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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

9.05 AM, FRIDAY, 11 MARCH 2016

Continued from 10.3.16

DAY 25

RESUMED **[9.05 am]**

COMMISSIONER WILSON: Good morning, everyone. Mr Duffy.

5

MR DUFFY: Commissioner, thank you. There's a matter I wish to raise in relation to a document that was tendered by my learned friend, Mr O'Sullivan, during his cross-examination of Dr Stathis yesterday. I'll mention the Delium reference, but it ought not go up whilst we're in open court, for a reason that I'll explain; it's
10 QHD0130011080. It's an email, and I'll hand up a copy to your Honour so you can see what I'm talking about.

So everyone can follow, it's an email that was sent from Mr Stathis to – Dr Stathis to Judi Krause and some others, and it contains an email chain. My concern is this –
15 sorry – I should firstly say it's a matter of procedure, and the reason that it ought not be put up is that the second of the emails towards the middle of the page does mention some patient names, and I can say as an outside, Commissioner, that Mr O'Sullivan has informed me that he proposes that a redacted version be tendered, and perhaps the appropriate course – he can address this – but it might be to substitute the
20 redacted version for the unredacted.

My concern is this, not with that directly: my concern is that there are, may I say, oblique references to someone called Bill having said something to someone, who then said it to someone else. My objection is this: I object to the document being
25 received as evidence that Dr Kingswell – if indeed he is the Bill – that Dr Kingswell said the things concerned or had those views. It ought not go in as evidence of that. And as I understand, Counsel Assisting has no intention of making that submissions in any event. So that is my objection, not to the reception of the document more generally.

30

COMMISSIONER WILSON: Mr O'Sullivan.

MR O'SULLIVAN: Commission, in our respectful opinion – our respectful submission, the objection is a good one, a correct one. The document, we only got
35 into our position a couple of days ago, so we didn't have it when Dr Kingswell was giving evidence, and my learned friend didn't have it when Dr Kingswell was giving evidence. So there has been no opportunity either by me or by Mr Duffy to ask Dr Kingswell. In those circumstances, it would be unfair, in our respectful submission, for the objection not to be allowed. The objection should be allowed, in our
40 submission.

COMMISSIONER WILSON: So you're content for none of the document to go in; is that the position?

45 MR O'SULLIVAN: No, no. The objection – may I take your Honour to the particular - - -

COMMISSIONER WILSON: Yes.

MR O'SULLIVAN: - - - aspects; is that convenient?

5 COMMISSIONER WILSON: Yes, certainly.

MR O'SULLIVAN: I won't read it out in open court out of sensitivity to my learned friend's client. If one goes to – the email commences 19 March, at the bottom of page 1 Commissioner – one sees the first line:

10

Notes of a phone call with Anna at the branch.

And if you turn over the page, 1081, Commissioner, two lines down, "Anna said" and there's a name there.

15

COMMISSIONER WILSON: Yes.

MR O'SULLIVAN: And there's – there are statements made about what that person said to be pushing for a Commission of Inquiry into the closure of Barrett.
20 He thinks it will buy us time to get other things set up before a decision is made on the 22 beds. That's one aspect of my learned friend's objection, that the document ought not be received as evidence that the person whose name there – Anna said that person – it not be received as evidence that that person Bill, whoever that may be, either had those views or said those things.

25

COMMISSIONER WILSON: Frankly, Mr O'Sullivan, I'm not very interested if people have those views or if they'd said those views, they'd said things like that. They don't interest me.

30 MR O'SULLIVAN: No, no.

COMMISSIONER WILSON: What I'm interested in is the content insofar as it relates to what facilities for mentally ill young people were proposed.

35 MR O'SULLIVAN: Yes.

COMMISSIONER WILSON: That's all that interests me.

MR O'SULLIVAN: And, with respect, we would have thought that's right. I'm
40 simply trying to explain the objection that's being taken, and the objection only goes to whether the document is evidence of the truth of what appears on the third and fourth lines of 1081 and the truth of the second line at 1080; very concerned that person would want another inquiry. That's my learned friend's concern. We're perfectly content for it to be received into evidence on the basis that it's not to be
45 regarded as evidence of the truth of those matters, and, with respect, we associate ourselves with your Honour's comments. That's got nothing to do with something that is of any concern to you, and nor should it be, Commissioner.

COMMISSIONER WILSON: It is of no concern to me at all.

MR O'SULLIVAN: Absolutely. My learned friend's simply trying to properly protect his client's interests, and all I'm trying to do is say that we have no objection
5 to that course, Commissioner.

COMMISSIONER WILSON: Alright. Well, as I understand the course that's proposed and to which you have no objection, it is this, that I receive the document, however where there are references to Bill it's not on the basis that it's put forward
10 as evidence that Dr Kingswell said these things.

MR O'SULLIVAN: That's right, your Honour.

COMMISSIONER WILSON: Alright. I receive it on that basis.
15

MS WILSON: Can I just - - -

MR O'SULLIVAN: Or have those views my learned friend wishes to - - -

20 COMMISSIONER WILSON: Yes, Ms Wilson. You've got a view on it too, have you?

MS WILSON: Just a little one.

25 COMMISSIONER WILSON: Yes.

MS WILSON: And can I just add my two cents worth. Taking up on your Commissioner's comments, the relevance, really, of this email into – in relation to the Terms of Reference of this Commission of Inquiry is very tangential. I just want
30 to place that on the record, and I think that is consistent with your – the Commissioner's views that you've just said. Thank you, Commissioner.

COMMISSIONER WILSON: Alright. Let's get on with the evidence. Now, Ms Wilson, I think you were cross-examining Dr Stathis.
35

STEPHEN STATHIS, CONTINUING [9.12 am]

40 **EXAMINATION BY MS WILSON**

MS WILSON: That is the case. Thank you, Commissioner. Dr Stathis, you were asked some questions about the Youth Mental Health Commitments
45 Committee?---Correct.

Now, you are a member of this Committee?---Yes.

And this Committee is looking at a 22-bed subacute facility?---Amongst other things.

Okay. And what are the other things that it's looking at?---We're looking at a range of options, including the possibility of a 22-bed unit. We're also looking and costing up other options; for instance, potentially three seven-bed units, two units of, say, 10 beds each, where they might be. We're looking at mapping of services across the State in terms of population mapping. We're then going to undertake service mapping of where units or services should be across the state, and we're doing that in parallel and in anticipation of the Commission's findings so that a body of work would already be completed beforehand so that we can – so that any decisions in terms of future services may be expedited.

Okay. So you had three meetings; is that the case?---That's correct.

And is it still early days in the committee's work?---Yes.

And all potions are on the table?---We haven't ruled anything out.

And you're doing many scoping exercises, looking at models of care, for example?---We're looking at models of care. We're looking, as I've said, population mapping, service mapping. We're looking at possible sites in terms of where these places could be placed, could be situated.

On a range of facilities?---On a range of facilities across the state, but mainly concentrating on the southeast corner.

Okay. And you – are you looking at the – a demarcation of a number of factors based on looking at age, service, diagnosis and geographic area?---Particularly in relation to the population mapping. They're looking at 13 to 18, 18 to 25, 16 to 21. In other words, we're doing a mapping right across the population of all HHSs across the State.

Okay. So for completeness, I'll just show you these documents. Can the witness see QHD.031.001.1501. I apologise, Commissioner. It appears I've got the wrong document. If the witness could see QHD.031.001.0464. Terms of Reference have been established?---Terms of Reference have been established.

And that is a - - -

COMMISSIONER WILSON: What is the document, Ms Wilson?

MS WILSON: It's just the Terms of Reference, Commissioner. We were provided it the other day.

COMMISSIONER WILSON: Of what?

MS WILSON: Of the Youth Mental Health Commitment Committee.

COMMISSIONER WILSON: There's no need for that to be redacted, is there?

MS WILSON: I wouldn't have thought so.

5 COMMISSIONER WILSON: Do you have the – what you call the unredacted version there; that's QHD0310010464?

MS WILSON: Commissioner, I've got a hard copy for yourself.

10 COMMISSIONER WILSON: Thank you.

MS WILSON: These are the Terms of Reference?---Thank you. Yes, that's correct.

Now, these Terms of Reference have been amended, have they, to – in one
15 aspect?---I believe so.

And is it the case that it has been amended that for the purpose of the committee planning, young people are considered to be from 13 to 18 years of age within the context of the proposed service models, however the needs of young adults aged 18
20 to 24 with developmental issues will also be considered?---Yes. We're particularly interested in the gaps of services for those young people aged 18 to 24.

Commissioner, I tender that document.

25 COMMISSIONER WILSON: Before you do so, Ms Wilson, where is that amendment to be made?

MS WILSON: I'm going to take you to another document, Commissioner, which will fit that in.

30

COMMISSIONER WILSON: Alright. Fine. Well, that document will become an exhibit.

MS WILSON: Can I take you to QHD.031.001.1171. This is the minutes of the
35 most recent meeting on 23 February 2016?---That's correct.

Okay. If we can go to 1172, and we can go down to the amended Terms of Reference, we can see there that all members present endorsed the following additions?---That's correct.

40

We can see that passage that I just read out to you about what young people are considered to be from. And if we can just go over the page, and there's also another addition to the Terms of Reference of considering patient flow and patient safety at transition points?---Yes.

45

Can you explain that to me?---Well, we're very interested in the transition between adolescent services and adult services and how to manage that transition more appropriately, particularly given the gaps in services for those young people.

5 Okay. And we can also see that on the screen we've got some data that the Committee has considered?---Yes. That's early data, but we've certainly considered that.

Okay. If I can take you to .1174, and if we can go down the page, please, we see
10 here there's a discussion that ensued. And if we can go over the page to 1175 and down – can we go to the bottom of the page? Can we go to the second-last dot point? And these are the matters that were discussed in the Committee - - -?---That's correct.

15 - - - that should decide on the age range for service options and identify the risk – and identify and risk manage any identified gaps between adolescent services and adult services. You gave some evidence, I think, with Counsel Assisting about – there's a potential – there is a gap or a potential gap between youth and adolescent services and adult services. What does this second dot point – does it feed into that
20 issue?---Yes. It's early days, but, for instance, using the current suite of services that we're rolling out, YPARC services have pushed up to 21 in Cairns, youth resi services have pushed up to 21 across the state. We're also considering, based on population mapping and service mapping and what can be provided across the State, what other services could be offered for that youth age group. Whether it's 18 to 21
25 or 18 to 24 is still being considered, particularly in relation to those young people with developmental vulnerabilities.

And what would your view be on a service mapping exercise, looking at the services that are provided for youth and adolescents and the services provided for adults?---I
30 believe I discuss that in one of my affidavits, and I have a very strong view that that needs to be undertaken so that we have a full understanding about where these young people are and what services are or – more rightly – are not available across the state in order that we can efficiently and appropriately roll out a continuum of care.

35 Feeding into that same topic, what about matters where some patients may have a dual diagnosis, that is, they have mental health issues and a disability?---I've had informal discussions with a range of different government organisations, and that is a real gap. There is – there are minimal services for young people with dual diagnosis, in particular what you said, cognitive impairments or other forms of disabilities with
40 co-morbid mental health problems across the state. This is a key gap in service delivery.

Thank you. Thank you, Commissioner. I have no further questions. I tender that document.

45

COMMISSIONER WILSON: Alright. Well, that document will be marked as an exhibit. Dr Stathis, you've talked about the two gaps, if I can call them such, that from 18 to – whether it's 21, 24 etcetera - - -?---Yes.

5 - - - and that relating to dual diagnosis for patients. These are problems, I take it, not just in Queensland but across the country - - -?---Yes.

- - - if not - - -?---If not globally.

10 - - - across the world, but - - -?---Yeah.

- - - we've got to limit our inquiries, I think. Is work being done on a national level with respect to these issues?---It would be interesting to – I'm not aware of that, Commissioner. No doubt there is some work being done, and I'd be interested to see
15 the rollout of the new national mental health plans and Queensland state mental health plans to see if they're included in that.

To what extent does Queensland, whether it be specifically Children's Health Queensland or Queensland Health or maybe some other department of government,
20 have input into setting the national agenda for these discussions?---There are Queensland representatives in the committee; I'm not one of them. And it would be difficult for me to comment further on that, Commissioner.

Alright. Thank you. Thanks, Ms Wilson.

25

MS WILSON: Thank you, Commissioner. No further questions.

COMMISSIONER WILSON: Anything arising out of my questions? Mr Freeburn, do you have any questions?

30

EXAMINATION BY MR FREEBURN [9.23 am]

35 MR FREEBURN: Just one point, Commissioner. Dr Stathis, I think, yesterday, you talked about, effectively, an email or a memo going out to the effect that people could see you if they wanted a bed?---Yes.

Now, I'm going to show you a hard copy of an email, and for the record it is
40 WMS.1007.0038.00001. It may not be able to be pulled up, but I may get the bailiff to show you so we can identify it, and then we'll arrange for copies.

COMMISSIONER WILSON: Is it possible to bring that document up?---Yes, that's the memo dated 22 October I referred to yesterday.

45

MR FREEBURN: Right. I will propose to tender that document.

COMMISSIONER WILSON: I think it should go on the screen, if possible.

MR FREEBURN: I don't think it'll be controversial with anybody.

5 MR DIEHM: I'm sure it's not, Commissioner, but I'd like to see it if I can.

COMMISSIONER WILSON: Is that the one?

MR FREEBURN: Yes.

10

MR DIEHM: Thank you, Commissioner.

MR FREEBURN: May Dr Stathis, stand down?

15 COMMISSIONER WILSON: Thanks very much, Dr Stathis?---Okay. Thank you.

That's the conclusion of the evidence. I don't expect that you'll be required further, but I'll only stand you down and not excuse you just in case?---Thank you.

20

WITNESS STOOD DOWN **[9.25 am]**

COMMISSIONER WILSON: That document will be an exhibit.

25

MR FREEBURN: Thank you.

COMMISSIONER WILSON: Ms Mellifont.

30 MS MELLIFONT: Commissioner, before the next witness is called can I deal with a housekeeping matter - - -

COMMISSIONER WILSON: Certainly.

35 MS MELLIFONT: - - - and that is that my client has produced three bundles of documents with respect to three transition patients, which fill in some gaps in terms of documents already tendered. Indexes to those documents were circulated yesterday, and I seek to tender them as three exhibits. They are indexed, and the hard copies are attached; Patient A, Patient M and Patient F.

40

COMMISSIONER WILSON: Does anyone have an objection. Very well. They will be received and marked as exhibits, if you'd give them to the bailiff.

MS MELLIFONT: Thank you, Commissioner.

45

COMMISSIONER WILSON: The next witness?

MR FREEBURN: I call Dr Michelle Fryer.

MICHELLE FRYER, SWORN **[9.27 am]**

5

EXAMINATION BY MR FREEBURN

10 MR FREEBURN: Dr Fryer, you've submitted two reports - - -?---Yes.

- - - to the Commission. One is dated 3 December 2015, and one 10 March 2016, which is yesterday?---Yes.

15 Commissioner, the first submission is exhibit 144, and for the operators it's RAN.001.0001.0001, and I should tender the second submission, which is RAN.001.0002.0001.

COMMISSIONER WILSON: The second one will be marked as an exhibit. I take
20 it all counsel have copies or access to it?

MR FREEBURN: They've been circulated. Dr Fryer, can I just ask you a little bit about process. You've put these submissions on behalf of the College?---Yes.

25 Does it mean that in the preparation of these submissions you sought the use of the Committee or the members widely or – or what?---So in the preparation of these documents, I sought – I consulted with my colleagues, child and adolescent psychiatrists in Queensland, and I also consulted with the Bi-national Committee of the Faculty of Child and Adolescent Psychiatry, particularly our current chair, Dr
30 Nick Cowell, in Perth.

When you say you consulted, you've – you obviously couldn't consult with 100 or so. You consulted with a number of them?---So we have a number of forums through which we communicate, such as by email, through meetings and there are
35 meetings of the Bi-national Committee through the year as well although not that frequent. So I consulted with those that I could access and tried to do so as broadly as I could.

Right.

40

COMMISSIONER WILSON: Dr Fryer, I'm having trouble hearing you?---Sorry.

Speak up and speak into the mic, please. Thank you.

45 MR FREEBURN: Now, I gather that in corralling all that – those different people there wasn't necessarily a consensus. There may have been contrary views and what you've done is distil as best you can - - -?---Yes.

- - - some of those views. Now, can I deal with this concept of a lack of evidence because that comes through in both of your submissions. It may not be true that this a evidence-free zone, that is, adolescent mental health but it's light in evidence, is that? Is that a fair characterisation?---When we come to the group of very severe and complex adolescents with mental illness and the issue of whether medium to long stay or medium and long stay units are beneficial or not the evidence becomes very sparse.

Yes?---I actually contacted the support – support staff at the college to have another search for me prior to the second submission and they found it very difficult to find relevant literature.

So in respect of those most severe adolescents that we're talking about here the evidence, as you say, is sparse?---Yes.

And is that naturally because we're talking about such a small group?---So it is a very small group – an important group but a very small group of young people.

Yes?---And that makes conducting research into the group difficult. It's also difficult to have a control group.

Yes?---So normally when you're trying to see [indistinct] and there's someone – something is effective you compare it with doing nothing or with a placebo. Clearly, when you've got a group of people who are severely ill you can't do nothing. But that does make researching efficacy – effectiveness more difficult.

Yes. Does the current evidence base support a particular form of intervention over another and what I mean by that is can we say that community care might assist a particular group of adolescents over brief inpatients stays over intermediate stays or long stays?---To my knowledge the short answer to that question is no, we don't have the evidence. Within subpopulations we're to say that the evidence for some disorders might indicate – or experience it's probably better to say would indicate that for young people with, for example, treatment resistance to their psychosis there is more evidence of an inpatient rehabilitation-type setting being useful whereas for others there is less evidence and more evidence for models of community care. We still have a long way to go in being able to give a definitive answer to your question.

If I can take you to paragraph 2 of your first submission, so that's the other – I'm interested in the concept of cost-effectiveness. Now, I can easily understand how the cost can be assessed – the cost of different types of services but I gather from what you just told me that the effectiveness is a difficult thing to judge. Is that right?---Yes.

Okay. Now, can I deal with the appropriate length of stay and if we go to paragraph 3 you say:

Australian mental health services are strategically guided by the National Mental Health Plan.

Now, you're aware, are you, of the Fourth National Mental Health Plan?---I'm aware of it. I have some knowledge of its content. I wouldn't say that I was familiar with it in great detail.

Okay. Without taking you to the document, could I suggest that that health plan includes long stay – that they use that expression – as one of the elements?---So I do look over the document in preparation for today and my reading of it is that it emphasises least restrictive care and community care - - -

Yes?--- - - - but also includes consideration of the need for a full continuum of care for patients of all severity of illness across the lifespan.

And that includes acute, long stay, Step Up Step Down, supported accommodation services and ambulatory and community-based services?---Yes.

Alright?---That document is talking across the lifespan as well so within that you have to look at different patient populations, age groups and what's most effective for subpopulations of everyone with mental illness.

When a document like that uses the expression long stay is there some profession definition of long stay?---No.

In your second submission, if we can go to that, on page 4 of that document. Now, if we scroll down a little – no, stop there. That first large paragraph that commences "As outlined" and there you say:

Overall the RANZCP supports consideration of a medium-term inpatient unit that provides extended treatment and rehabilitation.

Medium-term is your expression. Are we able to put some figures on that?---So I started using that to differentiate between acute units and long stay in the context of this Inquiry. There is no standard about what is a medium stay, what is a long stay as you have identified.

Yes?---For me in my thinking they're three to six months.

Yes?---It's very difficult to put a figure on especially for this group. One needs to be responsive to their needs but also have careful consideration of not just the benefits or potential benefits but also the potential risks of any intervention that's undertaken.

Yes. Alright. While we're here we probably should correct what I think is a typographical error. In the fourth last line you talk about the risks of de-institutionalisation. Do you see that – fourth last - - -?---Yeah, sorry. That should say - - -

It should be - - -?--- - - - institutionalisation not de-institutionalisation. Thank you.

Without going back to it, your first submission talked about the protracted admission of patients – sorry, the protracted admission of adolescents to inpatient facilities being the antithesis of the strategic direction. By protracted you're really meaning over 12 months, aren't you?---Yes.

Now, can I deal with this concept. What do you say to the proposition that patients of the Barrett cohort, they are very severe patients requiring long or medium term inpatient service. What do you say to the proposition that those patients being treated in an acute unit?---As the Commission has heard, those – the needs of those patients are different to acutely unwell patients where there's very much a focus on stabilisation of mental state, institution of often but not always medication and the correct treatment, and a move to return to community care as quickly as possible. That is not a rehabilitation focus so it is different to the needs of patients who have ongoing, what we term chronic, severe symptoms and severe illness.

Is the difficulty that you would end up with a situation where the long term patient would be sitting there watching acute patients come and go with all the drama of that while they were there as well as – is that one of the problems?---So if you're talking about co-locating - - -

Yes?--- - - - two different patient types in one unit, there are a number of risks associated with that. And as you've identified, the impact of the changes of the patient mix and the high acuity needs of the acute patients who are coming in to be stabilised to leave can have an impact on people who are there for longer.

And what about the risk to the acute patients? Is there a risk to the acute patients in having somebody there who's long term?---For some, potentially, in that they may think this is what's going to happen to me. So they might develop a negative or pessimistic view of their prognosis that might act as a dress and therefore impact negatively on their mental state.

But am I right in thinking your essential problem with it is that you – there are two different types of treatment for these two different cohorts?---It can be managed. But it's very labour intensive to manage that.

Right. Now, you know the Walker Centre has a six month target. They have a target - - -?---I understand that's the case. Yes.

Which fits within what you would recommend, correct?---For consideration of a subacute unit, about three to six months. Yep.

Now, can I ask you about dislocation from the family and community. Your submissions acknowledge that there may be a small group of adolescents who require a dedicated medium stay inpatient unit. And that unit is to provide extended treatment and rehabilitation. Is a particular – is one particular need for that patients

who might be dislocated from their family or might have a dysfunctional family?---The issue of dislocation from family is a risk. So wherever possible, we want to keep young people connected to their families and their communities and their schools and their friends. The issue of when family functioning, for whatever reason, is acting as a stressor for the young person is a different issue. And in some cases, that might be a reason for a young person to be placed, either temporarily or permanently, away from their family, depending on their age and their development and their needs.

You talk about this modern trend to try and treat people as close to their family as you possibly can. That's a model that doesn't work for some patients who have a dysfunctional family?---But we would still want to keep them connected to their school, their friends, any community activities that they're involved in. So that wider social context.

I see?---It's a – yep.

Now, if I can go to your second submission, you provide a table. I just wanted to quickly scroll down to the table. Now, that table is based on a 2015 survey. Is that right?---Yes.

And we've – we can produce the survey and in due course I will tender it as evidence. But your table is to the effect that there are 23.1 per cent of adolescents who have a severe – sorry, I'll go back. Can you explain that 23.1 per cent and how you got to that figure?---So I was attempting, for my own thinking, to try and bring some understanding of the context in Queensland.

Yes?---As I was writing my notes I thought it might be helpful to provide that more formally in addition to my testimony today. And I apologise that that ended up longer than my original submission. The authors of the survey – I'm not a health statistician.

Yes?---So they assessed for the presence of mental illness across the population. It's a very important academialogical study. And then they used a statistical method based on the self-report of symptoms and functional impact of the young people and their families to break those down into severity groups in accordance with established methods of doing so, so accepted methods of doing so. So of all the people with mental illness, 23.1 per cent of those were found to have severe mental illness, 32.8 per cent moderate and 44.1 per cent mild. And I've then applied those figures to the number of adolescents in Queensland.

So did you apply that figure to the 51,408 that's on the screen? Is that - - -?---So the breakdown into the three groups is a breakdown of that 51,000.

Right.

COMMISSIONER WILSON: Can I ask a question to see if I am following what you're saying. This breakdown in the report of the survey between severe, moderate and mild related to people of all ages?---So the survey was undertaken in children and adolescents up to the age of – I think including 17 years. We were stopping at
5 the 18th birthday.

Right?---And then we took that to the adolescent figures. And I - - -

So within the survey results, was there a distinction drawn between children and
10 adolescents?---There were distinctions in some parts of the survey. I'd have to go back to my notes regarding exactly how I derived these figures.

Alright. Thank you?---I think we were looking at the adolescent group but I would have to check to be sure.
15

Thank you.

MR FREEBURN: So, Doctor - - -?---The severe group is not the cohort of severe and complex.
20

No?---That would be looking at a consideration of subacute rehabilitation services or other intensive models of care.

Yes. So the 51,408 is Queensland children and adolescents up to 17?---That's an
25 estimate of the adolescents. So they gave prevalence figures. I think that's right, actually. They gave prevalence figures for subgroups of age. So children – and the adolescents, I think, were 13 to 17 years or 12 to 17 years. I'd have to double-check. And then that's the figures that we've used.

30 So the 51,000 is the adolescent figure for Queensland?---Yeah. So if you take the Queensland Government population production of how many adolescents there are in Queensland and then you look at the epidemiology data saying how many of those we would expect given the survey that was undertaken, what percentage of those are likely to have a mental illness. That's how I've come to that figure.
35

And then to go your further step and to break that down to severe, moderate and mild, where – how – what's the exercise involved there?---So within the survey – that was undertaken as part of the survey. So those percentages were the percentages that they found in the survey that broke down into those three groups.
40

Okay. So - - -?---And they've given a definition of how they arrived at those three groupings.

Right. Can I just clarify the survey. As I understand it – just tell me if I've got this
45 right – what they were actually surveying were particular types of diagnoses?---Mmm.

And, for example, they – included in the survey were anxiety disorder, major depressive disorder, ADHD and conduct disorder?---Could you scroll down, please.

Scroll down here?---Yeah. So - - -

5

So, yes, that's right?---Yeah. As I said, yes.

So those four things are part of the research, but there are things that are not part of the research?---Yes.

10

Psychosis, complex post-traumatic stress disorder, borderline personality disorder?---Psychosis was not included. I would have to double-check whether post-traumatic stress disorder was included with the anxiety disorders. It's certainly that there's a lot of anxiety symptoms as part of PTSD, so it may have been picked up in

15 that group. Developing personality disorders is difficult to assess for in the under-18 population, but comorbidity. So people who are developing personality difficulties often have problems with anxiety and depression, so I would expect that many of those would have been picked up in those areas.

20 Right. Would the same apply to something like anorexia nervosa – that is, it may well be a comorbidity with one of these other - - -?---There was some screening for disordered eating although they don't seem to have gone to confirmation of diagnosis with that group. So some problems with disordered eating would have been picked up and, again, comorbidity. So people with eating disorders often also have

25 problems with anxiety or low mood that may well have been picked up in those questions.

The people – the adolescents most likely to be served by a Barrett or a Walker would be patients with a psychosis or complex post-traumatic stress disorder or borderline –

30 developing borderline personality disorder?---There's not an accepted definition of complex post-traumatic stress disorder.

Right?---It's used clinically and in the literature, but it's not in either DSM or ICD-10 as a formal diagnosis. I say that because I want to be sure that we're talking about

35 the same thing, and I'm not sure how you're using that term.

Right. Okay. Well - - -?---There are a group of young people who've suffered abuse and neglect, and they tend to present with very complex symptom patterns that don't fit well into the current diagnostic systems and are often challenging to treat. And –

40 is that the group that you're referring to?

Yes, yes. And they would be at least some of the population of Walker and Barrett when it existed?---I would – I don't know enough about Walker to comment. Childhood abuse and neglect is a major predisposing factor – risk factor to a range of

45 problems with mental illness and psychological development. So you would expect to find it in a higher proportion of children and adolescents in mental health systems as compared to the general population.

Now, can I deal with AMYOS. Is – AMYOS is essentially a multidisciplinary team that goes out to see the young person in their home, and they might see them frequently – several times a week in order to assist them to overcome their mental illness. Is that a rough summary?---That's my understanding. Yes.

5

And in – it's called ambulatory – ambulatory?---Assertive.

Meaning the service goes out to the person rather than waiting for them to come in?---Yes.

10

Is a particular problem that such a service might get – might encounter that – the problem that I mentioned earlier, that if the person's home is the problem – if there's a dysfunctional home, they may not fit – the AMYOS service may not work?---One of the core principles of child and adolescent psychiatry is working with the family.

15

Yes?---So this is a core part of AMYOS's interventions and way of working. So they're not going into a home to work with the young person ignoring everything else that is happening.

20 Ignoring the family?---So their model of service is to work with the young person with their parents, with their support system, with their family and with the wider system as we refer to it, which is education or other community agencies, child safety if that's appropriate, youth justice – trying to bring those into a coordinated model of care that helps to support the young person and their family to address the
25 issues that are stopping them from achieving good mental health.

So family therapy, loosely described, is part of that service?---Yeah.

Alright. Now, can I take you to the next page of that – of your second submission.
30 Now, if we scroll down – sorry – to the fourth page. If we scroll down – see the sentence commencing:

Numbers of patients.

35 Sorry. The paragraph commencing:

Numbers of patients.

Now, you'll see about six lines down on the right-hand side you commence a
40 sentence:

It is probable that the development and provision of other intensive services such as AMYOS, supported education settings and residential settings with the requisite expertise can reduce and perhaps remove the need for subacute
45 *inpatient services.*

I just want to deal with that concept. Is it effectively what you are saying that if there is a whole suite of services available to adolescents then it's possible you may not need a subacute service?---It's possible. My thinking on this has evolved over time and through my involvement in this Inquiry and previously discussions around the closure of the Barrett Adolescent Centre. We come back to the problem that we don't have the evidence.

Yes. We don't have – well, isn't – if this is right – if you had a full suite of services but not subacute, then that might work – or possibly might work is your evidence. Is that right?---Yes.

But we don't have a full suite of services yet?---We don't yet. We're seeing the development of services like AMYOS and the rollout. That's been very promising.

Yes. Well, let's deal with AMYOS. AMYOS – there's about eight or nine AMYOS teams at present?---I know little about how far the rollout has been established.

Alright. We don't yet have a Step Up Step Down unit or facility?---I'm not - - -

Not sure?---Not sure.

All I'm suggesting is we're not there yet, are we, in terms of having the full suite of services other than the subacute?---I would agree with that understanding of the current situation.

Alright. One of the things that this Commission has heard is that a problem with, say, an AMYOS – setting up AMYOS service in a particular health service is getting the required expertise. You need a multidisciplinary team, so you need the expertise. Is that a problem that you're aware of?---That's a problem in child and adolescent psychiatry. That there is more workforce need than there are clinicians to meet it.

Now, you were involved as a member of the ECRG?---Yes.

And that included some fairly – some other people with particular child and adolescent psychiatry expertise?---Yes.

Professor Hazell?---Yes.

Dr James Scott, Dr David Hartman. He's a child and adolescent psychiatrist from Townsville?---Yes.

And Dr Sadler?---Yes.

Once the ECRG put in its report, which I can tell you was on 8 May 2013, are you aware whether anybody came back to that group to say there was going to be qualifications or modifications? Are you aware of the planning group?---I'm vaguely aware of the planning group. I did become aware that there were some

qualifications, as you put it, put to the recommendations. I cannot remember how or when I became aware of that.

But nobody formally said to you, "Look, we'd like to change – we'd like to adjust
5 these recommendations"?---I can't say it wasn't sent out formally as advice to the expert clinical reference group. I don't think it was, but I get a lot of emails.

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

10 COMMISSIONER WILSON: Does anyone wish to cross-examine Dr Fryer? No. Anyone else? You do, Mr O'Sullivan?

MR O'SULLIVAN: Only for five minutes if that's - - -

15 COMMISSIONER WILSON: Yes. That's - - -

MR O'SULLIVAN: Is that convenient, Commissioner?

COMMISSIONER WILSON: Yes, it is.

20

EXAMINATION BY MR O'SULLIVAN [10.05 am]

25 MR O'SULLIVAN: You have your second submission on the screen – I'm sorry. Dr Fryer, I appear for Lawrence Springborg who was the Minister for Health at the time. Do you follow?---Yes.

You were shown page 4 of your second statement. Is that up on the screen in front of
30 you?---I can't tell what page I'm looking at from what's on the screen - - -

If - - -?--- - - - it's enlarged.

If we could go to Delium number 4, there should be - - -?---Yeah.

35

- - - a number 2 at the top. Now, you'll see that there are three general principles you set out at the bottom of page 3 of 8 and over onto page 4?---Yes.

Then your next paragraph is an explanation of the college's support for consideration
40 of a medium-term inpatient unit that provides extended treatment and rehabilitation. You then go on to explain that there are concerns about the risks inherent in such models from institutionalisation and that such units may divert attention and resources from models of care that are community-based. You then go on to explain that it's essential that there is, firstly, clearly-defined model of care, clinical
45 governance and so on. Now, are you aware of whether there exist at the moment any clearly-defined models of care for a medium-term rehabilitation unit of the kind that we're speaking of here?---My understanding – a lot of that is actually derived from

listening to the other experts that appeared before this Commission of Inquiry – is that that is lacking, that the Walker unit has a model of care in development and that it does not mean that's not important if a service is to be developed, to develop a model of care based on the best available evidence.

5

Would it be right to say that the view of the college as expressed through you is that before one gets to first base of seriously considering an extended rehabilitation unit of this kind one would need, firstly, to develop a model of care?---That would be helpful.

10

It would be essential, wouldn't it?---Generally, when you start to develop a model of care you look at the evidence base.

Yes?---When the evidence base is lacking you need to go back to theoretical
15 principles.

Yes?---So an outline or a development of the model of care particularly with the core principles of the unit around who is it serving and what sort of aims and goals - - -

20 Yes?--- - - - would be essential. In a situation where evidence is lacking the model of care would need to be able to be responsive to the experience and learning of the unit as it is developed.

I understand. Now, you were asked some questions about AMYOS. In the
25 paragraph below the one I've taken you to, you give evidence about AMYOS. You say that AMYOS is a new model developed from a solid theoretical base and the Commission has heard evidence for and against such community models. The evidence base for effectiveness is small but developing. The position of the college is that such services are an important and potentially highly-effective model of care.
30 Is that your professional opinion?---Yes.

You go on to state, as I understand it, in the document that you wonder whether those adolescents admitted to the Barrett Centre might have been able to be cared for in the community if the current suite of services was available. Do you recall that
35 evidence?---Yes.

Does that remain your opinion?---Yes.

The nub of your view about the potential target group for an extended inpatient unit
40 are adolescents with severe psychosis which has been treatment-resistant to date?---Sorry, I missed the first part of that question.

I understand your evidence to be that the target group for whom, potentially, an extended inpatient rehabilitation facility or facilities might be appropriate are young
45 people with severe psychosis which is treatment-resistant?---Yes.

And for others, community care models is better supported by the evidence?---Generally, yes.

Yes. Are you able to – do you know whether those in the Barrett Centre were
5 patients who suffered from severe psychosis that was treatment-resistant?---I'm not that familiar with the patient mix from the Barrett Centre.

You can't say one or another?---Yeah.

10 And is it right to say that for adolescents who present with severe psychosis that's treatment-resistant the numbers are extremely small?---Yes.

How small is extremely small in your professional opinion?---I would be guessing.

15 And – no further questions, Commissioner. Thank you very much.

COMMISSIONER WILSON: Thanks. Does anyone else have any questions? Mr Freeburn, do you have anything else?

20 MR FREEBURN: No, Commissioner. May Dr Fryer stand down.

COMMISSIONER WILSON: Yes. Thank you very much, Doctor. You can stand down?---Thank you.

25 MR FREEBURN: Commissioner, I was going to suggest we take a morning break before Professor Martin.

COMMISSIONER WILSON: Now, he's lined up for what time?

30 MR FREEBURN: He's on the timetable as 10.45. I suggest if we adjourn to that time – excuse me.

COMMISSIONER WILSON: If you want to stand down, you can?---Thank you.

35

WITNESS STOOD DOWN **[10.11 am]**

MR FREEBURN: Sorry, I understand he is here, that is, Professor Martin is here
40 but I'm still suggesting that we adjourn till 10.45.

COMMISSIONER WILSON: Well, that's alright as long as it won't inconvenience Professor Martin too much. I'm happy to begin his evidence earlier if it suits counsel and suits him.

45

MR FREEBURN: Mr Lack will make some inquiries.

COMMISSIONER WILSON: Alright. While he's doing that there was an outstanding issue from yesterday of an affidavit with Ms McMillan, on behalf of West Moreton, was wanting to tender. What's the position with respect to that?

5 MR FITZPATRICK: Yes. Thank you, Commissioner. Commissioner - - -

COMMISSIONER WILSON: Mr Fitzpatrick.

MR FITZPATRICK: - - - my instructions are that that affidavit will not be pressed.

10

COMMISSIONER WILSON: Alright. Thank you. Mr Duffy.

MR DUFFY: Whilst waiting, Commissioner, there was a document that during Dr Kingswell's evidence was referred to. It's a draft of the National Mental Health
15 Service Planning Framework service element and activity descriptions. Commissioner, you will recall that the document that was put in when Dr Kingswell was being questioned was dated, I think, in October of 2013 and the question arose as to whether there was an earlier draft. I said I would seek them out. I've got it. Everyone has been given notice of this so I will formally tender that document now if
20 that's convenient.

COMMISSIONER WILSON: If you would, please. So this is an earlier draft of the National Mental Health Service Planning Framework service element and activity descriptions, this one being dated 1 November 2012. Is there any objection to that
25 going into evidence?

MR FREEBURN: No.

COMMISSIONER WILSON: That will become an exhibit.

30

MR DUFFY: Thank you.

COMMISSIONER WILSON: Yes, Mr Freeburn.

35 MR FREEBURN: I understand Professor Martin is available, Commissioner, soon. Ms Muir is coming across so we could probably get with a 15 or 20 minute - - -

COMMISSIONER WILSON: Alright.

40 MR FREEBURN: - - - adjournment.

COMMISSIONER WILSON: Well, we'll say 10.30 but if he's ready earlier and everyone else is ready let me know.

45 MR FREEBURN: Thank you.

ADJOURNED **[10.14 am]**

RESUMED **[10.34 am]**

5

MS MUIR: Commissioner, before I call – formally call Professor Graham Martin, there are some housekeeping issues with exhibits. Would you prefer that I dealt with those after the evidence if Ingrid Adamson perhaps or after this witness has been
10 stood down?

COMMISSIONER WILSON: Unless they affect this witness' evidence, I think I would prefer to receive this witness' evidence first.

15 MS MUIR: Thank you, Commissioner.

COMMISSIONER WILSON: Thank you.

MS MUIR: And they don't affect this witness. I call Professor Graham Martin.
20

GRAHAM MARTIN, SWORN **[10.34 am]**

25 **EXAMINATION BY MS MUIR**

MS MUIR: Commissioner, Professor Martin has provided two statements to the Commission, one dated 20 January 2016 and the supplementary statement dated 15
30 February 2016.

COMMISSIONER WILSON: Thank you.

MS MUIR: Professor Martin, you retired in December 2015 after nearly 50 years as
35 a medical practitioner and 35 years as a member of the Royal Australian and New Zealand College of Psychiatrists. Is that correct?---That's true.

Your extensive CV, Professor Martin, is exhibited to your affidavit at exhibit B and it outlines your qualifications and memberships. In 2009 is it correct too that you
40 received the Medal of the Order of Australia for your contributions to youth suicide prevention and child psychiatry?---Yes. That's correct.

Am I also correct in understanding that your primary employment contract in recent years was at the University of Queensland as Professor of Child and Adolescent
45 Psychiatry?---Yes.

And you also have been in part time private clinical practice as a child and family psychiatrist over the last 15 to 20 years?---Yes. That's true.

Professor Martin, the Commission does understand that you have particular expertise in relation to some particular forms of self-harm. I propose to ask you some questions about your expertise in this area but I will do that in closed court after these questions, Commissioner.

So, Professor Martin, am I correct in understanding your evidence that you have always tried to manage young people in your care outside of an inpatient setting if at all possible?---Yes. That's true, and if I can just give a small amount of background. I was in private practice full time way back in the 80s and during that time saw some extremely ill young people who had to be admitted. I admitted them to Fullarton Private Hospital and worked there for about four years and eventually was chair of the medical advisory board, for what that's worth. But I found the experience of that deeply unsatisfying because the young people had reached a stage where they were so distressed, so distraught, so difficult to manage that it just was virtually impossible even with the team approach and daily nursing care. And we often escalated treatments to use really serious stuff like ECT with young people which I abhor. And it suggested to me that we could do so much better if we actually got in much earlier and worked hard to stop young people ever getting to the level of inpatient care. I understand that some people do reach that and they do need that care. But I think my whole professional life has really been trying to stop young people ending up in hospital.

And so is another way of saying that – saying this is that young people are best managed in the least restrictive environment?---Yes, of course.

And then – so that means connection to family, community and friends is an important aspect of - - -?---Yes, with one caveat. I think if the family have been critical in the development of the problems then to talk about leaving them with the family or returning them to the family quickly is slightly odd unless the work has been done to ensure their safety and unless the word has been done on the family system to correct whatever the problems were.

Now, I did want to ask you some questions about your – this is with your experience with family therapy. I'll ask you some questions about that in more detail in a moment. I just wanted to go to a document that was sent through by your solicitors this morning that's been downloaded into Delium and it's – if we could go to CHS.500.0004.0001 at 0012. So if we can go to – sorry, 0001. Thank you. If we can go to the front page.

So this was a document – it's a review of Queensland community mental health services to children and young people. And it's back in January – sorry, back in January 1995. And leaving aside if we can then – from my review of this document, am I correct in understanding that you were part of a review team and I notice that on the committee too was Dr Sadler?---Yes.

And one thing I was interested to see in this document, if you go to the conclusions at 0012 – if we can scroll down to the conclusions. Thanks. I think it's, perhaps – sorry, 0011. My mistake. I suppose I just wanted to talk to you about back in 1995 the conclusion being that mental health services for children and young people
5 should be comprehensive with a continuum of care from the community through to intensive inpatient care. So my question is, and just tying in with what you've said about in your practice you've always tried to treat young people outside of the – of an inpatient service. But would I be correct in my understanding of your evidence, that's always been the case. The idea that treatment in the community is best
10 practice has been around for a long time?---Yes.

You've got to speak, sorry. Yes. So it's not a new concept?---No, absolutely not.

And nor is this idea – we've heard much about a continuum of care and a suite of
15 services. Back in 1995 that's what your report concluded?---Yes. I mean, it had implications because the services were in such a powerless state in 1995 and they were so poorly resourced and had such limited personnel that to ask for these things to be put in place was pie in the sky in many ways. So it's rather nice to see the way that the services have developed over the last 20 years.
20

And what's what I wanted to ask you about then, the development then of the services since 1995 to 2015 with, of course, our focus on young people with complex mental health issues. The services that you've seen develop, what services can you identify that you think have improved the service over the years between 1995 and
25 2015?---Phew.

I know that's a broad – that's a broad timeframe but perhaps if you could identify - - -?---Well, I think there are probably some strands that are worth identifying. One of those is that the spread across Queensland for local services has been quite
30 phenomenal. Now, clearly there are problems with that. Just excuse me. Because some of the places are so distant that it's difficult to service them so you have to have maybe two or three people there and then somebody has to fly out or you have to do something through an electronic means to make sure that they're supervised and cared for in the work that they're doing. So there are very real problems in the
35 distances in Queensland. But I think overall the services have burgeoned and it's been very exciting to watch that. In all of the major centres there are now major teams. We've got other inpatient units at Robina and further north as well as the ones in the city. So it's been – it's been really delightful to be part of that and to be part of the training and supervision aspects of that.
40

And by the training aspects you're talking about your involvement at the University of Queensland in training or is there separate aspects of training that you've been involved in?---Well, I think training has been a theme through all of my professional career because I believe that if people don't have the skills to do the job they're
45 going to find it awfully difficult and/or they may muck up. And you don't want that to be true. You don't want people to burnout, for instance, because they can't manage the kind of work that we do. So it's been very important to me to provide

that training. And I think we've been able to do that with each of the professions. I think we've had some astounding things happen in this State. There was one stage a couple of years back where, for instance, we had more trainees in child psychiatry than any other two States put together. I think that was a very special
5 acknowledgment of the kind of work that's been done and the kind of people who were doing the training. But that's also true for the other professions. So I think that the number of services, the complexity of the services – I think when I was first up here the chances of getting hotshot inpatient units was close to zero. There were inpatient units, but they weren't necessarily what we would have wanted, and those
10 now exist. They exist across the landscape, if you like. And I think with the new Children's Hospital Queensland those services running it – I think it's – it's really looking like child psychiatry is going to be fantastic over the next 20 years.

One thing the Commission has heard some evidence about is the difficulty in getting
15 the skilled and qualified professionals in regional areas?---Yes.

And not just psychiatrists. You mentioned a moment ago other professionals – so allied health professionals across the board. Is that your – can you comment on that – about the lack of – I suppose whether it's an attraction to go to regional areas and
20 the difficulty to get qualified people to service these important services in regional areas?---Well, I think where we should start, Commissioner, is really to say that the work exists in those areas and sometimes is more difficult in those areas whether or not you've got people to do the work. Now, in extremis, that might mean that the local hospital has somebody come through their emergency system and needs to be
25 flown into Brisbane or to the nearest centre where there are services. I think what we've tried to do as a theme is to work with people who had the qualifications and were already living or wanting to live in those areas and/or were seeking extra training. So I used to fly up to Mount Isa, for instance, once every couple of months, and we would have a day of consulting with difficult cases and with families. And
30 then the next day would be a training day where we would have local staff come in from all of the services – anybody who wanted to come. And we would take a theme and work on that and work on therapeutic techniques. And then at other times in the evenings, we would actually work with the specific therapists who might be doing the work with those young people. So I think those are the kinds of opportunities
35 that we need to take. And I think in a sense it's better to have people who are already happy in those rural or remote areas and train them up and support them thoroughly than to suddenly fly in young people who might be extremely good at what they do but who are then separated from their own families and from their own supports.
40

Thank you. Professor Martin, I wanted to ask you about this concept of re-parenting that you talk about in your statement. At paragraph 5, which is at – of the supplementary statement, CHS.900.006.0002. If we could scroll down to paragraph 5. Hopefully it should be on your screen – or you have your hard copy. I just
45 wanted to ask you – so you explain the need for a young person at times to undergo a re-parenting process and this can take an extended period of time. Can you just briefly explain what you mean by this re-parenting process?---Okay. Can we just say

to start off with – and I'm not talking in literal terms. We are not talking about professionals becoming the parent or parents. What we're talking about is an internal process. If I can give you an extreme example. If you have been sexually abused by your father frequently and severely in the family home, you start off with 5 a belief that all men are bastards and all men are abusers. And it's difficult to shake that belief unless you actually have not only the therapy which might argue the case differently or the experience of a large range of other males, let's say, who are not abusive and never intend to be abusive. So that you gain the sense that you can be very clear and say that man treated me extremely badly, but that man is an exception 10 and I now have the experience of all of these people who have treated me well and could be seen as, if you like, father figures. So an example might be a teacher at a school who takes a child under their wing and provides special support and liaises with either the family that they're living with or the foster family or whatever it is to ensure the care for that young person. They can act as a re-parenter, if you like. A 15 foster care arrangement in a sense is a process of re-parenting because you're providing caring people who've got some sort of training and who can deal with the anxieties and other issues that crop up. I think theoretically it's called object relations theory. We have people in our heads who we could call objects. And we see them as relating to one another and relating to us. And we need to have those to 20 rely on. Can I just say that under stress or anxiety it's very important to have really good objects whom we know would react to that anxiety or situation in a particular way rather than reverting to the old system. So I think there are all sorts of new programs that have developed. One of them is called schema therapy. I have taken the liberty of bringing a pile of documents that you may wish to look at or not. But 25 I've tried to pick out ones that would inform the issue of re-parenting if that's appropriate.

They're the documents attached to your statement?---Maybe.

30 Yeah. I think there are, Professor Martin - - -?---Okay.

- - - a number of very useful documents already in evidence?---Well, I've tried to provide documents that I thought might make the issues clear.

35 Can I ask this. Is – does such a process – can it become counter-therapeutic, as in, unhealthy dependent sort of attachments to staff – the teacher example or - - -?---Yes, yes. Of course. And that's why the team approach, for instance, and the supervisory processes in those systems are so important to ensure that those things are headed off nice and early. So, yes, they do occur.

40

And when you talk about an extended period of time, are you talking – and I suppose this will vary from case to case. At some time, does that extended period of time mean there would be a requirement for an inpatient admission, for example?---Yes. And can I use the phrase – if you're going to ask me how long does it take to re-45 parent, I cannot give you a month or a year or that kind of figure. What I've got to say to you is as long as it takes.

COMMISSIONER WILSON: Are you talking about admission to an acute unit?---I think that admission to an acute unit may be advisable and helpful in the early stages, but I think ultimately the process then has to be continued in the community one way or another. So I don't think you can necessarily do all of that in an acute unit, and
5 acute units are often extremely expensive, of course.

Thanks.

MS MUIR: Professor Martin, if we go to your second statement at 0003 in
10 paragraph 6 and 7, you talk about the re-parenting process occurring in an outpatient clinic for one to two years. But in paragraph 7 – in the inpatient setting the process can be shortened but may still take six to 12 months?---Yeah. I think – I think that's true. I think the more intensity you can bring to that, sometimes, the quicker these things happen. But it's not that it can't be dealt with on an outpatient basis. It's just
15 that it just takes longer.

You've given a great deal of evidence in your statement about this family therapy and that family – am I correct in understanding that family therapy is important in both inpatient care and outpatient care?---Yes. I've always believed that the child in
20 a sense is both the product of the family but also at the base the symptom of the family or the symptom of the family dynamics. So to see the child in isolation or to see the patient in isolation is ridiculous, in a sense, because if you then place them back in the family, they may well just revert to where they were because the family or the parents haven't changed. If I could just – again, I've provided this paper as
25 part of this bundle, but can I draw your attention to a 1962 paper which was about homeless men with schizophrenia who were, out of the passion of the local service, returned to their families. The therapists watched this process of restoration very closely and carefully. And I'm quoting the work of George Brown and Lyndon Wing. But the therapists could perceive a return to some of the original symptoms –
30 in other words, a return of the schizophrenia – within 45 minutes if the family were abusive or controlling or dictatorial or hadn't changed. So I've always believed that you have to counter that by, if possible, working with family members to help them adjust to changes or actually assist the changes. In some therapies, we've talked about the use of the family or a family member as a co-therapist. In other words, we
35 provide them with strategies that they can use in the home environment which will assist the therapeutic process.

Is there – is it difficult to get the balance, then, between family therapy and re-parenting?---Yes. I think – I think it is. I think in the best of all worlds, you would
40 like to be able to have the cheaper service of working on an outpatient basis, preferably working with, say, the child or the young person on a regular basis once a fortnight or once a week or whatever it is and then seeing the family once a fortnight or once a month to enhance what you're trying to do. And you might do that over one to two years until you feel and until the family feed back to you that actually
45 they are capable of making the changes or managing the situation or have got it, if you want to use a phrase.

The Commission has heard the expression "transference" - - -?---Yes.

- - - used during the course of these hearings. Is there a difference between – well, firstly, I should ask you what do you say transference means?---Well, it's a technical
5 term that comes out of psychoanalysis of the 19th century. And technically what it means is the transfer of perceived attributes from the real relationship or the real person or the real father or whoever it is in the real world to the therapist in the therapy room in the therapy context. So that's the technical term.

10 And so that's connecting back to what we – I asked you the question earlier about re-parenting and if attachments were then formed that may be counter-intuitive to the therapy. So – or have I missed – have I got – am I mixed up?---I think sometimes if you're not aware of the issue of transference you can misconstrue the love of the patient or the apparent care or love of the patient, if you want to put it that way, and
15 think that it's really about you. That's highly dangerous, and you need a supervisor. But you need to understand that the young person brings their experience and they may – I mean, in a sense, transference is one of those mechanisms that's very useful, because when you begin to recognise it, you can begin to work on that and help to change it so that it's more realistic because the danger is if you don't work on that,
20 the young person later on will be in relationships where they will use that mechanism again, and again, and again but not in therapy but in real life.

Thank you, Professor Martin. I just want to now take you to paragraph 31 of your statement which – the supplementary statement at 0014. And you say in this
25 paragraph that there will also be damaged people and young people who need longer term care. Some of whom will need inpatient care protection from adverse family dynamics and so on. You also talk in this paragraph that you consider that such long term inpatient care needs to be provided even if it is limited to the six months. So am I correct in understanding what you're saying in this paragraph, that you think it
30 needs to be there? Are you saying it is to be limited, or is your evidence that it will really need to be reviewed at the six month point and at some time, depending on the young person, it may need to be extended?---Look, I'm aware of the bureaucratic and financial imperative to limit services as much as you possibly can. So it's nice to be able to set these limits. But, from my perspective, they're silly because as I've
35 already said when you're working in this area you are trying to do the job to enable the young person to live their lives sensibly, sanely, happily in the community, ultimately. And so you work with them for as long as it's going to take. Now, I think that if there is, let's say, an ongoing threat or worry of abuse in the family then you are seriously going to ask the question about whether you can have this young
40 person going back into the family until you've got checks and balances or whatever that is to stop that process. There's no point – I mean, we always used to say that you could do months of therapy with a young person and they'd go back into the family and within 15 minutes the whole of your therapy was unravelled because nothing else changed. So, again, it comes back to that point I made before. I think
45 this is a complex area. And I like Peter Garrett's quote about - - -

I saw that on the front page of your paper?---Because we have to remember that these are future - - -

COMMISSIONER WILSON: You'd better tell me what it is?---Sorry?

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You'd better tell me what the quote is?---Sorry. I've got it somewhere.

MS MUIR: I think if you - - -?---It's if you scrapheap people, they will scrapheap your society.

10

COMMISSIONER WILSON: Thank you?---Peter Garrett, 60 Minutes, 1992. These are – I mean, we always have to have this perspective, don't we, that young people are the future of their communities, this State, this country. If we're not doing the job as we believe it should be done in its fullest and in agreement with
15 them, because always need that kind of feedback, then they're going to lead difficult lives and cause mayhem in one way or another. You know, they're going to get into drugs, or they're going to get into violence, or they're going to get back into prostitution or something like that as a result of the chronic abuse. I mean, there are many, many adverse outcomes that can happen. But if we get our therapies right we
20 can head some of that off.

MS MUIR: And, in fact, you talk about in your statement it being crucial to consider incorporating new evidence based therapies - - -?---Yes.

25 - - - for which there is an emerging research base. I wanted to make sure I understood which therapies you were talking about. So if we could go back to paragraph 11 and 12 of your supplementary statement at 0004 and 0005. Is this the cognitive behaviour therapy and dialectical behaviour therapy that you're referring about that it's important to incorporate or that's - - -?---Look, I think – I think what
30 we know about cognitive behavioural therapy is that actually it doesn't work awfully well with severely traumatised young people if it's on its own, unless it's enhanced in some kind of way. And Philip Hazell, who I know has spoken with this Commission, and I did some research in 2008 and '09 looking at CBT for young people who were self-harmers, self-cutters. And what we showed was that actually
35 CBT or those that had the CBT ended up slightly worse than those who hadn't had the treatment, which is an appalling outcome. And our paper has been reviled but it's a very important paper out there. So then you have to say, well, what was it about CBT? And I think it's a big cognitive. It's a bit black and white. You have to keep at it. You've got to keep working at it. And I don't think that it covers a lot of
40 areas of human function that need to be covered. If you look at dialectical behaviour therapy, which is Marsha Linehan's work over the last 15 or so years, 15 to 20 years, what she's done is to try and enhance CBT adding to it, for instance, mindfulness and a range of other specific techniques which allow young people to gain the skills to live in the real world even when they're severely abused. Now, the research has
45 been slow in coming through. But there is now very good research on adolescents. There has been some fantastic research done in this State with adults who were very distressed adults. And what's been shown is that DBT works.

You – sorry?---Can I just mention one other program of work. I think mindfulness appears in all sorts of different guises. So there's mindfulness based cognitive therapy, there's mindfulness based therapy, ACT. There are all sorts of other therapies which are based on the idea of helping the young person to be aware of what's going on in their head and make sense of it and work through to the point where they're doing what they really want to do. Again, mindfulness hadn't been used with young people very much but a PhD student of mine actually completed a randomised controlled trial with 100 young people and that showed tremendous – and that was with ordinary young people in CYMHS clinics. And that showed an extraordinary result. And I think gradually that work is getting quoted and my hope is that Queensland may actually even think about adopting mindfulness for the clinics in which we did the original work.

Professor Martin, those papers that you referred to are – you very helpfully exhibited to your statement. Commissioner, they're at – from exhibit H, I, J, K, L and M referred to in paragraph 11 of Professor Martin's statement?---Thank you.

I do want to ask you then, it seems to be an important emerging issue really about evaluation and evidence based outcome research in the context of mental health, in particular, at paragraph 10 of your statement, of your supplementary statement, at 0004. You say a major problem for mental health generally, and possibly inpatient services, is the paucity of evaluation of programs?---Yes. It's complex. But the first thing to say is that our job as clinical workers is really to do the clinical work. And, really, what we would like to do is to be left alone to just do the clinical work. We don't want to do anything else. There are strange people who like to take on the administration and good luck to them. But – and there are people who want to do other bits of it. And good luck to them. But the essence of a therapist is you just want to be with your clients and do the work. So the question is then how do we encourage those people to think about research or at least evaluation of the work that they're doing? And that's been a sore point because once a therapist is behind closed doors with their patient you've got no idea what they're doing. They can tell you what they're doing and I'm sure they're honest and sensible. And if you've got a good relationship with them, you'll get good results. But we also need to have some kinds of measures. We do have a suite of measures that are used. So we have a global assessment scale, call it what you will, child global assessment scale, CGAS. We have something called HoNOSCA, the Health of the Nation Outcome Scales for Children and Adolescents. And we have the SDQ. And it was demanded of people in our services that they should complete those documents rigorously and mount them on CIMHA, about which I think you've heard. This is the electronic system for all of our records. The problem them is who analyses that data. Where does it go? Who feeds it back to the clinical staff? Now, this is outrageous for me to say this, possibly, but I would guarantee that perhaps four or five per cent of therapists would have had the opportunity to sit down with a supervisor or with a senior staff member and go through the sequential results from those questionnaires. How can you improve your own practice? How can you maintain the quality of your practice if you don't know – if you don't have some kind of measure of what's going on? You can use very simple measures with young people. You can use, for instance, a 10

centimetre line and say that's not well or ill, this is well, put a cross where you believe you are now, and you can do that sequentially at the end of every therapy session, and by the end of that time you could look at those and you've got some, albeit primitive, measure of how your therapy is going.

So during the course - - -?---Sorry, I do talk a lot.

During the course of the inquiry, we have heard some evidence about there being limited compelling evidence for extended inpatient treatment. But as I understand your evidence, what you might say to that is that's because there's not the evaluation process and outcomes process in place to which that you can go to?---Well, I think that's right, and I think – can I just make a distinction here. Outcomes are not such things as length of stay or coming back into hospital. Those are outputs. They're things that happen down the track. The only outcomes that matter are whether these kids feel good, function well and can manage their lives and their families if that's appropriate. We don't do that. We're not supported to do that. And strangely, when we are supported to do that, like in a service called Evolve, which actually was fairly rigorous, strange things happened. So we actually – not we, but the staff – there were staff available with Evolve who were enabled to actually bring together the results from that large state-wide service, which, I think, started off with 10 sites. They managed to get 625 young people to have those questionnaires completed or close to being completed, and they were able to provide a very good report on that to the state government. One of the researchers wanted to take that a bit further, and asked me if I would assist to develop a paper out of that, which I did. That has been sitting on somebody's chair in Queensland Health for about 18 months, despite the fact that, originally, we had gone to a publisher, a very important journal internationally, called Psychological Medicine, and they were interested in the paper. Now, there are – there must be blocks somewhere about releasing data or releasing results or misperceptions of what those results might be telling people about your services. My personal belief is we must not only do the work, but we must disseminate it to make sure that other people don't make the same mistakes we do if we're making mistakes.

COMMISSIONER WILSON: Professor, Evolve is a program run by community services, is it?---It's a joint program between, I think, three services, but it is between community - - -

And the report you're talking about was a report to which department?---I can't answer that, Commissioner, I'm afraid. It was a – an overall report on the – on 625 cases. I can't give you the title of that.

MS MUIR: Professor Martin, I just was interested then in your – in the – in paragraph 11 on the screen, your third sentence, you say there it's also true that there is little evidence-based outcome research that supports many other treatment programs. So your concern is not just limited to evidence in relation to extended inpatient treatment services, it's more across the board; is that right?---Yes. I don't think that we've been very good in psychiatry – and I'm using psychiatry in a very

broad sense here; mental health if you like – and I don't think we've been very good at monitoring our own process and ensuring that we do well or do better. And – I mean, you know, there are some obvious examples. There – until recently, there was little work on psychoanalysis as a therapy, and yet what we know is many countries
5 adopted psychoanalysis and people had years and years of psychoanalytic treatment, but formal assessment of that was not available, and it was difficult to work out exactly what any given analyst was doing with any given patient, in other words, one of the best bits in that therapy. So I just think we need to get our own house in order, we need to ensure that kind of self-evaluation is there as a major item in all the work
10 we do. If it's only how did I do today, what I did think of my patients and/or talking that through with a colleague, well, at least that's something. But if we can then begin to get some little measures adage to that, we may do very much better.

So getting that house in order, I was wondering then – so a number of things would
15 have to come together. Would it – there'd have to be qualified people that could carry out the – apart from the clinician – and you referred to self-evaluation – if I understood what you said a moment ago though that it would also be useful to have someone who wasn't involved in the treatment conducting the research and the evaluation; was I correct in my understanding?---Well, at least collecting the
20 available data, which is there on CIMHA, and analysing that in such a way that you can feed back to the team leader and their team members how they're going. It just seems to me to have this kind of – I've always seen CIMHA as a bit of a black hole. You put a lot of information into it, and then nothing much comes out of it. That's not strictly fair, because I know that when we are referring people between services
25 we often are able to provide tremendous documentation on what has been done. But we are not – at least up until now, as far as I know, we haven't been able to get that data, analyse and fed back, and not – not in a draconian way, but just in a helpful training way, if you like.

30 And as another – then when we're talking about things all coming together or getting the house in order, really, then, you need enough funding to support the research; would that be a fair statement?---I certainly believe that within the service we need people who are experienced in the management of datasets and are enabled to actually work with the available data and/or begin to expand it for special
35 circumstances, and provide that to the team. There's no point in collecting this stuff unless you've got that loop that comes back to the team so that they can, in fact, do a continuous improvement process.

COMMISSIONER WILSON: Is that sort of data analysis a speciality of its
40 own?---You would certainly need to do some – you'd have to have some statistical experience, but I would have expected that on the ground probably a percentage of psychologists would have had that as part of their training, and most psychologists have to complete an Honours thesis and then go onto other work, which might include research work. So they've already got that experience. I think we could
45 encourage some of them to be enabled to do that work. I'm not saying that social workers and psychiatrists and others – nurses – don't do that, but it's less common to have that as part of their basic training.

COMMISSIONER WILSON: What I'm really wondering is, in Queensland or even in Australia, is there an available pool of people with the relevant experience – expertise and experience to do that work?---I believe so at the level that I'm talking about. I'm not talking about seeking National Health and Medical Research Council grants and running three-year specified programs. I'm talking about relatively simple clinical analysis and feedback processes. Yes, I believe that expertise probably exists in our teams but the pressures are such, from all sorts of quarters, that it doesn't – doesn't happen.

Thank you.

MS MUIR: Professor Martin, have you had the opportunity to look at the business case for the development of the statewide adolescent mental health extended treatment and rehabilitation model of care?---I have.

And - - -?---I only had it for a couple of days but, yes, I did go through it.

And you gave some evidence at the beginning about being excited about the next 20 years. Are these some of the things that excite you?---Well, I mean, this is perhaps a naughty thing to say but when you've actually produced an external report on the state and you've laid out some ideas about continuum of care and the use of various different therapies and then you see it cropping up 20 years later in a report, yeah, it's very gratifying. But if I set that to one side and perhaps stop it – come back to reality, yes, I think this is looking like the beginnings of a comprehensive program which has a continuum of care, which has checks and balances in it. I have worries about it so if I – just while we've just been talking about research can I just pick up one issue and that is I am – I'm an academic so when somebody puts a footnote on a project like this which is an academic paper I go and read the paper. And a paper was quoted with regard to a project in Victoria which was a program of, I think, some kind of assertive care and their conclusions were said to underpin the development of our Queensland program. If you go and read the actual results they say that – firstly, they say that the assertive care was no worse than standard care. Well, that's good. And the second thing they say is and there were two or three things where it looked as though it was better. Now, that, for me, is rather flimsy evidence on which to base the development of a service. And I think there is a rich – there's a rich lode of data in assertive community treatment of various types that I have – I have provided some to the Commissioner which I'm hoping will be helpful in that regard. But I – I don't think that we should be making decisions in this State based on what Fred told us or on what one piece of research tells us. I think we should be doing it based on the thorough analysis – a sensible analysis of good quality data. Now, don't misunderstand me. I'm not talking about, you know, a three year program with the medical research committees. That's just a hopeless process to get in to when you're a clinician or running a clinical service. What I'm talking about is meaningful data to the clinician and meaningful data to the families and the clients. I believe we can achieve that and we can achieve fairly rigorous work around that with fairly large numbers without too much in the way of financial resources being lost.

So as pleased as you are and with some caveat about the business case that you've had the chance to read, is it really the same as what you – you make the same point, would it be fair to say, in relation to the evidence for extended inpatient treatment that in both cases there's not compelling evidence either way. Is that - - -?---Yet.

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Yes?---I would have to say yet. And I'm not being a snotty-nosed academic. I mean, I really am not. I – I was a clinician for many, many, many years. I understand some of the issues. I've run services. I understand those issues. But you can do this work and it informs future work and the whole process of what it is that
10 you do behind closed doors as a therapist.

Having looked at that suite of services – the business case – and I realise it's just – you've had it for two days and – but in your opinion, though, does it – even if all those services were in place, does it still mean, in your opinion, there is still, as
15 you've said in your statement, there is still damaged people and young people who need longer-term inpatient care?---We have to allow for that. And – and it takes me back to that statement that I used earlier on which is we have to do whatever is necessary to help this young person live a reasonable life in our community and that includes the education alongside the therapy. It includes, if you like, restitution with
20 the family and the extended family if that's possible in the face of whatever it was that occurred to destroy this young person's life. So yes, I believe that it may be true. The problems don't go away. If you haven't got a longer-term service of some sort then the young person is going to spend an awfully long time in your acute units and they're actually more expensive than a longer-term unit. So it – it worries me
25 when we say no, no, we're not doing anything long-term, we're not going to do that. Well, okay, but these kids are still going to be troubled. They're still going to need admission. So either they're going to do, you know, a couple of months in an inpatient unit then go out, deteriorate – sorry – deteriorate and then come back into that inpatient unit in which case they could have stayed there and gone on with the
30 work. I just think we must not be silly about this. We have to think it through and there are young people who are grossly distorted by the trauma and abuse that they've suffered and I think it does take them a number of years to actually get to the point where they feel comfortable to live in the real world and confident that they can withstand the slings and arrows of outrageous fortune.
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Would you have concerns, Professor Martin, about the treatment of a young person in an acute unit when what they needed was extended treatment?---I think the dynamics of that might be awfully difficult. I can imagine there would be problems in running a unit if you were trying to do that where, as it were, one person was
40 privileged over another and adolescents are remarkably good at picking up other people's ideas and, you know, if that person can stay three months why can't I. So I think there might be a lot of management issues in having a unit like that. That's about it, I would suppose.

45 I just wanted to move on - - -?---It depends on the quality of your staff.

Sorry, I - - -?---It depends on the quality of your staff and if they can manage it, well, good.

In your statement you were asked some questions by the Commission in relation to
5 mental health services directed to the 18 to 25 year old age group and if we could go to 0006 and 0007 – your supplementary statement [indistinct] if we can – my understanding of your evidence – and correct me if I'm wrong – but you say you do not believe there was a need for special discrete mental health services for a particular arbitrary age group. Is that your – have I understood your evidence
10 correctly there?---Yes. I think bureaucrats seem to be lumpers and splitters, by which I mean they like discrete little boxes where they can fund to that box and rub their hands and walk away and not know what goes on in the box. Sorry. I'm being very rude. But I believe that we should have a mental health service which has the capacity to deal with anybody who comes through the door. And it should
15 acknowledge that there are some therapists who are very much more comfortable working with one age group or another. In other words, I could imagine a service in which you had, let's say – let's call it a young people's service in which there were half a dozen therapists who were extremely good at working with the 18 to 24s and there were other therapists who were extremely good at working with much younger
20 people. But if they're in the same building, they actually would be able to discuss those matters and the transition between them if that was, if there were going to be changes, would be so much easier to manage. I think what tends to happen is that if you are a lumper and a splitter you get all of these services going, you provide a mini bureaucracy for each of them, you soak up a lot of money in the bureaucratic
25 process. And I think you are then not allowing the full quality or numbers of the therapists. So I think we should be doing it according to the need of the clients and the expertise of the therapists. So I would say we should have a young person's service. I think it's silly to have 18 to 25 year olds – I've had several experiences where people have been grossly distressed at having to shift from a service where
30 they were doing extremely well, getting on with the therapist, making good progress and the service was no longer allowed to engage with that young person because the cut-off was 18.

So the chronological cut-off you're talking about?---The chronological cut-off. Yes.
35 I just think it's a bit of silliness.

COMMISSIONER WILSON: Is there a limit, though, to how young this young person's service should cater for? Should it cater for a 13 year old as well as for a 24 year old?---I think that's possible. If, for instance – and let me fantasise for a second.
40 If you had a building and you had corridors and one set of corridors led to the younger service and the younger therapists and – not younger therapists, but the therapists who were good with younger people and families – and another set of doorways led to the adolescent service and another set of doorways led to the older adolescent service, if somebody had to shift between those because they were still
45 struggling, it wouldn't be any big deal, particularly. It would be far less traumatic than some of the stuff that I've seen.

And you don't see any dangers to, say, the 13 year old being placed in this overall unit with the 24 year old?---If you're talking about inpatient services, yes, there are always concerns that older adolescents may deal not very well with younger people – try to control them, may tend to seek out to abuse them in some kind of way. Yes. Those issues do occur, so I think if we're talking in terms of inpatient services, this has to be handled very carefully. But I also think it's the maturity of the young person that is important to think about here rather than the age cut-off. So I know 18 year olds who've been in dedicated relationships for perhaps a year or more – full-on dedicated relationships – and they work and they are building up a nest egg to get a flat and they are adults. And there's absolutely no doubt that they are adults. I think it's reasonable for them to go to a more adult service. Conversely, I've met people in their 20s who are so infantile that they really need to be in a service that can cater for much younger people. So I think we need that flexibility, and I think it should be, to a certain extent, up to the clinical staff and the managers of that service as to whether they're prepared to take patient A or B.

One of the concerns that I'm still working through in my own mind is this: you talk about a service which really could cater for a very wide range in subgroups but where the subgroups are not rigorously defined. But then you draw a distinction between that overall concept and an inpatient unit. If there were a demonstrated need and desirability for some sort of extended treatment inpatient unit, what age span should that deal with?---Well, I'm hedging, and I've hedged already. But I think it comes back to the maturity of the young person. If you've got an 18 year old who's an adult, working, in a partnership, showing all the signs of adulthood, why shouldn't they be in an older adolescent inpatient unit.

I don't have any difficulty in understanding what you're saying at that end of the spectrum, but I'm still not sure what you're saying about how young a patient such a unit should take?---Well, we've always – I mean, we've always thought of young adolescents as around 13. Again, that's – it's often quite spurious because there are younger people who are very mature physically and intellectually. Would we go down to five year olds being in an inpatient unit like that? No. That would be - - -

Would you go down as far as 13 in some circumstances?---Yes.

I see. Thank you?---Yes, I would.

That's what I wanted to clarify?---Sorry.

Thanks.

MS MUIR: Commissioner, the next questions, I think it's safer to just ask in closed court. There's not many, but - - -

COMMISSIONER WILSON:

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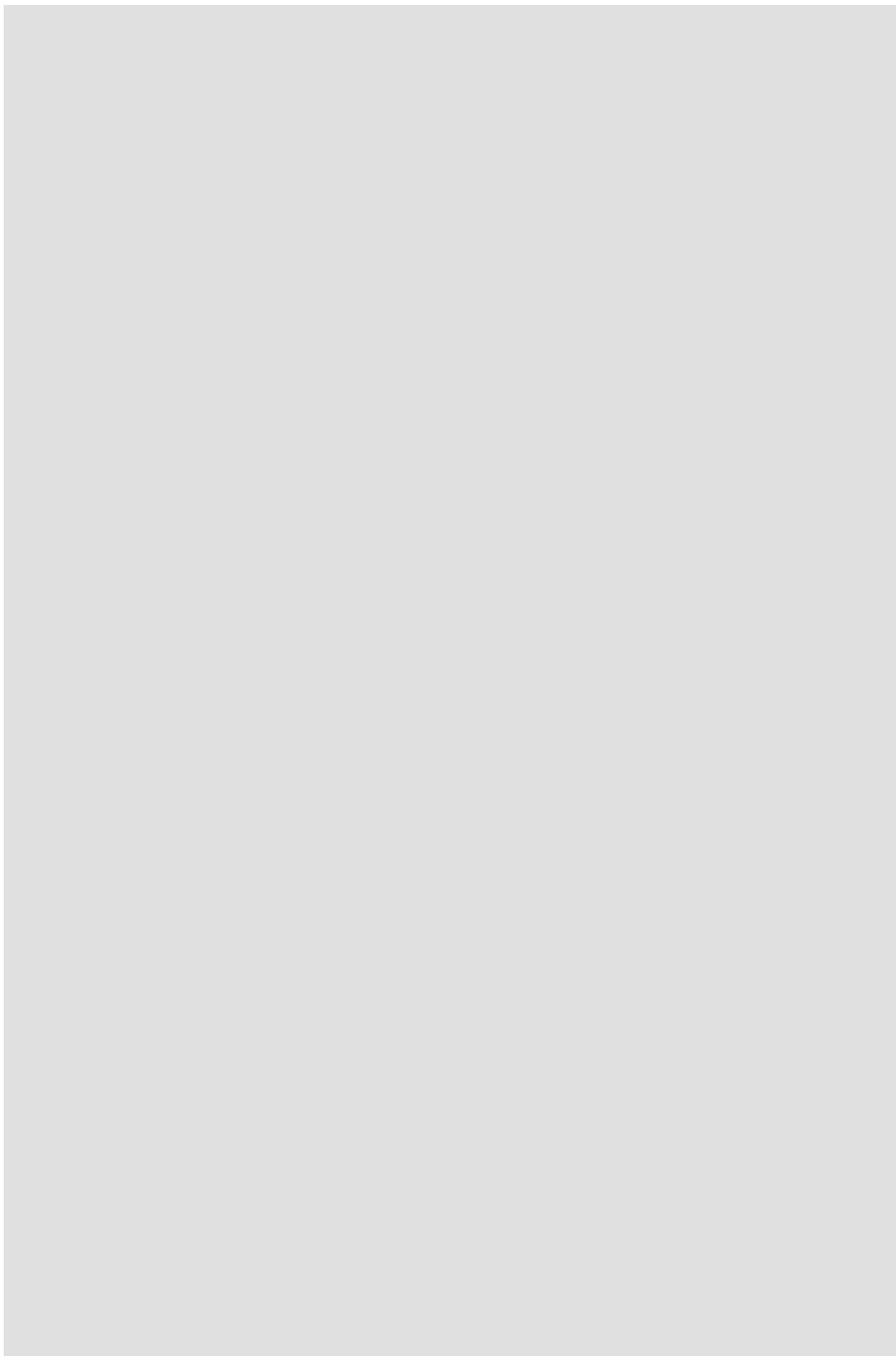

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EXAMINATION BY MR O'SULLIVAN [11.58 am]

MR O'SULLIstreVAN: Thank you, Commissioner. Professor, I appear for Lawrence Springborg who was the Minister for Health in 2012 and '13. It's the case, isn't it, that in your long and rather distinguished career one of your roles has been as a mentor to young medical students and then consultant psychiatrists?---Yes. That's true.

And is it the case that one of those young psychiatrists that you've mentored is Stephen Stathis?---That's true.

And have you mentored him and given him guidance over some time?---It's been delightful and yes.

And do you believe you're in a position to assess his knowledge and skill-base?---Yes.

And how would you describe that?---He's an exceptional child psychiatrist. I have to say he's an exceptional person as well. And behind that I would like to say that he's an exceptional paediatrician. He's got the double qualification. I don't actually know that much about his paediatrics so I can't really comment on that but he is, I believe, highly intelligent, highly capable and he's going to do great things for this State.

And is it the case that you personally had some role in his appointment or promotion to the position that he was given in early 2013?---Well, perhaps it's an arrogant thing to say or have said or to have written down but certainly I had a meeting with Dr Steer, I believe, in about 2012 and it was a private meeting where we were talking about possible futures. I was fairly clear that I did not wish to continue in the context of my having a spinal condition that I've had since 2009. I didn't believe that I was physically capable of continuing and apart from anything else I was just too bloody old, frankly. And we talked about possible successors and I suggested that Stephen was – would be a great successor in part because the new hospital was a paediatric hospital and Stephen has that facility to cross the boundaries between paediatrics and child psychiatry extremely well.

And you gave evidence a moment ago that based upon your knowledge of Dr Stephen Stathis' qualifications, skills and personal qualities I think you said that he's going to do great things for the State. You also gave evidence earlier that, in your professional opinion – I think the language you used was there are astounding things being done in the State and that you see the outlook in the next 20 years as being fantastic – you gave evidence earlier. Were you aware when you gave that evidence that one of the chief architects of the continuum of care that Queensland Health has developed since 2013 is Stephen Stathis?---It wouldn't surprise me. But it depends what you mean by architect and which drawings you're reading from. So with due respect I would suggest that the 1995 document which was produced for Queensland Health talked about a continuum of care and has been on the table ever since.

Yes. And that was the reference you gave earlier to having – when you saw the business case you saw echoed in that - - -?---Very much so.

- - - aspects of what had been produced 20 years ago and you've had, yourself, some involvement in what was produced in 1995?---Absolutely. I led that team.

Yes. It therefore wouldn't be surprising to you, would it, if you were told that Stephen Stathis himself was involved in developing the contemporary continuum of care that Queensland Health [indistinct] because you've mentored him?---I'd be absolutely delighted and honoured.

And has – have you been aware of – I withdraw that. Are you aware that in the Lady Cilento Hospital there is a child and adolescent inpatient ward?---Yes.

And you're aware that part of that ward is allocated to subacute extended-stay beds?---I've heard about that. I've not had the opportunity to visit the Lady Cilento or to visit the ward. I have been invited but my physical status was not such that would enable me to do that.

5

I understand?---So – and I – the other thing was that to tell you the truth I wanted to step aside and leave it to the people that I've worked with and trained because there are a large number of other people as well who are working on this project.

10 I understand. And it would be right to say that you're not familiar with the particular arrangements that have been made for the admission of young people into the subacute beds?---No. I would have to say I'm not aware.

And would it be right to say that you don't know what the uptake has been of those
15 subacute beds since they were made available?---I have no idea. I've heard people raise the possibility that if you've got subacute and acute together they may be problems between the young people but that's it and it's hearsay and I wouldn't be able to put a name to it.

20 Yes. In terms of numbers of admissions or numbers of those – numbers of young people admitted to the subacute beds, you just don't know?---Absolutely not.

Thank you, Commissioner.

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

MS MUIR: Commissioner, I should have – if I could tender the review of Queensland community – the 1995 document is CHS.500.0004.0001.

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COMMISSIONER WILSON: Very well. That will become an exhibit.

MS MUIR: Otherwise, I don't have any questions for Professor Martin and if he could be stood down?---Thank you. Thank you, Commissioner.

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COMMISSIONER WILSON: Thank you very much, Professor?---Could I just say in parting, I've deluged you with bits and pieces of paperwork. My intent was simply to try to provide a bit of background in the simplest possible format because I understand you've got mountains of paperwork to go through. I wish you luck.

40

Well, there are mountains but we very much value people like you. So thank you for providing it?---Thank you.

45 **WITNESS STOOD DOWN** **[12.05 pm]**

MS MUIR: Commissioner, I think I said I would deal with the exhibits. Perhaps it might best be done after Ms Adamson's evidence.

COMMISSIONER WILSON: Just a moment. Thank you very much. Yes, Ms
5 Muir.

MS MUIR: Commissioner, I had said I would deal with the issue of exhibits. There's just one matter I want to sort out while Ms Adamson is giving evidence so perhaps I could do that when that evidence is finished.
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COMMISSIONER WILSON: Very well.

MS MUIR: Thank you.

15 MR FREEBURN: Commissioner - - -

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

MR FREEBURN: I call Ingrid Adamson.
20

INGRID ADAMSON, AFFIRMED [12.07 pm]

25 **EXAMINATION BY MR FREEBURN**

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

30 MR FREEBURN: Ms Adamson, I'm just going to ask you a few questions about your statements. There are two of them. There's an original statement and a supplementary statement. And then I might deal with some tables that we've been discussing with Commission staff. If we could first of all go to your initial statement. The document ID is IAD.900.001.0001. And I want to go page 3 of the
35 document, please. Now, to give you the context, in this paragraph you talk about the key responsibilities and duties you have performed since commencing your role as project manager. And this is one of them, number D. See D at the top of that page?---Yes, I do.

40 And is it right that you were the, as you say there, the interface between, on the one hand, Children's Health Queensland, and on the other hand, West Moreton HHS?---Yes. That's correct.

And did that involve – did that role as the interface involve having either supervision
45 or participation in communications to parents and the documents called Fast Facts?---Not the Fast Facts. They were the remit of West Moreton.

Right. That is, they may have been – they were the remit of West Moreton and you didn't either participate, or supervise all of that process?---No. I did not contribute to those. No.

Alright. Thank you. And, otherwise, the interface – so forgetting for the moment the communications, did that involve – that process involve making sure that Children's Health Queensland and West Moreton Health and Hospital Service were coordinating their activities in relation to this project?---On some topics, yes, that was very appropriate. As you would be aware from the diagrams shown in the project plan we had three working groups. And I would work with the West Moreton contact Dr Leanne Geppert in regard to day-to-day operations of those working groups and the matters that we addressed. On some occasions, we would prepare joint correspondence, joint briefings for the Minister, the DGs, for our CEs, for the CE oversight committee and both Dr Leanne Geppert and I would work closely on those.

Alright. Now, I want to deal with one aspect of that, if we go further on in your affidavit to paragraph 50 on page 13. See page – paragraph 50?---Yes.

You're talking about your communications with Dr Geppert as a member of the steering committee and you say there that no Barrett Adolescent Centre patient required the services described as tier 3 in the ECRG recommendations upon the closure of the Barrett Adolescent Centre. Is that information you obtained from Dr Geppert?

MR FITZPATRICK: Commissioner, I rise at this point just to object on the basis that having looked at the transcript of Dr Geppert's evidence, this proposition wasn't put to her. I'll stand corrected but I have had review of the transcript.

COMMISSIONER WILSON: Well, you may well be correct. I'm still going to allow the question and if, having regard to the answer, whatever it is, you feel there are questions that ought to be put to Dr Geppert, she can be recalled, if necessary, by telephone or video link rather than bringing her in.

MR FITZPATRICK: I'm content with that.

MR FREEBURN: So, Ms Adamson, you've read that paragraph. Is that information that no Barrett Adolescent Centre patient required services described as tier 3 upon the closure of Barrett, is that information you got from Dr Geppert?---Not a simplistic answer. We actually had regular communication as I mentioned in that paragraph. As a steering committee member she would constantly update the steering committee as to how things were progressing. As you would also be aware in other exhibits, we also had updates in regard to the Barrett transition planning process. And because Dr Geppert was in the fortunate position to actually be aware of the services we were working on, as well as the transition planning that was taking place at West Moreton, she conveyed to me the sense that the tier 3 as described here wasn't something that the existing cohort would require.

Okay. You see, am I right in understanding that the system involved you and Dr Geppert having regular discussions. And if Dr Brennan in the transition needed a particular service or had a particular problem, the lines of communication were that Dr Brennan would talk to Dr Geppert about it who would talk to you about
5 it?---And/or Dr Stathis.

Right?---And then we would convene a meeting about that. So a concern might be raised, we wouldn't deal with it on the phone. We'd bring together the appropriate parties to talk about that, if needed.
10

Do you recall that happening? That - - -?---Frequently.

Frequent meetings?---In terms of conversations regarding service progression, what's being done, the operations of the working groups, yes, frequent.
15

But you talked about discussions and then you would empanel a meeting about it. Do you recall that any of these concerns – any of those concerns led to a meeting?---Not a formal meeting in the sense of an agenda and minutes and what have you. When I say a meeting I mean a meeting of people coming together
20 perhaps on the telephone. So we would often be on conference call with West Moreton.

You see the point I'm putting, which is it seems a rather indirect thing for Dr Brennan to speak to Dr Geppert, who speaks to you and/or Dr Stathis. Is that
25 - - -?---I think you're being specific about transition planning, and we weren't involved in transition planning.

Alright?---We were involved in updates with regard to how transition planning was progressing.
30

Alright. Was there no connection between what you call transition planning and the rolling out of the services as a part of the SWAETRI/AMHETI program?---No. There were clear distinctions between what West Moreton was looking after and what Children's Health Queensland was looking after. The connection point was
35 very much the interactions we would have and the advice that we would give each other at steering committee meetings, which were held on a fortnightly basis and/or informal conversations we might have via the telephone or email.

Alright. I just want to show you a particular Fast Facts – Fast Facts 10. And I know
40 that you said you had no particular involvement in it. For the operators, it's WMS.1002.0009.00834. Now, before we go to that, you talked about the connection. On the one hand, you're saying that West Moreton is doing the transition plans and on the other hand your group or the planning group 1 is looking at the suite of service options. What's the connection between those two
45 groups?---The connection in terms of people was definitely Dr Geppert as she was on both working group 1 and working group 2. In terms of the scope of work, there was no connection in the sense that transition planning was very much being done by the

clinical team at West Moreton and the new service planning was being done by the group that was convened for working group 1.

Wasn't the whole impetus and purpose in this developing services – wasn't that – didn't the impetus come from the idea that the Barrett Adolescent Centre was to close and there needed to be facilities for these – for the young people who were inpatients there to go to?---The scope was actually to look at contemporary services for the cohort aged 13 to 18 of similar diagnostic profiles as to those of the young people that were in the Barrett. So, no, it wasn't that narrow that it was only just looking at what happened to the young people at Barrett but it was also saying how better can we serve these consumers in Queensland. And that certainly was my understanding of the purpose of the project was to look at 13 to 18 year old services and look at how we could best roll those out. West Moreton was very clear to us particularly at the steering committee that the care and the clinical governance of the young people in the Barrett would remain in their remit.

So were West Moreton really restricted to transition plans that involved transitioning these patients to existing services?---Not restricted. We certainly explored with them – and hence why Dr Geppert was on working group 1. We explored the different tiers that were provided through ECRG. And then we looked at which of those tiers we could mobilise as quickly as possible and, if appropriate – and that was a clinical decision, if appropriate a consumer from the Barrett could utilise those services if that met with their treatment needs.

Alright. So if we just scroll down on this Fast Facts 10 to the third heading. Now, just to give you the context, this is 20 November 2013. You'll see there – and I don't know whether you've seen this before, but you'll see there:

> *Recent information from CHQ – CHQHHS has indicated that some of our future service options will not be fully operational for possibly 12 months.*

So then West Moreton effectively say:

> *Following through on our commitment that there be no gap –*

and they talk about what they're then going to do. Does this illustrate that at least West Moreton might have misapprehended what the other group was – what Children's Health Queensland were doing?---Not at all. In fact, it confirms how closely we were working together because what's already been put into evidence is the transition services that West Moreton had developed which they mention, too, here, in terms of a day program and supported accommodation. That certainly was a conversation – many conversations CHQ had with them around that being an interim plan whilst we mobilised and followed appropriate procurement processes for services that may take longer. Now, I want to distinguish that language – transition services is very different to a Barrett consumer transition plan. So a plan may incorporate some of those transition services or may, in fact, utilise existing services. But the transition plan certainly was developed in consultation with CHQ.

You see, this sentence starts with the proposition "recent information"?---Yes.

So doesn't that suggest that they've recently learned something?---Maybe that's more to do with the audience receiving the fact sheet than actually the awareness West Moreton had. So in terms of fact sheet number 9, this is a progression. That's how I interpret it. Certainly from West Moreton's perspective that I was definitely on the same page and certainly there when the project plan was submitted to the CE oversight committee in October.

And I gather you don't accept the proposition that – sorry. So the plan that CHQ were developing was a broader 13 to 17 year old adolescent patient plan not specific to Barrett Adolescent Centre patients?---Not specific in the sense that we were only catering for the individuals that were there. Certainly had regard for the diagnostic profiles of those young people and how they presented and how they came to be at the Barrett.

So West Moreton's job was really to transition those patients – those young people into either existing services or into other services that might come online as a result of CHQ's work?---CHQ and West Moreton's work. As they've noted here, they did start some interim services which CQH then eventually assumed governance for.

Right. Now, I just want to go to your supplementary statement, which is IAD.900.002.0004. Now, here we're talking about a parent presentation?---Yes.

And – I'm just trying to get a date for you. I think it's 4 November 2013. Yeah. So – and you'll see that on the next page the question or the paragraph ends with a question:

> *How were the presentations considered and incorporated into decision-making in the transition process?*

Now, if you just read your answer, it's in paragraphs 11, 12 and 13?---Yes.

So in 11, you talk about how you define evaluation. And in 12, you talk about the features of the parent presentation. And you say that you can't comment on how individual members incorporated this into their views. And then you say the transition process was the responsibility of West Moreton and you can't comment on how they incorporated that information. Can I just ask again, is – was there any process for acknowledging the parents' concerns, for considering them and for either incorporating them in the process or feedback about, well, we agree with you about these things, we disagree with you about those?---The historical context of this particular event was my understanding. West Moreton Lesley Dwyer put an invitation out to parents to write into West Moreton to comment and contribute their thoughts and feelings in regard to the transition planning for the young people. We also felt that there was a strong value in having that submission come to the steering committee so they too could be informed on how the young people's parents and families were feeling about the process. We

were given – well, sorry, I circulated to that steering committee that submission that was provided by the parents for the entire committee to read and digest. The parents presented. It provided an opportunity to ask questions at that presentation. And then following the meeting, after the parents left, the steering committee spent a period of time discussing, I guess, the similarities between what the parents had submitted and the work that we'd been doing to date in terms of the AMHETI program of work.

Wasn't the – weren't the parents essentially saying, "We take the view that a tier 3 type facility is necessary." That was the essential message that they were giving?---Yes, together with an onsite school.

Right. And was that view that the parents were expressing taken into account?---Absolutely, and is demonstrated in the model that we went forward with in terms of including what we considered a tier 3 service with onsite schooling. Absolutely. We felt that we had covered that.

And how? So how has that been covered?---With the subacute beds.

Right. And, ultimately, the Mater beds and the Lady Cilento beds?---Correct. Yes.

Now, if we go a bit further on in your supplementary affidavit – page 11 of that document, please, if we scroll down to paragraph 42. Now, I gather, Ms Adamson, because of your experience and your expertise, you were able to get to the view that the cost of this particular facility was going to exceed $5 million. You weren't being specific about dollars and cents. We're not talking estimates. But you are able to see fairly quickly what the cost of a particular facility is going to be?---In this particular case in regard to that paragraph, the Victorian YPARCs had, in fact, provided us with their costs.

Right?---So we were actually operating on quite solid figures.

Yes. And so what was the excess? You see there in the middle you say the cost of a single facility was in excess of 5 million. Was it – was the figure that the Victorians gave you 10, 20 or - - -?---No. It would've been five point something. But I don't recall off the top of my head. It will be in my exhibits – so, no - - -

I see?---If I had have said in excess of 6 million it would've been six point something.

I see?---So this is just in excess of five in that it's rounded down.

I see, I see. Alright. I understand. So your thinking at this time is that the approximate cost of a Step Up Step Down unit is likely to be north of 5 million and south of 6 million?---Correct.

At this point, didn't you have about $6 million of funding available from the Barrett Adolescent Centre recurrent funds? You see paragraph 41, you see there, the

5.8?---Yes. It's 5.88 million. And that was a combination of Barrett funds together with Redland funds of 2 million.

So is the problem here that you were balancing – the Step Up Step Down would take
5 all of the budget, all of that 5.8?---Yes.

And there would be nothing left?---Correct.

And nothing left for what?---Nothing left to provide young people with severe and
10 complex mental health with other options for assistance that – a YPARC in this sense or a Step Up Step Down wasn't going to be a panacea for every young person with complex mental health.

Wasn't it likely that you were going to need – I mean, let me put it this way. The
15 AMHETI suite of services is going to cost a lot more than $5.8 million, isn't it?---Yes.

So at some point you as a senior public servant are going to have to go to the Government of the day and say, we're going to need some money for these AMHETI
20 services?---Yes, which was what the purpose of the business case was.

I see. Is there a choice that you're making here that, well, we're not going to spend the 5.8 entirely on one Step Up Step Down service, we're going to start with spreading that $5.8 million across a few different services?---Not a simple decision
25 as that. What we did, particularly from the working group one, was we looked at a full range of services as was indicated by the ECRG. So they talked about tier 2A, tier 2B and tier 3. So we actually considered all of those service elements and said what is the best use of this very limited funding that we can make to reach a larger group of individuals? And as is outlined in the business case, through the
30 combination of AMYOS services, a day program and a youth resi we were actually able to take care of approximately 160 young people versus say, for example, the 15 that were in Barrett or, in fact, the 10 that would've been in a Step Up Step Down.

But wasn't the ECRG effectively saying that an essential part of the service is a tier 3
35 facility?---Yes. And a Step Up Step Down is actually considered a tier 2B.

Right. So what was the clinical – you're making these judgments. And I don't mean only you. But you're making these judgments based on what clinical information if it's not the ECRG report?---It is – it absolutely was on the ECRG report. And as you
40 would see from the outcomes of the working group 1, we actually did take the ECRG recommendations to them. We put up in – we – I co-facilitated with Dr Leanne Geppert and we put up around the room those different services. So we looked at mobile outreach, we looked at day program, we looked at resi and we looked at Step Up Step Downs and we looked at subacute beds. All of those options were put on
45 the table. What we were teasing through with clinicians from across the State – we weren't doing this in isolation or as a silo – was what are those best combinations? What do the different services think they're going to benefit most from? And that

helped guide it. But that was also being informed by where the population spread was, the level of acuity, what we understood those different levels of services to provide.

5 But aren't you necessarily putting aside the ECRG's statement that an essential part of this continuum is a tier 3 facility? You're putting that aside, aren't you?---No. We considered all the tiers. I think my statement is in reverse, is we didn't just only consider tier 3. We considered tier 2 as well.

10 Well, was there a progression at this time of a tier 3 facility? Because the parents had come to talk to you about that, hadn't they?---And subacute beds were a constant discussion in amongst our working group and as well as the steering committee. They were always on the table.

15 Now, on the table meaning - - -?---Up for discussion.

Right. But there's some point at which one has to go from discussion to saying to the government of the day, we need this money for these facilities?---Which we did in the business case. Yes.

20

Right. And the business case was when?---The business case developed from November and submitted to the CHQ board in January and was then presented to the Department of Health at their normal budgeting relationship management meeting through our chief financial officer.

25

Some time after January or February - - -?---April.

April 2014?---I can give you the exact date – or I hope the exact date. March.

30 COMMISSIONER WILSON: So to whom was the business case presented?---It was presented to the Department of Health. The Department of Health - - -

A particular branch of the Department of Health?---The – gosh – off the top of my head I would be giving you an incorrect name but it is definitely noted in my

35 exhibits.

Thank you?---It was emailed through to the particular parties that considered it.

Thank you.

40

MR FREEBURN: Am I right in thinking that there's also a facility to say to the mental health branch, we've got 5.8 but we need 6.7 to do these range of intermediate things. Is that right?---Not normally. The practice for seeking funding that is typically a conversation that's had between a hospital and health service and

45 the Department of Health.

So is it more normally done in the way you described by a business case presented - - -?---Yes.

- - - to the board which is then presented to the department?---Yes. That's correct.

5

So am I right in thinking that at his point there's no money for a capital build of a subacute facility?---At the time of the writing of the business case, no, there was no capital funding. There was just the 5.8 million operational funding.

10 And whilst there was enough money for a Step Up Step Down facility the judgment was made that that would effectively use all of the budget?---Yes.

And whilst as a part of this process is judgments about what's necessary, isn't it, in the sense that you put aside for the moment the subacute – sorry, I'll start again. On
15 the table – as you described it – is a subacute facility. On the table is Step Up Down Facilities and a number of other facilities?---Yes. Youth resis, day programs and assertive mobile outreach.

And so all of those things get collected up and put in the business case. Is that
20 right?---That's correct.

Okay. Now, I want to take you to those schedules that you've been discussing with Louise Norman from the staff – from the Commission staff and as these documents are being handed down can I just ask you about the process. There's three tables I'm
25 going to take you to and as I understand it you're in broad agreement with the Commission staff about all three tables. There are some – effectively some changes or modifications or notes you have made to each of the three of them?---Yes. That's correct.

30 And in each of the three of them they're noted in red?---Yes.

And essentially – tell me if I'm wrong but what's being done is to refine and clarify the various elements of those three tables?---It's listing the different services that - - -

35 Alright?--- - - - the Commissioner found available. Yes.

We better deal with them separately. Now - - -

COMMISSIONER WILSON: Can you wait a moment, please, Mr Freeburn, until
40 I've got a copy. They're being distributed at the moment.

MR FREEBURN: Yes.

COMMISSIONER WILSON: Does Ms Adamson have a copy? We need another
45 bundle for the witness if you could get that bundle, please.

MR FREEBURN: Here's one. There's one for the witness?---Thank you.

Now, can I take you first of all to the one that's got the colour on it.

COMMISSIONER WILSON: That's not very helpful, Mr Freeburn. They've all got some colour.

5

MR FREEBURN: The discussion – it's titled at the top right-hand corner Discussion Paper Number 4E and it originally started as part of the discussion paper documents. Page 1 of it has some blue and yellow and page 2 has some green and orange.

10

MR FITZPATRICK: Excuse me, Commissioner, we don't have a copy as yet.

MR FREEBURN: Okay. Now, the first one I want to go to is discussion paper number 4E.

15

UNIDENTIFIED SPEAKER: Excuse me, Commissioner, sorry, we don't – I don't have a copy of any of the documents as yet.

COMMISSIONER WILSON: Before you go on with 4E, you talked about a second

20 page. The one I've got is only one page in blue and a yellowy colour.

MR FREEBURN: There should be a second page to that document.

WITNESS: I only have the green and orange one.

25

MR FREEBURN: We should go back to the old-fashioned screen.

COMMISSIONER WILSON: Touché. Alright. If we're ready.

30 MR FREEBURN: So Ms Adamson, I might start. Hopefully, everybody has got a copy. The one that's called Discussion Paper 4E. It's a mapping of the adolescent mental health services in Queensland at four different points; is that right?---Yes. Public mental health. Yes.

35

Public mental health. So there's some mention of non-public health in that column that's headed Non-Queensland Health Services?---Yes.

But principally what this document is directed to is mapping the public health

40 services that are available and operating at these four points in time?---Yes. That's correct.

And I gather you largely agree with that subject to the comments that you've inserted in red on this document?---Yes. That's correct.

45

Alright. And I gather that you and Ms Norman can probably get to a point where you would be able to produce a document like this with your comments added that can be even a little bit more refined than this one?---Yes. That's right.

5 But for the moment, let's deal with this one. So the first part – the blue section – really identifies what was available as at the closure of the Barrett Adolescent Centre, which was the end of January 2014, correct?---The blue column?

Yes?---Is pre-Barrett closure.

10

Pre-Barrett?---The yellow column is as at the end of January.

I see. Yes. You're quite right. And then the next – the green is what was available on 31 December 2014?---Yes.

15

And the red or orange is current to the end of January 2016?---Yes.

Alright. Commissioner, I'll – at the end of this exercise, I'll tender these three documents. Can I deal now with the other large chart that you have, which is called
20 Discussion Paper number 4D. Now, I gather your comments on this are in blue?---Yes.

And, again, there's large agreement between you and Ms Norman about the content of this document?---That's right.

25

And is the object of this exercise to identify what were the service elements of the AMHETI program?---Continuum. Yes. With the addition of the adolescent acute inpatient units on the last column. That wasn't within our scope of AMHETI at the time.

30

I see. So - - -?---Yes. That's added - - -

The acute units have been added to that although they weren't part of the AMHETI program?---That's right.

35

And that provides a bit of a comparison, doesn't it, for the various criteria that's used – age ranges and all those - - -?---It, I guess, provides the end to the level of acuity. So the acute inpatients being at the highest level.

40 Okay. And your top range comment – the very top in the heading. The age range needs to be clearly identified. Can you explain that?---Yes. One of the criteria that is included in this table is an age range. It could lead to a little bit of confusion. I guess, if you were looking at this as the AMHETI continuum of services, we were very much operating within the scope of 13 to 17 years of age. Some of the services
45 that have been included in this table also go above that, and I'm also acknowledging the youth resi equally goes above the 17/18 year old age range. So I guess I wanted to be clear what the table was referring to. Is it doing zero through to 18. Is it 13

through to 24. Is it nondescript. It just wasn't clear when looking through those service continuums and the age categories.

For each of the different service elements, for example, if we go to a – to the
5 AMYOS service and we turn over to the second page, we can see the age range for that specific service?---Yes.

Okay. So your caution is AMHETI was concentrating on the 13 to 17 age group and – but it happens that some of these service elements cover that age group but cover it
10 either above and below in some cases?---It certainly goes above, not below.

Not below. Alright. Okay. And can I take you to the third table, which is something that we discussed with Dr Kingswell when he gave evidence. Now, this document is entitled Queensland Health Financial Data for Adolescent Mental Health Services.
15 And is the – the object of this exercise is to compare the approximate cost per head of each of the different service elements identified in the document?---Yes.

And you've added your comments, this time in red?---Yes.

20 And I gather you're in broad agreement but some elements of this are outside your area of experience?---Some of them are outside, such as the special school. And with regard to a couple of the other figures I guess the way that I went about calculating from the business case have differed from the way that they may have been calculated in this table. So there's some minor discrepancies but largely covers
25 it.

Alright. Okay. Thank you. So, Commissioner, in due course I'll tender those three tables. And that's all I have for this witness.

30 COMMISSIONER WILSON: Alright. Well, I'll note now that the three tables will be marked as exhibits.

MR FREEBURN: Thank you.

35 COMMISSIONER WILSON: Does anyone wish to cross-examine? Mr Fitzpatrick.

EXAMINATION BY MR FITZPATRICK [12.52 pm]

40

MR FITZPATRICK: With leave if you please, Commissioner.

COMMISSIONER WILSON: Yes.

45 MR FITZPATRICK: Ms Adamson, I'm Chris Fitzpatrick and I'm acting for West Moreton – one of its counsel. Can I just take you back, please, to where you were

asked about a parent presentation evening which occurred, as I understood you to say, on 4 November 2013?---It was a morning presentation. Yes.

A morning?---Yes.

5

Thank you. I apologise for that. Now, as I understood it, representatives of Children's Health Queensland were present at that and presented. Is that correct?---You're talking about the parent submission to the steering committee on 4 November?

10

Yes?---So the entire steering committee was present, on which CHQ sits and chairs.

I understand. Now, can you recall how many parents were present?---Yes. There was two that presented.

15

There were two?---Yeah.

And did you – in relation to the views that they made known, including in relation to a tier 3 facility and their aspirations about that, could you gather whether they were

20 their own –they were advocating for themselves or for others?---I got the – I can only speak from my personal receptive take on the information. I got the sense they were speaking on behalf of themselves as well as presenting their young people. They provided us with fact sheets on their – their young people that had been utilising Barrett.

25

I understand. So it was a very small group of two parents?---That presented to us. Yes.

I understand. And as I understood you to say, following the presentation, those

30 expressions by those parents were taken into account?---Absolutely. As I said, I circulated to the steering committee the written form of their presentation, which the entire steering committee received. I will assume they read – but we certainly had a dialogue at the table, going through some of the key points that they raised and comparing that to what we had already been developing for the AMHETI continuum

35 of care.

I understand. Yes. Thank you for clarifying that. That's all I have. Thank you, Commissioner.

40 COMMISSIONER WILSON: Does anyone else have any questions? Mr O'Sullivan.

EXAMINATION BY MR O'SULLIVAN [12.54 pm]

45

MR O'SULLIVAN: Could the witness be shown QHD.004.006.3930. Ms Adamson, I appear for Lawrence Springborg. If you go to 3931, you'll see there's an email from Michael Daubney of March last year?---Yes.

5 It's right, isn't it, that Dr Daubney was asked by Dr Stathis to look into the evidence base for extended inpatient treatment in a subacute setting - - -?---Yes.

- - - for adolescents? And the email of 30 March at 3931 was part of the response he provided?---Yes.

10

Go back to 3930, you will see there's an email that you wrote to Judi Krause and Stephen Stathis. You say – this is 17 March:

> *You need to raise your escalating concern. There seems to be an absence of*
> 15 *clinical justification in our briefing to the Minister and/or the Premier regarding the election proposal for a new Barrett.*

And you'll see the heading of the email is New Barrett. Then it refers to a plan of attack now to being – to prepare a policy submission to go to the election
20 commitments team. Have you seen that policy submission document?---It's an evolving piece of work. As you'll note, that was written in March 2015. Since then, we've had the youth elections commitment committee form.

And so you have not seen it or you have seen it, the submission – the policy
25 submission document?---No, I have not seen.

And do you know who has possession of it?---I don't even know if it exists. As I said, it was an evolving period of time, where we were – I should say the mental health branch was taking direction, so you'd have to check with them.

30

In the third paragraph down, you say:

> *I've been getting my messages through Anna at the branch, and if I understood correctly they don't feel I can tell the Premier that it is not a good idea, but*
> 35 *rather are working on the hope the costs alone will turn them off building a new centre.*

Who was Anna?---That was Anna Davis, at the mental health branch.

40 And you say that this seems like a very uninformed approach to quite a significant change in service approach. It'd be right to say that since that time there has been more work done?---Correct.

And that work has been done through the – if I can call it the elections
45 committee?---Yes.

Yes. Now, further up the page, there's a response to your email from Dr Stathis. He says he's happy to talk to the Premier's office and the Minister for Health, even if the branch feels constrained, and he supports that being escalated to Fiona. Who was Fiona?---Fiona Dugan, our chief executive of Children's Health Queensland.

5

And do you know – were you part of any meetings with the Premier or the Health Minister in relation to the issues that are dealt with in this email?---No, I was not.

And has Dr Stathis had those meetings, to your knowledge?---You'd have to check

10 with Dr Stathis.

Has he told you?

MS WILSON: That's hearsay?---I couldn't recall.

15

MR DIEHM: Further up – I'll withdraw that. I tender that three-page email – four-page email.

COMMISSIONER WILSON: What was the Delium reference again, please.

20

MR DIEHM: It's QHD.004.006.3930, if it please the Commission.

COMMISSIONER WILSON: Very well. That'll be an exhibit.

25 MR DIEHM: QHD. – if Dr Adamson could be shown QHD.013.001.1080. This is a redacted version of a document that Dr Stathis saw yesterday. Now, this is going forward in time to March, and I appreciate things have moved on since then. You'll see at the bottom of page 1080 there's the beginning of an email from you which commences on 1081. Now, you say at the beginning of your email to Judy Krause

30 and Stephen Stathis you have notes of a phone call with Anna at the branch yesterday. That was Anna Davis?---Yes.

And you've got some additional information, and you set out that information on your email at 1081?---Sorry, what's the question?

35

Did you set out the information you received from the branch in the email at page 1081?---It's just – at the top of the page it says my comments are in brackets below, so I can't confirm if that's – without reading the full email - - -

40 Yes?--- - - - as to whether that's my comments or whether that's what I was seeking the branch - - -

Of course, because it's a year or so ago?---Yeah.

45 I understand. If you go back, there's an email there from Judi Krause to you of 19 March 2015. Paragraph 3 refers to the 22-bed fiasco. Was that a view that you held in March 2015?---That it was a fiasco?

Yes?---No. My concern, which I was trying to highlight in my earlier email, was more around the fact that we had developed a continuum of care in the AMHETI project, and I couldn't see, personally, where the connection was to a 22-bed option.

5 I understand. Because you've done a lot of work as project manager, very hard, with Dr Stathis and Judy Krause to develop a continuum of care?---And the clinicians from around the state. So I really want to emphasise we didn't develop it in isolation.

10 Yes. Having regard to the clinicians around the State, a lot of work was done to develop a continuum of care, and your concern was a new 22-bed inpatient facility, you couldn't see how that would fit in?---My concern was that no one had been – well, my understanding was no one had been consulted, certainly not from Children's Health Queensland in that concept of having a 22-bed. So we would –
15 well, I was certainly confused as to where does this fit into the scheme of things at that time?

I tender the redacted document.

20 COMMISSIONER WILSON: Mr O'Sullivan, what's the relevance of this?

MR O'SULLIVAN: It's only relevant insofar as you consider that part of your role is to make a decision about what form of new facility, if any, should be built in Queensland.

25

COMMISSIONER WILSON: Well, I know – well, I've heard whispers that people think that I think that's part of my role. I don't think I've said I think that's part of my role.

30 MR O'SULLIVAN: No. Well, a lot of evidence has been led before you through Counsel Assisting, including the documents you've just seen to do with costings and so on. One assumes the relevance of that is that you've been asked to – you'll be invited in due course to make some sort of decision. Now - - -

35 COMMISSIONER WILSON: Well, it's a matter of how you interpret Term of Reference number 4, and I'll receive submissions about that in due course.

MR O'SULLIVAN: Well, that's what this evidence goes to, Commissioner.

40 COMMISSIONER WILSON: Well, I'll allow it in, but I don't know that it's of much weight, to be honest.

MR O'SULLIVAN: Thank you, Commissioner.

45 MS WILSON: Commissioner, can I be heard on that?

COMMISSIONER WILSON: Yes, Ms Wilson, if you want to.

MS WILSON: This witness is not a clinician. This witness is an administrative officer. The thoughts being expressed have to be seen in that context. This email should be put in its proper context for what it is. It takes this Commission no further, and its relevance to the Terms of Reference are difficult to see.

5

COMMISSIONER WILSON: Well, I certainly think that some of it's – does not seem at all relevant to me at the moment. I'm not sure about what's on the last page of this chain of emails. The problem is that I'm being presented with a chain of emails - - -

10

MS WILSON: Yes.

COMMISSIONER WILSON: - - - rather than specific emails.

15 MS WILSON: Well, perhaps – because of the content, perhaps then we could make submissions on it.

COMMISSIONER WILSON: On its going into evidence?

20 MS WILSON: On whether it should be received. I'm just only saying it because I just can't see the point of it myself - - -

COMMISSIONER WILSON: Well - - -

25 MS WILSON: - - - looking at the context of – from a clinician. Judy Krause is not a clinician – sorry – she's a clinician, but for asking this witness' viewpoint, who is an administrative officer.

COMMISSIONER WILSON: Mr O'Sullivan. I'm sorry, does Mr Freeburn want to
30 say something? I thought he was getting up.

MR FREEBURN: I was just going to make a practical suggestion, that you let it in and we can have the debate about its relevance and its weight on 21 March and subsequent.

35

COMMISSIONER WILSON: Well, hopefully the debate will be in writing; we won't spend too much time on 21 March on it. Yes, Mr O'Sullivan.

MR O'SULLIVAN: We respectfully agree with Mr Freeburn.

40

COMMISSIONER WILSON: I'll let it in on that basis. We're wasting time, really.

MR O'SULLIVAN: Yes. No further questions, Commissioner.

45 COMMISSIONER WILSON: Thank you. Does anyone else have any questions? Ms Wilson.

MS WILSON: Thank you, Commissioner.

COMMISSIONER WILSON: Sorry, Mr Mullins does first.

5 MR MULLINS: Your Honour, I - - -

COMMISSIONER WILSON: Mr Mullins, how long?

MR MULLINS: Commissioner, five minutes, with your leave.

10

COMMISSIONER WILSON: Very well. In open court? Open hearing?

MR MULLINS: In open court, thank you. Yes.

15 COMMISSIONER WILSON: Yes.

EXAMINATION BY MR MULLINS [1.04 pm]

20

MR MULLINS: Witness, you described that you attended a site visit to the Logan Hospital with Dr Stathis, Dr Geppert, Dr Sadler and Kevin Rodgers on 30 August 2013?---Yes.

25 Now, you actually didn't start officially until a few days after that, did you?---9 September.

And is it the case that from the time you started, there was no doubt that the – CHQ were engaged in the process of developing a new suite of services and West Moreton
30 engaged in transitioning the current cohort of patients; that's right?---My understanding was certainly developed from the project plans that were presented to me when I started.

Yes?---Yes.

35

And that's consistent with what I just said?---Yes.

And there was a possibility that if some of the new suite of services was available, that some of the cohort at Barrett might go into some of those new suite of services.
40 That's right?---That was absolutely a decision for the transition treating team.

But it was impossible for all of the services to be available at the time that Barrett was going to close?---Correct.

45 So why was it that you went to visit Logan Hospital on 30 August 2013?---My understanding was that every opportunity and every option was being explored as to what we could do both immediately and in the short term for the young people that

were at the Barrett Adolescent Centre. And one consideration that was on the table was whether the Logan Hospital site would be an option available.

But the term you use at paragraph 4 of your second statement is looking at Logan as
5 a potential site for relocation of the Barrett?---Yes.

So a complete relocation of the Barrett to Logan. Is that what was being looked at on 30 August?---From a short term perspective, in regard to the young people that were at the Barrett Adolescent Centre at The Park, with a view that the adult forensic
10 facility was not a good option to keep the young people there, it was looked at to say would we pick them up and move them until the new services and until transition planning had been completed? It was more of a risk management measure.

The second issue just relates to the meeting of 4 November 2013. At that meeting,
15 did you make it clear to the parents who were present that the tier 3 service was likely to be the two beds – two sub-acute beds at the Mater or Lady Cilento?---We certainly said subacute beds were a part of the model. We did not confirm any formal arrangements that had been reached or negotiated or discussed. That wasn't our place to do that at that meeting.
20
And did you understand the two parents that were present at that meeting were representing the parent body as a whole?---I don't have access to that information to confirm. I would be referring back to their report. It's not something I recall off the top of my head.
25
In addition to their oral presentation they had a written submission, didn't they?---Yes.

Thank you, Commissioner.
30
COMMISSIONER WILSON: Can I clarify one answer you gave. You said words to this effect, that at the meeting with the parents you said subacute beds were part of the model. But you then said something to the effect that you didn't disclose negotiations that were underway. Was that correct?---We didn't talk to the parents
35 that presented to us about the model specifically. But I think the question was around what information to have available to us. Now, we definitely had a website that was talking about a proposed model. We didn't talk to them about what we were negotiating or which parties we were going into partnership with or divulging any of that kind of information.
40
Did you even talk conceptually along the lines of these would be, however many, say, two beds in an acute ward which would be available on a swing basis?---Not at that meeting. No. That was really their opportunity to speak with the steering committee. The meeting we had in December with the Barrett Adolescent families
45 was where we shared the model as it had evolved.

Well, let's stay with the November meeting for the moment. Was anything said either by you or by the parents who were present to draw a distinction between the type of subacute beds which had been available at the Barrett Adolescent Centre and those which you were proposing in a hospital?---I don't believe we went into that
5 level of detail. I'd have to defer to the minutes.

Alright. Well, what about the meeting in December? Was that distinction drawn?---About being hospital based? That's certainly a term we used. Whether we – we didn't go into specifics around whether it was a subacute unit within an
10 inpatient unit in that degree of detail. It was a high level presentation on the model of care but it certainly said hospital based with onsite schooling.

So there was no clear picture presented at that December meeting that what you had in mind was something quite different from what had been at the Barrett Adolescent
15 Centre. Is that correct?---That would be an interpretation for the families of the presentation. We simply spoke about the new services that were being offered. We never spoke in the context of this is what you have now, this is what we're proposing going forward. We simply presented a model to them based on our clinical discussions.
20

So all you said was hospital-based subacute beds with education facilities; is that correct?---With on-site schooling.

With on-site schooling. That was all you said?---Yes. And there's a PowerPoint
25 that's been submitted to that.

Thank you. Any questions arising out of that before I come to Ms Wilson? Mr Mullins.

30 MR MULLINS: Just one. Thank you, Commissioner.

When you say a high level presentation, do I understand you to say that it was presented at a very high level of generality?---It didn't have the specifics regarding location, number of providers, number of staffing, budget figures. So, yes, high level
35 of summary detail.

Thank you.

COMMISSIONER WILSON: Ms Wilson, how long do you think you'll be?
40

MS WILSON: Less than 10, hopefully.

COMMISSIONER WILSON: Thank you.

45

EXAMINATION BY MS WILSON [1.10 pm]

MS WILSON: Ms Adamson, in response to one of the questions that my learned friend Mr O'Sullivan asked of you, one of your answers responded, "It's an evolving piece of work". And that's in response, from what I gather, to the 22-bed facility – the examination of the 22-bed facility?---Yes.

5

You are an observer of the youth mental health commitments committee?---Yes. That's correct.

It's fair to say, isn't it, that this committee is looking at the 22-bed facility and other
10 options in a very considered way?---Yes. That's correct.

Taking – looking at it from – taking out data, scoping, advice?---Yes.

With a consumer representative on that committee?---And a carer representative.

15

And a carer representative on that committee?---Consumer carer.

If I can take you to one of your exhibits of your statement – and bearing in mind that your exhibits take 23 volumes. If I can take you to IAD – the writing is too small for
20 me, Commissioner – .900.001.1578. This is exhibit ZD. I think my junior misread the number. Commissioner, the point is this: as I said, the exhibits attached to Ms Adamson's statement were 23 volumes and I don't think they've all been - - -

COMMISSIONER WILSON: I can picture the volumes in the Commission office.
25 They've had to have a special shelf.

MS WILSON: Well, there you go, Ms Adamson. You got a special shelf. Well, anyway, you're aware that in your statement you have set out in a table members of all the working groups?---Yes.

30

Okay. If I can take you now to the schedules that you were shown, that is, 4E. Now, that is the one that has got page 1 is blue half of the page and yellow the other half?---Yes.

35 Okay. Now, you sat down with Commission staff to work through this document this morning?---Yes.

And the table you were working off was on one page?---Yes.

40 And now this has gone to two pages?---Yes.

And in expanding, have some words dropped off? And if I can just take you to these perhaps amendments that it may have dropped off in the printing. If we can see in pre-BAC closure in the blue side on page 1 we have a column at the end of the blue
45 that is non-Queensland Health services provided?---Yes.

And then we have some commentary by you, as I see it, in red?---Yes.

And underneath that, should that read:

Services available/NGO.

5 ?---Are you talking about my comments in red?

Yes. It reads:

Account for the full spectrum of primary care services available.

10

There's just a bit that has fallen off?---I wouldn't know without comparing the two documents side-by-side. Sorry.

Perhaps the best process to be done is that we sit down in a considered way and look
15 at the two documents and we can get back the document to the Commission with the amendments that may have fallen off in the printing rather than going through the process here.

COMMISSIONER WILSON: Are you happy with that, Mr Freeburn?

20

MR FREEBURN: I'm content with that.

MS WILSON: Now, I'm going to show you a map that we were going to tender, but we'll take advantage of you being in the witness box. And I can hand one up to
25 the witness, and I can hand one to the Commissioner. Thank you very much. Have you seen this map before?---Yes, I have.

Now, this map – does this map reflect the Queensland Hospital and Health Services?---Yes.

30

And it contains where Child and Youth Mental Health Services are operating across theSstate?---Yes, according to the map symbols.

Right. And have you had an opportunity to look at the map and see if it's
35 correct?---Yes. I helped construct it.

You helped construct it. Okay. Commissioner, I tender that map.

COMMISSIONER WILSON: Very well. The map showing Hospital and Health
40 Services across the state will be an exhibit.

MS WILSON: Those are my questions for the witness, Commissioner.

COMMISSIONER WILSON: Is there anyone else before Mr Freeburn asks any
45 questions? Mr Freeburn.

MR FREEBURN: May Ms Adamson stand down?

COMMISSIONER WILSON: Yes. Thanks, Ms Adamson?---Thank you.

WITNESS STOOD DOWN **[1.16 pm]**

5

COMMISSIONER WILSON: Mr Freeburn, you intend to tender the schedules. You said in due course, I think.

10 MR FREEBURN: Yeah. I think we can resolve those technical difficulties and tender them later in the afternoon.

COMMISSIONER WILSON: Alright. My only concern is to ensure that all parties get copies of the ones you actually tender.

15

MR FREEBURN: Yes.

COMMISSIONER WILSON: That it's not just a process between Commission staff and the Crown.

20

MR FREEBURN: Well, we'll circulate one this afternoon and perhaps the other parties can look at it over the weekend and Monday and we'll correspond with them on Monday afternoon about it.

25 COMMISSIONER WILSON: Alright. Now, are there housekeeping matters to be dealt with? Can they be efficiently dealt with before lunch?

MS MUIR: I think so, Commissioner.

30 COMMISSIONER WILSON: Yes, Ms Muir. Mr Fitzpatrick.

MR FITZPATRICK: Commissioner, I'm sorry to rise, but, Commissioner, Ms McMillan's had a look at an extensive exhibit list. And I'm instructed that we would seek the luncheon adjournment in which to complete that review. So - - -

35

COMMISSIONER WILSON: Alright. I think that's probably sensible. I'm concerned about all of the staff in the hearing room – that they've been going since 9 o'clock this morning with only a very short break.

40 MS ROBB: Commissioner. Sorry. If I could just interrupt just to add a bit more fuel to the fire. We similarly have some concerns about some of the exhibit list we've been provided to. The initial problem is I don't appear to have access to any of the documents on them, so I'm not able to review them. That's the initial problem. We haven't been provided with them, but not only that I don't actually

45 have access to them. So - - -

COMMISSIONER WILSON: Well, I think we'd better - - -

MS MUIR: Commissioner, I'll talk to Ms Robb and whoever else has any issue in relation to access, and I'll see if I can resolve the issues.

COMMISSIONER WILSON: I thought that the exhibits were as soon as practicable
5 and redacted if necessary to go onto the web, but I've been just a tad busy in the last couple of weeks, and I'm not really sure how much has gone on the web.

MS ROBB: My understanding, Commissioner, is a lot of these documents actually haven't been referred to in the evidence. So there – we've been provided with
10 several lists during the morning from several parties. My concerns don't relate solely to documents provided by the Commission, I should add. There's some documents on the list from West Moreton that I've never seen before.

COMMISSIONER WILSON: Alright. Well, we'll sort it out and give you time to
15 do that. I think it's better that you have a little bit too much time than too little time. If we came back at 3 o'clock, would that suit everyone.

MS MUIR: That's convenient for me.

20 MR MULLINS: Yes. Thank you, Commissioner.

COMMISSIONER WILSON: Is there a problem from the Crown's perspective?

UNIDENTIFIED SPEAKER: In terms of the list we've been provided by various
25 parties, we haven't had a chance to ascertain whether we have access to all of those documents in Delium. So provided Mr Hill can ensure that all the parties have access to them in Delium in a timely way, then it can be dealt with this afternoon. But if they've not all been loaded into Delium, it might be difficult to resolve it by 3 pm.
30

COMMISSIONER WILSON: Yes. Mr Ben McMillan.

MR McMILLAN: Commissioner. Sorry. I'm sorry. I've been provided this morning with, I think, at least six pages of Delium references. I don't know whether
35 I have access to any of those documents, but it's certainly not possible for me acting by myself to review all of those documents to ascertain whether I have any submissions to make about them at all. Most of these documents – and I echo my learned friend Ms Robb's submission that we haven't – we just don't know what they are.
40

COMMISSIONER WILSON: I want everyone to have ample time. I'm also conscious that for all parties the next week and a-half will be very busy in the preparation of submissions. Can I leave it on the basis that we won't resume this afternoon but if these matters have not been finally resolved by the close of business
45 on Monday it may be necessary to convene for a short time perhaps on Tuesday.

MR McMILLAN: Thank you, Commissioner.

MR O'SULLIVAN: May I just ask one question.

COMMISSIONER WILSON: Yes, Mr O'Sullivan.

5 MR O'SULLIVAN: One question. Do you anticipate, Commissioner, documents being tendered and admitted without you actually sitting? Is that the process you envisage?

COMMISSIONER WILSON: Well, I understand that there were some documents
10 which I thought everyone was going to agree about it but maybe I was under - - -

MR O'SULLIVAN: Yes.

COMMISSIONER WILSON: - - - a misunderstanding there, which haven't been
15 mentioned in the public hearings - - -

MR O'SULLIVAN: Yes.

COMMISSIONER WILSON: - - - but nevertheless were to become exhibits.

20

MR O'SULLIVAN: Yes. That's partly - - -

COMMISSIONER WILSON: Is that answering your question or not?

25 MR O'SULLIVAN: No. I'm sorry - - -

COMMISSIONER WILSON: Alright. Well, tell me your question again.

MR O'SULLIVAN: It's my fault. The question arises as to the admission of new
30 documents into evidence.

COMMISSIONER WILSON: Yes.

MR O'SULLIVAN: The position had been we had been directed by Mr Hill to get
35 our house in order and tender them by 3 o'clock today and that's what the parties have been doing. It's generated a lot of material. I've got mine but everyone has got their own documents. My inquiry is this, Commissioner: insofar as there isn't dispute about the tendering of documents is the course you wish to adopt one whereby they don't – whereby the Commission does not need to reconvene for the
40 documents to be tendered can they be done in an informal way. Is that acceptable or is the process you envisage one where we will come back here and formally tender the documents?

COMMISSIONER WILSON: I was envisaging, subject to any submissions I may
45 receive, that it be done in an informal way - - -

MR O'SULLIVAN: Yes.

COMMISSIONER WILSON: - - - and it's only if there are unresolved issues - - -

MR O'SULLIVAN: Yes.

5 COMMISSIONER WILSON: - - - that it would be necessary to come back.

MR O'SULLIVAN: Thank you very much for that clarification.

COMMISSIONER WILSON: And I was hoping that by the close of business on
10 Monday it would be clear whether there were any unresolved issues about which it would be necessary to come back.

MR O'SULLIVAN: Yes. And we understand that and we will, I understand, obtain confirmation from Mr Hill that the documents have, indeed, been tendered and
15 admitted into evidence and so on but that's how you would proceed, Commissioner.

COMMISSIONER WILSON: Mr Hill is extraordinarily efficient. I'm sure you'll receive confirmation.

20 MR O'SULLIVAN: Thank you very much.

COMMISSIONER WILSON: Alright. Yes, Mr Fitzpatrick.

MR FITZPATRICK: Yes. Thank you, Commissioner. Commissioner, can I just
25 indicate that my learned friend Mr Mullins, on behalf of his three clients – Ms Wilkinson, Ms Olliver and Ms Pryde – has provided acknowledgements regarding certain matters arising in the transition of the three young persons involved. Those acknowledgements have resulted in a release – if I can put it in that way – on our part from any requirement to cross-examine those witnesses. The documents shouldn't
30 concern anybody but we acknowledge that they should be circulated so – including – I haven't had an opportunity to show them to Ms Muir either but if you - - -

COMMISSIONER WILSON: So I want to be clear what you're suggesting, Mr Fitzpatrick. Is it this that, yes, those documents should become exhibits and hence
35 all of the parties should have access to them - - -

MR FITZPATRICK: Yes.

COMMISSIONER WILSON: - - - but that they are documents which would be
40 redacted or maybe even redacted in full so that they're not on the public internet. Is that what you're suggesting?

MR FITZPATRICK: Yes. I think that's correct, Commissioner. But as I understand it, Commissioner, if it allays the concerns that anyone might have these
45 are a small – a select suite of the entire patient records for of these three young persons which, as I understand it, Counsel Assisting intends in due course to tender or exhibit in some way.

COMMISSIONER WILSON: Well, that is my understanding of what's proposed.

MR FITZPATRICK: But they are an acknowledgement on the part of those three witnesses and so go further than the basal records, if I can put it in that way. So if I
5 have liberty to circulate those and if any difficulties arise we'll draw those to - - -

COMMISSIONER WILSON: Yes. Well, they should be circulated on the basis that they're being circulated for the purposes of the Inquiry and that those who receive them shouldn't be distributing them further.
10
MR FITZPATRICK: Thank you, Commissioner.

COMMISSIONER WILSON: Alright. Yes, Ms Muir, anything else?

15 MS MUIR: No further matters, Commissioner.

COMMISSIONER WILSON: Very well. We'll adjourn and at this stage I'm definitely coming back on the Wednesday of – not next week but the following one to speak to submissions.
20

MATTER ADJOURNED at 1.25 pm UNTIL WEDNESDAY, 23 MARCH 2016