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

SUPPLEMENTARY SUBMISSIONS OF DR WILLIAM KINGSWELL REGARDING THE DRAFT NATIONAL MENTAL HEALTH SERVICE PLANNING FRAMEWORK

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SUMMARY OF SUBMISSIONS

1. These submissions are made on behalf of Dr William Kingswell.

2. Submissions are made in response to:

   a. The Commissioner's request to receive submissions about how to interpret the draft National Mental Health Service Planning Framework – Service Element and Activity Descriptions (**NMHSPF**); [1] and

   b. Submissions of Counsel Assisting on the Draft NMHSPF.

3. Supplementary written submissions regarding the NMHSPF have been made by the Hon Lawrence Springborg [2] and the State of Queensland. [3] Subject to what follows, those submissions should be accepted.

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1 There are two versions of the NMHSPF in evidence. The November 2012 version is Exhibit 289 (DBK.500.002.0620). The October 2013 version is Exhibit 233 (DBK.500.002.1128).

2 Addendum to written submissions on behalf of the Honourable Lawrence Springborg dated 15 April 2016 – Construction of the draft NMHSPF.

3 Supplementary submissions on behalf of the State of Queensland Regarding the Draft National Mental Health Service Planning Framework dated 15 April 2016.

THE TRUE SIGNIFICANCE OF NMHSPF

4. The NMHSPF is significant in two respects only.

5. The NMHSPF has primary significance because it uses terminology which the ECRG was expected to employ, but did not. The NMHSPF has secondary significance because it reflects contemporary thinking that institutionalised models of care are outdated.

6. Otherwise, the NMHSPF has no particular significance to the matters that the Commission must consider.

The primary significance of the NMHSPF

7. The ECRG terms of reference[4] directed the ECRG to consider models of care that "*align[ed] with … National mental health service planning frameworks*".[5] Dr Kingswell took this to mean that the ECRG would use NMHSPF terminology.[6] As it happens, the ECRG may not have been aware of NMHSPF terminology.[7]

8. For Dr Kingswell, the fact that the ECRG did not use NMHSPF terminology was a source of frustration. His frustration related to the ECRG's terminology, not to its recommendations. It is important to remember the relevant evidence on this point.

9. The relevant evidence begins at Transcript 13-23 line 25. Counsel Assisting directed Dr Kingswell to the ECRG's recommendation that "*A tier 3 service should be prioritised.*" Counsel Assisting then asked Dr Kingswell "*Did you agree with that?*"[8] Dr Kingswell said "*I wasn't happy with the language, but I was happy with the intent.*" Counsel Assisting then asked "*What were you unhappy about the*

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4 Included with Statement of Dr William Kingswell dated 21 October 2015 (Exhibit 68, DBK.900.001.0001 at DBK.900.001.0001.0230).

5 CHS.001.001.6019, Item 2.1; This is so notwithstanding the contrary proposition put to Dr Kingswell at T13-45, line 13

6 T13-23 lines 42-44.

7 T13-45 lines 9-17.

8 T13-23 lines 31-32.

language?"[9] Dr Kingswell said[10] that he thought that the remit of the ECRG was uncomfortably broad, bearing in mind that the ECRG was expected to provide a solution to a pressing issue, and then said:

> *I understood that they had been asked to constrain their thinking within the National Mental Health Service's planning framework, and I thought that was important to do so in that that was the policy document of all Australian governments. And I just thought it would have helped if we had a consistency of language, and so tier 3, I thought, was – I didn't – I don't think I actually got it for a while either, that I didn't – in fact, maybe I still don't – whether it's a build or a – or a service; that – that possibly still remains a little bit unclear for me. So, yes, I – it was completely comfortable with the idea that we needed extended inpatient facilities for a group of adolescents, tier 3, whatever you call it. Yes.*

10. The issue is picked up again at Transcript 13-29 line 29. Counsel Assisting asked Dr Kingswell whether he was "*really saying that [the ECRG] were wrong [to recommend] a tier 3?*" He responded[11] "*No, no. I just think that they had applied a language that wasn't – wasn't needed.*" Counsel Assisting challenged[12] this evidence, asking "*You weren't saying – using the expression tier 3 nonsense because of the language they used?*" Again, Dr Kingswell responded: [13]

> *That's not true. I was quite clearly using it because of the language that they used.* ***If you look at my actions in relation to the ECRG recommendations, you can see that we strenuously attempted to implement every one of them.*** [emphasis added]

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9 T13-23 line 35.

10 T 13-23 line 35 to Transcript 13-24 line 4.

11 T 13-29 lines 29-30.

12 T 13-29 lines 45-46.

13 T 13-29 line 46 – Transcript 13-29 lines 1–2.

11. Counsel Assisting challenged[14] Dr Kingswell again, asking whether he accepted "*the proposition that [he was] sceptical of the ECRG's recommendations?*" Dr Kingswell said[15]:

> *No. I sat on the – I sat on the planning group, and we accepted their recommendations and we worked on strategies to implement all of them. I was – I was not sceptical as such. I was just disappointed that they'd applied a language to their thinking that wasn't required. All that work had already been done at a national level.*

12. The questioning continued[16]:

> COUNSEL ASSISTING*: I see. And are you saying that the framework documents are inconsistent with the ECRG and their attitude?*
>
> DR KINGSWELL*: No. I think most of the elements that they have within their tiers are captured in the National Mental Health Services Planning Framework, and they could have used that document to describe those tiers rather than develop their own nomenclature for it. And when it came to tier 3, the National Mental Health Services Planning Framework would envisage that as a Step Up Step Down unit and then following from that YPARC model in Victoria and an acceptance that there would be some modification of that model in Queensland to meet the expectations of the reference group.*

13. It is submitted that this evidence establishes that Dr Kingswell's frustration with the ECRG Report related to its terminology, not its recommendations.

14. One further point needs to be made.

15. Counsel Assisting contend[17] that Dr Kingswell was wrong to describe that ECRG's recommendations as "*at odds*" with the NMHSPF. These submissions miss the point. The fact is, regardless of whether the ECRG's recommendations are "*at odds*" with the NMHSPF, Dr Kingswell attempted to facilitate implementation of them through his role on the Planning Group and subsequently as a member of the Oversight

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14 T 13-44 line 39-40.

15 T 13-44 line 40-44.

16 T 13-44 line 46 – T 13-44 line 7.

17 Submissions of Counsel Assisting on the Draft NMHSPF at [33].

Committee. Of course, it may be that Dr Kingswell was mistaken about what the ECRG actually recommended (a tier 3 "facility" or a tier 3 "service"), but that is a different issue.

NMHSPF and outdated model of care

16. Dr Kingswell plainly believed that the BAC model of care was outdated.[18] That is because, in his view, the BAC model of care represented an institutionalised, rather than community-based, model of care.[19] Dr Kingswell is not alone disfavouring institutionalised models of care. Many witnesses gave evidence to similar effect.[20] It is unnecessary to recite their evidence here.

17. The NMHSPF is relevant to models of care only in this way. The NMHSPF *reflects* contemporary medical opinion that community-based care is preferable to institutionalised care. The NMHSPF is not the *source* of this medical opinion, it merely *reflects* it. The NMHSPF did not instigate the shift in medical opinion away from institutionalised care, towards community-based care: this shift had been occurring for decades.[21]

18. When Dr Kingswell proposed that the Redlands Project could be cancelled, he did so, in (small) part, because he believed that the Redlands Project envisioned an outdated model of care. Dr Kingswell believed the Redlands model of care was outdated because of contemporary medical opinion, not because of the NMHSPF.

19. It is important to not to overstate the significance of the model of care issue in this respect. The Redlands Project was plagued with problems: delays, budget overruns and environmental issues. Moreover, the cancellation occurred in the context of the

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18 Statement of Dr William Kingswell dated 21 October 2015 (Exhibit 68, DBK.900.001.0001 at DBK.900.001.0001.0007).

19 T 13-37 and 13-62.

20 See evidence referred to in Submissions of Dr William Kingswell dated 23 March 2016 at [177]–[195].

21 T 13-37 and 13-62. See also ECRG Report at WMS.9000.006.00865 "*A key principle for child and youth mental health services, which his accepted by all members of the ECRG, is that young people are treated in the least restrictive environment possible*".

implementation of a "fiscal repair strategy" by the State Government. Dr Kingswell recalls being asked to contribute approximately $100 million in savings across the Queensland Health budget.[22] His evidence is to the effect that this was the primary reason why he proposed that the Redlands Project could be cancelled. As he said:[23]

> *I would never have offered up substantial mental health infrastructure as some sacrifice to the greater corporate good. You will see from my emails back from 2008 that I thought that that project would have been a – notwithstanding that I didn't want the Barrett Adolescent Centre relocated from Wacol to Redlands that I thought that that was critical infrastructure that would have been very useful in Metro South to bolster its overall service provision for adolescents.*
>
> *[Diehm QC:] Right?---And I remained of that view.*

20. From Dr Kingswell's perspective, the model of care issue was certainly not the most significant reason why the Redlands Project was cancelled. Any perceived inconsistency between the Redlands model of care and the work that had been done to develop the NMHSPF was similarly not a significant reason.

21. Counsel Assisting refer[24] to evidence from Dr Cleary to the effect that Dr Kingswell advised the continuation of the Redlands Project was not appropriate for a range of reasons including:

> *the proposed unit continued a model of care that was now not considered contemporary. Contemporary models were moving from institutional care to community based care. Dr Kingswell indicated that there was work being undertaken nationally that indicated that institutional models of care were not considered contemporary under the draft 'National Mental Health Service Planning Framework'.*

22. Dr Kingswell was not asked about discussing the NMHSPF with Dr Cleary. Had he been asked about the issue, I am instructed that he would have said that he had in fact had numerous discussions with other persons involved in the preparation of the

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22 See Submissions of Dr William Kingswell dated 23 March 2016 at [90]-[91].

23 T 13-60 lines 36–42.

24 Submissions of Counsel Assisting on the Draft NMHSPF at [65].

NMHSPF between October 2011 and May 2012; and that his understanding from those discussions was that the thinking of those experts involved in developing the NMHSPF favoured community-based care rather than institutionalised care.

23. It is accepted that as at May 2012, the documents that presently are before the Commission comprising the draft NMHSPF were not yet available. There may have been earlier drafts, but there is no evidence before the Commission of that. In any event, there is no doubt that work had been done by then on developing the NMHSPF. That work reflected what is undoubtedly the weight of opinion, which is that community-based rather than institutionalised care was preferred.

24. Assuming that Dr Kingswell did mention the work being undertaken on developing the NMHSPF to Dr Cleary, that advice was entirely consistent with what the then current thinking was. Dr Kingswell never advised that the NMHSPF required that the Redlands Project be cancelled.

25. It is submitted that the Commissioner would not find that Dr Kingswell advised that the Redlands Project should be cancelled because of the NMHSPF. First, there is no evidence (apart from the above) that the NMHSPF had any real bearing on the cancellation of the Redlands Project. In this regard, it is notable that NMHSPF is not referred to in the May 2012 Briefing Note. Secondly, Dr Kingswell accepts that the NMHSPF documentation was at material times a draft, albeit now well developed. Dr Kingswell's view about the Redlands model of care was, in truth, based on his assessment of contemporary medical opinion, not on any NMHSPF documents that then existed. The NMHSPF was ancillary to Dr Kingswell's independently justified view that contemporary medical opinion did not support the model of care envisioned for Redlands.

CONCLUSIONS

26. In my submission, it is not necessary for the Commission to reach a concluded view about the proper construction of the draft NMHSPF documents.

27. Insofar as the Commission considers that it is necessary to do so, then I respectfully adopt the written submissions of the State of Queensland and the Hon Lawrence Springborg MP in that respect, save for one qualification.

28. The Hon Lawrence Springborg MP submits that evidence about the meaning of the NMHSPF should be called from appropriately qualified experts. That is in my submission unnecessary: the Commission has already heard sufficient evidence from appropriately qualified experts, ie Dr Kingswell and Dr Kotzé.

29. Dr Kingswell and Dr Kotzé have had considerable involvement in drafting the NMHSPF. Dr Kingswell was Deputy Chair of the NMHSPF Executive Group. He was the only Queensland representative on that Group. He is eminently qualified to assist in the meaning of the NMHSPF, it being a technical document "*prepared by expert clinicians for expert clinicians*".[25]

30. At paragraph 15 of its submissions, the State of Queensland identifies those experts who formed part of the Executive Group, the Modelling, Working Group and Reference Group, other direct contributors and the Project Team for the NMHSPF. They include Dr Kingswell and Dr Kotzé. They do not include Dr Groves or Ms Janet Anderson.

31. Dr Groves had involvement in the NMHSPF only in its very early stages.[26] He accepts that "*soon after the middle of 2011*" he "*had no further direct involvement in Queensland's participation on the project*". He regained access to the NMHSPF in May 2013 but, as Dr Groves says, "*the project was [then] well advanced*". The fact is, between 2011 and 2013, Dr Kingswell had far greater involvement than Dr Groves in actually developing the NMHSPF. Dr Kingswell's evidence as to the meaning of the NMHSPF should be preferred to that of Dr Groves.

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25 Further Written Submissions on Behalf of the Honourable Lawrence Springborg MP dated 15 April 2016, at 2.

26 Statement of Dr Aaron Groves dated 21 January 2016 at [188]-[196].

32. As for Ms Janet Anderson, there is no evidence that she had any involvement in the drafting of the NMHSPF. The extent of her familiarity with the document is a matter for speculation. Dr Kingswell's and Dr Kotzé's evidence as to the NMHSPF's meaning should be preferred.

33. If, contrary to my submission, the Commission considers that further evidence about the NMHSPF is desirable, then it is submitted that any or all of the following persons should be called to give evidence: Mr Bill Buckingham, Mr Gaven Stewart, Mr Kevin Fjeldsoe and Mr Brian Woods.

34. Counsel Assisting submit[27] that Dr Kingswell "*seemed to get confused in his evidence regarding taxonomy*" under the NMHSPF. That is an unfair criticism. A fair reading of the evidence reveals that any confusion arose solely as a result of the form of questions that were posed in cross-examination.[28]

35. Finally, Counsel Assisting submit that Dr Kingswell's understanding of the NMHSPF was based on "*illusive conversations with others*". Again, that criticism is unfair. First, Dr Kingswell was never cross-examined about "*illusive conversations*". Had he been asked about such conversations, he could have given some explanation about them. He cannot fairly be criticised now for failing to give details of conversations he was not asked about. Secondly, it is perfectly legitimate for a professional such as Dr Kingswell to rely upon conversations with other professionals. In this regard I note the submissions made at Transcript 28-12.

36. In conclusion, there is no proper basis on the evidence for a criticism of Dr Kingswell arising out of his references to the thinking or language reflected in the work done to develop the draft documentation articulating the NMHSPF.

Adrian Duffy QC
Counsel for Dr Kingswell
19 April 2016

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[27] Submissions of Counsel Assisting on the Draft NMHSPF at [65].

[28] See Transcript 13-35/37.