EXHIBIT 84

BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

AFFIDAVIT

Brett Michael Charles McDermott of c/- Meridian Lawyers, Level 8, 60 Edward Street, Brisbane, solemnly and sincerely affirms and declares:

1. I make this affidavit in response to the Requirement to Produce Documents and the Requirement to Give Information in a Written Statement (and the accompanying Schedule thereto) issued by the Honourable Margaret Wilson QC, Commissioner, Barrett Adolescent Centre Commission of Inquiry (the Commission), dated 26 October 2015.

Background and experience

2. I am currently the Professor of Psychiatry, a joint appointment with James Cook University and the Townsville Health and Hospital Service, Queensland Health. The clinical commitment associated with this role is with the Townsville Child and Youth Mental Health Service (CYMHS).

3. I am also an Adjunct Professor at the Queensland University of Technology and a By-Fellow of Churchill College, Cambridge University UK.

4. In October 2015 I completed a nine year term as a Board Director of beyondblue - the national depression initiative.

Signed: Brett Michael Charles McDermott

Taken by: Veronica Dubois, Commissioner for Declarations

AFFIDAVIT
Filed on behalf of Prof. Brett McDermott

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Our Ref: AGJ:DJD:2011113

5. My qualifications include a Bachelor of Medical Science (BMedSc), Bachelor of Medicine (MB), Bachelor of Surgery (BS), a Doctorate in Medicine (MD), a Certificate of Training in Child and Adolescent Psychiatry (CertChildPsych), and I am a Fellow of the Royal Australian and New Zealand College of Psychiatrists (FRANZCP).

6. Exhibit **BMCM-1** to this affidavit is a copy of my curriculum vitae (CV).

CYMHS – Mater Health Service

7. From May 2002 to November 2014, I was the Executive Director, CYMHS, Mater Health Service.

8. Mater CYMHS provided a comprehensive range of child and youth mental health services to a dedicated catchment area on the south side of Brisbane, including suburbs to the east of the Brisbane CBD such as Carindale, to the southeast including Mt Gravatt, and to the southwest to include Inala.

9. Services at the Mater Health Services South Brisbane campus included a 12-bed child and adolescent inpatient unit, a day program, a consultation-liaison service (which provided a service to paediatric patients who had a psychological component to their illness), Adolescent Drug and Alcohol Withdrawal Service (ADAWS), and the Mater CYMHS management unit and research centre.

10. Mater CYMHS also provided community clinics within its catchment area including at Greenslopes, Yeronga, Mt Gravatt and Inala.

11. In addition, Mater CYMHS hosted a specific service for children who were wards of the State (part of the 'Evolve' state-wide services), an infant mental health team, and provided the Queensland state-wide child and adolescent mental health disaster response.

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12. My key duties and responsibilities as the Executive Director of Mater CYMHS were:

    (a) Principal leader of the strategic direction of the service, which included the conceptualisation and initiation of new services, as well as input into the running and direction of existing services.

    (b) Lead role in the provision of clinical services - this included my role as the Senior Child and Adolescent Psychiatrist in the service. I was the line manager of medical practitioners and responsible for the overall clinical care of patients. In this role I worked closely with the Executive Manager of Mater CYMHS whose responsibilities were more administrative and human resources related.

    (c) Given Mater CYMHS was one of the two very large child and youth mental health services in Queensland, I was often asked to be involved in statewide processes including advice around statewide issues (for example, the development of new services such as the Evolve services for children who were wards of the state and the service developments in Townsville). Often this was informal; at times it involved membership of various committees.

Mater Adolescent and Young Adult Centre (MAYAC)

13. In the period from around June 2013 to December 2014, I was the Director of MAYAC.

14. MAYAC was in the development phase during that period, and my role as director at that time was wholly related to developing a new model of care and a complete new service.

15. As MAYAC was then in the development phase, no MAYAC clinical service had opened, and as such there were no clinical responsibilities associated with the service, or patients seen during that period.

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16. My duties and responsibilities were about service development, including general medical adolescent services, psychological services to adolescents whose primary presentation was a physical illness, and the development of a private adolescent integrated mental health inpatient and day program.

17. Other duties were chairing a process that developed the financial model of the service.

18. Similarly, I chaired a process that was tasked with re-purposing the soon to be de-commissioned Mater Children's Hospital into an entity suitable for the new MAYAC service.

Specialist knowledge

Overview of practice and particular areas of interest in adolescent psychiatry

19. For the 13 years when I was Executive Director, Mater CYMHS, my practice was approximately equally divided into three elements – leadership, research and clinical practice.

20. In terms of leadership, I had responsibility for the overall strategic direction of the service, including new clinical undertakings. I was responsible for the management and supervision of medical practitioners, child and adolescent psychiatrists, psychiatry registrars in training and other medical colleagues. Part of this leadership was around psychiatric emergencies and complex cases.

21. Research initiatives focused on two areas:
    (a) I was responsible for the child and adolescent mental health disaster response across several Queensland disasters, as well as input into incidents in other states. I took a strong evidence based medicine approach to these initiatives and inspection of my CV (see: Ex BMCM-1) will find a range of disaster specific publications focusing on models of care and treatment.

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(b) Applied research relating to CYMHS practice in the public setting. This was a broad area and again, inspection of my CV will find publications related to specific diagnoses (for example, Chair of the NHMRC-beyondblue Clinical Practice Guidelines in Adolescent and Youth Depression); psychological aspects of physical illnesses such as diabetes, medication use and prescription; violence and aggression on the inpatient unit; and aspects of the drug and alcohol service delivery.

22. My clinical responsibilities included significant on-call responsibilities, coverage of consultant leave from any area of the service, and providing second opinions around areas of personal clinical experience, such as children and adolescents with eating disorders, and children who experienced emotional trauma, either single event trauma or more complex presentations.

23. All my publications and conference presentations are included in the relevant sections of my CV.

Maintenance of relevancy of knowledge in adolescent psychiatry

24. I have complied with the Australian and New Zealand College of Psychiatrists Maintenance of Professional Standards (MoPS) regime and hold a certificate of currency. Various activities are counted for MoPS including peer review, grand-round and conference attendance, journal clubs and other training activities.

25. Further, I have maintained my relevancy of knowledge by being an active presenter to my peers at national and international conferences, as well as being a frequent presenter of training workshops. The latter includes being engaged by Phoenix Australia: the Australian Centre for Post-traumatic Mental Health, to co-author and then deliver the training on the treatment of Post Traumatic Stress Disorder (PTSD) in children and adolescents. I have also provided numerous training workshops for an organisation called Compass (both the Australian and

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New Zealand divisions) on the topics of eating disorders, PTSD, and challenging behaviour in children and adolescents.

26. Finally, the process of research publication involves very rigorous scrutiny by peers during the approval process. It can be argued that every publication requires relevancy of knowledge to pass this hurdle.

Research into models of care

27. I have published several papers in international peer reviewed journals that relate to child and adolescent mental health models of care.

28. In 2014 I was the lead author of a publication on a stepped-care model for the provision of post-disaster child and adolescent mental health services.

29. In 2002 I was the lead author of a publication that specifically considered the illness burden of child and adolescent mental health patients across inpatient, day program and community settings.

30. Numerous other publications talk to aspects of service provision such as medication prescribing patterns, the range of patient comorbidity (those with multiple diagnoses) and impairment, and aggression and violence in service settings, for example:

- McDermott BM, Cobham VE. A Stepped Care Model of Post-Disaster Child and Adolescent Mental Health Service Provision. European Journal of Psychotraumatology. 5, 24294, http://dx.doi.org/10.3402/ejpt.v5.24294, 2014.

- Park C., McDermott BM, Loy J, Dean P. Patterns of adolescent's admission to a general adult inpatient psychiatric hospital and implications for service provision. Australasian Psychiatry 2011, 19(4): 345-349.

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- Dean AJ, Gibbon P, McDermott BM, Davidson T, Scott J. Exposure to aggression and the impact on staff in a child and adolescent inpatient unit. Archives of Psychiatric Nursing 2010 24(1), 15-26.

- Dean A, Scott J., McDermott BM. Changing utilisation of PRN sedation in a child and adolescent psychiatric inpatient unit. Australian and New Zealand Journal of Psychiatry 2009 43(4):360-365.

- McDermott BM, McKelvey R, Roberts L, Davies L. Severity of Children's Psychopathology and Impairment and Its Relationship to Treatment Setting. Psychiatric Services 2002; 53(1): 57 – 62.

The Barrett Adolescent Centre ('BAC')

Documentation

31. To protect patient confidentiality and sensitive service provision issues it has been my practice not to forward work emails to my home (private) email address.

32. Similarly, when I completed my tenure as Executive Director, Mater CYMHS, I ensured I did not retain any Mater documents at my home office.

33. I do not have access to the emails from my time as Executive Director, Mater CYMHS.

34. I have extensively searched my home (private) emails and home office and have been unable to locate any emails or other documents relating to the Commission's Terms of Reference. I am not surprised by this.

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Barrett Adolescent Centre, Consultation on Aggression and Violence at the BAC

35. To the best of my recollection, the BAC consultation on aggression and violence, and the subsequent report, *Barrett Adolescent Centre, Consultation on Aggression and Violence at the BAC* (the report), was requested from senior mental health management at the West Moreton Mental Health Service. That said, the actual individual was likely to have been either Dr. Terry Stedman (I think this was the case) or Dr. Trevor Sadler (Director of the BAC).

36. I believe that the initial contact was likely to have been by telephone. Given the usual time required to obtain the services of members of a review group and the length of time to conduct the review and then write such a report I believe I would have been contacted some 6 months before the submission of the final report, which report is dated August 2003.

37. As is my practice, I would have asked for terms of reference.

38. I recall that one member of the four person consultation group was Ms Karen Gullick, who was a very senior child and adolescent mental health nurse from Western Australia. I worked with Ms Gullick in the past, and believe that I contacted her personally to be part of the review.

39. I am of the opinion that the other review members were suggested by West Moreton Mental Health Service.

40. I have no records of or private emails about communications or consultations in relation to how I became involved in this review, and this information is likely to be in my Mater emails.

41. I have no records of or private emails about any letter of retention/commission to me to co-author the report, and this information is likely to be in my Mater emails.

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42. Once the report was completed it was delivered to the West Moreton Mental Health Service. I believe it was submitted to the then Director of the service, Dr. Terry Stedman.

43. Whilst not familiar with the line of management and/or the usual business practice of the West Moreton Mental Health Service, the consultation group worked under an assumption that the responsibility for considering the recommendations of the report, and if considered appropriate, implementing those recommendations, was the Director of the BAC, under the line management of the Director of the West Moreton Mental Health Service.

44. Following the submission of the report I had no further or ongoing, formal or informal role with the West Moreton Mental Health Service or the BAC in relation to the report and/or the recommendations made therein. Consistent with this I have no knowledge whether or not the recommendations were followed, or if any action was taken with regard to the recommendations contained within the report.

45. I have been provided with a copy of this report by the Commission. Exhibit **BMCM-2** to this affidavit is a copy of the report

Redlands Project

46. In early 2008 I was contacted about becoming involved in reviewing redevelopment options for the BAC.

47. I believe Dr Aaron Groves, the then Director of Mental Health in Queensland Health contacted me in this regard.

48. It is also possible that I was contacted by Mr Kevin Fjelsoe, who was a senior mental health administrator working with the mental health division under Dr

[redacted] [redacted]

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Groves, as I recall that Mr Fjelsoe had carriage of infrastructure development in the mental health branch.

49. My recollection is that I was involved in one or two face-to-face meetings of the redevelopment group.

50. I recall a particular half day site visit in which the group went to potential BAC redevelopment sites, including a 'green field' site on the Wacol Mental Health Campus (the Wacol site), a 'green field' site adjacent to the Mater Private Hospital Redland (the Redlands site), and an existing building on the Royal Brisbane Hospital campus (the building that was at that time the Child and Family Treatment Unit (CAFTU) building (the CAFTU site)).

51. I have been provided with a copy of the *Report of the site evaluation subgroup* by the Commission and note that the group also considered a site near the Logan Hospital and one at Rogers Street Spring Hill. Exhibit **BMCM-3** to this affidavit is a copy of that report.

52. I had no particular leadership role in this group, but rather I was a member of the group with content expertise in the delivery of child and youth mental health services and with a specific emphasis on understanding the relationship between inpatient and day program services. This was partly because, at that time, I was the director of an inpatient and day program (at the time the only child and youth mental health day program in Queensland) and I also had at least one academic publication relating to inpatient and day program patients (see: para 30 above, the 2002 reference).

53. I recall being involved in the deliberations of the group. I recall arguing strongly that the Wacol site was, in my opinion, not appropriate because it was on a large mental health campus, the site was increasingly a place of restricted care (for example, the building of the Medium Secure Forensic Mental Health Unit), and the group had been verbally advised that it might be the place where

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accommodation was to be provided for convicted sex offenders who had not been able to live in a community because of strong negative community advocacy following discovery of their identity and past history. I was of the opinion that one or more convicted sex offenders could in no sense be housed close to adolescents who were vulnerable because of mental illness and/or personal experience of abuse.

54. I recall also arguing against the CAFTU site given the building's age, the amount of work required to refurbish the building, the fact that it would not easily accommodate a day program, and my concerns about the geographical closeness to Fortitude Valley and the ability of vulnerable adolescents to meet with, or be targeted by potential criminal elements, such as those selling illicit drugs.

55. The report of the site evaluation group recommended the Redlands site (see Executive Summary, page 3 of site evaluation report).

56. I believe that this recommendation was accepted and the process thereafter became the 'Redlands project'.

57. It is my understanding that the individual who was ultimately responsible for considering and implementing the recommendation was the then Director of Mental Health in Queensland, Dr Aaron Groves.

58. I believe that the recommendations were followed in that at a subsequent date (which date I cannot recall), probably as part of the deliberations of the Redlands project, I saw architectural plans for a redevelopment of the BAC, and the plans clearly referred to the Redlands (also known as Cleveland) site.

59. To the best of my recollection the Redlands project was a natural extension of the group who recommended the Redlands site for the redevelopment of the BAC.

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60. For similar reasons for asking me to be part of the site relocation group, the Redlands project required child adolescent service delivery expertise in terms of both inpatient and day program units, and it would have been natural for me to have been asked to continue on with this process.

61. I do not recall when I was asked to be involved in the project.

62. I believe that it is likely that I would have been asked by the same person who requested my involvement with the site evaluation group - the Director of Mental Health, Dr Aaron Groves, and that I was asked informally by telephone, and then with some follow-up documentation, likely to be by email.

63. I also recall that the Redlands group meetings were chaired by Associate Professor David Crompton (Executive Director, Mental Health Metro South). Mater CYMHS was the largest CYMHS in the Metro South region and for this reason I was well known to Professor Crompton.

64. My role in the Redlands project was to provide child adolescent mental health service provision content expertise, including the perspective of a director who ran an inpatient and day program.

65. Given my authorship of the 2003 report on aggression and violence at the BAC, it may also have been seen that I had useful input around patient safety. Indeed, by the time of the Redlands project I had co-authored several publications about staff safety and aggression and violence of child and adolescent mental health inpatient units, for example:

- Dean AJ., Duke S., Scott J., Bor W., George M., McDermott BM. Predictors of aggressive behaviour during admission to a child and adolescent inpatient unit and impact on clinical outcomes. Australian and New Zealand Journal of Psychiatry, 2008, 42(6): 536-543.

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66. The Commission has provided me with seven documents that relate to the Redlands project. These are the minutes of the meetings of the Queensland Health Capital Works Program Metro South group. Meeting dates were: 17/09/2009, 15/10/2009, 29/04/2010, 27/05/2010, 24/06/2010, 24/02/2011 and 24/03/2011. Exhibits **BMCM-4, BMCM-5, BMCM-6, BMCM-7, BMCM-8, BMCM-9** and **BMCM-10** respectively to this affidavit are copies of those minutes.

67. I cannot recall whether any specific recommendations, findings or decisions relating to the Redlands project were made and I am not aware of any summary document containing any such recommendations, findings or decisions.

68. However, as noted above, I do recall seeing architectural plans for a unit that was to replace the BAC on the Redland site.

69. I also recall that the redevelopment process was, as is often the case, not without some difficulty. This is clear from the minutes of the Redlands project, for example, concerns about security (meeting of 17/09/2009 - Ex **BMCM-4**), about the senior BAC staff not relocating to the new facility (meeting of 15/10/2009 – Ex **BMCM-5**) and whether budget constraints would impact the provision of a day program (meeting of 24/06/2010 – Ex **BMCM-8**).

70. Other issues that I recall were delays in deciding where the actual buildings would be placed on the Redlands site because of two very Queensland issues - whether protected species such as koalas were on the site (see comment, "koalas study was underway" meeting of 27/05/2010 – Ex **BMCM-7**), and the possibility of an area being of specific aboriginal significance. I recall that these factors created some limitations on where the built structure could be placed.

71. I believe that if recommendations were made, they would have been submitted to the Director of Mental Health in Queensland, who was still Dr Aaron Groves at that time.

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72. Given his position as Director of Mental Health in Queensland, I believe Dr. Aaron Groves would have been central to considering or implementing any recommendations and financial decisions, the latter influenced by expert briefing on the matter. However, I have no knowledge whether Dr Groves had the delegation for the ultimate decision on the project or whether this was his line manager.

73. It may also have been the case that implementation was delegated to Metro South Mental Health (Executive Director, Associate Professor David Crompton) given that Redlands was in the Metro South catchment area.

74. As the BAC was not redeveloped at the Redland site, there must have been a decision made to stop this process. I had no involvement in making that decision, I was not consulted about that decision, and do not have any knowledge about who made the decision or when it was made.

75. My recollection is that the Redlands project, which was about the built environment of the new centre, was complimented by a process which considered the best model of care for the new service entity – model of service delivery (MOSD) for the adolescent treatment and rehabilitation centre (AITRC).

76. Accordingly, I became involved in that process in the same way as I did in relation to my involvement in the Redlands project. That is, consideration of the best model of care for the new service entity required child adolescent service delivery expertise in terms of both inpatient to day program units, and it would have been natural for me to have been asked to be involved with this process.

77. In my private emails I have not found any communications or consultations regarding how or when I became involved in the MOSD for AITRC project, however, I believe I would have been asked to be involved in the process by the same person who requested my involvement with the site evaluation group and

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the Redlands project - the Director of Mental Health, Dr Aaron Groves, and perhaps Professor Compton.

78. The Commission has provided me with a copy minutes of a meeting titled, "Meeting to review model of service delivery (MOSD) for adolescent integrated treatment and rehabilitation centre (AITRC)", dated 10/02/2010, which I attended. Exhibit **BMCM-11** to this affidavit is a copy of those minutes.

79. My role in the MOSD for AITRC was to provide content expertise in the organisation, management and clinical aspects of a child inpatient and day program, and systems issues about how such a facility should interact with other services. However, I was not the only senior clinician with this role.

80. Further, my recollection is that this was not a consultation, but rather I was part of a group process featuring the shared experience of several clinicians. This is consistent with the membership of the group which was mostly senior clinicians, as identified in the minutes (Ex **BMCM-11**).

81. I found this process entirely appropriate, particularly because no matter how long or how well the BAC had functioned during its operational life, a new facility such as the AITRC would have required changes in policies and practices (for instance, around safety and leave from the site), as well as providing an opportunity to consider any contemporary research or theoretical influences to the new services offered at the centre.

82. I note that the minutes (Ex **BMCM-11**) detail a discussion about clinical matters very appropriate to a MOSD (for example, referral pathways, inclusion and exclusion criteria and length of stay), as well as a discussion about important management issues (for example, that AITRC should have "*line management .... by a well resourced CYMHS service*" - page 3 of the minutes).

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83. Further, the minutes detail provisional recommendations. However, I cannot recall, nor have evidence that the MOSD work and process lead to a specific document or report. Consistent with this, I am not aware of any finalised recommendations or findings that came out of this process.

84. If any final recommendations were made, in my view there are two possibilities in relation to who they were made to. They may have been made by submission to the Executive Director of Metro South, Associate Professor David Crompton. However, given the Chair of the group was the Acting-Executive Director of Royal Children's Hospital CYMHS, it is likely that the recommendations would have been forwarded to the then Director of Mental Health in Queensland.

85. It is my understanding that by this time Dr Aaron Groves was no longer the Director of Mental Health in Queensland, and Dr William Kingswell was either the acting or permanent Director. I am unsure of the exact timing of this change.

86. The other major change around this time was the creation of the Queensland Children's Hospital and Health Board. My understanding was that AITRC was to be line managed by this service.

87. If the Queensland Children's Hospital and Health Board structure was established by this time, then the Executive Director of this service was Ms Judi Krause. Ms Krause was also the Chair of the MOSD review group. In this new Queensland children's service role, Ms Krause may have been responsible for implementing the recommendations.

88. Given this was a significant new initiative, I would anticipate involvement of the new Director of Mental Health in Queensland, Dr Kingswell.

89. Please note, however, that my comments in this respect are supposition and others will be more knowledgeable than myself about these matters.

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90. I have no knowledge of whether recommendations or findings from this MOSD for AITRC process were followed and/or whether there were any actions taken. Even if a finalised recommendation document was submitted, the recommendations were specific to AITRC which was never built. Clearly recommendations could not have been actioned.

91. To the best of my recollection there were no other reviews, meetings, projects, assessments and/or reports relating to the BAC in which I was involved.

Decision to close the BAC

92. On 8 November 2012, I was a witness in the Queensland Child Protection Commission of Inquiry.

93. On that date I gave evidence that I had been informed that the BAC would be closed at Christmas.

94. My recollection is that one to two days prior to my scheduled time to give evidence at that Commission of Inquiry, and probably one day prior, on 7 November 2012, I had a telephone discussion with the Director of the Barrett Adolescent Centre, Dr. Trevor Sadler.

95. I recall that Dr. Sadler seemed very concerned, and when I enquired why, he informed me that he had been told by senior management at West Moreton Health District that a decision had been made to close the BAC by Christmas of that year.

96. I do not recall if he gave the specific name of the individual who gave him this information.

97. I questioned him as to whether there was some chance that this information was not correct and he advised me that he had been told in an official capacity that this was the case.

[redacted] [redacted]

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98. That telephone conversation was the only communication in any form and with any person and was the only means by which I became informed about the closure of the BAC.

99. I do not recall discussing or communicating this information in any way with any other person between the time I was told the information by Dr Sadler and when I informed the Commission of Inquiry of it.

100. After considering that this information was credible and reliable, I took no immediate action, but was aware that I was to appear before the Queensland Child Protection Commission of Inquiry the following day. I formed the opinion that the information was relevant to that Commission of Inquiry - that a Queensland facility whose clientele were individuals who had in many cases been subject to serious child protection issues, including in some cases sexual abuse, physical abuse or emotional neglect, was going to be closed during the time of the sitting of that Inquiry. Accordingly I decided to inform the Commission of my knowledge of the closure of the BAC.

101. The closure of the BAC was not a new discourse, and had been a point of discussion amongst child and adolescent psychiatrists, other mental health workers and consumers for many years. For example:

(a) Nine years earlier, in the 2003 consultation report on aggression and violence at the BAC (Ex **BMCM-2**), in recommendation 19 (p.9) it was noted that "*senior BAC and park management should .... advance with Queensland Health the issue of the continued funding and support of the BAC*".

(b) Further, under Section 7 Long Term Issues the Continuing Role of the BAC (p.45 of the report) it was noted, "*a pervasive theme among staff, and in the review team's opinion a significant barrier to change at the BAC is the uncertainty of the unit*".

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(c) The Redlands project and the MOSD/AITRC proceeded on the basis that at some stage the BAC would be closed.

102. The development and commissioning of a new facility for this patient group was seen with considerable enthusiasm.

103. My concern, when I was informed in November 2012 that BAC was to close at Christmas of that year and when I gave evidence at the Child Protection Commission of Inquiry in 2012, was the possibility of losing this new service - a place where some of the most disturbed adolescents in Queensland could receive high quality care that was more intensive and longer in duration than could be provided in an acute inpatient unit.

104. Further, a new unit would have been integrated and managed within a wider CYMHS and have been influenced by contemporary evidence-based medicine interventions.

105. I did not engage in discussing these well known and long-standing issues at the time of the Child Protection Commission of Inquiry.

106. I find it difficult to apportion subsequent events in relation to the BAC to anything that I said at the Queensland Child Protection Commission of Inquiry. It may be that my comments had no effect and an announcement would have been made in due course in any case.

107. I had very little involvement after giving my evidence to the Queensland Child Protection Commission of Inquiry. My recollection is that I gave one media interview.

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108. I was aware of increased media interest in the BAC and the plight of adolescents with severe mental health needs. I am also aware that consumers became more active in their support of the BAC at this time.

109. I note the subsequent considerable work to transition patients from the BAC and new service initiatives to care for this patient group. Some may feel that consumer and media awareness of the closure of the BAC had some influence in the robustness of this process and the fact that the BAC funding was put aside for these services.

Transition arrangements

Stakeholder consultation in respect of transition arrangements

110. The Commission has provided me with an email from Lauren Stocks, Administrative Officer, Planning and Partnerships Unit, Mental Health Alcohol and Other Drugs Branch, Queensland Health, dated 20/11/2012, requesting attendance at a stakeholder meeting to discuss the BAC. Exhibit **BMCM-12** to this affidavit is a copy of that email.

111. I have no independent recollection of the meeting referred to therein.

112. It may be that Erica Lee, the Executive Manager of Mater CYMHS (who I note from the email, was also an invitee) attended on behalf of both of us. This was a common occurrence in such circumstances, particularly if I had some pressing clinical issue to attend to.

113. The Commission has also provided me with an email from Leslie Dwyer, Chief Executive Officer, West Moreton Hospital and Health Service (mistakenly dated 11/14/2012) seeking support in developing an alternative model or models of service for the BAC. Exhibit **BMCM-13** to this affidavit is a copy of that email.

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114. It is my belief this approach subsequently led to a BAC transition process that more centrally involved staff from the new Children's Health Queensland. I had no leadership role in this process, was not a member on a transition group or committee and do not recall receiving the email.

115. In terms of any other stakeholder consultation in respect to the transition arrangements for the BAC clients, I had no formal involvement in this process and cannot recall attending any stakeholder meetings.

116. However, I do recall direct conversations with Dr Ann Brennan, consultant child and adolescent psychiatrist employed by Queensland Health to be the clinical lead of the process to transition patients from the BAC [redacted]

117. My role in this process was that if any BAC patient was to be formally transferred to the Mater CYMHS service this had to be approved by myself. This was consistent with my role as the Executive Director of Mater CYMHS. Consistent with this I note a document titled "Transition services planning", dated 27/11/13, provided to me by the Commission. Under the heading 'Tier 3 option' is the text, "*CHQ meeting with Brett McDermott to discuss arrangement between CAFTU and Mater Inpatient Acute Unit = aiming to secure 2 or 3 beds for extended treatment and rehabilitation from Feb 2014*". I do not know who the author of that document was. Exhibit **BMCM-14** to this affidavit is a copy of that document.

118. Regarding bed availability for BAC patients at the Mater inpatient unit, this was successfully negotiated [redacted]

119. In terms of the interaction between Dr Brennan and myself, this was not a process that required documentation. Rather it was a clinical decision process and [redacted]

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subsequent action. I made it known to Dr Brennan that Mater CYMHS was happy to be of whatever assistance we could to her (as it related to transition plans for BAC patients).

120. [redacted]

121. [redacted]

122. [redacted]

Reference or planning groups in respect of transition arrangements

123. I do not recall being invited to be an attendee or participate in any reference group or planning group in respect to the transition arrangements for clients of the BAC, and I had no role in any such reference groups or planning groups.

124. Mater CYMHS was asked to provide input in the form of an attendee to this process.

125. I recollect that in deliberations with the Executive Manager of the CYMHS, Ms. Erica Lee we nominated Ms Amanda Tilse to be the Mater representative. I recall

[redacted] ..... [redacted] .....

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that it was reasoned that Ms Tilse was an excellent nominee for the process, given her role as the Service Coordinator of the Mater CYMHS campus services and therefore responsible for the management of our inpatient and day programs. Further, for many years she had been the team leader of the Mater CYMHS day program.

126. Given my lack of involvement in the reference groups or planning groups, it is difficult for me to comment on whether any recommendations or findings from the process were followed or implemented. However, I am aware that since that process a new residential placement option (YPETRI) has opened. There has also been a new service for intensive support for adolescents at risk (AMYOS). This suggests positive outcomes from the process.

127. It is my understanding that the process was under the auspice of the Queensland Children's Health and Hospital Service, Mental Health Branch, Executive Director, Ms Judi Krause, and Ms Krause received any recommendations or findings from the reference groups or planning groups, but I have no personal knowledge of this.

128. I have no knowledge whether or not any recommendations or findings were followed and whether there were any other relevant actions taken following the reference or planning groups.

Transition of BAC clients

Consideration of transition of BAC clients to Mater CYMHS

129. As noted above, a meeting between Children's Health Queensland (CHQ) and myself to make beds available in the (acute/short-stay) Mater inpatient unit is detailed in the document 'Transition Service Planning' (Ex **BMCM-14**). I do not have the exact dates of such meeting(s) but confirm that such occurred. I cannot specifically recall, but believe that Dr Stephen Staphis (Medical Director, CHQ)

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was involved, and that there was a successful outcome in that [redacted]

130. I only recall communications or consultations in relation to [redacted]

131. As noted above, I recall being telephoned, as the senior Mater CYMHS psychiatrist, by Dr Anne Brennan to discuss the case of a [redacted]

132. [redacted]

133. [redacted]

134. [redacted]

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135. [redacted]

136. [redacted]

Effect of transition arrangements on CYMHS and MAYAC

137. MAYAC was not operational (being still in the development stage) at this time so there were no implications to this service by the closure of BAC.

138. [redacted]

139. The length of stay at the Mater CYMHS inpatient unit was generally very brief – one to three day crisis admission, to one to three weeks for diagnostic clarification and/or commencing or changing pharmacological treatment or psychological treatment.

140. At Mater CYMHS, longer stays were deemed potentially non-therapeutic given the possibility of young people learning new problem-coping behaviour (for example, self-inflicted cutting) from other patients, dynamic issues around developing a non-therapeutic staff versus patient culture, or the understandable

[redacted] [redacted]

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distress of a long stay patient seeing numerous other youth being admitted and subsequently being discharged to home or other less restrictive accommodation alternatives.

141. [redacted]

Concerns re transition arrangements

142. As noted above, there were some general concerns in relation to a patient staying more than the average length of time in the Mater CYMHS acute inpatient unit. To reiterate, some of these concerns include learning new dysfunctional ways of coping from other patients; familiarity with the ward structure and staff over time leading to an alteration of the dynamics around patients and staff, and at its most problematic, patients developing a belligerent or antagonistic attitude; and distress at remaining on the unit week by week when all other patients are admitted and discharged.

143. These issues are well established and are part of the clinical experience of running an inpatient unit.

144. As part of my usual practice, I would have discussed these issues with our inpatient management team and our Mater CYMHS executive group.

145. I also recall that I discussed these issues with Dr Ann Brennan and Dr Stephen Staphis from Children's Health Queensland.

[redacted]

[redacted]

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146. An issue specific to the BAC transition group was the possibility that this group of patients were unlike other patients transferred to an acute inpatient unit in that they may be experiencing significant institutionalisation secondary to long-term inpatient care.

147. These matters were discussed, pre-admission with CHQ clinicians (Dr Brennan and Dr Staphis) and Mater CYMHS inpatient team leadership.

148. No specific action was taken, other than mindfulness of these issues in our formulation of the patient's case, therapy goal setting and management on the ward.

Transition of patients to Mater CYMHS

149. To the best of my recollection Mater CYMHS accepted all referrals to it from BAC.

150. [redacted]

151. It was the view of Mater Health Services that we held clinical responsibility for any patient living in our catchment area. We were also mindful that the closure of the BAC was an unusual circumstance that required special consideration and responsiveness of the child and youth mental health sector.

152. [redacted]

[redacted]
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153. It is my opinion that the various policy frameworks that have shaped the way mental health services have been delivered in Queensland have been suitable and appropriate in determining the nature of models of care for adolescent mental health services in Queensland.

154. Evidence of this is the recent development of the child and youth campus in Townsville which includes a brief stay inpatient unit and an outpatient day program facility that can provide a more intense and longer therapeutic experience (several days a week for several months) in a less restrictive environment.

155. Similar to this facility, the BAC redevelopment project was to be influenced by these principles.

Opinion

156. Having regard to my expertise in the field of child and adolescent psychiatry, I have been requested by the Commission to provide my opinion in relation to a number of matters.

157. It is my opinion that during the period 2012 to 2014, the BAC was adequate as a facility to care for the patients of the BAC, however I am qualified in this determination.

158. My support for the BAC was based on the anecdotal evidence that during the period of time the BAC was open (more than 20 years), no patient had committed suicide whilst at the facility.

159. Further, there was no accumulation of critical incidents and events, or suicides of former patients of the BAC reported either by the media or through government inquiry or reports, or research.

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160. Anecdotal evidence is not strong evidence but it does give face validity to the notion that the BAC was therapeutic and good outcomes could be expected.

161. However, from an empirical and evidence based medicine perspective, over the more than 20 years of operation of the BAC, I am not aware of one scientific publication that provided evidence of effectiveness of the therapy provided by the BAC - for example, evidence of symptom reduction, resolution of disorders, less impairment or higher functioning.

162. My evidence at the Child Protection Commission of Inquiry may have been perceived as me strongly supporting the BAC model of care.

163. However, my position was that I strongly supported the process of relocation of the BAC and hoped that a contemporary program and model of care would be delivered for the children of Queensland (as had been considered in the Redlands project and MOSD for AITRC process). My concern at that time was that that process might not occur.

164. It is my view that with the BAC closure in January 2014 it was appropriate to replace it with another similar facility, with the caveat that the contemporary program elements identified in MOSD for AITRC process be embedded in the similar facility.

165. However, the importance of the replacement facility was more around management and immersing that new centre within the culture of a large robust dynamic child and adolescent mental health service, rather than any simple geographical proximity.

166. Also of importance was not having the line management of the new facility under an adult mental health service, given that the latter would not be employing child and youth mental health professionals who could provide the new facility with

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