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

AFFIDAVIT

Judi Krause of 199 Grey Street, South Brisbane in the State of Queensland, Divisional Director, states on oath:

On 24 January 2016 I was provided with a Requirement to Give Further Information in a Second Supplementary Written Statement.

On 28 January 2016 I was provided with a Requirement to Attend to Give Information and Answer Questions. I attended at the Commission on 29 January 2016.

Subsequent to this meeting on 29 January 2016, I was provided with an amended schedule of questions to be answered in a second supplementary statement. My responses to these questions appear below (incorporating the numbering used in the amended schedule).

Reasons for the closure of the BAC

Q.1 With reference to paragraph 3(d) of Ms Krause's supplementary statement and paragraph 12(f) of Ms Krause's statement:

(a) Does Ms Krause agree that there was a lack of step down services available to support transition of patients from the BAC to less restrictive services? If so, does Ms Krause agree that the lack of appropriate step-down services is likely to have contributed to an increased length of stay than otherwise would be the case?

In relation to 12(f) I was referring to discharge planning. I was aware that discharge planning had been an issue at BAC from my involvement in the 2010 review of BAC. I

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recall having informal discussions with Dr Sadler in or around 2010 where he said that there were limited services to discharge patients to. It would seem that there was a lack of step down services in 2010. My understanding of available services was based on the review conducted in 2010.

(b) Why was the long lengths of stay resulting from problematic discharge planning a reason to close the BAC?

In reference to 3(d), I was not referring to discharge planning. In 12(f) I did not state that long lengths of stay was a reason to close BAC of itself. My point was that the level of institutionalisation created by long lengths of stay was not healthy or helpful for the young patients at BAC or their family.

Q.2 With reference to paragraph 3(d) of Ms Krause's supplementary statement:

(a) What is an "enhanced CYMHS service"?

An "enhanced CYMHS service" is a CYMHS service offering services beyond the service offered by community CYMHS.

(b) Please list any other "enhanced CYMHS services" which were developed after 2010.

The day programs and acute inpatient services established at Toowoomba and Townsville and the Adolescent Mental Health Extended Treatment Initiative (AMHETI) services (AMYOS, Resis, Step Up Step Down (SUSDU), the day programs and sub-acute beds) are all enhanced CYMHS services, that is they are service options in addition to community CYMHS.

(c) To your knowledge, how many of the Barrett Adolescent Centre ("the BAC") patients were discharged to these services (and the inpatient and day program services in Toowoomba and Townsville) after the BAC closed?

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(d) During Ms Krause's conversation with Dr Trevor Sadler in 2010, did Dr Sadler at any time suggest that the lack of services to discharge patients should be used as a reason to support the closure of the BAC? If not, how did Ms Krause form the opinion that it should be used to support the closure of the BAC?

I had a number of informal discussions with Dr Sadler in 2010. It was during the process of reviewing the model of service delivery. My recollection is that the discussions involved a group of people, not just me. As far as I can recall there was never any discussion about the closure of BAC in 2010. I did not ever form the opinion suggested by the above question.

At paragraph 12 of my statement dated 26 November 2015, I stated my awareness of many reasons which supported the closure decision.

Q.3 The Commission understands from paragraph 6 of Ms Krause's supplementary statement that she "believed that in 2010, there was very limited youth accommodation available for adolescents under 18 years of age and no supported youth accommodation that was suitable for young people with mental health issues". With reference to paragraph 3(d) of Ms Krause's supplementary statement:

(a) Please confirm whether the fact that in 2010 "there was very limited youth accommodation available for adolescents under 18 years of age and no supported youth accommodation that was suitable for young people with mental health issues" is a belief held by Ms Krause and/or whether she discussed this informally with Dr Sadler during the review of the Queensland Health State-wide Model of Service Delivery for the Adolescent Treatment and Rehabilitation Inpatient Service ("the MOSD BAC") in 2010, or otherwise.

In paragraph 6 of my supplementary statement, I stated my belief. It is not otherwise documented. I believe from my recollection of those discussions that I discussed the issue with Dr Trevor Sadler. I understand that it was well known across the sector.

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(b) How, if at all, did the lack of accommodation referred to in paragraph 6 of Ms Krause's statement support the closure of the BAC?

In paragraph 12 of my first statement, I stated my awareness of a range of reasons which supported the closure of BAC. In paragraph 6 of my supplementary statement I did not refer to a lack of accommodation being a reason to close BAC.

I was not an active decision maker involved in the closure decision.

(c) Between 2010 and the closure of the BAC in 2014, to Ms Krause's knowledge was there an increase in the number of accommodation options available to adolescents under 18 years of age experiencing mental health issues? If the number of accommodation options had increased by 2014 and a lack of options/services to discharge patients to was a reason to close the BAC, does Ms Krause agree that an increase in the options/services available to discharge patients to, supports the BAC remaining open? If Ms Krause disagrees, please explain why.

I do not know whether there was an increase in accommodation options specifically designed for adolescents. I am aware of the two therapeutic residential services in Morayfield and Goodna funded by Child Safety which, as I understand the criteria, are available only to young people who are within the child protection system.

I cannot answer the second part of this question. I have not stated that a lack of options/services to discharge patients to was a reason to close BAC.

Barrett Adolescent Strategy Meeting

Q.4 The Commission understands from exhibit G to Ms Krause's statement, that following the meeting on 23 July 2013, the Barrett Adolescent Strategy would move into the implementation phase which would be led by Children's Health Queensland Hospital and Health Service ("CHQHHS"). The Commission also understands that Ms Krause was one of CHQHHS representatives who was asked to propose membership for the implementation steering committee. Please provide details of who Ms Krause proposed to make up the membership

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of the implementation steering committee (which the Commission understands later became the Statewide Adolescent Extended Treatment Rehabilitation Implementation Strategy Steering Committee ("the SWAETRIS Steering Committee") and why.

I do not recall being asked to propose membership for the implementation steering committee.

Q.5 Please answer question 2(b). Namely, please confirm when, under what circumstances and by whom Ms Krause was asked to participate in the Barrett Adolescent Strategy Planning Group.

I do not recall but I think it would have been Dr Peter Steer, the former Chief Executive of Children's Health Queensland Hospital and Health Service.

Q.6 The Commission understands from paragraph 3(b) of Ms Krause's supplementary statement that she became aware of the fact that the Park Centre for Mental Health ("the Park") was expanding its adult forensic footprint and that this was deemed an inappropriate environment for 13 to 18 year old adolescents through the Barrett Adolescent Strategy Project Plan ("the BAS Project Plan") which was provided to her for the purposes of establishing the AMHETI. With reference to the BAS Project Plan, exhibit A to Ms Krause's supplementary statement, please answer the following questions:

(a) The BAS Project Plan states that "once the implementation plan has achieved the endorsed model(s) of care for the current patients, the building that houses the service of the BAC will be decommissioned". The Commission understands that the building which housed the BAC was decommissioned when it closed in January 2014 but that the implementation plan for the endorsed model(s) of service was not achieved until after this (some of the models of service were implemented as early as February 2014 and as late as November 2015, as per paragraph 10(h)(v) of Ms Krause's supplementary statement). To Ms Krause's knowledge, why was the building which housed the BAC decommissioned prior to the implementation of the AMHETI models of service when the BAS Project Plan stated that this would not occur?

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The decommissioning of the building is a matter for West Moreton. I only attended one strategy meeting and cannot comment on this.

(b) The BAS Project Plan states that "it is assumed that the endorsed model of care will be implemented in a two staged process ie it will initially be applied to meet the needs of the current consumers in BAC and then implemented more widely across the state as per the parameters of the endorsed model of care". What did Ms Krause understand "the endorsed model of care" to mean? Did Ms Krause understand this to be a reference to the suite of AMHETI services? Please comment on whether this two staged implementation process actually occurred.

The project plan predates the development of the AMHETI suite of services. It is a West Moreton document which I cannot comment further on.

AMHETI/SWATRIS and the development of alternative services

Q.7 The Commission understands from paragraph 24(c) of Ms Krause's supplementary statement, that "the AMHETI was not tasked to complete an exhaustive literature review of all service models available nationally and internationally for adolescent extended treatment and rehabilitation. It was my understanding that the ECRG had undertaken this foundation work". However, Ms Krause states in paragraph 7 of her supplementary statement and paragraph 29 of her statement, that the SWAETRIS Steering Committee reviewed literature on adolescent extended treatment and rehabilitation. Please advise which of these statements is correct.

Both statements were correct within the context that they were given. There is a difference between an exhaustive literature review and reviewing literature.

Q.8 The Commission understands from paragraph 7 of Ms Krause's supplementary statement that the literature on adolescent extended treatment and rehabilitation which was reviewed by Dr Stephen Stathis, Ms Ingrid Adamson and Mr Krause during the SWAETRIS Steering Committee has previously been provided to the Commission. Please advise the Commission when the literature was provided

and if it was exhibited to another witness statement, please identify the witness, exhibit number and page number.

I do not have a copy of this literature. My understanding from my management of Ms Adamson is that she has provided all documents relevant to the Commission's terms of reference. I believe that this material would be included in Ms Adamson's disclosure.

Q.9 The Commission understands from paragraph 10(c) of Ms Krause's supplementary statement that following her visit to the Walker and Rivendell Units in New South Wales, "no additional formal information was able to be collected on the resource differences between New South Wales and Queensland." Why was Ms Krause unable to collect additional information and what attempts if any, were made by her to obtain the additional information?

In paragraph 10(c) of my supplementary statement I have documented the information that was collected. That information was sufficient and no additional material needed to be sought.

Q.10 The Site Report at exhibit F to Ms Krause's supplementary statement, summarises her visit to the Walker and Rivendell Units in New South Wales, stating that there was a "strong consultation liaison model supporting the paediatric services" for "young people in non-mental health wards at hospitals" in New South Wales. Please provide further details in relation to this "strong consultation liaison model" and whether such a model existed in Queensland at the time or exists now.

In NSW where there was a lack of adolescent inpatient beds, young people were admitted to paediatric services with local child and youth mental health services providing consultation liaison - that is providing an in-reach model supporting the young person and family during hospitalisation. I believe this is informally done in Queensland where CYMHS have the capabilities and community resources to support this model. In Queensland, there is no dedicated funding for consultation liaison models in most CYMHS teams.

Q.11 In paragraph 10(d) of her supplementary statement Ms Krause states that the Site Report also, "articulates the availability of resources such as day programs

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and residential group homes within New South Wales." Please comment on the extent to which these types of resources were available in Queensland at the time.

As previously stated, there were three day programs in Queensland – Toowoomba, Townsville and South Brisbane, Mater. At that time, there were two therapeutic residential facilities at Goodna and Morayfield. These two residential facilities were exclusively for children under the child protection system – not available to the general population. In NSW, I believe there are also NGO services that operate group homes. As far as I am aware, there are no services in Queensland directly equivalent to the group homes in NSW.

Q.13 Explain the extent, if any, to which the service options in the Transitional Plan of Services and Overview developed by West Moreton Hospital and Health Service ("WMHHS"), (and contained in exhibit G to Ms Krause's supplementary statement) informed the AMHETI Business Case?

The exhibit referred to was a West Moreton transition document. Broad categories were included in the AMHETI business case to that extent the West Moreton transition document did inform the business case (intensive mobile outreach, day program etc).

Q.17 Further to question 10(h)(iv), please answer the following questions:

(a) Which gaps in the continuum of care services have continued since the AMHETI Business Case was finalised due to new funding not being forthcoming?

We have not received any funding for standalone sub-acute beds. Not all Hospital and Health Services have AMYOS (there are 9) set up (7 via AMHETI funding and 2 in Cairns and Rockhampton from the initiative responding to the deaths of 8 family members in Cairns).

There is no funding for SUSDU facilities in Queensland (one proposed for Cairns is funded separately).

There is only one resi rehab in Southeast Queensland at Greenslopes. The Time Out House initiative in Cairns was converted to a resi and there have been an additional 2

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resis established in Townsville via a Government initiative (outside of AMHETI funding). These are not yet operational.

The business case explains the phased funding over three years requiring approximately $23 million.

(b) Which gaps in the continuum of care services have been closed or resolved since the AMHETI Business Case was finalised due to new funding being provided?

We have received funding for the 9 AMYOS teams, we have a day program in North Brisbane, we have the Resi at Greenslopes and the two resis in Townsville and one in Cairns which was initially a Time Out House Initiative – total of 4 resis in Queensland.

Q.19 At paragraph 15(b) of Ms Krause's supplementary statement she has provided an explanation about how the AMHETI was aligned with the Expert Clinical Reference Group ("the ECRG") recommendations in their entirety. The Commission understands from the SWAETRIS Project Plan (which was included as exhibit Z to Ms Krause's statement) that the purpose of the SWAETRIS/AMHETI was to develop service options within a state-wide mental health model of service for adolescent extended treatment and rehabilitation, and an implementation plan to achieve the alternative model of service. The SWAETRIS Project Plan also states that the purpose of the SWAETRIS/ AMHETI was to "ensure continuity of care for adolescents currently admitted to the BAC, and on the wait list, through a supported discharge/transition process". In relation to Ms Krause's response regarding ECRG recommendation 3, please explain how a description of the transition planning undertaken by WM HHS demonstrates how the AMHETI aligns with ECRG recommendation 3. In particular, please elaborate on how the activities undertaken during the SWAETRIS/AMHETI to develop service options within a state-wide mental health model of service for adolescent extended treatment and rehabilitation (and an implementation plan to achieve the alternative model of service) aligned with ECRG recommendation 3.

West Moreton was responsible for the transition patients and managing the waitlist. West Moreton indicated to Children's Health Queensland that no patient required an

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adolescent subacute bed on closure of the BAC. Tier 3 sub-acute beds at Mater were available in line with the ECRG recommendation 3.

Q.21 With reference to paragraph 15(b) of Ms Krause's supplementary statement and her evidence as to how the AMHETI was aligned with ECRG recommendation 5, please answer the following questions:

(a) The Commission understands that ECRG recommendation 5 included a statement that "access *to on*-site *schooling (including suitably qualified educators) is considered essential for Tiers 2 (day programs) and 3".* The Commission also understands from paragraph 15(b) of Ms Krause's supplementary statement that *"educators are onsite in all day programs and the subacute beds have access to the special purpose school at the Lady Cilento".* Please answer the following questions:

(i) Please confirm whether Ms Krause is referring to the Special Purpose School (or BAC School) at Yeronga or the Lady Cilento Children's Hospital School when she states that the *"subacute beds have access to the special purpose school at the Lady Cilento".*

I am referring to Lady Cilento Children's Hospital School.

(ii) Please confirm that educators are on site for all day programs (which the Commission understands is a reference to Tier 2a services including Assertive Mobile Youth Outreach Service ("AMYOS") and all adolescent community residential services (which the Commission understands includes Tier 2b services such as residential rehabilitation units and step up/step down services)

AMYOS do not have onsite schooling. AMYOS seeks to re-engage young people, if necessary, to educational service providers or link to vocational programs.

There are no Step Up Step Down programs currently operational.

As far as I'm aware, all Day Programs have access to onsite education (that may be via a visiting teacher). Children's Health Queensland South Brisbane Day Program has access to Lady Cilento Hospital School with onsite teachers, and Brisbane North Day

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Program has onsite teachers provided by Department of Education and Training (DET).

(iii) If educators are not onsite for all Tier 2a and Tier 2b services, explain how the AMHETI aligns with ECRG recommendation 5.

The tier system was merely a classification system used by the ECRG and adopted by Children's Health Queensland for communication purposes only. The tiers have no relevance outside of assisting with the understanding of the ECRG categorisation of the suite of services it recommended. As aforementioned there is no tier system formally recognised within Queensland. The only onsite education is provided alongside acute and subacute beds and day programs. Education services are determined by DET, not Children's Health Queensland.

Q.23 At paragraph 16(d)(ii) of Ms Krause's supplementary statement she states that "there was no defined model of service for the BAC upon which to model the sub-acute bed service". Please explain what Ms Krause means when she says there is no "defined model".

As far as I am aware there was no endorsed model of service delivery for the BAC (through the Mental Health Alcohol and Other Drugs Branch (MHAODB) Model of Service Delivery state-wide endorsement process). I am aware that there was a draft model for subacute beds developed for the Redlands subacute model. That proposal was not progressed or endorsed because the Redlands project was cancelled.

Q.25 Please confirm how Ms Krause's answer to question 15(b) also answers question 23(b). In particular, please explain which ECRG recommendations were most influential in the SWAETRIS Steering Committee's redevelopment of replacement services and to what extent the most influential ECRG recommendations aligned with the input and suggestions of the two parents.

In paragraph 15(b) I articulated the tiers and recommendations of the ECRG and aligned the AMHETI services. Paragraph 10h(i) of my supplementary statement articulates a phased approach to implementation.

The implementation of the ECRG recommendations was most influenced by the availability of funds, population data which drives service demand, local mental health services capacity to establish and support services in the proposed locations and broad consultation with stakeholders. As I recall the parent's submission was primarily directed to a replacement BAC. Subacute beds were available at the Mater and the Lady Cilento Children's Hospital. There was no available funding for a new capital build for standalone subacute beds.

Q.27 The Commission understands from paragraph 25 of Ms Krause's supplementary statement that Ms Krause is responsible for oversight of the AMHETI suite of services that CHQHHS administers. Please explain how Ms Krause carries out this responsibility and what policies, procedures or governance structures are in place to oversee these services.

Exhibit A to this affidavit is a copy of the organisational chart which outlines my reporting relationships to Children's Health Queensland executive and the Board and the CYMHS staff that directly report to me and the reporting structures below. Children's Health Queensland has a robust governance framework, inclusive of a broad range of policies and procedures which align and comply with the National Safety and Quality Health Service Standards as outlined by the Australian Commission on Safety and Quality in Health Care. Children's Health Queensland is an accredited organisation through this process.

Q.28 Further to question 26, please explain the difference, if any, between the concept of "continuity of care" and "clinical care" in the context of adolescent mental health.

Clinical care is any direct care provided to a patient. Continuity of care reflects the longitudinal care pathway for a patient. Continuity of care could include seamless transition between services.

Q.29 Further to question 26, please confirm that Ms Krause is of the opinion that ensuring "continuity of care for adolescents currently admitted to BAC, and on the wait list, through a supported discharge/transition process to the most appropriate care option/s that suit individual consumer needs, and that are located in (or as near to) their local community" was not within the scope of the

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SWAETRIS/AMHETI despite it being included as an objective of the SWAETRIS in the Project Plan for the SWAETRIS (exhibit Z to Ms Krause's statement). Please confirm why Ms Krause holds this opinion. In Ms Krause's view, was WMHHS, including the Consumer Transition Working Group (later re-named as the Barrett Adolescent Centre Transition Panel), responsible for both the clinical care of BAC patients and ensuring their continuity of care?

I do not recall stating it was out of scope of the SWAETRIS. I stated that Children's Health Queensland did not have responsibility for BAC consumers or the wait list management as this was the responsibility of West Moreton. West Moreton and the receiving mental health services would have shared responsibility for the continuity of care for individual patients that were discharged from BAC.

Q30. The Commission understands that an assumption listed in the Project Plan for the SWAETRIS (exhibit Z to Ms Krause's statement) was that "not all service options within the state-wide model that will be proposed will be available by early 2014. However, there is a commitment to ensure that there is no gap to service delivery for the adolescent target group". The Commission notes that 1.8.1 of the Project Plan for the SWAETRIS defines the target consumer group as adolescents with severe and persistent mental health problems of a medium to high level acuity requiring extended treatment and rehabilitation. The Commission understands that this definition is not confined to adolescents who were admitted to the BAC or on the BAC waitlist. How did the SWAETRIS/AMHETI Steering Committee ensure that there was no gap to service delivery for the broader adolescent target group given that the full continuum of services was planned to be delivered over a three year period as referred to in section 5.2 of version 4.0 of the AMHETI Business Case?

On page 14 at paragraph 10(h)(iv) of my supplementary statement, I articulated that there would continue to be gaps if the business case was not funded in its entirety. My understanding of this 'assumption' referred to above, is that it refers more to the BAC clients and those on the waiting list rather than an inference that the SWAETRIS is responsible for resolving all existing gaps in service during the phased approach of funding proposed for the AMHETI suite of services.

Q.33 The Commission understands from paragraph 28 of Ms Krause's supplementary statement that one of the reasons that the Walker and Riven dell Units were not totally suitable to model AMHETI services from was because "the Rivendell model was five days per week only and necessitated families from NSW to provide interim accommodation for the weekends or transport young people home for the weekends. This was a difficult concept to promote in a geographically diverse state such as Queensland". The Commission also understands from exhibit F to Ms Krause's supplementary statement that in relation to the Rivendell Unit, "it was noted that the parents are very motivated and engaged and will collect their children for the weekend, with some regional families renting nearby units. For children without homes to return, they are accommodated in a refuge for the weekend. This did not appear to be a common occurrence". Exhibit F to Ms Krause's supplementary statement also states that "twenty-five percent of adolescents are within Rivendell's catchment and the remaining seventy-five percent are managed by local health districts until they can be accommodated by Rivendell". Please answer the following questions:

(a) Please elaborate on why the SWATERIS/AMHETI Steering Committee thought it may be difficult to promote the concept of providing interim accommodation or transport home on the weekends if the AMHETI services were modelled from the Rivendell model of service?

NSW is a fairly compact state and my understanding from discussions during our visit is that most referrals were within a 4 hour radius of the Rivendell unit so patients were able to return home to their families on the weekend, stay with relatives in Sydney or alternatively rent accommodation in Sydney.

The opinion of the SWAETRIS was that Queensland is a geographically diverse state and to establish a five day per week Brisbane based program, would potentially limit equitable access to the service by residents outside of the South East Queensland corner due to travel and cost implications. It was not felt that this model would be supported across the CYMHS sector particularly by our Central and North Queensland colleagues.

(b) Why did exhibit F to Ms Krause's supplementary statement state that the Rivendell Unit "compliments (the ECRG's) Tier 2 and potentially Tier 2b"

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if the SWATERIS/AMHETI Steering Committee thought the Rivendell Unit was not totally suitable to model AMHETI services from?

Rivendell does compliment these elements within the ECRG's descriptive tiers. While the AMHETI services have not been solely modelled on Rivendell, there are components that have been integrated such as day programs and proposed SUSDU which are bed based facilities. Rivendell does not align with sub acute beds as it cannot cater for young people who require a secure facility.

(c) The Commission understands that the Walker Unit operates twenty four hours a day, seven days a week. Given that adolescents who access the Walker Unit would not require interim accommodation or transport home on the weekends and that exhibit F to Ms Krause's supplementary statement states that "the Walker Unit would complement Tier 3 by providing a subacute, contemporary, bed-based model of care", please explain why the Walker Unit was not totally suitable to model the AMHETI services from, as referred to in paragraph 28 of Ms Krause's supplementary statement?

The Walker Unit is a 24/7 inpatient facility. AMHETI does not have any funding for subacute beds and has not developed any model of what the subacute beds will look like.

The Walker Unit was not supported by the MHAODB. The cohort at the Walker Unit at the time of our visit were different to the cohort at the BAC (i.e. Walker Unit had patients with psychosis secondary to developmental delays such as intellectual impairment and Autism Spectrum Disorder, whereas BAC allegedly had more young people with emergent personality disorders secondary to trauma).

Please refer to paragraph 28 of my supplementary statement which addresses this issue.

Review of the MOSD BAC for the Redland Facility

Q.42 Further to question 22 and in relation to the MOSD BAC, please respond to the following questions:

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(c) The Commission understands from Dr Brett McDermott's email of 11 February 2010, that it may have taken up to three years for the AETRC to be *"line managed"* by a *"larger CYMHS service"*. Does Ms Krause agree that it may have taken up to three years (if so, why).

My interpretation of Dr McDermott's email is that he is referring to the future amalgamation of the then named Queensland Children's Hospital which was approximately 3 years in the future at that stage (opening date of what is now known as the Lady Cilento Children's Hospital was not finalised in 2010). Dr McDermott is suggesting that the governance of the BAC once it moves to Redlands is to come under the Mater CYMHS in the interim until the proposed amalgamation of the Mater CYMHS with the Royal Children's Hospital CYMHS to form what is now Children's Health Queensland, CYMHS. This would then provide the over-arching governance from a large CYMHS service.

(j) The Commission understands from an email Ms Krause sent on 8 July 2010 (exhibit K to Ms Krause's supplementary statement) that:

(i) *"It was* reiterated *that the governance model would be under Metro South Health Service District not CHQ as our original document proposed"*. Who reiterated this to Ms Krause and why did the governance model have to be under Metro South Hospital and Health Service ("Metro South") instead of CHQHHS?

Dr David Crompton. I am not clear who made this decision or why it was made.

(ii) *"The Planning team are asking that we address specific areas in relation to the MOSD that may have implications on the site design/development"*. The Commission understands these areas may have related to the HDU area and the configuration of beds. State whether this is correct and if so, explain how these areas were addressed through further review of the MOSD BAC.

I cannot recall specifically what the site design/development issues were but the email referenced above outlines that there will be no day therapy program or parent retreat. To the best of my recall there had been changes proposed to the configuration of the beds which put them under a single roofline and there was no high dependency unit

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included. The final version of the Model of Service Delivery (MOSD) presented to Dr Crompton did not have reference to a day program or parent retreat. As the MOSD is a high level document without specific operational detail, other changes to the floorplan did not impact on work the expert group had done to date, so further modifications were not required.

Subacute beds at the Mater Children's Hospital and Lady Cilento Children's Hospital

Q.44 With reference to paragraph15(b) of Ms Krause's supplementary statement, the Commission understands that ECRG recommendation 3 included a statement that "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 the BAC is closed"• The Commission also understands that ECRG recommendation 2 included a statement that a "tier 3 service should be prioritised to provide extended treatment and rehabilitation for adolescents with several and persistent mental illness." Please confirm that the sub-acute beds at the Mater Children's Hospital, now at the Lady Cilento Children's Hospital, are the "Tier 3 alternatives" referred to in ECRG recommendation 3. If so, please explain how these sub-acute beds were "prioritised" by the AMHETI as referred to in ECRG recommendation 2 and how they were made "available in a timely manner" as referred to in ECRG recommendation 2 (particularly given that they were not operational until February 2014 after the BAC had already closed).

Yes I can confirm that these beds are tier 3 alternatives. West Moreton had informed Children's Health Queensland that no current BAC client required transfer to an adolescent sub acute bed. If this had been required then arrangements for a sub acute bed at the Mater would have been progressed prior to the closure of BAC.

My understanding is Dr Peter Steer liaised with Dr Brett McDermott at the Mater to ensure that there would be access to sub acute beds from February 2014 as per the ECRG's recommendations. I believe documentation of this discussion has been provided in Ingrid Adamson's exhibits. This meeting was arranged once there was a confirmed closure date for BAC. I was not present at this meeting.

Q.46 The Commission understands that version 0.1 of the AMHETI Business Case dated December 2013 states that the subacute bed-based unit would be "a new

service providing medium-term, intensive, hospital-based treatment in a secure and safe environment with up to 10 beds on a hospital campus" and that the 2 to 3 sub acute beds at the inpatient unit at the Mater Children's Hospital were an interim measure that would close upon the establishment of the 10 bed subacute inpatient unit. The Commission also understands that Appendix 2 and 3 of version 1.0 and 2.0 of the AMHETI Business Case still refer to the establishment of an 8-10 subacute unit. However, section 3.5 of version 1.0 and 2.0 of the AMHETI Business Case states that "should the need for this unit (the subacute unit) be confirmed, planning is underway to allocate space for a four bed unit within the Lady Cilento Children's Hospital at South Brisbane". The Commission also understands that version 3.0 of the AMHETI Business Case which was drafted in April 2014, addressed this inconsistency by amending Appendix 2 and 3 to state that the number of beds at the sub acute inpatient unit would be 2 to 4. Please explain why the number of beds was reduced from 8-10 to 2-4 and confirm when, how and by whom this decision was made.

The model of service summary drafted in Appendix 2 and 3 was a proposed model based on the National Mental Health Planning Service Framework (NMHPSF) that is the recommended size in this framework. Initial drafting of the Business Case was based on the best case scenario should we be able to secure all new operational funding for the new continuum of care. The situation evolved as the Lady Cilento Children's Hospital commissioning reached a conclusion and following conversations with the Department of Health that I was made aware of, it became clear that the quantity of new funds we sought was not available.

We (myself, Ms Ingrid Adamson, Dr Stephen Stathis and Children's Health Queensland executive) revised the business case to reflect this. We felt at the time it was more realistic to aim to secure funding for 2 – 4 beds than propose a larger standalone unit.

Q.47 The Commission understands that version 1.0 of the AMHETI Business Case dated February 2014 was amended to include a statement that "at this point in time the demand for this (subacute beds) service is unclear. However, it was noted by the ECRG that this service is an essential component of an overall model of care as there is a small group of young people whose needs cannot be

safely and effectively met through alternative service types". Why was demand for the subacute beds unclear as at February 2014?

Based on conversations with West Moreton we were of the understanding that there were no current BAC consumers who required an adolescent sub acute service. In the stakeholders workshops held in October 2013 it is my understanding (as I was on leave) that there was minimal support for the need for sub acute beds for this cohort of young people. Therefore we used the term 'unclear' until we had more information about the future demand for these sub acute beds.

Q.49 The Commission understands from exhibit U to Ms Krause's statement that at the Statewide Child and Youth Mental Health, Alcohol and Other Drugs Clinical Group ("the MHAOD Clinical Group") meeting on 10 December 2013 (co-chaired by Ms Krause), there was a discussion about:

(b) Whether the proposed sub-acute beds would include secure forensic beds. The Commission understands that Ms Krause "stated that no assumptions made but this had not been the initial thinking". Please elaborate on the discussions which occurred at this meeting regarding the inclusion of secure forensic beds.

From memory there was an observation from members of the group that there are no secure forensic mental health inpatient beds for adolescents and that this had been identified by the Department of Youth Justice and the Department of Communities, Child Safety and Disability Services as a service gap for young people in their systems displaying challenging or difficult behaviours. It was determined by the SWAETRIS that secure forensic beds were deemed out of scope as articulated in the Project Plan.

Q.52 The Commission understands from the document titled 'State-wide Assessment Panel Protocol' (included in exhibit ZJ to Ingrid Adamson's statement, pp. 5946-5954) that a patient "will not be eligible for a state-wide subacute bed if they primarily need support with substance misuse issues". Why is the subacute bed model of service not appropriate to support patients with substance misuse issues?

If the primary issue is drug and alcohol and not mental health then a mental health facility would not be an appropriate option. Young people would be better served in a

dedicated drug and alcohol facility. If the client has a dual diagnosis (drug and alcohol and mental health issues) they would be triaged and assessed based on clinical need to determine if they would be admitted which is consistent with all referrals to the sub acute beds.

Q.53 The Commission understands from paragraph 16(a) of Ms Krause's supplementary statement that "to date there have only been six referrals to the subacute beds, **Please answer the following questions:**

(d)

The email above is clarifying for Ms Dougan that there are no dedicated sub acute beds funded at the Lady Cilento Children's Hospital but the sub acute beds were part of our acute adolescent unit and were only utilised on demand. The clients were managed via individualised treatment plans with a rehabilitative focus.

There was no specific sub acute model developed for the clients but their recovery oriented treatment goals reflected their clinical needs . In my view this does meet the requirements of the ECRG's tier 3 option.

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Q.54 What is the basis for Ms Krause's opinion that "the provision of alternative services such as day programs and AMYOS services appear to have reduced the need for subacute admissions for some young people" and that "other young people may have elected to utilise mental health services closer to their homes" as outlined in paragraph 16(b) of her supplementary statement?

The absence of referrals was the basis for my opinion and anecdotal discussions with clinicians for example

Q.58 Further to question 16(d)(ii):

(a) Please confirm that the only basis for delivering the Tier 3 services recommended by the ECRG as part of an adolescent inpatient unit was a lack of funding to establish the Tier 3 services in a standalone unit. If so, please explain why there was a lack of funding and what steps were taken by CHQHHS to source funding for a standalone Tier 3 service. Explain how a standalone subacute bed unit would have been different to the subacute beds at the Lady Cilento Children's Hospital, including any differences in the model of care.

A lack of funding was not the only basis for delivering these services, it was one element. Other factors included minimal support across the CYMHS sector for sub acute beds (as evidenced in the consultation process undertaken) and lack of compelling demand post closure of the BAC. We were mindful of the ECRG recommendations and the members of the community who were advocating for sub acute beds.

The decision was made to make available a small number of beds within the existing acute unit and monitor the demand. It was anticipated that this demand trend would support a stronger position for advocating for further resources to establish sub acute beds.

The business case reflected Children's Health Queensland's efforts to secure funding via meetings with the Department of Health, which I understand Ms Ingrid Adamson has already provided to the Commission.

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The Model of Service would need to reflect the facility i.e. stand alone or integrated within an acute unit, the number of beds and the workforce profile, so it would need to be developed once a decision is made regarding what, if any, sub acute beds will be funded.

(c) The Commission understands that the BAC is listed as an example of *Service Category 2.3.2 - Subacute Services (Residential and Hospital or Nursing Home Based)* in the draft NMHSPF. In Ms Krause's opinion, which Service Element within *Service Category 2.3.2 - Subacute Services (Residential and Hospital or Nursing Home Based)* is the BAC an example of? For example, in Ms Krause's opinion, is the BAC is an example of *Service Element 2.3.2.5 - Subacute Intensive Care Service (Hospital)?* If so, please explain why the BAC is not considered a contemporary model of care within this Service Element given that the model of care for the subacute bed-based service is modelled on the same Service Element. The Commission understands that the average length of stay for this Service Element is 120 days with an expected maximum stay of less than 180 days. Apart from the length of stay, what features of the BAC model are not considered contemporary according to this Service Element? How has the sub acute bed-based model of care been designed to ensure that it aligns with contemporary practice? Please answer this question by referring to this Service Element and *Service Category 2.3.2 - Subacute Services (Residential and Hospital or Nursing Home Based).*

In my opinion BAC would best be described as Service Element 3.2.5 Sub Acute Intensive Care Hospital. The NMHSPF has a range of service descriptors and length of stay is significant as it is recommended to be 120 days with expected maximum stay of less than 180 days. The BAC model clearly (and I believe regularly) exceeded these recommended timeframes within the NMHSPF.

The NMHSPF is a high level document and the operational elements of a service model are not articulated in the extracts from this framework, which I have been privy to and have been previously exhibited to my supplementary affidavit (Exhibit H). This makes aligning contemporary practice or indeed the specifics of the MOSD review undertaken in 2010 with the extracts of the framework very difficult. I believe other

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examples of non-contemporary practice which were identified as occurring at BAC are reflected in the previously discussed 2009 review. As previously stated the MOSD review in 2010 addressed issues raised in the 2009 review of BAC and there is currently no completed and endorsed MOSD for sub acute beds.

Q.59 Further to question 16(e):

(c) The Commission understands that the average length of stay at the BAC was longer than three months, which is the proposed average length of stay for patients admitted to the subacute beds at the Lady Cilento Children's Hospital (with a proposed maximum length of stay of six months). State whether this is correct, and explain the basis on which the SWAETRIS/AMHETI Steering Committee decided to make the proposed average length of stay for the subacute beds three months with a proposed maximum stay of six months.

This is correct and the basis of decision making was that it aligned with the NMHSPF recommended timeframes for sub acute beds.

(e) The Commission understands from paragraph 16(e) of Ms Krause's supplementary statement that one of the significant differences between the subacute beds at the Lady Cilento Children's Hospital and the BAC model is "the *individualised treatment planning for the Lady Cilento clients with evidence based interventions*" and the *"strong focus on family involvement and family therapy"*. Please confirm whether Ms Krause is stating that the BAC model did not include individualised treatment planning, evidence based interventions and a strong focus on family involvement and family therapy and if so, explain the basis for this statement.

I am stating primarily what the Children's Health Queensland CYMHS focuses on. The basis for this statement is the 2009 review indicated that there was a lack of evidence informed treatment interventions at BAC. Children's Health Queensland CYMHS has a strong focus on parental engagement and family based interventions as an integral part of the recovery process.

(f) The Commission understands from paragraph 16(e) of Ms Krause's supplementary statement that one of the significant differences between the subacute beds at the Lady Cilento Children's Hospital and the BAC model was that the subacute bed-based model has "less emphasis on a group approach to therapy such as milieu or adventure therapy". Are group approaches to therapy, such as milieu or adventure therapy used at all in the subacute bed-based model? If so, please explain to what extent and in what circumstances these approaches are used. Please confirm whether the basis for placing less emphasis on group approaches to therapy in the subacute bed-based model is the 2009 Review of the BAC which was undertaken by Garry Walter, Psychiatrist and Director of Mental Health, Rivendell Unit, Martin Baker, Psychologist, Rivendell Unit and Michelle George, Nurse Unit Manager at the Mater (included in exhibit X to Ms Krause's statement). If so, please explain how placing less emphasis on group approaches to therapies aligns with the recommendations in the 2009 Review of the BAC that:

(i) "If BAC is seen as a Therapeutic Community utilising a Milieu approach, that this approach is formalised, key activities identified and documented and appropriate training and supervision for staff provided".

(ii) "Adventure Therapy may continue but, if so, this should be seen as a component part of an overall therapeutic approach".

The Lady Cilento Children's Hospital has not utilised a group therapeutic approach or adventure therapy for sub acute clients as there have only been [redacted] These approaches could be integrated into a model of service delivery for sub acute beds if clinically indicated and if staff had appropriate training and supervision in these modalities.

Q.60 The Commission refers to an email from Ms Krause to Ms Fionnagh Dougan dated 10 September 2015. Please answer the following questions:

(a) Why does Ms Krause describe the subacute beds at the Lady Cilento Children's Hospital as *"virtual beds"* in her email?

The term virtual beds was used because there are no gazetted sub acute beds funded within the Lady Cilento Children's Hospital. The four sub acute beds are part of the

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acute adolescent bed numbers and while four beds can be utilised as sub acute they are not exclusively held for the use of sub acute clients they are swing beds occupied based on demand.

(b) Why was the detailed subacute model of service not completed as at the date of this email (10 September 2015)?

The detailed sub acute model of service delivery was put on hold as there was no indication of whether future sub acute beds would be funded and no understanding of bed numbers, facility design or workforce profile to form the basis of the model. Children's Health Queensland developed a state-wide sub acute discussion paper to help with future planning and to review the national and international literature to determine which diagnostic group of young people would most benefit from sub acute beds, which evidence informed treatment modalities would be most helpful and the efficacy and outcomes of bed based extended treatment for adolescents. This discussion paper will be provided to the Commission once completed, estimated to be early February 2016.

(c) What are the *"functional issues in the months post amalgamation"* with the Lady Cilento Children's Hospital which Ms Krause describes in her email and why were these given priority over completing the detailed subacute model of service?

There were some defect and design issues being addressed within the 8b mental health space at the Lady Cilento Children's Hospital. These were prioritised based on potential risk to clients and staff and the fact that there was a definitive timeframe for defect liability issues to be addressed by the Lady Cilento Children's Hospital project team post commissioning.

As aforementioned a sub acute model of service delivery needs to be informed by facility design/location (i.e. stand alone or integrated), bed numbers and staffing profiles to be able to successfully progress.

(d) Why was "establishing *other components of AMHETI*" a *"higher priority"* than completing the detailed model of service for the subacute beds especially when ECRG recommendation 2 included a statement that a

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"tier 3 service should be prioritised to provided extended treatment and rehabilitation for adolescents with several and persistent mental illness"?

There was minimal demand for the sub acute beds and no future funding commitment to guide design, location etc. which would influence the model. Other components of AMHETI which were prioritised by the CYMHS sector during the consultation process were more urgent as they were funded, and services needed to be developed and operationalised i.e. AMYOS teams and North Brisbane Day Program.

(e) Explain the basis for Ms Krause's statement in her email that *"none of our psychiatrists felt comfortable establishing a model of care that we could not base on contemporary evidence"*. Which psychiatrists expressed this view and what explanation was given, if any, as the basis of their views?

Dr Michael Daubney and Dr Stephen Stathis were unable to find compelling evidence to support any particular model of service for the management of adolescents in sub acute facilities. I am not clear if they sought the opinions of other Child Psychiatrists. Most evidence supported assertive community based treatment.

As aforementioned, the development of the Statewide Sub Acute Discussion Paper resulted from seeking contemporary evidence about the efficacy of sub acute beds for adolescents and was designed to be an internal Children's Health Queensland CYMHS document. MHAODB then requested a copy of this document to inform the further development of intensive adolescent extended treatment and rehabilitation services. MHAODB have been provided with a draft of this document and the final version will be forwarded to them and Commission by early February 2016.

Q.61 Further to question 33:

(a) What are Ms Sophie Morson's qualifications and expertise?

Ms Morson is a senior clinical psychologist with Children's Health Queensland CYMHS and has over fifteen years of experience within Child and Youth Mental Health.

(b) Why did Ms Krause select Ms Sophie Morson to author the discussion paper/further develop models of service the statewide subacute bed package in 2015?

Ms Morson had the capability and capacity to undertake this task. Ms Morson has previously undertaken projects of a similar nature and is skilled in reviewing literature and summarising findings in an objective manner.

(c) What directions did Ms Krause give Ms Sophie Morson?

To undertake a literature review and provide a balanced discussion paper outlining the evidence supporting sub acute care and the recommended treatment models and identifying which young people benefit most from sub acute care. Ms Morson was also asked to incorporate examples of the lived experience of consumers and carers wherever possible in the discussion paper.

(d) The Commission understands that the impetus for Ms Krause directing Ms Sophie Morson to author the discussion paper on subacute beds referred to in paragraph 33 of Ms Krause's supplementary statement was to inform planning for the State Government's pre-election commitment to "establish a Tier 3, subacute facility with up to 22 beds for young people, including 20 place day programs, integrated special school step down facility and family accommodation" (see email from Ms Krause to Ms Fionnagh Dougan dated 10 September 2015). State whether this is correct and if not, explain what the impetus was.

This was an internal document to support the development of a model of service delivery for sub acute beds and it was deemed to also be helpful to inform the state-wide group developing the Rebuilding Intensive Mental Health Care for Adolescents. As aforementioned MHAODB have been provided with a draft copy of this discussion paper to supplement their own research into this area which I understand is being undertaken by Ms Karen Rocket and overseen by Ms Anna Davis, Ms Sandra Eyre and ultimately Dr Bill Kingswell.

(f) Explain how the discussion paper "may support a more thoughtful approach" to the State Government's pre-election commitment to "establish a Tier 3, subacute facility with up to 22 beds for young people, including 20 place day programs, integrated special school step down

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facility and family accommodation" (see email from Ms Krause to Ms Fionnagh Dougan dated 10 September 2015)?

It may assist with providing the national and international best practice for management of adolescents with moderate to severe mental health issues and guide the development and thinking around the continuum of care for adolescent extended treatment and rehabilitation for Queensland, particularly the sub acute beds component of this.

(g) Explain how "the national and international evidence in treatment of the type of clients who historically have required subacute care" which is being considered as part of the preparation of the discussion paper "points to assertive community based care and does not support long term institutional care" as stated in Ms Krause's email to Ms Fionnagh Dougan dated 10 September 2015.

As stated there is little compelling evidence available through the literature to support long term extended treatment inpatient care for adolescents. These outcomes will be articulated in more depth within the State-wide Sub Acute Discussion Paper.

Step Up Step Down service and residential rehabilitation units

Q.63 Further to question 10(g), the Commission understands from paragraph 10(g) of Ms Krause's supplementary statement that Ms Krause *had no involvement in the decision making*" for the Cairns step up/step down unit ("SUSDU") but that *"CHQHHS has participated in the refinement of the Model of Service Delivery".* The Commission also understands that the latest draft of the model of service for the Cairns SUSDU unit was published in October 2015 (exhibit D to supplementary statement of Dr Stephen Stathis). Please answer the following questions:

(a) How has CHQHHS participated in the refinement of model of service delivery for the Cairns SUSDU? Please provide as many details as possible.

We were involved in collaboratively developing the model of service delivery and provided a staff member to MHAODB to undertake documenting the model of service

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delivery. This work built on the original SUSDU model of service delivery that was attached to the AMHETI business case.

(b) Please confirm that Cairns Hospital and Health Service and the MHAODB have also participated in the refinement of the model of service for Cairns SUSDU (in addition to managing the planning phase) and identify any other entities which have participated.

Yes I confirm that representatives from MHAODB and Cairns Hospital and Health Service aiso participated in this process. No other entities participated to my knowledge.

(c) How has the model of service delivery for the Cairns SUSDU been refined?

Modifications were made to suit Cairns Hospital and Health Service and at the direction of MHAODB. For example the age range was modified to be from 16 – 21 and the defined catchment area was not extended to the Northern Cluster but confined more to the Cairns Hospital and Health Service area with some potential to admit from adjoining regions.

(d) What are the differences between the model of service for SUSDU contained in Appendix 3 of version 4.0 of the AMHETI Business Case dated July 2014 and the latest draft of the model of service which was published in October 2015? Please provide as many details as possible.

See previous response in 63(c) for examples.

Q.65 In relation to paragraph 24(b) of Ms Krause's statement, please answer the following questions:

(a) Please explain why the age range of the Y-PARC model was modified in the proposal for the SUSDU from 16 to 25 years of age, to 16 to 21 years of age.

The age range was modified as the proposed funding was to cater for adolescents rather than young adults (22-25 years). Reducing the upper age limit to 21 years

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ensures the adolescent's needs was the focus of the initiative yet at the same time catering for those older youth (18 to 21 years) whose developmental stage may not align with their chronological age, often due to periods of developmental arrest secondary to their mental health issues.

These young people have been identified as requiring a more therapeutic, systemically and family focussed, wrap around care system which is more aligned with the CYMHS approach than with the adult mental health model.

(b) Please explain the basis for the decision to make the lower age range of the SUSDU model 16 years of age with flexibility so as not to exclude 13 to 15 year olds. Why did the SUSDU model not nominate a lower age range of 13, as a way of ensuring that 13 to 15 year olds were not excluded?

Children's Health Queensland at all times has advocated strongly for the needs of younger adolescents and see it as potentially discriminatory to exclude the younger age range when we are focussing on the development of the CYMHS extended treatment and rehabilitation continuum of care, which within Queensland is young people under 18.

While we acknowledge the challenges in alignment of service delivery for older youth between 18 and 21 we are also cognizant of the significant needs of a small cohort of young people aged 13 – 15.

We are currently negotiating with MHAODB to consider a younger cohort for any SUSDU that was funded to be within the Children's Health Queensland local catchment so the younger age range are not inadvertently excluded from a SUSDU model of care. It is my opinion that assuming that young people in the lower adolescent age range do not require access to SUSDU's is a grave risk to the CYMHS continuum of care for adolescent extended treatment and rehabilitation.

(c) What is the staff to patient ratio used in the Y-PARC model?

The staff to patient ratio of the Y-PARC model varies from facility to facility. I am unable to definitively answer this question and suggest you refer to MIND Australia the lead agency of Y-PARC's in Dandenong and Frankston, Victoria.

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(d) What is the staff to patient ratio used in the SUSDU model?

The staffing model would be based on the NMHSPF extracts which was exhibited to my supplementary statement (Exhibit H). The ratio would be dependent upon the age range of the SUSDU and the bed numbers/ occupancy levels. I cannot definitively answer this question.

(e) Why does the SUSDU model have a greater focus on family visiting space and family therapy interventions than the Y-PARC model?

This was in response to the age range being lower than the Y-PARC SUSDU and the likelihood of more family interventions and more family focussed care. This is consistent with the more family inclusive CYMHS approach and is more developmentally appropriate for many adolescents. Literature supports family involvement as a strong predictor of adolescent/emerging adult engagement with mental health services.

Q.67 The Commission understands from paragraph 24(c) of Ms Krause's supplementary statement, that Ms Krause does not recall the ECRG specifically referencing the Y-PARC model in their Tier 2b element and that "the majority of the detail supporting the SUSDU model of service under AMHETI was sourced from the NMHSF and site visits to Victoria". The Commission also understands from a document drafted by Ms Krause in August 2013, and titled 'Adolescent Extended Treatment and Rehabilitation Models-Summary of Site Visits to Victoria' (exhibit E to the supplementary statement of Dr Stephen Stathis) ("the Victoria Visit Site Report"), that Ms Krause initially thought that with significant adaptations, the Y-PARC model would align with the ECRG's Tier 3 element. In particular, the Victoria Visit Site Report states that "The Y-PARC model would complement Tier 1, by providing both a step up and step down subacute contemporary bed based model of care. It would further support Tier 2 and 2b. With significant adaptations, the Y-PARC model could potentially meet some of the Tier 3 requirements". One of Ms Krause's recommendations in the Victoria Visit Site Report was that consideration should be given to "scoping a model based on Y-PARC with adaptations to meet the geographically diverse needs of

Queensland and modified to suit an adolescent cohort. This would align with Tier 3". Please answer the following questions:

(a) When Ms Krause wrote the Victoria Visit Site Report, what were the *"significant adaptations"* that she had in mind in order to make the Y-PARC model meet some of the Tier 3 requirements? Was it possible to make these *"significant adaptations"?* Why or why not?

As outlined in the above referenced document (which was just a summary of our site visits and recommendations for consideration rather than for formal endorsement of an implementation plan).

Model adaptations would include:

- Decreasing the age range to 14 – 17 years (this would impact on staffing levels required and ratio of health professionals vs. NGO/youth workers, consent and duty of care issues relating to minors)
- Broadening the catchment from local to a more cluster based or state-wide model
- Increasing the length of stay up to 3 months (extended stays can be negotiated on an individual basis by the treating team).
- Provision of in–reach educational and vocational support to the Y-PARC students with an aim of linking them back to their local community on discharge or consideration of an outreach model to local education/ vocational support facilities able to provide interim support for young people and linkages back to their community of origin.

To elaborate - broadening the catchment included having the Y-PARC's not integrated within just one Hospital and Health Service (or equivalent) which is the situation in Victoria. If Queensland was to emulate the integrated model this would require a greater number of SUSDU's with one SUSDSU potentially located in each metropolitan and regional service. If only a few SUSDU's were funded and they relied on being integrated exclusively to a Hospital and Health Service it would exclude people from being admitted if they did not reside in the geographical catchment. The concept of an extended number of SUSDU's was not deemed financially viable as all SUSDU's in Queensland would require new capital and new recurrent funding.

It was proposed in the initial roll out of AMHETI that one SUSDU be situated in each cluster of Hospital and Health Services. This would be one in the Southern Cluster, one in the Central Cluster and one in the Northern Cluster. In my view this would be the bare minimum of SUSDU's required and once outcomes were evaluated, additional SUSDU's should be considered.

Other adaptations would be to modify the age range to meet the needs of the CYMHS cohort, 14 – 17 with flexibility for younger adolescents to be admitted when required and flexibility for young people who are turning 18.

These facilities would need to be secure and if they were to replace a tier 3 (as outlined by the ECRG) they would need to be authorised facilities under the Mental Health Act to enable involuntary admissions. If they were to align with tier 3 there may be a requirement for these facilities to be co-located with an acute hospital to provide the required emergency medical and security support.

To align with the ECRG's tier 3 there would need to be access to on site schooling which was not a feature of the Victorian Y-PARC model.

The length of stay would need to comply with the NMHSPF for sub acute beds which is 3 – 6 months and not the 28 day model of Y-PARC's.

Some of these adaptations have been recommended for integration into the MOSD for SUSDU's. As aforementioned Cairns will operationalise and modify the model to suit their geographical requirements as directed by their executive and board and supported by MHAODB.

(c) Given that Ms Krause had originally envisaged that the Y-PARC model could be adapted to align with the ECRG's Tier 3 element, why was the Y-PARC model instead adapted (into the SUSDU model) to align with the ECRG's Tier 2b element?

Informal consultation occurred with key stakeholders including Y-PARC staff (during the site visits), MIND Australia staff, Dr Sandra Radovini, MHAODB staff, CYMHS sector representatives and the SWAETRI Steering Committee. It was felt after the

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aforementioned consultations that the SUSDU was better aligned with the ECRG's tier 2b as it is designed to be a shorter term community bed based facility.

There remains potential to re-evaluate this if no funding for sub acute beds is forthcoming, particularly in relation to extending the length of stay to align with the NMHSPF as outlined in my response to question 67(a).

Q.68 Further to question 27(b), please explain:

(b) What Ms Krause means when she describes the residential rehabilitation unit model of care as less secure than the SUSDU model of care.

The residential rehabilitation model is an open facility which young people can freely come and go from. The SUSDU is a more secure facility as staff can swipe access clients/ visitors in and out and thus can monitor who is exiting and entering the facility more effectively.

Linkages between adult and adolescent mental health services

Q.78 Version 0.3 of the AMHETI Business Case dated January 2014 states that *"the residential rehabilitation unit is currently the only service in the continuum that specifically accommodates an age range up to 21 years old. Whilst other services proposed would be able to service the same age range, it is not a supported mental health position in Queensland".* The Commission understands that this content is still included in version 4.0 of the AMHETI Business Case which is dated July 2014. Please answer the following questions:

(a) Why are the residential rehabilitation units the only AMHETI service which specifically accommodated an age range up to 21 years of age?

As the residential rehabilitation facilities are longer stay (up to 12 months) and have an aim to support young people to further develop their independent living skills as part of their mental health recovery it was deemed to be developmentally appropriate to extend the age to cater for young people up to 21 years of age. Based on a decision by the MHAODB the SUSDU in Cairns will also cater for young people from 16 up to 21 years of age.

(b) In what circumstances was it envisaged that the other AMHETI services would be able to service the same age range as the residential rehabilitation units? Please answer this question specifically for each of the other AMHETI services.

I will begin by providing background context to this question. The funding for AMHETI has been from the Child and Youth sector (ex BAC operational funds). These funds are dedicated for young people from 13 up to 18 and as we were tasked with developing a continuum of care for this age range the AMHETI services reflected this. The aim of AMHETI is to provide a responsive, developmentally appropriate and recovery oriented continuum of care for adolescents. AMHETI was designed for the CYMHS adolescent age range (13 up to 18) but with an awareness of the internationally recognised neuro-developmental literature which identifies the specific needs of the 18 – 25 year old population. As outlined in response 78(a) this was acknowledged by extending the age range for resi rehabilitation facilities to 21.

There would need to be a robust funding model to support extending AMHETI services in their entirety up to 21. The risk would be diluting the funds dedicated to the CYMHS sector and reducing the responsiveness of the sector to provide early and targeted interventions for at risk younger adolescents and reduce the impact of emerging mental health issues.

In my understanding of the sector all CYMHS services regularly continue to provide services to young people who turn 18 during their episode of care, particularly if developmentally the young person is still at high school and living at home. Young people turning 18 would only be transitioned to adult mental health services when it was deemed that their mental health issues were enduring and would benefit from/ and be appropriately treated within the adult mental health system.

AMYOS – would have potential to have flexibility in the upper age range, currently this would be a clinical decision made by the treating team and the Hospital and Health Service within which the AMYOS team resided.

Day Programs – As above, particularly if the young person was engaged in educational/ vocational programs.

SUSDU – Age range has been determined to be 16 – 21

Resi Rehab – Age range extends to 21

Sub acute beds – Currently co-located within the Lady Cilento Children's Hospital (a paediatric hospital). There is flexibility with young people admitted who turned 18 during their episode of care to remain an inpatient.

Future sub acute bed funding may potentially enable admission of young people in the 18 – 21 age range, who were developmentally appropriate to be co-located with vulnerable younger adolescents. This may vary from case to case which supports a flexible approach to age criterions rather than a blanket approach to extending age ranges.

(c) Why was this?

As aforementioned issues to consider are the developmental trajectory of young people including those from 18 – 21, the vulnerability of younger adolescents and the funding models to support a more flexible approach which would include additional funding to the CYMHS sector to support expanding services up to 21 years of age.

Q.79 The Commission understands from paragraph 27(a) of Ms Krause's statement that "the AMHETI services build on existing linkages across the Queensland mental health sector and rely upon existing processes within Child and Youth Mental Health Services and Adult Mental Health Services to ensure a smooth transition". Please answer the following questions:

(a) Please describe in detail the *"existing linkages across the Queensland mental health sector"* and how the AMHETI services build on these linkages.

I cannot comment on all Hospital and Health Services linkages and processes throughout Queensland but will respond to the question in general terms.

All Hospital and Health Services should have awareness of local referral processes for young people to transition from child and youth mental health to adult mental health

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services. CYMHS services should have local mechanisms in place to engage with their community mental health sector, which may involve regular partnership forums, consortium meetings and inter-agency meetings to discuss specific shared cases or impending transition cases. This would be inclusive of the primary health care networks, school and university counsellors, local General Practitioners, private psychiatrists and other allied health practitioners and non-Government agencies such as headspace that are available in their local areas.

There are many service provider directories available for local areas which details the range of services available, eligibility criteria and referral processes. Most Hospital and Health Services have Service Integration Coordinators (SIC) whose role it is to actively engage with the community mental health sector and other key agencies such as housing, employment and disability support. The SIC often takes an active role in the development of partnerships with these other agencies to ensure a smooth transition of clients and to assist them to integrate back into their community.

My understanding is that in integrated public mental health services the SIC roles are across the life span and would support the transition of CYMHS clients to the adult mental health services within the Hospital and Health Service. You would need to seek further information from these Hospital and Health Services in relation to documented pathways supporting transitions.

Unfortunately there is only a 0.5 FTE SIC dedicated to CYMHS within Queensland and this role is located within Children's Health Queensland. This role has actively co-ordinated interagency meetings relating to transitioning young people from CYMHS to the public adult mental health services where assertive discharge planning occurs inclusive of the provision of comprehensive clinical history and supporting the young person and their family to engage with their new case manager and treating team in the adult mental system. This may involve the CYMHS case manager taking the client to appointments with their new treating team (whether public or within the private or NGO sector) and assisting with orientating them to the adult system of care.

AMHETI services build relationships and align with these existing linkages as they are integrated into the continuum of care for CYMHS thereby utilising current referral pathways and processes to transition young people, where clinically indicated, to community adult based services using the mechanisms outlined above.

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(b) What are the *"existing processes within Child and Youth Mental Health Services and Adult Mental Health Services to ensure a smooth transition"?* How do these processes align with the current position/policy that CYMHS only caters for young people from 0 years of age up to 18 years of age as referred to in paragraph 27(c) of Ms Krause's supplementary statement?

I cannot comment on all Hospital and Health Services across Queensland but I have outlined my general understanding of CYMHS transition processes above in response to 78(b). These processes align with the current age range of CYMHS which is up to the young person's 18th birthday as they support the smooth transition of young people from CYMHS into the community adult mental health sector with the flexibility to cater for their individual needs.

(c) What are the transition challenges referred to in paragraph 27(a) of Ms Krause's supplementary statement? How does the fact that the integrated services (which the AMHETI suite of services was promoted to) are mindful of these *"transition challenges"* assist in building linkages to adult mental health services and ensuring a smooth transition from adolescent mental health services?

There are a range of transitional challenges. These include the potential for young people who are receiving systemic and family focussed care through the CYMHS system to have difficulty finding an alternative adult mental health service that can provide the level of developmentally appropriate intervention they may have been receiving at CYMHS. There are a range of reasons for this including:

1. There is a change in autonomy from a child and adolescent and family oriented system to an individual oriented system within the adult mental health sector. There are changes to legal and confidentiality status. Research suggests many young people and their families find this difficult to navigate. This has led to poor engagement for young people in the 18 –21 age range with adult mental health treatment services which for some has resulted in a deterioration of their mental state and increased crisis presentations.

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2. CYMHS provide services for a broad range of young people with moderate to severe mental health issues inclusive of significant impairment secondary to trauma, disruptive attachment and familial disharmony, emotional and behavioural disturbances and conduct disorders. There are also a percentage of young people with co-morbid developmental delays such as Autism Spectrum Disorders. These young people often do not meet the admission criteria for adult mental health services (particularly public services), which typically has a narrower range of diagnostic categories.

3. Many NGO and primary health care service providers are only able to provide a limited amount of individual sessions, which are aligned to funding models such as ATAPS (Access to Allied Health Professional Services), Better Access and other such programs. Most are unable to work in an interagency model of care which involves active engagement with the other service providers and systems that the young person is engaged with i.e. education/ vocational, employment etc. Few of the non-government community adult mental health systems have access to a full multidisciplinary team which young people accessing CYMHS have benefited from and many are not able to fund health professionals with the clinical expertise and experience to manage the complexity of the young people who are exiting from CYMHS.

Headspace centres primarily work on a business model and services vary from centre to centre. In our experience they are often unable to continue to see young people for longer term individual or family therapy and have less capacity to work systemically with other agencies and provide the case management CYMHS services previously had.

Many private psychiatrists do not bulk bill, so for young people to access private services post CYMHS can be very expensive and often has to be supplemented by their parents.

The fact that there is an awareness of the challenges across the sector ensures that transition across services remains a priority for Hospital and Health Services to address and continue to refine referral pathways and communication across the CYMHS and adult community mental health sector. It further serves to keep the issue

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topical and provide opportunities to advocate for alternative solutions for the emerging adult population, including discreet services.

Q.80 The Commission understands from paragraph 27(a) of Ms Krause's supplementary statement that *"the AMHETI Business Case in section 4, 'issues', notes that the age range for child and youth services within Queensland does not typically extend to young people over the age of 18. Adult mental health services do not accept young people under 18. This remains an outstanding issue for the Queensland Mental Health Sector and has been raised at the State-wide Clinical Network Meeting as an opportunity for further service improvement".* Please answer the following questions:

(a) Please confirm whether the *"outstanding issue"* Ms Krause is referring to is a lack of alignment between adolescent and adult mental health services in that patients in the 18-25 year age group, or a similar age group, are not adequately dealt with by either adolescent or adult mental health services. If so, does this lack of alignment mean that patients in that age group, or a similar age group, commonly experience problems in their transition from adolescent to adult mental health services?

The outstanding issue referred to could be described as a 'lack of alignment' between CYMHS services and adult mental health services. This is more overt within the public mental health sector as I have outlined in response 79(c).

As aforementioned, there is growing evidence that the emerging adult has discreet developmental requirements that are not met within the adult mental health model and that the CYMHS family focussed and systemic model is better aligned with this cohort.

There is currently a lack of policy direction for both child and youth mental health and the emerging adult cohort. To adequately cater for this group there would need to be state commitment to appropriately fund both the CYMHS and the emerging adult sectors, reduce inflexible chronological age barriers and ensure a responsive service to address what is often the 'peak onset time' for enduring mental health disorders.

(b) Please elaborate on the discussions held at the State-wide Clinical Network Meeting in relation to this *"outstanding issue"* and what

opportunities were identified for further service improvement. Please provide copies of minutes from any meetings where this was discussed.

I was not present at this meeting and cannot provide the minutes. I suggest you contact the secretariat Ms Ailie Perich to provide you with the minutes.

Dr Stephen Stathis attends this meeting (and I will proxy for him on occasion). Dr Stathis had reported back to me that transitions from child and youth to adult mental health services was raised within that meeting and I understand a transitions guidelines was developed as an outcome of these discussions. i further understand Dr Stathis has already provided a copy of this document to the Commission.

(c) Is there a need for mental health services directed to the 18 to 25 year age group, or a similar age group and if so, explain generally what services are needed and whether this need was discussed during the State-wide Clinical Network Meeting?

As aforementioned, I was not at the Clinical Network meeting where this issue was discussed so cannot comment on this. It is not my understanding that there has been any state wide policy direction in relation to manage the gaps in service delivery for emerging adults (18 – 25 years). I cannot comment further on what services would be required to meet the needs of this cohort without a comprehensive mapping exercise to identify the specific gaps.

Based on my knowledge of the literature the CYMHS model of care with its focus on systemic and family focussed approaches combined with individual therapeutic engagement is a more robust model to base future emerging adult services on.

Further questions agreed upon during Ms Krause's attendance at the Commission on 29 January 2016

Q.1 What does Ms Krause mean when she uses the phrase "contemporary model of care" and what are the elements of a contemporary model of care? How does this fit in within the service categories and/or elements in the draft NMHSPF?

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My interpretation of contemporary model of care within CYMHS incorporates consumer and carer centred, recovery focussed treatment, provided in the least restrictive environment as close to home as possible.

Treatment modalities should be evidence informed and representative of a range of therapeutic interventions appropriate for children and adolescents such as family based therapies, trauma and attachment informed therapies, cognitive behavioural therapies and psychodynamic expressive therapies. Staff should be credentialed or registered (or equivalent) clinicians who access regular professional development and clinical supervision.

There should be a robust governance system with clear operational roles, policies and procedures that guide practice, which complies with the National Standards for Mental Health Services 2010 and the Australian Council on Healthcare Standards (ACHS) National Safety and Quality Health Service (NSQHS).

There should be flexible access to the service delivery with clinic based and outreach capacity, access to after-hours services with a crisis response component, hospital avoidance programs and strong interagency and systemic partnerships to support consumers and their families.

These concepts align with the elements of the NMHSPF (according to the draft extracts exhibited to my supplementary affidavit) in the following ways:

Service Element – Intensive Community Treatment Services (ICTS) 0 – 17 years: this is a community based service (least restrictive environment) it has outreach capacity, extended hours and potential for multiple sessions per week, developmentally appropriate evidence informed interventions (flexible access & evidence informed interventions)

Service Element – Day Program (Child and Adolescent 0 – 17 years): community based service (lease restrictive environment), multiple sessions per week (flexible access), integration with education programs and evidence informed interventions with recovery and discharge planning.

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Service Category – Sub Acute Services (residential and Hospital or Nursing Home Based): hospital based preference for client to be voluntary (least restrictive principles), specialist evidence informed interventions provided by registered/credentialed staff with rehabilitative focus of care.

Service Element – Step Up Step Down Youth: community based, average length of Stay – 21 days (least restrictive and close to home), delivered in partnership with NGO, provision of short term transitional recovery focussed care, family engagement.

Q.2 Can Ms Krause distinguish between how the terms "model of service delivery" and "models of care" are generally used within CYMHS sector?

In my opinion these terms are sometimes used interchangeably within the CYMHS and broader mental health sector.

My personal understanding of the distinction is that a Model of Service Delivery is an overarching high-level document that is aspirational in nature and intended to describe aspects of the service delivery inclusive of the target population, the functions, operation and governance of the service. The Model of Service Delivery document includes hyperlinks to resources that can inform clinical practice, including key state and national policy documents, standards, protocols and guidelines.

The model of care outlines how the clinical care is delivered and will operationalise the Model of Service Delivery and may necessitate other local supporting documentation such as operational guidelines and work unit instructions that are very specific and provide more detailed information about the work unit's clinical care delivery.

I cannot state categorically that my interpretation of these terms is a shared view across the CYMHS sector.

Q.3 Please explain Ms Krause's understanding of Milieu therapy.

Milieu therapy is by definition a form of psychotherapy that occurs within an inpatient setting and involves structuring the environment in order to effect behavioural change and improve the individual's psychological health and functioning (Skinner, 1979).

Multidisciplinary staff can participate in milieu therapy and it provides a framework for practice incorporating the key elements below:

- Containment - provision of safety and security.
- Validation – provision of an affirming therapeutic environment, particularly during staff interactions.
- Structured interactions – purposeful interactions that support the client to interact with others and provision of environmental routine and structure and clear behavioural expectations and appropriate limit setting.
- Open communication – supportive staff – client relationships, appropriate role modelling from staff and positive reinforcement and reassurance assist clients to improve self-esteem and confidence. Clients are encouraged to make decisions, contribute to ward management and become less passive and less dependent.

Disadvantages identified in the literature can be blurred roles between staff and clients, inconsistent application of milieu therapy by staff, the individual's needs and concerns may not be met as the focus can be more on the group processes and the transition back into the community can be difficult for some clients (Kaplan and Sadock, 1998). For staff to understand and consistently implement the principles of milieu therapy appropriate orientation, professional development and supervision in this framework would need to be available. I am not aware of any recent formal training in milieu therapy that has been developed and implemented for CYMHS staff in Queensland.

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

Sworn by Judi Krause on 4 February 2016)
at 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

CERTIFICATE OF EXHIBIT

Exhibit A to the affidavit of Judith Krause sworn on 4 February 2016

[redacted]

Deponent

[redacted]

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

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