In the matter of the *Commissions of Inquiry Act 1950*
Commissions of Inquiry Order (No.4) 2015
Barrett Adolescent Centre Commission of Inquiry

AFFIDAVIT

PETER JOHN BLATCH OAM of [redacted] Queensland, retiree states on oath:

Professional Background

1. From 1 January 2015 I have been retired from the position of Assistant Regional Director, School Performance, Special and Specific Purpose Schools within the Department of Education and Training as it was then known. I held that position from 2011 until 2014.

2. During my employment the "Department of Education" has had various titles under different governments. For the purpose of this affidavit I will simply refer to "the Department" to cover all of those different titles.

3. My academic qualifications are:

   (a) Diploma of Teaching, Primary and Secondary Schools - Mt Gravatt Teachers' College 1973;

   (b) Master of Educational Studies – University of Queensland 1979; and

   (c) Master of Educational Administration - University of Queensland 1988.

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On behalf of the State of Queensland

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4. I am a Life Member of the Queensland Association of Special Education Leaders and I have previously been a member of the Australian Association of Special Education from 1976 until 2001.

5. My only professional role between 2012 and 2014 was that of Assistant Regional Director, School Performance, Special and Specific Purpose Schools. In that role I was responsible for the supervision of 25 principals of special and specific purpose schools in the Brisbane Metropolitan Region, which included Barrett Adolescent Centre Special School ("School"). I was also responsible for delivering special education services across the 256 government schools in the Brisbane Metropolitan Region.

6. If a principal had a concern regarding any operational and professional matters at the school, I would provide them support as their line manager. I would supervise the principal and undertake their performance development plan with them annually. I would meet formally with each principal at least once each term as well as with the collective group of principals. I would also meet with the individual principals additionally as required to provide support. I was the Director-General's representative and was tasked with ensuring correct practices in schools. I had authority to commence disciplinary action against principals if required.

7. Within my role as Assistant Regional Director I was also responsible for the whole of State services for students with low incidence disabilities.

8. Towards the end of the time period when the School was located at Wacol, I would meet frequently with the principal and staff. The School at that time was located near to my home and I would drop in on the way to or from work and also would meet the principal off-site as required for a cup of coffee to provide support or supervision.

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The BAC School at Wacol

9. I have been aware of the School since its creation in the mid-1980s. Between 1984 and 2001 I was working in a small team within the Department's Central Office, in a role which was originally titled Coordinator of Education, Physically Handicapped Students and later titled Senior Education Officer (Operations). My role was to ensure that special schools were operating appropriately and for the transfer of the responsibility for services previously provided by the Endeavour Foundation to the Department. I was responsible to the Director of Special Education.

10. I was not involved in the establishment of the School, but I was aware of the development because of the size of our team and the fact that the school was unique. There was only one other agreement between the Department of Health and the Department of Education to provide a similar school model of operation. The other school was for young people with severe intellectual and multiple impairments. That school was the Woody Point Special School and I am aware that Department of Health provided clinical staff to support the medical needs of students enrolled at that school.

11. From the mid-1980s I understood that the School at Wacol was created to provide education programs for young people with what was then described as "psychiatric disturbances". As far as I am aware there was not much in the way of support services for that group at that time. I recall the school was established and designated a "special school" by the Minister for Education when it commenced.

12. In my role as Assistant Regional Director I was aware that the School at Wacol existed to provide support for adolescent patients of Queensland Health who were in residence or receiving psychiatric support and mental health treatment at the Barrett Adolescent Centre at Wacol. The school staff worked under the direction of the principal, in multi-

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disciplinary teams which included staff from the Barrett Adolescent Centre employed by Queensland Health.

13. In theory there was no limit to the number of students that the school could have, but in reality the number of students was limited by the number of inpatients and day patients at the Barrett Adolescent Centre.

14. The physical structure of the School at Wacol was such that it was located in part of a single building that also housed other health programs and was adjacent to the residential area for patients.

15. The School staffing structure included a principal and the fulltime equivalent of 5.3 teachers and 5 teacher's aides. The teachers and teacher aides undertook specific duties as negotiated with the principal to support the educational needs of the students enrolled at the School at any time.

16. The principal recruited staff according to the needs of the School. All teachers were required to teach the core subjects of Maths and English, but I cannot recall if they were trained in these specialist secondary areas. Many also had additional special education teacher training.

17. Under legislation, namely the *Education (General Provisions) Act 2006*, all students in special education must have an individual education or learning plan. The School had an overarching curriculum, but the individual students' plans were highly specialised based on the individual needs of each student. The principal, in consultation with parents, would set the individual learning plans for the students. Teachers would meet individually with the students and parents (where appropriate) to work through the learning plan.

18. When patients were of school age they were required to attend school.

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19. The School's reporting structure and relationship with the Department was the same as any other government school in Queensland. The Principal was the accountable officer with the Assistant Regional Director supervising the principal. The Assistant Regional Director reports to the Regional Director.

20. As with all government schools the funding came from the Department. This was allocated at the start of each year, after Day 8 of the school year, based on actual and anticipated enrolments. Staffing of teachers and teacher's aides at the School each year was consistently at around 5.3 teachers and 5 teacher's aides based on an average of 18 to 20 students being supported annually. As with all schools the principal had capacity at any time to request additional staff if student numbers increased or extenuating circumstances arose.

21. Whilst notional funding for most schools came through the Regional Office, the School was funded directly from the Central Office to the School. This was the process used for the five specific purpose schools - i.e. those schools which also included Milpera School for immigrants, the two hospital schools at the Mater Hospital and the Royal Brisbane Hospital, Tennyson Special School and the subject School.

22. I was formally aware of an issue raised by a social worker from Queensland Health about the principal in around August 2014. [redacted] This matter was raised by Dr Bill Kingswell during 2014 and was referred to the Department's Ethical Standards Unit (ESU). I was later told in an official capacity by Carmel Davis, Principal Adviser, Education Services, that the principal was cleared.

23. I was also formally made aware on 25 October 2013 by Sharon Kelly, one of the West Moreton Hospital and Health Services contacts, that Ms Justine Oxenham, a teacher from the School used her private email to contact the Minister for Health expressing

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her opinions regarding the closure of the Barrett Adolescent Centre. I referred this to Carmel Davis, Principal Adviser, Education Services, for referral to Ethical Standards Unit. I received a copy of the email referring the matter. I was later informed by Ms Davis that the matter had been dealt with.

24. I noted this concern expressed by Ms Kelly and reminded the principal to ensure that staff were reminded generally of their professional responsibilities especially regarding communications as government employees.

25. On at least four other occasions over a fifteen month period from November 2012, one of my contacts from the West Moreton Hospital and Health Service (either Sharon Kelly or Dr Leanne Geppart) contacted me informally regarding specific issues. Each time it was indicated that the contact was not an official complaint, but they wished to alert me to their perception that School staff were:

(a) becoming involved in issues at the Barrett Adolescent Centre which the QH officers did not consider to be part of their educational responsibilities. These included supporting parent advocacy meetings and later, meetings with community members and politicians. I discussed these issues after each contact with the principal and later the staff. Reminding staff that in their role they were only concerned about students' education became a theme.

(b) contacting parents regarding the pending closure of the Barrett Adolescent Centre. I advised Queensland Health contacts that our staff were in regular contact with parents as required as part of any school operation and especially in a special school where progress regarding individual plans is regularly reviewed. I also advised that I would remind staff of their professional duties, which I did.

(c) contacting the Queensland Teachers' Union who made visits to the Barrett Adolescent Centre. I advised Queensland Health that this was an accepted practice and regular occurrence in most schools especially given the circumstances. The School relocation was occurring concurrent to a number of local schools being closed.

(d) removing School property namely a School fence. That removal had occurred under the direction of the principal so that the fence could be relocated to the new Yeronga site for the School.

(e) stealing a fence from the Barrett Adolescent Centre. The principal was aware of the theft and had reported it to the police as well as providing video footage of the theft. The Principal advised me that the theft did not involve any School staff.

26. Prior to Nov 2012, I had only met annually with the Director of the Barrett Adolescent Centre, Dr Trevor Sadler. After Dr Sadler left I met with Dr Anne Brennan. They did not raise complaints or concerns with me.

Visits to the School

27. From 2011 until August 2013 I visited the School at least once every 10 weeks (that is once every school term) and also met independently with the principal at least once every ten weeks. From August 2013 following the announcement by Queensland Health to close the Barrett Adolescent Centre, I met with the principal and staff on a very regular basis according to need. I was also in regular contact with the principal or acting principal through other meetings we held that included other principals.

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28. I have reviewed my electronic diary as provided to me by the Department and noted that I made the following visits to the School at Wacol in 2012 and 2013 and Yeronga in 2014.

DATE	
2012	
8/03/2012	Assistant Regional Director Visit
21/05/2012	Assistant Regional Director Visit
18/09/2012	Assistant Regional Director Visit
8/11/2012	Quadrennial School Review with school community at Bundamba TAFE
12/11/2012	Assistant Regional Director Visit
11/12/2012	Assistant Regional Director Visit
2013	
18/03/2013	Assistant Regional Director Visit
14/05/2013	Assistant Regional Director Visit
2/08/2013	Assistant Regional Director Visit
6/08/2013	Assistant Regional Director Visit – Acting Assistant Regional Director (Wayne Wilkinson) and Human Resources Manager Visit (I was on annual leave until September)
6/09/2013	Assistant Regional Director Visit
8/10/2013	Assistant Regional Director Visit (I was absent on sick leave from 15.10 - 28.10 but was in touch with the Principal while I was ill via phone.)
1/11/2013	Assistant Regional Director Visit

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6/11/2013	Assistant Regional Director Visit (advised of closure)
12/11/2013	Assistant Regional Director Visit
26/11/2013	Assistant Regional Director Visit
3/12/2013	Assistant Regional Director & Principal (off site)
11/12/2013	Assistant Regional Director Visit
12/12/2013	Assistant Regional Director Visit
2014	
10/02/2014	Assistant Regional Director Visit
28/03/2014	Assistant Regional Director Visit
30/04/2014	Assistant Regional Director Visit
8/05/2014	Assistant Regional Director Visit
12/5/2014	Assistant Regional Director Visit
24/06/2914	Assistant Regional Director, Principal and Manager, Human Resources
23/07/2014	Assistant Regional Director Visit
24/07/2014	Regional Director, Assistant Regional Director and Principal with community reps at Regional Office
19/08/2014	Assistant Regional Director Visit
20/08/2014	Assistant Regional Director Visit
2/09/2014	Assistant Regional Director & Regional Director Mark Campling Visit
5/09/2014	Assistant Regional Director to introduce Acting Assistant Regional Director Jenny Hart while I was on leave

[redacted] [redacted]

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9/09/2014	Assistant Regional Director with Regional Director & Prof David Crompton from Queensland Health (Assistant Regional Director on leave 11.09.14 – 27.10.14)
Term 4	Ms Jenny Hart was Appointed Acting Assistant Regional Director while I was on leave from 11 September to 27 October 2014. Following my return she continued to assist in supporting transition of the mental health programs including the amalgamation of the two hospital schools and also the School at Yeronga, until the end of the 2014 school year.
29/10/2014	My Assistant Regional Director Visit
27/11/2014	My Assistant Regional Director Visit
3/12/2014	My Assistant Regional Director Visit

29. Prior to the announcement of the decision to close the School on 6 August 2013, in 2012 there was an announcement of the closure as part of a Commission of Inquiry and a subsequent ABC news report about that announcement. Shortly after that announcement, the principal of the School (Mr Kevin Rogers) took a leave of absence. He returned to his position for a short period before taking another leave of absence. The teachers of the school knew that he was unwell and were concerned. During informal meetings, I continued to reassure the staff as a group that the Department was educationally committed to seeing the students' progress through their schooling. I cannot recall any other concerns at the School prior to the announcement of the closure decision in August 2013.

30. Following the date of the announcement I became concerned regarding:

(a) the ability of the teaching staff to separate their educational programming issues from their general concern regarding the students' health. The staff expressed concerns to me that the decision would not ensure all students would get the mental health support that they would need. In response to these concerns I re-iterated to the School staff that they were to focus on providing the educational support and should raise any concerns that they had with respect to health issues with the clinical staff;

(b) the well-being of staff and students particularly as time progressed. The staff and students were expressing concerns about the clinical staff, with whom the students had built bonds, were being re-deployed. I commend the Acting Principal on the links established with the non-government organisations, Headspace and Optum (both recognised experts in this area and used by the Department), which provided additional support for the staff at the School;

(c) the continuity of educational programs for the students who were each on individualised programs. It was anticipated that at some point in time there would be a ratio of about 4 teachers to 6 students and staff had personal concerns about whether the educational program through the School would be sustainable;

(d) the viability of the educational program if the program was to be relocated to a geographical area that was not central to nor accessible by the students;

(e) the perceptions of parents and community members regarding the continuity of the educational program. In particular, there were concerns about how the Department would continue to fund the educational program at the School if there was only a small group of students. In reality this was not a matter for

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concern because there were similar funding arrangements for small groups of students in secondary school programs in small regional areas of Queensland;

(f) the venue of the school in the short term. There were about ten different options for the relocation of the School. The site at Yeronga was considered best in the short-term because of its location and the receptive attitude of the staff and community of Yeronga State High School, which was already located on the Yeronga campus belonging to the Department;

(g) the transition from the current to the new models of educational provision which would be established to support the new mental health service delivery plan which was announced during 2014; and

(h) the potential break down of trust between Queensland Health staff and School staff as evidenced by my comments in paragraph 25 above.

The Closure Decision (as defined in the Terms of Reference)

31. The School has never been closed. It was relocated from Wacol to a site at Yeronga and more recently to Tennyson.

32. On 8 November 2012 I was advised informally by Dr Sadler that the Barrett Adolescent Centre was likely to close. This likelihood was confirmed by Sharon Kelly, Executive Director, West Moreton Hospital and Health Service who contacted me by phone a few days later. I cannot recall the specific date on which Ms Kelly called, but I recall it was before 16 November 2012 based on email correspondence from Principal Kevin Rodgers of 16/ 11/2013 which references my earlier contact.

33. On 5 August 2013 I was phoned by either Sharon Kelly or Dr Lesley Geppart from West Moreton Hospital and Health Service who advised me that an announcement would be made the next day (6 August, 2013) that the Barrett Adolescent Centre would

be closed on a date that was still to be determined - but in the near future, and likely before the end of January 2014. The reason I was given for that decision was that The Park where the Barrett Adolescent Centre was located was to be used solely as facilities for forensic adult mental health care and treatment.

34. This meant that the Department would need to relocate the School for the start of the 2014 school year.

35. I was also told by Sharon Kelly or Lesley Geppart at that time that the Department could no longer use the name "Barrett Adolescent Centre Special School". I advised that this could not occur arbitrarily, as there were Departmental requirements to change the name or to close a school. The School had been gazetted with that name in 1985 by the Minister for Education, and that names of schools could not be changed without Ministerial approval after significant community consultation.

36. The reasons for the relocation of the School which I proposed in consultation with the Regional Director (Chris Rider) and Deputy Director-General (Patrea Walton) were:

(a) I was advised by officers from West Moreton Hospital and Health Service that the current School site at Wacol would not be available from the start of 2014;

(b) the educational needs of the students at the School had not changed and so the students still required an alternative highly individualised educational program;

(c) there were a number of students still to complete their formal senior schooling education and an alternative, separate school setting was necessary;

(d) by legislation, there is a defined process that must be followed to close any school which includes community consultation that requires at least six months duration;

(e) Departmental standards are that the programs for secondary aged students in their final years of schooling (as many of the School students were) should not be disrupted – meaning a timeline of up to two years could be required for students in Years 11 and 12; and

(f) the Minister for Education had announced earlier that week that, following an extensive consultation process, a number of schools would be closing and there would be no further school closures.

37. In early 2013, at the request of the Regional Director, I convened a small working group which developed options for possible relocation of the School. The relocation working group was intended to be a small but effective group which represented stakeholders and expert opinions. Membership of the relocation working group included:

(a) myself as the Assistant Regional Director (Special and Specific Purpose Schools);

(b) the acting principal of the School, Deborah Rankin;

(c) Michelle Bond, Principal, Royal Children's Special School and the Department's representative on the Expert Group established by Queensland Health regarding mental health provision,

(d) Judith Duncker, Regional Manager responsible for staffing; and

(e) Cliff Kuskopf, Regional Manager responsible for facilities.

[redacted]

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38. The purpose of the relocation working group was to consider all options available for relocating the School and to make a recommendation on the most suitable option. The factors that determined the most suitable option included:

(a) continuity of educational programs for the students, which was essential;

(b) minimum disruption to the education and well-being of students and staff; and

(c) proximity to the original Barrett Adolescent Centre location and travel and transport for students and staff.

39. The relocation working group considered a number of potential relocation sites including Coorparoo State High School, Sunnybank State High School, Everton Park State High School, Glenala State High School and Tennyson Special School and the Yeronga State High School.

40. Ultimately the Yeronga State High School was identified as the only suitable option for the relocation of the School for the 2014 school year. This was because Yeronga was an acceptable geographical location, had a separate area / building available which meant the School could operate independently from the Yeronga State High School and the location was in close proximity to the local mental health facility that was being utilised by some of the students of the School at the time. Yeronga was also in close proximity to the Lady Cilento Children's Hospital. The principal of the Yeronga State High School was also very accommodating and welcoming of the students of the School, which assisted greatly in the transition process.

41. In forming the recommendation to relocate the School to Yeronga, the relocation working group consulted with a number of relevant stakeholders including the School's education staff, parents of the School's students, the Queensland Teachers Union and clinical experts.

42. I met personally with the School principal and acting principal on a frequent basis and received email correspondence from education staff. I recall the education staff position was that Yeronga was the most suitable relocation option.

43. I organised a meeting with [redacted] who was consulted as the parents' representative and I recall meeting to discuss the Barrett Adolescent Centre closure and options being considered for relocating the School. [redacted] raised concerns with me regarding the mental health welfare of all students arising as a result of the closure of the Barrett Adolescent Centre. I explained to [redacted] that the role of the Department of Education was to provide education services and informed [redacted] of the efforts being made to relocate the School.

44. I also discussed the issue of relocating the School with the Queensland Teachers Union. I participated in bi-annual meetings with the Queensland Teachers Union and have records that I met with the Union on 4 November 2013, 13 December 2013, 25 July 2014, 18 August 2014 and 3 December 2014. A number of Queensland Public Schools were being closed during this period and I made it clear to the Teachers Union that the School was being relocated and was not going to be closed.

45. Other stakeholders with whom I met and sought feedback included the following:

(a) Queensland Association of Special Education Leaders Metropolitan Region (meetings on 12 September 2013, 14 November 2013 and 19 March 2014);

(b) Secondary School Principals in Metropolitan Region (meetings on 20 May 2013 and 19 November 2013); and

(c) Queensland Parents and Citizens' Association (meeting on 24 July 2014).

46. Documents considered by the relocation working group included:

(a) Departmental procedures including transition arrangements for secondary aged programs and departmental calendar of events;

(b) the School's Quadrennial Plan for 2013-2017;

(c) draft working documents relating to future models of service delivery for the Department of Education and Training regarding mental health provision being developed concurrently by working group; and

(d) reports and advice received from Queensland Health regarding other models of service.

47. Members of the relocation working group had also met with Dr Stephen Stathis to seek input regarding the future model of educational practices for mental health provision. Dr Stathis had travelled to Victoria and provided me with a copy of a presentation he had prepared regarding his research on the Victorian models. Expert opinions were also sought from other educators including members of the Metropolitan Region Mental Health Strategy Group and Queensland Association of Special Education Leaders.

48. The following reports were considered by the relocation working group:

(a) results of report from the expert group established by Queensland Health on mental health;

(b) current Departmental and wider education practices on mental health provisions in mainstream schools;

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(c) initiatives arising from the More Support for Students With Disabilities Project that was building teacher and staff capacity in mental health throughout Queensland; and

(d) proposed changes occurring from the amalgamation of the two childrens' hospitals.

49. The working group developed a draft document to assist identify and measure potential school sites against the selected criteria.

50. I personally advised staff at the School at a lunch staff meeting on 6 November 2013 that the School would be relocating to Yeronga for the start of 2014.

51. The reasons provided to the School staff regarding the relocation of the School are provided above at paragraph 36 of my affidavit.

52. There was a formal process in place for informing the School education staff of the relocation. I asked the principal to convene a meeting at a time she selected so I could advise as many staff as possible at once of the relocation. Staff were advised that:

(a) the School was relocating to grounds at the rear of Yeronga State High School for 2014 only, with the likelihood of again relocating to Tennyson Special School in 2015;

(b) the School would continue to operate as their own school;

(c) the location was for 12 months only due to the Yeronga State High School requiring the buildings for the new cohort of Year 7s who would be moving in 2015;

(d) discussions would occur confirming a site for 2015 based on other Departmental issues; and

(e) they would continue to be consulted.

53. I understand that acting principal, Deborah Rankin, contacted any staff member who was not present and informed them of the decision.

54. The School did not close. However, I was aware of concerns about the potential impact of the School closing, were it to occur. I raised these in discussions with the Deputy Director-General, Regional Director, officers from Queensland Health and also the Queensland Teachers Union in our meetings.

55. Those concerns raised related to students and education staff and included:

(a) meeting students' educational needs;

(b) inability to support these students in their local schools;

(c) returning students to situations where they had previously failed;

(d) suitability of distance education to meet the students' needs;

(e) capacity of some school communities to support students; and

(f) preparedness of current School staff to provide service to their students in a different model of service delivery.

56. The most significant concern raised by the education staff was their concern for the students' mental health with the closure of the Barrett Adolescent Centre. I provided advice to the education staff that they were teachers and not mental health experts and that if they held concerns, they should follow the procedures advised by West Moreton Hospital and Health Service, namely encourage the students to contact their mental health service providers or call '000'. I frequently reminded the education staff that they were to leave the mental health issues to the mental health experts.

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57. After the announcement of the closure of the Barrett Adolescent Centre, I became aware of student concerns through my communications with education staff. I was informed that students were concerned about the following:

(a) leaving their residential centre where they received their health and school support;

(b) the continuity of their educational program; and

(c) separation from fellow students with whom they had worked closely.

58. I discussed with the education staff the need to support each of the students and to share medical concerns with relevant staff at the West Moreton Hospital and Health Service. I also told staff they should reassure students that their educational programs would continue as they had in the past.

59. Education staff raised their own concerns regarding the closure of the Barrett Adolescent Centre. These concerns were raised with me on my visits to the School and included:

(a) the viability and continuity of the programs currently in operation at the School;

(b) their future employment with the Department of Education and Training;

(c) the new models of service delivery that needed to occur;

(d) the expertise available in other schools to support these students;

(e) the monitoring system used to ensure these and future students continued to receive an educational program;

(f) continuity of educational support across a much broader continuum of service provision (now the State rather than just one centre).

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60. In response to the above concerns, I reassured the education staff that they would be involved in assisting to shape future educational service options for these students and that their very specific expertise would be required, especially to skill other teachers and support staff and to develop new models of education which were responsive to Queensland Health's new service delivery model.

61. I also recall education staff expressed concern about:

(a) student welfare after school hours;

(b) the extent to which families could support their children; and

(c) the different methods of operating between education and other support agencies involved after the closure of the Barrett Adolescent Centre - teachers are required to demonstrate a duty of care issues for students, while some adult mental health care agencies regarded students who were 18 as adults and required that student to self-refer, when in the teachers opinion, they had no ability to do so.

62. I emphasised to the education staff that their expertise was in education and it was important that this remained the focus and that any concerns they or the students had regarding mental health issues needed to be referred to Queensland Health staff or the mental health providers to address. I also informed staff that it was important that students were encouraged to contact their mental health care provider or when unable to do so that emergency services be contacted by calling '000'.

63. The announcement of the closure of the Barrett Adolescent Centre on 6 August 2013 affected the morale of the education staff, particularly the principal Mr Kevin Rogers, who ended up taking extended sick leave.

64. There was no reduction in education staff numbers following the closure announcement. However, when one teaching position became vacant, I advised that it was not to be filled at that time without discussing the issue with me because of decreased enrolments. This was normal practice in all special schools at the time.

65. The operations of the School continued as usual following the closure announcement, until it was relocated to Yeronga in early 2014. All permanent teachers and teacher aides were guaranteed employment.

66. For 6 months in early 2014, as part of the transfer process and to help support the students, the School engaged the services of a psychiatric nurse who was a registered and endorsed mental health specialist. The nurse engaged by the Department of Education was a former member of the clinical staff at the Barrett Adolescent Centre. The nurse had a good working history and therapeutic relationship with the students, which was a significant factor in why he was the successful applicant.

Relocation of the School to Yeronga

67. At the request of the Regional Director in early 2013, I convened a small working group which developed options for the relocation of the School. The processes involved in the decision to relocate the School to Yeronga are fully set out in paragraph 37 to 49 of my affidavit. The recommendation of the relocation working group to relocate to Yeronga was presented to the Regional Director for discussion with the Deputy Director-General. The Regional Director ultimately made the decision to relocate the School to Yeronga. I communicated the decision to education staff during a meeting on 6 November 2013.

68. The information provided in paragraphs 37 to 49 of my affidavit explains the considerations, recommendations, stakeholder concerns, documents, expert advice

and reports that were taken into consideration when making the recommendation to relocate the School to Yeronga.

69. I was a member of the relocation working group that made the recommendation to relocate the School to Yeronga to the Regional Director.

70. The information provided in paragraph 14 of my affidavit explains why the School was relocated and not closed.

71. I did form the view that the Department of Education and Training was relocating the school to Yeronga because of political issues and gazettal requirements. There is a specific process that must be followed to close any school. That process included community consultation over a 6 month period. The School could not be closed without this process occurring. Further to the legislative requirements for closure, Departmental standards were such that the programs for secondary aged students in their final years of schooling, being years 11 and 12, should not be disrupted. There were a number of students in years 11 and 12 at the School at the time of the closure decision.

72. Furthermore, the Minister for Education had announced earlier that week that following an extensive consultation process, a number of schools would be closing and that there would be no other schools closed.

73. I cannot recall specifically to whom I expressed my views referred to in paragraphs 71 and 72 above.

74. The Yeronga site was chosen as the relocation site because it best suited the criteria the relocation working group had established. Each special needs school has its own needs. The Yeronga site was not specifically suited to a special needs school, however it was suitable for the School during the transition process.

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75. The School continued to operate as a separate school at the Yeronga site and continued to provide continuity of educational programs and support to the existing student population. No new students were enrolled.

76. The School encountered a number of operational issues at the Yeronga site including information technology and facility issues. Throughout the 2014 school year, education staff became concerned with the adequacy of mental health services provided to the students. I understood that as the students mental health services were no longer managed through the Barrett Adolescent Centre, each student had a private mental health care provider.

77. Education staff expressed concern to me that they believed the level of mental health care provided to the students was not adequate. I constantly reminded teachers that they were not mental health experts and that they should contact the students' parents, the patients' mental health care provider or encourage the student to contact their mental health professionals if they held concerns or to call triple zero. I am aware that on one occasion an education staff member attempted to contact a patient's private mental health care provider to report concerns. On that occasion the staff member was informed the private mental health care provider could not discuss the patient's care due to legal issues.

Transition arrangements

78. The principal of the School, supported by the School team, was responsible for the education transition of the students following the closure announcement.

79. Students needed to continue to achieve Individual Senior Schooling Plans as negotiated with parents and the students. The delivery of education services changed for a number of students as they were no longer inpatients at the Barrett Adolescent Centre. Transportation of students to the School at Yeronga became an issue as all

[redacted]

A J.P., C.Dec., Solicitor

the students using the onsite education programs would have to make their way to the School at Yeronga.

80. This was problematic for some students, especially during the earlier period of the transition to Yeronga. I understand the School principal would on occasion use the School's vehicle to pick up students from their residence. This was done in accordance with negotiations with the students, their parents and the School. These types of arrangements are not unusual for special schools.

81. Some students required assistance in attending off site education programs. For example, one student was undertaking a Certificate 3 in childcare. School education staff provided support to all students during the transition process. Transition plans were also completed for the students.

82. Transition arrangements were managed and administered by the School principal supported by the School education staff.

83. The education staff had total involvement in the education transition of the students.

84. Education Transition Plans were drafted and developed for each student and approved by the School principal. Additional support was also provided at that time by another experienced principal, Mrs Michelle Bond, Principal Royal Children's Hospital School who had also expertise in the area. I also provided assistance as the Assistant Regional Director. There was no change in curriculum or education planning content – the transition planning concentrated on social and emotional issues associated with the transfer.

85. [redacted]

[redacted]

Deponent

A J.P., C.Dec., Solicitor

[redacted] Both the principal and I reported these concerns back to staff at West Moreton Hospital and Health Service who assured us they had suitable contingencies in place and for teachers to advise the students to contact their mental health care providers or call '000'.

86. Another issue which contributed to this concern was the change in clinical staff following the first rumours that the Barrett Adolescent Centre was going to close in late 2012. In late 2012 and throughout 2013 the education staff expressed concerns to me that there were a lot of clinical staff at the Barrett Adolescent Centre leaving to accept other positions. The education staff expressed concern that there was a lack of continuity in the clinical staff attending to the students.

87. Each student's educational needs was reviewed frequently throughout the transition process with individual case conferences held frequently.

88. The School has always had an effective tracking system regarding past students and their transitions either back to a mainstream school or to other service providers. The School continued these services, as there is a requirement to report on past students through an annual pathways survey conducted by the Department of Education. The principal established these monitoring arrangements and reported on these from an educational perspective.

89. Additionally, a simple tracking tool was developed by the principal and myself to monitor student transitions. This was emailed by the principal to myself on a regular, and as needed, basis occurring approximately every fortnight. I held no concerns for the adequacy of education services provided to the students during the transition period and I continued to monitor the student transitions until I retired at the end of 2014.

Relocation to Tennyson

90. The School was relocated away from Yeronga because the Yeronga State High School required the space used by the School to accommodate the new Year 7 students who were joining Yeronga State High School in 2015. It was always agreed that the Yeronga site was only to be used for the 2014 school year.

91. The decision to relocate the School to the Tennyson site involved a similar process to that used to identify the Yeronga site. I was a member of a second working party, which identified Tennyson as a suitable site. That recommendation was made to the Regional Director and following a discussion with the Deputy Director General, the Regional Director made the decision to relocate the school to Tennyson. I cannot recall how this decision was communicated as it occurred while I was on annual leave.

92. The second working group had been established to develop a position paper in response to the model of mental health service provision developed by Queensland Health.

93. Membership of the second working group included:

(a) myself as the Assistant Regional Director (Special and Specific Purpose Schools);

(b) Mrs Debbie Rankin, Acting Principal of the School;

(c) Michelle Bond, Principal, Royal Children's Special School and the Department of Education and Training representative on the expert group established by Queensland Health regarding mental health provision;

(d) Mrs Susan Christensen, Principal, Mater Hospital Special School;

(e) Ms Susan Fleming, Principal, Tennyson Special School; and

[redacted] [redacted]

Deponent A J.P., C.Dec., Solicitor

(f) Brian Day, Senior Guidance officer with expertise in mental health.

94. Considerations of the working group included:

(a) the decreasing number of students enrolled at the School – there was only expected to be two students;

(b) continuity of their educational programs, which was essential;

(c) minimum disruption to the education and well-being of students and staff;

(d) access to independent transport for students

(e) proximity to other service providers;

(f) the fact that there were no students expected to be enrolled at Tennyson Special School due to a change in departmental provision for behaviour support services – in the previous year the Tennyson Special School still had primary school aged students; and

(g) proximity to the new Lady Cilento Children's Hospital school and to support staff who may be working across both campuses.

95. The following matters were considered by the relocation working group:

(a) results of the report from the expert group established by Queensland Health on mental health;

(b) education expertise on provision of mental health from literature;

(c) current departmental and wider education practices on mental health provisions in mainstream schools;

[redacted] [redacted]

Deponent A J.P., C.Dec., Solicitor

(d) changes to the departmental practices of providing special services funds to schools which would mean Tennyson Special School would be unlikely to have student enrolments in 2015;

(e) initiatives arising from the More Support for Students With Disabilities Project that was building teacher and staff capacity in mental health throughout the State in 2014 and 2015; and

(f) proposed changes occurring from the amalgamation of the two childrens' hospitals.

96. In forming the recommendation to relocate the School to Tennyson, the relocation working group consulted with a number of relevant stakeholders including the School's education staff, parents of the School's students, the Queensland Teachers Union and clinical experts.

97. Other stakeholders with whom I met and sought feedback included the following:

(a) Queensland Teachers Union including 18.08.14. Assistant Director-General Bevan Brennan attended also;

(b) Queensland Association of Special Education Leaders Metropolitan Region; on 19.03.14 and 5 09.14 and 12.11.14 and

(c) Secondary School Principals in Metropolitan Region including 20.05.14.

98. Documents considered by the second working group included:

(a) Departmental procedures;

(b) the School's Quadrennial Plan for 2013-2017;

(c) draft working documents relating to future models of service delivery for the Department of Education and Training regarding mental health provision being developed concurrently by working group; and

(d) reports and advice received from Queensland Health regarding other models of service.

99. The second relocation working group also sought expert advice by way of comments from other educators, including members of the Metropolitan Region Mental Health Strategy Group and principals of special schools including through Queensland Association of Special Education Leaders Metropolitan Region and the Secondary School Principals Association.

100. As a member of the second Working Group, I made the recommendation to the Regional Director that the School be relocated to Tennyson.

101. The second working group also considered a model of education that might be delivered in conjunction with the multi-tiered model of health care being developed by Queensland Health. On that issue, the second working group formulated a recommendation that the resources for the School, the Tennyson Special School and the hospital schools at the Mater and the Royal Brisbane hospitals be combined and allocated to the Lady Cilento hospital school, of which Michelle Bond would be principal. Michelle would then oversee the provision of a new model of education that would work with Queensland Health's model of care. This recommendation was also yet to undergo public consultation. .

102. The recommendation was approved by the Minister in August 2014 but was not presented to Cabinet before the new government was elected in 2015.

103. As I am now retired, I am not aware of any future plans for the School at Tennyson.

104. I am not aware of any intention to utilise the current model of the School on a long term basis.

105. As I am not a health care specialist, I am not aware if the School in its current form is still suited to treating adolescents with complex mental health needs.

106. I am not aware of any alternative service models that may be better suited to treating adolescents with complex mental health needs.

All the facts sworn to in this affidavit are true to my knowledge and belief except as stated otherwise.

[redacted]

Sworn by PETER JOHN BLATCH on 22 November 2015 at Brisbane in the presence of:

[redacted]

[redacted]

A Justice of the Peace, C.Dec., Solicitor

Deponent A J.P., C.Dec., Solicitor

In the matter of the *Commissions of Inquiry Act 1950*

Commissions of Inquiry Order (No.4) 2015

Barrett Adolescent Centre Commission of Inquiry

AFFIDAVIT

PETER JOHN BLATCH OAM of [redacted] Queensland, retiree states on oath:

1. I refer to my substantive affidavit provided in this Commission of Inquiry, sworn earlier today.

2. On two occasions in that affidavit, I refer to documents, which are now provided to me and are **Exhibits A** and **B** to this affidavit. The documents are as follows:-

Paragraph Number	Document
46(c)	*Draft Discussion – In Confidence, Educational Service Provision for Adolescent Students with Significant Mental Health Needs*

[redacted] [redacted]

Deponent A J.P., C.Dec., Solicitor

AFFIDAVIT

On behalf of the State of Queensland

Crown Solicitor
11th Floor, State Law Building
50 Ann Street
BRISBANE QLD 4000

[redacted]

48(a)	*West Moreton Hospital and Health Service – Expert Clinical Reference Group Recommendations, Barrett Adolescent Strategy*

All the facts sworn to in this affidavit are true to my knowledge and belief except as stated otherwise.

20 November 2015

Sworn by Peter John Blatch on at Brisbane)
Brisbane in the presence of:)
)
)

[redacted]

[redacted]

A Justice of the Peace, C.Dec., Solicitor

In the matter of the *Commissions of Inquiry Act 1950*

Commissions of Inquiry Order (No.4) 2015

Barrett Adolescent Centre Commission of Inquiry

EXHIBITS

Exhibit A and B the Affidavit of PETER JOHN BLATCH sworn on 20 November 2015

[redacted] [redacted]

Deponent A J.P., C.Dec., Solicitor

In the matter of the *Commissions of Inquiry Act 1950*

Commissions of Inquiry Order (No.4) 2015

Barrett Adolescent Centre Commission of Inquiry

Exhibit No	Exhibit description	Page numbers
A	*Draft Discussion – In Confidence, Educational Service Provision for Adolescent Students with Significant Mental Health Needs*	5 – 8
B	*West Moreton Hospital and Health Service – Expert Clinical Reference Group Recommendations, Barrett Adolescent Strategy*	9 - 15

EXHIBIT 25

DET.900.002.0036

DRAFT DISCUSSION – IN CONFIDENCE

EDUCATIONAL SERVICE PROVISION FOR ADOLESCENT STUDENTS WITH SIGNIFICANT MENTAL HEALTH NEEDS

(in response to a Proposed Statewide Adolescent Mental Health Extended Treatment and Rehabilitation Service Continuum provided by Queensland Health)

Service Element	Assertive Mobile Youth Outreach Service	Day Program	Step Up / Step Down Unit	Subacute Bed-Based Unit	Residential Rehabilitation
Overview	Provides ongoing recovery-oriented assessment, assertive treatment and care through intensive mobile interventions in a community or residential setting.	Provides a flexible range of intensive therapy, extended treatment and rehabilitation options within a therapeutic milieu.	Provides short-term treatment with services from specialist trained mental health staff and NGO staff.	Provides medium-term intensive hospital-based treatment and rehabilitation services in a secure, safe, structured environment.	Provides longer term accommodation and recovery oriented treatment with inreach services from specialist trained mental health staff with NGO support.
Primary referral	CYMHS	CYMHS	CYMHS / Acute Inpatient Unit	Statewide Admission Panel	CYMHS or Adult Mental Health Services
Length of stay	Case-by-case basis	120 days; max 180 days	28 days	120 days; max 180 days	Up to 365 days
Unit Size	Minimum 2 staff per AMYOS team	10-15 adolescents per day	12-14 beds	4 beds; seclusion room	10 beds
Existing in Qld	Nil	Mater, Toowoomba, Townsville	Nil	Nil	Nil
Proposed sites with implementation over 4 years	North Brisbane, Logan, Redcliffe-Caboolture, Toowoomba, Bundaberg/Wide Bay, Central West Qld, South Brisbane, South West Qld, Cairns, Rockhampton, Gold Coast, Ipswich, Sunshine Coast, Townsville, Mt Isa, Mackay	North Brisbane (critical- Stafford) South Brisbane (Logan) Gold Coast. In future likely to start in suburbs not be hospitals.	North Brisbane South Brisbane North Qld (Dependent upon NGO sector appetite, provider agnostic)	1 BBU in CHC catchment. Not likely until 2016, dependent on additional funds from Cabinet.	Cluster based (north/ Central /Southern) (Dependent upon NGO sector appetite, provider agnostic) Likely to open shortly at Greenslopes.
Education Options (Qld)	Support local schooling	Inreach; Onsite; Distance Ed and/or local schooling	Inreach; Onsite; Distance Ed and/or local schooling	Onsite and or Distance Ed	Support local schooling
Implications for Educational provision	Student will need a negotiated education plan. Need contact with each student's school with reference to school nurse and Youth Support worker. Contact through school based staff Specialist Guidance support as required. Case manager nominated at school and a negotiated education plan is developed, implemented and periodically reviewed if mental health issues are impacting on student engagement in education.	Student will need a negotiated education plan. Overall responsibility is to support these students up to one semester through their home school. Specialist regional teachers known as Support Teachers, Mental Health (STMH) support these students to link with their enrolled school wherever possible. There may be a need to arrange flexible learning programs with each student's enrolled school, Statewide School for Mental Health SSMH (to be created) or another similar local school and using SDE, NGOs, TAFE etc. School personnel and clinical care providers work with student to collaboratively develop transition plan into educational setting. Follow up occurs to ensure student engages in education.	Student will need a negotiated education plan. As student may be up to 4 weeks living away from their home and school, when Health request, specialist regional teachers (STMH) support these students with an negotiated education plan developed in consultation with each student's school or the SSMH (Statewide School for Mental Health to be created) The STMH maintains contact with student's school and arranges suitable transition plan. School personnel and clinical care providers work with student to collaboratively develop transition plan into educational setting. Follow up occurs to ensure student engages in education. (This is similar to enrolments now of students at a hospital school.)	Student will need a negotiated education plan. As student is away from home and school for up to six months, the STMH will support through designing and delivering the negotiated education plan developed in consultation with each student's school. This could include: • Enrolment at the SSMH (to be created Statewide School for Mental Health) • direct teaching at the centre • accessing another similar school • using SDE, • Or NGOs, RTOs, TAFE etc. School personnel and clinical care providers work with student to collaboratively develop transition plan into educational setting. Follow up occurs to ensure student engages in education.	Students aged to 18 years, will need a negotiated education plan. As the student is away from home and school for up to six months, the STMH will support through designing and delivering the negotiated education plan developed in consultation with each student's school. This could include: • Enrolment at the SSMH (to be created Statewide School for Mental Health) • direct teaching at the centre • accessing another similar school • or using SDE, • Or NGOs, RTOs, TAFE etc. School personnel and clinical care providers work with student to collaboratively develop transition plan into educational setting. Follow up occurs to ensure student engages in education.

EXHIBIT 25

DET.900.002.0037

DRAFT DISCUSSION – IN CONFIDENCE

EDUCATIONAL SERVICE PROVISION FOR ADOLESCENT STUDENTS WITH SIGNIFICANT MENTAL HEALTH NEEDS

(In response to a Proposed Statewide Adolescent Mental Health Extended Treatment and Rehabilitation Service Continuum provided by Queensland Health)

Service Element	Outreach Service	Day Program	Step Up / Step Down Unit	Statewide Rehabilitation Unit	Residential Rehab Unit
Overview	Provides ongoing recovery-oriented assessment, assertive treatment and care through intensive mobile interventions in a community or residential setting.	Provides a flexible range of intensive therapy, extended treatment and rehabilitation options within a therapeutic milieu.	Provides short-term treatment with services from specialist trained mental health staff and NGO staff.	Provides medium-term intensive hospital-based treatment and rehabilitation services in a secure, safe, structured environment.	Provides longer term accommodation and recovery oriented treatment with inreach services from specialist trained mental health staff with NGO support.
Referral Pathway	CYMHS	CYMHS	CYMHS / Acute inpatient Unit	Statewide Admission Panel	CYMHS or Adult Mental Health Services
Length of Stay	Case-by-case basis	120 days; max 180 days	28 days	120 days; max 180 days	Up to 365 days
Unit Size	Minimum 2 staff per AMYOS team	10-15 adolescents per day	12-14 beds	4 beds; seclusion room	10 beds
Current Statewide	Nil	Mater, Toowoomba, Townsville	Nil	Nil	Nil
Proposed statewide implementation over 4 years	North Brisbane, Logan, Redcliffe-Caboolture, Toowoomba, Bundaberg/Wide Bay, Central West Qld, South Brisbane, South West Qld, Cairns, Rockhampton, Gold Coast, Ipswich, Sunshine Coast, Townsville, Mt Isa, Mackay	North Brisbane (critical- Stafford) South Brisbane (Logan) Gold Coast. In future likely to start in suburbs not be hospitals.	North Brisbane South Brisbane North Qld (Dependent upon NGO sector appetite, provider agnostic)	1 BBU in CHC catchment. Not likely until 2016, dependent on additional funds from Cabinet.	Cluster based (north/ Central /Southern) (Dependent upon NGO sector appetite, provider agnostic) Likely to open shortly at Greenslopes.
Education Options (QH)	Support local schooling	Inreach; Onsite; Distance Ed and/or local schooling	Inreach; Onsite; Distance Ed and/or local schooling	Onsite and or Distance Ed	Support local schooling
Implications for Educational provision	Student will need a negotiated education plan. Need contact with each student's school with reference to school nurse and Youth Support worker. Contact through school based staff Specialist Guidance support as required. Case manager nominated at school and a negotiated education plan is developed, implemented and periodically reviewed if mental health issues are impacting on student engagement in education.	Student will need a negotiated education plan. Overall responsibility is to support these students up to one semester through their home school. Specialist regional teachers known as Support Teachers, Mental Health (STMH) support these students to link with their enrolled school wherever possible. There may be a need to arrange flexible learning programs with each student's enrolled school, Statewide School for Mental Health SSMH (to be created) or another similar local school and using SDE, NGOs, TAFE etc. School personnel and clinical care providers work with student to collaboratively develop transition plan into educational setting. Follow up occurs to ensure student engages in education.	Student will need a negotiated education plan. As student may be up to 4 weeks living away from their home and school, when Health request, specialist regional teachers (STMH) support these students with an negotiated education plan developed in consultation with each student's school or the SSMH (Statewide School for Mental Health to be created) The STMH maintains contact with student's school and arranges suitable transition plan. School personnel and clinical care providers work with student to collaboratively develop transition plan into educational setting. Follow up occurs to ensure student engages in education. (This is similar to enrolments now of students at a hospital school.)	Student will need a negotiated education plan. As student is away from home and school for up to six months, the STMH will support through designing and delivering the negotiated education plan developed in consultation with each student's school. This could include: • Enrolment at the SSMH (to be created Statewide School for Mental Health) • direct teaching at the centre • accessing another similar school • using SDE, • Or NGOs, RTOs, TAFE etc. School personnel and clinical care providers work with student to collaboratively develop transition plan into educational setting. Follow up occurs to ensure student engages in education.	Students aged to 18 years, will need a negotiated education plan. As the student is away from home and school for up to six months, the STMH will support through designing and delivering the negotiated education plan developed in consultation with each student's school. This could include: • Enrolment at the SSMH (to be created Statewide School for Mental Health) • direct teaching at the centre • accessing another similar school • or using SDE, • Or NGOs, RTOs, TAFE etc. School personnel and clinical care providers work with student to collaboratively develop transition plan into educational setting. Follow up occurs to ensure student engages in education.

EXHIBIT 25

DET.900.002.0038

DRAFT DISCUSSION – IN CONFIDENCE

EDUCATIONAL SERVICE PROVISION FOR ADOLESCENT STUDENTS WITH SIGNIFICANT MENTAL HEALTH NEEDS

(In response to a Proposed Statewide Adolescent Mental Health Extended Treatment and Rehabilitation Service Continuum provided by Queensland Health)

TIER 1: Local CHYS and e-CHYMS.

Service Element	Assertive Mobile Youth Outreach Service	Day Program	Step Up / Step Down Unit	Residential Rehab Unit	Subacute Bed-Based Unit
Tier	Tier 2A	Tier 2A	Tier 2B	Tier 2B	Tier 3
Overview	Provides ongoing recovery-oriented assessment, assertive treatment and care through intensive mobile interventions in a community or residential setting.	Provides a flexible range of intensive therapy, extended treatment and rehabilitation options within a therapeutic milieu Regional based including training YP does not require acute inpatient service. History of school exclusion and refusal, social difficulties, requiring group based work. Have supportive home environment. Live within proximity of day program	Provides short-term treatment with services from specialist trained mental health staff and NGO staff. YP does not require acute inpatient service.	Provides longer term accommodation and recovery oriented treatment with inreach services from specialist trained mental health staff with NGO support For YP who don't require inpatient care, able to consent to treatment and unable to return home.	Provides medium-term intensive hospital-based treatment and rehabilitation services in a secure, safe, structured environment. YP needs to be actively engaged in Mental Health services to be referred.
Primary Referral	CYMHS	CYMHS	CYMHS / Acute Inpatient Unit	CYMHS or Adult Mental Health Services	Statewide Admission Panel
Research model	AMYOS, Victoria		Y Path Vic.		
Length of stay	Case-by-case basis	120 days; max 180 days	28 days	3-6 months	120 days; max 180 days
Unit Size	2 staff per team, up to 6 teams	10-15 adolescents per day	12-14 beds	5- 10 beds	4 beds; seclusion room
Ages	13 -18 years	13 -18 years	13 -18 years	16- 21 years	
Existing in Qld	Nil	Mater, Toowoomba, Townsville	Nil	Nil	Nil
Proposed sites with implementation over 4 years	North Brisbane, Logan, Redcliffe-Caboolture, Toowoomba, Bundaberg /Wide Bay, Central West Qld, South Brisbane, South West Qld, Cairns, Rockhampton, Gold Coast, Ipswich, Sunshine Coast, Townsville, Mt Isa, Mackay	North Brisbane (critical- Stafford) South Brisbane (Logan) Gold Coast. Therapy provided at Day Program. In future likely to start in suburbs not solely in hospitals.	Take time to develop. North Brisbane, South Brisbane, North Qld. NGO run and operationally in partnership with Health staff contributing. Not likely in short term.	Cluster based (north/ Central /Southern (Dependent upon NGO sector appetite) 5 bed unit opened at Greenslopes, operated by the NGO, After-care. Mental Health Clinicians attached to unit support YW. YP to access outside supports. CYMH, TAFE, group and family work	1 BBU in CHC catchment. : Lady Cilento Hospital?? Not likely until 2016, dependent on additional funds from Cabinet.
Education Options (QH)	Support local schooling	Inreach; Onsite; Distance Ed and/or local schooling	Inreach; Onsite; Distance Ed and/or local schooling	Support local schooling	Onsite and or Distance Ed
Implications DETE educational provision	Student will need a negotiated education plan. Need contact with each student's school with reference to school nurse and Youth Support worker. Contact through school based staff Specialist Guidance support as required. Case manager nominated at school and a negotiated education plan is developed, implemented and periodically reviewed if mental health issues are impacting on student engagement in education. Educational model needs to still respond to younger students with MH issues not accessing CHYMS	Student will need a negotiated education plan. Overall responsibility is to support these students up to one semester through their home school. Specialist regional teachers known as Support Teachers, Mental Health (STMH) support these students to link with their enrolled school wherever possible. There may be a need to arrange flexible learning programs with each student's enrolled school, Statewide School for Mental Health SSMH (to be created) or another similar local school and using SDE, NGOs, TAFE etc. School personnel and clinical care providers work with student to collaboratively develop transition plan into or returning to educational setting. Follow up occurs to ensure student engages in education.	Student will need a negotiated education plan. As student may be up to 4 weeks living away from their home and school, when Health request, specialist regional teachers (STMH) support these students with a negotiated education plan developed in consultation with each student's school or the SSMH (Statewide School for Mental Health to be created). School personnel and clinical care providers work with student to collaboratively develop transition plan into or returning to the educational setting. Follow up occurs to ensure student engages in education. (This is similar to enrolments now of students at a hospital school.)	Students aged to 18 years, will need a negotiated education plan. The student wherever possible attends their previous school. The STMH will support through liaison with each student's school. This could include: • Continued enrolment at school • Enrolment at SSMH • direct teaching at the centre • accessing another similar school • using SDE, • Or NGOs, RTOs, TAFE etc. School personnel and clinical care providers work with student to collaboratively develop transition plan into educational setting. Follow up occurs to ensure student engages in education.	Student will need a negotiated education plan. As student is away from home and school for up to six months, the STMH will support through designing and delivering the negotiated education plan developed in consultation with each student's school. This could include: • Enrolment at the SSMH • direct teaching at the centre • accessing another similar school • using SDE, • Or NGOs, RTOs, TAFE etc. School personnel and clinical care providers work with student to collaboratively develop transition plan into educational setting. Follow up occurs to ensure student engages in education.

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EXHIBIT 25

DET.900.002.0039

Additional Information

- Will be a phased approach dependent on funding and availability of skilled workforce.
- Will be based within the local mental health infrastructure. YP must be involved in the community CYMH program to access tiers.
- Demand has increased 4 fold for primary MH care of the last 4 years
- 75% of population live in the SE corner
- Psychiatrist will be based with E CYMH to support local workers with video conferencing

EXHIBIT 25

DET.900.002.0040

West Moreton Hospital and Health Service

'B'

Expert Clinical Reference Group Recommendations

Barrett Adolescent Strategy

July 2013

Queensland Government

Adolescent Extended Treatment and Rehabilitation Services (AETRS) Recommendations Submitted to the West Moreton Hospital and Health Board

1. Broader consultation and formal planning processes are essential in guiding the next steps required for service development, acknowledging that services need to align with the National Mental Health Service Planning Framework

ECRG Recommendations	Planning Group Recommendations
a) Further work will be required at a statewide level to translate these concepts into a model of service and to develop implementation and funding plans.	**Accept with the following considerations.** The responsibility for this task at a statewide level sits with the Mental Health Alcohol and Other Drugs Branch and the Children's Health Services. A collaborative partnership is proposed.
b) Formal planning including consultation with stakeholder groups will be required.	**Accept with the following considerations.** This body of work should be incorporated into the statewide planning and implementation process (as above).

2. Inpatient extended treatment and rehabilitation care (Tier 3) is an essential service component

ECRG Recommendation	Planning Group Recommendation
a) A Tier 3 service should be prioritised to provide extended treatment and rehabilitation for adolescents with severe and persistent mental illness.	**Accept with the following considerations.** Further work is needed to detail the service model for a Tier 3. Models involving a statewide, clinical bed-based service (such as the Barrett Adolescent Centre) are not considered contemporary within the National Mental Health Service Planning Framework *(in draft)*. However, there are alternative bed-based models involving clinical and non-clinical service components (e.g., Y-PARC in Victoria) that can be developed in

ECRG Recommendation	Planning Group Recommendation
	Queensland to meet the requirement of this recommendation. Contestability reforms in Queensland may allow for this service component to be provider agnostic.

3. Interim service provision if BAC closes and Tier 3 is not available is associated with risk

ECRG Recommendations	Planning Group Recommendations
a) Safe, high quality service provision for adolescents requiring extended treatment and rehabilitation requires a Tier 3 service alternative to be available in a timely manner if BAC is closed.	**Accept.**
b) Interim service provision for current and 'wait list' consumers of BAC while Tier 3 service options are established must prioritise the needs of each of these individuals and their families/carers. 'Wrap-around care' for each individual will be essential.	**Accept with the following considerations.** While this may be a complex process for some consumers and their individual needs, it was noted that this course of action could start immediately, and that it was feasible. The potential to utilise current BAC operational funds (temporarily) to 'wrap-around' each consumer's return to their local community was noted as a significant benefit. The relevant local community should play a lead role in the discharge of the consumer from BAC and their return to home. The local services need to be consulted around their ability to provide 'wrap-around' care.
c) BAC staff (clinical and educational) must receive individual care and case management if BAC closes, and their specialist skill and knowledge must be recognised and maintained.	**Accept.** The ECRG and the Planning Group strongly supported this recommendation.

4. Duration of treatment

ECRG Recommendation	Planning Group Recommendation
a) 'Up to 12 months' has been identified by the ECRG as a reasonable duration of treatment, but it was noted that this depends on the availability of effective step-down services and a suitable community residence for the young person. It is important to note that like all mental health service provision, there will be a range in the duration of admission.	**Accept with the following considerations.** This issue requires further deliberation within the statewide planning process. The duration of treatment needs some parameters to be set, however, this is primarily a clinical issue that is considered on a case-by-case basis by the treating team and the consumer.

5. Education resource essential: on-site school for Tiers 2 and 3

ECRG Recommendations	Planning Group Recommendations
a) Access to on-site schooling (including suitably qualified educators), is considered essential for Tiers 2 (day programs) and 3. It is the position of the ECRG that a Band 7 Specific Purpose School (provided by Department of Education, Training and Employment) is required for a Tier 3 service.	**Accept with the following considerations.** The Planning Group recommends removing *"Band 7"* from the ECRG recommendation. All educational services need to be evaluated by Department of Education, Training and Employment (DETE) on a case-by-case basis, taking into consideration service model, location, student numbers and complexity. The Planning Group supports the statement that educational resources are essential to adolescent extended treatment and rehabilitation services. The Planning Group recommends consultation with DETE once a statewide model is finalised.

ECRG Recommendations	Planning Group Recommendations
b) As an aside, consideration should also be given to the establishment of a multi-site, statewide education service for children/adolescents in acute units (hub and spoke model).	**Accept with the following consideration.** The Planning Group recommends this statement should be changed to read as: Strong consideration should be given to the establishment of a multi-site, statewide education service for children/adolescents in acute units (hub and spoke model).

5. Residential Service: Important for governance to be with CYMHS; capacity and capability requires further consideration

ECRG Recommendations	Planning Group Recommendations
a) It is considered vital that further consultation and planning is conducted on the best service model for adolescent non-government/private residential and therapeutic services in community mental health. A pilot site is essential.	**Accept with the following consideration.** Note that this service could be provider agnostic.
b) Governance should remain with the local CYMHS or treating mental health team.	**Accept.**
c) It is essential that residential services are staffed adequately and that they have clear service and consumer outcome targets.	**Accept.**

13

7. Equitable access to AETRS for all adolescents and families is high priority; need to enhance service provision in North Queensland (and regional areas)

ECRG Recommendations	Planning Group Recommendations
a) Local service provision to North Queensland should be addressed immediately by ensuring a full range of CYMHS services are available in Townsville, including a residential community-based service.	Accept.
b) If a decision is made to close BAC, this should not be finalised before the range of service options in Townsville are opened and available to consumers and their families/carers.	Accept.

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