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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

9.32 AM, WEDNESDAY, 17 FEBRUARY 2016

Continued from 16.2.16

DAY 8

RESUMED **[9.32 am]**

COMMISSIONER WILSON: Good morning, ladies and gentlemen. I'm sorry for
5 the late start.

MR DIEHM: Commissioner, just before the evidence commences I have an application for an order that permits Dr Brennan to see the transcript – read the transcript of the evidence of Professor McDermott that was given in closed hearings
10 yesterday. You may recall, Commissioner, that you were prepared to order that Dr Brennan could remain in the courtroom though she had been watching it on live stream and it would enable her to give more detailed instructions about matters that Professor McDermott spoke of in his evidence yesterday.

15 COMMISSIONER WILSON: Alright. Does any other counsel wish to say anything about that? Mr Diehm, I will allow Dr Brennan to have a copy of the transcript of the closed hearing of Professor McDermott's evidence from yesterday.

MR DIEHM: Thank you, Commissioner.

20

COMMISSIONER WILSON: Now, are there any appearances this morning which there weren't yesterday?

MR J.M. HARPER: Yes, Commissioner. My name is Harper - - -

25

COMMISSIONER WILSON: Speak up, would you.

MR HARPER: My name is Harper, initials J.M. I appear instructed by Shine Lawyers on behalf of Ms Pryde, Ms Olliver and Ms Wilkinson.

30

COMMISSIONER WILSON: Thank you.

MR HARPER: Commissioner.

35 MR J.J. ALLEN QC: Good morning, Commissioner. Allen spelt A-l-l-e-n, initials J.J., Queen's counsel for Metro North Hospital and Health Service and in particular this morning for Dr James Scott.

COMMISSIONER WILSON: Thanks, Mr Allen. Anyone else?

40

MR J. O'REGAN: Commissioner, O'Regan - - -

COMMISSIONER WILSON: Speak up, Mr O'Regan.

45 MR O'REGAN: O'Regan, apostrophe – sorry, initial J., for the Honourable Lawrence Springborg.

COMMISSIONER WILSON: Thank you.

MS S.V. ROBB: Commissioner, Robb, R-o-b-b, initials S.V. Just to let the parties know as well, we're now acting for Liam Huxter and Graham Dyer.

5

COMMISSIONER WILSON: In addition to the other nurses.

MS ROBB: In addition to the other nurses.

10 COMMISSIONER WILSON: Very well. Thank you.

MS ROBB: Thank you, Commissioner.

COMMISSIONER WILSON: That's it? Mr Freeburn.

15

MR FREEBURN: Commissioner, I call James Scott and he's instantly arrived into the witness box.

COMMISSIONER WILSON: Would you stand up please, Doctor.

20

JAMES GRAHAM SCOTT, SWORN **[9.34 am]**

25 **EXAMINATION BY MR FREEBURN**

MR FREEBURN: Commissioner, Professor Scott's witness statement is MNH.900.003.0001.

30

COMMISSIONER WILSON: Thank you.

MR FREEBURN: Dr Scott, can I first of all ask you about ECRG and your involvement in the ECRG?---I was invited to be a member of the ECRG.

35

Alright. If I can take you first of all – you deal with it in your statement at paragraph 43. So if we can go to page 8 of that document, please.

MS McMILLAN: Commissioner, could the witness speak up a bit. Even though

40 I'm sitting close to him it's difficult to hear him.

COMMISSIONER WILSON: Thanks, Ms McMillan. You'll have to speak into the microphones. You can adjust them a little?---Sure.

45 Thank you.

MR FREEBURN: Professor Scott, there in that paragraph you describe the expertise of the members of the ECRG as being significant and that the ECRG was an appropriate representation for that group. Correct?---That's correct.

5 I'd just like to, for a moment, explore that expertise. If you can go to page 94 of that document which is exhibit JS8. Now, if we scroll down a little we can see the members of the ECRG. I think there are 12 of them. Can I just ask you, you personally have extensive clinical experience in the field of child and adolescent psychiatry?---That is correct. I acquired my fellowship in child – as a child and
10 adolescent psychiatrist in 2001 and have been working in community and acute settings since that time.

And the others on this list – so you're number 2 on this list – but the others on this list, are they mostly clinicians directly practising in the area of child and adolescent
15 health – mental health?---All of them are either clinicians or were clinicians at that time or had extensive experiences as clinicians. The exceptions – I can't comment on Amelia Callaghan's clinical experience. She was with Headspace. I'm not sure what her clinical experience was. And Kevin Rodgers had a background in education.
20

Alright. And obviously the other – the consumer and the carer representative – let's not identify them – but they won't be clinicians?---No. That's correct.

No. Alright. But with those exceptions, the group is made up of a substantial
25 number of practising clinicians?---I think the group gave a wide array of clinical experience in the child and youth mental health sector from various disciplines. That was one of the strengths of the group because it wasn't just a medical group. We had psychologists. We had – we had other allied health professionals – nursing staff – other allied health professionals on the group as well.
30

Right. And before I leave that document if we go to page 94 of the document. Sorry, it should be the third page of that exhibit so if we scroll down a little we'll see. Just go back up a little, please. Keep going. Keep going a little. Alright.

35 Sorry, 2.1 deals with in effect what the ECRG was to do. It was to come up with a contemporary model of care to effectively – as we can see from the last dot point – replace Barrett Adolescent Centre?---That's correct.

Alright. Now, can I just – you're aware, weren't you, that a planning group sat
40 above the ECRG?---It's hard for me to recall exactly what I was aware of at that time. I was aware that persons were writing a model or – or proposing a model that the ECRG was to give advice and – and – and input into. I wasn't aware who was on that planning group and what that was made up of or the expertise of that group.

45 Alright. Well, let's just have a look at that. I'd like go to document WMS.1002.0002.00070. Now, if you have a look at this document – if you just scroll up we can – you can see it's the Barrett Adolescent Strategy Planning Group.

And you can see there seven attendees at this meeting and two apologies. Is it accurate to say from your knowledge that of those nine people, about two are practising clinicians?---I would regard Dr Sadler, Dr Stathis and Dr Hartman at that time as practising clinicians.

5

Alright. Three. Alright. Now, can I take you to – I'm going to take you to one of the ECRG meeting minutes. You exhibit them in your affidavit – sorry, attached to your witness statement. I'd like to go back to the witness statement and to page 90 and 91 of that document, please. Now, if you just scroll up to see – there were a
10 whole series of meetings, and minutes were prepared for each of them. Is that right?---That's correct.

I know the document has got a watermark on it of "draft", but were there final ones that you're aware of?---I can't recall if there were or not.

15

Right. Now, if we just scroll up a bit, we'll see which meeting we're talking about here. So back – no, up. Yep. Keep going. 27 March 2013. So this is fairly late in the piece, and you're an attendee at this meeting. Now, if we go back to page 90, please. Now, you'll see here that the committee is considering the different tier
20 levels, and tier 2B is said to be the residential component. If we scroll down a bit further, we see tier 3. I just wanted to ask you about those words:

> *The majority of members were supportive of both tier 2 and 3, with some concern regarding the inclusion of an NGO residential component.*

25

And then if you see a bit further down, the third dot point under that heading Tier 3, "The chair" – now, I gather that's Dr Geppert?---That's right.

Continuing:

30

> *...clearly clarified with the ECRG members that tier 3 will be included in the recommended model. However, in the short term, the tier 3 option will not be considered due to the absence of capital funding and location, and therefore the ECRG needs to consider how to make tier 2 work.*

35

Does that accord with your recollection of what happened at the meeting?---That's consistent with my recollection. What I recall was that there was a – initially a strong push in these meetings to have community-based care – so community residentials and non-government organisation type residentials, with these young
40 people being able to access acute inpatient units when required. The group had concerns about that model, partly because there's often not beds available in the acute inpatient units, and partly because the young people who had previously been cared for at the Barrett would have difficulties being supported with a non-government residential. We could see problems with that, and so there were
45 concerns that it was just a tier 2 or tier 2B with acute inpatient units, and thus the group pushed for – or recommended that a tier 3, which is like an extended stay hospital setting, be available to young people also.

Alright. Now, if we scroll down a bit further, I just want to further refresh your memory and then I'll put a summary of it to you. There's a heading, Member Options, we can see there. And the first dot point:

5 *Possible impact on inpatient beds if the tier 3 is not implemented is that long stay patients will take up acute beds.*

And then there's a statement there that:

10 *Mixing the two types of consumers is not helpful.*

Is that – can you explain what that means?---Yeah. The young persons who typically referred to the Barrett were those – the one thing they had in common was that they were unable to be supported in either community settings or acute inpatient settings.
15 So they would be admitted to an acute inpatient unit and were unable to be discharged safely back into community centres or settings, and often their admissions were quite protracted, so it might be several months, and there was no clear discharge strategy available to these young persons, and so the Barrett was thus an option where time pressure was taken away and young people could be referred onto
20 the Barrett. Now, the difficulty of having young people who have long, protracted stays in hospital in an acute inpatient unit is that these young people see the others – other patients come and go. It distresses them. They form relationships with these people, and then the other young people leave, are discharged, and it gives the young person who's left in the unit the sense of hopelessness and despair, and with that it
25 often escalates the symptoms that they have.

Alright. Now, I just want to return to the original point I was making. If we scroll up a little, just to the next page, you see Mr Rodgers, who's the principal of the school – of the Barrett Adolescent Centre school – he notes a cost in losing the BAC,
30 and then that prompts – if we scroll to the top of the next page:

The chair acknowledged this statement and clarified again that the reality is that in the foreseeable future tier 3 will not be progressed.

35 So is it the case that Dr Geppert was really saying a tier 3 replacement of the Barrett Centre is off the table?---It – I think we all held the hope that there would be something of that nature available, but clearly, from the minutes, Dr Geppert was indicating that.

40 Is that your recollection of what was happening at the meetings?---I can't entirely recall. I don't mean to be unhelpful. I actually – I still held some sort of hope that there might be something available for these young people.

And ultimately, you did specify that there should be a tier 3 facility?---That's right.

45

Alright. And if we scroll down a little bit further, we'll see a section in bold:

Members of the ECRG unanimously supported the retention of the tier 3 option in the recommended service model.

That's what you're saying. You're all - - -?---Yeah - - -

5

As you expressed it, you're all hoping that – you're all wishing that there be a tier 3 on the table?---Yeah. I think that the ECRG was concerned by the direction it was being taken as far as not having a replacement centre for the Barrett Adolescent Centre, and I think we wanted to voice our opinions in the strongest manner that, you
10 know, there needed to be something to look after these kids.

Alright. And when you say "these kids", I think in these documents the "target group" is an expression used. We're talking, are we, about kids who, I think as you mentioned, don't fit or can't be adequately dealt with in other services?---That's
15 correct, or certainly other services that were available at that time.

Right.

COMMISSIONER WILSON: Mr Freeburn, would you keep an eye on the time.

20

MR FREEBURN: Yes.

COMMISSIONER WILSON: You've been going for almost 20 minutes.

25 MR FREEBURN: Do you recall that at some point you were given a model of service or a model of care for what had been proposed for Redlands? I think you exhibit it to your witness statement, but - - -?---Yeah. Many years ago we were involved with the – I was involved in an initial meeting about Redlands. Again, I can't recall specifically if that was given to us during the ECRG meetings or not. If
30 it's in the minutes, it was.

Alright. I'll just continue on to the next point. Now, a moment ago you mentioned that that was then. I just want to explore with you –the Barrett Adolescent Centre closed in January 2014. Are you aware of what services were available to the Barrett
35 cohort in Queensland from that point?---My understanding was that there was enriched care available through the usual CYMHS community services, so the young persons who were patients at the Barrett could get care through either Child and Youth Mental Health Services, or through those that were approaching 18 or over 18 going to the adult mental health services. This was perhaps an enriched version of
40 what was already on offer, but I don't think it was any sort of new therapy or anything like that, as far as I'm aware.

COMMISSIONER WILSON: Did you say an enriched version?---Yeah. By enriched version, I think that they were allocated case managers who were – you
45 know, it was their job to sort of meet the needs of a young person and their families and such. I'm aware of a young person who I saw privately

And the service that got from local CYMHS service was over and above what the standard care would've been.

UNIDENTIFIED SPEAKER: Excuse me, Commissioner - - -

5

UNIDENTIFIED SPEAKER: Excuse me - - -

COMMISSIONER WILSON: Just a moment, would you.

10 MS WILSON: Commissioner, if the doctor is going to continue with this evidence then this evidence should be in closed court.

COMMISSIONER WILSON: Well, I don't require any further clarification at the moment, Doctor. We'll see.

15

MR FREEBURN: Doctor, we're just careful not to identify people?---Sure.

And sometimes we can identify people by referring to one particular person and their – what's happened?---I understand that. Sorry.

20

So the enriched services that you're talking about, what are they known by in CYMHS? Are they community care centres, are they?---No. When I'm talking about enriched services, I think the patients of the Barrett were seen as a cohort that did require that extra care. And I think there was extra attention paid to them by case managers within the community services. I'm not aware – I'm not saying it didn't exist – I'm just not aware of the other services that might have been available to them.

25

All right. Okay. Now, Doctor, as I read the ECRG report, the ECRG report is fairly clear that a tier 3 facility was needed for this cohort of people. And is that still the case, in your view?---I am less certain about – I think that there are possibly – there are other community models that operate around the world and other jurisdictions where there's specialist therapies available to provide care for young people in the community. As a rule, as an absolute rule, young people are best cared for at home with their families. So whenever that can take place, it should. What that often requires is extra disability support. It requires specialised and intensive therapy to be available in the community settings. And when those other services aren't available – and also extra educational support as well, schools being willing to look after these kids and educate these kids. When those aren't available, that's where we sort of find that young people can't be managed in a community and, thus, are needing an inpatient facility to look after them.

30

35

40

And the cohort that we're talking about are at the extreme end?---That's correct.

45 There's a new service called AMYOS, I think designed and run by Dr Daubney?---That's correct.

Is it accurate to say that that's – I'm going to try and speed things up. But is it accurate to say that that service is essentially a group of professionals, health professionals, who go out to a person's place, treat them in their home and might visit on a sort of – three or four times a week?---That's correct. So AMYOS stands for the Assertive Mobile Youth Outreach Service. There's a similar service that operates in Victoria. It has a – it's underpinned by an evidence based model of care called mentalisation based therapy. And, really, it's this combination of a specialised therapy that's there to support the young person and their families in the way they interact and the way they cope with difficulties. So it's a combination of the therapy plus the intensity of it and the fact that it is mobile, it can go out to families and also the experience of the clinicians that are doing it and the ongoing training of supervision they get. This allows them to look after a much higher level of severity of illness in young people than what could normally be managed by a standard CYMHS service.

And am I right in thinking the only limitation on an AMYOS program is if it happens that the family is dysfunctional and that the family situation is a problem?---I think where the family are unwilling to see themselves as part of a solution it's very hard for AMYOS to be effective. That goes for all mental health care of children and adolescents though.

Yes. Excuse me. Thank you, Commissioner.

COMMISSIONER WILSON: Thank you. Ms Wilson.

EXAMINATION BY MS WILSON **[10.00 am]**

MS WILSON: Thank you, Commissioner. I'll just get my spot.

Can I just pick up, Doctor, on what – an answer that you gave to Counsel Assisting. And that answer involved this, and I might be doing it in shorthand which may not be of – doing you a disservice. So perhaps if we can expand on that. You said that the best rule for treatment is at home with the families. That's the starting point and then you try to build a treatment service around that. Is that the case?---That's correct.

Okay. And with respect to young people with long term severe and complex mental health needs, is it the case that the primary aim of the extended treatment and rehabilitation model of care is to provide an integrated continuum of care outside of the inpatient setting and as close to their home as possible?---Where that's possible, absolutely.

All right. And then if we can just look at one of those matters that I referred to you, one of the three elements of integrated continuum of care. If I could just ask you some questions of your knowledge and experience of an integrated continuum of care. So as I understand it in terms of a continuum of care, at one end you have the

community based services. And that is the CYMHS clinics. And at the other end there are acute beds. Is that – am I right in proceeding on that basis?---That'd be a reasonable way to explain it.

5 Okay. And when we're talking about the community based services, that is the Child Youth Mental Health Service clinics known as CYMHS?---That's correct.

So when I'm talking about CYMHS, you know what I'm talking about?---I know what you're talking about. Yep.

10

And that should adequately be reflected in the transcript. Now, looking at those two ends, community CYMHS – sorry, you're presently working at the Royal Brisbane Women's Hospital?---That's right.

15 Okay. And community CYMHS is available at the Royal Brisbane and Women's Hospital, isn't it?---No. It's within the - - -

Within the district?---Within the district. That's right.

20 Yes, not exactly in the hospital but within the district. And acute beds, at the other end of the spectrum, are available at the Royal Brisbane Women's Hospital?---They are.

So now let's fill out what's in-between. Now, you were asked some questions about 25 AMYOS and you refer to AMYOS in your statement where you actually go through and you say what's good about AMYOS and what's not so good, in your view?---Not what's not so good, where its limitations are.

Okay. Now, is it the case that AMYOS is driven by the patient's need and that it not 30 just is on a static three or four days a week but it's driven by the need and that could be every day?---That's correct. So AMYOS has its flexibility. It could even be as persons recover they can step back and see them far less frequently.

Okay. And then working through there's the Residential Rehabilitation Services 35 which provides long term accommodation up to a year for long term accommodation recovery orientated treatment for 16 to 21 year olds who have moved out of the acute phase of the mental illness but lack the skills or the expertise for independent living. Do you have any knowledge or experience working with the services that are provided with the Residential Rehabilitation Services, otherwise often referred to as 40 the resis?---Not really. No.

Okay. And so you're not – you're not aware of the services they provide?---I'm aware of what they call resis which are run by child safety. I'm not sure if they're the same services or not.

45

No, the ones that I'm referring to are not. There are two youth residential resis that I'm referring to, and they are in Greenslopes and Cairns. Do you have any

experience of those?---I have heard of them. I've never met a staff member or patient.

Okay. Then there's the day programs, and day programs are available at the Royal
5 Brisbane and Women's Hospital catchment; that's the case?---They've got one up – that's correct, yes.

Yes. Okay. And then are you – have – are you aware of the proposed Step Up Step Down units, which is a new service type for young people in Queensland, with the
10 first to commence in 2017/2018 in Cairns?---Again, I've heard of them. I don't know any detail about them.

Okay. So when you say you've heard of them, are you aware that they provide a step up service option to prevent inpatient admission through intense short-term treatment
15 and a step down option to assist early in seamless transition for young people when re-entering the community following inpatient admission?---That would be congruent with what I'm aware of, yes.

And then there is subacute beds, and are you aware that subacute beds are available
20 at Lady Cilento?---I'm aware they're available, yes.

Okay. And we've had – you've been taken to some documents where the term "tier 3" is used, and tier 3 would involve subacute beds that could be available at Lady Cilento. Is that the case?---That could be the case, yeah.
25

Okay. And there were subacute beds that were available after Barrett closed at the Mater. Were you aware of that?---I wasn't aware of that, no.

Okay. Now – so I've just given you a little sketch of the planned services. Were you
30 aware that they don't necessarily have to operate as a standalone option, but there's flexibility between them? You're aware of that, Doctor?---That's right.

And that, importantly, treatment plans are specifically designed to meet the needs of the individual?---That's right.
35

So, Doctor, when I ask a question you have to - - -?---Sorry.

- - - say "yes" - - -?---Yes.

40 - - - "no" or give me – or give some other answer - - -?---Sorry.

- - - that you wish, but it has to be recorded, and nods can't be recorded on transcript?---Thank you.

45 Okay. So I've just taken you through that suite, and would you accept that that suite improved the treatment options available to meet the needs of patients getting treatment in the mental health services – the youth and adolescent mental health

services?---Relevant to 2013, that's a much larger range of options. It certainly improves the options available.

Okay. And even just even looking at – in your own bailiwick in terms of the Royal
5 Brisbane and Women's Hospital, where we've seen we've got the community CYMHS, the day program and AMYOS. Not all of those services were available, do you say, in November?---No, the day program and AMYOS was not available.

And would you be aware that here is educational support provided in the acute unit at
10 the Royal Brisbane and Women's Hospital?---That's right.

And that the day program also has education services associated with it?---That's right.

15 And I wouldn't – you may not know of the actual details of that because that's not your specialty, but you're just aware that there are education services provided with that?---Yes.

Now, perhaps if I can – we can just go back to your statement, which is, if I can call
20 it up on the screen, MNH.900.003.012 – page 012. And, in fact, if we can just scroll down a little bit more, and if we can just go to – I'm actually looking at paragraph 80, which I've got the – and I apologise, Commissioner. I've got the number – okay. If we keep on going to paragraph 80, that's where we refer to AMYOS. Okay. And this is where you discuss AMYOS here and assess AMYOS. And you talk about
25 what is a – when it is a good alternative, and we see that in 80(a), and 80(b) you say that it is not a good alternative. And I think that the important words there are "particularly in isolation"?---That's right.

Okay. Now, I've just taken some time to step you through a suite of services.
30 Would you accept that that suite of services provides flexibility to deal with the situations that you set out in paragraph 80? And take your time if you need to?---No, I don't think it does. You've still got the issue where young people have a family that aren't able to support them and support their needs and such, and I don't think the suite of services which you've outlined would meet the needs of those young
35 people.

Okay. I referred you to the resis, and I think that you fairly said that you've got no experience with the resis?---Correct, yes.

40 So you're not aware whether the resis would be able to pick up that gap that you see?---Yeah. Look, that's a fair point, sorry. I omitted the resis in my mind. I think resis were there, but they possibly couldn't meet that group.

In conjunction, though, as I said, with the other services available?---The other
45 services, yes.

Yes. So - - -?---Yes, I'm happy to recant on that and say, yep, the resis are there. I accept that.

Okay. And then if we can just go down to (c), and – 80 – paragraph 80(c): subacute
5 beds. That's what you're referring to. The patients that you're referring to in 80(c) require subacute beds. Is that the case? Or can they also be dealt with – I'm just trying to understand where you see it. Can they also be dealt with in the suite of services with the flexibility that's offered?---I think the – there still remains a small proportion of persons who have persistent eating disorders or persistent psychotic
10 disorders or persistent mood disorders that can't be supported in day programs, and the other options which you've discussed and such. The difficulty of subacute beds – I was at the Lady Cilento Hospital a couple of weeks ago, looking at the unit there, and it's certainly not somewhere where I would want a young person housed for any length of time. It's up on a high level. The outdoor areas are small courtyards.
15 There's no cover from the sun. There's a gym with an exercise bike sitting in the corner that looks like it hasn't been used since it's been placed there. I think that it would be an unhealthy environment for any young person to be there for any length of time.

20 Okay. But – but is it the case that where treatment is going is you're wanting for this – the continuum of services to ensure that they're there for the least amount of time as possible and to get them back - - -?---That's right.

- - - into the community?---Yep.

25

Okay. Thank you, Doctor. They're the only questions that I have for you.

COMMISSIONER WILSON: When you're ready, Ms McMillan.

30 MS McMILLAN: Yes, thank you, Commissioner.

EXAMINATION BY MS McMILLAN **[10.13 am]**

35

MS McMILLAN: Dr Scott, can I just take up a couple of things with you initially. Talking about eating disorders, I understand – is this correct – that the model largely used for treating them is called the Maudsley model of care?---In the community, that's correct, yes.

40

Yes. And generally, as I understand it, the aim of that is to treat them in the community and only hospitalise if, for instance, they may medically – that is, their weight drops to such a stage that they need to have feeding attended to and/or some psychiatric care at that time as an inpatient?---That's correct.

45

Right. And that might be either acute or subacute - - -?---That's right.

- - - depending on how they're faring. Right. Thank you. Now, can I ask you when you refer to resis, is what you mean the residential care facilities that are provided pursuant to the Child Protection Act?---That was – when I'm thinking of resis - - -

5 That's what you mean?--- - - - that's my experience of them, yes.

And you understand that's for young people pursuant to child protection orders who can't or don't want to live at their residence?---That's right.

10 Their family residence. Right. So we're talking about two different things. Right. Okay. Thank you. Now, the statement you've put before the Commission, that was taken by my learned friend Mr Freeburn and another person; correct?---That's correct.

15 And I take it, because there are questions annexed to it, that you raised matters that you thought were relevant in relation to this Inquiry?---I think – well, I was asked questions about the – about various aspects and given the opportunity to expand upon my answers.

20 Right. Thank you. Now, can I go, please, to page 2 of your statement which is MNH9000030002. Right. Now, can I just scroll down – have you scroll down, please, to paragraph 9:

Sometime between 2002/2009 I attended the Park centre.

25

So do you remember which years you attended?---No, I don't.

And how many occasions?---On one occasion.

30 One occasion. Right. Thank you. Now, is it fair to say – sorry, I'll withdraw that question. Now, going to page 8 of that statement which is paragraph 39 I want you to go to – sorry, I should backtrack. Could we go to page 6, firstly. Right. Now, you had input, didn't you into what might be called the Redlands project, if I can put it that way?---I – I was at least one meeting around that project.

35

Alright. And you were part of a group, weren't you, that meant – you meant to review a model of service delivery for Redlands?---That's correct.

And that included people such as Judy Krause was the chair. Correct?---That's
40 correct.

Dr Sadler was involved?---That's correct.

Dr Penny Brassey who was a clinical director of CYMHS Townsville?---That's
45 correct.

Fiona Cameron who was the statewide principal project officer of CYMHS?---Yes.

Do you know Erica Lee, a manager of CYMHS at the Mater?---Yes.

Dr, now Professor, McDermott?---Yes.

5 Yourself and Dr Michael Daubney?---That's correct.

Correct. So you worked on, as I've said, a model of service delivery for Redlands?---Yes.

10 And is it the case – and if you need to I can take you to the document – that you, particularly, articulated that the best treatment gains were often in the first six months of treatment and you suggested it would be useful to look at the Rivendell model in New South Wales?---I – I've had a look at this document just this morning and I see that's there. And that would be consistent with my view - - -

15

Right?--- - - - still, that what you get from hospitalisation – most of it you get early on.

Alright. And were you aware – and I can show you a document if you wish – that Dr
20 Sadler indicated that he was critical of the six month treatment timeframe. Do you remember that?---Not specifically.

But that was consistent with what you understood of his views?---It – it may have been. Again, I can't specifically recall one way or another.

25

And there's no evidence for that period of care but did you understand that as a group, generally, there was a view held that there was equally no evidence for a one to three year admission?---That's right.

30 Right. And so you were part of that group?---Yes.

Right. Thank you. Right. Now, I'll go to page 8, thanks. Now, paragraphs 39 to 41, you say at 41 you're not persuaded that the condition of the building or the co-location were decisive reasons – and I'll come to the reasons in a minute – but from
35 what you say you had only been there once between 2002 and 2009. Correct?---That's right.

Thank you. Now, you say that based on discussions and your involvement with the ECRG, your understanding [indistinct] reasons were the buildings and the co-
40 location. Correct?---That's right.

Right. Can I take you, please, to the terms of reference for the ECRG – JAS8 at page 94 of your statement. And if you just scroll down to Scope and Functions. So there you will see, don't you, that the group was to consider and articulate a contemporary
45 model of care – evidence-based, sustainable in line with the Queensland mental health policy. Correct?---Yes.

And will take into account the clinical services capability and will replace the Barrett Adolescent Centre. So clearly, what was articulated there, I suggest to you, were reasons other than just the physical state of the building and it being co-located. Correct?---That's right.

5

Right. Now, you've annexed a number of the minutes of the ECRG, haven't you?---That's right.

And whilst it has draft stamped upon it you accept, don't you that each meeting in
10 turn the minutes of the prior meeting were accepted. Correct?---Were confirmed. Yes.

So you don't dispute the contents of the minutes as set out there?---No.

15 Right. Thank you. Now, is it fair to say you're fairly critical of Dr Geppert in your statement, aren't you?---I – no, I'm not sure I'd say I was critical of her. I – I would say that Dr Geppert was tasked with proposing a model to us which had been developed by the planning committee - - -

20 So sorry, this is the planning group - - -?---Planning group, sorry.

- - - at West Moreton?---Yeah.

Right?---Yeah, planning group.

25

So you say that, what, she was effectively given riding instructions, if we can put it colloquially, by the planning group?---I felt that she was leading the Expert Clinical Reference Group in a certain way and I think that that was not our role to be led. I think our role was to give feedback.

30

And can we then take you to, please, to page 58 and then into 59, please, of this statement. So that's the minutes of the first meeting. You're an apology there but I see that obviously you received the minutes, didn't you, after meeting?---That's right.

35

And you will see under 1.1 on page 59, please, that the chair – and that's Dr Geppert, correct – noted cancellation of Redlands, noted the condition of the current facility, noted the Queensland Plan for Mental Health, that young people are to be treated close to their homes, etcetera, in the least restrictive environment and you can read
40 on for yourself and that's consistent with your understanding of the Queensland Mental Health Plan?---That's correct.

Which, of course, would be a guiding principle, wouldn't it?---It is.

45 If you're looking at any new model of service delivery - - -?---That's correct.

- - - in this space. Where to from here – you can read that for yourself – task of the ECRG is to recommend a statewide model of care. Governance is provided by the planning group and will be responsible for responding to consumers and their families. But if we go over the page on 4.1 – so that's page 60 – so you'll see that there was highest priority current consumers of the BAC but you will also see about most of the way down of those first dot points that the endorsed terms of reference for the group and provided the following feedback – does not clearly articulate the complexity and severity, etcetera. So it was clear there that there was questioning at that point – the first meeting, wasn't there – about the terms of the reference and it not being clearly articulated to obviously accommodate the complexity and severity and other issues. So there was obviously discussion from day 1 about those terms of reference clearly articulating those goals. Correct?---That's correct.

And you'd accept that in other meetings there's further refinement of the terms of reference, isn't there?---That's right.

And you'd be clearly aware that Dr Sadler obviously was a very strong advocate for the Barrett Centre?---Yes.

And Mr Rodgers, the education person, was also what might be termed a strong advocate for the Barrett Centre?---That's right.

So clearly it was a group with at least two who were very clearly of the view that the Barrett should continue?---That's right.

Thank you. And it's the case, isn't it – so we'll take in 9 January, 65, feedback on the 2.1 – 65. So feedback on ECRG, terms of reference to be considered by the planning group. Do you see that?---That's right.

And that was at a meeting you were present at; correct?---That's right.

Right. And, of course, as it went on there were consumer advocates appointed, weren't there, to the ECRG as well?---That's correct.

And I won't name them, but you're aware they were there, and they gave feedback as well throughout the process?---That's right.

Thank you. And there was, it's fair to say from the minutes, fairly detailed discussion about what model of care or models of care were to be presented and how that might best be achieved; correct?---That's correct.

And you raise at paragraph 55 of your statement, 0010 on page 10 itself:

> *It was established with a sense of urgency, the ECRG. In order to properly review and devise a model of care to support the most severely impaired*

adolescents would've been to conduct a systematic search of all potential care options for adolescents.

Correct?---That's correct.

5

They did that, though, didn't they?---I don't know if they did.

Right. Let's go to that, thanks. Right. Page 67. So this is the ECRG meeting on 9 January that you were present at?---Okay.

10

Near the top of that page:

Varying degrees of knowledge of current adolescent services, whether private non-government or public. Agreement to commence a mapping exercise. Will exercise in identifying current gaps.

15

Well, that's identifying, isn't it, what services are available and what gaps aren't?---No, I'm not sure it is. I think I'm talking about a different thing or referring to a different thing to what you're referring to there. What I'm referring to is if the

20 government was going to do a large capital spend on a new unit or a new service, they should be looking at jurisdictions around the world to see what's available, rather than just looking at what might be done in Queensland or in Australia. And I don't think that exercise was taken – done robustly.

25 To do a worldwide search of other - - -?---Well, you'd look to Europe, to the United States, to see, well, what are they doing with extended hospitalisations or extended care of adolescents in those jurisdictions.

But when you were on the Redlands project, you, as I think, accepted that you

30 thought Rivendell, for instance, in New South Wales was a good model to look at?---I - - -

And, indeed, Professor Hazell was part of the ECRG, wasn't he - - -?---He was.

35 - - - form that. And I'd take it that you'd accept that the undoubted reason why a number of you as clinicians were appointed is drawing on your experience and expertise - - -?---That's correct.

- - - which would include knowledge of what was going on overseas?---I'm not –

40 certainly I can only speak for myself. I couldn't say with any confidence that I'm aware of or familiar with the evidence of services that are going on overseas.

I see. So when you say, 55 and 56 in your statement, we should read that as there wasn't an undertaking to evaluate services overseas?---That's right.

45

Right. Thank you---I think that the point that I wanted to communicate with this is that if the government – government will only do this sort of spend once in a

generation, and if they're going to do it, then it'd be wise to look to other jurisdictions outside of Australia to see what's been done, and does it actually work.

Well, there's two things. We have to operate, don't we, in Australia within the mental health framework; correct?---Yep, sure.

And Queensland has a mental health plan which is proscriptive, correct, to an extent?---No, I don't think it is. I think it provides some broad direction for the way that mental health services should go. I don't think it's proscriptive at all.

Right. Okay. Now, Redlands was a proposed big capital spend, wasn't it?---It was.

Didn't look overseas - - -?---No.

- - - models there, did you?---Didn't.

No, thanks. And in terms of the ECRG, at paragraph 50 on page 9 of your statement you heard the model proposed by Dr Geppert. Now, what was the model? You refer to a model. What was the model? Is that what – is that what's referred to as number JS10 of your statement?---Can we bring up JS10?

Yes. It's page – from page 98. Just scroll down that. You can have a look at that to familiarise yourself, Dr Scott, and then over the page, please. See the preamble?---I do. I do. Could I go back to the date of the meeting which you were talking about there?

Well, I don't know. I'm just referring to your statement, where you say - - -?---Okay.

- - - after attending a number – paragraph 50 – and heard the model. So - - -?---Yes. So - - -

- - - that would presume that was near the end of the process?---No, it wasn't. It was fairly early on in the process, and certainly at that stage it was – a [indistinct] discussion of a tier 3 model. It was very much – and the emphasis, as I recall it, was using the acute inpatient units to care for and support these young persons that would've previously been looked after by the Barrett Adolescent Centre. That was the part that raised concerns for me, that that, in isolation, without other facilities available, was going to result in suboptimal care for these young people, as well as to block the beds and the flow-through of patients to the acute adolescent units.

Sorry, you'd only by late March attended three meetings, so it must've been, I suggest, late in the process, the ECRG, for you to be expressing that opinion?---What I'm sharing with you is what I recall. What I recall was that a model was put forth that didn't have any mention of tier 3. It was really emphasising the role of the acute adolescent inpatient units to look after persons that would've previously been cared for by the Barrett Adolescent Centre. I had concerns about that.

So, for instance, the minutes of meetings of 7 December were – you weren't attending. That was the first one. In the definitions:

Target group of the ECRG agreed to look at service models for Barrett, draft adolescent extended treatment MOS, Walker unit, etcetera.

So those are tier 3 services, aren't they?---They are tier 3 services.

And - - -?---And it might've been – it might've been, as Dr Geppert was outlining, that there was not capital funding available that would be allocated for a tier 3 service, so that was out of scope. That might've been where members of the group, including myself, were saying, well, actually, that is not the correct way to go. That's not okay.

Well, page 68 of this – this is the ECRG minutes of 9 January. You were at that meeting. This is exactly your point, isn't it:

Experience from New South Wales: mix of acute and persistent presentation within an acute unit destabilising.

So very much the issues that you talked about; correct?---That's correct.

In your statement. High level service. Further down:

Two target groups: high intensity/severe needs, step down subacute.

All of those things that very much reflect your concerns about that Barrett cohort, if I can put it; correct?---That's correct.

Alright. And the next meeting that – 16 January, which you were not at, page 75 of your statement, there's discussion there and the page before about, for instance, consideration of group of smaller residential bed-based units with a limited timeframe of up to six months. So that clearly, one would think, would address some of your concerns about the – this patient cohort, wouldn't it?---It would.

Yeah. Because that's what you were talking about, the six months, when you were back at the Redlands situation?---That's right.

And that's what your understanding is really the Rivendell model, if I can put it that way?---Yeah. Rivendell – the six months or even a little bit shorter, actually, but that's right.

And, indeed, the minutes of 13 February, page 79, as I understand the tenor of your evidence, you say, in effect, Dr Geppert had been given directions or an understanding from the planning group and was really implementing that. That's what you're saying?---Sorry, could you repeat that?

What, as I understand it, the tenor of your evidence is that Dr Geppert had been effectively given either a direction or an understanding from the planning group?---Yeah. In my evidence I'm giving an opinion.

5 Right?---This is what I sensed.

Right. Page 79, the minutes of the 13th of February, a meeting you were at:

Awaiting response from the planning group regarding the amendments to the
10 *terms of reference.*

So they are waiting for the terms of reference. The planning group had endorsed the inclusion of consumer and carer representatives?---That's right.

15 Yes. So they were actually supportive of that group expanding to include that. Correct?---That's correct.

Consumer representatives. And you know they provided feedback, don't you? Yes.

20 And then – and, again, in the minutes of the 27th of March, page 89, talking about a draft model of care. There were issues discussed such as the educational components. Correct?---That's correct.

Future funding?---Yes.

25

It's specifically addressed here too and I think Mr Freeburn took you to tier 3 over the page?---That's right.

So even at the last minutes of meeting, clearly tier 3 along with those other tiers were
30 being discussed, weren't they?---That's correct.

Now, you provided feedback to the draft model of service, didn't you?---I did.

And you've not annexed the emails but you've referred to it at JS9, page 96 of your
35 statement. And you'll see from that that the preamble document was amended to reflect that change, wasn't it?---That's right.

And added the following – do you want to see your email that you sent?---No. That's okay.

40

And it was to all members of the ECRG, wasn't it? All these emails, all feedback was circulated to everybody?---We tend to reply all. That's right.

Yes. And you also provided feedback on the next page, the 23rd of April:

45

I'd really like for people who make the decisions to hear this feedback from parents and consumers.

Then you said you'd be overseas after that, didn't you?---That's right.

All right. So in terms of that process, you say that paragraph 59 and following of page 11 of your statement that Ms – I can't possibly pronounce the name – I think
5 it's Vaoita Turituri, sent a final draft of the proposed service model. Dr Sadler responded. You've attached his response, haven't you?---That's right.

And you said you don't:

10 *Although I do recall those documents, don't remember if any other ECRG members provided feedback separately.*

You don't recall that?---Not specifically. No.

15 But do you accept that they did?---I'm sure they would have.

Right. Well, perhaps we might show you the documents. Could we first go to document WMS6006000251916. The description of the document is an email from Amanda Tilse to the group in general. This was following an email trail on the 5th of
20 May where Leanne Geppert had said to you, amongst others:

The version 4 of the service model elements document and the preamble for the BAC strategy.

25 You remember receiving that?---It's there. So - - -

Yes. And so we'll go to 16. That's 51916. Yes. I might show the witness this. This might hasten it, Commissioner.

30 Could the witness be shown this, please.

MR FREEBURN: Excuse me, Commissioner, so that I can follow that can I have a description of what we're looking at?

35 MS McMILLAN: I just – I did. I said it's an email from Amanda Tilse in response to Leanne Geppert's email forwarding to the members of the ECRG the strategy. But I'm happy for Mr Freeburn to - - -

MR FREEBURN: Dates? Can I have a date, please?

40

MS McMILLAN: 5th of May.

WITNESS: It says:

45 *Hi Leanne, I endorse the document as is. Regards, Amanda.*

MS McMILLAN: Okay. So that's feedback, isn't it?---That's feedback.

Do you – the next document, 51651, from Michelle Fryer who is also a member of that ECRG. Yes. Show him, please. Commissioner, I'll just show you that as well on its way.

5 COMMISSIONER WILSON: If you would, please.

MS McMILLAN: You see that's from Michelle Fryer, Dr Fryer?---That's correct.

And then I'll show you a bundle of emails from Mr Rodgers, Dr Sadler, Professor
10 Hazell. And I'll show you, the Commissioner. I've shown Mr Freeburn those.

Have you had a look at those, Dr Scott?---I haven't looked - - -

They're still with the Commissioner. Sorry?---Yes.

15

Have a look at those, please, Doctor?---Thank you.

Yes. You accept that they're all responses endorsing, other than Dr Sadler's caveats?---That's right.

20

All right. Commissioner, I might tender those as a bundle.

COMMISSIONER WILSON: I think I should read them into the record so that it's clear. What exhibit number are we up to? This is 174. These documents will
25 together be exhibit 174. WMS6006000251651, which at the top of the page contains an email from Michelle Fryer to [redacted] and others of 6 May 2013. The next document is WMS6006000252227 which is an email from Philip Hazell to Leanne Geppert and others of 17 April 2013. There are other emails in that document. The next is WMS6006000232974 which on the first – sorry, the top of the page contains
30 an email from Dr Sadler to [redacted] and others of 6 May 2013. And the next is WMS6006000251738. At the top of the page is an email from Kevin Rodgers to Leanne Geppert and others of 6 May 2013.

35 **EXHIBIT #174 BUNDLE OF EMAILS**

MS McMILLAN: Thank you, Commissioner. Now, Dr Scott, in terms then of paragraphs 46 and following – sorry, paragraphs 64 and following, you've set out at
40 62 the ECRG finalised and endorsed its report. And you say:

> *The risk was referenced to without a tier 3 facility risk to themselves and without adequate supports.*

45 But, indeed, there was a specific footnote about – wasn't there, about what might be available in terms of a tier 3, wasn't there?---In the final model?

Yes?---That's correct.

Yes. And you say:

5 *Knowing the patients who I'd referred, I was firmly of the view without high levels such as BAC that some of them would die.*

So you were clearly very concerned, I suggest to you?---I was very concerned.

10 All right. But on the 6th of May you sent an email, didn't you, to the ECRG:

Dear Leanne, endorse document as is –

in relation to that service model that - - -?---That's correct.

15

Just have a look at that, Dr Scott?---That's correct.

Yes. I tender that, Commissioner.

20 COMMISSIONER WILSON: Could I have it back please, Mr Bailiff. This will be exhibit 00175. It is WMS6006000251279. It begins with an email from James Scott to [redacted] and others of 6 May 2013.

25 **EXHIBIT #00175 ADMITTED AND MARKED**

MS McMILLAN: Thank you. So despite the concerns you've expressed in paragraph 65 you'd accept none of that found its way into your feedback?---Could 30 we bring up paragraph 65 again, please.

Continuing:

Knowing the patients who I had referred –

35

So this is subsequent to this model of service being circulated – page 11 of your statement –

I was firmly of the view that without high level care such as the BAC it was 40 *probable or at the very least possible that some of them would die. Of course, a feature of the cohort of adolescents treated at the BAC was that many have high levels of suicide.*

So this is in the context of you setting out Dr Sadler's response to that model. It's 45 finalised on the JAS12 but prior to it finalising there's feedback from a number of the members including yourself endorsing that model. Correct?---If I could have a moment just to read though this.

Sure?---So – so just to clarify what I meant to communicate by the evidence and what I think I have, the key recommendation was that the inpatient extended treatment and rehabilitation care, ie., a tier 3 or a hospital-type facility with extended care was the essential component and then in 65 I'm saying that that is required knowing the patients that I had referred to the Barrett Adolescent Centre in the past, that's something which I thought was still essential.

But I'm suggesting to you that from your email you expressed no particular concerns about the model of service that was proposed. Correct?---My – my understanding that while the service was a tier 3 it was going to be looked at and developed in due course.

Right. Thank you. But do you accept that the import of what you put there indicates that you had a high level of concern, it would seem, about the model as proposed emanating from the ECRG?---Sorry, I'm not sure.

Would you accept the import of your evidence in that statement suggests a high level concern held by you about the model that had emanated from the ECRG?---No.

No. Right. You mentioned some feedback but you only annexed Dr Sadler's email. Why didn't you annex your email that I've just put to you saying you endorsed the model?---That – that was broad so the evidence that – that had been annexed – the emails had been annexed were brought to me by either the Metro North legal services – so they were forwarded on.

From Metro North?---From Metro North so - - -

And you didn't have your own email?---No.

And you didn't have a recollection of sending that email?---That I endorsed it or - - -

Yes?---Not specifically, no.

Alright. But yet you say at paragraph 50 of your statement that you recollect saying in meetings words to the effect that won't work?---Very early on - - -

Yeah?--- - - - so again, I'm – I'm – I'm not sure that I'm communicating the timing - - -

Sorry. Can I - - -?--- - - - of these clearly.

Can I just bring you back to the question?---Sure.

You don't recollect, for instance, sending that email saying I endorse the model. Correct?---No. I don't. But I'm not - - -

Right?--- - - - surprised that I had – I did.

Right. And yet at paragraph 50 you can recollect a meeting that is about three years ago, you saying words to the effect that won't work?---Yes.

Yes. Thank you, Commissioner.

5

COMMISSIONER WILSON: Does anyone else have any cross-examination? Mr Allen, I know he's your client. I'll just see if there's anyone else with cross-examination first.

10 MR HARPER: Commissioner - - -

COMMISSIONER WILSON: Yes, Mr Harper.

MR HARPER: - - - I just have a few brief questions.

15

EXAMINATION BY MR HARPER **[10.50 am]**

20 MR HARPER: Dr Scott, it's the case, is it, in your early evidence that you felt that a limitation on the ECRG process was that maintaining the Barrett Centre or something similar was effectively off the table from the start?---That's what was communicated to us, yes.

25 And in the end the recommendations which you made – or the ECRG made – reflected that in the recommendation for a tier 3 facility to be provided in the future?---That's correct.

Now, if I can just then take you to some of your evidence about current programs

30 that are available. Is it the case then that your evidence is that some of the, what we'll the BAC cohort, can be assisted through quite an intense community-based model?---Yes.

That notion of a wrap-around care is important?---Yes.

35

Is it the case, though, that to your understanding no such program of that level of intensity was in place at the time of the closure of the Barrett Centre?---That's correct.

40 That was a significant concern for you at the time, wasn't it?---That was.

And again, that was expressed in the ECRG?---That was.

And it was reflected in the ECRG recommendation about the continuation of a tier 3

45 facility?---That's right.

With that intense community-based model there are some limits on that, aren't there?---There are limits on that. Yes.

It doesn't cover the whole cohort of patients which the Barrett Centre previously covered?---No, it wouldn't.

Is it the case, too, that if the community-based model is not sufficiently resourced patients can fall through the cracks?---That – that's very much the case. For these community-based models to work there has to be adequate resourcing, adequate training and adequate provisions to ensure that staff continue to get supervision and support with the care they're delivering to these young people.

And even aside from resourcing if it's not managed appropriately patients can fall through the cracks as well?---That's right.

And of course, the consequences of that can be quite severe, can't they?---That's right.

In light of all of those things, is it your view that there is still value in the maintenance of a tier 3 facility going forward?---I'm actually undecided upon that for a couple of reasons. I haven't worked within adolescent inpatient facilities as a director, as a consultant psychiatrist consistently since about 2010. I have done some periods of time working at it so – but – but I haven't had that consistent responsibility. I am aware that there's been some very interesting community-based programs developed overseas and in other jurisdictions that I think are well worth a look at. I'm also aware when I went back to look through the evidence about extended hospitalisations and how effective are – are they, there's a real lack of evidence about whether or not they work. So I'm not strongly of a view that there should be or shouldn't be a tier 3 model in place. I think that people need to have a really good look at what the evidence is and what the other alternatives might be before investing such a large sum of money into such a facility.

I have no further questions.

COMMISSIONER WILSON: Thank you. Now, is there anyone else? Mr Allen

EXAMINATION BY MR ALLEN **[10.54 am]**

MR ALLEN: Thank you, Commissioner.

Dr Scott, you were asked some questions by my learned friend, Ms McMillan, about the ultimate proposal by the ECRG and any type of endorsements that came from the ECRG of that model of care. You were also asked questions about having disagreed with the model proposed by Dr Geppert saying that that won't work. Now, I just want to clarify how those things fit together or don't. Could I take you to your

statement – page 9 of your statement at MNH.900.003.009 and if we could go up a little bit so that we can see paragraph 48. Okay. Thank you. Now, in paragraph 48 you're talking about a model of care put forward to the ECRG?---That's correct.

5 You see that?---Yes.

And that's been brought to the ECRG, is it, by Dr Geppert?---That's right.

Who's a member of the planning group?---That's right.

10

Okay. And you describe that model of care in paragraph 48 as being one involving housing adolescent mental health patients in the community near an acute unit?---That's right.

15 With the idea being that the patient will be admitted to the acute unit when needed?---That's right.

Okay. So you then talk about in paragraph 49 your view that that was problematic?---That's right.

20

And then at paragraph 50, if we scroll down a bit, you say that after you had attended a number of meetings and heard the model proposed by Dr Geppert – that's the one you've described in the previous paragraphs - - -?---That's right.

25 - - - you expressed your view to the ECRG that that was inadequate and said words to the effect of "That won't work"?---That's right.

Okay. So that's one model of care which was brought to the ECRG by Dr Geppert from the planning group?---That's right.

30

And you said that wouldn't work?---That's right.

And you never ultimately endorsed that, did you?---No.

35 Neither did any other member of the ECRG?---No, that model was rejected.

Okay. So let's look at what was endorsed, then, ultimately. If we go forward two pages to MNH.900.003.0011, page 11 of your statement, scroll down a little. Paragraph 62, on or about 8 May 2013 the ECRG finalised and endorsed its report on
40 proposed service model elements, and a copy is at JS12?---That's correct.

If we can go to JS12, which is at page 133 of your statement, this is – and what follows. This is a document which was produced by the expert clinical reference group?---That's right.

45

Okay. And can we go to the next page - - -?---Sorry, it's a document that was endorsed by the expert, not produced by the expert clinical reference group. It was endorsed.

5 Ultimately endorsed?---Yeah.

Okay. So when you were being asked questions about a model of service that was endorsed, it was this document?---That's right.

10 Okay. So if we go to the next page, so page 134, and just scroll down a little. Okay. Second paragraph:

Service model elements document proposes four tiers of service.

15 ?---That's right.

And they include tier 3?---That's correct.

Okay. So that would be something equivalent to the Barrett Centre?---That's right.

20

Okay. And just to make it completely clear, if we go forward two more pages, page 136, then we see under the subheading:

Interim arrangements after BAC closes and before tier 3 is established –

25

So that's before a replacement is established?---Yes.

Continuing:

30 *...are at risk.*

And you talk about risks?---Yes.

And then in the second dot point you talk about the scenario of BAC being closed
35 and, particularly if tier 3 is not immediately available, a need for attention to that?---That's right, yep.

And in recommendations, paragraph (a):

40 *Safe high quality service provision for adolescents requiring extended treatment and rehabilitation requires a tier 3 service alternative to be available in a timely manner if BAC is closed.*

?---That's correct.

45

Okay. So it is the case, isn't it, that, as you said in response to a question from Mr Freeburn, where he took you to some of the minutes, that ultimately the members of the ECRG unanimously supported the retention of a tier 3 option - - -?---That's right.

5 - - - in the recommended service model?---Yes.

Okay. Now, you were asked some questions by my learned friend Ms McMillan, whereby she sought to attribute to you an assertion that the result had been predetermined, in fact; that Ms – Dr Geppert had been given her riding instructions
10 from the planning group, which was essentially that there would be no tier 3 alternative?---That's right, yes.

Okay. And I think you said you got the sense of that?---I had the sense of that. That was my opinion.

15

Right. It was never made explicit?---No.

Okay. Could I ask you to look at this, and it's one of the documents that was listed as one you might be taken to, and it's document WMS.0012.0001.04639, and it's a
20 West Moreton Hospital and Health Service project plan, the project starting on 16 November 2012. That's of course well before your involvement in the ECRG?---That's right.

And do we see that the – it's the Barrett Adolescent strategy?---Yes.

25

And the background of the project notes, amongst other things, that previously there'd been a capital allocation to rebuild BAC in a new location?---That's right.

And that was going to be deliver at Redlands, which would replace the BAC. Due to
30 environmental and other issues, the project could not proceed and has now ceased?---That's right.

And then the last dot point:

35 *The capital allocation previously attached to the rebuild of BAC has been redirected to other Queensland Health capital priorities. This capital funding is currently no longer available for a rebuild of BAC at an alternative site.*

?---See that.

40

Okay. Were you made aware of that when you were asked to contribute your time and expertise to the ECRG?---That was raised at – I actually can't recall, but I see when I went through the minutes of the ECRG meeting that that was raised at some point in those meetings.

45

But there was a lot of time on behalf of the professionals who were enlisted to provide their services to the ECRG advocating for and discussing the need for a tier 3 service?---That's right.

5 Were you ever told that there was no point?---No. I think – and I'll go back to the statement Ms McMillan made before. She inferred that I was critical of Dr Geppert in my evidence. I certainly don't mean to be critical of Dr Geppert. What I mean to say is that I think she was in a very difficult situation, whereby my sense was that she was tasked with having to get this model up without a tier 3, and that the ECRG was
10 saying we're really worried if a tier 3 is not there, and we would recommend that a tier 3 facility be available.

Yes. And could we just go two more pages on in this document, the project plan. Outer scope, the second category:

15

As there is no longer a current capital allocation to rebuild BAC on another site, the models of care to be developed must exclude this as an option.

?---Yeah. It was never that explicit to us.

20

No. Thank you. Yes, thank you, Commissioner.

COMMISSIONER WILSON: Mr Freeburn, anything in reply?

25 MR FREEBURN: I have nothing further. May Dr Scott be stood down?

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

30

WITNESS STOOD DOWN **[11.03 am]**

MR ALLEN: Could I likewise be excused, Commissioner?

35

COMMISSIONER WILSON: Yes, certainly.

MR ALLEN: Thank you, your Honour.

40 COMMISSIONER WILSON: Can I say one thing before the next witness is called. Because time is limited, we have tried to establish a procedure whereby notice of intention to cross-examine is given. A notice of intention to rely on certain documents is given. Mr Harper, maybe there's been a slip up somewhere, but I didn't know you were going to cross-examine.

45

MR HARPER: Apologise, your Honour. We hadn't given notice of it.

COMMISSIONER WILSON: Alright. Well - - -

MR HARPER: There were matters raised during the evidence which we thought needed to be addressed.

5

COMMISSIONER WILSON: - - - no harm has been done this morning, but in future would you do so.

MR HARPER: Thank you, your Honour.

10

COMMISSIONER WILSON: Thanks.

MR FREEBURN: Commissioner, can I just mention one matter that needs to be raised. During Ms McMillan's cross-examination a carer's representative was
15 identified in the course of the emails. I just mention it because there should be discussions between the parties about carefully redacting not only the documents and carefully checking – I think an attempt was made in the short time we had those documents – but also it may be that the name was mentioned in the course of discussing the emails, so it may be necessary to redact a part of the transcript, but,
20 again, we'll have a look at that.

MS McMILLAN: Well, certainly her name shouldn't be there. It should be redacted. It's pretty apparent who it is, so that should be - - -

25 COMMISSIONER WILSON: Yes. Yes. I don't recall it from the oral questioning, but - - -

MS McMILLAN: No, no, and I deliberately did not identify in the oral questioning. It'll only be that email which can easily, I would've thought, be redacted, her name.

30

COMMISSIONER WILSON: Well, it certainly will be, but if extra care could be taken next time - - -

MS McMILLAN: Yes, sure.

35

COMMISSIONER WILSON: - - - before putting documents – thanks.

MR FREEBURN: Is that an appropriate time for - - -

40 COMMISSIONER WILSON: Yes. Time is short. Twenty past 11. Would the court orderly adjourn, please, until 20 past 11.

ADJOURNED **[11.05 am]**

45

RESUMED **[11.21 am]**

MR FREEBURN: Commissioner, I call Professor Philip Hazell.

PHILIP LOUIS HAZELL, SWORN [11.21 am]

5

EXAMINATION BY MR FREEBURN

10 MR FREEBURN: Commissioner, Professor Hazell's witness statement is document ID WIT.900.005.0001.

COMMISSIONER WILSON: Thanks, Mr Freeburn.

15 MR FREEBURN: Now, Professor, can I take you first of all, before we go to your statement, to a document which is a project plan. It's document WMS.0012.0001.14639. Professor, you may not have seen this document before. Or have you seen this document before?---Yes. I've seen the document before.

20 Have you seen it in the course of preparing for this case or this Commission or had you seen it before that?---I've seen it in the course of preparing for this Commission. But I noticed that I also had a copy of it in my email correspondence at the time I was a participant of the ECRG.

25 Right.

COMMISSIONER WILSON: Professor, I'm having a little difficulty in hearing you?---I beg your pardon.

30 If you could speak into the mic, thanks?---Yep.

MR FREEBURN: Can I take you to page 3 of that document. You see there's a heading on the left Out of Scope. And you see it says:

35 *As there is no longer a current capital allocation to rebuild BAC on another site, the model(s) of care to be developed must exclude this as an option.*

Were you conscious of the limitation at the time you were on the ECRG?---I was conscious there was a predicament about infrastructure and funding for
40 infrastructure. But I saw that as not antagonistic to the idea of developing a model of care that involved tier 3 services.

All right. And isn't this effectively taking the tier 3 option off the table?---I interpreted it as taking the new build option off the table. But there could have been
45 other creative solutions such as refurbishing an existing facility, finding an alternative accommodation for the service.

Right. Okay. Now, I want to take you to a document which is – you'll recall that there are a whole lot of ECRG meetings. There are about five or six that I can see?---Yes.

5 And during the course of them, minutes were prepared – or at least in draft, they're marked draft. But minutes were prepared in the course of the meetings?---Yes.

Now, I want to take you to a bundle of them. There's what looks like a bundle of either all or most of them. The reference is CHS.001.001.6054. Now, if we go to 10 page 30 of that document, which should have a page ending 6083. Now, you'll see that this is the meeting on the 27th of March which is, I gather, fairly late in the process?---Yes.

And the – you'll see that the chair is Dr Geppert and you phone in, I gather, by 15 teleconference?---Correct.

Now, if we go to page 31, the next page, you'll see item 3.2. Now, you see there:

> *The chair –*

20

that's Dr Geppert –

> *spoke to the proposed draft service elements table.*

25 ?---Yes.

And then, again, at the bottom, the last dot point:

> *It was reiterated that there is no funding for a capital project and no identified*
30 *location.*

?---Yes.

So this, fairly late in the process, the – Dr Geppert or somebody is saying that there is 35 no money, no funding for a tier 3 project?---Yes.

And that accords with your recollection of the meetings?---Yes, it does.

And then if we go to page 33. At the top of that page, 33, which should be 6086 in 40 the Delium references, the second dot point on that page. This is, again, the same meeting, Professor Hazell?---Yes.

It was suggested – sorry, you'll see the first dot point. There was a question regarding whether acute child and youth inpatient units could be utilised in the 45 interim to meet the needs of adolescents prior to the establishment of a tier 3 service?---Yes.

So this is being discussed as an alternative to a tier 3 facility?---Well, it's been discussed, I think, in this context as a transition phase until time – such time that infrastructure would be available to develop a tier 3 facility.

5 So whether acute services could be used to accommodate extended treatment patients?---Correct.

Then the next dot point:

10 *It was suggested that adolescents requiring more intensive services than possible from a tier 3 service would not have their needs met if only tier 2 is available.*

?---Correct.

15

And I assume you can't recall who was saying that but are you able to recall anything about that discussion?---No. I don't recall anything specific about that discussion. I know that my contribution to that line of conversation would've been based on my experience and observation of longer term or more severely unwell
20 young people being managed in acute units.

Right. So, in essence, you're saying you agree with that?---Yes.

And agreed with that at the time - - -?---Yes.

25

- - - and agree with it now?---Yes.

And then if we scroll down a bit further we see the heading Tier 3. You'll see there's a passage:

30

The majority of members were supportive of both tier 2 and 3.

?---Yes.

35 That's your recollection?---Yes.

And the third dot point:

The chair –

40

that's Dr Geppert –

clearly clarified with the ECRG members that tier 3 will be included in the recommended model. However, in the short term the tier 3 option was not –
45 *will not be considered due to the absence of capital funding and location.*

?---Yes.

All right. And you'll see there that there's a dot point:

Therefore, the ECRG needs to consider how to make tier 3 work.

5 ?---I think it says how to make tier 2 work.

Sorry, "tier 2 work". And is that your recollection of what Dr Geppert was saying? You haven't got a tier 3; you have to make tier 2 work?---I can't – I can't recall who made that point, whether it was Dr Geppert or one of the other members of the
10 committee.

Alright. And one more page on. You see at the top of the page:

The chair acknowledged this statement –

15

which is a – we can see it's a statement of Mr Rodgers –

and clarified again that the reality is that in the foreseeable future tier 3 will not be progressed.

20

?---Yes.

Now, just if we scroll down a little bit more, just to the last point in that section, you see there's a section in bold:

25

Members of the ECRG unanimously supported the retention of the tier 3 option in the recommended service model.

Is that your recollection, that it was unanimous?---Yes.

30

Alright. Can I ask you about a concept: contemporary model of care. Do you know what it – can you explain what it is or is it – are we talking about a defined concept?---I don't think it has a defined or specific definition. It's one of those terms that people I think assume they know what it means, because it's common language.
35 What I thought it meant in the context of the ECRG was, first of all, that it reflected practice that was being conducted elsewhere, so in real time, and that, secondly, that it would need to comply with a conform to national, state-wide and international planning frameworks.

40 And your centre, the Walker Centre, the one that you set up - - -?---Yes.

- - - does that – would you describe that as having a contemporary model of care?---Yes.

45 Does it have actually a formalised model of care?---Yes, it does. It now has a model of service document that follows the same template as the Rivendell document.

Right. Has that recently happened?---Yes.

And it was – the Walker Centre was set up, were you, in 2009?---Correct.

5 In the period from 2009 to relatively recently, it did – it may not have had a formalised model of care, but it had a model of care in draft or some sort of informal sense?---It had a model of care from the outset. The – what's different is that we've now articulated it in great detail - - -

10 Right?--- - - - whereas initially it was more of a draft – well, not a draft, but a broad-brush model of service.

Right. Now, there are no plans to close the Walker Centre that you know of?---Not that I know of.

15

In one of the ECRG – can I deal for a moment with the cohort that the ECRG was designing a model for?---Yes.

There's reference to it as the target group. We're dealing with – are we dealing with 20 kids that cannot be accommodated in community-based centres or – what sort of kids are we dealing with?---So we're dealing with young people whose mental health problems and often other problems associated with the mental health problem have not responded to treatment in a less restrictive and less intensive care environment.

25 So they're at the extreme end of the scale?---Correct.

And typically how many young people would you have at the Walker Centre at any one time?---So we have 12 beds, which are usually fully occupied, give or take transitioning a patient in or out from the unit, and we cycle through approximately 24 30 to 28 patients per year.

Now, I just want to cover a concept. In this Commission we've heard of the prospect of subacute beds within an acute ward. Are you able to comment on whether that's a good clinical practice or otherwise?---The experience that I've had in developing and 35 working with an acute unit in Newcastle before I moved to Sydney was that there were major challenges in managing the more severe and persistently unwell young people in the acute ward environment. The challenges were, first of all, resource allocation. So inevitably acutely unwell, recently arrived patients tend to soak up most of the clinician time and attention. It's a reality. It's unavoidable, because you 40 need to quickly assess a situation and try and resolve the immediate distress. So the first problem is an issue of resource allocation. The second issue is a problem with milieu. So with our severe and persistently unwell patients, we're trying as hard as we can to get them to a stable state where there's not too much fluctuation in their emotional regulation and their behaviour, but because of the nature of their illnesses 45 they're still quite vulnerable and brittle. The experience in an acute unit is that every time you introduce a new acutely unwell patient you destabilise the longer-term patients. So that is going to be

the risk of running a subacute service within the confines of an acute unit. Some of those concerns can be mitigated by ensuring that there are adequate resources, but it's not going to alter the milieu issue.

5 Yes. Alright. Now, can I just focus for a moment on the cohort that you have at Walker?---Yes.

Would it be accurate to describe that cohort as comprising a majority of intellectually impaired young people and young people with severe psychosis?---No, that would be
10 an incorrect characterisation. I've looked at the diagnostic data over several years for the Walker unit. Patients with psychosis make up about 50 per cent of the cohort. The remaining 50 per cent are made up of a combination of young people with severe and relentless suicidality from any cause, severe and treatment-resistant mood disorder, and neuropsychiatric conditions, typically autism. But the autism group
15 also overlap with our psychosis group, so we have – quite a few of our patients with psychotic illness also have autism. Now, within the patient population we don't exclude young people with intellectual disabilities, so they form part of the patient group, but they certainly don't form a large part of the patient group. Their incidence within the unit kind of reflects their prevalence in the community.
20
And at the Walker Centre I gather there's family involvement in the various therapies?---Yes. That's correct. A minimum expectation is that families will be involved in – in sessions with the – with the treating team on about a fortnightly basis. But there are opportunities within the Walker Unit to intensify that
25 engagement where it's felt appropriate. So we actually have now a family pod within the unit so we can have parents and other family members staying in the unit for a – a period of a week or so where we can work intensively with them with – with the patient – with the young person.

30 It wouldn't be accurate to describe the family involvement at the Walker Unit as an involvement on admission, at a midpoint and at the end?---No. That – that description is the – the times when we're most likely to use the family admission. So we might bring a family in at the outset of a young person's stay at the Walker Unit while they're settling the young person in. We might do it again in the midpoint
35 when there's some family work that needs to be specifically addressed and at the endpoint preparing the young person for discharge and – and ensuring that the family know what to expect when the young person leaves – leaves the unit.

So those three points are probably intensive - - -?---Correct.
40
- - - but you also have – I think you described it - - -?---Yes. There's - - -

- - - fortnightly or - - -?---Yes.

45 Alright. I just want to deal with what in the Commission we call the alignment issue. And this is probably uncontroversial but the way psychiatric medical services treat adolescents – or need to treat adolescents and the way they treat adults is quite

different. Is that accurate?---Well, there are some similarities in the – the approaches in treatment but there are some distinct differences and the distinct differences are because of the developmental stage and needs of the – of the patients.

5 So what are the major differences between the way services treat adults and the way they treat adolescents?---Adolescents. Family engagement or carer engagement with a young person is mandatory whereas with adults, while it's espoused as an important principle it's not an essential component of – of care. The – with our longer-stay patients our focus is on education whereas with adults it will be if
10 anything rehabilitation or vocational rehabilitation.

Adolescent services generally cover the period, say, 13 to 18 years old?---It varies according to the jurisdiction you're in. Twelve to 18 is quite typical. Thirteen to 17 a narrower range in some places. And then you'll have services that talk about 12 to
15 25 although they tend to describe those services as youth rather than adolescent.

Right. Do you perceive that there's a – I'm sort of drawing on your overall expertise – but do you perceive that there's a gap that – whether they finish at 17 or 18 – do you perceive that there's a gap because the 17 or 18 year olds are often – this is
20 probably an inelegant expression but undeveloped or immature?---Yeah. So there's great variability in the maturation of young people. So there are 16/17 year olds who can cope quite comfortably with an adult mental health environment and they will manage in an adult ward without any difficulty. They're mature, they're quite self-reliant. And then there are other young people whose level of maturity means they
25 may still be really unable to cope with that environment until their mid-20s.

And the Walker and Barrett cohorts, would they typically fall into the first or the second?---Neither. These – we have underdeveloped youngsters in the Walker Unit. We also have very mature youngsters in the – in the Walker Unit so - - -
30
Alright. And one last point, is institutionalisation a risk in the Walker Unit and, if so, how is it dealt with?---We – we assess our patients at the outset for a range of risks and one of them is dependency – dependency on the unit and the unit actually getting in the way of the person's maturation and development. So we recognise that from
35 the outset and we have many steps to mitigate against that.

Those are my questions.

COMMISSIONER WILSON: Thank you. Ms Wilson.
40

EXAMINATION BY MS WILSON [11.45 am]

45 MS WILSON: Thank you, Commissioner.

Professor, I would just pick up on the last questions that Counsel Assisting asked you in relation to whether you thought there was a gap in the services. I was just a bit unclear. Do you think that there is a gap?---There is unmet need in the community. There is unmet need for mental health problems right across the age span. There are particular risks in transition between particular age groups to the next and a major risk area is the transition between adolescence and adulthood. I wouldn't characterise that as necessarily a gap but more as a challenge.

Okay. And are you dealing with the knowledge of your services in New South Wales or do you have any knowledge of services in Queensland?---Well, I'm actually basing my knowledge on national and international literature.

Okay. If a so-called gap is identified, the way to address that, would you say, would be to do a service-mapping exercise to undertake the similarities and differences between the current services, the needs for specific age groups, maturity, the diagnosis – those sort of things involved in a service-mapping exercise?---Yes.

Okay. Now, if I can take you to your statement, please, and if I can take you to WIT900.005.0017 and that's paragraph 97. You refer there to a continuum of services?---Yes.

Okay. Now, the continuum of services starts from community-based services to acute units. Is that correct?---Yes. And the continuum really begins with primary care.

Primary care?---Yeah.

Okay. And acute beds is at one end of the spectrum – at the - - -?---Well, they actually characterise tier 3 services as being at the – the far end of the spectrum. The acute services are along that spectrum.

Okay. And do you put sub-acute into that as well?---Yes.

Okay. So moving up to that we've got community-based and you say primary care starting very early. Then you've got community-based and in your statement you refer to a service like assertive community treatment outreach. Is that like what we've got in Queensland is the AMYOS which is the mobile outreach services?---I believe so.

And that provides mobile assertive engagement and prevention - - -?---Yes.

- - - focused interventions in the community?---Yes.

And in Queensland are you aware that there are two youth residential rehabilitation services called resis – and I'll just explain what they are. They provide long-term accommodation up to 365 days and recovery-oriented treatment for 16 to 21 year olds who have moved out the acute phase of their mental illness but lack the skills or

expertise for independent living or a stable place of accommodation?---No. I'm not familiar with those services.

Okay. Day programs you are?---Yes.

5

You refer to that in your statement. There is a proposed Step Up Step Down unit which is a new service type for young people in Queensland with the first to commence in 2017 and '18 in Cairns. And this provides a step up service option to prevent inpatient admission through intense short-term treatment and a step down
10 option to assist early and seamless transition for young people when re-entering the community following an inpatient admission. Are you aware of any kind of service like that?---No.

Okay. And then we've got – moving along the spectrum we've got – well, moving
15 along the continuum we've got sub-acute beds which provides medium-term intensive hospital-based treatment in a safe and structured environment for young people with severe or complex symptoms of mental illness and significant disturbance or behaviour that precludes them from receiving treatment in a less-restrictive environment?---Yes.

20

Okay. And then we get to acute beds. And along that continuum that's not a static – there's not just one that's a stand-alone. You can move between – is it best practice that you be able to move between each of these treating services?---Yes. And – and that should be driven by phase of illness and stage of development.

25

And so driven by individual treatment?---Correct.

Okay. Okay. And going through all of those services that I set out and just gave you a little sketch of all of the services provided in the continuum, that that kind of
30 continuum in care that has planned to take all of those elements as well as the community clinics and the acute beds satisfies all national and international benchmarks for best practice in adolescent mental health?---I'll need you to repeat that question.

35 Okay. Looking at a continuum of care, and the continuum of care that I've taken you through?---Yes.

And I can take you through again if you require it?---Yep.

40 That has planned to include all of those elements and those elements that I've taken you through including AMYOS, resis, day beds, Step Up Step Down program, subacute beds to acute beds along with the community based services. That continuum would satisfy all national and international benchmarks for best practice - - -

45

COMMISSIONER WILSON: Excuse me, Professor. Don't answer that. Ms Wilson, how can this witness answer that question when he has said that he doesn't have familiarity with the type of resi that's in Queensland - - -

5 MS WILSON: I accept that.

COMMISSIONER WILSON: - - - or with the Step Up Step Down that's proposed?

MS WILSON: I accept that. I accept that, Commissioner. Thank you.

10

COMMISSIONER WILSON: Ms McMillan.

EXAMINATION BY MS McMILLAN [11.51 am]

15

MS McMILLAN: Yes. Thank you.

Professor Hazell, could I just take you to a few points that you've made in your
20 statement. Could I take you to page 8, please, of the statement? And, I'm sorry, for some reason my copy doesn't have the number. It'll be paragraph 39 I'm particularly looking at. Right. So, Professor, you were asked some questions about the type or profile, if I can put it that way, of patients within the Walker or adolescents. What do you – what term do you use?---Patients.

25

Patients. Right. Thanks. So is this correct in understanding paragraphs 39 to 41, an important component or Walker is that the referring agency has skid in the game, if I can put it that way. That they're seen, one would think, as an integral part of the process with Walker. So it's not like they refer and then step out. You continue to
30 involve them?---Yes. That is correct.

Right. And I understand that that would have considerable benefits, wouldn't it?---Yes.

35 What are the particular benefits that you think?---The – at the very beginning of an admission we're already thinking about discharge planning. And discharge planning must involve the receiving agency, the people that are going to provide the ongoing care.

40 Yes?---So we need the referrers to be fully aware of what the treatment goals are, how successful or not we have been in achieving them. And we need to prepare the referrers for the ongoing management of the young person.

All right. So – and that, no doubt, provides great consistency then between what
45 treatment you're providing and understanding what both the referrer can and perhaps can't do?---Yes. That's a good point, that we need – and we strive to ensure that the

management that we discharge a patient on is doable within the community environment. Yes.

Because, inevitably – and can I suggest particularly in mental health issues – there's
5 always a constraint in terms of what resources may or may not be available?---I would characterise the main difficulty as being complexity. If you make the treatment too complex, then it's too difficult to deliver.

To implement?---Yep.

10

All right. Thank you.

COMMISSIONER WILSON: Could you keep your voice up, please, Ms McMillan, or speak into the mic.

15

MS McMILLAN: I'm sorry. I'm sorry. That's not usually a problem for me but I apologise for that.

In terms then of paragraph 42, you talk about the assessment process for referrals.
20 As I understand it, another integral part, it would seem, is the involvement of the family and their environment?---Correct.

And I – is it correct that you undertake family therapy both at Walker and Rivendell?---Correct.

25

And what's the form of the family therapy?---It varies according to need. So at the lowest end of intensity it's psychoeducation. But at the more complex end it's systemic family therapy.

30 So perhaps can I use an example, so if you assessed that an individual patient there needs to be intensive therapy, it could be at least weekly or perhaps more so than that?---If required.

If required. And less so, it just really depends on the needs?---Correct.

35

And what form does the therapy take? Is that – I infer from that that, in fact, members of your staff may, in fact, go out to the family environment?---Not while the young person is a patient of the unit.

40 Right. They come in?---Yeah. The point about visiting the family is part of the intake process.

Assessment. Yes?---So it's making sure that our clinicians understand the environment from which the young person is coming.

45

Right. Okay. And the family therapy when they come into the unit, who is that undertaken by? Is that undertaken by a clinician such as yourself or is it by allied

health or a mixture of both?---A mixture. So most of our psychiatrists are trained in family therapy but also so are most of our social workers and psychologists.

Right. Okay. Thank you. Professor, paragraph 49 which is page 10 of your
5 statement, you talk about unusual for them to stay longer than six months and there's a couple of outliers. There appears to be some, can I put it, resonance about the six months. Is that right? Why is six months perhaps particularly chosen or identified?---Yes. We chose six months because that's the median length of stay. Or for a long time it has been the median length of stay at Rivendell. And we based the
10 Walker model on Rivendell but it's a more stepped up, more intense version of Rivendell. It was never intended that the six months should be an absolute but it was a guide.

All right---And the experience of our service has been that for most young people we
15 can achieve the goals that we set out to do within that timeframe.

And yet we've seen, with respect, Professor, that that if one looks at one indicator to be quite successful, paragraph 32, you depose that the Walker unit's 28 day readmission rate is currently zero?---Correct.

20

So that, I suppose, informs you that maybe the balance is probably fairly right?---Yes. The 28 day readmission rate is, I think, only to facilities within our LHD. So if a young person has gone to another local health district we won't pick up those data.

25

No?---But my knowledge is that it's extremely rare for one of our Walker patients to be readmitted to hospital post discharge.

All right. Okay. I think you say within the 28 days?---Correct.

30

So that – obviously, the 28 days signifies to you, I suppose, that there's not any acuity immediately after their discharge?---Correct.

Right. Okay. Thank you. And I take it that stays longer than six months – what sort
35 of issues in your mind would that create? Does it, therefore, if you have long term – longer term, one, two, even four years, what sort of issues might that create?---So to – my recall of the longest stay we've had is less than two years. So we've never had a patient for four years. The length of – a protracted admission, first of all, indicates the problem is severe. So that's really the first thing: that the clinical problem is
40 severe and somewhat intractable so we're having to work harder to get the young person well. But the complications of spending longer in hospital, it's longer time away from opportunities to interact with family, re-engage with school and so on. So it's keeping the young person away from their normative experiences.

45 And, I suppose, their peers as well because that goes with school, doesn't it?---Correct.

And I take it – is it fair to say also that your continuing engagement with the referring service also assists with the young patient not becoming too attached, for instance, to a clinician there? That there's that idea that they'll be handed back over to the referrer so that there's, again, that consistency but also not the risk of them becoming too attached?---It is possibly a benefit. The – but transference is a risk in an inpatient environment. Again, it's one of the risks that we need to mitigate against.

And particularly if it's a stay of six months or more - - -?---Correct.

- - - that would obviously be quite a – I imagine, a significant issue to consider?---Yes. One of the mitigating factors against attachment to one staff member is that the approach is very much a team approach.

All right?---So all the young people are interacting with a range of staff.

Okay. Thanks. And I take it too that the mix for Walker is obviously very severe and disabling presentations of psychosis, as you've mentioned - - -?---Yes.

- - - or unremitting suicidality. So you're seeing the most serious, if you like, of the adolescents in the Walker Unit?---Correct.

Thank you. Now, can I ask you a couple of questions about the ECRG process because my learned friend Mr Freeburn did. Firstly, the model of service proposed – that was in May of 2013. You endorsed that, did you not, by email?---Yes.

Alright. Thank you. Perhaps if the witness could be shown that in that bundle of emails, Commissioner, that I tendered.

COMMISSIONER WILSON: Well, I'll have the bundle given back to you, and you can show him which one you want.

MS McMILLAN: Yes, I'm happy to do that, thank you, your Honour. This is the bundle which was exhibit 174, I'm reminded by - - -

COMMISSIONER WILSON: One-seven-four.

MS McMILLAN: - - - my very efficient instructing solicitor.

Do you isolate one there that's from yourself, Professor?---Yes, I do.

Right. Okay. Thank you. Perhaps if you just hand that back. Professor, can I ask you in that document – and the reference is MNH.900.003.0104 - - -

COMMISSIONER WILSON: Is that the first page of the document or the particular page you want - - -

MS McMILLAN: No, it's page 4 of that document.

COMMISSIONER WILSON: You need to cite the first page.

5 MS McMILLAN: Yes. I'm sorry, your Honour – sorry, Commissioner.

It's page 4 of the proposed service model elements. The first page is headed Preamble.

10 COMMISSIONER WILSON: And what's the reference to the first page?

MS McMILLAN: The rest – I'm reading from the – MNH.900.003.0098. This was as annexed to Dr Scott's affidavit.

15 COMMISSIONER WILSON: I'm sure the operator will try and find that document.

MS McMILLAN: Professor, I might perhaps ask you this. This might be another way of doing it. In that final model, do you recollect there was clearly a discussion of tier 3?---Yes.

20

Alright. And do you remember that there was, if you like, a caveat to that, and it appears in a footnote:

> *Until funding and location is available for tier 3, all young people requiring*
> 25 *extended treatment and rehabilitation will receive services through tiers 1 and 2A, B, ie., utilising existing CYMHS community mental health day programs and acute inpatient units until the new day program and residential service providers are established.*

30 ?---Yes.

Yes. And, in fact, that's up on the screen now. That sounds right to you?---Yes.

Right. Okay. Yes, thank you. I've got nothing further with this witness,
35 Commissioner. Thank you.

COMMISSIONER WILSON: Thank you. Anyone else wishing to cross-examine Professor Hazell? Mr McMillan.

40 MR McMILLAN: Commissioner, I didn't give notice of an intention to cross-examine, but there is one very brief matter that - - -

COMMISSIONER WILSON: You have leave.

45 MR McMILLAN: - - - I seek leave to deal with arising from the oral evidence. Thank you.

EXAMINATION BY MR McMILLAN [12.03 pm]

MR McMILLAN: Professor, you stated in your evidence-in-chief in response to
5 questions by my learned friend Mr Freeburn that with the longer stay patients, your focus was on education. Is it the case, then, that the presence of an onsite school at Rivendell is really critical to that focus?---Yes. The – I might amplify my response about education. With the young person with severe and persistent mental illness, one has to take a holistic approach to their care, because their predicament is going to
10 interfere with every aspect of their life, not just their cognition and thoughts and feelings. So it interferes with their educational progress and also interferes with their interpersonal functioning, their friendships, and it interferes with their health. So our programs have to attend to all those aspects of the young person's care, and we certainly highlight education as an essential component of the treatment package.

15

I'm interested particularly in the presence of an onsite educational facility, rather than the patients at Rivendell and at the Walker Unit somehow accessing education in another way. Is it the case that the presence of an onsite school is critical to the achievement of that goal?---In the example of the Walker Unit, it couldn't be
20 delivered any other way because the patients – most are involuntary, so it wouldn't be feasible to – or safe or clinically reasonable to take them offsite. With the case of the Rivendell patients, they're more ambulant. It would be feasible to offer the educational program offsite, but there are major advantages in providing it onsite. They include that if a young person becomes destabilised, distressed, they have very
25 quick access to clinicians, and one of the practices we have is if a young person's in class, not managing, needs time out, a nurse or one of the allied health with either sit with them for a period or take them out of the class and then return them to the classroom when they're ready.

30 And is it important that the teachers that are delivering that educational service, if I can use that expression – is it important that they have experience or particular expertise in teaching young people with mental illness?---The teachers that work at the Rivendell school generally have come from a special education background. It doesn't always mean it's been working with a mental – a mentally ill population. It
35 may be children with other special needs, such as intellectual disability or behavioural problems, but they're teachers who have a recognition that their job is more than delivering the curriculum.

Thank you. Those are my questions. Thank you, Commissioner.

40

COMMISSIONER WILSON: Thank you. Mr Freeburn, anything in response?

MR FREEBURN: Just two very short points.

45

EXAMINATION BY MR FREEBURN [12.06 pm]

MR FREEBURN: Professor, you were asked some questions by Ms McMillan about the 28 day readmission rate?---Yes.

And I think your answer was to the effect of it's at zero, but the data is somewhat limited because it refers only to people – sorry, you're catching the data only within that particular health district?---That's' correct.

Just in sort of wider sense, is there data available to measure the success or otherwise of the Walker Unit?---There are blunt measures that at least give us an indication of how we're doing, so there are – we routinely collect measures of global assessment of functioning, which are done at admission and through admission and on discharge. It's the same measures that are used in the acute units, and we consider a 10 point or greater improvement on a scale of zero to 100 as improvement. If you stay within the same 10 point band it's no improvement. If you – if your scores drop below 10, then you've got worse. In our population, two-thirds of young people on discharge have improved; one-third have stayed the same, and nobody's got worse.

And is that the only measure that you're able to – it's obviously an inherently - - -?---We – we have – we have finer-grade symptom measures, but actually the global assessment of function measures are the most reliable indicators of how people are going to do in the longer term.

Alright. Thank you. Commissioner, may Professor Hazell stand down.

COMMISSIONER WILSON: Yes, thank you, Professor. You can stand down.

WITNESS STOOD DOWN [12.08 pm]

COMMISSIONER WILSON: Now, any more witnesses before lunch?

MR FREEBURN: No.

COMMISSIONER WILSON: Are there any administrative matters that can be dealt with?

MR FREEBURN: There's two matters, Commissioner. The list that I handed up on Monday – exhibit 34 from that list on Monday was actually tendered by Ms Wilson on 19 November and marked as exhibit 10, so we can rule out exhibit 34.

COMMISSIONER WILSON: Alright. Well, the recording of the list of exhibits will just show a blank against 34.

MR FREEBURN: Thank you. And there's five additional statements that should become exhibits. Can I hand up a provisional list, and I understand this has been circulated to the parties.

COMMISSIONER WILSON: There are some puzzled faces beside you at the bar table, Mr Freeburn. Make sure the parties know what it is you're handing up.

MR FREEBURN: Perhaps they can have a look at that over luncheon.

5

COMMISSIONER WILSON: In preparing this list and provisionally assigning exhibit numbers, I suppose you've not taken account of the documents which were tendered this morning in the course of the oral hearings, or have you?

10 MR FREEBURN: No, I haven't. I'll take that back and renumber - - -

COMMISSIONER WILSON: Alright. Well - - -

MS McMILLAN: Commissioner, thanks for that. I haven't seen all of those, so
15 we'll need to consider that over lunch.

COMMISSIONER WILSON: Well, sort anything out over the lunch break, which looks like being longer than usual.

20 MS McMILLAN: Yes. Sorry, there's just one issue I wanted to raise when my learned friend is finished.

COMMISSIONER WILSON: Have you got any other points, Mr Freeburn?

25 MR FREEBURN: No.

COMMISSIONER WILSON: Thank you. Yes, Ms McMillan.

MS McMILLAN: Just to be really clear, when I was adducing evidence from Dr
30 Scott, I recollect you'd made an order about the redaction in that email, but I think in identifying them you may have identified, perhaps, a carer's name, which is my fault for not pointing that out to you. Perhaps that should also be redacted from the transcript.

35 COMMISSIONER WILSON: Well, could you have your solicitor contact Mr Thompson over the lunch break - - -

MS McMILLAN: I'll have that done.

40 COMMISSIONER WILSON: - - - and sort it all out - - -

MS McMILLAN: Yes.

COMMISSIONER WILSON: - - - so that the document can be properly redacted
45 and go into the Delium database. Thanks. Now, I understand that Ms Callaghan is to give evidence this afternoon, and she's lined up for 2 o'clock. Is that correct?

MR FREEBURN: I think I had 2.30. I'll just – no, you're quite correct, 2 o'clock.

COMMISSIONER WILSON: Very well. Would you adjourn, please, until 2 pm.

5

ADJOURNED [12.11 pm]

RESUMED [1.59 pm]

10

COMMISSIONER WILSON: Good afternoon, everyone. Ms Muir.

MS MUIR: Good afternoon, Commissioner. Could I just deal with one
15 housekeeping matter. Can I hand to you a list containing five other statements that are to be tendered as exhibits. I have a copy of this document for all the parties' representatives, and I'll make it available at the end of today's hearing.

COMMISSIONER WILSON: The copy you've given me, the document which has
20 180 against it has both a code and a name. Now, I take it that this is someone whose name should be treated as confidential, is it?

MS MUIR: That's correct, Commissioner.

25 COMMISSIONER WILSON: So is there a copy just with the code?

MS MUIR: I understood that there will be a copy just with the code being made available, but the parties have this copy with the name of the person so they can identify them, of course.

30

COMMISSIONER WILSON: All right. Well, does anyone have any objection if I add these five affidavits to the bundle of affidavits which have already been assigned exhibit numbers? Very well. And I will have the numbers provisionally assigned, which go from 176 through to 180. When you're ready, Ms Muir.

35

MS MUIR: Thank you, Commissioner. I call Amelia Jane Callaghan.

AMELIA JANE CALLAGHAN, SWORN [2.01 pm]

40

EXAMINATION BY MS MUIR

45 MS MUIR: Commissioner, before I ask Ms Callaghan some questions, can I tell you that most of my questions can be addressed in open court. There are some that I propose need to be dealt with in closed court. Mr Diehm has told me that all of his

questions will need to be asked in closed court. What I propose is that we deal with all the open court questions, so I ask mine and then the other counsel that have questions that can be asked in open court ask theirs, and then we close the court and I can deal with my closed court questions and so can the other legal representatives, if
5 that is something that - - -

COMMISSIONER WILSON: Well, it sounds sensible to me. Does anyone have any contrary view? Let's proceed on that basis.

10 MS MUIR: Thank you, Commissioner. Ms Callaghan has provided one statement. It's dated 14 January 2016, and it's at HSP.900.0001.0001.

Ms Callaghan, that should be on the screen in front of you?---Yes.

15 I understand from your statement that from June 2011 to June 2015 you were the state manager for Queensland and Northern Territory for the Headspace National Youth Mental Health Foundation. Is that correct?---Yes, it is.

Can you just explain briefly what your role was at the time?---Yes. So Headspace
20 National office contracts a number of lead agencies to run the Headspace centres locally. My role was in relation to making sure that those lead agencies were complying with the contracts that we had granted them, performing as expected for a normal Headspace centre, and also supporting them in terms of any developmental aspects of – around improving the operations of their centre. I didn't have any day-
25 to-day, like, operational management of those centres or any part in clinical management or operation of those centres.

And you use the expression "lead agency". Can you just perhaps explain to the Commission what you mean by that expression?---So when there's a Headspace
30 centre set up, a - - -

COMMISSIONER WILSON: Speak into the mic?---Okay. Sorry. When a Headspace centre is established, organisations apply – put in a submission to be a lead agency for the Headspace centre. They're supported by a consortium of other
35 organisations, but essentially the lead agency is contracted to manage and deliver the service on behalf of Headspace National Office.

MS MUIR: You mentioned that you didn't have any involvement in clinical care, but you have qualifications. You have a Bachelor in Social Science (Psychology), a
40 Graduate Diploma in Psychology and a Masters in Social Administration. Is that correct?---Yes, it is.

Now, if we could go to page 2 of your statement, which is HSP.900.0001.0002. We can see there's six dot points, where it talks about the aim of Headspace. Am I
45 correct in my understanding of your evidence that Headspace services are really an early intervention focus service, with the majority of the services delivery limited to a maximum of 10 sessions?---Yes, that's correct.

And catering for the 12 to 25 age group? You'll have to speak into the microphone?---Yes. Yes, that's correct.

And I understand from your statement as well that there were 10 Headspace centres open in Queensland during the time that the Barrett Centre was in operation?---Yes, that's correct.

Am I right in thinking that the way Headspace operates is that a young person is referred there from an allied health practitioner located within the particular region of that Headspace service, and that the cost of that session is covered under the Better Access Scheme?---In most cases. So a referral is received from a variety of sources. Doesn't need to be an allied health professional. Majority are self-referrals or referrals from family members or GPs or schools. From the referral point, we do what's called a Headspace assessment and then assess the needs of the young person. In most scenarios, that results in a mental health care plan and the young person being able to access 10 sessions using the mental health care plan.

That's what I wanted to understand a little bit more. So just taking a step back, so there's no need for a doctor referral to Headspace?---No.

And is there a process for accepting a referral? Is this the assessment that you just spoke about?---So in most centres there is a Headspace assessment. Following the assessment, that assessment is taken to a clinical review or case review meeting of allied health professionals. Normally there's someone as a clinical manager or clinical team leader who participates in those meetings and discusses the presenting needs of the young person and also the appropriate plan. It could be – because Headspace services are delivering physical health, mental health, drug and alcohol and social vocational services, the recommended plan of action could be a variety of all of those. Some service is delivered onsite and some delivered offsite.

Okay. So when you talk about delivered offsite, does that mean on occasions someone from Headspace may go to the young person's home?---Home visits are not likely. They are delivered under the early psychosis program, but home visits for what we call the Headspace primary centres, which is the normal centres off a primary care platform – are unlikely to do home visits.

Okay. So if the young person wouldn't access the Headspace centre, where else would they go to – as part of the care and management within Headspace auspices? I thought your evidence a moment ago – and I may have misunderstood you – was that the young person may not only receive the care through Headspace actually at the Headspace centre?---So the – as I mentioned before, the lead agencies have a consortium of organisations. So services may be provided by consortium members onsite, or we may refer as an adjunct to the care to a consortium member. Alternatively, if there's a specialised need, for example, sexual assault counselling, and we don't have that specialisation available onsite, we may refer the young person to a – as an example, you know, a specialised service that can respond to their presenting need.

Okay. I want to ask you about what happens to young people that you think need to be referred on in a moment, but when you talk about consortium, could you give an example of when you would need to bring in someone that was part of that consortium?---The clearest example is probably employment services or employment education services. So if a young person is requiring those kind of services we would, in most Headspace centres, have someone onsite either a day a week or half a day or a day fortnightly who can deliver educational and employment services to that young person. So that's an example. But there may be other services, for example, outside of the allied health provided under the mental health care plan. There may be more social needs which may be provided by a youth worker, for example, from someone like PCYC or another consortium or community stakeholder. Indigenous services, culturally and linguistically diverse services, they may also be an example of other services that we bring in to meet the specific needs of the young person.

So am I correct in my understanding, then, that on occasions, then, young people who access Headspace may need to be referred on to a more appropriate service?---Yes.

In your statement I understand that whilst the Barrett Centre was in operation, Headspace couldn't refer any young people directly to the Barrett Centre but that referrals were progressed through the local children's health children and – sorry, Queensland Health Child and Youth Mental Health Service?---Yes.

Alright. So Barrett Centre was a referral option for Headspace?---Yes.

I'll ask you some more questions about the capacity of Headspace staff to deal with those adolescents that accessed the Barrett Centre with severe and complex mental health issues in a moment. But do I take it – and my understanding from your statement is that you seem to accept that Headspace doesn't have the capacity to treat those young adults with severe and complex mental health issues?---I think that's an incorrect assumption from my statement. I just wouldn't mind clarifying that. While we are primarily aimed at early intervention, the centre is dependent on their lead and their consortium partners may be able to manage young people who present as more complex. We wouldn't be doing that in isolation as an independent Headspace service but in conjunction with our lead agency and the consortium members or partners. For example, if we were given a referral from a Headspace – you know, to Headspace for someone who was more complex, if in that particular region we had a private psychiatrist who delivered sessions, we had a GP, we had our local child and youth mental health services participating in case reviews, we had private providers onsite that perhaps had worked previously in child and youth mental health services or in other more complex settings, we may look at as a collection what we could provide that was appropriate and safe to do so from that centre and who else we needed to bring in as an adjunct to that treatment.

You actually in your statement do talk about the type of professionals that work within Headspace. And you referred to psychiatrists, general practitioners, psychologists, social workers and occupational therapists. Now, does that mean that at every Headspace service in Queensland there are all five of those professions
5 working there?---No, not necessarily.

So that's what you were saying before, it would depend on whether, for example, there was a psychiatrist that was available?---Yes. It would depend on the capacity of the staffing profile at the centre through Headspace funds but also the staffing
10 profile that's accessible through perhaps the lead agency or partner organisations.

And, of course, it would entail on occasions getting access to complete medical records of the young person and things like that?---Yes.

15 I just want to move on then for a moment to your involvement with the expert clinical reference group shared by Dr Leanne Geppert that we have heard about so far in the inquiry. And in your statement you say that on 28 November 2012 you were appointed a member of that expert committee. Is that correct?---Yes.

20 You will have to speak up a little bit?---Yes. Sorry. I'm – yes.

In paragraph 7 of your statement which is – actually, we don't need to go to paragraph 7. You say that:

25 *It's my recollection that the ECRG was informed by the chair, Leanne Geppert, that the decision to close the Barrett Centre –*

or the BAC –

30 *had been made. I'm not sure of when this occurred but I believe it was in the early meetings of the committee.*

If I could just take you to paragraph 15 of your statement which is HSP.900.0001.0013. I was wondering if that helps with your recollection because if
35 you look on the bottom of the page, further down, you talk about the minutes of the ECRG meeting held on the 27th of February. And there talks about:

The capital allocation previously attached for the rebuild of the Barrett Centre is no longer available and the Barrett Centre will not be built on an alternative
40 *site.*

Was that when you understood that there had been a decision to close the Barrett Centre?---That – so that – just to clarify, that point that you're referring to is not part of my statement but part of the questions I received from the Commission. But - - -
45

Sorry. I – but - - -?---So in - - -

I'm taking you to those minutes to see if it assists in you – you were unsure when you found out about the decision to close the Barrett Centre and I was trying to give some context to when you may – and you say it was early on and you were appointed in November 2013. So I was trying to give some context in a timeline sense of when
5 you may have found out that there had been a decision to close the Barrett Centre?---I can't recall when that happened.

In your statement you state that you had concerns about the decision to close the Barrett Centre at The Park and that these decisions were related to there being no
10 alternative treatment options available for this client group. I'm – and, of course, you mean – the client group meaning the young people who were accessing the Barrett Centre?---Yes.

Can you just tell me what you knew about this group of young people at the
15 time?---At the time of joining the ECRG - - -

Yes?--- - - - or through the course of joining the ECRG?

Well, at the time that you express your concerns about the decision to close the
20 Barrett Centre?---Sorry, can you please take me to that section in my statement?

Yes. If we go to – it's paragraph 9 which is on HSP.900.0001.0009?---So you're referring to the paragraph at the top there?

25 Yes?---Yes. So when I first – this is prior to my involvement in the ECRG when I first heard through social media and news that there was a closure of the Barrett Centre. I did have concerns in relation to the closure because of my understanding of the gap that would be left there. So my understanding at the moment that the Barrett Centre serviced clients that could not be serviced within their local region that had
30 either been offered treatment services locally that had not yielded positive results and required the intensive kind of support that was delivered at the Barrett.

So – and my question was, at that time though had you ever been to the Barrett Centre?---I had been there once. But, again, my recollection of when is quite vague.
35 When I worked at Child and Youth Mental Health Services on the Gold Coast but I can't – I'm unclear about when that was. It was a very long time ago.

Did you understand, for example, at the time that it was an inpatient facility?---Yes.

40 And that it had 15 beds?---Yes.

Now, when you were appointed to the ECRG by Dr Geppert, had you had any professional involvement with Dr Geppert prior to your appointment?---Yes, I had.

45 In what capacity had you worked with Dr Geppert?---We were both on a Queensland early psychosis steering committee.

Now, if we could go to paragraph 13(b) of your statement which is HSP.900.0001.0012. Okay. Now, here you say that the period of your appointment to the ECRG was somewhat vague. There was a sense of urgency given the timeframe to stop services at the Barrett Centre site at that time was June 2013.
5 Given that the intention or the announcement to close the Barrett Centre was made by the Minister on 6 August 2013, and the recommendations of the ECRG were not published until July 2013, I just want to get some understanding of what time you had been told that there was an intention to cease the services at the Barrett site in June 2013?---It's my understanding that that's in the project plan that was provided
10 to us at the commencement of the ECRG. But I would need to double check that.

I will – we're just having a look for that, Ms Callaghan?---Sure.

Just – if we can continue on, then, in paragraph 13(d)(ii) which is on
15 HSP.900.0001.0013, you say there that:

> *While it was not documented or verbalised specifically it was my understanding that the report was not to advocate for the continued operation of the Barrett Centre in its current form or at its current location.*

20

So just so we're clear, you're talking about the ECRG report and that that report was not to advocate for the continued operation of the Barrett Centre in its current form or at its current location?---Yes.

25 So does that mean that you felt from the outset that the expert committee was being led that particular way?---It was my understanding that the expert reference committee was not to advocate for the continued operation of the Barrett in its current location or in its current structure.

30 Okay. But you say it wasn't documented or verbalised so I was just trying to understand what gave you that impression?---Yes. So it was in – so in a number of minutes there was talk about, for example, the funding being redirected so there was no – we were aware that there was no funding for a purpose-built facility. It was in a number of documents that the continued operation of the Barrett onsite with a secure
35 unit was not appropriate. There were a number of more indirect references around things like wanting to comply with the State Mental Health Plan, for example, offering services closest to the young person's usual place residence and in the most least restrictive manner. So while it wasn't, as I said, more directly specified the conversations around that in relation to there's no money to build a new service –
40 there's no – we don't believe that this operational model is in line with contemporary evidence and the way the conversations were redirected around what I call broader parameters of service like least restrictive practice or, you know, closer to the family home – those were the types of things that led me to the understanding that Barrett was not to continue operating in its current location or form.

45

Now, on page 18 of your statement which is .0018, at the bottom of that page is the commencement of a table that I just wanted to – the second dot point – I just wanted to understand your second dot point?---Yeah.

5 And have you got that?---Yes.

Yes. You set out your views with respect to the ECRG and the planning group and you say there:

10 *In relation to the inpatient extended treatment and rehabilitation care tier 3 recommendation –*

The tier 3 being an essential service component, you say that you agree with the reply from the planning group, that is, that:

15

alternative bed-based models could be developed but they did not have to be inpatient.

I just want to understand what you understood to be bed-based without
20 inpatient?---So my interpretation of that is something similar to Y-PARC model where you have a residential service for young people that still has the clinical expertise on offer, that also has the ability to step up clients if they become more acute or more chronic – you know – sorry, not chronic – more acute in their presentation but is able to offer, though, a more, if I could say, less clinical, less
25 medicalised, less hospitalised-type environment than an inpatient unit, that's more like a – not a family home necessarily but, you know, more like a home environment where younger people can reside but still have the access to the clinical support and services that they require in order to get well.

30 So I understand – and correct me if I'm wrong – that your evidence is that despite the ECRG considering a tier 3 service to be an essential service component your view is that if the other recommended service options were available, you say it was unclear to you whether a tier 3 inpatient service would be necessary. And I'm happy to - - -?---Yes. And what I - - -

35

I can take you to your statement - - -?---No. I – I'm familiar with that statement. And I just want to, I suppose, clarify what I mean by that. I think when you have a really holistic continuum of services available for young people so if we're able to offer early intervention services plus tier 2A, tier 2B services that are solid, that are
40 working together in an integrated manner where we don't have young people falling through the gaps which is the case at the moment, where we have intensive mobile outreach services that are providing services to young people who won't come into clinic-based services, I think we – it remains unseen whether we need an inpatient hospitalised clinical model of service when all of those tiers are in operation. I do
45 think we would still require some form of intensive rehabilitation-type service but I'm not clear that it would need to be an inpatient unit.

Well, you mentioned a moment ago that you feel at the moment there's some young people falling through the gap. Are you able to sort of identify those young people that you're concerned about?---Sure. So as I mentioned Headspace – the majority of Headspace is the early intervention clients. Depending on the region, again, there's
5 different gaps, I suppose. Let's say if the Headspace centre is only really able or equipped to deliver early intervention services and yet the Child and Youth Mental Service in the area has a large wait list or is actually only taking very, you know, quite severe and unwell services, there are still clients in the middle of that that are unable to be assisted, that are too complex for Headspace but not complex enough
10 for Child and Youth Mental Health Services. This is – for our services and particularly in my role as state manager – this is particularly an area that we've spent a lot of time talking about, where there's clients that are perhaps too high need, too complex for Headspace but are not quite reaching the criteria to be accepted into their local Child and Youth Mental Health Services.
15
COMMISSIONER WILSON: I think I understand what you've just said but that isn't in relation to Headspace vis-à-vis Child and Youth Mental Health Services. What did you mean when you talked about the gaps in relation to the sorts of patients who would have been at the Barrett Adolescent Centre and the proposed continuum
20 of care?---I think one of the challenges for me was geographical in relation to that, as well, when we looked at referral rates as part of the committee and where they were coming from. And certainly the feedback I was hearing also from the Headspace service in – in North Queensland – in Cairns and Townsville – were also indicating that there were perhaps clients in those regions that would have been accepted to
25 Barrett Adolescent Centre but didn't want to leave their particular areas or for some other reason were not able to – or didn't attend the Barrett Adolescent Centre.

Okay. Thank you.

30 MS MUIR: If I could just take you to – it's HSP.900.0001.0016. It's paragraph 17(d) and this is where I asked you a question before about whether – trying to clarify what you meant by unclear. Now – but you do say:

At best it was likely to be a very small group requiring these services.

35
What I don't understand from your explanation there is what happens to that very small group that do require a tier 3 inpatient service?---I think that for me to clarify the words tier 3 and inpatient are not the same thing. I think it is – and – and maybe it's my ignorance in misunderstanding the way terms are being used here but I – I
40 think that there's clients that have a tier 3 need that can access, I would hope, in a fully developed model would be able to access services that could meet those needs without it being an inpatient unit. So - - -

And look, I should have asked you what your understanding of a tier 3 service is so
45 perhaps you could tell the Commission what your understanding of a tier 3 service is?---So my understanding of a tier 3 service is a services that targets and – and can respond to the needs of young people with severe and persistent mental health issues

that require intensive support. What I – what I don't – and for me, you know, to clarify, I have some concern that the words Barrett Adolescent Centre, tier 3 and inpatient are all being used interchangeably, so to say the Barrett Centre should or shouldn't have closed is not for me to say whether tier 3 should or shouldn't exist. I do think we need a tier 3 service. I'm not convinced that it needs to be an inpatient unit that – the type of the Barrett Adolescent Centre.

Well, you in fact refer to in your statement the Step Up Step Down and the youth resis. What about the subacute beds? Do you have a view about the – those beds being part of the suite of services available to young people with these complex mental health needs?---Are you asking whether there should be subacute units available for young people?

Yes, whether there should be - - -?---Yes, there should be.

Do you see there's ever a need for admission to an inpatient unit for this cohort of - - -?---Completely. I don't – I agree there's a need and that there's a time for admission, but I don't think it should be, you know, up to two years. I don't think it should be for long extended stays. I think there's a time that young people need to be admitted. I'm not against inpatient services at all and completely acknowledge that there's many occasions where, you know – and, again, currently running an early psychosis program. Inpatient admissions are definitely needed. But should they be long stays? I don't think they should be long stays.

So in your – I appreciate in Headspace that your role is not a clinical one, but I suppose I'd like to understand from your perspective have you had to ever deal directly with young people with severe and complex mental health issues?---Yes, I have.

And with their families?---Yes.

And you would understand, then, that some would say – and perhaps if we can focus, then, on regional centres – some would say, "Yes, we accept, you know, that it's best to treat our child close to home and in a less restricted environment, but if our child needs to get the best treatment and it means having to be admitted as an inpatient, then that's what we want." Do you understand that lament?---Sure.

Okay. And do you accept, then – and I suppose is it your evidence, then, that that is the small group of young people that may require some inpatient admission?---Yes, but again, I think there's a difference between inpatient admission and extended tier 3 treatment.

So you mentioned before when you were talking about the extended treatment – I think – did you say sort of two years? You know, you don't at all like the idea of what you understood was happening at the Barrett Centre, I take it, that there were some young people that had been admitted for two years?---Look, it's not for me to

comment on those individual cases. I completely understand there's guidelines and there's situations where young people require greater periods of care. As you can see from the recommendations of the ECRG, we were talking up to 12 months, but there may also be exceptional cases to that. Theoretically, so not commenting on any
5 individual care, no, I don't like the concept of a young person spending years within an inpatient unit.

But you accept, then, as the ECRG committee seems to have accepted, that there was a need for a certain group of young people for admission up to a period of 12
10 months?---Sorry, can you repeat the question?

So do you accept that there would be on occasions a need for a young person to be admitted as an inpatient for up to 12 months?---Under that existing model of care, yes.

15

COMMISSIONER WILSON: What do you mean by that?---Well, what I mean by that is - - -

The existing model of care, that's - - -?---If the – well, in regards to the services that
20 we have currently on offer to young people. What I mean in regards to that is if there were better options available, then there may not be the need to admit someone in an inpatient unit for 12 months. If there were alternatives available where a young person can live, receive 24 hour supervision, access to specialised medical and psychiatric care, you know, within a safe environment but with the option of stepping
25 them up should they become, you know, acutely suicidal or unmanageable, I don't think we would need a 12 month inpatient stay.

Can I ask you this: you seemed a moment ago to acknowledge that there may be some cases where a period of inpatient care is necessary?---Yes.

30

Have you given any thought to the maximum desired period of such inpatient care?---I have my own personal view, but in regards to – you know, I'd defer to evidence in relation to that if it existed.

35 Thank you.

MS MUIR: I just wanted to – at the beginning of your statement you talk about, when the Barrett Centre did exist, that it was one of the places that Headspace would refer – I realise Headspace couldn't' refer a young people to the Barrett directly; that
40 they'd go through their local CYMHS. So accepting that that happened, and I understand from your statement that that did happen, where now would you say that same young person would receive the similar services that the Barrett Centre offered?---I think it depends on where they're regionally located. So my – and I must say I haven't been in a state manager role for some time now, so I'm not as
45 across the new models that may be emerging, but my understanding is that there's currently probably a gap in North Queensland still in

relation to alternative models of care. If they were here, in the southeast Brisbane area, I would look to referring to the Greenslopes residential unit.

And what about the mobile – the AMYOS units? Have you had any dealings with
5 those units?---I haven't had any dealings directly, only reports that were made through the state-wide AETRS meetings that updated around progress of recruiting to AMYOS workers in particular regions across Queensland.

Can I just take you to page 19 of your statement, which is .0019, and then this is the
10 – the ECRG committee concerns in relation to interim service provision if the Barrett Centre closes and tier 3 services not being available being associated with risk. And you agreed with that concern, did you, at the time?---Yes, I did.

And so when the Barrett Centre closed at the end of January 2014, can I just – what
15 was your understanding about any available tier 3 services for Barrett Centre patients at that time?---My understanding was that the alternatives were very limited, but was informed that brokerage funds had been made available in order to provide individualised transition plans for those clients to offset the gap, I suppose, that was there.
20
I'm not sure I understand – you'll have to just explain to me what you mean. So you accept, do you, that there weren't any available tier 3 services for patients from the Barrett Centre to transition prior to the Barrett Centre closing?---My understanding is that the Greenslopes residential unit was open at that time. I'm not sure how many
25 people were referred to that unit or if it was used as a referral option, but my understanding was that that was established at the time. Obviously not an inpatient unit, but certainly my understanding was that it was intended to be an intensive residential support service for young people with complex needs.

30 So it would surprise you to know that it actually didn't open until March 2014?---Yes, I wasn't aware of that.

COMMISSIONER WILSON: Keep an eye on the time, Ms Muir.

35 MS MUIR: Ms Callaghan, you were a member of the Adolescent Mental Health Extended Treatment Initiative Steering Committee, which is this AMHETI committee, and it was formed in September 2013, and I understand the recommendations were to develop mental health services that best meet the needs of young people across Queensland. Was that your - - -?---Yes.
40
- - - understanding of the committee?---Yes.

And this was obviously all young people that require mental health services, not just those with severe and complex mental health issues?---Yes, that was my
45 understanding.

And, indeed, that's why – I think if we go to page 34 of your statement, 0034 – you were, I understand, keen to join this group because it had the greatest potential to impact Headspace centres and that you had a particular desire to advocate for services in Queensland, as requested by Headspace centres outside of southeast
5 Queensland?---Yes, that's the – in relation to the service options working party, one of the three working parties for that committee.

And I think with some qualification, though, you accept the general proposition that Headspace as a service alone is not an appropriate service for adolescents for severe
10 and complex mental health issues to access?---Unless that particular Headspace centre has access to more specialised services, including psychiatric services, yes.

So I suppose my point was your focus on the AMHETI steering committee was more on the – you know, the availability of the really – and important availability of early
15 intervention services, as opposed to that more complex group of young people that have existing complex and severe - - -?---Yes.

- - - mental health issues?---Yes.

20 Commissioner, they're my only questions in open court.

COMMISSIONER WILSON: All right. Does anyone wish to - - -

MS MUIR: Thank you.

25

COMMISSIONER WILSON: - - - cross-examine at this stage? Mr Fitzpatrick – sorry?

MS ROSENGREN: I – I would like to as well, Commissioner. If I could have
30 leave, and it's just one very brief issue that's arisen now.

COMMISSIONER WILSON: All right. Well, I'll go in order. We'll come to you, Ms Rosengren.

35 MS ROSENGREN: Thank you, Commissioner.

COMMISSIONER WILSON: Thank you. Mr Fitzpatrick.

MR FITZPATRICK: Yes, thank you, Commissioner.

40

EXAMINATION BY MR FITZPATRICK **[2.42 pm]**

45 MR FITZPATRICK: Ms Callaghan, I'm Chris Fitzpatrick and I'm one of the counsel for West Moreton. I just have a couple of things. It seems that towards the

latter part of 2012 you were invited onto an expert group known as the ECRG, which you've referred to in your statement?---Yes.

And am I right to think that that group appears to have met between about December
5 2012 and March of 2013?---Yes, that's correct.

There look to be at least – or about six meetings of that group?---Yes.

And it looks to me as if you attended, either in person or on the telephone, all but one
10 of those. Does that sound right?---That sounds right.

Now, the meeting was – the meetings were chaired by Dr Geppert. Is that correct?---Yes, that's correct.

15 Would you tell the Commission, please – I withdraw that. I think you said you knew Dr Geppert by prior association?---Yes.

Would you tell the Commission, please, whether during your membership of the ECRG you ever had any concerns with Dr Geppert's chairmanship of the
20 group?---No, I didn't have any concerns about her chairmanship of the group.

Did you ever see any evidence on the part of Dr Geppert of an attempt to influence the recommendations which the group might make?---I think that – my understanding was that Leanne had some parameters within which we were required
25 to work or some scope of our terms of reference, and I think she worked to keep us within those parameters and within that scope, but I didn't see that as influence of the outcome.

No. And the parameters that you've referred to – was it your understanding that they
30 included some policy matters, such as the Queensland Mental Health Plan of 2006?---Yes, that's correct.

Which was, by this time of your committee, government policy. Is that correct?---I'm not sure if it was policy as yet, but that – it's my recollection that that
35 was referred to as a guiding document that we needed to stick within those principles.

Yes, all right?---Talk louder. Okay.

40 Bailiff to the rescue. And were some other parameters, on your understanding, the factual matrix in which the committee came together which was or included the fact that the Minister had already announced that the Barrett Centre was to close. Is that correct?---Yes, that's correct.

45 Excuse me, Commissioner.

WITNESS: I think it was flagged as a - - -

MR FITZPATRICK: It was flagged. Thank you for that. And was there also an awareness on the part of the group that funding for a facility at Redlands had been diverted?---Yes, that's in the minutes of the first meeting.

5 I see. All right. Now, did – now, Ms Callaghan, from your involvement in it, do you recall if the committee attempted to conduct some sort of systematic search of the potential care options for target consumers, namely, adolescents with complex needs?---My recollection – and I'm a bit blurry because I'm not sure – I'm not 100 per cent sure which committee undertook this review, but there was some service
10 mapping activity that was done that provided a table of referral options and service options for young people.

I see. And on your recollection, was that an attempt by the committee to come to grips with what was out there in the marketplace by way of service options for this
15 group of consumers?---Yes, but as I said, I'm not sure whether it was the ECRG meeting or the AMHETI meeting that did that activity, but it was certainly undertaken.

And, Ms Callaghan, I take it that as part of your participation in this group you
20 reviewed the minutes as they were made available to you?---Yes.

Did you ever have any concerns that the minutes did not fairly record the deliberations of the group?---No, I had no concerns regarding the minutes.

25 All right. And I take it that you endorsed the written recommendations of the ECRG when they issued finally in about May 2013. Does that seem right?---Yes, I did. Yes.

All right. Now, Ms Callaghan, you were asked – you were taken by my learned
30 friend Ms Muir to a time when you embarked on participation in the group, and I think in your statement you explain that you had received some emails from Headspace offices. Are you familiar with that part of your statement?---Yes.

And am I right to think that those emails incited in you some concerns about the
35 potential Barrett closure?---Yes.

You thought that there might be – I think you explained a service gap?---Yes.

All right. Now, is it the case or is it not the case, tell us which, that your
40 participation in the group over the following months from when you commenced with it allayed those concerns?---Yes, they did.

I see. And how was that – how did that come about?---If I talk for the expert reference group to begin with, the recommendations – I believe we identified the
45 issues but the recommendations made took into account those concerns. You know, for example, greater consultation, needing to look at implementation, a greater need for looking at evidence and alternative models. I was satisfied that any concerns I

had for the expert reference group were covered within the recommendations and would be picked up forthcoming. And in the future, meetings that I attended and the next committees that I sat on, for example, as concerns were raised they identified how they were addressing those concerns. For example, when a gap in the service was identified, we were informed that brokerage funds were available and that wraparound services would be offered and that there was a transition panel that was coordinating the care of the young people.

I see. And when you say the next committee, are you referring, I take it, to the SWAETRI group?---Yes.

Ms Callaghan, I just want to take you to, in fact, the final recommendation. So, Commissioner, I have it at this document. It's MMH.900.003.0001 at page 0133.

COMMISSIONER WILSON: There it is on the screen.

MR FITZPATRICK: Thank you, Commissioner.

COMMISSIONER WILSON: Perfectly cited.

MR FITZPATRICK: It was the first time I - - -

COMMISSIONER WILSON: It was easy to turn up.

MR FITZPATRICK: I read everything, Commissioner.

Now, Ms Callaghan, please take the time to satisfy yourself that that is the final report of the expert group of which you were a member. And could I ask, please, that you be taken to page 0136. Now, if we scroll down, please. Thank you.

Now, I'm trying to come to grips with this but it looks to me as if, based on this written document, that the recommendation of your group was:

> *(a) That a tier 3 service should be prioritised to provide extended treatment and rehabilitation for adolescents with severe and persistent mental illness.*

And then there is then some dot points that appear underneath that which state:

> *Interim arrangements after BAC closes and the four tier 3 is established are at risk of offering suboptimal clinical care, etcetera, and attention should be given to those matters.*

Then there's another dot point:

> *In the case of BAC being closed, and particularly if tier 3 is not immediately available, a high priority and concern for your group was the transitioning of current BAC consumers and those on the waiting list.*

?---Yes.

Correct?---Yes. Correct.

5 And then the third dot point deals with the potential loss of specialist staff which we needn't be concerned with at the present. And so am I right to think that being conscious of those facts your committee then recommended:

> *(a) That a safe, high quality service provision for adolescents requiring*
> 10 *extended treatment and rehabilitation requires a tier 3 service alternative to be available in a timely manner if BAC is closed.*

?---Yes.

15 And then:

> *(b) Interim service provision for current and waitlist consumers of BAC while tier 3 service options are established must prioritise the needs of each of these individuals and their families/carers. "Wraparound" care for each individual*
> 20 *will be essential.*

?---Yes.

So am I right to think that your group was cognisant of the fact or at least the
25 possibility that the tier 3 alternative may not be available by the time the BAC closed and so in that event an individualised package known as a wraparound package should be devised for each affected individual?---Yes. That's my understanding.

Was that the recommendation of your group?---Yes.

30

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

COMMISSIONER WILSON: Alright. Anyone else, Mr Diehm, at this stage?

35 MR DIEHM: Commissioner, some of the evidence that's been given has diminished my concern that some of my questions would be inappropriate for open court. But there's still something of a risk and there are other parts that plainly would.

40 COMMISSIONER WILSON: Well, do you want to do the open court ones now?

MR DIEHM: My preference would be to do it all in closed court and, Commissioner, later if it turned out that some part of it could be published then the transcript could be released. But if your preference is for it to be in open court, then
45 I'll proceed as far as I can.

COMMISSIONER WILSON: Well, I do want to do as much as we reasonably can in open court because this Commission's terms of reference require it to conduct the proceedings in an open and transparent manner.

5 MR DIEHM: Yes.

COMMISSIONER WILSON: So if there are things you can do in open court, please do.

10 MR DIEHM: If I run into concerns I'll raise them again.

COMMISSIONER WILSON: Very well.

15 **EXAMINATION BY MR DIEHM [2.58 pm]**

MR DIEHM: Thank you, Commissioner.

20 Ms Callaghan, my name is Diehm and I appear on behalf of Dr Brennan with respect to the questions that I'm asking you this afternoon. If I could ask for the witness' statement to be up on the screen. Thank you. And if we could go to page 0004 – I'm sorry, if we can go to page 5.

25 Bear with me, please, Ms Callaghan. In light of your answers I may pass over parts of questions that I would've otherwise been going to ask you. And in that regard, I apologise, and I will ask to go to page 22. In subparagraph (c) there you will see a paragraph that commenced with respect to headspace as part of your answer?---Yes.

30 I just invite you to familiarise yourself again with your answer there. Having regard to what you've said to Ms Muir in your answers earlier this afternoon, do you consider that that observation needs some qualification?---Yes.

And is the qualification effectively this, that it may have been suitable – that is,
35 Headspace's services may have been suitable for some, at least, of the existing clients of BAC, depending firstly upon which particular Headspace service it was and what it had available to provide?---Yes.

Would a second qualification to the statement be that it would also depend upon the
40 particular individual patient and as to what that patient's needs were?---Yes.

And it may also depend, having regard to that individual patient and that patient's needs, upon what other services that patient was going to be accessing concurrently?---Yes.

45

One of the other matters that you've identified in that paragraph as being of some concern was that Headspace's service delivery you said was limited to a maximum of

10 sessions under the Better Access Scheme. But, in fact, what – the way you've described it there is that the majority of Headspace's service delivery is so limited?---The majority, yes.

5 Right. And by the Better Access Scheme, you're referring to the Medicare scheme - - -?---Yes.

- - - with respect to the payments that are able to be made for an individual patient under Medicare for such consultations?---Yes, I am.

10

Commissioner, could I ask that the document WIT.900.019.0001 be put on the screen. And if we can go, then, please to page 0132. Now, this is a paper that has been annexed to a statement by Professor McGorry, and it's a paper of which he was one of the authors, along with Ms Rickwood and Mr Telford and Ms Mazza and Ms

15 Parker and a Mr or Ms Tanti?---Mmm.

You're familiar with this particular paper?---Yes.

Those authors are persons known to you to be particularly familiar with the

20 Headspace service delivery?---Yes.

All right. And have you had occasion to read this paper recently?---Not recently.

All right. Can I ask you just – if we can just scroll down to the second paragraph in

25 the left-hand column that begins there with the "As the Headspace network has grown". If I can just invite you to read that to yourself. Are you content with the description there of the role of Headspace and, in particular, the role of Headspace within the broader suite of services offered to young people with mental illness - - -?---Yes.

30

- - - in our community? And, in particular, where it distinguishes – makes the distinction of Headspace to say that it is a non-stigmatising, inclusive, no wrong door approach?---Yes.

35 And that as opposed to other mental health services or some other mental health services, it is not highly targeted with clear exclusion criteria?---Yes, that's correct.

And on the strength of that, it's right to say that whilst Headspace has a particular interest in targeting early interventions, it does not confine itself to early intervention

40 cases?---That's correct.

Subject, of course, to what the services are available locally and – or through that particular Headspace facility, and what the needs of the patient are?---Yes.

45 If I can ask if we can go, then, to the second page, 133. And see a table there with respect to the number of Headspace service sessions attended, and so on, and we can

see that there is across the top columns that break down the service provision, relevantly here in the second column to mental health and behaviour?---Yes.

And if we follow that column down we can see, ultimately, that there's a breakdown
5 of percentages for number of sessions attended for the cohort of patients being surveyed there?---Yes.

If we go back to the previous page – I should've done this before, I'm sorry – under the heading of Methods there, we can see that the participants in this data collection
10 are over a 12 month period, somewhat conveniently touching upon the period we're dealing with here?---Yes.

Just speak your responses?---Yes.

15 Yes. Now, if we go back, then, to the table on the next page, we can see that the result of the data collection showed that in that 12 month period, 11.5 per cent of those who were attending for mental health and behaviour, in fact, had 10 or more sessions?---Yes.

20 Then if I can ask for the operator to take us to page 135, 0135. We again see another table there, and it's the second section in particular I'm interested in, so if we could scroll down a bit further, thank you. If at any stage you need to see other parts of that table, please say so. But there, under a heading of Main Funding Sources, by rank, for service type of mental health we see in the first column that MBS was the
25 source of funding for 57.4 per cent of the service cost that was involved?---Yes.

So that's the Medicare scheme, isn't it?---Yes.

So what goes with that is that 42.6 per cent of the cost of mental health service
30 provision by Headspace in that period of time the subject of the survey came from other sources?---Yes.

And, by rank, the next highest source of funding was Headspace itself?---Yes.

35 That is, presumably its recurrent grants and other fundraising sources that it had available to it?---It's Headspace national office funding grant, yes.

Yes. And then there's a further one, ATAPS, which is the - - -?---Access to allied psychological services.

40

Thank you. So, again, another government scheme - - -?---Yes.

- - - funded mental health care provision?---Yes.

45 So where you have identified in your statement the limitation that arises by virtue of the Medicare scheme, what I suggest to you is that what you are really alluding to is that the preference with respect to the provision of mental health services through

Headspace centres is to access the Medicare funding where that is possible to do - - -?---Yes.

- - - but that if there is a need for provision of mental health services through
5 Headspace centres that exceeds that or is outside the bounds of what can be provided for under the Medicare scheme, there is, indeed, a substantial range of funding available to cover those costs?---Not necessarily. I think it's worth, in my view, looking at this data. I think what is perhaps skewing some of this is in more regional, remote, rural areas, where there isn't an MBS workforce available, more services are
10 readily provided through the Headspace funds. That's not necessarily the case in – in a metro or larger regional areas where the expectation is that a Medicare workforce is available. So I'm just qualifying – I'm not sure that these figures, for example, where 29.5 per cent is provided by headspace – if we were to look at that for a breakdown of region whether we'd actually see that that – a large majority of that
15 29.5 per cent represents more rural regional areas rather than your metropolitan areas.

I'll come back to that in just a moment. But we know from the first table I took you to within this paper that there are a significant number of Headspace attendees –
20 young people in particular in the order of 11.5 per cent of the cohort who were accessing Headspace services at a higher frequency than covered by the Medicare scheme?---Yes.

So they must have been taking the benefit of funding from other sources?---Yes.
25
Back to your point that you just made, the implication of that is this, is it not, that whether funding by virtue of the limitations under the Medicare scheme is an issue that restricts the provision of services to an individual young person is again very much a question of the particular Headspace service that they are going to?---Yes, it
30 is.

Because some will have greater access to the MBS scheme than others?---Yes.

Some will have greater access to other funding sources than others?---Yes.
35
And it's going to be a very much individual response?---That's right.

Thank you. Can I as if we can be taken to page 0146 and, again, now, this is again an exhibit to the statement of Professor McGorry PDM7 – an article headed
40 Headspace Australia's Innovation in Youth Mental Health: Who are the Clients and Why are They Presenting. Are you familiar with this article?---Yes, I am.

Have you read it recently?---Not recently.

45 Thank you. Again, the authors are not all of the authors from the previous but most of them?---Yes.

I'll just see if we can deal with it a little more quickly given the nature of the evidence that you've already given. The effect of the survey that this article reflects, I suggest, is that Headspace does in fact deal with and provide assistance to young people with mental health conditions that are serious conditions?---In some
5 occasions, yes.

Yes. And that whilst the data that was collected for the purposes of this analysis showed that a-third of the clients who attended at Headspace for mental health reasons had not previously seen any mental health professional. The implication that
10 follows is that two-thirds of them had?---That seems like a reasonable view.

Alright. Now, that doesn't tell us anything about the individuals within those two-thirds as to whether they have been seeing often and for a long period of time or for only a short period of time?---Yes.

15

But it still tells us something of the mix with respect to patients when there is an interest in targeting early intervention - - -?---Yes.

- - - in that regard. The article tells us – if we can go to page 148 – and, yes, if we
20 can scroll down towards the bottom of the page, please. If we start on the paragraph that ends in the left-hand column we can see there some statistics about the stage of illness development across the different age groups. And that breaks up into percentages the extent of the condition by reference to whether or not, for instance, the condition was a serious and ongoing mental disorder up to the other end of the
25 spectrum where there was no mental disorder?---Yes.

That sort of analysis is consistent with your experience - - -?---Yes.

- - - about the mix of patients at headspace?---Yes.

30

And again tends to reflect the idea that you've spoken about in qualification of what appeared in your statement that, really, you've got to look at it on an individual patient basis and look at it in the context of the particular headspace service?---Yes.

35 Alright. Having regard to what you said to Ms Muir – I'm sorry, just before I finish that – I withdraw that. Having regard to what you said to Ms Muir, what the Commission can know is this, I suggest, that when those individual circumstances present themselves, that is, the particular profile of the – or the particular circumstances of the individual patient, the capability of the particular Headspace
40 centre that those circumstances combined with the capability are considered very carefully by a group of professionals perhaps of varying qualification before in fact the patient is accepted as a patient at a headspace centre?---Yes. And I would also add one of the other things you mentioned earlier about – in that question was also the other services that that young person was already accessing - - -

45

Quite so?--- - - - in the broader community is also considered - - -

Thank you?--- - - - prior to making a decision.

Yes. In his statement, Professor McGorry expressed this view – and I'm simply asking you as to whether or not it reflects your experience as well. He said:
5
> *Approximately one-third of patients that are receiving services through Headspace present with complex and severe mental health issues similar in complexion to the BAC cohort.*

10 ?---I think one-third is probably quite high. I think it's probably smaller than a – in my experience.

Yes?---It's probably smaller than a-third. I don't think 33 per cent of the clients coming to Headspace centres would – would fit criteria and are that severe and
15 complex in nature. I think it's probably lower than that and I think the figures quoted in the paper that they've reported around six per cent on that page that you referred to earlier with serious and ongoing mental disorders is probably closer to what I've experienced and seen and heard than 33 per cent.

20 Could I ask you to – if we can go to page 148 which we may already be on. I think we are, in fact. Do you see the column in the middle – the bottom column in the middle?---Of text.

Of text, sorry, yes?---Yes, yes.
25
Twenty-nine per cent it commences?---Yes.

Just read that - - -?---Sorry, twenty - - -

30 - - - to yourself?---Okay.

Now, that figure, I suggest, seems to combine some of the figures from the column to its left so, for instance, those – 18.8 per cent with the full threshold diagnosis, 3.5 per cent with periods of remission and 6.4 per cent with serious and ongoing mental
35 disorder. But that figure of itself tends to suggest that Professor McGorry's estimate may well be correct. Do you agree?---I think if it's you combine – my – my – my thinking around clients that were in Barrett Adolescent Centre was clients that more closely aligned with the stage of onset data that's reported there with stage of onset data being not just those who meet threshold for diagnosis but those that have
40 actually been through some significant period of treatment and that that treatment has been of not great effect, and actually that they still are, you know, experiencing ongoing mental health issues for an extended duration.

So that of itself makes some assumptions about the individual BAC patients within
45 the cohort of BAC patients, doesn't it, as to them all meeting those criteria?---Yes, that's correct.

And that assumption - - -?---That's my assumption.

It's not one that you can validate, is it?---No, that's just my understanding of – in terms of what would be – previously, what would have been an appropriate referral to Barrett Adolescent Centre. They would've been some of the criteria that I would've taken into consideration. My understanding is they needed to have been through other treatment modalities before – and that those modalities had been unsuccessful in producing positive outcomes before they would actually be seen as being appropriate for Barrett.

All right. So that is assuming something based upon what the patient would be like when admitted to Barrett - - -?---Yes.

- - - as opposed to what they might be like when they're being discharged?---Correct.

And you'd appreciate and expect that they may not be the same thing?---That's right.

Thank you. Just one final thing I wanted to ask you about. If we can go back to Ms Callaghan's statement, the HSP.900. Thank you. And if we can go then, please – I want to deal with your paragraph number 24, which commences at page 24. Now, the particular part that I'm interested in asking you about – you can come to the text of the answer in a moment, but in broad terms you were asked about advice that you gave to – or that it was thought and supposed that you had given to Dr Leanne Geppert about requesting all Queensland Headspace services to identify whether they had any ex-BAC patients referred to them at the time of the BAC closure. And you responded in the affirmative, that you had – or, in effect, in the affirmative that you had, in fact, been making inquiries, and you explain the context for that arising in circumstances after the time of learning of the deaths of three patients?---Yes.

Commissioner, I'm inclined to leave the further questions about that – I may as well not have started it, I appreciate, but I think I probably should not pursue that until we've closed the court.

COMMISSIONER WILSON: All right. Is there anything else in open court?

MR DIEHM: No, nothing more from me.

COMMISSIONER WILSON: All right. I know Ms Rosengren has a question. Does anyone else? Ms Rosengren, you've got the floor.

MS ROSENGREN: Thank you, Commissioner.

EXAMINATION BY MS ROSENGREN **[3.23 pm]**

MS ROSENGREN: Ms Callaghan, my name's Jennifer Rosengren and I appear for Dr Sadler, and I just want to address with you the ECRG meetings and the recommendation that was made to the effect that any tier 3 service – that the length of stay be for a period of approximately 12 months, and you gave that evidence
5 earlier, I think, in response to some questions by Counsel Assisting or Mr Fitzpatrick. And it was known by you at that time, wasn't it, that there had been some young people who had been patients at the Barrett Adolescent Centre whose lengths of stay had been in excess of that?---Yes, that's correct.

10 And I think you indicated helpfully in cross – in answer to some questions that one of those reasons – one of the reasons for that, as far as you understood it to be, was the complexity of the presenting symptoms for some of those young people?---Yes, and the – the need to take into consideration individual – while you have guidelines, there are some individual cases that may be exceptions to those.
15

That's right, and those patients who are at the more severe end of the spectrum, and that's why it's very difficult placing a time limitation on a facility in terms of lengths of stay, such as the Barrett Adolescent Centre?---Yes.

20 Were you also aware that there were – some other major contributing factors to the length of stay issues at the Barrett Adolescent Centre, that they were resourcing issues that were totally unrelated or anything that Dr Sadler and his staff had any control over?---I don't recall that – being advised of that.

25 What I'm referring to in particular is after the public announcement of the closure of the centre in November 2012, there were resourcing issues in terms of the permanency of the staff and the experience of the clinicians that were being provided for – or that were available to the centre. Were you aware that that was an issue?---Not at the time. I became aware of it after the fact, but not at the time I was
30 on the committee.

And were you also made aware at that time that one of the other issues that Dr Sadler and his staff were faced with from a length of time perspective, in terms of – I mean, he himself is obviously an advocate of the less time spent in these facilities the
35 better. There's no doubt about that. But the other challenge that confronted him and his staff was, at that stage, the lack of appropriate step down facilities for these young people to be transferred to?---Yes, and I believe I've noted that in some parts in my statement.

40 Thank you. I have no further questions.

COMMISSIONER WILSON: Very well. Now, I'm conscious of the time - - -

MS MUIR: Commissioner, could I seek – I have two questions.
45

COMMISSIONER WILSON: All right. This is in open court?

MS MUIR: Yes.

COMMISSIONER WILSON: This has gone a lot longer this afternoon than was anticipated. We should finish at 4, and we do need to have a break before then, but
5 ask the questions now.

MS MUIR: Thank you, Commissioner.

10 **EXAMINATION BY MS MUIR** **[3.26 pm]**

MS MUIR: Ms Callaghan, I just wanted to ask you how many child and adolescent psychiatrists does Headspace employ in Queensland?---I don't know offhand, but I
15 believe it's in – probably in exhibit – I think it's D of my statement, which refers to the staff breakdown at Headspace centres. Is it okay if I refer to my notes?

Yes, that's on page .0053?---So as indicated in exhibit D, at 2015, Quarter 4, there was only .55. That would indicate – I believe that that would indicate staff that are
20 employed through Headspace funding, not in relation to psychiatrists that were providing services under Medicare, under a private contract or contractual arrangement.

So how many psychiatrists are - - -?---Providing services through Medicare?

25

- - - providing services in Queensland?---I'm not sure I can, sorry.

And you can't say the locations?---I can't recall – and, again, I could probably give you some indication currently, but at the time I couldn't accurately recall back in
30 2013 how many private psychiatrists were operating at Headspace centres.

And if we can just go to .0022 of your statement. Now, correct me if I'm wrong. With respect to Headspace, you didn't think that any of the existing clients at the Barrett Centre would be appropriate for referral to Headspace: that was a view that
35 you held back in 2013?---That was my view back in 2013.

And you don't change that view?---I hold that view generally, but, again, I'm not probably aware of the detail in relation to the individuals and the clients that were in the Barrett Centre to be able to make a specific call on that. Generally, we don't
40 promote Headspace services for clients with severe and complex mental health issues. We promote Headspace for early intervention. That's an area we know we do well and we know we can deliver safely.

Thank you, Commissioner.

45

COMMISSIONER WILSON: All right. We'll take a break of just 10 minutes. So 20 to 4. Can I say when we come back, the courtroom will be closed and the live streaming off.

WITNESS STOOD DOWN

ADJOURNED **[3.29 pm]**

RESUMED **[3.39 pm]**

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WITNESS STOOD DOWN **[3.51 pm]**

COMMISSIONER WILSON: That concludes the proceeding for this afternoon. There's nothing else anyone wants to raise?

MS MUIR: No further witnesses and nothing - - -

COMMISSIONER WILSON: Very well.

MS MUIR: We can adjourn.

COMMISSIONER WILSON: Would you adjourn, please, until 9.30 tomorrow morning.

MATTER ADJOURNED at 3.51 pm UNTIL THURSDAY, 18 FEBRUARY 2016