FURTHER WRITTEN SUBMISSIONS ON BEHALF OF THE HONOURABLE LAWRENCE SPRINGBORG MP

15 April 2016

Submissions as to the draft National Framework[1]

Opinions and beliefs of Dr William Kingswell
(Executive Director, Mental Health Alcohol and other Drugs Branch)

The oral address on behalf of Mr Springborg has identified the evidence of Dr Kingswell on this point (T27-67:4-T27:73:22).

It is submitted that the Commissioner would accept, and should find, as follows:

1. Dr Kingswell believed during 2012 and 2013 that the Barrett Centre, and the facility proposed at Redlands, and any other clinically staffed, bed-based adolescent extended inpatient treatment and rehabilitation service, or building for such a service,[2] was not consistent with the draft National Framework for Mental Health;[3]

2. Dr Kingswell believed that this meant that such a service, or building, was (a) clinically, not contemporary, and (b) unlikely to attract Commonwealth funding;

3. Dr Kingswell believed that it was important for any services that replaced the Barrett Centre to be clinically contemporary, and capable of attracting Commonwealth funding;

4. the view in 1. above is reflected in item 2a) of the report of the Planning Group (in evidence at eg. WMB.9000.0001.00162, part of MC-19 to the affidavit of Mary Corbett sworn 23 October 2015, Ex 41);

5. the views in 1 to 3 above were held by Dr Kingswell honestly, and in good faith, and were reaonable (and in particular, this finding is consistent with Dr Kingswell's evidence that he had personal knowledge of the genesis of the draft National Framework, and of the views of the planning team as to what they intended by it: see T13-48:44).

Interpretation of the National Framework document

To be properly informed, the Commission would call for evidence from the authors of the relevant parts of the National Framework document, or from others able to speak with authority as to its proper interpretation, as at 2012 and 2013.

It is submitted that the appropriate course is to call for that evidence, if the Commissioner considers that TOR 4 requires the Report to address models of future service delivery, or the Commissioner intends to do so, or if the Commissioner intends to give any weight at all to the late request from Counsel Assisting

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[1] Draft National Mental Health Service Planning Framework, Service Elements and Activity Descriptors; also, note 3 below.
[2] Viz. including a service or building meeting the description of a "design-specific and clinically staffed bed-based service" (ECRG Report, Preamble, second page, second paragraph – viz. the language on which Counsel Assisting particularly relied in oral closing submissions at T26-9:15-20), as opposed to community-based residential facilities (such as Y-PARC) providing treatment for sub-acute adolescent patients.
[3] The versions of this document that are in evidence are dated 1 November 2012 (DBK.500.002.0620, Ex 289) and October 2013 (DBK.500.002.1128).

(contained in a lengthy document served on 14 April 2016) to find that Dr Kingswell was, in fact, wrong in the views summarised in 1. and 2. above.

The National Framework document is not a statute, or a contract, or other legal instrument that a Judge, Counsel or solicitors can properly claim expertise in interpreting.

The National Framework document is, instead, a highly specialised health infrastructure and health service planning document that has been prepared by expert clinicians for expert clinicians. The subjective common intention of the drafters of the document is relevant to its proper construction. As well, a real rather than superficial understanding of the clinical context, and of the genesis of the relevant parts of the document, is also essential to its construction.

It is submitted that it would be an error of methodology for the Commissioner, or Counsel, to claim an ability to understand and to interpret the document where there exists ambiguity in its plain meaning.

The submissions to be served on behalf of Mr Springborg on the proper interpretation of the National Framework document will be provided in response to the Commissioner's request for assistance on that point, and with the caveat that the solicitors and Counsel lack clinical expertise, and do not have access to the assistance of any appropriate expert.

Those submissions will follow separately once completed.

Submissions from the Royal College (the Queensland Branch of the Faculty of Child and Adolescent Psychiatry of the Royal Australian and New College of Psychiatrists)

It was submitted during oral address that the submissions to the Commission from the Royal College "*strongly recommends that you do not adopt the view that the appropriate course is to recommend in favour of an extended inpatient unit*" (T27-76 L6-10).

That reference was to the written submission of the Royal College dated 3 December 2015 (Ex 144). Dr Fryer there states as follows:

> "*It is strongly advised that the Inquiry recommends against the development of a long stay psychiatric facility for the treatment of adolescents with mental health disorders*" (Ex 144 at p 4 of 5; Submission dated 3 December 2015)

The Commissioner observed that there is a definite shift between the first long submission of the Royal College (dated 3 December 2015, Ex 144) and the later submission (dated 10 March 2016, Ex 288): T27-91 L 20-21.

In this regard, and because the point was addressed in oral submissions, the Commissioner's attention is drawn to page 4 of the second submission from the Royal College, which states that the College supports "consideration of a medium term in-patient unit that provides extended treatment and rehabilitation" (Ex 288).

It is also noted that immediately after this statement, the second submission from the Royal College goes on to express concern that such a model carries clinical risks, and that such units may divert attention and resources from models of care that are community based (at p 4 of Ex 288). The submission then expresses the view that the numbers of patients who might meet the criteria for such admission are small and that "it is probable" that the development and provision of other intensive community-based services such as AMYOS, and supported residential settings with the requisite expertise "can reduce and perhaps remove the need for sub-acute inpatient services" (at page 4 of Ex 288). The conclusions of the second submission do not make any express reference to sub-acute inpatient care (at pp 7-8, Ex 288).

The Commissioner is otherwise referred to the summary of the evidence of Dr Fryer at [2.30] to [2.33] of the written submissions for Mr Springborg dated 23 March 2016.

Item 10 on the list of topics to be addressed in oral submissions

No oral submission was made in relation to the second part of item 10 on the list of topics identified as points to be addressed in oral submissions; viz. the response of Counsel Assisting to the criticisms made of them in the written submissions in chief (T27-29 L33-34).

The following is submitted on that point:

1. The response provided by Counsel Assisting was that these criticisms, and those advanced by the State of Queensland (represented by Crown Law) and by West Moreton (represented by Corrs Chambers Westgarth) in their written submissions, was that the criticisms were in each case "*an unnecessary distraction and do not matter*" (T26-18 L29-33).[4]

2. That is a remarkable and wholly inadequate response. What should have occurred is either an attempt to answer the criticisms made, or an acknowledgment of what parts of the criticisms are accepted. If Counsel Assisting required more time to respond, or to reduce their response to writing to save time at the oral hearing, they could and should have asked for that. To respond that these criticisms are "*an unnecessary distraction and do not matter*" is, with respect, entirely unsatisfactory.

3. An adequate and proper response to the criticisms made on behalf of Mr Springborg would have been either to (a) press paragraph [204] of the written submissions of Counsel Assisting dated 18 March 2016, and to seek to answer Mr Springborg's submission that paragraph [204] is improper, and a wholly unjustified attack on his integrity, and to otherwise respond to the detailed criticisms made in Part 2 of the written submissions of Mr Springborg, or (b) withdraw paragraph [204], and to otherwise concede that some or all of criticisms in Part 2 of the written submissions for Mr Springborg are accepted. Neither of these courses has been adopted. The course that has been adopted is inadequate and inappropriate.

Dominic Q'Sullivan QC

James O'Regan

15 April 2016

[4] "I have used the expression matters that matter on purpose. That is because, as you have no doubt read, there are a few sets of written submissions that contain strong criticisms of the submissions and the approach of Counsel Assisting. We as Counsel Assisting do not think that we can assist you in responding to those matters. They are, in our submission, an unnecessary distraction, and do not matter. There is one exception…": T26-18 L29-33.

Addendum to written submissions on behalf of the Honourable Lawrence Springborg dated 15 April 2016

Construction of the draft NMHSPF

1. These submissions respond to the Commissioner's request for submissions on the construction of the National Mental Health Service Planning Framework (**NMHSPF**).[1]

2. There are two drafts of the document in evidence: a November 2012 draft (ex 289) and an October 2013 draft (ex 233).

3. These submissions are provided as they have been requested by the Commissioner. However, we repeat our caveat that the NMHSPF is a highly specialised health infrastructure and health service planning document that has been prepared by expert clinicians for expert clinicians. The subjective common intention of the drafters of the document is relevant to its proper construction. As well, a real rather than superficial understanding of the clinical context, and of the genesis of the relevant parts of the document, is also essential to its construction.

Considering the NMHSPF text only

4. We first consider the NMHSPF by considering only the text of the document.

5. We agree with the submissions of Counsel Assisting that, on the issue of whether the Redlands project (**Redlands**) was consistent with the NMHSPF, the relevant service elements within the NMHSPF are (using the October 2013 numbering) 2.3.2.5 and 2.3.3.1.[2]

6. It is submitted that Redlands is consistent with neither of those service elements, and thus Redlands is not consistent with the NMHSPF.

Redlands

7. When considering the NMHSPF, it is useful to recall that Redlands was intended:

   (a) to service patients aged 13 to 17 years who were eligible to attend high-school;[3]

   (b) to have a six month maximum length of stay; [4]

   (c) to include an integrated school.[5]

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[1] T27-61:L10-12.
[2] Counsel Assisting submissions at 33.
[3] See for example, the draft model of service at Ex. 43, MSS.900.0002.0001 at .0224 (The service "*is available for Queensland adolescents: aged 13 – 17 years; eligible to attend high school*").
[4] See for example, the draft model of service at Ex. 43, MSS.900.0002.0001 at .0224.
[5] See the Report of the Site Evaluation Group at p3 ("*The Barrett School is a critical component of the service and must be included in the redevelopment of the service at any site.*"): Ex. 43, MSS.900.0002.0001 at .0231.

Service Element 2.3.2.5 (Service element 1.2.6 in the November 2012 document)

8. The NMHSPF details "service categories" which are broken down into more detailed "service elements".

9. For present purposes the relevant service category is (in November 2012) 1.2 "sub-acute services"[6] and (in October 2013) 2.3.2 "sub-acute services (residential or hospital or nursing home based)".[7]

10. For each version, the service category is divided into three service elements:

    (a) Step up/step down services (service element 1.2.2/2.3.21);

    (b) Community-based rehabilitation services (service element 1.2.4/2.3.21);

    (c) Intensive care services – (service element 1.2.6/2.3.2.5).

11. A critical question is thus whether the intensive care services (service element 2.3.2.5/1.2.6) are intended to apply to young persons in the age range of 13 to 17 years.

12. There is some indication that they may. In both the November 2012 document and the October 2013 document, the table of attributes for intensive care services provides that the Target Age is:[8]

> *Adults, older adults and* ***selected young people with special needs****.* [Emphasis added]

13. However, when one considers the earlier discussion of the three service elements, it is apparent that the "selected young people" eligible for intensive care services is restricted to persons aged 16 and older (eg, the 16 to 25 cohort elsewhere described as "adolescent" – see paragraph 14 below) and does not include the ages 13 to 17 cohort. Rather, this younger cohort is catered for exclusively by the Step Up/Step Down services and the community-based rehabilitation services.

14. In particular, the October 2013 document provides:

> *Distinguishing Features*
>
> - ...
> - ***Sub-acute step up/down and sub acute rehabilitation units young people (12-17) and/or adolescents (16-25) are delivered in community residential settings.***
> - ...

[6] Ex 289 at .1192.
[7] November 2012 p65 [Ex 289 at .1192]; October 2013 at p252 (ex 233 at .0871).
[8] November 2012 p73 [Ex 289 at .1200]; October 2013 at p268 (ex 233 at .0887).

- ***Sub-acute intensive care services are provided for ages 16 to 65+*** *as collocations with other inpatient services on general hospital campuses or in some cases psychiatric hospital campuses. [Emphasis added]*

15. The November 2012 document also includes (at p66) the last dot point quoted above.[9]

16. It is thus apparent that:

    (a) the NMHSPF proposed (non-community based) intensive sub-acute services only for persons aged 16 or above;

    (b) the NMHSPF proposed only community based sub-acute services for persons aged 12 to 15;

    (c) thus Redlands, which proposed a non-community based sub-acute service for persons aged 13 to 17, was not consistent with the NMHSPF.

17. Further, it is apparent from the NMHSPF that the community-based sub-acute services (viz, step-up/step down and community-based rehabilitation services) were intended to address the needs Redlands was proposed to meet. For example:

    (a) The Target Age of those services was expressed as (in November 2012) "*Young people 13 to 18 (those eligible to attend high school)*" and (in October 2013) "*Youth (12-17) or (16-24)*".

    (b) Their features and services were expressed to include (in November 2012) "*close collaboration with education providers*"[10] and (in October 2013) "*The service takes an integrated approach to clinical recovery and psychosocial interventions with* ***a focus on*** *stabilisation and management of illness,* ***engagement or reengagement in*** *positive and supportive social, family,* ***educational*** *and vocational connections*" [emphasis added].[11]

    (c) In contrast, the intensive care services descriptions make no mention of education or social connections but focus on safety and support to independent living (which is consistent with them being targeted to an older, post-school age group).

18. Redlands was thus inconsistent with the NMHSPF, as it provided a non-community based service, whereas for the target age group the NMHSPF provided for only community-based services.

Service Element 2.3.3.1 (Service element 1.3.1 in the November 2012 document)

19. It is apparent that service element 2.3.3.1/1.3.1 refers to a service materially different from that proposed at Redlands.

20. Service element 2.3.3.1/1.3.1 provided for in the NMHSPF:

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[9] November 2012 p66 [Ex 289 at .1193].
[10] Page 71: at .1198 (Key Distinguishing Features).
[11] Page 255: at .0874.

(a) is a non-acute service (BAC was, and Redlands was proposed to be, a sub-acute service);

(b) the key differences between sub-acute and non-acute services were (in both documents) described as follows:[12]

> *Sub-acute and non-acute bed-based services are part of a spectrum of services and, as such, share some characteristics – for example, a focus on rehabilitation. The key difference is that non-acute services provide care over an extended period – with* ***an expected length of stay in excess of 6 months.*** *[Emphasis added]*

(c) The distinguishing features includes that:

> *Gains are expected to occur slowly and stays are measured in months and years. Measures of average lengths of stay are often distorted by the need to provide continuing care for some people over decades.* [13]

(d) Another distinguishing feature is that:[14]

> *These extended stay programs are* ***not suitable for young people****. [Emphasis added]*

(e) The Target Age of "*Adults, older adults and selected young people with special needs*"[15] needs to be read in light of the above distinguishing feature. It is submitted that the proper construction is that, as with the sub-acute intensive care services considered above, the "selected young people with special needs" would be restricted to those close to 18 years of age and exclude the younger cohort (12-15, for example).

(f) The Key Distinguishing Features include "*a strong focus on safety, security and risk assessment and management.*" As with the sub-acute intensive care services considered above, there is no mention in service description of education or social connections.

21. It is clear that the non-acute services in the NMHSPF were services of a different nature to that proposed at Redlands. Service element 2.3.3.1/1.3.1 is a long-term (in excess of 6 month) service targeted at older (presumably post-school) patients. It is different from the shorter stay (maximum 6 month), younger patient (13-17), education-focussed service proposed at Redlands.

22. Redlands thus did not fall within the non-acute services described in the NMHSPF.

Evidence of Dr Kingswell

23. The above discussion shows that Dr Kingswell's understanding of the NMHSPF (to the effect that it did not intend the intensive care services to apply to children and youth[16]) is

[12] November 2012 p74 [Ex 289 at .1201]; October 2013 at p271 (ex 233 at .0890).
[13] November 2012 p74 [Ex 289 at .1201]; October 2013 at p271 (ex 233 at .0890).
[14] November 2012 p74 [Ex 289 at .1201]; October 2013 at p271 (ex 233 at .0890).
[15] November 2012 p76 [Ex 289 at .1203]; October 2013 at p273 (ex 233 at .0892)
[16] T13-48:39-45.

consistent with a textual construction of the NMHSPF. Counsel Assisting's submissions to the contrary[17] should be rejected.

24. Counsel Assisting also criticise Dr Kingswell for adopting an understanding of the NMHSPF "*not ... based on the draft NMHSPF itself but ... based on illusive conversations with others*".[18] This criticism should also be rejected.

(a) First, as discussed above, Dr Kingswell's understanding is consistent with the text of the document. The construction advance by Counsel Assisting is not.

(b) Second, it is unfair and inaccurate to describe the conversations as "illusive". Dr Kingswell said the conversations were with the NMHSPF planning team.[19] Dr Kingswell was on the NMHSPF Executive Group. There is no reason to doubt the conversations occurred. Counsel Assisting neither challenged Dr Kingswell's evidence that the conversations occurred nor asked him to provide greater detail regarding the conversations. The pejorative adjective of "illusive" should not have been used.

(c) Third, it is entirely unsurprising and proper that Dr Kingswell's understanding of the document should be based on his discussion with the NMHSPF planning team. The NMHSPF is not a legal text. It is a document for clinicians and expert public health administrators. It was appropriate for Dr Kingswell to seek to understand what the expert authors in fact intended. Indeed, it would be inappropriate and dangerous for someone in the position of Dr Kingswell to insist in a literal interpretation of a medical document if he or she were aware that the expert authors had intended a different meaning.

(d) Finally, we refer to our earlier submissions[20] and those of the State[21] with respect to the appropriateness of public health administrators relying on oral discussions as well as written texts in undertaking their roles. The submission of Counsel Assisting assumes that such an approach is undesirable. That submission is contrary to the evidence and, as a matter of common experience and common sense, wrong.

Conclusions

25. On a textual construction of the document (and subject to the caveats we expressed earlier about non-clinicians construing such a document):

(a) Redlands was not consistent with either the November 2012 or the October 2013 draft of the NMHSPF;

(b) Dr Kingswell's understanding of the NMHSPF is consistent with the text of the document.

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[17] For example, Counsel Assisting submissions at [33] and [94].
[18] Counsel Assisting submissions at [81].
[19] T13-48:39-45
[20] COI.028.0017.0001 at [6.17].
[21] COI.028.0002.0001 at [25]-[31].