 22 para 95.
- 6 Exhibit 14, Statement of Ingrid Adamson, 24 November 2015, p 18 para 75 and p 22 para 96.
- 7 Exhibit 114, Statement of Ingrid Adamson, 24 November 2015, Attachment A to that statement, Curriculum Vitae of Ingrid Adamson.
- 8 Exhibit 17, Statement of John Allan, 8 January 2016, p 1 para 4; Exhibit 17, Statement of John Allan, 8 January 2016, Attachment B to that Statement, Curriculum Vitae of John Allan.
- 9 Exhibit 17, Statement of John Allan, 8 January 2016, pp 1–2 para 5.
- 10 Exhibit 17, Statement of John Allan, 8 January 2016, p 2 para 6.
- 11 Exhibit 17, Statement of John Allan, 8 January 2016, p 2 para 8.
- 12 Exhibit 17, Statement of John Allan, 8 January 2016, p 2 para 7.
- 13 Exhibit 17, Statement of John Allan, 8 January 2016, p 2 para 7.
- 14 Exhibit 17, Statement of John Allan, 8 January 2016, p 1 para 2.
- 15 Exhibit 17, Statement of John Allan, 8 January 2016, p 1 para 3.
- 16 Exhibit 19, Statement of Janine Armitage, 14 December 2015, Attachment B to that Statement, Curriculum Vitae of Janine Armitage, p 27.
- 17 Exhibit 19, Statement of Janine Armitage, 14 December 2015, Attachment B to that Statement, Curriculum Vitae of Janine Armitage, p 27.
- 18 Exhibit 19, Statement of Janine Armitage, 14 December 2015, Attachment B to that Statement, Curriculum Vitae of Janine Armitage.
- 19 Exhibit 23, Statement of Matthew Beswick, 30 October 2015, p 1 para 1.
- 20 Exhibit 23, Statement of Matthew Beswick, 30 October 2015, p 3 para 2.
- 21 Exhibit 20, Statement of Darren Bate, 13 November 2015, p 1 para 2 and p 2 para 5.
- 22 Exhibit 20, Statement of Darren Bate, 13 November 2015, p 1 paras 2 and 3.
- 23 Exhibit 25, Statement of Peter Blatch, 20 November 2015, p 2 para 5.
- 24 Exhibit 25, Statement of Peter Blatch, 20 November 2015, p 2 para 5.
- 25 Exhibit 25, Statement of Peter Blatch, 20 November 2015, p 2 para 5.
- 26 Exhibit 25, Statement of Peter Blatch, 20 November 2015, p 1 para 1.
- 27 Exhibit 25, Statement of Peter Blatch, 20 November 2015, p 1 para 3.
- 28 Exhibit 27, Statement of Cary Breakey, 29 September 2015, Attachment B to that statement, Curriculum Vitae of Cary Breakey.
- 29 Exhibit 27, Statement of Cary Breakey, 29 September 2015, p 2 para 5.
- 30 Exhibit 27, Statement of Cary Breakey, 29 September 2015, p 2 para 4.
- 31 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 1 para 3.
- 32 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 2 para 5 and Attachment AB-3 to that statement, Letter of Appointment 10 September 2013, pp 63–65.
- 33 Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 2–3 paras 5 and 6.
- 34 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 3 paras 6 and 7.
- 35 Exhibit 28, Statement of Anne Brennan, 23 October 2015, pp 3–4 paras 8 and 13.
- 36 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 3 para 9.
- 37 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 4 para 14.
- 38 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 3 para 7.
- 39 Exhibit 64, Statement of Elisabeth Hoehn, 18 November 2015, pp 1–2 para 4 and p 8 para 29.

- 40 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 4 para 12; At the time, Hoehn’s substantive position was Program Director and Consultant Child Psychiatrist, Future Families, Children of Parents with a Mental Illness Program, Queensland Centre for Perinatal and Infant Mental Health and Parent Aide Unit, Nundah: Exhibit 64, Statement of Elisabeth Hoehn, 18 November 2015, pp 1–2 para 4.
- 41 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 4 para 12.
- 42 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 1 para 1.
- 43 Exhibit 28, Statement of Anne Brennan, 23 October 2015, p 2 para 4.
- 44 Exhibit 30, Statement of William Brennan, 16 November 2015, p 1 para 2.2, p 2 para 3 and p 3 para 6.3.
- 45 Exhibit 30, Statement of William Brennan, 16 November 2015, p 2 para 3.2.
- 46 Exhibit 30, Statement of William Brennan, 16 November 2015, p 2 para 3.1.
- 47 Exhibit 30, Statement of William Brennan, 16 November 2015, p 8 para 8.3.
- 48 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 31 para 20.2.
- 49 Exhibit 32, Statement of Amelia Callaghan, 14 January 2016, p 1 para 2a.
- 50 Exhibit 32, Statement of Amelia Callaghan, 14 January 2016, p 1 para 1.
- 51 Exhibit 32, Statement of Amelia Callaghan, 14 January 2016, p 12 para 13. Exhibit 32, Statement of Amelia Callaghan, 14 January 2016, pp 12–13 para 13c.
- 52 Exhibit 32, Statement of Amelia Callaghan, 14 January 2016, p 30 para 25. Exhibit 32, Statement of Amelia Callaghan, 14 January 2016, p 31 para 25b.
- 53 Exhibit 32, Statement of Amelia Callaghan, 14 January 2016, p 33 para 27.
- 54 Exhibit 32, Statement of Amelia Callaghan, 14 January 2016, p 1 para 1.
- 55 Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 2 para 5.2.
- 56 Exhibit 181, West Moreton 2012–13 Annual Report, p 13.
- 57 Exhibit 36, Statement of Angela Clarke, 20 November 2015, p 1 para 2.6 and Attachment AC-01 to that statement, Curriculum Vitae of Angela Clarke.
- 58 Exhibit 36, Statement of Angela Clarke, 20 November 2015, p 1 para 2.6 and Attachment AC-01 to that statement, Curriculum Vitae of Angela Clarke.
- 59 Exhibit 38, Statement of Vanessa Clayworth, 27 October 2015, Attachment VC-1 to that statement, Curriculum vitae of Vanessa Clayworth.
- 60 Exhibit 38, Statement of Vanessa Clayworth, 27 October 2015, p 1 para 2.1.
- 61 Exhibit 38, Statement of Vanessa Clayworth, 27 October 2015, p 2 para 4.1.
- 62 Exhibit 40, Statement of Michael Cleary, 21 December 2015, Attachment MIC-4 to that statement, Role Description for Deputy Director-General Health Service and Clinical Innovation Division.
- 63 Exhibit 40, Statement of Michael Cleary, 21 December 2015, p 2 para 6.
- 64 Exhibit 40, Statement of Michael Cleary, 21 December 2012, p 3 para 13.
- 65 Exhibit 40, Statement of Michael Cleary, 21 December 2012, Attachment MCI-2 to that statement, Curriculum Vitae.
- 66 Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 1 para 2.1(a) and p 2 para 4.1.
- 67 Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 5 para 7.1 and 7.2.
- 68 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-1 to that statement, Curriculum Vitae of Mary Corbett; Exhibit 181, West Moreton 2012–13 Annual Report, p 12.
- 69 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-01 to that statement, Curriculum vitae, pp 50–52.
- 70 Exhibit 41, Statement of Mary Corbett, 23 October 2015, Attachment MC-01 to that statement, Curriculum vitae, p 52.
- 71 Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 2 para 5.2.
- 72 Exhibit 181, West Moreton 2012–13 Annual Report, p 14.
- 73 Exhibit 43, Statement of David Crompton, 19 October 2015, p 1 para A.
- 74 Exhibit 43, Statement of David Crompton, 19 October 2015, p 1 para B and Attachment to that statement, Curriculum Vitae of David Crompton, p 41.
- 75 Exhibit 43, Statement of David Crompton, 19 October 2015, pp 7–8 paras 32 and 33.
- 76 Exhibit 43, Statement of David Crompton, 19 October 2015, p 1 para A.
- 77 Exhibit 43, Statement of David Crompton, 19 October 2015, Attachment to that statement, Curriculum Vitae of David Crompton.

- 78 Exhibit 43, Statement of David Crompton, 19 October 2015, Attachment to that statement, Curriculum Vitae of David Crompton.
- 79 Exhibit 43, Statement of David Crompton, 19 October 2015, p 1 para C.
- 80 Exhibit 45, Statement of Susan Daniel, 30 October 2015, p 2 para 1(d).
- 81 Exhibit 45, Statement of Susan Daniel, 30 October 2015, p 4 para 5.
- 82 Exhibit 45, Statement of Susan Daniel, 30 October 2015, p 3 para 2.
- 83 Exhibit 47, Statement of Lorraine Dowell, 27 November 2015, Attachment LMD-1 to that statement, Curriculum Vitae of Lorraine Dowell.
- 84 Exhibit 47, Statement of Lorraine Dowell, 27 November 2015, p 2 para 2.3.
- 85 Exhibit 47, Statement of Lorraine Dowell, 27 November 2015, Attachment LMD-1 to that statement, Curriculum Vitae.
- 86 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, p 1 para 2.1.
- 87 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015 p 22 para 12.4(a) – 12.4(e)
- 88 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, Attachment LD-01 to that statement, Curriculum Vitae of Lesley Dwyer, p 1–8.
- 89 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, Attachment LD-01 to that statement, Curriculum Vitae of Lesley Dwyer, p 1–8.
- 90 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, Attachment LD-01 to that statement, Curriculum Vitae of Lesley Dwyer, p 1.
- 91 Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 2 para 5.2; Exhibit 50, Statement of Timothy Eltham, 9 December 2015, p 1 para 2.3, including Exhibit TCE-2, letter from Lawrence Springborg to Timothy Eltham dated 18 September 2012; Exhibit 50, Statement of Timothy Eltham, 23 October 2015, Attachment TCE-2, letter from Lawrence Springborg to Timothy Eltham dated 4 June 2013.
- 92 Exhibit 50, Statement of Timothy Eltham, 9 December 2015, p 2 para 5.1.
- 93 Exhibit 50, Statement of Timothy Eltham, 9 December 2015, Attachment TCE-01 to that statement, Curriculum Vitae of Timothy Eltham; Exhibit 181, West Moreton 2012-13 Annual Report, p 12.
- 94 Exhibit 50, Statement of Timothy Eltham, 9 December 2015, p 1 para 2.1.
- 95 Exhibit 181, West Moreton 2012–13 Annual Report, p 15.
- 96 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, Attachment LG-1 to that statement, Curriculum Vitae of Leanne Geppert.
- 97 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, Attachment LG-1 to that statement, Curriculum Vitae of Leanne Geppert, p 46.
- 98 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, p 3 para 2.5
- 99 Exhibit 55, Statement of Leanne Geppert, Attachment LG-1 to that statement, Curriculum Vitae of Leanne Geppert, p 47.
- 100 Exhibit 58, Statement of Aaron Groves, 21 January 2016, Attachment AG-1 to that statement, Curriculum Vitae of Aaron Groves.
- 101 Exhibit 58, Statement of Aaron Groves, 21 January 2016, Attachment AG-1 to that statement, Curriculum Vitae of Aaron Groves.
- 102 Exhibit 62, Statement of Megan Hayes, 19 November 2015, p 1 para 2.1 and Attachment MH-01 to that Statement, Curriculum Vitae of Megan Hayes.
- 103 Exhibit 62, Statement of Megan Hayes, 19 November 2015, p 4 para 7.1.
- 104 Exhibit 63, Statement of Philip Hazell, 5 November 2015, p 1 para 1 and 3.
- 105 Exhibit 63, Statement of Philip Hazell, 5 November 2015, p 14 para 76.
- 106 Exhibit 64, Statement of Elisabeth Hoehn, 18 November 2015, Attachment C to that statement, Curriculum Vitae, p 32.
- 107 Exhibit 64, Statement of Elisabeth Hoehn, 18 November 2015, p 8 para 29.
- 108 Exhibit 64, Statement of Elisabeth Hoehn, 18 November 2015, p 6 para 25.
- 109 Exhibit 64, Statement of Elisabeth Hoehn, 18 November 2015, p 8 para 30.
- 110 Exhibit 64, Statement of Elisabeth Hoehn, 18 November 2015, Attachment C to that statement, Curriculum Vitae, p 32.
- 111 Exhibit 64, Statement of Elisabeth Hoehn, 18 November 2015, Attachment C to that statement, Curriculum Vitae, p 32.
- 112 Exhibit 65, Statement of Carol Hughes, 27 November 2015, p 1 para 2.1.
- 113 Exhibit 65, Statement of Carol Hughes, 27 November 2015, p 5 para 7.1.
- 114 Exhibit 65, Statement of Carol Hughes, 27 November 2015, Attachment A to that statement, Curriculum Vitae, p 39.

- 115 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 1 para 2.1(d).
- 116 From 1 July 2012, with the commencement of the HHS Act, this title became Executive Director Primary and Community Health, WMHHS. Kelly was on a period of leave from 30 August 2012 until 14 September 2012.
- 117 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 3 para 6.5.
- 118 Exhibit 68, Statement of William Kingswell, 21 October 2015, p 1 para 1.
- 119 Exhibit 68, Statement of William Kingswell, 21 October 2015, p 20 para 30.
- 120 Transcript, Jeanette Young, 7 March 2016, p 21-66 lines 44-45. The Chief Health Officer is a role created by s 52 of the HHB Act. Young has held the position of Chief Health Officer since 2005: Exhibit 186, Statement of Jeannette Young, p 2 para 6.
- 121 Exhibit 40, Statement of Michael Cleary, 21 December 2015, p 3 para 10.
- 122 Exhibit 68, Statement of William Kingswell, 21 October 2015, p 1 para 1.
- 123 Exhibit 68, Statement of William Kingswell, 21 October 2015, Attachment 1 to that statement, Curriculum Vitae of William Kingswell, p 24.
- 124 Exhibit 68, Statement of William Kingswell, 21 October 2015, Attachment 1 to that statement, Curriculum Vitae of William Kingswell, p 23.
- 125 Exhibit 69, Statement of Mara Kochardy, 29 October 2015, p 2 para 1(d) and p 14 para 28(a).
- 126 Exhibit 71, Statement of Beth Kotzé, 18 December 2015, p 1 para 4.
- 127 Exhibit 71, Statement of Beth Kotzé, 18 December 2015, p 3 para 10.
- 128 Exhibit 71, Statement of Beth Kotzé, 18 December 2015, Attachment A to that statement, curriculum vitae, p 33.
- 129 Exhibit 72, Statement of Judith Krause, 26 November 2015, p 1 para 3.
- 130 Exhibit 72, Statement of Judith Krause, 26 November 2015, p 15 para 60-61.
- 131 Exhibit 72, Statement of Judith Krause, 26 November 2015, p 7 para 22.
- 132 Exhibit 72, Statement of Judith Krause, 26 November 2015, p 11 para 41.
- 133 Exhibit 72, Statement of Judith Krause, 26 November 2015, p 19 para 76.
- 134 Exhibit 77, Statement of Moira Macleod, 5 November 2015, p 1 para 1.
- 135 Exhibit 77, Statement of Moira Macleod, 5 November 2015, p 3 para 4.
- 136 Exhibit 77, Statement of Moira Macleod, 5 November 2015, p 2 para 1.
- 137 Exhibit 81, Statement of Graham Martin, 20 January 2016, p 2 para 8 and Attachment B to that statement, Academic Portfolio of Achievement – Graham Martin, p 23.
- 138 Exhibit 81, Statement of Graham Martin, 20 January 2016, p 2 para 8.
- 139 Exhibit 81, Statement of Graham Martin, 20 January 2016, p 6 para 23.
- 140 Exhibit 81, Statement of Graham Martin, 20 January 2016, p 2 para 9.
- 141 Exhibit 81, Statement of Graham Martin, 20 January 2016, p 2 para 7 and Attachment B to that statement, Academic Portfolio of Graham Martin, p 26.
- 142 Exhibit 83, Statement of Ian Maynard, 1 February 2016, p 3 par 9.
- 143 Exhibit 83, Statement of Ian Maynard, 1 February 2016, p 3 para 10.
- 144 Exhibit 83, Statement of Ian Maynard, 1 February 2016, p 4 para 12.
- 145 Exhibit 83, Statement of Ian Maynard, 1 February 2016, p 6 para 18.
- 146 Exhibit 83, Statement of Ian Maynard, 1 February 2016, p 4 para 15.
- 147 Exhibit 83, Statement of Ian Maynard, 1 February 2016, Attachment IGM-2 to that statement, Curriculum Vitae, p 52.
- 148 Exhibit 84, Statement of Brett McDermott, 10 November 2015, p 2 para 7.
- 149 Exhibit 84, Statement of Brett McDermott, 10 November 2015, p 4 para 21.
- 150 Exhibit 84, Statement of Brett McDermott, 10 November 2015, p 3 paras 13 and 14.
- 151 Exhibit 84, Statement of Brett McDermott, 10 November 2015, p 6 para 27.
- 152 Exhibit 86, Statement of Patrick McGorry, 3 February 2016, p 2 para 2.
- 153 Exhibit 86, Statement of Patrick McGorry, 3 February 2016, p 1 para 1.
- 154 Exhibit 86, Statement of Patrick McGorry, 3 February 2016, p 2 para 3.
- 155 Exhibit 87, Statement of Pdraig McGrath, 16 November 2015, p 1 para 2.1 and Attachment PM-2 to that statement, Position Description Nursing Director, p 38.
- 156 Exhibit 87, Statement of Pdraig McGrath, 16 November 2015, p 1 para 2.1-2.3.

- 157 Exhibit 87, Statement of Pdraig McGrath, 16 November 2015, p 1 para 2.5.
- 158 Exhibit 87, Statement of Pdraig McGrath, 16 November 2015, p 2 para 2.7.
- 159 Exhibit 87, Statement of Pdraig McGrath, 16 November 2015, p 17 para 14.9.
- 160 Exhibit 181, West Moreton 2012–13 Annual Report, p 13.
- 161 Exhibit 89, Statement of Darren Neillie, 23 October 2015, p 1 para 2.1.
- 162 Exhibit 89, Statement of Darren Neillie, 23 October 2015, p 2 para 2.4.
- 163 Exhibit 89, Statement of Darren Neillie, 23 October 2015, p 2 para 3.2.
- 164 Exhibit 89, Statement of Darren Neillie, 23 October 2015, Attachment A to that statement, Curriculum Vitae, p 16.
- 165 Exhibit 91, Statement of Margaret Nightingale, 24 November 2015, p 2 para 10.
- 166 Exhibit 91, Statement of Margaret Nightingale, 24 November 2015, p 1 para 5, p 2 para 6-7.
- 167 Exhibit 96, Statement of Justine Oxenham, 24 November 2015, p 2 para 3.
- 168 Exhibit 96, Statement of Justine Oxenham, 24 November 2015, p 2 para 4(a).
- 169 Exhibit 96, Statement of Justine Oxenham, 24 November 2015, Attachment 34 to that statement, Curriculum Vitae, p 93.
- 170 Exhibit 96, Statement of Justine Oxenham, 24 November 2015, p 2 para 3.
- 171 Exhibit 94, Statement of Anthony O'Connell, 6 January 2016, p 1 para 2.
- 172 Exhibit 94, Statement of Anthony O'Connell, 6 January 2016, Attachment AOC-2 to that statement, Curriculum Vitae of Anthony O'Connell, p 134.
- 173 Exhibit 94, Statement of Anthony O'Connell, 6 January 2016, p 2 para 2.
- 174 Exhibit 94, Statement of Anthony O'Connell, 6 January 2016, p 2 para 2.
- 175 Exhibit 94, Statement of Anthony O'Connell, 6 January 2016, Attachment AOC-2 to that statement, Curriculum Vitae of Anthony O'Connell, p 34.
- 176 Exhibit 41, Statement of Mary Corbett, 23 October 2015, p 2 para 5.2.
- 177 Exhibit 181, West Moreton 2012–13 Annual Report, p 14.
- 178 Exhibit 103, Statement of Thomas Pettet, 4 December 2015, Attachment TJP-1 to that statement, Curriculum Vitae of Thomas Pettet, p 7.
- 179 Exhibit 103, Statement of Thomas Pettet, 4 December 2015, p 1 para 2.
- 180 Exhibit 103, Statement of Thomas Pettet, 4 December 2015, Attachment TJP-1 to that statement, Curriculum Vitae of Thomas Pettet, p 7.
- 181 Exhibit 106, Statement of Deborah Rankin, 11 October 2015, p 2 para 10.
- 182 Exhibit 106, Statement of Deborah Rankin, 11 October 2015, p 3 para 11.
- 183 Exhibit 106, Statement of Deborah Rankin, 11 October 2015, p 3 para 12.
- 184 Exhibit 106, Statement of Deborah Rankin, 11 October 2015, p 2 para 8 and 9.
- 185 Exhibit 106, Statement of Deborah Rankin, 11 October 2015, p 1 paras 4–6.
- 186 Exhibit 109, Statement of Rosangela Richardson, 30 October 2015, p 1 para 1(c).
- 187 Exhibit 109, Statement of Rosangela Richardson, 30 October 2015, p 2 para 4.
- 188 Exhibit 109, Statement of Rosangela Richardson, 30 October 2015, p 1 para 1.
- 189 Exhibit 110, Statement of Kevin Rodgers, 10 December 2015, p 2 paras 8 and 9.
- 190 Exhibit 110, Statement of Kevin Rodgers, 10 December 2015, p 1 para 3.
- 191 Exhibit 110, Statement of Kevin Rodgers, 10 December 2015, p 2 para 4.
- 192 Exhibit 111, Statement of Kimberley Sadler, 14 December 2015, p 1 para 1.
- 193 Exhibit 111, Statement of Kimberley Sadler, 14 December 2015, p 2 para 10.
- 194 Exhibit 111, Statement of Kimberley Sadler, 14 December 2015, Attachment KS-1 to that statement, Curriculum Vitae, p 19.
- 195 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 2 para 13 (d).
- 196 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 7 paras 32 and 33.
- 197 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, pp 7–8 para 34.
- 198 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 3 para 14.
- 199 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 3 para 13.

- 200 Exhibit 112, Statement of Trevor Sadler, 11 December 2015, p 3 para 13(g).
- 201 Exhibit 112, Statement of Trevor Sadler, Attachment A to that statement, Curriculum Vitae of Trevor Sadler, p 57.
- 202 Exhibit 113, Statement of Stephen Sault, 15 December 2012, p 2 para 2.
- 203 Exhibit 113, Statement of Stephen Sault, 15 December 2012, p 2 para 2.
- 204 Exhibit 113, Statement of Stephen Sault, 15 December 2012, p 1 para 1.
- 205 Exhibit 114, Statement of James Scott, 4 February 2016, p 1 para 4 and Attachment JS-1 to that statement, Curriculum Vitae of James Scott.
- 206 Exhibit 114, Statement of James Scott, 4 February 2016, p 4 para 17.
- 207 Exhibit 114, Statement of James Scott, 4 February 2016, p 2 para 5.
- 208 Exhibit 114, Statement of James Scott, 4 February 2016, p 2 para 6.
- 209 Exhibit 117, Statement of Tania Skippen, 13 November 2015, p 1 para 2.
- 210 Exhibit 117, Statement of Tania Skippen, 13 November 2015, p 4 para 6.
- 211 Exhibit 117, Statement of Tania Skippen, 13 November 2015, p 4 para 6(e).
- 212 Exhibit 117, Statement of Tania Skippen, 13 November 2015, Attachment A to that statement, Curriculum Vitae of Tania Skippen, p 28.
- 213 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, p 1 para 1.
- 214 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, p 1 para 3.
- 215 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, p 2 para 4 and 5.
- 216 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, p 3 para 12.
- 217 Exhibit 122, Statement of Stephen Stathis, 5 November 2015, p 1 para 3.
- 218 Exhibit 122, Statement of Stephen Stathis, 5 November 2015, Attachment A to that statement, Curriculum Vitae of Stephen Stathis, p 20.
- 219 Exhibit 124, Statement of Terry Stedman, 16 October 2015, p 1 para 2.1 and Attachment TJS-1 to that statement, Curriculum Vitae of Terry Stedman, p 32.
- 220 Exhibit 124, Statement of Terry Stedman, 16 October 2015, p 21 para 24.10.
- 221 Exhibit 124, Statement of Terry Stedman, 16 October 2015, p 21 para 24.14.
- 222 Exhibit 124, Statement of Terry Stedman, 16 October 2015, Attachment TJS-1 to that statement, Curriculum Vitae of Terry Stedman, p 32.
- 223 Exhibit 125, Statement of Peter Steer, 15 December 2015, p 1 para 3 and Attachment B to that statement, Curriculum Vitae of Peter Steer.
- 224 Exhibit 125
- 225 Exhibit 125, Statement of Peter Steer, 15 December 2015, p 8 para 30.
- 226 Exhibit 125, Statement of Peter Steer, 15 December 2015, Attachment B to that statement, Curriculum Vitae of Peter Steer.
- 227 Exhibit 125, Statement of Peter Steer, 15 December 2015, Attachment B to that statement, Curriculum Vitae of Peter Steer, p 24-26.
- 228 Exhibit 130, Statement of Lesley van Schoubroeck, 26 October 201, p 2 para 4 and Attachment B to that Statement, Letter of Appointment.
- 229 Exhibit 130, Statement of Lesley van Schoubroeck, 26 October 201, p 2 para 7.
- 230 Exhibit 130, Statement of Lesley van Schoubroeck, 26 October 2015, Attachment C to that statement, Position Description of Mental Health Commissioner.
- 231 Exhibit 130, Statement of Lesley van Schoubroeck, 26 October 2015, Attachment A to that statement, Curriculum Vitae, p 15.
- 232 Exhibit 130, Statement of Lesley van Schoubroeck, 26 October 2015, p 1 para 3.
- 233 Exhibit 129, Statement of Ashleigh Trinder, 30 October 2015, Attachment AT-1 to that statement, Curriculum Vitae of Ashleigh Trinder.
- 234 Exhibit 129, Statement of Ashleigh Trinder, 30 October 2015, Attachment AT-1 to that statement, Curriculum Vitae of Ashleigh Trinder.
- 235 Exhibit 134 Statement of Patrea Walton, 21 October 2015, p 1 paras 1 and 3.
- 236 Exhibit 135, Statement of David Ward, 4 February 2016, Attachment DJW-1 to that statement, Curriculum Vitae of David Ward.

- 237 Exhibit 135, Statement of David Ward, 4 February 2016, Attachment DJW-1 to that statement, Curriculum Vitae of David Ward, p 13.
- 238 Exhibit 135, Statement of David Ward, 8 February 2016, p 6 para 33.
- 239 Exhibit 135, Statement of David Ward, 8 February 2016, p 1 para 1.
- 240 Exhibit 137, Supplementary Statement of Georgia Watkins-Allen, 30 January 2016, Attachment A to that statement, Curriculum Vitae of Georgia Watkins-Allen.
- 241 Exhibit 137, Supplementary Statement of Georgia Watkins-Allen, 30 January 2016, Attachment B to that statement, Employee Movement – Temporary.
- 242 Exhibit 137, Supplementary Statement of Georgia Watkins-Allen, 30 January 2016, p 1 para 6.
- 243 Exhibit 140, Statement of Lourdes Wong, 22 December 2015, p 2 para 2(a).
- 244 Exhibit 140, Statement of Lourdes Wong, 22 December 2015, Attachment A to that statement, Curriculum vitae of Lourdes Wong, p 14.
- 245 Exhibit 140, Statement of Lourdes Wong, 22 December 2015, p 1 para 1.
- 246 Exhibit 142, Statement of Peta-Louise Yorke, 3 November 2015, p 2 para 1.
- 247 Exhibit 142, Statement of Peta-Louise Yorke, 3 November 2015, p 2 para 1.
- 248 Exhibit 142, Statement of Peta-Louise Yorke, 3 November 2015, Attachment A to that statement, Curriculum Vitae of Peta-Louise Yorke, p 18.
- 249 Exhibit 186, Statement of Jeanette Young, 15 February 2016, p 2 para 6.
- 250 *S 52, Hospital and Health Boards Act 2011.*
- 251 *S 53, Hospital and Health Boards Act 2011.*
- 252 Transcript, Jeanette Young, 7 March 2016, p 21-66 line 44.
- 253 Exhibit 186, Statement of Jeanette Young, 15 February 2016, p 2 para 9.
- 254 Transcript, Jeanette Young, 7 March 2016, p 21-73 line 1.
- 255 Exhibit 186, Statement of Jeanette Young, 15 February 2016, p 1 para 3 and Attachment B to that statement, Curriculum Vitae of Jeannette Young, p 31.
- 256 Exhibit 186, Statement of Jeanette Young, 15 February 2016, p 1 para 2.
- 257 Exhibit 186, Statement of Jeanette Young, 15 February 2016, p 1 para 3 and Attachment B to that statement, Curriculum Vitae of Jeannette Young, p 27.
- 258 Exhibit 143, Statement of Victoria Young, 30 October 2015, p 2 para 2(a).
- 259 Exhibit 143, Statement of Victoria Young, 30 October 2015, Attachment A to that statement, Curriculum Vitae of Victoria Young, p 15.

Appendix E – Processes of the Commission

Introduction

The Barrett Adolescent Centre Commission of Inquiry (the Commission) was established under the *Commissions of Inquiry Order (No. 4) 2015*, made by the Governor in Council on 16 July 2015. The Commission was required to make full and careful inquiry into a number of matters related to the closure of the Barrett Adolescent Centre (the BAC) including the bases of the closure decision, the adequacy of the transition arrangements for BAC clients, the adequacy of care, support and services provided to BAC patients and their families, and the consideration given to any alternatives to closure.

The Commission commenced on 14 September 2015.

The Honourable Margaret Wilson QC was appointed as Commissioner to lead the inquiry and Mr Paul Freeburn QC and Ms Catherine Muir were engaged as Counsel Assisting. A number of suitably qualified people were also retained or seconded to the Commission as legal officers, researchers, and administrative officers.

Scope of the inquiry

The scope of the Commission's inquiry was defined by the terms of reference in *Commissions of Inquiry Order (No. 4) 2015*, reproduced in appendix A.

Timeframe for the inquiry

The Commission was initially required to report to the Premier of Queensland by 14 January 2016 however, this timeframe was extended to 24 June 2016 by *Commissions of Inquiry Amendment Order (No. 3) 2015*, made by the Governor in Council on 10 December 2015.

Establishment

In the month prior to the Commission's commencement, office premises at level 10, 179 North Quay, Brisbane were obtained, key personnel were recruited, administrative arrangements were put in place and other preparations were made.

The Commission called for submissions on its website and through notices in the press, including *The Courier-Mail* and *The Australian*, as well as the following regional newspapers:

Bundaberg News Mail	Gympie Times	Sunshine Coast Daily
Cairns Post	Mackay Daily Mercury	Toowoomba Chronicle
Fraser Coast Chronicle	North West Star (Mount Isa)	Townsville Bulletin
Gladstone Observer	Queensland Times (Ipswich)	Warwick Daily News
Gold Coast Bulletin	Rockhampton Morning Bulletin	

At the first public hearing on 30 September 2015, the Commissioner encouraged any person who believed they had information that might assist the Commission in carrying out its work to contact the Commission's Executive Director, and explained that it was not necessary to wait to receive a notice from the Commission.¹

Appendix G provides the 38 parties granted leave to appear before the Commission.

Sensitivity

The significant and legitimate sensitivity about many of the issues the Commission had to address was recognised from the outset. This included:

- sensitivity because of the vulnerability of young people who suffer mental illness
- sensitivity because of the challenges young people's mental illness can present to their families, friends and carers
- sensitivity because of the varied demands their illness places on those engaged in their management, whether they be medical practitioners, nurses, allied health workers, social workers, teachers, clerical workers or whoever
- sensitivity because of community attitudes and concerns.²

Contact with former BAC patients and their families

It was necessary for Commission staff to contact a number of former BAC patients and their families to obtain evidence about the adequacy of the transition arrangements and the care, support and services that were provided during the transition.

The Commission was provided with files relating to 41 young people who were either former patients of the BAC or on the waitlist or assessment list for admission to the BAC. The Commission made contact with 34 families whose children were admitted or on the waitlist for admission. Of those families, the Commission took 22 statements from 17 family members and five patients.

Some patients and families were not contacted by Commission staff. The decision not to initiate contact with them was based on careful and thorough review of the documents, and concern to avoid compromising the welfare of young people with mental illness.

Commission staff were very privileged to speak to a number of young people and their families; they understood that, for some, contact would cause unnecessary anxiety, stress and in some cases, harm.

Privacy

Witnesses who were former BAC patients or family members of those patients deserved privacy. The evidence of many health professionals referred to or identified former BAC patients and their families. The sensitivity of the issues the Commission had to address and its undertaking to do all that was reasonably necessary to avoid compromising the welfare of young people with mental illness meant that the processes it adopted to ensure confidentiality were often complex and fraught.

The Commissioner issued a *Confidentiality Guideline* on 12 October 2015 which was designed to ensure that both Commission staff and parties treated sensitive information as confidential. The Commissioner made an order prohibiting the publication of some evidence, including personal medical records of former BAC patients, on 15 October 2015, and subsequently amended it on 28 January 2016 and 16 February 2016. In its final form, the order prohibited the publication of an extensive list of materials.

Redacting information identified in the non-publication order was a key process for maintaining confidentiality. Commission staff reviewed and redacted over 45 000 pages of text prior to its use and publication, and sought parties' feedback on those redactions.

Other claims of confidentiality

Some parties submitted that certain documents, or parts of documents, ought to be afforded confidentiality on the basis they were "commercial-in-confidence". The Commissioner afforded confidentiality on this basis to information contained in the statement of an Aftercare employee which identified staffing profiles and structures, the details of specific Aftercare programs and the measurement of outcomes.

The National Mental Health Service Planning Framework (NMHSPF) and accompanying technical manual and communiques were produced to the Commission. These were not afforded confidentiality. However, the NMHSPF Modelling Draft Estimator Tool was afforded confidentiality on account of risks associated with releasing it publicly, including its draft nature and the unreliable outputs that might result from inexperienced use of it.

Documents and disclosure

On the first day of the Inquiry, the Commissioner issued a *Document Management Protocol* which outlined the Commission's intention to receive, manage and consider all materials electronically and set out details of how materials were required to be collected, digitised and provided to the Commission.

In response to Notices to Produce Documents, the Commission received over 112 000 documents from a number of sources. Some of the challenges associated with the production of documents are described in some detail below.

Delays and difficulties with the production of documents generally

There was considerable delay by some parties in producing documents to the Commission. The delays were largely due to the information technology systems in place within a number of Queensland Government departments. Some parties, who were no longer working for the State or who were separately represented were unable to comply with the Commission's notices in a timely manner because the documents contemplated by the notices were held by the State.

The Commission attempted to assist the parties with the information management challenges they faced in complying with the notices in the following ways:

- On 15 September 2015, a litigation support consultant was made available to meet with Crown Law to discuss the challenges of managing large volumes of material, the approach the Commission was taking and the function of the Commission's *Document Management Protocol*.
- In late September 2015, the Commission offered Crown Law's staff a number of hours of free training on the Delium litigation support system used by it.
- Between 21 September 2015 and 16 November 2015, a number of meetings were held between Counsel Assisting and Crown Law in relation to substantial delays in the production of documents by its clients, namely Queensland Health, the Department of Communities, Child Safety and Disability Services, the Department of Education and

Training, the Department of Housing and Public Works, the Department of Premier and Cabinet, the Queensland Treasury and Children’s Health Queensland Hospital and Health Service (CHQ). The purpose of the meetings was to discuss the scope of the Commission’s notices and to devise a working solution (including the agreement outlined below limiting the production of certain types of documents) to the difficulties encountered by Crown Law and its clients in the production of documents.

Despite the *Document Management Protocol* specifying that parties should take reasonable steps to ensure that duplicates were removed from produced documents, the Commission received a significant number of duplicates. The Commission drafted detailed notices in an attempt to limit the number of irrelevant documents that might be produced, but nevertheless many irrelevant documents were produced.

In some cases, the Commission agreed to limit the documents to be produced in response to notices issued. Those agreements were informed by the principle of proportionality, to ensure that the costs of the production of documents were not disproportionate to the likely benefits.

Queensland Health and Department of Education, Training and Employment documents

To respond effectively to notices issued by the Commission, searches of email systems needed to be conducted. In the cases of Queensland Health and the Department of Education, Training and Employment, there were particular problems and delays encountered getting access to material, let alone assessing it against the notices. The problems stemmed from relevant emails being stored in the current email system (Exchange) as well as in an off-line backup of a superseded email system (GroupWise). The design of the superseded email system and systemic limitations of the restoration process were such that mere restoration of the information was forecast to take many months, after which there would have to be review by legal staff. The whole process was likely to involve considerable expense.

The Commissioner, Counsel Assisting and Commission staff met with Crown Law, the Crown Solicitor and staff from the relevant government agencies on 16 November 2015 about the production of emails. An agreement was reached to the following effect:

- Certain email accounts were treated as a high priority for restoration and review by Crown Law.
- Where possible, time periods of interest to the Commission were narrowed to reduce the volume of material to be reviewed from the high priority accounts.
- Legal representatives of employees not represented by Crown Law were given access to their email accounts so that they could respond to their own notices.

On 24 November 2015, a further agreement was reached with Crown Law that the Commission would suspend the requirement to produce material from non-priority email accounts on the basis that the time, effort and cost associated with the production of this material could not be justified having regard to the likely benefit to be obtained from the production of the material.

CHQ documents and statements

It proved difficult to obtain sufficient information from CHQ to allow Commission staff properly to understand and usefully describe the similarities and differences between the Adolescent Mental Health Extended Treatment Initiative (AMHETI) services. The model of service delivery

used by Queensland Health to describe each mental health service is a high-level document that describes a service's client group, interventions and operations in the broadest terms using language largely derived from national and state policy documents. There is little, and in some cases no, difference in the description of the client group and interventions provided by each service. Consequently, the models of service delivery do little to illuminate the extent to which each service might be more or less suitable for adolescents with specific mental health problems and different personal circumstances.

The non-government service provider for two of the youth residential rehabilitation units (Aftercare) provided very useful statements describing the role, operations and management of the Brisbane and Cairns units as well as case study information on clients of their services to help the Commission understand these services.

Claims of privilege

Some documents produced to the Commission were subject to claims of public interest immunity and parliamentary privilege, which the State of Queensland was unwilling to waive.

The Commission agreed not to publish documents protected by public interest immunity.

The issue of parliamentary privilege was discussed at length. After receiving written and oral submissions from Counsel Assisting and parties with leave to appear, the Commissioner ruled that the question of parliamentary privilege had to be decided on a document-by-document basis, and that mere production of a document to the Commission would not necessarily have the effect of breaching parliamentary privilege.

Requests for access to documents

Throughout the course of the inquiry, the Commission received a number of requests from parties for access to documents produced to the Commission. It attempted to meet all reasonable requests for access to documents relevant to the interests of the parties making the requests.

Witnesses and witness statements

154 witnesses assisted the Commission with its inquiry, including 106 who were legally represented and 48 who did not have legal representation.

The Commission received a total of 224 witness statements, all of which were tendered as exhibits. Some of the witness statements were prepared by Commission staff, who conducted over 80 interviews with witnesses, while others were prepared by the witnesses themselves or their legal representatives.

113 of the 154 individual witnesses who assisted the Commission with its inquiry were either current or former public servants or Queensland Government employees. Of these, 32 were represented by Crown Law with a further 35 electing to have separate legal representation from 13 law firms in line with *Queensland Government Indemnity Guideline*.³

The legal representation of public servants and employees of the Queensland Government presented the following challenges for the Commission:

- On a number of occasions, Crown Law objected to the Commission initiating

contact with a witness directly on the basis that the witness may have been entitled to representation through Crown Law. Dealing with those objections delayed the gathering of information for the inquiry.

- On at least one occasion, a witness expressed concern that their legal representative had advised them not to include all the information that the witness considered was relevant to the Commission's terms of reference.
- Several witnesses expressed concern about the impact of giving evidence to the Commission on their continued employment with the Queensland Government. The Commission was not in a position to assess the inherent validity of this concern.

The Commission is grateful for the cooperation and assistance provided by all witnesses and their lawyers. A number of health professionals provided extremely valuable contributions. The Commission is particularly grateful to Dr Aaron Groves who gave several days of his time, supported by the generosity of the South Australian Government. The Commission also thanks Professor Patrick McGorry and Dr Philip Hazell for the time they generously gave to assist it.

The Commission thanks former BAC patients and their parents and families for their invaluable contribution to its work.

Discussion papers and interpretation notes

Interpretation notes and discussion papers were circulated amongst parties to better inform submissions to, and determinations by, the Commissioner. The table below lists the discussion papers and interpretation notes which were circulated by Counsel Assisting.

Discussion papers and Interpretation notes	Date circulated
Discussion Paper 1 – Regarding a Joint Application for confidentiality	8 October 2015
Discussion Paper 2 – Crown Law representation of State employees	18 October 2015
Discussion Paper 3 – Procedural matters to be settled at the directions hearing on 28 January 2016	25 January 2016
Discussion Paper 4 – Key Points, as ordered on 28 January 2016	10 February 2016
Discussion Paper 4A – Relevant Legislation	12 February 2016
Discussion Paper 4B – National and State Mental Health Background and Policy	12 February 2016
Discussion Paper 4C – Reasons for Closure as per the available evidence	12 February 2016
Discussion Paper 4D – Comparison of AMHETI service elements	12 February 2016
Discussion Paper 4E – Service mapping	12 February 2016
Working Document – Transition Clients	29 February 2016
Interpretation Note – Terms of Reference and Transition Clients	8 March 2016

Site visits

On 21 October 2015, the Commissioner, Junior Counsel Assisting and Commission staff visited the BAC building at The Park. This Commission thanks West Moreton Hospital and Health Service (West Moreton HHS) and its representatives for arranging this site visit.

On 8 February 2016, the Commissioner, Senior Counsel Assisting and a Commission staff member visited the child and adolescent mental health facilities at the Lady Cilento Children's Hospital. The Commission thanks CHQ for arranging this site visit.

Hearings

The Commission conducted public hearings in the Brisbane Magistrates Court at 363 George Street, Brisbane on 28 days between 30 September 2015 and 15 April 2016.

To promote access to and transparency of the proceedings, cameras were used to live-stream views of the hearing room to the Internet and to a media gallery set up outside the hearing room. All evidence was presented electronically and screens were placed throughout the hearing room so that documents were visible to all parties, the public gallery and the media gallery. Operators were dedicated to managing the live-stream as well as the display of electronic evidence. Some witnesses gave evidence remotely by video link and telephone.

Because of the nature and subject matter of the material to be examined during the hearings, some of the oral evidence was received in closed sessions to ensure compliance with the Commission's *Confidentiality Protocol* and the non-publication order. During closed sessions the public gallery was cleared and the streams to the Internet and media gallery were suspended.

The Commission thanks the Brisbane Magistrates Court for its assistance and cooperation during the hearings.

External engagements

The Commission engaged a number of external contractors. Below is a list of contractors and the services they provided:

- Auscript – recording and transcription services
- UnitingCare Community – counselling services, available during hearings for anyone who may have become distressed by the proceedings
- e.law – Delium litigation support and evidence management system, in-court technology, live streaming services and ad-hoc para-legal services.

The Commission thanks each of them for their assistance and support. In particular, it thanks the UnitingCare Community Counsellors who attended the public hearings between 15 February 2016 and 11 March 2016 to provide support and assistance to parties and members of the public, and who staffed a dedicated telephone support line which was available to all parties and Commission staff.

Records management

The Commission used the litigation support system, Delium, to manage evidence throughout the life of the inquiry. Administrative records were kept in the records management system of the Department of Justice and Attorney-General (eDOCS).

The only hard copy records obtained by the Commission were the original signed statements of witnesses. Managing all other documents electronically allowed the Inquiry to be conducted in an efficient and expeditious manner.

The Commission's records have been managed in accordance with the *Commission of Inquiry Retention and Disposal Schedule* (QDAN 676 version 2) issued by the Queensland State Archivist under the *Public Records Act 2002* (Qld). At completion of the Commission, hard copy records were transferred to the Queensland State Archivist with the Department of Justice and Attorney-General nominated as the relevant and responsible public authority to manage the electronic records.

Applications to access the Commission's records should be made to the Department of Justice and Attorney-General by writing to its Privacy and Right to Information Unit at GPO Box 149, Brisbane, Queensland, 4001 or by email to RTIAdministration@justice.qld.gov.au.

Media

The Commissioner approved Media Guidelines recognising the importance of the media's role in informing the community about its work and containing detailed arrangements for media access to the Commission's public hearings. Broadcasting proceedings, including re-broadcasting footage from the live-stream, was not permitted. To ensure there was sufficient space for parties and members of the public, the Commission established a secondary/media gallery outside the hearing room which included the live stream sent to the Internet and the view of any document displayed during the hearing.

Prior to each of the Commission's hearings (or in the case of the hearings for the receipt of oral evidence, prior to the block of hearings), the Commission issued a media advisory notice to key media contacts. These media advisories set out the nature and purpose of the hearings and reminded the media about the Commissioner's non-publication order. They also asked journalists and media organisations to be mindful of the sensitivity of issues relating to mental illness that were likely to be addressed in evidence before the Commission and provided links to the *Mindframe* National Media Initiative.

The Commission promoted the Australian Government's *Mindframe* National Media Initiative to parties and media representatives covering the Inquiry.⁴ The Commission thanks media representatives and journalists for their professionalism and understanding of the need to balance the confidential and sensitive nature of the issues under consideration by the Commission with the importance of conducting the inquiry in an open and independent manner.

Assistance and staffing

The Commissioner wishes to thank Counsel Assisting and the Commission staff for their dedication and energy.

Emeritus Professor Barry Nurcombe, a retired Professor of Child and Adolescent Psychiatry at The University of Queensland, was retained as a consultant to the Commission. His assistance in explaining the psychiatric evidence and issues, particularly in relation to patient records, and his wisdom, were invaluable.

The names of Commission staff appear in appendix F.

(Endnotes)

- 1 Transcript, Commissioner, 30 September 2015, p 1-5 lines 1–4.
- 2 Transcript, Commissioner, 30 September 2015, p 1-5 lines 12–20.
- 3 The remainder were employed by Hospital and Health Services (such as West Moreton HHS and Metro North HHS) which elected to engage alternative legal representation for their employees or were not legally represented.
- 4 Transcript, Commissioner, 30 September 2015, p 1-6 lines 20–25.

Appendix F

Commission staff

Commissioner	The Hon Margaret Wilson QC	14 September 2015–24 June 2016
Counsel Assisting	Paul Freeburn QC	18 August 2015–24 June 2016
	Catherine Muir	17 August 2015–24 June 2016
	Patricia Feeney	9 December 2015–24 March 2016
Executive Director	Ashley Hill	24 August 2015–30 June 2016
Consultant Psychiatrist	Barry Nurcombe	23 September 2015–24 June 2016
Senior Solicitor	David Thompson	14 September 2015–17 June 2016
Principal Legal Officers	Rachel Cornes	21 September 2015–30 June 2016
	Joanna Cull	8 February 2016–30 June 2016
	Andrew Lossberg	21 September 2015–17 January 2016
	Stacey Parker	21 September 2015–24 June 2016
Senior Legal Officers	Catherine Browning	9 November 2015–27 May 2016
	Yi Chen	21 September 2015–1 January 2016
	Samuel McCarthy	16 November 2015–11 April 2016
	Alistair Tonks	10 September 2015–27 April 2016
	Jessica Whitby	11 January 2016–8 June 2016
	Maria Zappala	21 September 2015–20 May 2016
Legal Officers	Tara Bosworth	4 January 2016–14 June 2016
	Michelle Delpont	16 November 2015–30 June 2016
	Kate Dodgson	14 September 2015–15 January 2016
	Alexandra Ganis	11 January 2016–30 June 2016
	David McGrath	25 January 2016–3 June 2016
	Bronwen Peberdy	18 January 2016–30 June 2016
	Alice Pinkerton	21 September 2015–27 May 2016
Associate to the Commissioner and Legal Officer	Joshua Sproule	8 February 2016–30 June 2016
Research Directors	Mark Lynch	26 August 2015–30 January 2016
	Christopher Keen	25 January 2016–13 May 2016
Senior Research Officers	Susan Jewell	21 September 2015–20 May 2016
	Louise Norman	14 September 2015–1 May 2016

	Helene Wells	18 January 2016–24 June 2016
Research Officer and Legal Officer	Emily Vale	24 August 2015–22 January 2016
Media Director	Tim Goodwin	9 September 2015–30 June 2016
Executive Officer	Amelia Barker	21 September 2015–30 June 2016
Office Manager	Catherine Edwards	17 August 2015–30 June 2016
Senior Administration Officer	Kirsty Petersen	21 September 2015–30 June 2016
Records Manager	James Mann	31 August 2015–30 June 2016
Administration Officers	Brett Ashton	9 September 2015–30 June 2016
	Joanne Healy	13 November 2015–15 June 2016
Secretarial Officers	Catherine Aird	21 September 2015–24 June 2016
	Grace Guarrera	10 November 2015–25 May 2016
	Susanne McKeen	14 September 2015–13 November 2015
Paralegals	William Johnson	8 February 2016–24 June 2016
	Xavier Lake	23 February 2016–7 June 2016
Court Orderly	Michael Hinge	16 November 2015–11 December 2015
		15 February 2016–12 April 2016

Appendix G

Legal representatives

Granted leave to appear	Counsel	Instructing solicitors
State of Queensland and Hospital and Health Services established under the <i>Hospital and Health Boards Act 2011</i> (Qld), other than West Moreton Hospital and Health Service and its Board, Metro North Hospital and Health Service and its Board and Metro South Hospital and Health Service and its Board	E. S. Wilson QC N. J. Kefford J. Crawford	Crown Law
West Moreton Hospital and Health Service and its Board	P.V. Ambrose QC (until January 2016) K.A. McMillan QC (from January 2016) C. J. Fitzpatrick (from January 2016)	Corrs Chambers Westgarth Lawyers
Metro North Hospital and Health Service and its Board	J.J. Allen QC	Metro North Legal Services
Metro South Hospital and Health Services	K.A. Mellifont QC M. Zerner	Clayton Utz
The Hon Lawrence Springborg MP	D.B. O'Sullivan QC J. O'Regan	McCullough, Robertson Lawyers
William Kingswell	A.W. Duffy QC	Ashurst
Anne Brennan Michael Cleary Anthony O'Connell	G.W. Diehm QC C.J. Conway	Avant Law
Trevor Sadler	J. M. Rosengren	K & L Gates Lawyers
Matthew Beswick Janelle Bowra Christie Burke Susan Daniel Graham Dyer Liam Huxter Mara Kochardy Moir Macleod Rosangela Richardson Stephen Sault Lourdes Wong Peta-Louise Yorke Victoria Young	S. Robb	Roberts & Kane Solicitors

Vanita Olliver Nichole Pryde Justine Wilkinson	B. Wessling-Smith J.M. Harper G. R. Mullins	Shine Lawyers
Deborah Rankin	B.I. McMillan	Gilshenan & Luton Legal Practice
Brett McDermott	K. Philipson	Meridian Lawyers
Darren Bate Megan Vizzard		McInnes Wilson Lawyers
Justine Oxenham	A. McLean Williams	Sparke Helmore Lawyers
Georgia Watkins-Allen	A. O'Brien	RBG Lawyers
Michael Daubney Thomas Pettet		Moray & Agnew Lawyers
Aaron Groves		Franklin Athanasellis Cullen Lawyers
Ian Maynard	D. O'Brien QC A. Nicholas	Herbert Smith Freehills
Ronald Simpson	P.J. McCafferty	Kaden Boriss Legal
Cristelle Mulvogue	D. Callaghan	TressCox Lawyers

