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TRANSCRIPT OF PROCEEDINGS

THE HONOURABLE MARGARET WILSON QC, Commissioner

MR P. FREEBURN QC, Counsel Assisting

MS C. MUIR, Counsel Assisting

IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

COMMISSIONS OF INQUIRY ORDER (No. 4) 2015

BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

BRISBANE

9.30 AM, TUESDAY, 16 FEBRUARY 2016

Continued from 15.2.16

DAY 7

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RESUMED **[9.30 am]**

COMMISSIONER WILSON: Good morning everyone. Are there any changes in the appearances from yesterday?

MR P.J. McCAFFERTY: Commissioner, my name is McCafferty, initials P.J. I appear for Mr Simpson instructed by Kaden Boriss.

COMMISSIONER WILSON: Thanks, Mr McCafferty. Anyone else?

MR D.G. PRATT: May it please the Commission, a change from yesterday, I'm for Dr Groves. Pratt, initials D.G. from Franklin Athanasellis Cullen. Appearing with me today is MS BANDERSTOEP, B-a-n-d-e-r-s-t-o-e-p, initial L.

COMMISSIONER WILSON: B-a-n-d-e-r - - -

MR PRATT: s-t-o-e-p.

COMMISSIONER WILSON: - - - s-t-o-e-p.

MR PRATT: Yes. Banderstoep, initial L.

COMMISSIONER WILSON: Thank you. And - - -

MR PRATT: My colleague at the firm Franklin Athanasellis Cullen.

COMMISSIONER WILSON: Thank you.

MR PRATT: Thank you.

COMMISSIONER WILSON: Thanks, Mr Pratt. Any other changes? No. Mr Freeburn.

MR FREEBURN: Commissioner, I call Professor David Crompton.

DAVID ROBERT CROMPTON, SWORN **[9.32 am]**

EXAMINATION BY MR FREEBURN

COMMISSIONER WILSON: Yes, Mr Freeburn, when you're ready. You've got half an hour.

MR FREEBURN: Thank you.

Professor Crompton, I understand that you have a correction to make to your witness statement. And I understand it's on page 24. Now, Commissioner, this is a section of the witness statement that is confidential so – but I think I can get through it without closing the court.

COMMISSIONER WILSON: Let's try to do so.

MR FREEBURN: I think most of the parties should have an unredacted version.

Professor Crompton, on page 24 your correction is to, as I understand it, paragraph 86(d). Correct? We can probably get your statement – it's probably fairly pointless getting your statement up. So if we can just deal with a hard copy. Have you got a hard copy?

COMMISSIONER WILSON: You can take my copy if it's going to save time.

MR FREEBURN: Alright. Now - - -?---So it's 86(d), you said?

Page 24?---Yes.

You'll see there's a small (d), the third paragraph on the page?---Yes.

And there's a person there whose initial – she's a staff member, Angela Hain?---Yes.

And as I understand it, you want – she's not of BAC, she's of the Mood team?---Yeah, Metro South Hospital and Health Service Mood team. Yes. That's true.

And what – and you refer to the mood team elsewhere in your - - -?---That's part of – well part of our community care teams. It's a specialised part of the program.

Alright. Thank you. So with that correction, you're happy with the contents of your witness statement?---Yes.

Alright. Now, can I just – in paragraph 34 of your witness statement and, operators, I wonder if we could get that up on the screen. Have you managed to get that? Technical problems. Okay. Well, I'll see if I can deal with it. So you might remember this, Professor, you deal with having established a user group that had the task of guiding the design and development at the new Redlands site?---Yes. That's correct.

And that group met several times and you were at some of the meetings?---Yes. I was at some of the meetings. And some meetings I was absent.

Right. And those meetings that you refer to in your statement are called facility project team meetings. Is that - - -?---What page – what paragraph is that?

So paragraph 34, page 8. If you just want to check that?---Paragraph 4 describes what the user groups there, their tasks were. I don't see that it's actually listed there, the actual name. But that's - - -

COMMISSIONER WILSON: I'm sorry, Professor. You're going to have to speak into the mic?---Sorry.

It's a bit awkward when you have the folder. If you want to put the folder in front of you, do?---Yes. So paragraph 34 refers to the user groups, what their task was of guiding the design and development of the new unit. And it describes what the – to ensure the facility was developed. It's not actually listed there what the name of those groups are but they were, from my recollection, called the facility program.

Facility?---Yep.

Facility team?---Yep, yep.

Alright. And the system was that they were held, at least initially, on a monthly basis?---That would be close to it. There was initially – there was a number of meetings held. I haven't got those dates in front of me but there was very regular meetings and then – and then there was a change in the frequency of the meetings. Yes.

Alright. And the system was that minutes were taken at the meeting and they were subsequently approved. Is that - - -?---Yes. So meetings would – minutes would be taken from the meeting and then what would occur is the minutes would be distributed for – the people would be in agreement what was the content in there and then they would then come back to a subsequent meeting for agreement as the usual meeting process that we're all in agreement and signed off on.

And that process enabled you to stay up to date with what was happening even though you might not have attended the last meeting?---Yes. That's correct.

Now, you said a moment ago that the meetings were monthly or at least similarly to monthly initially and then they were at different time lengths?---Yes.

One of the paragraphs of your affidavit, if you could look at it, would demonstrate the dates of the various meetings. In looking at that you can see that there are a number of gaps – is that – do you remember reasons for gaps in those meetings?---Look, I can't recall. But meetings at times depend on that there's a quorum available.

Yes?---There may have been other issues that arose that might've prevented a meeting to occur. But I can't remember the specific reasons why each meeting would not occur.

Right. And in paragraph 39 of your statement it's not – you don't – it's not necessary for you to go it but you talk about receiving, on 28 August 2012, a memorandum from Glenn Rashleigh, R-a-s-h-l-e-i-g-h, of the Chief Health Infrastructure Office which – the letter is addressed to Dr Richard Ashby. And it advised that a decision of government had been made to defer a number of capital delivery projects including the proposed Redlands facility. Do you remember getting that – a copy of that letter?---It's a – I think it was a memorandum.

Memorandum, sorry?---Yes, I do recall that.

And had there been prior notice to you of – did that come as a surprise?---I don't recall a prior notice to it. It was a decision made by the Department, and they would notify us of – of that decision.

Right. But that was the first time you had been advised that there was a decision to defer the Redlands project?---Yes.

When we look at the minutes of the meeting – the minutes of the meetings, the last of them occurred back before, I think, in February of that year. So there's a big gap between February 2012 and August 2012. Do you know why that happened?---I can't specifically remember why there was a gap at that time.

Right.

COMMISSIONER WILSON: Mr Freeburn, I hesitate to interrupt, but I just looked at the document that you referred to, the email, and it talks of to cancel or defer a small number of capital projects, and this includes the cancellation of Redlands. I think you put it to the witness it was the deferral – can't you hear me?

MR FREEBURN: I can't hear you.

COMMISSIONER WILSON: Alright. I'll say that again. I've just looked at the – what I think is the memorandum from Glen Rashleigh to Lesley Dwyer and Richard Ashby, which refers to a decision by government to cancel or defer a small number of capital delivery projects. This includes the cancellation of the replacement adolescent mental health unit at Redlands. I think you put it to the witness it was a deferral.

MR FREEBURN: I'm sorry. It was a cancellation - - -?---Yep.

- - - professor?---Yes, sorry. I – I – I – sorry – I – I interpret that's what you were - - -

Alright?---Yep.

Now, I want to take you to a few minutes of those meetings. So we'll see if the technical problems have been overcome. The first document for the record is meeting number 1, WMS.0026.0005.34761. So if we just scroll up a bit. Now, Professor, can you make out that alright on the screen?---Yes, I can.

And that's the committee that we were speaking of?---Yes.

And we can see that you were present and – I think you were chair of that meeting?---Yes.

And that's meeting number 1; correct?---Yes, that's what it says on the document.

Alright. Now, can I just – if we go to page – the page ending 63, the third page in the document, you see item 2.0?---Yes.

Just read that and just get yourself a little bit familiar with that?---Yes.

So is – in – is this a fair summary of it: the meeting discussed what the model of care or model of service would be for the proposed facility?---Yes, that was – that's a – a fair summary of that point there. There was a discussion - - -

And - - -?--- - - - there, and then I pointed out there needs to be – understand what is needed to be shown and what – and to ensure that we had an appropriate model of service delivery, such as appropriate staffing levels.

Right. And you were to put – you see in the action you were to put together some information to pass onto the members of the committee; correct?---Yes.

And TS: that means Trevor Sadler?---I assume it is, without – but I'd need to clarify. Is there a summary of abbreviations?

There is, but they've actually got it wrong. If you go to the front page, you'll see that – we go back to the – page 1, you'll see that Terry Carter is there on the screen as TC, and then if we scroll down we can see that - - -?---Yes, yes.

- - - Terry - - -?---I – I'll agree that I – most likely is Trevor Sadler.

Yes. And so what was proposed was a – that Trevor Sadler could present a model of service delivery at the next meeting?---If that was – yes, he was able to do that. Yes.

And we can go to the meeting number 2, which is QHD.003.001.2655. And if we scroll down to the same item, two point – which should be on page 2, fairly sure you weren't at this meeting?---Sorry, can you – can you scroll? I'm just checking whether – whether I was present.

Okay. We'll just scroll up to the top page, please. I think you were an apology?---Yes, I'm an apology.

You're the second apology. But if we look at – go back to item 2.0, we can see that there's a presentation on the – on the proposed model of service, and also a presentation of the BAC model of service?---Yes.

Alright. Now, I just wanted to go to the next one in the sequence, which is MS – sorry – MSS.001.002.0297. Number again? MSS – there's actually two numbers on my version, but MSS.001.002.0297. Can't find it? Excuse me. It looks like it'll take a little time to get - alright. We might proceed with something else for the moment. Can I take you to document DBK.001.001.0067. It's a briefing note. Now, Professor, have you seen that briefing note before preparing for this Commission?---Can you scroll down and I'll just – so that I can see the whole document, please. Thank you. Keep scrolling down. If we could go down to the bottom to the signatures. The answer to that is no. I would not – I wouldn't have seen this document prior to the Commission.

Alright. And nobody consulted with you about this briefing note?---No.

Can I just draw your attention – if we go back to the first page. Can we go back to the first page, please. And if we just scroll down a little to item number 2 under Headline Issues. Now, you see in the first dot point there the RAETU. That's the Redlands project, correct?---Yes.

And you'll see there there's three reasons attributed to the decision to cease this particular capital program. One is multiple delays?---Yes.

Were you conscious that that was a concern about the project when you were on these committee meetings?---I'm always – I mean, at this – can I just say at the time that we were doing this, we had about – be about three to four other builds that were going on. 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.

But nothing extraordinary?---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 remain always a concern for me as the person tasked with the responsibility of delivering mental health services in the area.

Alright?---And particularly as this was a state-wide facility.

And, Professor Crompton, you'll see the second reason is that it had an estimated budget overrun of $1.4 million?---Yes.

Can I just ask you this: was the budget for this project a budget that was fixed, or was it subject to further budgetary provisions?---So like all building budgets, there is

a figure that is provided at the beginning. And what happens is that in building costs there is an escalation in building costs that may occur, or there may be other changes that are necessitated for the infrastructure. And therefore if there is an increase in costs, you then have to seek approval for that and then it is a departmental decision as to whether that approval is granted.

Alright. And you'll see the word in the second sentence:

> *Recent sector advice proposes a re-scoping of the clinical service model and government structure for the unit.*

Do you know what that means?---If you – so in my statement, I've said that there – and you saw previously there was an issue around the – there was a presentation of the model of service and then there was another model of service that was being looked at. And my advice – I'm not a child and adolescent expert, so these matters are referred to the appropriate group to develop what they would perceive as a model of service. And then ultimately because it's a state-wide program there would be a requirement that it goes to the child and youth network for the state who comes and determines what that model of service – what they would recommend for the model of service. And then for that to be approved by appropriate people.

So let me sort of summarise. The model of service was always a matter that was going to be developed in the course of these committee meetings, correct?---So the model of service would not be developed during the course of the meetings.

I see?---The model of service would be done externally by a group of experts in that area.

Yes?---And they would then present advice as to what they would perceive as the most appropriate. But then it was always going to be a requirement then it would go to the Child and – Child and Youth Mental Health Network for the state to have an agreement as to whether that is appropriate. And then it would also – while I would give agreement to it, it would also be referred up into the department for agreement.

So the aim is for the new Redlands facility to start with a new model of – developed model of care – model of service?---Well, I guess that's – I wouldn't say that it's the aim that it starts with the new model. It's to be that they determine what the model would be, because the model may be the model that was previously existed, but it may be that they desire a new one and they need to determine what that will be.

Alright. Well, we'll come back to the development of that model in a minute. In fact, can we get up – we should have a document with meetings 3, 13 and 11 on it. Okay. Well, this is meeting number 3 – 15 October 2009. And it looks like you're there, correct?---Yes, I am.

And if we turn to the item 2.2 – sorry – 2.0 on page 2 of the document?---Thank you.

Thank you. Now, if we turn to – I'll get you to have a look at 2.0. We can see that – it's now on the screen – BB – that's – by the signatures, that looks like it's Brett Bricknell?---Brett Bricknell.

Yeah. He's the executive director of Redlands and Wynnum Hospitals?---What's his role at the time. I think at the time, yes, he would have been that. He's in a different position, but I can't recall when the exact change of those positions occurred.

Alright. And then if we just quickly go to item 2?---Yes.

Members discussed issues that may arise with chopping of trees due to koalas. BB advised members that the water flow issues have been resolved. Correct?---That's what – yeah. That's what it says. Yes.

And – Alright.

And – alright. Okay. We can read the rest. So, operators, can we get up number 13, is – or number 11? Can we get up the next one? Alright. Now, this is meeting number 11. Now, you were not at this meeting. If we turn to item – turn to the second page of the document - - -?---Can I just scroll down to very that, please?

Yep?---Yes.

You're the first apology. If we scroll down to – we can see – if we look at items 3.0 and 4.0, we should see – we can see there that a koala report is due back, and then see the master program progress report. Now, this deals with the model of service. Can you just have a read and familiarise yourself with that?---Yes.

So at this time, that separate group that you're talking about had all but finalised the model of service for the Redlands facility; correct?---At that stage, it would appear that that's what they're saying, that the – this final ratification process, it would be dependent upon how long that ratification process takes. But it would appear to be close to that.

There was a document pretty close to final, and it needed to be finished off and ratified; correct?---Yep.

And if we can just go to the last of the ones on that – in that bundle, number 13, see this is a meeting, number 13, on 16 September 2010. Again, you're – you can see that page on the screen; you're an apology. I just want to take you to the second page of the document and to item 3.0. That's it. Now, the paragraph down the bottom, dealing with koalas: just read that and familiarise yourself with that?---Yes.

Now, am I right in assuming that, essentially, the plans for the project had been adapted to accommodate for the koala population?---That's what the document indicates in there, that there would be an issue around koala habitat, and we'd – and the – and the committee would have received advice saying this is what you need to.

Alright. And is that your recollection? Is it – or is that - - -?---Well, as it says, I wasn't at that meeting.

Yes. But it is your - - -?---But my understanding of it is that's the process we'd reached at that point.

Yes?---That's the advice that I'd received, and that's what's recorded in there.

Alright.

COMMISSIONER WILSON: Mr Freeburn, I know you've had some technical problems this morning. How much longer do you think you'll be?

MR FREEBURN: Just a couple – just about five minutes. Now, can I ask you to go to a document, WNS6006.0002.54301. Now, I just want to – this is a briefing note, and I know it doesn't involve you. But I just want to address this issue of the model of service again. If we go to paragraph 18 on page 3 of the document – now, just have a read of paragraph 18?---Yep.

So does that accord with your recollection of particularly the last sentence, that the model of service delivery had been finalised by the 22nd of July 2010?---So you're referring to paragraph 19?

Eighteen?---Eighteen, sorry. Yeah.

Sorry, the last sentence in paragraph 18?---Look, I have – I'm not clear on the – the exact date that would have been, but it would have – it must have been close to that time, because there had been a series of discussion around what the model would look like.

Alright. Thank you, Commissioner. That's all I have.

COMMISSIONER WILSON: Thank you. Now, this is your client; is that right, Ms Wilson?

MS E. WILSON QC: I'm sorry, your Honour – I'm sorry, Commissioner?

COMMISSIONER WILSON: Are you representing - - -

MS WILSON: No, no, no, no.

COMMISSIONER WILSON: Alright. You're next then.

MS MELLIFONT: I am, your Honour.

COMMISSIONER WILSON: Thanks. Okay.

EXAMINATION BY MS WILSON [10.08 am]

MS WILSON: Professor Crompton, you're presently the executive director of the addiction and mental health services at Metro South Hospital and Health Service?---That's correct.

And you've been in that role since June 2012?---Yes, that's correct.

Now, in terms of services for adolescents and mental health issues, in your bailiwick out at Metro South Hospital and Health Services, what services are available, do you – that you know of?---So current services that sit within our – our area, remembering that the – one part of our catchment, the services in the community are provided by Lady Cilento, the - - -

Yep?--- - - - children's health network, so that sits within the Princess Alexandra catchment, the Redlands area and the Logan area. We have community teams across that – those services, so they're outpatient services. We have an AMYOS services being commenced that provides services in the – in the area, and we have – within the – it's called the Logan-Beaudesert Wellbeing Program. We have a youth and family program which ranges in age from around about 16 up to about 24, and that is particularly focused in the Logan area, and it is a community-based program. We also have in the community the Evolve program, which is funded through the Department of Child Safety, and that is specifically aimed for – for young people who have very specific needs and – and related to child safety and Department of – that Department. And we also have inpatient services and acute service based at Logan. And our teams also reach into the emergency departments at both the Redlands and Logan Hospitals.

Okay. Were any of these services that you've just run through – were they available when the Redlands facility was being considered?---So the AMYOS service was not. The Logan-Beaudesert Wellbeing child and youth program was not, but the remainder of the services, yes, they were.

So just running through that list, AMYOS no, the acute program yes, the Evolve program?---Evolve program, yes.

And the Youth and Family Program?---No, the Youth and Family Program was not.

Okay. And do you have any knowledge of the other program – the other planned services that – well, maybe I start from there. At one – are you aware that there's a spectrum of services that should be provided? At one end, you've got the community services and at the other you've got the acute inpatient. And it's in between the continuum of services that I've interested in, and you've named a couple of those, such as the AMYOS program. Have you had any experience with the Residential Rehabilitation Services, the Resis?---No, our service does not have a

residential program for young people. But I am familiar with those services in other states.

Okay. And are you aware of the Step Up Step Down program – the proposed Step Up Step Down Program?---The current proposals?

Yes?---Yes, I'm aware that there's a proposal that these would occur.

Okay. And then we've got subacute beds available. Are you aware of subacute beds being available in Queensland for services and the facilities available in relation to that?---No, I'm not.

Have you visited the Lady Cilento Hospital in a professional capacity?---Sorry, I haven't – okay. Sorry. Okay. I'm with you now. So I haven't visited the Lady Cilento Hospital, but I am aware that there are longer-term beds available - - -

Okay?--- - - - at that site.

Now, let's just go back to the – and to be fair, your focus is now not on youth and adolescent services; is that right?---No. My – my job encompasses the provision of good-quality addiction and mental healthcare for – across the age range, from - - -

Right?--- - - - sort of, young children, including babies, up to older adults. So I have a responsibility for delivery of those services across metro site – region, but I am not a child and adolescent expert. So I defer to the advice of them, to that specific group in decision making.

Okay. So in the services – the programs that are offered by Metro South Hospital and Health Services, do they – are you aware whether they have an education service associated with them?---Yes. The – the acute inpatient unit has a – a teacher that provides services on a – each school day.

Okay. And - - -

COMMISSIONER WILSON: Which – I'm sorry – which acute unit are you referring to?---The Logan Adolescent Unit, so that's ward 2A.

Thank you.

MS WILSON: Okay. And do you have any view about whether having educational services assists in the rehabilitation of young people with mental health issues?---My advice is that yes, it does. It's a very important part of, you know, sort of, directing young people who have a mental health problem, working with them, and educational services should be part of that process, even in an acute setting. And – and that certainly works well with the young people.

And there's a program, isn't there, out at Metro South Hospital and Health Services called Edlink? Can you tell me [indistinct] about that?---So Edlink is part of one of – part of the team, and Edlink plays a role in the linking in with the various educational services across the region, providing education. They do work educating staff, they do work in helping people identify issues that are occurring within schools. And so they provide an in-reach and – so it's a point that schools can reach out to them – and they play a role in a number of programs – well, a couple of programs that we run, for example, more recently, the Positive Mindset Festival, which was actually working with schools to develop mental health first aid within those schools to assist teachers etcetera.

Okay. Now, in terms of adolescent mental – adolescent – youth and adolescent mental health services and adult mental health services, has Metro South Hospital and Health Services got any services that address that spectrum from – that bridge between adolescent – youth and adolescent to adult services?---So at the Logan site that's one of the reasons we introduced the youth and family program because it's identified and the advice given to me is it's a period of complexity as people – their development trajectory is different on each occasion. So the advice to me is that we – we needed a program that actually helped, particularly in an area of rapid population growth so we have that at that site. But we also have procedures around the transition of people from one team to another and people are working – and they work across to support young people transitioning to adult services.

Okay. Do you identify any gap between the services – between youth and adolescent and adult?---So can you define what you mean by a gap.

Well, from – is there – when you finish youth and adolescent is there a gap then before you go onto adult or should there be more of a bridging spectrum that joins the two?---So – so I go back and one of the issues that we started at Logan was a program that was to bridge – to bridge that gap. In an ideal world we would have an expansion of that program and we think that's important but we've done one stage and we're testing that that's working. And then we're analysing to ascertain whether it works. What's very important is in the transition period of anybody from any part of the program there's the – there is a very good link between clinicians and people working together.

On another matter does Metro South Hospital and Health Service receive referrals of adolescents with mental health issues who require a secure bed?---We – so again, it depends on your definition of secure. We receive young people who are admitted into our service that require high dependency beds and depending on the level of severity of that individual, where we can place those people at a particular point in time and from time to time there is – because of the risk of aggression we will have to care for them in a high dependency unit and in those occasions we will have increased level of nursing support for those young people.

And is this – is there a high or low demand in terms of that type of referral to your services?---I wouldn't define it as a high demand but every time that service is required it – it poses particular issues for us to manage those young people carefully.

Okay. And is that – what is the – what are the demands that have been put on that service – does it happen a lot? Does it happen rarely? Can you give us some idea about - - -?---Look, you – we will probably have – you know, I'm sort of estimating at the moment from my memory it'd be about half a dozen to a dozen young people annually that may require a high dependency unit for a period of time.

So - - -?---But often that's a very brief period of time.

Okay. So that's a very brief period. So six to 12 for a brief period of time?---Yeah. What I'm saying for most of them. There is occasionally some that require a longer period.

Thank you, Commissioner. No further questions.

COMMISSIONER WILSON: Ms McMillan.

EXAMINATION BY MS McMILLAN [10.19 am]

MS McMILLAN: Yes. Thank you, Commissioner.

Professor Crompton, as I understand the answers you framed them through the reference point that you're not a child and adolescent psychiatrist. Correct. Thank you. Now, in relation to paragraph 64 of your statement which is MSS900020017?--- Yep, page that's - - -

Page - - -?--- - - - page 17 - - -

- - - 17 of your statement?--- - - - paragraph 64.

Sixty-four and 65 and can I just ask you to pause there and I want to take you back for a moment. As I understand it you say you had no part and in fact weren't aware of the decision to cease the Redlands project until you were notified by that memorandum. Correct?---That's my - - -

And you - - -?--- - - - my recollection.

- - - I take it, inferentially, have no knowledge of whether, for instance, West Moreton Health Service had any consultation in that process either?---I wouldn't be aware of that.

Yeah. Thank you. Thank you. Now, in relation to what you say about tier 3, I take it tier 3 is not a term that you would ordinarily use?---Look, I – I don't necessarily talk in that language but I - - -

No?--- - - - understand a tier 3 - - -

[indistinct] tier 3?---Tier 3, yeah.

And you say at 65:

> *We were receiving the cohort of one of which was a high risk category for self-harm including suicide. Observed that even if there was a tier 3 replacement facility these risks would have been evident and need to be managed.*

Do I take it from what you say that one can never mitigate totally against a risk?---No. It's not possible to totally remove risk.

Particularly when you're talking about mental health issues?---Particularly mental health issues but, yeah.

So – yes. Thank you. In relation to the utilisation of Logan as perhaps an interim measure – and if we go back to page 15 of that document which is here – page 15 of your statement as well, Professor Crompton. Paragraph 56(b)?---Yeah.

I take it from that – is this a fair way of putting it – that you relied on the advice that you were given by experts in that field within Metro South?---The advice that it not be used. Is that what - - -

Yes?--- - - - you're asking.

Yes?---That was the advice that I – I – I received. My recollection is that there were other people who also visited the site to determine the appropriateness of the design.

And Professor, can I ask you then about the patients which were transitioned, if I can put it that way. Now, again, as I understand it, the situation was you devolved down, if you like, to the teams and the team leaders. They would advise you if they needed any extra resources such as staffing or other allocation. Correct?---So – that's correct.

Yes. Thank you. In relation to – I want to ask you about a document which is JRK – so this is an annexure to the statement of Judi Krause. You know Ms Krause?---Yes, I do.

I wonder if I could just get that up. It's JRK9000010485. So I'm after page 0485.

Professor, do you just want to read that letter through to the end and just familiarise yourself with it. I mean read it to yourself?---Can you scroll down a bit further.

So if you could go over the page?---Yes, ma'am. Yes.

Right. So do you recollect receiving that letter, Professor?---Can I just go back to the top and I'll just have a look - - -

Yes thanks?--- - - - at the date on this.

It's 2010 – March?---Yeah.

So we're going back some way?---Yes. I don't - - -

And no doubt you've received a lot of letters?---The – yeah. I'm not specifically - - -

Yeah?--- - - - recollection but I'm aware that that I had been given - - -

Yes?--- - - - that Ms Krause had communicated with me. Yeah.

Alright. And you know that it enclosed, as it says in the first line, the draft model of service?---Yep.

[Indistinct] for formally known as the Barrett Adolescent Centre. If I could take you down to the paragraph near the bottom of that page that starts:

There are a range –

Now, I take it from what you understood that was an appropriate range of recommendations to be making? Treatment being defined to a six month period in most cases?---Okay. So the advice received from this group was this was what they, as child and adolescent experts, what they felt was the appropriate model. At that stage they – well, I'm the director of the service but I'm not an expert in this area. This is their expertise. They're saying this is what they believe the model should look like and, therefore, that would be what would be presented to committees and also ultimately to the Department and the Child Youth Network for the State for agreement.

If we can go to the next page, please, to the paragraph that starts:

As you are aware, Dr Trevor Sadler –

Now, that paragraph there "was unable to participate", it says. About mid-way of that paragraph:

Trevor felt strongly that the model proposed above did not encapsulate the complexity of the AETRC cohort and was simplistic in nature. The group noted he was critical of the six month treatment timeframe suggesting there was no evidence. The group note there is equally no evidence for a one to three year

admission. These lengthy periods of care are more costly, block beds and appear ..... inconsistent with generalising change ..... local setting.

Again, do you have any personal knowledge of that or was that, again, communicated to you by this group?---That was – my recollection would be communicated by the group. I mean, I was aware there was a view around the model and that was part of the decision to refer it off to people who are experts to make a decision around what would the model look like.

Alright. Thank you. Could I then take you, please, to a document annexed to your affidavit, MSS0020054 – MSS0020120054. Professor, this is a document headed – well, maybe it's – there's two different documents. I don't know which is correct. MSS90000020449. Can I suggest while that's being brought up, I'm referring you to a document annexed called the Metro South Mental Health Services Procedure. And this particularly relates to inter-district transfer of mental health consumers within staff of the Queensland Health Service districts. Do you recollect that document?---Yes. I recollect – recollect the document.

That's not the right document?---But I don't think that's the correct one.

No. So it's MSS00020449. Professor, maybe I'll start while we're waiting for this document. As I said, the - - -

COMMISSIONER WILSON: Excuse me, Ms McMillan, if this is the correct document it can be shown to the witness in hard copy.

MS McMILLAN: That would be faster, I think. Yes.

COMMISSIONER WILSON: But you have a look and make sure?---Did you want to - - -

MS McMILLAN: Could I - - -

COMMISSIONER WILSON: Show it to Ms McMillan first, please.

MS McMILLAN: Yes. That is exactly it. Yes. Thank you, Commissioner.

Professor, do you just want to have a look at it and familiarise yourself with it. Probably down to the second page of that document will be sufficient, Professor?---Yes.

Right. So, Professor, did you author this document or have anything to do with the authoring of it?---I was the final approver of the document.

Right?---This is a document that arose from a working group that covered all the mental health services in what was then the southern area health service at the time.

So that was the Gold Coast, Metro South, the – Ipswich, West Moreton, Toowoomba, Darling Downs and South West.

Yes. Right. Thank you. So you say in the background that mental health consumers are at an increased risk of harm during periods of transition. I suppose that's hardly surprising, is it?---I would always regard that as an issue when people are transitioning, whether it's from an inpatient service or across to a – from one community team or to one part of the – one service to another.

And going down to principles:

> *The transfer process including the time it takes will complete will be consistent with consumers' recovery care, treatment plans –*

etcetera. So, again, I suppose a statement of a fairly basic principle. Correct?---Mmm.

If we go over the page of that document:

> *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 the ongoing care.*

Correct?---That's correct.

And that has always been the case, hasn't it?---Yes. I would have thought generally that would be the case for most places. But - - -

And I take it then it would not be standard process, if you like, for there to be follow up by the transferring facility or health care service once the patient had been transferred effectively into your service's care?---So if you go to page 1 of that in the last dot point, some transfers of care may require a shared care arrangement for a period of time. But that's a matter of clinical decision making between the two teams.

Yes. And that would be made very apparent, I imagine, that it was a shared clinical endeavour. Correct?---Mmm.

So that, generally speaking though, it's not done in practice, is it, for a referrer service?---It's not something that's done, you know, regularly.

No. And, indeed, it could be potentially disruptive to the development of a new therapeutic relationship, couldn't it?---Look, there is a potential as people move, separate from one service to another, from one clinician to another. There is a potential for an exacerbation of symptoms. As a person moves on from one place to another there is that potential.

Okay. And the – and one would think too that what works alongside with the transition is you are referring to an appropriate service or suite of services to provide appropriately for that patient's care?---Yes. I mean, a decision has been made that a person is moving from A to B. And within Queensland Health there is a range of services we provide. And it would be an expectation that we have – particularly in Metro South – that we would have services available to cover those – the needs of individuals.

Right. And that would be the same whether it was, for instance, any mental health patient or some of the former Barrett cohort. Correct? Your arrangements for those care – for their care?---The arrangements for – generally, would be that process, that it's a clinician to clinician arrangement that is made for the clinical care of that individual.

Yes. Thank you. Thank you, Commissioner.

COMMISSIONER WILSON: To ensure the record is complete, the document has two Delium reference numbers on it. The first is MSS0020120054 and the other is MSS90000020449. And it was called a Metro South Mental Health Services Procedure: Inter-District Transfer of Mental Health Consumers within South Queensland Health Service Districts.

MR FREEBURN: Commissioner, in the old language it was exhibit 32 to Professor Crompton's statement.

COMMISSIONER WILSON: The old language is useful sometimes. Alright. Mr Wessling-Smith, do you have any questions?

MR WESSLING-SMITH: No, not - - -

COMMISSIONER WILSON: You don't after all?

MR WESSLING-SMITH: Not any longer, Commissioner.

COMMISSIONER WILSON: Thank you. Yes, Ms Mellifont.

EXAMINATION BY MS MELLIFONT **[10.35 am]**

MS MELLIFONT: Thank you, Commissioner. Can I start, please, with document DBK.001.001.0067. This is the briefing note for approval – the first of them that you were taken to. Can I ask, please, that we go down to the heading Headline Issues and the first dot point.

Professor, you recall you were taken to that first dot point. Can I tell you that the date of this document as signed is 16 May 2012 and ask you to orient yourself in terms of time in that respect. You were taken specifically to the words:

> *Recent sector advice proposes a re-scoping of the clinical service model and governance structure for the unit.*

?---Mmm.

I take it that you had no part in the preparation of, drafting of or settling of this briefing note. Is that correct?---That's correct.

And so you have no knowledge specifically what is referred to by the author or authors of this document as to "recent sector advice"; is that correct?---No. I've got no specific knowledge of that.

And, in fact, up until you received the memorandum from Mr Rashleigh that the Redlands project was being cancelled, your understanding was – your mindset was that any issues which had arisen in the development of the project were continuing to be worked through?---That is correct.

That includes issues such as obligations in respect of koalas and environmental concerns, correct?---Yes.

And any outstanding issues in respect of model of service delivery?---That is correct.

Can I just clarify some terminology, because "user group" can be used frequently across government, and ask if these propositions are correct. The user group tasked with guiding the design and development of the new Adolescent Extended Treatment and Rehabilitation Centre on the Redlands site was called the facility project team meeting?---That's correct.

There was a separate smaller user group meeting consisting of a core group of relevant persons established to inform the AETRC, that is, the Adolescent Extended Treatment and Rehabilitation Centre, oversight of specific requirements for the AETRC. Is that correct?---That's correct.

And there were a number of other user groups, for example, one chaired by a senior architect of project services and one chaired by – the Barrett Adolescent Centre HR Planning Group chaired by an acting advisor of people and culture – Metro South for example?---That's correct.

Now, each of the user groups consisted of subject matter experts selected to assist with the tasks to be performed by that particular user group?---That would be correct.

Okay. And to report back to the FPTM?---That's correct.

And the FPTM itself included representatives from the Mental Health branch of Queensland Health and Health Planning Information Division of Queensland Health known as HPID?---Yes.

And HPID was responsible for making decisions in relation to the progress of the AETRC project; is that correct?---That would be correct.

It kept Gantt, G-a-n-t-t, chart to monitor the project?---Yes. That would be the usual process.

And the Mental Health branch was ultimately responsible for signing off on the model of service delivery, correct?---The – the process would be that they need to approve what we're going to be doing.

Okay. And in respect of the model of service delivery, subject matter experts such as Ms Krause were part of a working group to review that and to report back to the FPTM, relying on their collective expertise as to what was required in the context of child and adolescent services, correct?---Yes. That's correct.

Can I take you, please, to document MSS.001.002.0297. These are meeting minutes for 12 October 2009. Can I take you, please, down the page – in fact, over the page, please, to heading number 2, item number 2.0. Might be having some technical difficulties. I can deal without the document coming up.

Professor Crompton, if you can take it from me that 2.0 reflects that water flow issues have been resolved, now, is that a reference to it being ascertained that the particular site was an overland flow path and therefore building construction had to take that into account. Correct?---That is correct.

Okay. And that was going to be, as you understood it, taken into account by architectural design which allowed for the building to be sufficiently high so as to protect itself against floodwaters?---That would be correct.

Thank you. Nothing further, Commissioner. Thank you.

COMMISSIONER WILSON: Thank you, Ms Mellifont. Mr Freeburn, do you have any further questions?

EXAMINATION BY MR FREEBURN [10.42 am]

MR FREEBURN: Commissioner, I just wanted to clarify one concept with Professor Crompton.

COMMISSIONER WILSON: Yes.

MR FREEBURN: Professor, you were asked a question by Ms McMillan about secure beds. And you gave an answer about – which referred to the concept of high-dependency beds?---Mmm.

Can you just explain – are they the same or similar concepts?---So I'm referring to within our service. So if you're talking about what outline for longer stay patients or consumers – young people, so – such as medium-secure where people may be there for a longer period of time or, indeed, for high-risk patients for people who might have committed murder, for example, during their mental illness – they're levels. High-dependency units attached to acute care facilities, and they're usually designed for managing people who are acutely unwell who have particular risks of – whether it be self-harm to them or to other people or they're, because of the nature of the illness, at risk of absconding and therefore giving harm to themselves if they were in the community – or to others. And so we have specific areas which have a higher nursing ratio. For example, it might be – it would be – one of our areas would be a one nurse to two patients. And in those cases, if necessary, it can go to a one-to-one ratio. And depending on the level of severity of risk to people, you may involve security services to be present because of dangerousness to individuals. In those cases, most people remain there for a period from a couple of days. Occasionally, people may be there a number of weeks depending on the severity of their illness, but most people it's a – it's a shorter period of time and then they transition back into an – the acute bed – beds of that ward.

Alright. So, as I understand it, the high-dependency beds would usually be attached to an acute unit, and the security really refers to – it might refer to a whole facility?---So the – so a high-dependency unit will have increased levels of security. So in terms of nursing, there will be a requirement around the doors particularly being of a certain standard to prevent people absconding through them and that there will be fences or surrounding areas that would aim to prevent people climbing over those buildings.

Alright. Thank you. That's all I have, Commissioner.

COMMISSIONER WILSON: Thank you, Professor. You can stand down.

WITNESS STOOD DOWN **[10.45 am]**

MS MELLIFONT: Commissioner, might I be heard on a stand-down as opposed to excusal. Professor Compton is going overseas for an extended period from 27 February. Can I therefore ask that he be excused?

COMMISSIONER WILSON: Well, I suppose there's a possibility we could need him again before 27 February. I certainly don't want to stop him going overseas.

MS MELLIFONT: No.

COMMISSIONER WILSON: Would it be possible for him to maintain contact with you so that if we did need something further arrangements could be made to take the evidence by video link?

MS MELLIFONT: Yes, your Honour. And it might be that given that the parties are now on notice that he's leaving on 27 February, that there should be a deadline, perhaps 23 February, if anybody's to raise additional issues for Professor Crompton. I'm not sure of the precise itinerary location, the capacity to do a video link at particular dates. So in an effort to inconvenience Professor Crompton the least on his holidays, could I ask that he therefore be excused subject to the possibility of recall before he goes?

COMMISSIONER WILSON: I'm going to take it step by step.

MS MELLIFONT: Yes.

COMMISSIONER WILSON: As I say, I certainly don't want to interfere with his holiday if I possibly can.

MS MELLIFONT: Yes.

COMMISSIONER WILSON: I'll stand him down until the 27th, and if you could be in touch with counsel assisting so that some contact arrangements can be made should we need to call him again. I certainly hope it won't be necessary for his sake, but I don't want to close the door at this stage.

MS MELLIFONT: Thank you, your Honour.

COMMISSIONER WILSON: Alright.

MS MUIR: Commissioner, can I raise one matter before you adjourn for the morning break? The next witness to be called is Professor Brett McDermott.

COMMISSIONER WILSON: Yes, Ms Muir.

MS MUIR: There's a series of questions that I would like to ask Professor McDermott that touch upon confidential issues. I propose to ask them at the beginning. So I propose that when we return after we break that the court be closed.

COMMISSIONER WILSON: Well, I don't see any difficulty in doing that. Are there any persons who would normally be expected to leave the courtroom you feel might stay?

MS MUIR: Commissioner, from Counsel Assisting's perspective I'm quite content for Dr Brennan to stay when I'm cross-examining Professor McDermott about the issues.

COMMISSIONER WILSON: Does any other counsel want to say anything about that? No? Well, when we resume after morning tea the hearing will be closed. That means the live streaming must be off, and I'll need to be assured it is. Those who are in the public gallery, unless they're legal representatives, will have to remain outside. Dr Brennan can, however, remain inside. Is that clear to everyone? Very well.

MS MUIR: And one further matter, Commissioner: I envisage that then any other counsel that had questions relating to any confidential issues should raise those questions while the court's closed, and then there's another chance in open court for uncontroversial matters.

COMMISSIONER WILSON: Well, it would be ideal if that's possible, and I'll encourage you to do it, but I'm not going to say the court can't be closed again should the need arise - - -

MS MUIR: Thank you, Commissioner.

COMMISSIONER WILSON: During the evidence. Alright. Would you adjourn, please, to five past 11.

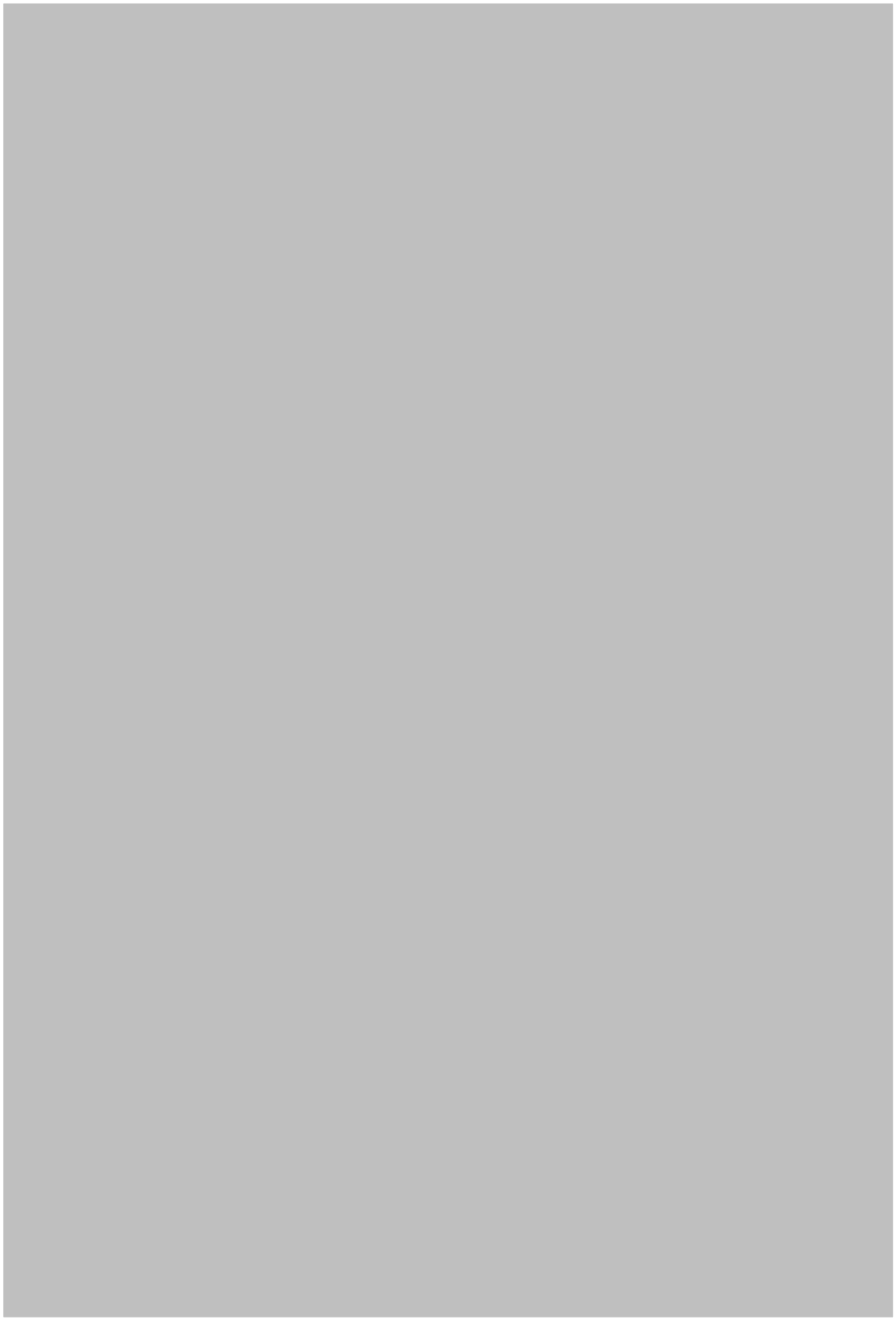
ADJOURNED **[10.49 am]**

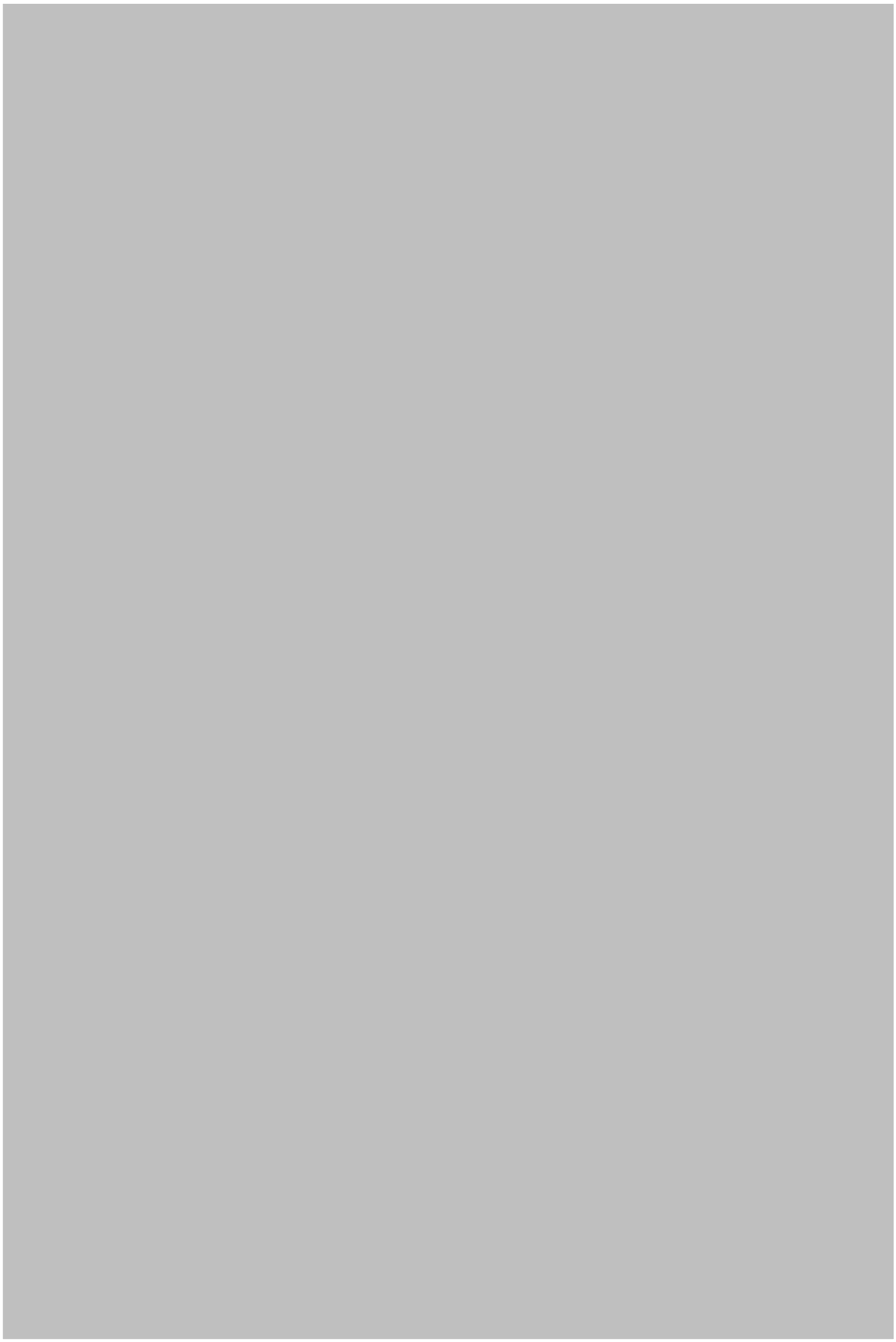
RESUMED **[11.11 am]**

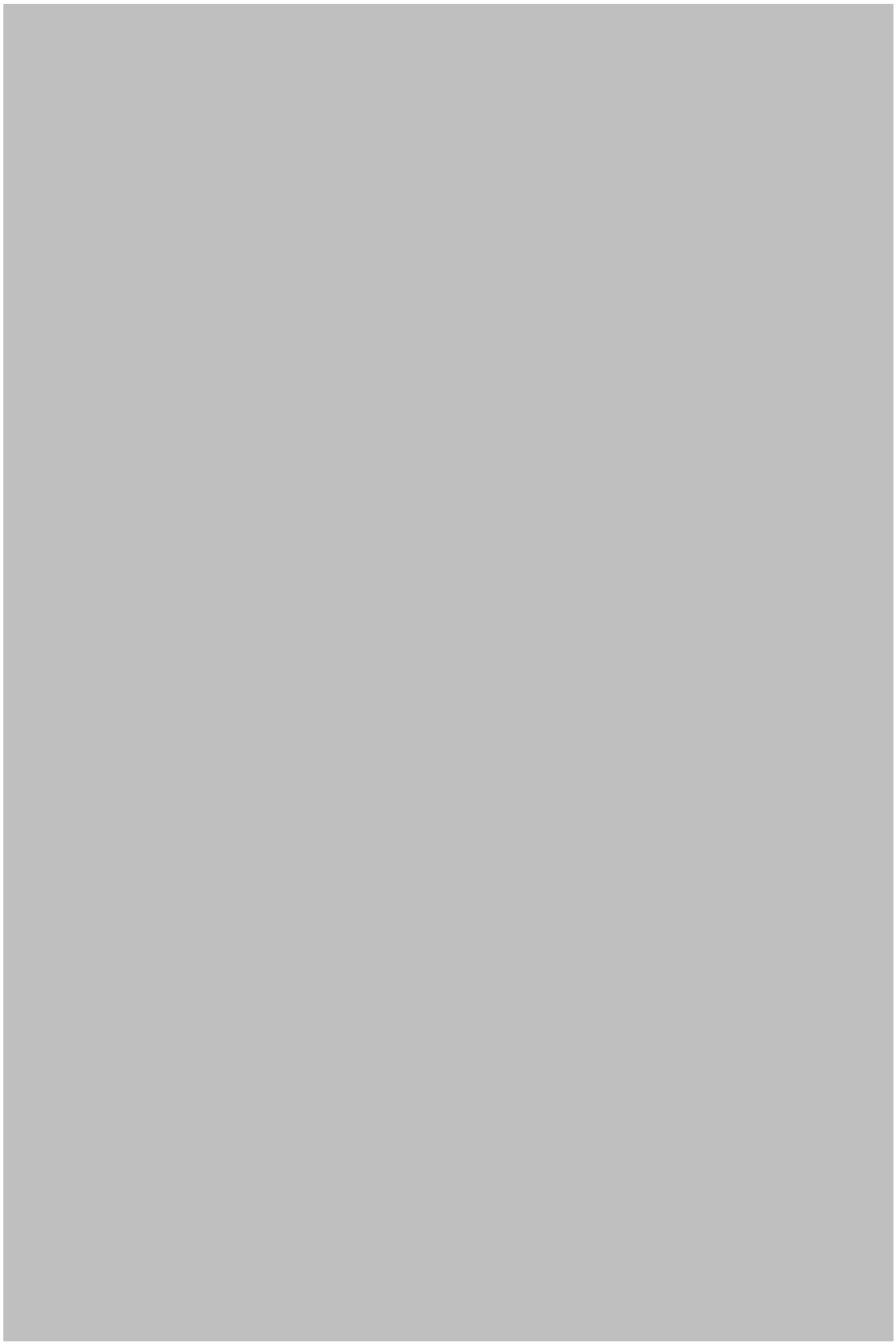
[redacted]

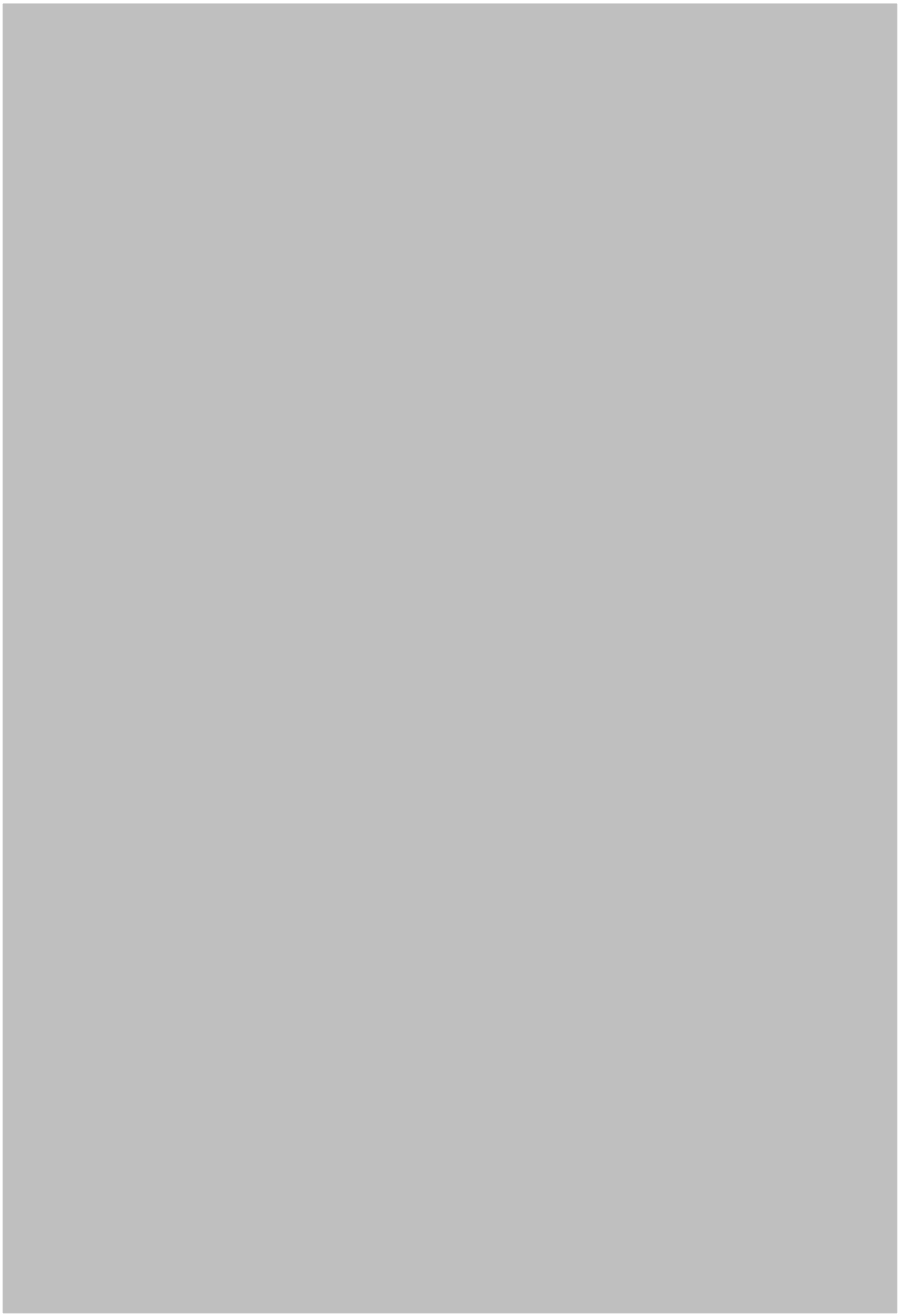
BRETT CHARLES McDERMOTT, AFFIRMED **[11.11 am]**

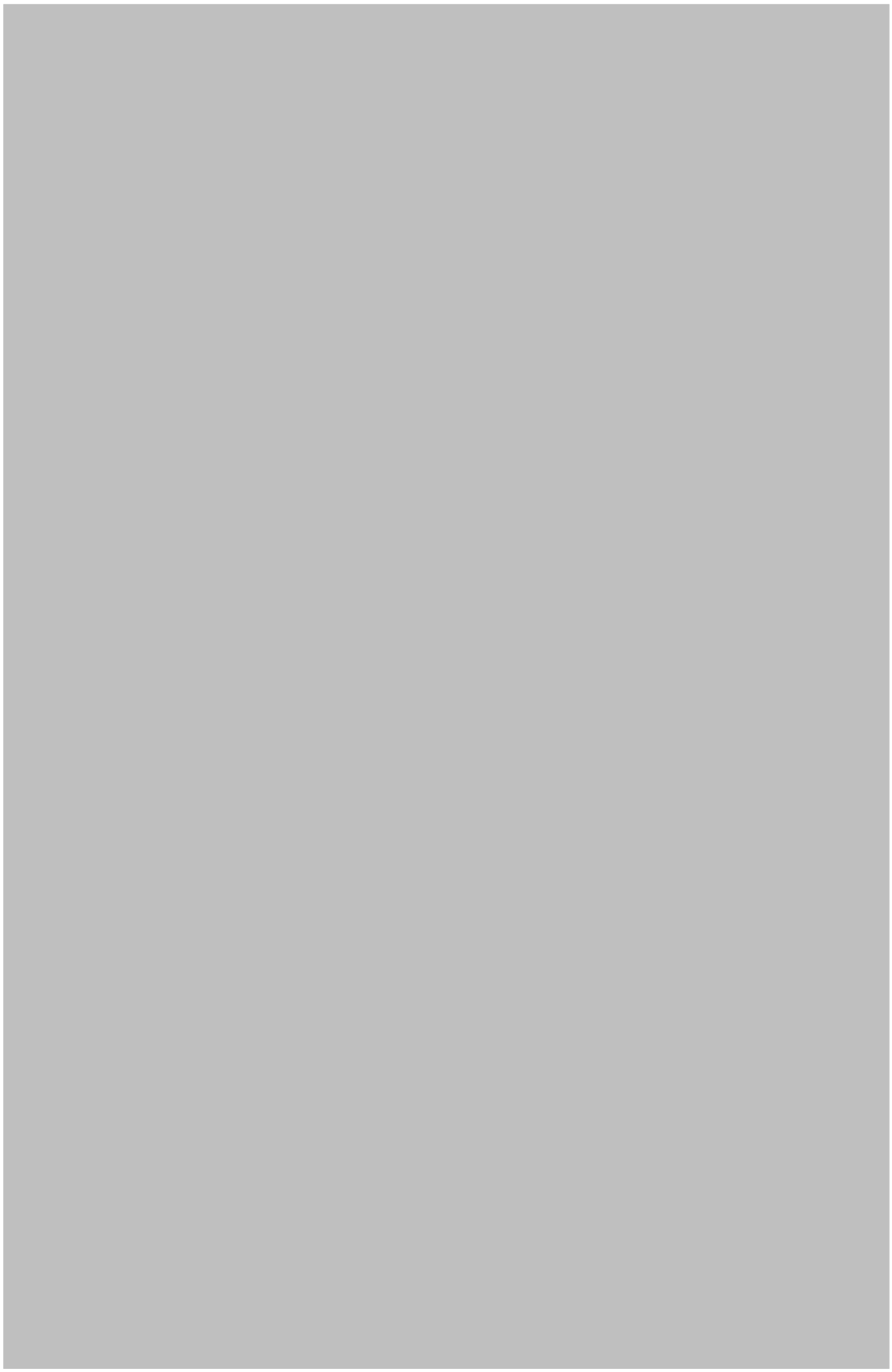
[redacted]

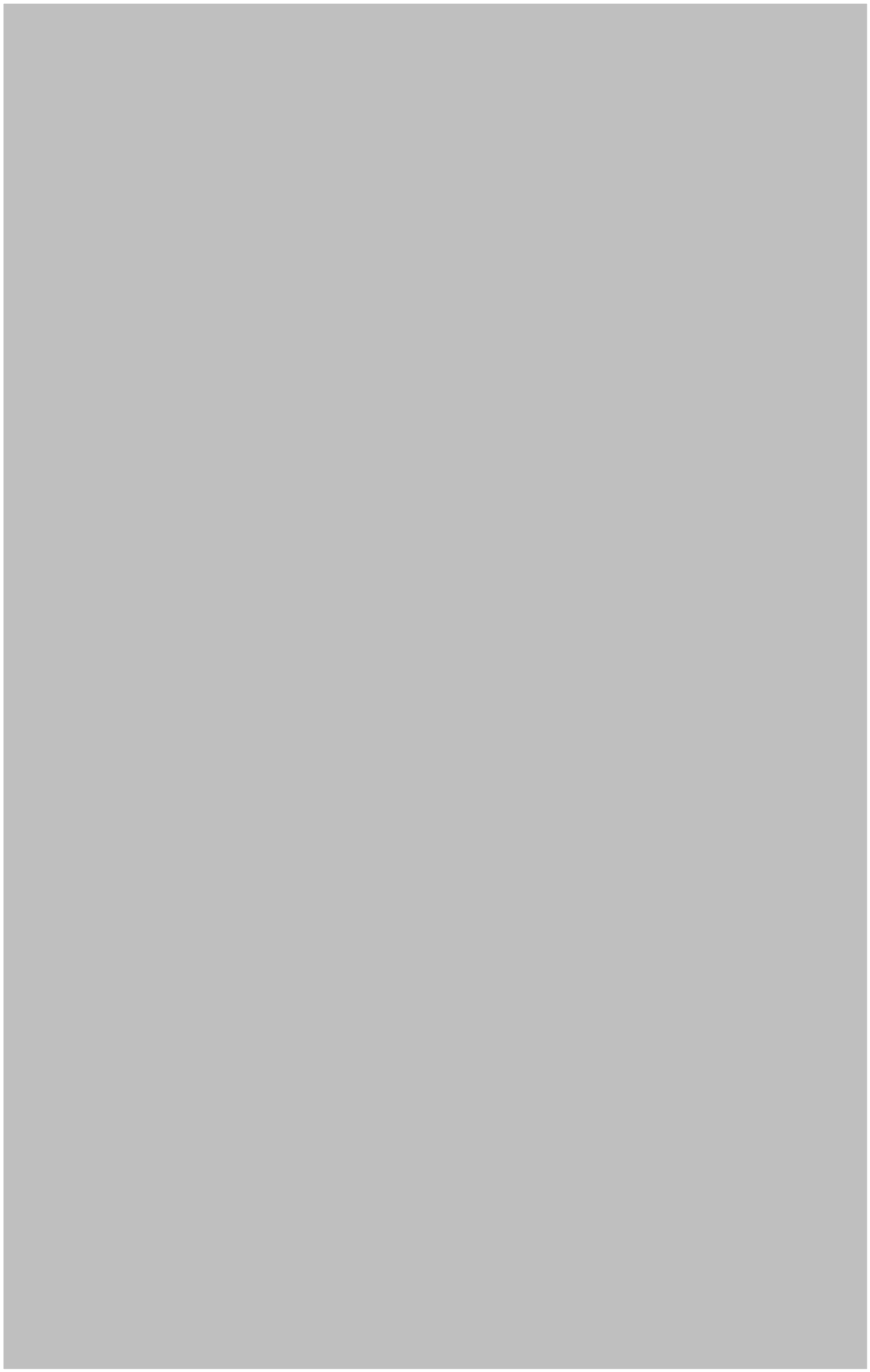


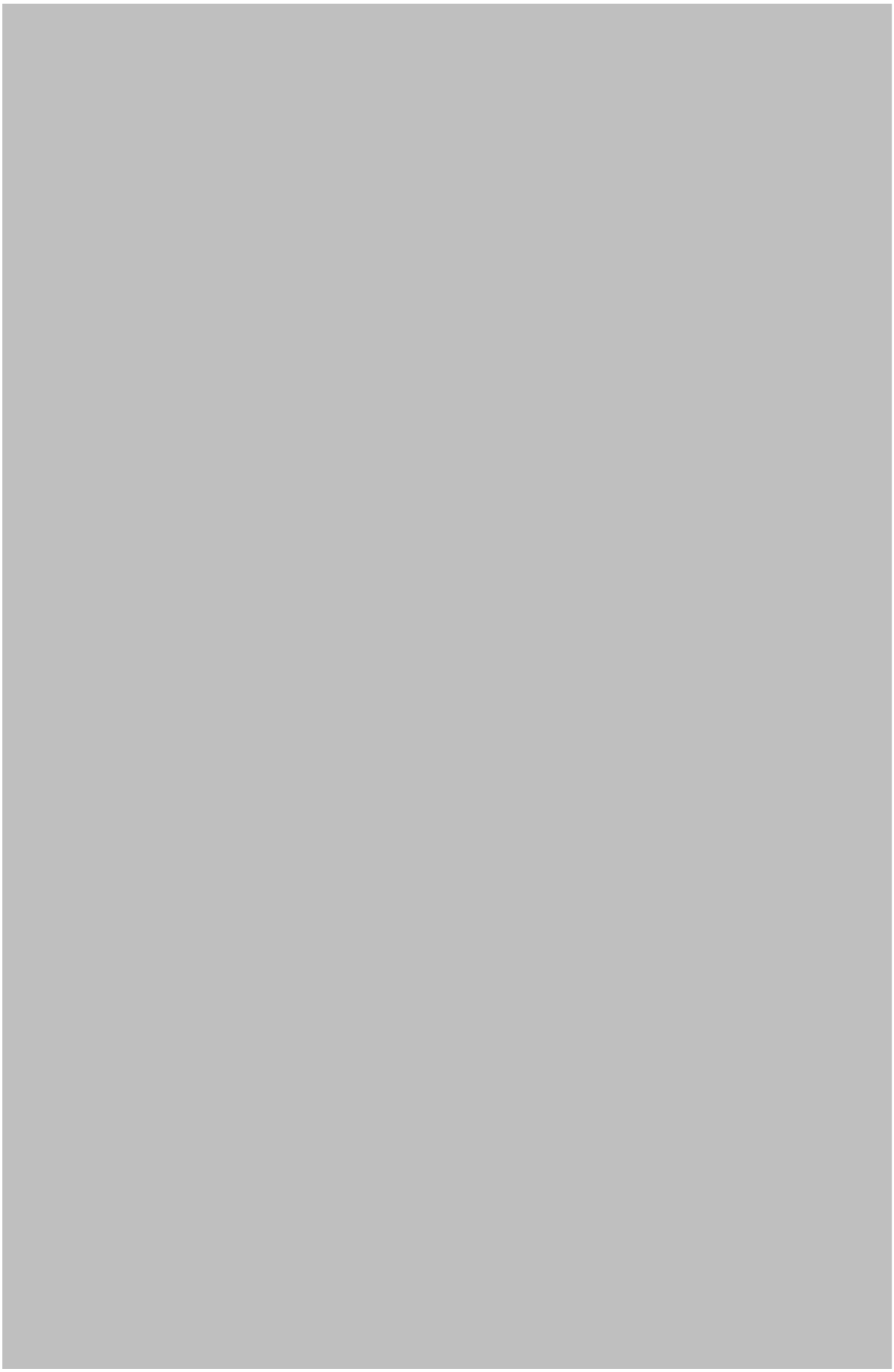


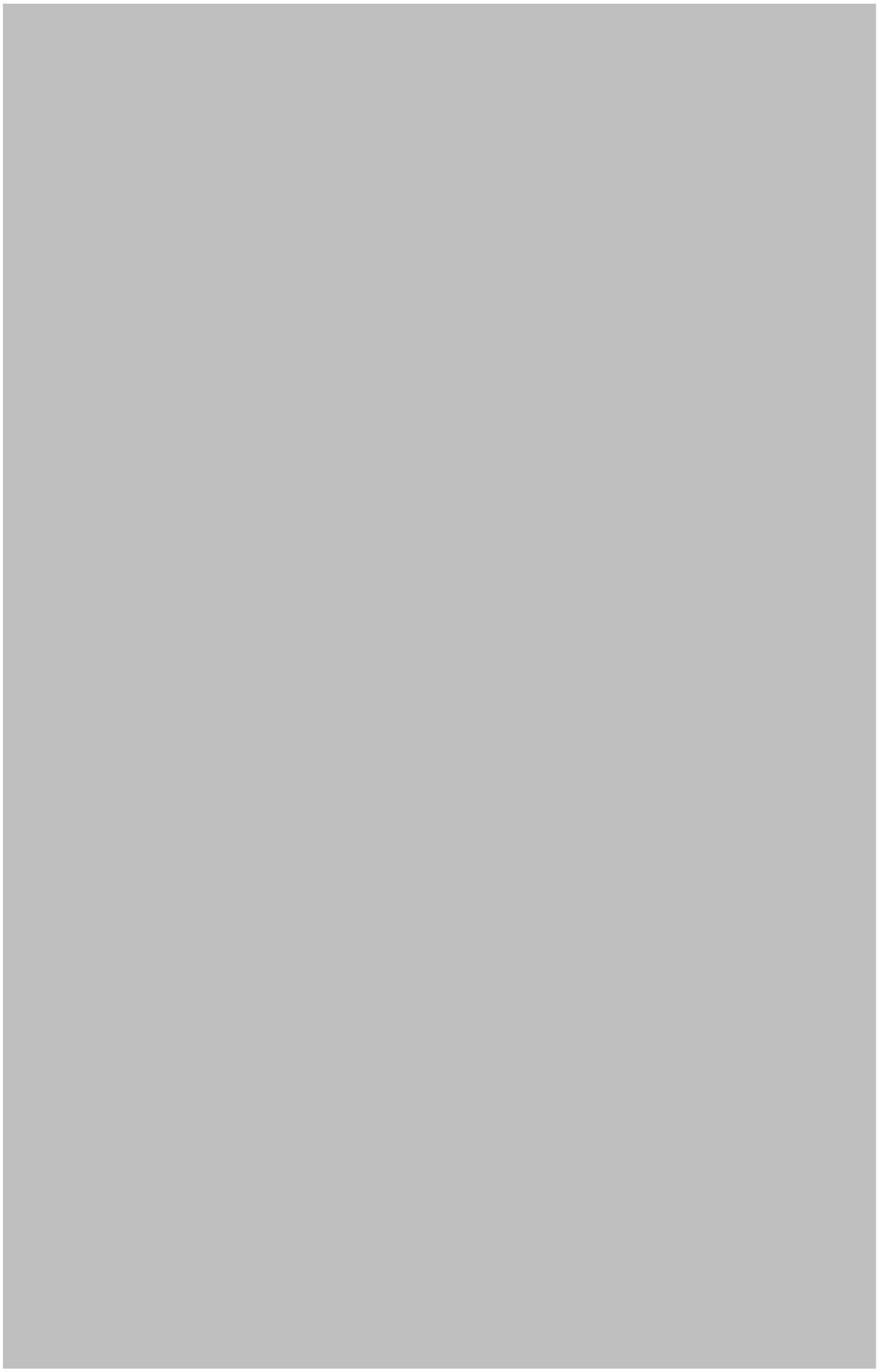


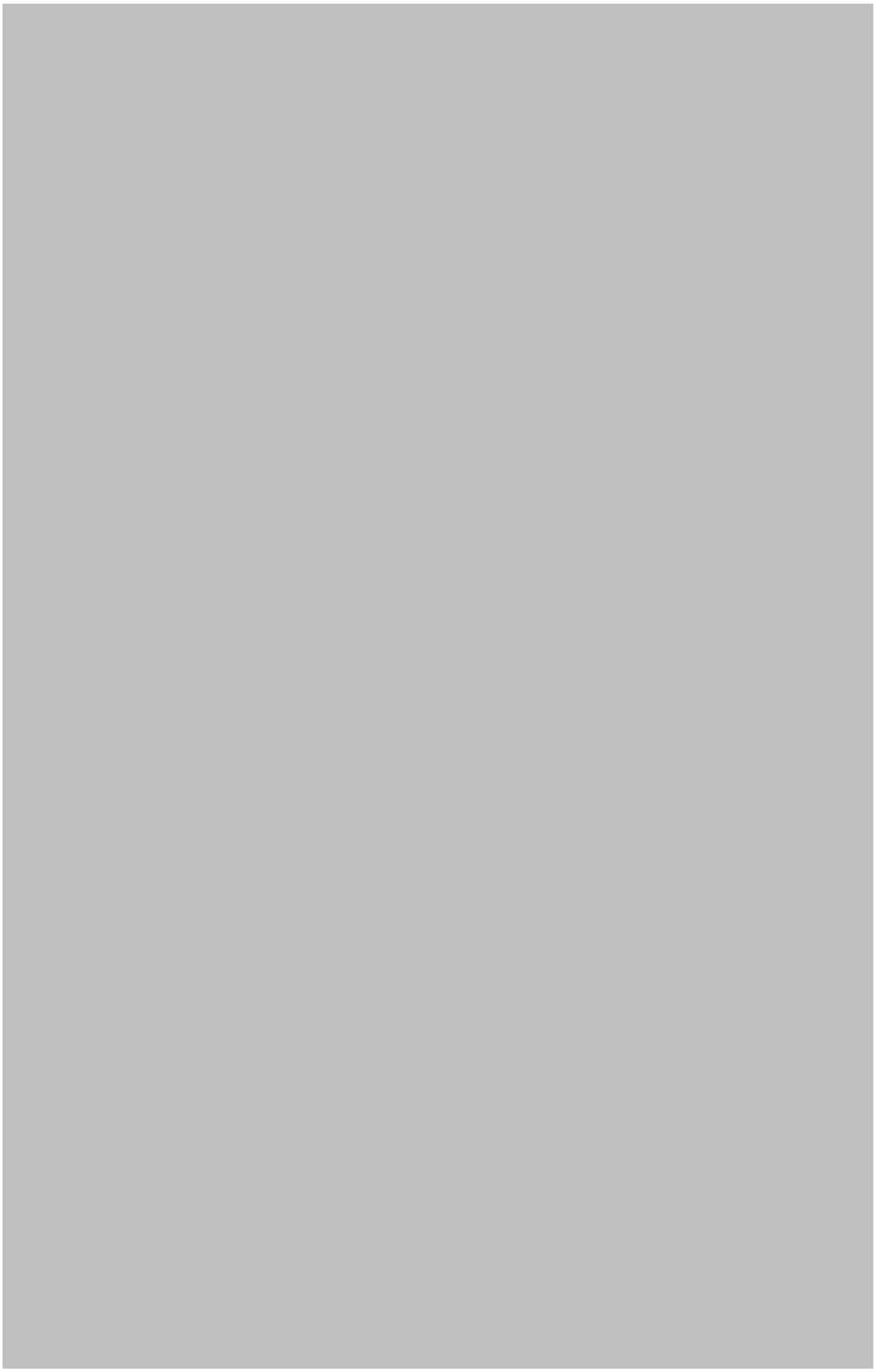


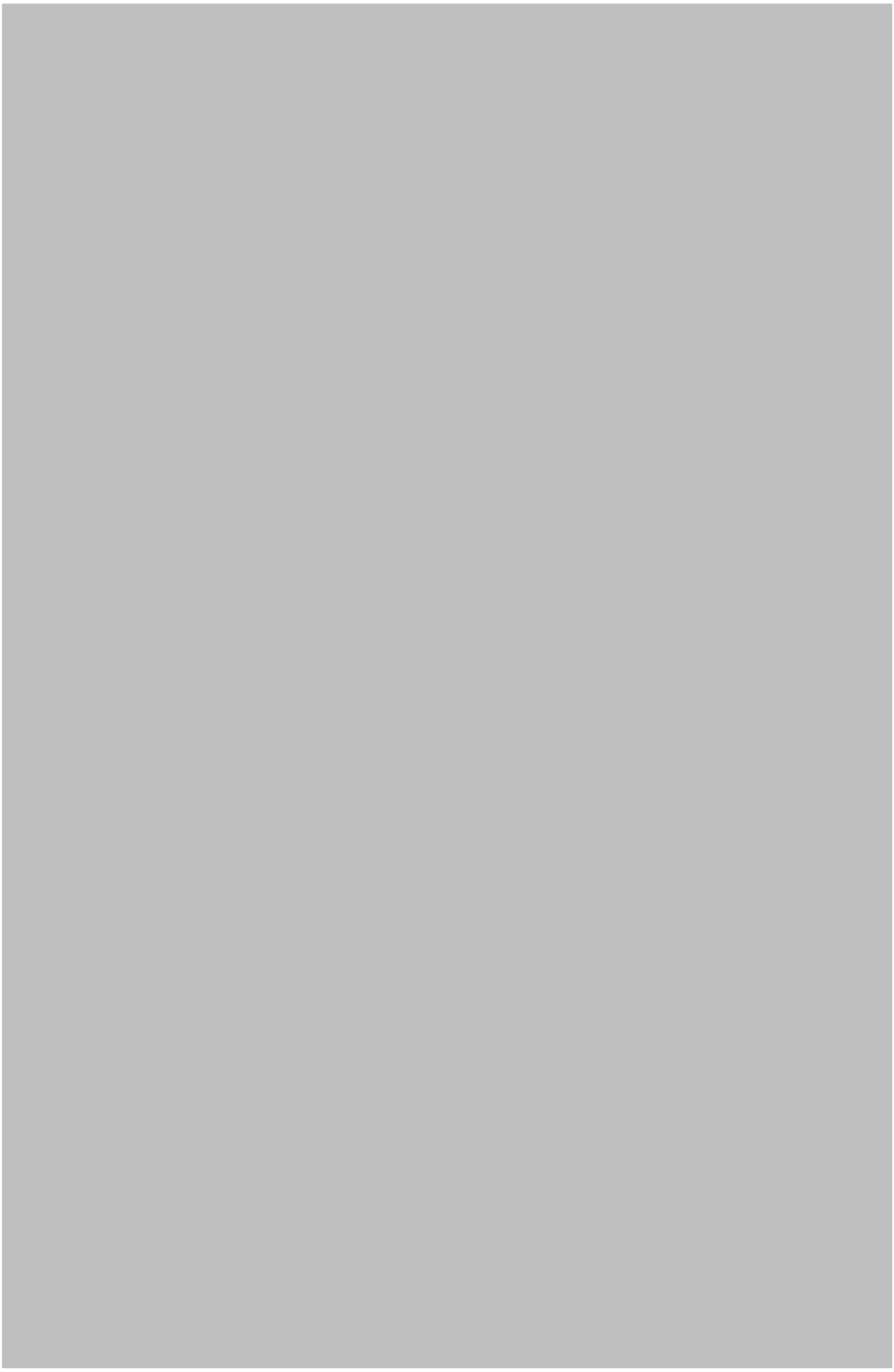


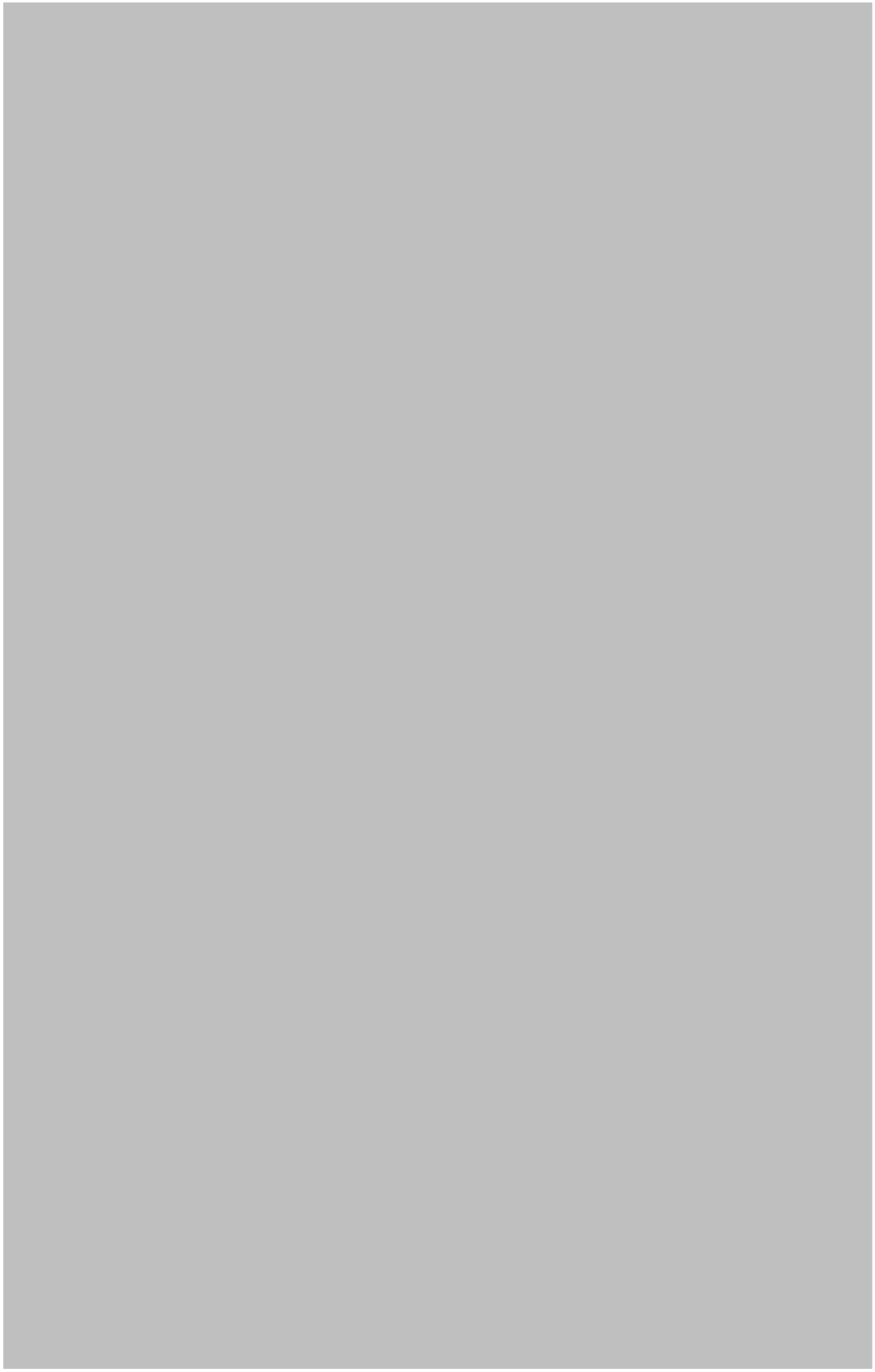


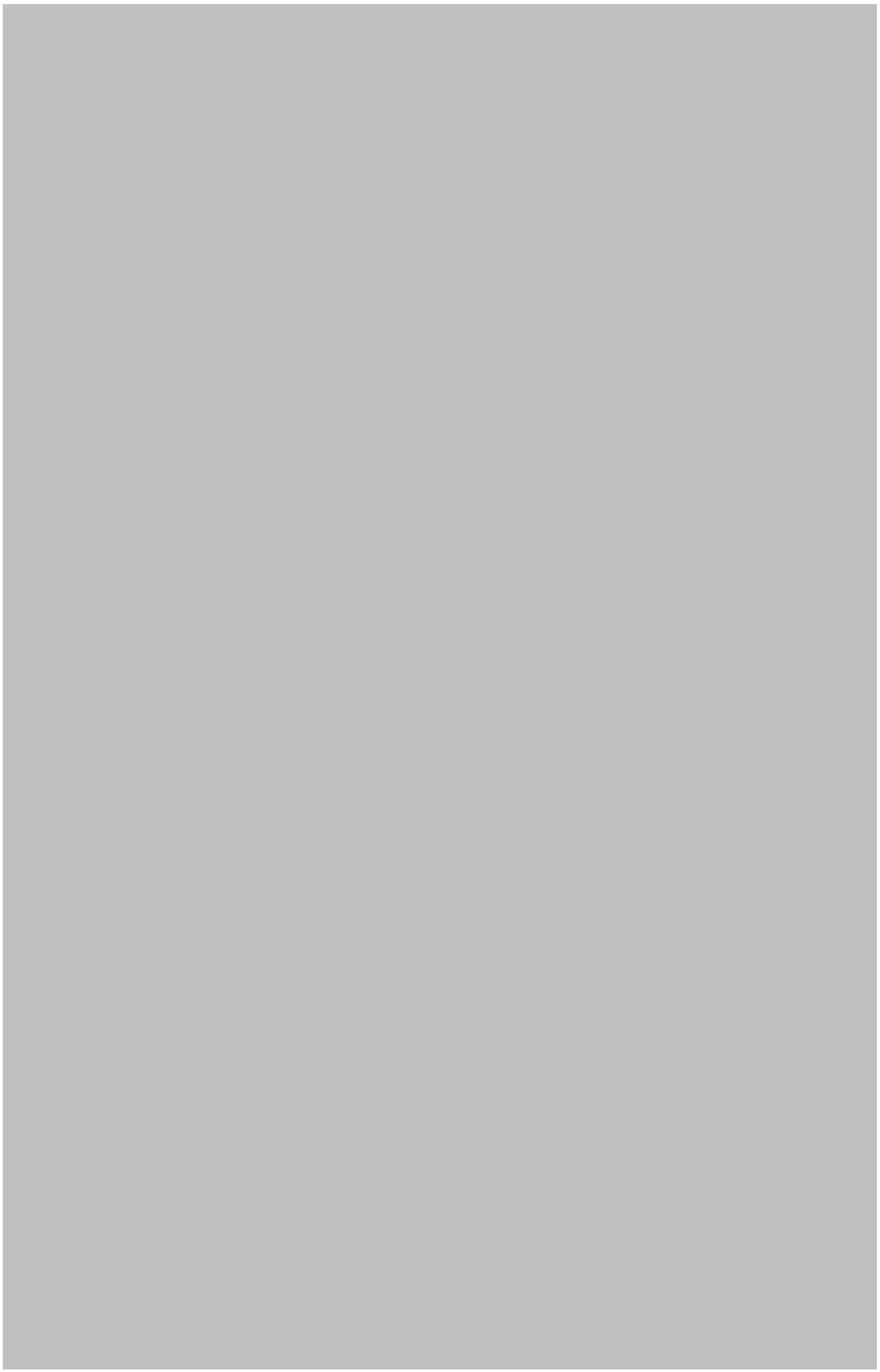


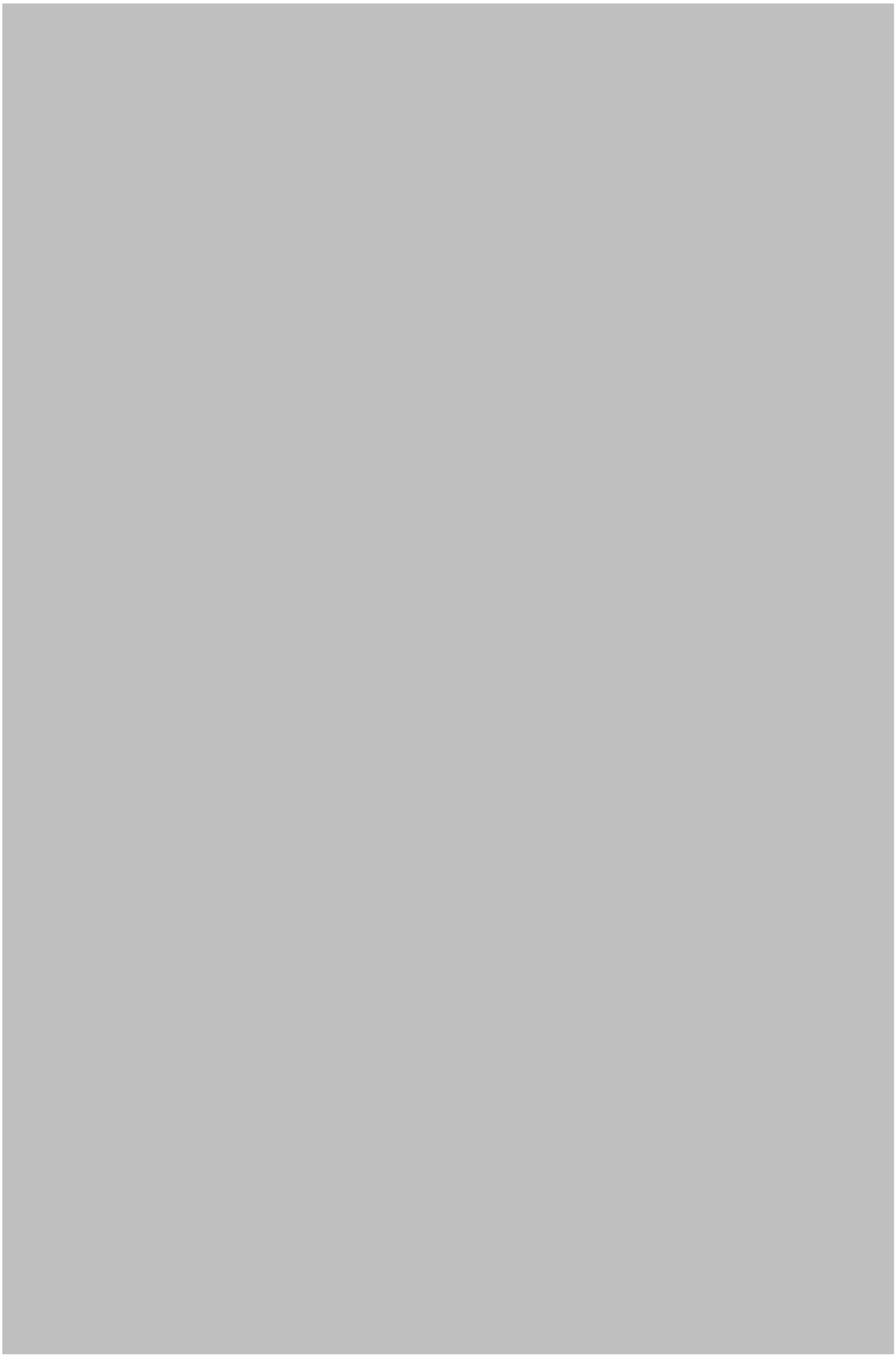


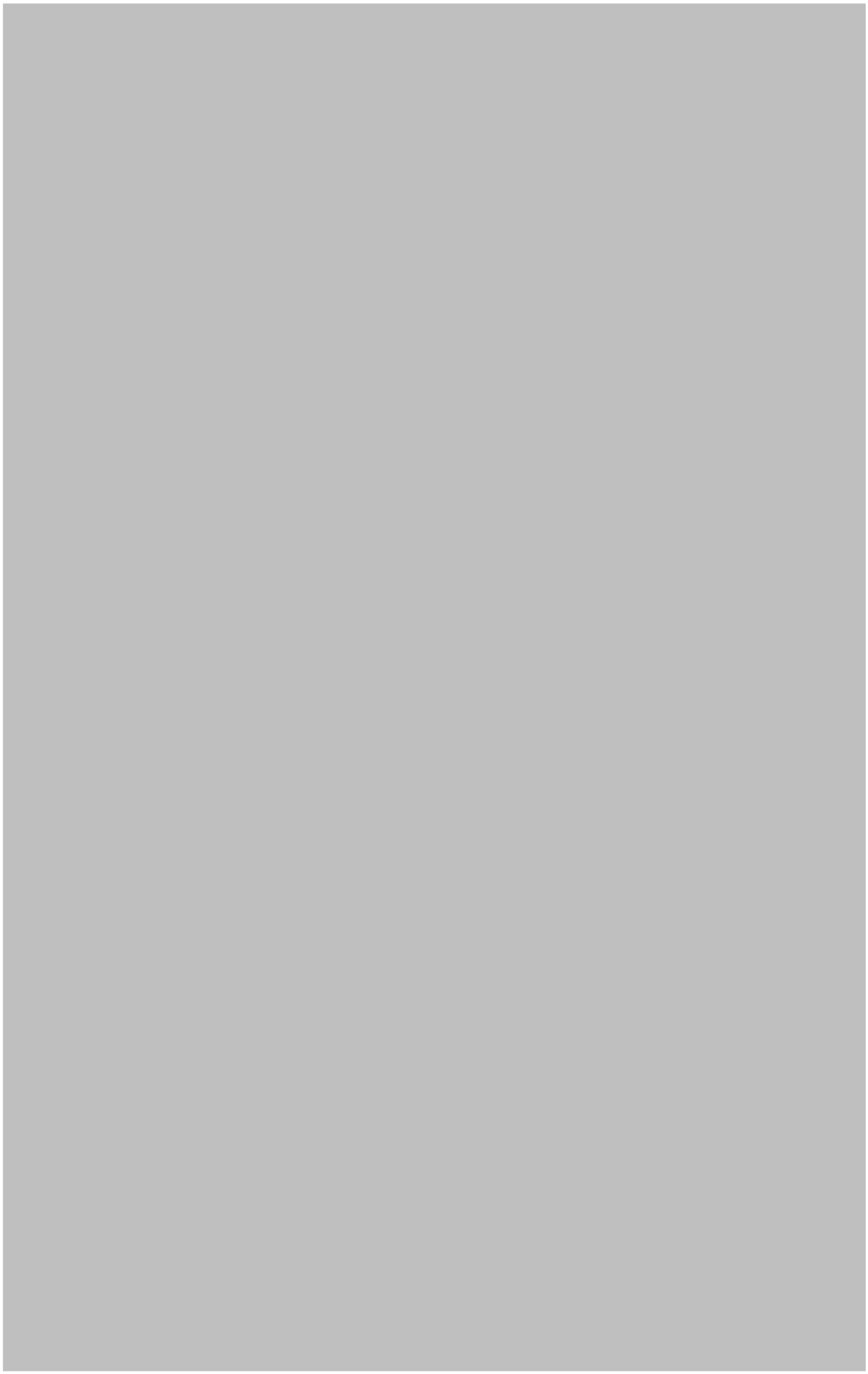


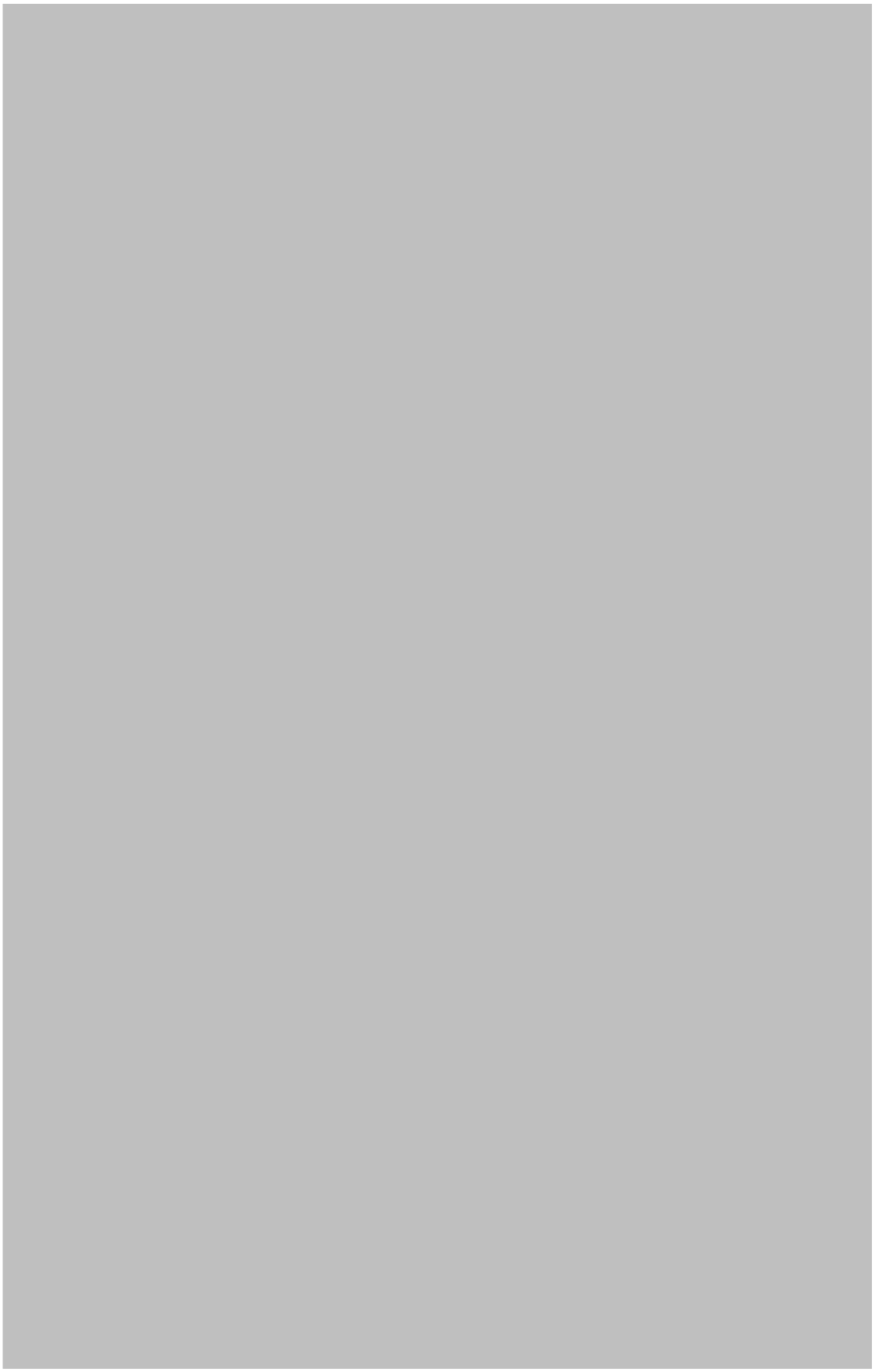


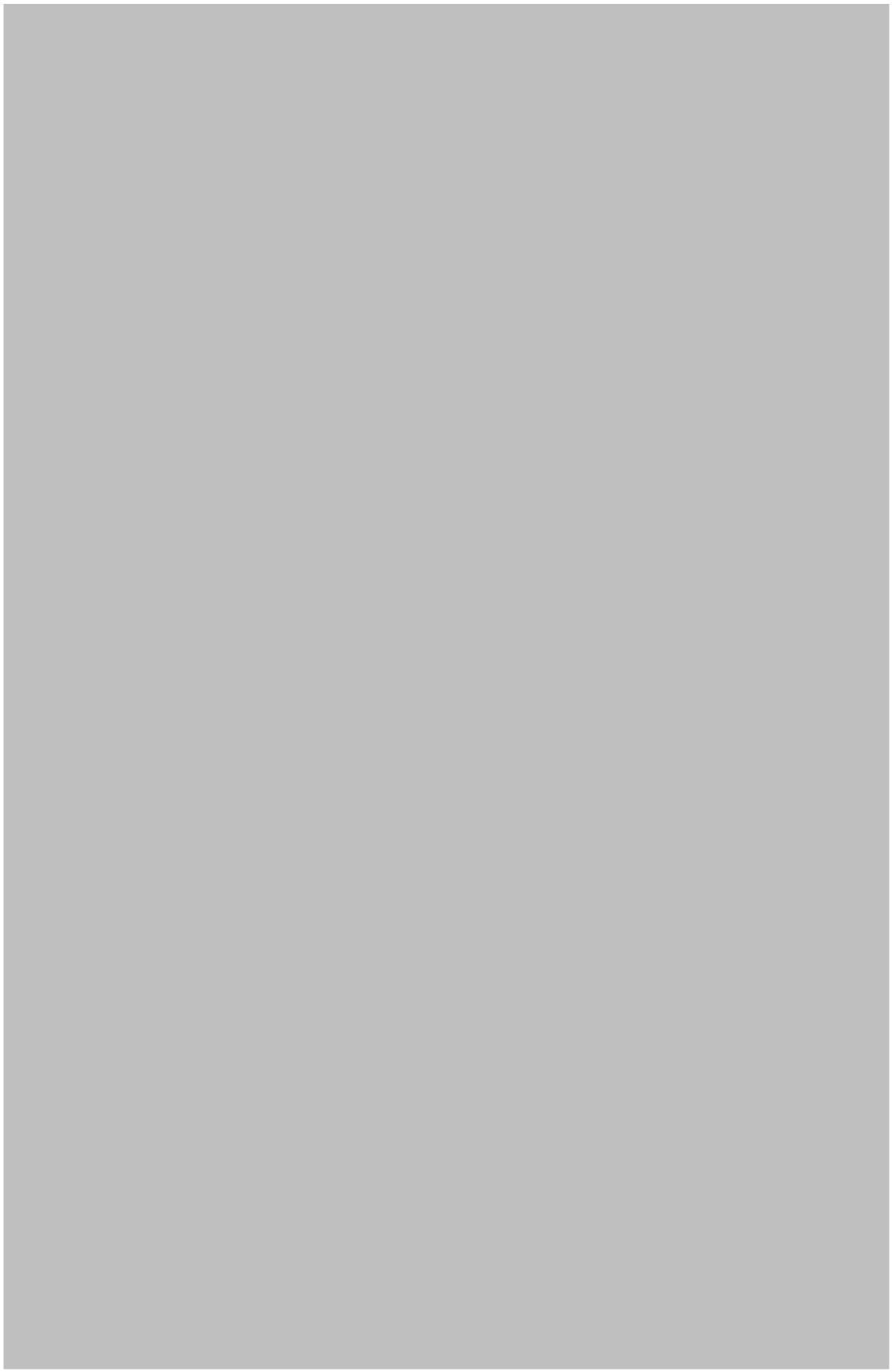


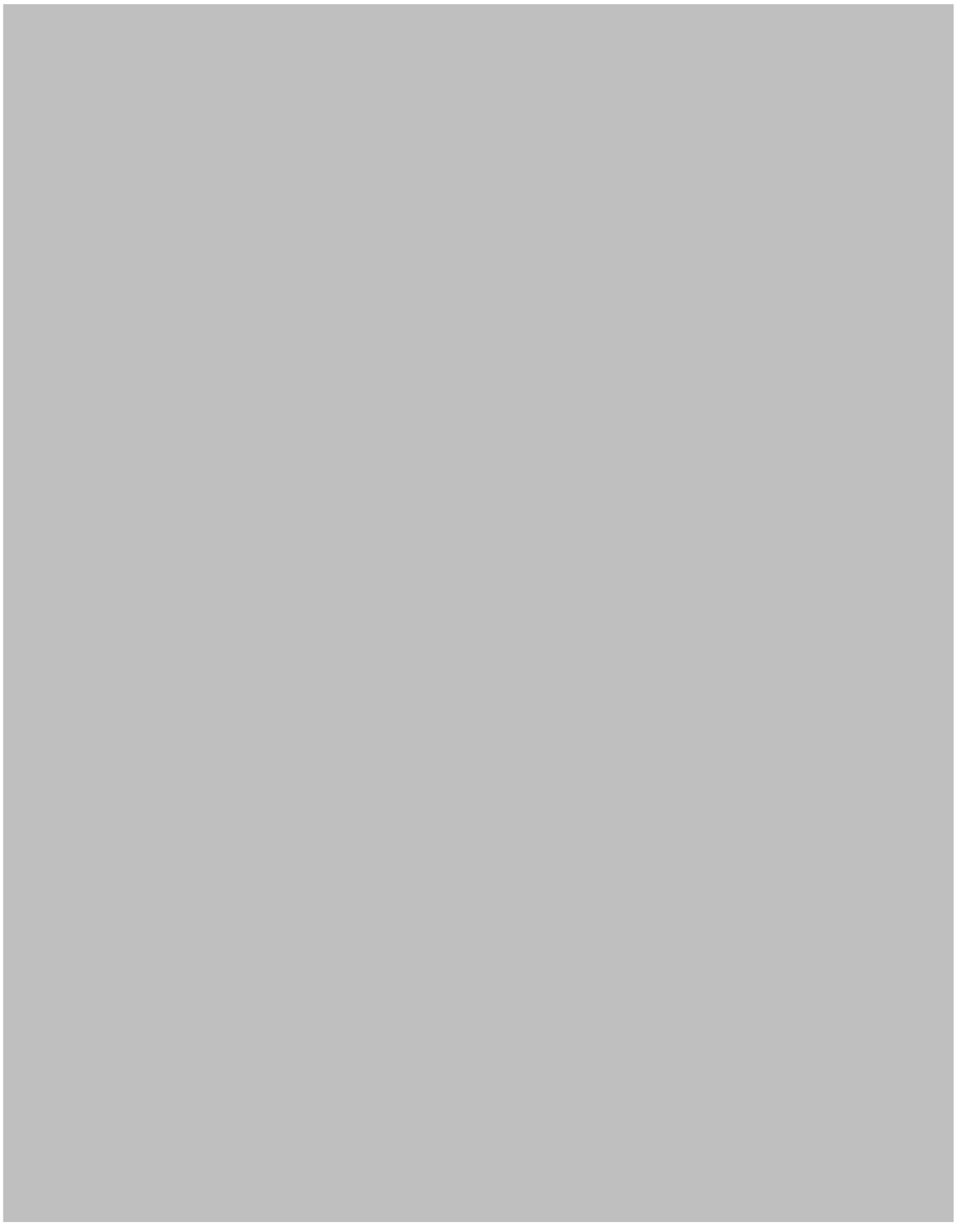












EXAMINATION BY MS MUIR **[12.15 pm]**

MS MUIR: Professor McDermott, if we could go to paragraph 151, which is at point 027 of your statement. While we're waiting for the screen to come up, in this paragraph, you say that you were mindful that the closure of the Barrett Centre was

an unusual circumstance that required special consideration and responsiveness of the child and youth mental health sector. I want to ask you some questions about that. Do you mean by this statement that it was unusual because it was the closure of an entire facility, almost – you could describe it as the emptying out of a facility?---Yes.

Yes. So would you consider that a mammoth task?---Yes.

And would you consider, insofar as you're looking at transitioning patients out in those circumstances, unprecedented in Queensland?---It's unprecedented to – to my knowledge. I've been in Queensland since about 2001, so to my knowledge it's unprecedented.

So should there have been, in your opinion, some – any particular special guidelines or plans established before such a task was even undertaken?---Yes.

And – for example, would you say things such as looking at the lead time that was required?---Yes.

Would you also think – and we heard some evidence this morning from Professor Crompton about the procedure for Metro South Mental Health Services and their procedure for inter-district transfer, and that document describes it being well-established that mental health consumers are at an increased risk of harm during periods of transition. Would you agree with that statement?---Yes.

And there's a number of principles that apply, and one of the principles set out, at least in the Metro South Mental Health Services document, was that some transfers of consumer care may require a shared care arrangement for a period of time?---That's correct.

So would that be something that you would have thought should have been considered or could have been considered in the instance of the planning of the transitioning or closing of the Barrett Centre?---For complex cases, that's quite an established and well-used principle.

Now, are you able to also, perhaps, tell the Commissioner any other types of guidelines or plans that you should have – that you would think ought to have been at least considered when planning the transition of the patients out, pending the closure?---The most important thing that I suggest about transition is time, and I would have thought a frame from the announcement of the closure to transition of about six months would have been very – well, would have been adequate. During this time, you could have achieved two things. You could have potentially discharged those who would have been within the six month period. So their care experience would have been unchanged. But for the more complex people, you could have, if you like, interdigitated with a service that was to take up that person and you could have a period shared care, and is – relationships established with the

next therapy team prior to leaving the first place of care. So that's a fairly – fairly established principle.

Thank you, Professor McDermott. If I could now go to paragraph 117 of your statement, which is .195, now, I don't need to take you to the exhibit at the moment, but you make reference to a document titled Transition Services Planning, and this document is dated 27 November 2013, and states that you're aiming to secure two or three beds for extended treatment and rehabilitation from February 2014 at the Mater inpatient unit; do you agree?---That's correct.

Are you able to say how many beds actually became available after February 2014?---That's somewhat difficult, because there was no formal agreement that it was going to be two or going to be three or going to be four. It was a – sort of, an as-needs circumstance. So we, at no stage, said these two beds are for Barrett Adolescent patients. What we said was, you know, beds are available if the need arises.

So is it your evidence that beds were available before February 2014?---If I had been approached and asked for beds, beds would have been available before then.

But you're not suggesting you were approached?---I'm suggesting because it didn't happen, I probably wasn't approached.

Now, if we could go to paragraph 142 of your statement, which is .026, I just want to ask you you've – your evidence is, isn't it, that you have some concerns about adolescents staying longer than usual in an acute unit - - -?---That's correct.

- - - such as the acute unit at the Mater when it was called the Mater. I just want to ask you some general questions about your concerns, and before I do I'd like to ask you what do you know about the subacute beds at the Lady Cilento?---Almost nothing.

Do you know anything about them at all? When you say almost nothing, then does that mean there's something?---I'll qualify my statement to – I'll qualify my statement to a nothing.

Do you have a general concern about the idea or the concept of the location of subacute beds for an extended six-month stay? Do you have any concerns at all about their location in an acute ward?---Yes.

Are you able to tell the Commission what those concerns are?---Sure, sure. I think acute wards are very, very unusual places. They are places where, you know, your bedroom is different, your kitchen is different, your bathroom is different, you're living with different people. Your nurses change shift every eight hours or 10 hours. There's a range of professionals that come and go. It's very highly-ordered, but unusual to the, kind of, normal ecology of a family. Not only that, individuals come in, sometimes daily, who are highly distressed, who might have cut themselves off

and, really, in a very, kind of, a – you know, damaging and profound way. They might have taken a major overdose. There's a – they might have been distressed because of recent notification of sexual or physical abuse. But they are places which are often not settled, often there is noise, often there is violence. There is quite a lot of literature about staff, for instance, being assaulted on acute inpatient wards. These are places that I don't think are places for rehabilitation and we want to step down someone to a home-like environment. So, generally speaking, I think that inpatient ward hospital base for great acuity, stepping down into highly-scaffolded but, you know, quite home-like environment as the second step, and I would encourage the Commissioner – I'm allowed to speak to you directly – there is a – there is a five-bed residential unit called ADAWS. It's a drug and alcohol residential unit for – in Clarence Street in Woolloongabba, and it has a wonderful, home-like environment for five adolescents, within reach of mental health professionals. So it is possible to have this step-down, home-like experience that's an intermediate between home and inpatient unit.

So just taking you back again to the – your concerns about the location – I think, in a sense, you're saying in a medicalised environment – an extended stay in a hospital, is that one of your concerns, at least?---Yes.

Do you think though, perhaps, could – would your concerns be diminished somewhat if there were separate rooms available to each of the young people that were admitted and they had some privacy and they weren't necessarily mixing with the acute patients on the ward?---You can try to make the experiences more and more and more homelike and the more you achieve that the less my concerns but at the end of the day you will always be in a large hospital and all that goes with that. But at the end of the day you still come and go on leave to a hospital. You go past ambulances and all this kind of thing so – but if you can achieve a homelike environment then my concerns are somewhat assuaged.

When you talk about Step Down and I think you referred to the ADAWS as an example of an example of a nice home environment but Step Down is one step down though isn't this – it's a step down from the type of – at least medium term need for some more extensive care that a young persons might require before they then take that next step, for example, to a youth resi. Is there a level up from Step Down?---So if I can slightly paraphrase I think you've just asked me is there a place for more extended care.

Yes?---Well, I think the difficulty the Commission is going to have – and again, I don't mean to put words in anyone's mouth – I think people vary in their opinion about the relative merit of extended care and how much we need. I have a strong suspicion in a State the size of Queensland, especially southeast Queensland, that there will be a constant need for a very small number of beds probably in the order of, you know, three to five so a small number of individuals who have such, you know, profound levels of need that they need more than a Step Down and they shouldn't be in an inpatient. So for instance, I mean, as an example and in no sense giving the name of anybody we have had individuals who have had 30 to 40 serious

self-harm episodes in a 12 month period. Now, that's an incredibly troubled individual who shouldn't be in an inpatient unit. In both directions we should protect other inpatients from the influence of that person and then from people coming and going who would be difficult to manage in a Step Down. Now, the question is whether they could be managed in a residential or they need an inpatient extended stay facility.

So when you talk about, I guess, someone that's had continued episodes of self-harm and if those young people were accessing acute wards and your examples relate to a number of readmissions to acute wards and that would give you some concern, I imagine – repeated admissions?---Yes.

So for that particular patient would you speak in language like stabilisation and in some cases would you agree that stabilisation could take at least six months?---We would – I mean, I think stabilisation is a – is a very reasonable term. They need almost, you know, daily interaction and the attempt is to stop a revolving door of self-harm/admission, self-harm/admission. And the way to do that is potentially to admit them and it is those individuals – if you added up their days of recurrent inpatient care easily adds up to three to six months. So they're using that amount already and to put them in a – a care situation for three to six months I think is reasonable.

And statistically, though, I imagine that you're not in a position, as you sit in the witness box today, to assist with any assessment of the numbers of young people that fall within that category?---Those - - -

Or are you, Professor McDermott?---Those numbers are – are actually obtainable. Okay. I mean, they're clearly not in my head but the, you know, Consumer Integrated Mental Health database – CIMHA – could actually extract individuals who are adolescents who have multiple stays and I think that would be an interesting data to look at. That – that data is available.

Thank you, Professor McDermott. Commissioner, I am conscious of the time and I have certainly exceeded my time allowance, however, I can say I had discussions with other counsel and it may be that a lot of the questions I'm asking will cover their time. So in other words I think I'm being in some cases given some time or lent some time.

COMMISSIONER WILSON: This morning hasn't run as smoothly as one might hope so I've not said anything about the time. How much longer do you think you'll be, Ms Muir?

MS MUIR: Commissioner, I could still be another 20 minutes. I'm happy to look at my questions and the ones that – I'm happy to - - -

COMMISSIONER WILSON: Well, I think that you should keep going. Do it as expeditiously as you reasonably can.

MS MUIR: I understand that Professor Groves is – Dr Groves is giving evidence this afternoon and - - -

COMMISSIONER WILSON: Well, I do want to finish one witness. I'm sure Professor McDermott would like to get away. If needs be, if no one objects I'll sit through the lunch break to finish it so that he can get away. Would that suit you, Professor?---Well, I'd you didn't miss your lunch, Commissioner.

I think I'll survive?---I'll – I'll survive with you.

Alright.

MS McMILLAN: It's a conditional gift of time for Counsel Assisting.

MS WILSON: Yes, it's a lend. We want it back.

MS MUIR: Now, at paragraph 126 of your statement which is point 023, you explained that you weren't involved in reference or planning groups looking at new services to adolescents with severe mental health issues but that you understand a few of the available services. So I just wanted to ask you a couple of questions about what you know about these options such as the YPETRIE or the Greenslopes youth residential resi. Do you know much about that service?---Yes.

And do you have an opinion about the service?---I – I think that in principle it's an extremely good idea. I think, again, it's got this kind of element of home-likeness. It's more ecologically appropriate to adolescents. It's inner-city enough but not close enough to be near our, you know, sort of dangerous precincts but is inner-city enough to be close to the Lady Cilento Hospital and other major service provides. I'm aware that it has a – a very senior and well-respected manager of the overarching organisation and I think they employed a very senior former child clinician as the residential manager so in principle I think it's a very good idea.

And have you heard then of the Assertive Mobile Youth Outreach Services - - -?---Yeah.

- - - or AMYOS?---Yeah. Yes.

And do you understand that this service began operating in July 2014 in certain locations?---Yeah.

Have you had any firsthand experience with this service?---I was aware of some of the presentations, if you like, of the early model of care and I am aware in Townsville where I am currently – we have two AMYOS workers.

And, Professor McDermott, how do you see – or do you see the benefits of such a service insofar as the cohort of Barrett Centre patients are concerned and their – that type of cohort being able to access such a service? Is that a good thing in your

opinion?---I think it's an extremely good thing. I think the mobile capacity has been sorely missing in child and youth mental health. I think that in child and youth mental health, often if a patient didn't turn up then that was seen as not terribly problematic. This type of facility means that they can go to the individual. They can go to their home or go to their street or go and actually find them and be proactive and hopefully extend the therapeutic experience. So I think mobility and youth are a very good combination.

Would there be any types of conditions or perhaps even family circumstances that you perceive may not be perhaps suitable to such a service. So perhaps, for example, if there was dysfunction in the family would you see that the AMYOS service would be less useful?---I think the AYMOS service need to have expertise in family therapy and understanding families and understanding family dysfunction. And at low levels of kind of crises in families they actually should be very good at that. I don't foresee that they would be doing extensive long term family therapy because that would take a lot of time. But I see that – I mean, one of the things about child and youth mental health is you actually have to be credible at working with families. The one group that I would be concerned about would be individuals who are particularly violent. Clearly, mobility and outreach puts you outside the clinic, outside the hospital in potentially dangerous situations. Now, luckily we have CYFOS which is the Youth Forensic Outreach Service, so that group is covered.

So looking at these services, do you think that the availability of some of these services goes some way towards filling the gap left by the closure of the Barrett Centre?---Yes, I do.

Do you think they go all the way?---Well, my caveat around this is that Queensland and Australia general has, in my opinion, an extremely poor record in effective evaluation. So my overarching concern is that these units would not be evaluated, these interesting service initiatives will not be evaluated like, unfortunately, the Barrett Adolescent Centre was not evaluated. And so in terms of the true efficacy of these services, the effectiveness, we are in danger of never knowing. And there is a mistaken belief amongst many health bureaucrats that things like key performance indicators in any sense tell you whether a patient has got better or not. And they don't.

COMMISSIONER WILSON: Professor, are you talking about external evaluation?---Well, I don't particular mind, Commissioner, who does it. But we have no tradition of doing good quality evaluations. So, for instance, I have a strong suspicion that the youth residence and AMYOS will be able to tell you how many patients they've seen, how often they've seen them, possibly what was wrong with them. But if the typical, you know, service model persists we will not know if their presenting problems actually improved.

Thank you.

MS MUIR: I did want to ask you a question on this, I guess, evaluation. And when you use that expression, you said we're no good at evaluation. Do you mean outcome research? Is that the context that you're using?---I mean – okay. Thank you for that qualification. We are very poor at looking at the, you know, clinical effectiveness of our interventions.

Who's we?---Well, every – well, we are every mental health service that I've worked for in Australia.

I asked we because I know in your statement you make a comment about your concern about if a Barrett Centre replacement is tendered out to a non-government organisation that you consider such organisations have a limited track record for conducting outcome research. So my question about that was going to be is it any better than the research that you have – the outcome research that's done within other – within government departments?---Okay. Government departments collect outcome measures. They don't - - -

But your point is the evaluation?---No, no. My point is that these outcome measures are very rarely analysed in a credible way. And there is no iterative process where you collect outcome measures, you look to see if you're doing a good job, you keep doing more of what's good, you change and reform what's bad and you have an ongoing iterative process. Queensland – you know, and I include myself in this. Although, the – although, my unit research more than any others probably arguably. But we're very bad at this and I think that, you know, some of the things at this Commission would be much more easily answered if we were actually better at this.

Professor McDermott, if we could go to paragraph 167 of your statement which is at PBM.001.002.030. And this is where you mention national and state principles that you were saying are clearly relevant under the heading Appropriate Model of Care for the Barrett Centre Cohort. And you refer to things such as 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. Now, obviously, the Barrett Centre model didn't provide the least restrictive care or access to services close to home as it was a statewide service. But my question is, would it be preferable for young people to stay at home, for example, in – I'm just picking, a place out west or – without adequate services, or be away from home and receiving care at a place like the Barrett Centre?---Sure. I mean, the – I mean, that's a patient by patient decision. So, for instance, you might be able to provide very high quality services out west with a telepsychiatry model and coalescence of what there is locally. And I was, in fact, a consultant to three towns out west and you could go out there once every three months. You could actually telepsychiatry out there weekly. There are quite comprehensive things you can do. But, clearly, on a case by case basis sometimes that is not enough and they have to come to another service. Now, it's an interesting question about whether they should come to an extended inpatient – sorry, outpatient or, for instance, another model like a residential model and if they need intensity go into a day program which

I, frankly, would prefer for a whole range of reasons. So, you know, it's very hard to answer that question.

And, look, I accept that it has to be on a case by case basis and the reason behind the question is the Commission and perhaps so you can understand, the evidence from – that the Commission receives includes, without identifying at all, a number of statements from families who aren't based in Brisbane or – that say, well, you know, the Queensland Government wants to bring the children closer to their families, but we want our child to get treatment, and she can't get the treatment when she's with us. And so that's why it is – that's why I was interested for your view in relation to that small group that can't get the treatment because of their location, because of the services not being available. And so do you accept that, sometimes, where there's no access to services closer to home, and even if it means the delivery is not in the least restrictive care, that there is a need for a young person to leave home to get some treatment?---There is no doubt in my mind that some people have to leave home to get some form of more intensive treatment experience.

I just wanted to ask you a couple of questions about evidence base. Now, when you look at the appropriate model of care – sorry – when you look at the national and state principles that you say are clearly relevant, such as the delivery of least restrictive care and access to service closer to home, I guess, to most of us, they seem fairly obvious things. But is there an evidence base for – behind these principles?---I mean, absolutely. The evidence base is stronger around individual therapies and what actually is in the therapeutic mix than some of those overarching principles. So, for instance, there would be no meta-analysis of randomised control trials of good access versus poor access. Some of these principles would not have a scientific basis. The scientific basis is much more around therapies. These principles though have, you know, stood the test of four national mental health plans, and – you know, they're – they're generally not disputed by anyone.

If we go to – in your statement, there's a section where you deal with evidence base at – at paragraph 172, you talk about the poor evidence base of many child and adolescent mental health treatment approaches. So – and you stand by that statement, no doubt? You need to speak, Professor McDermott?---Apologies. Yes.

So how could this evidence base be developed or improved?---Okay. The – well, for instance – I mean, we are mandated to collect outcome measurement. We are mandated to collect that at assessment, discharge, and every three months. Now, you know, as a minimum that should not only be collated, it should be analysed and published. There should be publication of not only individual therapies, but systems of care, and, in fact, in the literature now there are, you know, comparative trials between whole systems of care. If you don't do this, you'll actually never be able to answer some of the, really, most pertinent questions. So, for instance, if someone is admitted for deliberate self-harm the current system can't tell you other than anecdote whether their self-harming improved by that admission or was still improved at six months, 12 months and five years later. These are, really, not difficult tasks, but they're philosophical changes. There is a feeling amongst many

health people that KPIs are, you know, what you actually need to collect. So, for instance, we have a KPI called a 28-day readmission rate. That tells you if patients are readmitted within 28 days or not and there is an imputation that if they're admitted more than a certain level then your service is not doing a very good job. What we don't collect is by the way, you're admitted for depression, and is your depression better? We actually don't collect that. You know – you know, if you're admitted for, you know, command hallucinations, you know, are they actually improved? I mean, there actually is one measure for that that's very rarely analysed, but it's highly subjective and it's probably not a good measure. So, you know, if – in the next generation of Queensland Health, I would actually like it to be able to stand up and say well, the key presenting complaints to our services are actually improving. I don't think that's a big ask.

Is one of the difficulties with measuring condition or improvement of depression is because, as you say, it's very subjective and it is – some of the conditions, when we're just thinking about when you're considering the young people that were admitted to the Barrett Centre is that it would be very difficult to assess recovery in the sense that most of us see it as either completely better or – so if you're saying you're somewhat better or marginally better, are you saying that those sort of statistics are the statistics that should have been – that need to be collected?---I – I will give what I think is a helpful example. In our research after natural disasters, we have submitted a paper that says if you have post-traumatic stress disorder after a natural disaster, at 12 months later you are symptom-free. You also have improved quality of life and you have decreased functional impairment, and your school attendance has improved. Now, we have none of those measures in routine, day-to-day mental health. And we can say at 12 months later your symptoms haven't recurred. We cannot tell that in routine mental health.

Thank you, Professor McDermott. Just while we're on the – been talking about evidence base and – so perhaps I could take you to the study, the – of Dr Ward – well, I'll take a step back. You're aware, aren't you, of a PhD thesis entitled The Long Sleepover, the Lived Experience of Teenagers, Parents and Staff, and an Adolescent Psychiatry Limit?---Yes.

Have you read that thesis?---Yes.

And, Professor McDermott - - -?---I must qualify that answer. I've read it to the point where I believed it was so methodologically problematic that I stopped reading it.

Okay. So to the extent that it's described as a valuable – well, to any extent that it's described as valuable research, what do you say?

COMMISSIONER WILSON: Don't answer that, Doctor. Ms Muir, how can Professor McDermott answer that question? Who described it in that way? What was the standing of the person or persons who describe it in that way? You know, I might describe it that way, but I'm totally inexpert in the field.

MS MUIR: Commissioner, I asked the question because it's described in such a way in the recent discussion paper that has been produced by Children's Health, which deals with subacute beds.

COMMISSIONER WILSON: Well, I think you really need to approach the issue in a different way if you do want to explore the value of the thesis. But Professor McDermott has told you, in effect, that he didn't read it all because he was forming the view that it was problematic in its methodology.

MS MUIR: Commissioner, I've got other questions that I can ask.

COMMISSIONER WILSON: Very well.

MS MUIR: If I could go to document WMS.0021.0001.02748. Now, I just want to ask you some – a few questions about the time around when you gave evidence in the Queensland Child Protection Commission of Inquiry on 8 November 2012. Now, what was – how did you feel at the time about the decision to close the Barrett Centre?---I was extremely worried.

Why were you worried?---Because the timeline given to me was about seven weeks, and I've already indicated that I thought that was a extremely dangerous timeline in terms of being able to adequately care for those individuals.

But you know now that the Centre didn't close within that timeline. And you understand, Professor McDermott, don't you, that then the announcement – the final decision in relation – well, at least the announcement of the closure of the Barrett Centre was not until August 2013?---I'm aware of that.

Yes. And so insofar as the timeframes for, then, the closure and – did you have any knowledge at the time about – once the announcement was made, did you have any knowledge about when the Centre was to close?---Which announcement are we talking about?

6 August 2013?---No, no.

So you weren't involved at all, were you, in relation any time limitations or not about when the Centre was to close?---No, no. That's correct.

If we could go to page 71, which is point 106 of your statement?---Apologies. What point was that?

Page – paragraph 35. Sorry, Professor McDermott.

COMMISSIONER WILSON: Paragraph 35 of Professor McDermott's statement, is it?

MS MUIR: Yes, which is - - -

COMMISSIONER WILSON: The statement is up on the screen now.

MS MUIR: Sorry. That's my – it's actually point 070. It's page 35 of the – of your exhibits. And this relates to the Barrett Adolescent Centre Consultation on Aggression and Violence at the Barrett Centre report of August 2003. And in paragraph 20 in the context of the Barrett, you talk about with contemporary understanding of the burden of youth homelessness and school exclusion, the Barrett Centre provides an excellent opportunity for youth with mental health and challenging behaviour to live in a safe environment and receive high quality educational and psychological input. Has your view of the benefits of the Barrett school changed from 2003 to now?---Yes.

And, in fact, you say in paragraph – if I can go to 171 of your statement, which is at point 030. Your evidence there is that – you talk about the developmental appropriateness concerns and the importance of adolescents engaging in normal adolescent behaviour such as mainstream schools. I'd just like to understand your shift in view over that passage of time?---I'm not allowed to say ageing – normal ageing, am I. Okay. My shift in views – I have been quite interested and exposed to things like Multisystemic Therapy. Multisystemic Therapy or MST is an American-based therapy that has now about six randomised controlled trials looking at some of the most problematic youth. And it's actually finding extremely good outcomes. And this was a process that's kind of – in fact, we trialled a MST team at the Mater, you know, very rigorously and got some good outcome measurement. And they have also been rolled out in New Zealand and Western Australia. These teams have things that are, I think, truly exciting. They have very low case loads. A case manager might only see four or five individuals. They have completely non-clinic-based care. They have care in the back yard and the front yard and the living room. They do extensive family work, and they see extremely tough kids, but they work incredibly hard to integrate them to school and to normal pro-social kind of undertakings. So I've been exposed to all of that kind of work. I've also been very impressed with the acuity of young people being seen at day programs. And I think day programs – in my mind, you go during the day, you have a very strong focus on skills acquisition and then you go home at night to practice that change every day and for six months. So I think that since 2004 when I wrote that there have been some really interesting changes that move us away from long-term residential care and the problems that I see in that to things which I think are more contemporary and more – again, I use this word, you know, social ecology – that are more consistent with normal adolescent development.

Just in relation to the – you mentioned day programs. And I just wanted to ask you something about – in your statement in paragraphs 52 of your statement, which is point 010. And this is at a time when you were involved in the Redlands project?---Yeah.

And you say that at that time you were the director of an inpatient and day program – at the time, the only child and youth day program in Queensland?---Apologies. I'm a bit lost. So is it - - -

Paragraph 52?---Fifty-two. Just a second. Yes. I see it. Yeah.

Yeah. So I was confused because my – well, my understanding of the Barrett Centre was that it had a day program which has operated since the Barrett Centre opened. And so some of the adolescents attended the Barrett as a day patient, as well. And I was just curious to know, then, perhaps were you unaware that the Barrett Centre had a day program?---No, no. I was very aware that they had that program. I think there is kind of a semantic issue about my conceptualisations of day programs. The Barrett day program – rightfully called a day program. I have no issue with that. I see that as sort of like an integrated whole of service. Our day program was very stand-alone, so I've just seen those as being different entities, but I can completely understand how you'd both call them a day program.

Thank you, Professor McDermott. Commissioner, I have no further questions for Professor McDermott.

COMMISSIONER WILSON: Alright. How long will you be, Ms Wilson?

MS WILSON: I'll try to be as quick as possible, Commissioner.

COMMISSIONER WILSON: Well, what does that mean?

MS WILSON: I reckon if – 10 to 15.

COMMISSIONER WILSON: Alright. And what about you, Ms McMillan?

MS McMILLAN: I still think probably half an hour.

COMMISSIONER WILSON: Well, we'll deal with Ms Wilson's cross-examination and then see if everyone in the courtroom, including the staff, need a break. But it will have to be a short one.

EXAMINATION BY MS WILSON **[1.06 pm]**

MS WILSON: Thank you, Commissioner.

Professor, I am going to just address quickly, hopefully, a number of issues. You've been asked questions by Counsel Assisting about a number of the services that are available in the present continuum of care in relation to youth and adolescent mental health. You've referred to AMYOS, you've referred to resis which you talked very highly about ADOS down at Woolloongabba, you've also referred to the importance of the day programs, you've also referred to the value of any Step Up Step Down program and then we've also been asked questions about subacute beds but you said that you have no knowledge of what's happening at Lady Cilento. Commissioner, yesterday I – as my learned junior has pointed out – I called Lady Cilento, Lady

Cilento subacute facility. It's only that there is subacute beds available at Lady Cilento. So if I can correct that for the record. And then following on that you get to the inpatient acute. This suite of services that I've gone through that you've spoken about today, this suite of services provide a comprehensive continuum of services which is intended and designed to reduce the need for any extended stay in any acute facility. Do you accept that?---Yes.

And it is working, isn't it?---I'm not sure.

And the reason that you say that you're not sure is that you say that there's just no assessment that has been done?---Well, there's two reasons. That's one reason and it's probably too early, by the way, to do that assessment. So there is no criticism about that care pathway. But also, you know, I think we need to look at who's going into those range of services? Do they marry up with the people who would've gone to the Barrett? And, also, do we need – you know, we need to see if people are tracking. So, for instance, are people using only one of those, you know, service elements or is actually their comprehensiveness around them and that would – you know, I think that would be impressive. And if there was it could fulfil the role.

Yes. Okay. But the continuum of care of these services provided, you'd accept are a comprehensive – prima facie, are a comprehensive continuum of care services to meet the needs of adolescent mental health?---Absolutely.

Now - - -

COMMISSIONER WILSON: Ms Wilson, sorry to interrupt, but I didn't understand an answer that the Professor gave a moment ago and I would like to clarify it.

MS WILSON: Certainly.

COMMISSIONER WILSON: You said you didn't know whether people were tracking?---Yes.

Whether they were using only one service. And then I thought you were moving on to talking about them using a number of services and something around them. I just missed what you were saying?---Okay. If these are a replacement for the Barrett cohort, then what you'd find is "patient a" would, you know, be case managed by AMYOS, they would go to the – "patient a" would go to the residence, "patient a" would also go to the day program and that would be a package of care around them. 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 you'd find 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.

So when you talk about a package of care around the patient, is that what's called wraparound or is that something different?---Wraparound is a confusing term

because there was a service in America that called itself Wraparound. So, unfortunately, there is a technical almost copyrighted Wraparound and then there is a lay term about wrapping around. So I try not to use the term at all.

You see, it was used in the Barrett Adolescent Centre context within the ECRG and planning group documents. There was a reference to wraparound?---Well, they're probably talking about comprehensiveness around an individual. But there is actually a technical entity called a wraparound.

Alright?---And they're different.

Thank you.

MS WILSON: Thank you, Commissioner.

In terms of – in response to one of my questions you talked about replacing the services for the Barrett cohort. These services, that is the continuum of care services, does more than that, doesn't it, because it looks at the greater needs required across Queensland than more than simply just the Barrett cohort?---Absolutely. Yes, yes.

Alright. Now, one other question. You talked about in response to a question by Counsel Assisting that some people need to leave home to get treatment. Do you recall that?---Yes.

Okay. Now, the services that are provided in this suite of services, that is, the continuum of care, can – you would expect, wouldn't you, that people requiring treatment away from their home can provide that treatment within this suite of services?---Can you just say that again, please?

Sure we'll start with the premise that you say that some people need to leave home to get treatment?---Yes.

The suite of services that we've discussed, going through from AMYOS down to the subacute beds, the treatment that they may need – this question might be too hypothetical. The treatment that they may need should be able to be provided within this suite of services?---I think the suite of services is an incredibly kind of, you know, impressive, you know, attempt to provide that. And we await to see – I will take the opportunity to say something else. There is the added advantage, of course, is that that suite has been replicated in Far North Queensland in terms of, you know, AMYOS and residential. And so that suite should actually allow people to, again, have that intensity closer to their home.

So it's got greater outreach?---Yes.

Okay?---It has greater reach.

Thank you. Now, I just want to ask you a question in terms of any gap that you may see in the alignment of adolescent and adult mental health services in Queensland. Well, do you believe that there is any gap?---There is always a gap. There is a gap. Services stop and other services start. And one of the things that people need to understand is that often the conditions treated by those two service sectors are actually very different. So, for instance, adult mental health is much more exposed to and has to respond to psychosis, manic depressive psychosis and bipolar disorder. Child and adolescent are much more exposed to dysregulated behaviour, chronic self harm, depression and anxiety. So there will always be a gap, partly because the conditions are different. Alright. Now, does transfer between the two services happen? Yes. Does it happen well? Well, it's very variable. Okay. And it depends; it's probably on a condition by condition basis. The transfer of psychosis, I suspect, happens really very well because, again, that's a really core expertise of adolescent mental health. The transfer of things like complex PTSD and borderline functioning would happen less well, anxiety disorder generally less well, eating disorders quite well. So it's a sort of an illness by illness proposition.

Okay. Now, if there is any determining what services there may be required to address any gap, consistent with your evidence contained in your statement, would you agree that what needs to be done is there needs to be a service mapping exercise undertaken to look at any differences between current services available in CYMHS versus mental – adult mental health services looking at identifying services needs for specific age groups or specific diagnoses, identify potential gaps in service deliveries in these age groups and forming an options paper with a number of stakeholders?---I think that almost every five years there should be a service mapping exercise because services develop. Services have great ideas. They do – they do things and other services don't know about that. So, you know, I think that's a very reasonable thing that should actually happen more often.

Okay. And just in a hypothetical way, do you have any view upon a service being provided between the age group of 12 and 25?---I have a very strong view about that and I'm now going to give it to you - - -

I feel you are. I do feel that you are. Yes?--- - - - that my 13 year old should never ever, ever be in a service with a 24 year old who's psychotic with ice. And that's that. My 13 year old is – by the way, all my 13 year olds have grown up. They're not – this is rhetorical. But, you know, this is just anathema to me. They shouldn't be in the same service. By the way, beyond the emotion there's two other kind of more reasonable positions. And one is that, as I've said before, the conditions are different and, therefore, the expertise is different. But, also, in Australia we have a whole bunch of entities that go up to the age of 18. So, for instance, school education does not go to 25, it goes to 18. Child protection does not go to 25, it goes to 18. Juvenile justice does not go to 25, it goes generally to 18 and sometimes 17. You know, disabilities doesn't go to 25, it goes to 18. To build a 12 to 25 service, you cross four or five major longstanding institutions of our society with no guarantee that the people on that side of it would know anything about that side of it and vice versa.

And my last number of questions is addressed to if there's any demand for secure beds for forensic adolescence and severely disturbed young people in an acute phase, do – does Townsville Hospital and Health Services receive referrals of adolescents with mental health issues who require a secure bed?---Yeah. And in this case you're talking about a forensic bed.

Yes, I am. Or severely disturbed young people?---Yes, it does.

And could you give me any indication whether you say that there is a high or low demand in terms of that type of referral?---There's a low demand. And, for instance, in the last three months we have transferred one individual from the adolescent inpatient unit to the adult inpatient unit because of dangerousness and some other issues.

Thank you, Commissioner. They're all the questions I have. Thank you, Professor.

COMMISSIONER WILSON: Alright. Now, you'll be 40 minutes, did you say?

UNIDENTIFIED SPEAKER: No, no, no. I have been cut down to 30 and I may be shorter.

COMMISSIONER WILSON: Alright.

UNIDENTIFIED SPEAKER: So I'm happy to commence - - -

COMMISSIONER WILSON: Well, I'll just see how long everyone else is going to be. Who else has questions of Professor McDermott?

UNIDENTIFIED SPEAKER: I have one question, Commissioner.

COMMISSIONER WILSON: Right. That should be hopefully quick.

UNIDENTIFIED SPEAKER: Yes.

COMMISSIONER WILSON: Anyone else?

UNIDENTIFIED SPEAKER: I do have a few questions, Commissioner. But I would imagine I'll be no longer than five minutes.

UNIDENTIFIED SPEAKER: And sub 10 minutes, Commissioner.

COMMISSIONER WILSON: Alright. And, Ms Philipson, will you have questions?

MS PHILIPSON: It depends what arises out of any further cross-examination but probably not.

COMMISSIONER WILSON: Alright. And - - -

UNIDENTIFIED SPEAKER: I also expect to have five to 10 minutes.

COMMISSIONER WILSON: Okay. I really think for the sake of the staff in this hearing room there must be a break. We'll come back at 1.45.

WITNESS STOOD DOWN

ADJOURNED **[1.18 pm]**

RESUMED **[1.48 pm]**

BRETT McDERMOTT, CONTINUING

EXAMINATION BY MS McMILLAN

COMMISSIONER WILSON: Yes, Ms McMillan.

MS McMILLAN: Yes. I may be shorter than I initially indicated. It's marvellous what a break does.

Professor, can I ask you please, firstly, to look at page 14 of your statement, paragraph 75 and 77. Professor, in terms of – this was obviously about the Redlands site, I can put it that way, and you make some comments about the model of service delivery. Correct?---Correct.

Yeah. Can I ask you, firstly, it would be quite normal, I assume, and in fact essential for any health facility or service to have a model of service delivery, would it not?---Absolutely.

And from what you understood of the Redlands model of service delivery did that differ from the Barrett situation, if I can put it that way?---The – the Redlands model – I can't recall ever seeing a final version but I think it was heading towards difference.

Okay. In what ways? Can you recollect?---Okay. Well, from my own personal perspective I was extremely keen that it should be integrated much more strongly - - -

Yes?--- - - - comprehensively with Child and Youth Mental Health. I wanted there to be a much greater in-reach of other staff. I wanted there to be much greater sharing of staff.

Sorry, and you mean sharing of staff, what, between other parts of that health service or you mean between different health services?---Between other parts of Child and Youth Mental Health.

Right. Okay?---I wanted greater exposure to research and evaluation and, you know, and there conversations with I was party and advocated for a shorter model of care and a more discrete and clear duration of care.

Right. And you know Ms Krause – Judi Krause, don't you?---That's correct.

And in fact the document I put to Professor Crompton this morning – she writes to Professor Crompton – I'm paraphrasing – that generally the group – the Redlands group, if I can put it that way, looked at a model of care of extended treatment not more than six months?---That's correct.

Is that - - -?---That's correct.

And does that accord with your understanding of where perhaps contemporaneous understanding of the best models of care, if I can put it that way, for child and adolescents?---Well, it's consistent with what the group thought was a better model of care than the existing model of care.

Yeah. Sorry, and you were a member of that group, weren't you?---That's correct.

Yes. Alright. Thank you. Now, Professor, in terms of – Dr Breakey gave some evidence yesterday that at Barrett, really, from day 1 it was thought that discharge should be planned for. I take it that's a fairly normal situation that - - -?---That's correct.

- - - would exist. And would it, in terms of even pre-admission if not at admission some sort of either plan or ideas of how a patient may be effectively discharged?---If the admission in an acute inpatient unit is not an emergency - - -

Yeah?--- - - - if it's a booked or planned admission - - -

Yes?--- - - - then where they get discharged to is always discussed before accepting the patient.

Right. Because you need to work toward a plan, I imagine?---Well, there's two reasons. That's one reason and the other reason is, you know, the occasional person – and this is not talking about Barrett at all - - -

Yes?--- - - - but the occasional person gets into an inpatient unit and their care around them collapses and they're – they're stuck there. And that's a very bad situation for the young person.

Right. Okay. Thank you. I take it that would really adhere to an patient, wouldn't it - - -?---Yes.

- - - in an inpatient facility, that you'd need to have some care or structure around what they'd move to?---Correct.

Right. Now, you asked before about the sub-acute beds that I understand you and Dr Stathis had emails and conversations about. Correct?---Well, again, there's a terminology issue here.

Well, perhaps you'd - - -?---I never called them sub-acute. There were some beds at the Mater - - -

Yes?--- - - - which we were happy to make available.

Right. And can I put it this way: they were not for acute admissions?---Yes, yes.

You obviously always had your acute admission beds. What did you understand was the take-up rate of those beds that you said were available if need be?---My understanding that – that none of them were – were taken advantage of.

Thank you. Alright. Can I ask you in relation further to your statement, paragraphs – just excuse me – 140 which you've been taken to before on page 25 of your statement over the page?---Yeah.

Now, you say at Mater CYMHS longer stays were deemed potential non-therapeutic given those factors you identified and if you go over the page, probably all of those save for the distress of a long-stay patient seeing numerous other youth being admitted and subsequently discharged would be common to the Barrett Centre, wouldn't it? So what I'm talking about is the possibility of young people learning new problem-coping behaviour, for example, you say self-inflicted cutting from other patients, etcetera?---There – they are possibilities in any unit.

Yes?---Absolutely.

But certainly from what you know of the Barrett Centre they must be, one would think particularly given the length of time of a number of the stays of patients there, indicative of issues which would arise?---When you talk of institutionalisation - - -

Yes?--- - - - these are some of the features of institutionalisation.

Right?---So, yes.

Well, in fact, I want to take you then to 146 when you talk about significant institutionalisation. So can you explain – those are some examples – what else would you include in that term institutionalisation?---When you are out of a normal family context and this could be any context.

Yeah?---It could be the military. It could be prison. It could be any context. It could be a long stay. You are in danger of taking up some, if you like, idiosyncratic, you know, behaviours and elements of that new environment.

Right?---So you know, in the military one is always concerned about contagion around drinking, for instance, as an example. 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 regress behaviour. If you had exposure to endemic rates of self-harm you might pick up self-harming. Okay.

Yeah?---If you have someone who is disruptive in a school setting day in and day out you might acquire that. So it's not so much the Barrett. It's about any long – and it can happen quite quickly – after two or three months – any exposure to an unusual setting you can pick up these behaviours.

Right. And I suppose with Barrett particularly you're looking at, as you understood it, the inpatients, if I can use that word inpatients, or adolescents there mostly had complex diagnoses and most of them had a trauma as part of – trauma as part of their, what, presenting symptoms or how would you describe it?---Well, most of them had complex presentations - - -

Right?--- - - - and most of them had – I mean, one conceptualisation is they were dysregulated. They had problems controlling mood, behaviour, sense of identity, sometimes sleep and eating. They were kind of dysregulated.

Right. And I suppose a degree of dysregulation is not unusual in adolescence because that is a time where a number of those factors come to the fore. What was obviously of particular not was that these were sufficiently clinically concerning - - -?---Yes.

- - - for their admission. Right. And in terms of that issue, the other issue is that for adolescents their peer relationships are very important, aren't they?---Yes.

So that if they're in an institution for a lengthy period of time you both have the others have complex presentations and also the fact that they take on and are very much guided by their peer relationships, aren't they?---One of the problems is you don't have extensive modelling of more normal behaviour.

Well, I suppose that was implicit perhaps in my question but what I meant is you're not getting the modelling that you would do in the wider community?---Indeed. Indeed.

And I'll come to it in a moment – is that part of what you seem to have changed in your views about the schooling?---Yes.

Right. And I'll come to that in a moment. So is that why, as I understand, when we go back to Redlands, six months being for an extended stay, is that because of your concerns particularly if not only about institutionalisation?---It was a primary driver of my – of my wanting to have a shorter period of time.

Right. Okay. Thank you. Now, Professor, can I ask you about your attitude to schooling. You were taken to your 2003 review and I note there is an email that – I think Counsel Assisting have provided us to – an email by yourself to Dr Stathis. And the reference is QHD.004.005.9014. Professor, just to give some context, you will see – I will let you read that for yourself. Alright. Thank you. Now, I'll just backtrack for a moment. So your views about schooling had changed. What had changed in terms of your views about it post-2003?---I think this scenario in no sense can be, you know, bundled up with my former views about schooling. This is actually a very unusual situation where before you had a school geographically intimately located to 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.

Yes?---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 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 have none of the scaffolding that was there at the Barrett Adolescent Centre. Hence my email.

Right. And so are you saying from that – what leads from that – if they're sufficiently concerning a presentation to require mental health assistance, one would look at perhaps from what you referred before such as day programs and other ways of dealing with that rather than a school, it seems, trying to provide to some extent mental health assistance internally?---I mean, this is a school with a cohort of young people who had serious and complex needs running what they – I assume was a school without any of the scaffolding of those other things. So, again, I was completely disapproving of this. And your point that if it was in a day program or another setting would have been much more appropriate.

Alright. And do I take it from your earlier evidence, as well, that your view generally, for instance, issues such as schooling is that one should do one's best to have them integrate back into a fairly normal schooling environment, if I could put it that way?---Where possible. Where possible.

Where possible. Because the rationale must be, apart from anything else, that's what one would expect they should return to once they're well enough?---So the Mater day program - - -

Yes?--- - - - had a period of time when you went full-time to the Mater school, which was very skilled with this particular client group, and you decrease with the Mater school as you increase with your normal school. So that's a very nice model.

So it's a tapering, if you like?---Yes.

Okay. And that's consistent and can be modified depending on whether their condition fluctuates, I imagine?---And monitored.

Right. Monitored. Alright. Thank you. Now, I want to ask you – you were asked some questions about Dr Ward's thesis, and I think – I may be paraphrasing what you said, but you said you stopped reading because you had issues with the methodology employed by him?---Correct.

Now, just pausing there. In your CV – and this is page 39 and following, so page 4, actually, of your CV – you discuss and set out some of your research activities. So the Sutherland Bushfire Trauma Project – I think that assessed 4000 children, didn't it?---Yeah.

Over the page, one reads the eating disorders team – 200 children; the database project – greater than 2000 children – just as some examples of your empirical research, correct?---Yes.

Alright. Tell us what your concerns or your views about, firstly, the methodology employed by Dr Ward?---Okay. And I would like to put the caveat that I think it's just incredibly commendable that he's done this research and there's been research at the Barrett. And I'm strongly supportive of that.

Yes?---The issue is really one of generalisation and one of interpretation of the findings and how we can build that into our understanding of models of care. So, for instance, he saw 13 young people of which two were excluded later – in fact, three. So there were kind of 10. Now, over 30 years or 25 years, there was probably 600 people, so that's, like, two per cent of the population. Statistically, there's 98 per cent noise. There was even eight who refused at the time. So to extrapolate from 10 to the reality of 25 years of a service is actually, you know, methodologically incredibly unsound because it needs a very small deviation in the other 98 per cent for it to be completely wrong – first thing. Second thing is that I think there were some major biases in how it was done. So, for instance, you have someone who works at a unit for eight years who's highly invested – they go to work every day for eight years. They probably think highly of the unit. They ask young people about the unit. Young people say good things about the unit and you concluded the unit is worthwhile. Now, the conflict of interest around that is spectacular. And the subjectivity is spectacular. Now, we published a paper two weeks ago. It was qualitative research – same kind of research. We got someone independent to type up all the narratives. Half these narratives were actually typed up by the doctor. And then we got someone completely independent to do the analysis who knew of none of my hypotheses, none of my a priori perceptions. They didn't know anything

that was in my head, and they went off and they found these interesting findings that were completely independent. They were completely objective, alright. Now, that's good research. My criticism of this research is actually not to the good doctor; it's to his supervisors. This, you know, at a pilot level, should have been stopped and someone should have said this is easy to fix. Triple your sample size and get someone independent to do the analysis or get someone independent to ask the questions. If I've got an ITO and I want to get out, maybe I'll say what I think you want me to say.

Well, I was going to ask you that. At least, it seems, half of them were on ITOs, so - - -?---Well, again, I mean, this is wonderfully subjective and that's, of course, anathema to research, because research needs to be, unfortunately, fairly cold and objective, and this was not. So after about, you know, a certain number of pages, I actually stopped reading it because I didn't want to know the results because I might remember them, because they're based on data which I don't respect, okay.

Alright. Thank you. I just want to ask you – one of the titles in the thesis – and it's seen as a sub-theme is Barrett as a second parent. Would that cause you some concern for Barrett to be viewed as a second parent?---Not really. I think that's a – consistent with an attachment of psychodynamic literature which talks – talks like that. So I think there is a – there is a school of mental health that actually uses those kind of words.

Right. Okay. But I suppose when it – did you read those pages where it talked about the staff taking on parenting roles: supervising homework, etcetera – did you read any of those pages?---You know, I glanced across those words. I mean, that's actually not that inappropriate. For instance, you might model very, very, you know, effective parenting. And that's actually fine. I don't have an issue with that.

Right. Okay. But I suppose you come back to the other issues that you've raised about institutionalisation in terms of your concerns for them being there and those matters that you've raised at paragraph 146?---Well, are we now still talking about the research thesis or are we talking about the Barrett?

I'm asking you were there any other issues that – I should be fair to you – identified in Dr Ward's thesis that you wanted to speak of?---Okay. So my process is – because I have limited intellectual capacity – is when I find it methodologically - - -

Surely not, Professor McDermott?---No, no. When I find it methodologically unsound, I stop reading, so I haven't read past methods.

Alright. Thank you, Commissioner.

COMMISSIONER WILSON: Mr Diehm.

EXAMINATION BY MR DIEHM **[2.08 pm]**

MR DIEHM: Commissioner, before I proceed to ask a question, it does arise out of something that Professor – or an answer Professor McDermott gave to a question in the closed proceedings, but it does not relate to a subject matter that would have ordinarily been expected to be the subject of the closed proceedings.

COMMISSIONER WILSON: Well, can I put it this way: can you deal with it here, in an open hearing?

MR DIEHM: I think I can, yes. I'm confident I can.

COMMISSIONER WILSON: Well, let's try.

MR DIEHM: Thank you. Professor McDermott, before the time when Dr Brennan actually commenced in the role of acting clinical director of the Barrett Centre, you did not have any conversation with her about the merits of her doing so, did you?---I thought I was really very, very clear that my recollection was she asked me about the job before she took it.

Alright. Well, I put it to you there was no such conversation?---Okay. Well, that's – we will have to differ about that.

Thank you. That's all I have, Commissioner. Thank you.

COMMISSIONER WILSON: Mr Wessling-Smith.

MR WESSLING-SMITH: Thank you, your Honour – Commissioner.

EXAMINATION BY MR WESSLING-SMITH [2.09 pm]

MR WESSLING-SMITH: Professor, can I just put some things to you, and I'll get you agree or disagree and comment on it as you wish. In Queensland each year, there's a relatively small number of adolescents like those of the Barrett cohort and like that unnamed patient you referred to may have been the 40 instances of self-harm in a year. And those adolescents require extended treatment, and by extended I mean three to six months, sometimes more than six months; would you agree with that?---There's a little missing word of clarification there. Are you saying extended inpatient residential treatment or just extended treatment?

Yes, thank you; extended inpatient residential treatment, where they can receive treatment by a range of medical professionals, which would vary for each patient, but may include a psychiatrist, psychologist, occupational therapist, social worker etcetera?---I don't think anyone in the world can actually answer that question. I think that we don't actually have evidence – for instance, we don't have evidence that the Barrett Adolescent Centre didn't do a fantastic job. We don't have evidence it didn't do a fantastic job, right? We don't have evidence either way. Now, a lot of

people around the world would say that that particular person – and it would be a very credible thing to say – that that person would benefit from three to six months of treatment.

Alright. So if we concentrate, say, on that person then, that person – it would be reasonable for them to live away from home to receive those treatments?---Yes.

It would be – it follows, therefore, that they would need somewhere to stay, and you've already commented on what that accommodation should be like; if I recall, as less like the ward of a hospital as possible?---Yes.

You'd agree with that? That person may also require nursing staff to check on him and her, and, again, that may vary; it might be every 15 minutes, it might be every couple of hours. You'd agree with that?---Doesn't have to be nursing staff, but some form of mental health-trained person. Yes.

Alright. And, ideally, they should have access to education - - -?---Yes.

Of the type that was being provided at the Barrett Centre, but if the adolescent could deal with it a normal school, so to speak?---With the other caveat that the type of education often accessed by these young people would be colloquially called a flexi-school. It wouldn't be that recognisable as a typical curriculum. It would be tailored for someone who might have missed a lot of school and had, you know, outcomes that were different to mainstream outcomes.

Thank you. And for that person, the extended treatment preferably shouldn't take place in an acute ward of a hospital [indistinct]?---That would be my preference.

Professor, since the closure of the Barrett Centre the sort of facility that would just run through with all of those items in place: is there a facility like that in Queensland?---The – and, again, the sort of nuance here is that the – the – the care alternative is not encompassed in one service, but child and youth mental health would argue that the continuum provides that by a residence and the various other elements. Now, whether that actually proves up: I've mentioned time and time again that we don't know. But the state would say – and I don't mean the State here, I mean child and youth mental health – would say yes, this is a credible alternative, and I would agree.

Alright. Can I just move to one other issue, and that is that you gave some evidence about what happens when patients turn 18. It's inappropriate to have 13 year olds or 24 year olds etcetera. So there is this cut-off point at 18. Could you ever foresee a situation where you had a 19 year old, but that 19 year old, to put it in a layman's perspective, is like a 16, 17 year old with the life experience, knowledge, and the amount that they've been to school? If you had someone like that, would there be a better outcome, potentially for them, if they were treated in an adolescent facility?---The best services in the world, I think, are where one director can ring up another director and say it doesn't actually matter the person's age, developmentally,

they fit more with you and me, and that's accepted. So we have often, over a long decade, taken 19 and 20 year olds who were developmentally 15, and an example is a young person with severe anorexia who their weight is – and I'm making this up; this is not a patient – but whose weight is 43 kilos, they're 21, they haven't been to school for five years because of chronic malnutrition. They do not belong in a ward with someone with schizophrenia, and there are many times when we have accepted those patients and they have done very well, and the reverse happens. The 16 year old who has committed violent crime and has a long history and has a drug-induced psychosis does not belong in – and they go to adult. So the best services are flexible.

COMMISSIONER WILSON: Can I ask what you meant by we have done this? Were you referring to what you did at the Mater or were you referring to state-controlled hospitals - - -?---Okay.

- - - or to something else?---I'm – I'm referring to the Mater, but I would have a strong suspicion that other directors would do this as well.

Thank you.

MR WESSLING-SMITH: Thank you, Commissioner. Thank you, Professor. That's all I have.

COMMISSIONER WILSON: Ms Rosengren.

MS ROSENGREN: Thank you, Commissioner.

EXAMINATION BY MS ROSENGREN [2.16 pm]

MS ROSENGREN: Professor McDermott, I am appearing for Dr Sadler, and you would be pleased to know I've only got a very few questions for you. Can I start by taking you to paragraph 157 of your statement, please, and it's on page 28. It's up on the screen now, and you refer to the fact there, Professor, that subject to some qualifications that between 2012 and 2014, from your knowledge of the Barrett Adolescent Centre that it was an adequate facility to care for the sub-cohort of adolescents who were there, am I correct in understanding that one of the factors that you rely on in support of your conclusion in that regard is what you've detailed there in the following paragraph, being 158, and that is that I think you identify there that the Barrett Adolescent Centre was operational for more than 20 years. And, in fact, we know from other evidence it was about 30 years, and that's with the inpatient component having been established in 1983. And over that entire period, no adolescent attending the Barrett Adolescent Centre committing suicide whilst being treated at that centre?---I think in answer to that I would just like to reiterate that there is no evidence at all that it wasn't a place of – of very good care.

And I think there is – I can explore with you very briefly. There's obviously a difference between anecdotal evidence and scientific evidence, which is what you've been referring to in questions from previous counsel. In relation to the anecdotal evidence, that's what we've got. And I think – would you agree with this, Dr Sadler's understanding, that there had been no one as far as he is aware who had been – in the last 20 years or so who had been a patient at the Barrett Adolescent Centre who died within even 12 months of being discharged from that centre. Is that consistent with your understanding?---I have no different information to that.

Yes. So from an anecdotal point of view, appreciating the difference between that and scientific evidence, would you agree that that is very persuasive and it's just about as persuasive as anecdotal evidence goes, that you can have a mental health facility operating like that for some 30 years. It's a facility that's treating the most vulnerable adolescents in our society and its track record over that entire period is not one single person attending it has committed suicide within 12 months, this is prior to its closure?---Well, possibly because (a) we don't know if the anecdotal evidence is true. So (a) we don't know if that's true. And, secondly, again, as a matter of science, the numbers were very, very low. And in the same period of time, the Mater inpatient unit, which also didn't have a suicide, saw probably 20 times more people. So we'd actually have to – we'd actually have to look at it. It actually might not be surprising because the numbers are low. What I think is that it's extremely commendable but I don't know – I can make no comment more than that.

Okay. Now, in terms of the scientific evaluation moving forward, I take it that you know Professor McGorry?---Absolutely.

And I just wanted to ask you something, an observation that he makes in one of his statements – in his statement. And he says:

> *There are difficulties in assessing a service such as the Barrett Adolescent Centre by reference to an evidence base.*

He says:

> *One of the principle reasons for this is that the adolescents who form the cohort at the centre were the most damaged and so the number of young people who fall within it are relatively small and that necessarily means that traditional sources of scientific sources are difficult to assemble.*

Do you agree with that?---No, I don't agree with it.

And why is it that you don't agree with that?---Well, you know, Professor McGorry has done some, you know, world leading research in incredibly difficult areas like early onset psychosis. I mean, these are very difficult populations. There's lots of research around the world of people who have been, you know, serially and profoundly sexually abused and they've done really very good quality research in those areas. I mean, we've don't research in natural disasters which, by the way, are

fairly disastrous and difficult circumstances to do research in. I don't believe that over, you know, 25, 27 years that research couldn't have been done, even observational research which doesn't involve the young person. So I actually don't believe that. Again, it's not criticism in that I don't think any professional can be everything. And I've never said that Dr Sadler should suddenly be a magnificent researcher. What I'm saying is that it would probably – a lot of the questions we have today wouldn't be asked if we had some comprehensive research done at the Barrett.

What Professor McGorry says, because of the relatively small number of adolescents who were being treated there, that he thinks that the best measure of the success of that centre would be looking at measuring individual outcomes. Do you agree with that?---That would be helpful.

Okay?---By the way, we don't have that.

And is that the case in relation to most mental health services throughout Queensland?---Well, again, I made it, I thought, quite clear that this is a service wide problem – service wide, an industry wide problem. Yes, absolutely.

Thank you, Professor McDermott. I have no further questions for you.

COMMISSIONER WILSON: Mr McMillan.

EXAMINATION BY MR McMILLAN [2.22 pm]

MR McMILLAN: Thank you, Commissioner.

Professor McDermott, I represent Deborah Rankin who's the acting principal of the Barrett School. Do you recall being contacted in early 2014 by Kevin Rodgers who was then the principal regarding a request by him for consultant psychiatrist hours at the school to support the work they were doing?---Yes.

Is it the case that there was some delay in actually scheduling a meeting with him and that that meeting, in fact, occurred with him and Deborah Rankin on 3 April 2014?---I know the meeting happened.

Were you aware that Mr Rodgers had previously contacted Dr Stathis and advanced that request? Dr Stathis had referred him to you instead?---I think so. Yeah.

Do you know why he was referred to you instead of Dr Stathis?---Because the school – my understanding was the school was at Yeronga which was 100 yards across the road to Yeronga Child and Youth Mental Health Service which was under my directorship.

So it wasn't the case that he was referred to you because there was an expectation that support would be provided by Dr Sadler [indistinct]?---No, no, no. Not at all. I think it was because geographically it was in my catchment.

When you met with Mr Rodgers and Ms Rankin on 3 April, they told you, did they, that they had received an offer from Dr Sadler to provide the support that they'd requested?---Yes.

And you told them, didn't you, during that meeting that you didn't think that was appropriate that he was the person to deliver those services?---Yes.

Without going to the factual basis of Dr Sadler's standing down, was the fact that he had been stood down from the Barrett Centre previously the reason for that opinion?---Yes.

Notwithstanding your view that Dr Sadler was not the appropriate person to provide those services, you didn't offer anyone else to provide those services to the school, did you?---That's correct.

Is that because you formed the view during that meeting that the model that was being adopted by the Barrett School at that time was not an appropriate one?---That's correct.

But I think the words that you used in an email that my learned friend Ms McMillan took you to earlier, you considered that it was flawed?---That does sound like me.

Perhaps you should be shown the email again, Commissioner. It's document QHD.004.005.9014. And it's the paragraph numbered 2 of that email that I'm interested in asking you about, Professor. You'll see the second last sentence of that paragraph you've written:

I think the model of the Barrett School going forward in this fashion is flawed.

?---Yes.

Now, at that stage it was the extent of your knowledge about the model being adopted by the Barrett School, that information which had been conveyed to you by Mr Rodgers and Ms Rankin in that meeting?---Yes.

You have no experience or expertise in the model of service delivery for education services, do you?---Absolutely not.

And you have no experience as a teacher of adolescents or in - - -?---Absolutely not.

- - - high school administration?---And, of course, my comment flawed was not based on that at all.

You're commenting upon the model being adopted by the Barrett School though, aren't you?---I'm commenting on the model of in reach of mental health to a school facility of which I'm an expert.

You said earlier that you were extremely concerned that the Barrett School was delivering the service it was delivering with only .5 of a mental health [indistinct]. Did that not - - -?---And my concern was the .5 mental health [indistinct].

Did that not support and encourage you to assist them in providing the consultant psychiatrist support they had specifically requested?---Absolutely not because they needed much, much more than a consultant psychiatrist. They needed – you know, to do this properly they probably needed individual case management. They probably needed a multidisciplinary team. They probably needed resources that were fundamentally more than a part-time psychiatrist.

Did you discuss what your assumptions about their needs were with them during that meeting?---I can't recall.

Did you discuss your assumptions about their needs with Dr Sadler who had significant experience working with the school?---I discussed my assumptions working with them with my executive director and my senior leadership group.

Was it after that meeting with Mr Rodgers and Ms Rankin that you proposed and sent the email to Dr Stathis which is on the screen?---I'm not sure. I'm not sure.

I think you accepted or you said in answer to a question I asked you a moment ago that the extent of your knowledge about the school and its operations at Yeronga came from a meeting with Mr Rodgers and Ms Rankin. So it follows, then, that you composed this email after that meeting?---Unless there was some other information that I can't recall. There might have been an email before that. There might have been some information from Dr Stathis.

It appears from the – I think the time of the email – it has been redacted, but can I suggest to you that the email was sent perhaps not long after that meeting?---I'm very happy to take your word, if you know the date, that it happened afterwards.

Is it the case that you were concerned to promptly inform Dr Stathis of your concerns?---Well, that would be suggested by the email.

And if I can take you to the last sentence of the paragraph number 2 – and you said:

Whatever occurs, a joint response with a lead from CHQ seems appropriate.

Is it the case that you were seeking to dissuade Dr Stathis from providing the support that had been requested by Mr Rodgers and Ms Rankin, as well?---Absolutely not. I'm probably pointing out to Dr Stathis that the response to the closure of the Barrett

Adolescent Centre was primarily a CHQ responsibility, not a Mater responsibility. So that is probably what I'm pointing out.

And that is notwithstanding the physical proximity of your service to the school and your opinion that is set out in paragraph 151 of your statement that your service had clinical responsibility for any patient living in your catchment?---I point out that these people weren't living in my catchment. They were - - -

How did you know that?---Well, they were coming into the Barrett school. We knew who was in our catchment. So these were patients coming from somewhere else into a school facility. They were the responsibility of CHQ, not me.

Is it the case that at the time you composed this email you knew of each and every student that was attending the Barrett school and the fact they didn't live in your catchment?---Unlikely.

Finally, Professor, I wanted to ask you about the evidence you gave earlier in relation to the models of care which you've described in paragraph 167 of your statement where you've used the expression normalisation rather than pathology. You were asked some questions earlier about the use of the school experience as a normalising experience. You're aware, aren't you, that a significant portion of the Barrett cohort of patients had had a extremely poor engagement with educational services over many years – some of them – prior to their admission to the Barrett Centre?---That's correct.

And I think you gave evidence yourself a few moments ago using the example of someone who hadn't been to school for five years and who had chronic malnutrition. That was a common experience for patients of this cohort that had this level of mental health illness, wasn't it?---I believe so.

That being the case, wouldn't you agree that it is, in fact, a normalising experience for those patients to then be put into an environment where they do attend school on a regular basis with other adolescents of similar age?---Are you talking about together in the same cohort of dysregulated adolescents?

Yes, yes?---No.

There are normalising influences, aren't there, from them being exposed to routine attendance at school and appropriate – sorry – and normalised adult behaviour that they would have been exposed to at the Barrett Adolescent Centre?---I don't know what they were exposed to at the Barrett Adolescent School.

And, finally, in relation to the questions you were asked about the extension of adolescent programs to people over the age of 18, you described in your evidence-in-chief that school generally goes to the age of 18. Are you aware that in Queensland people have a right to 24 semesters of primary and secondary education?---I'm not aware of that.

And that if they have not attained those 24 semesters of education by the time they turn 18, there is provision for any principal to extent the enrolment of that student to beyond the age of 18 so that they gain that 24 semesters of education. Are you aware of that?---No. I'm not aware of that.

In those circumstances, then, it would be quite appropriate and expected, wouldn't it, that a person who has suffered significant and severe mental illness over many years and has therefore missed out on a period of their education could continue that education beyond the age of 18?---Absolutely.

You don't suggest, do you, that because someone has experienced significant mental illness they oughtn't have that opportunity?---No, I don't suggest that.

Excuse me for a moment, Commissioner. I have no further questions. Thank you.

COMMISSIONER WILSON: Does anyone else have any questions? Ms Muir, do you have any?

MS MUIR: No further questions, Commissioner.

COMMISSIONER WILSON: Can the witness be stood down?

MS MUIR: yes.

COMMISSIONER WILSON: All right. Thank you very much, Professor?---Thank you.

WITNESS STOOD DOWN **[2.34 pm]**

MR McMILLAN: Commissioner – I'm sorry. It is, of course, a matter for Counsel Assisting, but I simply note that both Ms McMillan QC and I referred Professor McDermott to that email that I understand is not yet in evidence. It's not exhibited to the statement, so I don't think it is, in fact, in evidence before the Commission. I leave it in the hands of Counsel Assisting as to whether it's proposed to be tendered.

MS MUIR: Sorry. Commissioner, I think that it could be tendered as an exhibit.

COMMISSIONER WILSON: Alright. Does anyone have any objection?

MS McMILLAN: No, but I thought it was part of a wider bundle of material that we've been given by Counsel Assisting relating to Professor McDermott.

MS MUIR: It was.

MS McMILLAN: Which is why I didn't cross-examine him about that, because I understood it was – it had gone in.

MS MUIR: It hasn't gone in, because only the statements have been tendered as exhibits and there has been no formal tender of any of the documents that had been listed as identified.

COMMISSIONER WILSON: Well, Mr McMillan has proposed that it should actually be formally tendered. Are you going to do that?

MS MUIR: I can formally tender - - -

COMMISSIONER WILSON: Alright. It will become the next exhibit. It will be exhibit 174.

EXHIBIT #174 ADMITTED AND MARKED

MS MUIR: Thank you, Commissioner.

COMMISSIONER WILSON: That is the email which is QHD.004.005.9014.

MS WILSON: Commissioner, could I just raise something that is being – that some of our clients have raised with us that they're watching this on the live stream and it's very difficult to keep up with what documents are being referred to if it's only referred to the Delium number. So perhaps when people are referring to documents they should give the title so that people watching on live stream can get a better understanding of what document is being referred to.

COMMISSIONER WILSON: I think that's a good idea. If I can say, overnight, I think certainly within the Commission and probably in consultation with counsel generally, were going to have to review the references to documents. I spoke with our Executive Director over the lunch break about some of the problems that we've had this morning, and he wants to speak to me this afternoon but gave me the impression that there is a problem in the way documents are being identified by counsel. So I foreshadow that there will be some communications overnight to improve the process. But for this afternoon, it would be a good idea if something is referred to not only by its Delium number but also as an email between A and B on the blank day of blank.

MS WILSON: Thank you, Commissioner.

COMMISSIONER WILSON: Mr Freeburn, when you're ready.

MR FREEBURN: Commissioner, I call Dr Aaron Groves.

AARON GROVES, AFFIRMED **[2.37 pm]**

EXAMINATION BY MR FREEBURN **[2.34 pm]**

COMMISSIONER WILSON: Thank you. Take a seat?---Thank you.

MR FREEBURN: Dr Groves, you've given a statement in these proceedings?---Yes, Mr Freeburn.

It's actually in the form of a statutory declaration?---That's correct.

And if we can call it up, because we'll be going to a few parts of it. It's document GRA.020.001.0001, and it's exhibit 58.

Now, Dr Groves, I first of all want to take you paragraphs 24 to 35 of your statutory declaration which deals with the establishment of Queensland Mental Health Commission?---Yes.

And I'm going to ask you a few questions about that topic?---Yes.

You were, as you say, the leader of a team that designed the Queensland Mental Health Commission or at least as it was originally proposed?---That's right. As it was originally proposed.

And we can probably cut this short but there are – am I right in thinking there are two major differences between the Queensland Mental Health Commission that we've ended up and the one that was proposed by you, those being your proposal included a separate budget for the commission that you proposed and your commission didn't propose any – that the Commissioner be subject to directions of the Minister?---That's correct.

So those are the – are they the two major differences between your model and the eventual model?---They're the two major changes that I'm aware of from the work that we did and from my knowledge of the Mental Health Commission as it currently exists.

Alright. And you able to tell us the practical impact that that might have on – well, let's deal with the budget first. What's the practical impact of not effectively separating the Queensland Health – Mental Health Commission's budget?---There is one model of commissions that exists in the world where commissions hold budgets and therefore if one of their primary functions is to determine what they will purchase and who they will purchase that from so there are models of commissions where they hold the entire budget for mental health and then that allows them to decide which provider they will buy their services from which may be Queensland Health. It may be other providers. There are other models where a commission

might hold the vast majority of mental health funding but some aspects that can't be taken out historical funding remain where they are. For example, funding that might be linked into hospitals and provide services in emergency departments. It's difficult to disentangle that so that might remain. So there are different models that exist.

Alright. And your model opted for the one with a budget. Why was that in broad terms?---Perhaps I should preface by saying it was not so much my model, it was the model that was endorsed by the government at the time.

Yes?---That went through a very solid process of governance which included chief executives from four government departments who oversaw the development and recommendations that came forward. My understanding is that after enormous consultation with the sector there was a sizeable group of people who believed rightly or wrongly that mental health funding from time to time didn't get to where it was intended to go to and that a commission that held the funds would then be able to more clearly be accountable for how that funding would go to where it was intended to go. There was, it's worthwhile me saying, a group of people who shared a different view. On the balance of views at the time that was the – the decision of the Queensland government at that time.

Right. And what's the practical impact of the other aspect that we talked about a moment ago of a provision in the Act that says that the commissioner is subject to the direction of the Minister. What does that practically mean?---Look, that's one of the things that was debated for a very long period of time. At the beginning of the announcement about the commission the government indicated that they wished to have a strongly independent commission and those were the words that were used. It was difficult given that any entity that is an entity of government can be entirely independent from the Minister that it reports to. But my understanding was that there was a strong intention in government that the commission had the capacity to give the advice it needed to give and also to provide services in a way in which it would be – be providing them without the, I suppose, the restriction of a Minister putting a particular view about a certain aspect in place. I'm clearly, I must say here, speculating as to the reason for that particular aspect but that would be one outcome. But as I said, at the end of the day it – it depends very much on the particular model of independence that would be determined.

Alright. Now, I want to take you to a different topic – to the Queensland Plan for Mental Health 2007 to 2017. Now, that's – you again, were one of the leaders of the group that developed that plan?---That's correct.

And if we go to paragraph 52 of your witness statement, please?---Yes.

I just wanted to ask you about the relationship between the Queensland Plan for Mental Health 2007 to 2017 and this plan that you – or this report that you talk about here – the Queensland Child and Youth Mental Health Plan 2006 to 2011?---It may be helpful, Commissioner, if I can give you some historical context. The 10 year mental health strategy in Queensland which had commenced 10 years before – in fact

nine years before I had come to Queensland was coming towards an end. In 2006 I was asked by the then Director-General of Queensland Health to prepare a plan for mental health. At that time it was expected that that plan would be a five year plan. It was expected that it would also be finished in 2006. So our original thinking about the plan was that it was a 2006 to 2011 plan and, indeed, you will see reference in the Queensland child and youth plan that refers to a Queensland plan 2006 to 2011 for mental health. What occurred was that there was a short period of time to develop a plan and I was keen that that plan be developed in as comprehensive a manner as is possible. I established a number of expert groups. From memory there was about 15. There may have been slightly more than that. Those groups were charged with the responsibility of looking at mental health from a planning perspective through the prism that was most relevant to their expertise. So for example, there was a forensic group, there was a group that looked at child and adolescent issues and so on. The group that was established to do this was the child and youth network which I think you've had referred to earlier on this morning. That network was responsible for doing this planning work in conjunction with my staff and they brought forward a report that made recommendations about the important planning elements that should be considered in the Queensland Plan for Mental Health. Their document wasn't a government-endorsed, cabinet-endorsed plan. It was a plan but its purpose was to inform the greater Queensland Plan for Mental Health. That needed to go through a serious process of costing so that it would be taken to government for consideration so that they would consider which aspects of it they would fund. So it's an informing document rather than one that has the status of being an endorsed by Queensland Health plan, for example.

So am I right in thinking you started with this Queensland Child and Youth Mental Health Plan and out of that process came a wider – the wider plan – the 2007 to 2017 plan?---That's correct. In addition, we overlaid several other processes. For example, we needed to be clear about the evidence base that would support any aspects of what we would state to government was important. So we went through a process of commissioning independently a group to look at appropriate benchmarks for all aspects of the plan. We did a stocktake of the capital works requirements in Queensland Health facilities and used all of those to inform each of the sub-plans which were being used to come up with a comprehensive whole of health plan.

And each sub-plan was supported by an expert group?---That's right.

All right. Now, if I can take you to – excuse me a moment – 127 of your statutory declaration?---Yes.

Now, here, you talk about the process involved in the cessation of the Redlands project, okay?---Yes.

Are you aware of any particular change in policy or change in expert opinion which led to that decision to cease Redlands?---No.

Even now?---No.

There's discussion in documents before the Commission about a state-wide service - - -?---Yes.

- - - and the BAC was a state-wide service. Are there particular situations where a state-wide service is the most appropriate or the best method of caring for patients?---Yes. There – there – there are numerous examples where state-wide services are the best way of providing services. I suppose the most common way for people to conceptualise this is when the nature of the service to be provided is very small in volume and where, to satisfactorily provide that type of service, you introduce safety and quality concerns if you spread that everywhere. So, for example, in mental health it's commonly recognised in most jurisdictions in Australia that forensic mental health services have a high degree of speciality. There's a great degree of concern over the nature of those services. And whilst community mental health services might be quite widespread, the tip of the iceberg, as I'll refer to it – which may well be high-secure inpatient beds – are of small in number and such specialisation that, perhaps, they should be provided in one site or in a few number of sites compared with, for example, the number of health and hospital services that a state might have.

And in this, the BAC dealt with severe mental illness in adolescents. Is that one of those services that you were talking about?---Perhaps [indistinct] turn perhaps more to what was being proposed in the plan, which was the relocated service.

Right?---What we were clearly looking at was a relocated service that would have a new service model, that would be much more clearly defined as to the inclusion and exclusion criteria, the length of stay and how it would be connected in with the full range of child and youth mental health services. Our belief at the time – and it's still my belief – is that there is a need for that type of unit for a state with a population size of Queensland's. What needed to occur was there needed to be reform, and reform needed to take the format of better linking-in to all child adolescent and youth services for services that might needed for the person once they leave the Barrett Adolescent Centre, and that that service needed to be more consistent with the direction which we were heading, which was, I think as evidence has been said this morning, was a shorter length of stay to try and mitigate institutionalisation effects from long lengths of stay.

All right. I'm going to deal with my second-last topic, which is a thing called the National Mental Health Service Planning Framework?---Yes.

Now, I gather from your statutory declaration that that is a document that has been prepared with the cooperation of the Commonwealth and a number of the states; correct?---Yes.

And it has been prepared over the period from about 2010 until now?---Perhaps if I explain the background. In my submission, I've talked about national mental health strategy and planning. One of the difficulties when the fourth plan was being considered was that we did not know in this country where we needed to be heading

in terms of planning for mental health services, that is, it was clear there was no agreed framework which said how much of what types of services we needed to have where. Therefore, when Health Minister agreed to the fourth National Mental Health Plan, action 16, which is the action called the development of the National Mental Health Service Planning Framework, was considered a foundation action, that is, it was considered one of the most important ones to be delivered during the life of the fourth plan. The Commonwealth set aside more than $1 million in funding and approached New South Wales with an agreed subcontract to Queensland to develop that framework. That framework, as I understand, commenced its actual project structure during 2011 and finished in 2013 its first phase.

Right. But since then, it has continued to be developed?---That's correct. So my understanding is that the project funding from the Commonwealth ceased in 2013. At that point in time, New South Wales delivered a number of products as part of the outcomes of their contract with Commonwealth, which included what was called an estimator tool – is now called a decision support tool – together with a range of other products which, together, formed that National Mental Health Service Planning Framework.

All right?---After that period of time, the products were made available under very strict instructions to each jurisdiction to allow them to use that planning framework to inform state planning, but also as a developmental process so that errors, corrections, thoughts and changes would go back to the project so that a final version of the framework would be developed that would iron out the difference between a framework which was developed, if you like, through the evidence that we had and experts and the application of that in a state planning environment, which it had not been through until that point in time.

And, Dr Groves, I gather it's not controversial that the framework is still in development and still in draft?---That's correct.

And I gather also it's not intended to be comprehensive, that is, cover every service across the country?---That was one of the very important elements that was stated throughout the life of the framework. It was not possible for it to be all things for all people, but for most situations for most people, and I think it has achieved that well.

So if you were to try and use it – and I don't propose to – but if you decided to use it and you accepted the limitations of it that you explained, would it enable one to make at least some sort of assessment of subacute bed services that might be needed for a particular stay?---Perhaps I should mention here that I was engaged in 2013 by the West Australian Mental Health Commission to do precisely that task. I was their state clinical planner for mental health, and took the framework as it existed at that point in time and modelled it against the West Australian population to make recommendations to the commission about what was the optimal level of services that they needed to have of all types that the framework can do. It does that and it does it with the need to adapt certain parts which have been found subsequently to be incorrect.

Right. But I suppose my point is it's – if one was looking at the different types of services that a framework deals with and allows you to use the estimator tool, one of those services that one might use it for would be – however one calls it – a Barrett or a Redlands or a tier 3 – that type of subacute facility?---That's correct. It will give you a number which indicates the predicted number of subacute beds right across the whole life span. So it will do it broken down by the known epidemiology for mental illness across each age group. It does it less well where the number it produces is very low. So in adults and older adults where the numbers are higher, there is more robustness in the number it comes up with. The younger the age group is, the less the number it is, and the more prone to error. That's in the instrument, but the simple answer is it gives a number.

Right. Now, just the last point. You left Queensland Health when?---I left Queensland Health's employment in August of 2012. I ceased doing the role in relation to planning in October 2011.

And you didn't leave on good terms?---No.

Are there – is there subsequent legal matters – I don't need you to go into the detail?

MS WILSON: Commissioner, why is this relevant? Why is this relevant to the Terms of Reference for this Inquiry?

COMMISSIONER WILSON: Well, I'm not going to answer that.

MR FREEBURN: I was anticipating that some questions may be asked, but I'm happy to stop now.

COMMISSIONER WILSON: Well, perhaps you could explain the relevance, Mr Freeburn – explain what you submit is the relevance.

MR FREEBURN: I'm sorry.

COMMISSIONER WILSON: Could you explain what you submit is the relevance of this evidence.

MR FREEBURN: Commissioner, I was anticipating that Dr Groves may be asked about details of this. If he's not going to be asked about it, then plainly it's not relevant. I won't persist with the questions.

COMMISSIONER WILSON: Very well. Thanks.

MS WILSON: Thank you, Commissioner.

COMMISSIONER WILSON: How long will you be, Ms Wilson?

MS WILSON: Perhaps 15 minutes, but perhaps even shorter depending upon the answers of Dr - - -

COMMISSIONER WILSON: Alright. Well, after your cross-examination there will be a break before we proceed with the rest.

MS WILSON: Thank you, Commissioner.

EXAMINATION BY MS WILSON **[3.00 pm]**

MS WILSON: Commissioner – sorry. Doctor, you've been asked a number of questions by Counsel Assisting in relation to the establishment of the Queensland Mental Health Commission. Do you recall that?---Yes.

Now, you have no knowledge of any practical budget impacts in relation – in Queensland?---No.

Okay. And you've no knowledge whether any direction has been given by the Minister?---No.

And, Commissioner, I do note that the Commissioner herself was here yesterday and wasn't asked the same series of questions, so there is – some assistance could have been provided, perhaps, yesterday by her answers to that series of questions. And moving on to another issue, since 2012, you haven't been practising in Queensland or been involved in the Queensland system?---That's correct.

First of all, you went to Western Australia; is that the case?---That's correct.

And now presently you're working in South Australia?---That's correct.

Now, you've been in the back of the court today, listening to the evidence of Dr McDermott?---Yes.

Professor McDermott. And is it the case that you have not, since moving from Queensland, maintained detailed knowledge about the services – the suite of services provided to the Child and Youth Mental Health Services in Queensland?---That's correct.

But this morning you would have got a fair idea listening to Dr – Professor McDermott?---I did.

And you heard me go through a number of those services. And I can just go through in a quick – just in a quick dot points – just take you through them?---I can take you to – I have actually been to the Lady Cilento Hospital, and I have seen the subacute beds.

Okay. Well, that's good. We'll start there. So you have been to the Lady Cilento Hospital. So that's the subacute beds?---Well, a unit that includes some subacute beds in it.

Some subacute beds. Okay. And then moving – and then that is part of the spectrum of services – the suite of services provided?---That's right. Yes.

That is only one part. And another part is the AMYOS. I think you've heard in the last couple of days - - -?---And the others – and the others I have no knowledge of.

No knowledge of the contents of?---That's correct.

Okay. So now can I take you, then, to paragraph 98 of your statement?---Yes.

Now, can I just take a helicopter view before I ask you some questions about paragraph 98?---Yes.

What you did hear this morning was that there are a number of services offering different types of services throughout Queensland going from mobile outreach services referred to as AMYOS. You heard the professor talk about resis?---Yes.

And the good work that's being done by resis. And I think you might have been here yesterday when you heard me asking questions describing a resi as a rehabilitation service that's providing long-term accommodation up to 365 days and recovery-orientated treatment for 16 to 21 year olds who have moved out of that acute phase of their mental illness but lack the skills or expertise for independent living. And you've heard the professor talk today about day programs which aim to reduce the severity of mental health symptoms and promote effective participation in areas such as schooling, social functioning, symptom management and other life skills. Then there is the proposed step up and step down units. And you've heard the professor talk about those this morning?---Yes.

And then – as you say, you have been out to the Lady Cilento?---Yes.

Okay. So just giving you that just as a sketch of what's available in terms of the suite of services – and there's a term that's used, isn't it, is the continuum of services?---Yes.

And that's – what do you understand is the continuum of services?---It's a suite of services that cover the various different elements that, if added together, from a planning perspective should meet the needs of the group of people who you're targeting.

Okay. Now, bearing in mind – and I appreciate that you haven't got detailed knowledge of each and every one of those services, but those services would cover, just from the basics that you've heard, the matters that you raise in paragraph 98?---I

believe they would if they were a comprehensive suite applied right across Queensland.

Okay. Now, I just have one other question – and then - where do you get from your experience there are around 100 adolescents and youth in Queensland – the number 100. Where do you get that from, Doctor?---I think the number is around – and that's an estimate based on my knowledge of doing significant planning both in Queensland, Western Australia and in South Australia. And it is looking at the group of people who are emerging adults, however we wish to define them in that age group, who have the most severe forms of mental illness usually associated with a number of other complex trauma issues and a significant amount of family breakdown often as the consequence of the way in which they have been affected by the symptoms they have. And 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 no 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.

Yes?---It's about needing to have extensive treatment and rehab. And I believe that that is the number that we would be thinking about if taking a planning approach in Queensland.

Okay. And – but then again, I suppose that a caveat is put on that that you haven't been in Queensland and working in Queensland for some time and across the detail?---The epidemiology of Queensland hasn't changed that much in the last three years.

Okay. Just another issue that I wish to raise with you is about alignment?---Yes.

You've heard me ask a series of questions about alignment?---Yes.

And I don't want to go through it. Do you know what I'm talking about?---Yes.

That is, the alignment between youth – adolescent youth and mental health into adult. And you've heard me put the proposition about a mapping service that should be taken before embarking upon any – defining what these programs should be?---And I agree with your proposition.

Okay. Thank you, Doctor.

COMMISSIONER WILSON: Twenty-five past 3.

WITNESS STOOD DOWN

ADJOURNED **[3.07 pm]**

RESUMED **[3.26 pm]**

AARON GROVES, CONTINUING

COMMISSIONER WILSON: We're up to you, Ms McMillan, I think.

MS McMILLAN: I don't have any questions now. Thank you, Commissioner.

COMMISSIONER WILSON: Alright. Does anyone else have any questions of Dr Groves? What about Dr Groves' own representative?

MR PRATT: No, nothing. Thank you, Commissioner.

COMMISSIONER WILSON: Mr Freeburn, do you want to clarify anything.

EXAMINATION BY MR FREEBURN **[3.27 pm]**

MR FREEBURN: Yes, please. Just one thing.

Dr Groves, I think you said in answer to Ms Wilson's questions that you have been to the Lady Cilento and you'd seen the acute beds in the acute ward – sorry, sub-acute - - -?---Both the sub-acute and the acute beds.

- - - beds in the acute ward?---Yes.

What did you observe about that process?---About the process or the facility?

The facility?---I think the facility has a very good – infrastructure is very modern inpatient unit. I think it's quite impressive particularly compared with other child acute units throughout the country. My understanding from talking to staff is that there are some current difficulties in the length of stay and flow through the unit because some people have a length of stay that is longer – or exceeds what's expected and that the number of sub-acute beds isn't sufficient for all of the people for that unit. That's what I was told at the time. I have nothing further to add than that. I think I might make the comment, though, it was really designed primarily to be an acute unit on both sides – the youth side and the child side. I think that Professor McDermott talked about the difficulties of providing a good range of care in a more homelike environment in an acute unit. I think that whilst the Lady Cilento Hospital's service is clearly modern and much better designed than – than many

others it doesn't mitigate all of those issues. But it's certainly a lot better than might otherwise have been the case.

Am I right in thinking that an acute service is a more medicalised environment?---Yeah, by its very nature it is. I mean, even mental health units which are less medical than say, for example, an acute paediatric unit or an acute surgical unit, they – they are still medical by their very nature. They are hospital beds. They need to reach a whole lot of hospital standards. Those standards are very different from what you try and provide in a residential facility however you form it.

Commissioner, I have nothing further. May Dr Groves stand down?

COMMISSIONER WILSON: Yes. Thank you, Dr Groves. You can stand down. Thank you very much.

WITNESS STOOD DOWN [3.29 pm]

COMMISSIONER WILSON: Now, there are no more witnesses this afternoon?

MR FREEBURN: No, Commissioner.

COMMISSIONER WILSON: Can you adjourn please till 9.30 in the morning?

MATTER ADJOURNED at 3.29 pm UNTIL
WEDNESDAY, 17 FEBRUARY 2016