BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

Commissions of Inquiry Act 1950
Section 5(1)(d)

STATEMENT OF KEVIN FJELDSOE

Name of Witness:	**Kevin James Fjeldsoe OAM**
Date of birth:	
Current address:	
Occupation:	**Semi-retired / Consultant to the University of Queensland**
Contact details (phone/email):	**C/- Crown Law**
Statement taken by:	

I **KEVIN JAMES FJELDSOE** make oath and state as follows:

1. I have been semi-retired since September 2012.

2. I am currently undertaking work as a Consultant to the University of Queensland as a mental health service planner.

Background and experience

3. My background is in public mental health service delivery. I have previously worked as a Mental Health Nurse, including at The Park Centre for Mental Health. When working at The Park and elsewhere, I worked with a significant number of other staff who have given evidence before this commission.

4. I have worked as a Clinician, Manager, Director of Nursing, Executive Director of a District Mental Health Service, State Manager and, more recently, as the Director of the Mental Health Plan Implementation Unit, Queensland Health.

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5. As Director of the Mental Health Plan Implementation Unit, I was involved in the planning and process mapping associated with the development of the Queensland Plan for Mental Health 2007-2017. I had also previously contributed to the development of the Queensland Mental Health Plan 1996-2006.

6. In addition to the above roles, I have had experience:

   (a) working as a research project manager for the Mental Health Policy and Epidemiology Group at the Queensland Centre Mental Health Research. My primary area of research interest is evidence informed service planning and its application to practice.

   (b) providing service planning advice and/or conducted service reviews in each Australian jurisdiction and in New Zealand.

   (c) working on the national project team in the development of the first National Mental Health Service Planning Framework (**NMHSPF**). I provide further details in respect of the NMHSPF, below.

   In 2012 I was awarded the Medal of the Order of Australia for my work in mental health service reform and development.

7. A copy of my current curriculum vitae is attached and marked **'KJF-1'**.

Development of the NMHSPF

Governance structure

8. Attached and marked **'KJF-2'** is an extract from the NMHSPF Project Charter, which explains the governance structure developed to support the NMHSPF project.

9. In essence, the project was led by an Executive Group, with membership that included representatives of the Commonwealth and from each State. Initially Dr Aaron Groves was the Queensland representative on this group, however when he moved to Western Australia he was replaced by Dr Kingswell.

10. The Executive Group reported to a separate Commonwealth Group.

11. Beneath the Executive Group was a Project Team, led by New South Wales. This team did what could be best described as "the grunt work". Some members of the Project Team were full-time, particularly those based in New South Wales. Some members undertook

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secretariat work (such as organising meetings), others were involved in the consolidation of information provided by reference groups and providing that information back to the Executive Group. I was a member of the project team.

12. The structure also included a Modelling Group. That group included technical experts and academics. They were responsible for developing the epidemiological frameworks, and decision making tools. They were essentially responsible for developing and managing the functionality of the NMHSP tool.

13. At the bottom of the governance structure were a series of expert reference (or working) groups, with expert clinicians having been either seconded or commissioned to the project. As is listed in the NMHSPF there were many experts in all areas of mental health service delivery involved in the design of the NMHSPF. I am not sure of the total number of people involved but if you included all those involved directly or indirectly through commissioned work I would not be surprised if there were around 200 experts from across Australia, engaged in the project.

14. The expert groups focused on specific areas including child and youth, adult, older adults, bed-based services, community support non-government sector and ambulatory public sector services.

15. Each of the reference groups had, where possible, both a carer and consumer and non-government sector representative within their membership.

My role

16. From 2010 until September 2012 I was one of Queensland's representatives on the Project Team.

17. I was also a member of the expert group which focused on bed-based services and I attended the modelling group and executive group as an observer/representative of the project team.

Meeting in October 2013

18. A final meeting and workshop of the NMHSPF was held in October 2013.

19. At that time, the NMHSPF documents (including the Excel modelling document, or tool) were produced on USB, and a copy was given to the executive representative of each State.

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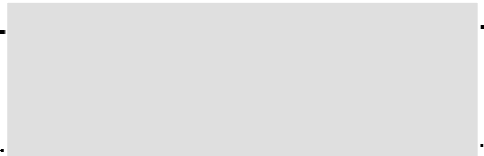

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20. I do not recall whether the NMHSPF had the watermark "Draft in Confidence Not for Circulation or Citation" on it. It may have done so.

21. The intention was that the tool would be taken away and used by each State to inform service planning work which they may be undertaking with a view to enabling continuous improvement and refinement. This is made clear by the diagram in the NMHSPF Project Charter called *"Define/Align/Refine development cycle for the NMHSPF"*. A copy of this diagram is attached and marked **'KJF-3'.**

22. This was the first time that the completed NMHSPF documentation had been distributed. However I am aware that Jurisdictional representatives on the Executive Group including the Queensland representative did have access to documentation prior to release as it was developed. This group was responsible for approval of documents and decisions as they were being made during the process.

23. I also know that in Queensland and in other places the tool including the taxonomy was presented to various groups as it was being developed. I recall that in Queensland I did a presentation for the senior leadership forum where I presented the taxonomy and an update on the development of the decision support tool.

Application of the NMHSPF

24. The taxonomy of the NMHSPF tool incorporates each of the mental health interventions or service types for which, in the opinion of the expert reference groups, there existed sufficient evidence for inclusion. It also included those elements which were considered on the basis of experience and expert opinion that should be provided. In essence specialist sub-groups reviewed what evidence they could find, combined their collective experience and reached that view.

25. No one whom I spoke with involved in any of these groups voiced the opinion, in my presence, that it was a good idea to institutionalise young people for long periods, which as I understand it was the model of service for the Barrett Adolescent Centre (**BAC**).

26. I am aware of the "some not all" principle which is acknowledged in the NMHSPF documents.

27. I do not interpret this to mean that the NMHSPF would necessarily foreshadow the inclusion of a specific service or facility, not otherwise provided for in the NMHSPF similar to that previously provided at the BAC.

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28. The principle is primarily intended to allow some flexibility on the part of the local services to accommodate certain variances within their target consumer population. For example, a care package may have 20-30 elements that the average person receiving that package needs for 12 months. The NMHSPF allows for the construction of care packages for all available circumstances, by averaging the care packages out. Some of the recipients may have very severe needs and require more. A large number will have moderate needs. Some may need less.

29. I am aware that the NMHSPF has been used in a number of jurisdictions to support service planning work. The proposition that the NMHSPF is in draft form and should not therefore be used is, in my view unreasonable. While it has its limitations, it is clear that it represents more than three years work to systematically collect and consolidate evidence and views of a large number of academics, practicing clinicians, non-government service providers and consumers and carers on the best mix and quantum of services which should be provided to a given population. A resource of this type has never previously been available, to ignore it would not seem to me to be a reasonable option.

Limits of use

30. I have been asked by the Commission to comment on any limits on the use of the NMHSPF.

31. In response, I would say firstly that the NMHSPF has not yet been developed in respect of forensic, trans-cultural, indigenous or rural and remote populations. These are obvious limitations.

32. Secondly, it was clear that the NMHSPF tool has the potential to be misinterpreted. I believe that this was explained to jurisdictional representatives on the Executive Committee prior to and at the time that the tool was released. That is the reason why the tool was not made more widely available. For example, if someone did not know how to use the tool, then they could easily misinterpret the results and outputs. Further, the results given by the tool cannot always be taken at face value. A person using the tool would first need to know, for example, the current and expected levels for a particular service to test the face validity of the output.

33. Thirdly, there are still errors in the tool that are being ironed out. Improvements are being continuously made. The development of the NMHSPF is ambitious work. I have always understood it to be a process of continuous improvement. This is made clear by

the diagram in the NMHSPF Project Charter called: *"Define/Align/Refine development cycle for the NMHSPF"*. A copy of this diagram is attached and marked **'KJF-3'**.

Interpretation of the NMHSPF

Service Element 2.3.2.5: Sub-Acute Intensive Care Service (Hospital)

34. I have been asked by the Commission to comment on the interpretation of Service Element 2.3.2.5: Sub-Acute Intensive Care Service (Hospital).

35. Service element 2.3.2.5 is expressed as "gazetted". This means that the service is provided in an authorised mental health facility. This enables the involuntary detention of a patient.

36. An intensive care service is provided in a locked or secure unit and in order to be admitted to such a unit a patient must be detained under the Mental Health Act. If someone is absent without permission from a facility within this service element, it is a significant problem and pursuant to the Mental Health Act 2000 a notification must be made to the Director of Mental Health.

37. The service element is described as providing "a reasonably high level of security... with a strong focus on safety and security and risk assessment and management". It is my belief that those responsible for the development of this service element were referring to care which would be provided in a unit which is designed to meet the needs of adults in a secure environment, which would include air-locked monitored entry, high fences with anti-climb construction, highly secure single rooms which may be locked and restricted access to most areas. Patients may often have histories of violence and may have been on forensic orders although these units should not be confused with high secure forensic units. These units are provided in one form or another in every state in Australia. There is one at The Park, not far from where the BAC previously operated.

38. It would be expected that patients would respond to treatment in less than six months. The average length of stay should be around 120 days.

39. In my view, service element 2.3.2.5 is an adult unit that is intended to be accessed by adults and selected young people with special needs in very rare circumstances. For example, a mature 17 year old with a complicated acquired brain injury or who is in a psychotic state, very dangerous, may have injured other people and cannot be safely managed in an adolescent acute unit, may be admitted into the service. This is a very rare circumstance but does happen and therefore was included. I believe that this sort of

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inclusion is common when services are being described. It recognises the limitations of rigid application of age specific definitions of need.

40. In my view, service element 2.3.2.5 does not contemplate an inpatient bed-based mental health service for adolescents (such as that which was provided at the BAC). To suggest that service element 2.3.2.5 (or the NMHSPF) envisages a separate secure service of this type for young people is not accurate. A misinterpretation of this sort would perhaps demonstrate the concerns about misuse referred to earlier in this statement.

Service Element 2.3.3.1 – Non-Acute – Intensive Care Service (Hospital)

41. Service element 2.3.3.1 targets people with chronic unremitting patterns of illness which may result in high levels of risk of self-harm or aggression. An effective response to treatment may take many months or years. Support for these people in a secure environment can be required for a very long time.

42. The focus of service element 2.3.3.1 is on non-acute care aimed at symptom alleviation. Given the level of functional impairment and the effects of long term institutionalisation likely to be present in the users of this service element there is also a significant need to focus on programs aimed at effecting rehabilitation over an extended period.

43. The service element is described as providing "a reasonably high level of security... with a strong focus on safety and security, risk assessment and management". It is my understanding that those responsible for the development of this service element were referring to care which would be provided in a unit which is designed to meet the needs of adults in a secure environment. This would include air-locked monitored entry, high fences with anti-climb construction, highly secure single rooms which may be locked and restricted access to most areas. Patients may often have histories of violence and may have been on forensic orders although these units should not be confused with high secure forensic units. These units are provided in one form or another in every state in Australia. There is one at The Park, not far from where the BAC previously operated.

44. In my view, service element 2.3.3.1 is an adult unit that is intended to be accessed by adults and selected young people with special needs in very rare circumstances. For example, a mature 17 year old with a complicated acquired brain injury or who is in a psychotic state, very dangerous, may have injured other people and cannot be safely

managed in an adolescent acute unit, may be admitted into the service. This is a very rare circumstance but does happen and therefore was included. I believe that this sort of inclusion is common when services are being described. It recognises the limitations of rigid application of age specific definitions of need.

45. In my view, service element 2.3.3.1 does not contemplate an inpatient bed-based mental health service for adolescents (such as that which was provided for at the BAC). To suggest that service element 2.3.3.1 (or the NMHSPF) envisages a separate secure service of this type for young people is not accurate. A misinterpretation of this sort would perhaps demonstrate the concerns about misuse referred to earlier in this statement.

Community-based care

46. I believe that in other states in Australia community based services have been developed to support young people including those with complex needs who may have been, in Queensland, admitted to the BAC. My understanding is that the NMHSPF reference groups considered services currently provided in Victoria and South Australia to be good examples.

47. I believe that long term institutional care of the type which was previously provided at the BAC may, despite the best efforts of staff, further complicate the already significant problems that some of those referred there might have.

48. While comparisons of child and youth services with services for adults and older people are not always useful they may be in the context of institutional reform. I recall that when the first of the adult community-care/residential units were built in Queensland and institutional based services were closed, many believed that services would not cope and that patients would suffer. However, most people now believe that things are much better (including particularly the consumers and their families), than they were when these consumers were in institutional care facilities. I understand that has also been the experience in other Australian states such as Victoria.

49. In Queensland, community based services for young people have improved dramatically since the time when the BAC was opened. There were no adolescent inpatient services available at that time and access to specialist community based services was extremely limited. There are now specialist community teams in each HHS and access to local or regional adolescent acute inpatient services is generally available. I recall that expenditure per capita on services for children and young people in Queensland had increased to the point that it was amongst the highest in the country.

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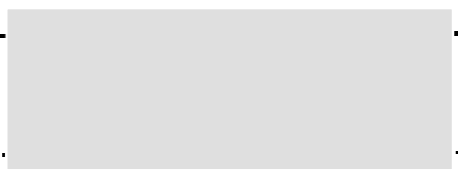

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OATHS ACT 1867 (DECLARATION)

I KEVIN JOHN FJELDSOE do solemnly and sincerely declare that:

(1) This written statement by me dated 09 May 2016 is true to the best of my knowledge and belief: and

(2) I make this statement knowing that if it were admitted as evidence, I may be liable to prosecution for stating in it anything I know to be false.

And I make this solemn declaration conscientiously believing the same to be true and by virtue of the provisions of the *Oaths Act 1867*.

[redacted] .....Signature

Taken and declared before me at BRISBANE QLD this NINE day of MAY .....2016.

[redacted]

Taken B

Justice of the Peace / Commissioner for Declarations / Lawyer

[redacted] .....

Witness Signature:

.....

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BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

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INDEX OF ANNEXURES

Bound and marked "**KJF-1**" to "**KJF-3**" are the annexures to the Statutory Declaration of **KEVIN JAMES FJELDSOE** declared 9 May 2016:

Annexure	Document	Date	Page
KJF-1	Curriculum Vitae, Kevin Fjeldsoe		
KJF-2	NMHSPF Project Charter (Extract – pages 15-17: Project governance structure)	October 2013	
KJF-3	Define/Align/Refine development cycle for the NMHSPF	October 2013	

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

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BRIEF CURRICULUM VITAE

Kevin James Fjeldsoe OAM

October 2015

Curriculum Vitae
KJ Fjeldsoe

PERSONAL DETAILS

Name: Kevin James Fjeldsoe OAM

Postal Address:

Contact Numbers:

Email Address:

Current Position:
Researcher/Consultant
University of Queensland
Policy and Epidemiology Group
Queensland Centre for Mental Health Research
The Park Centre for Mental Health
Wacol
Q 4076

Referees:
Professor Harvey Whiteford
Director
Queensland Centre for Mental Health Research
The Park Centre for Mental Health
Wacol
Q 4076

Professor Graham Mellsop
Waikato Clinical School
Waikato Hospital
Hamilton
NEW ZEALAND

AWARDS AND QUALIFICATIONS

1977	Psychiatric Nursing Certificate Baillie Henderson Health Services, Toowoomba Qld
1980	General Nursing Certificate Recipient of Award for Academic and Clinical Excellence Southport General Hospital QLD
1989	Post Graduate Diploma Applied Science (Management) Awarded with Distinction Queensland University of Technology
1992	Certificate - Community Mental Health Training Program Commend Training Program - Community Psychiatry St Vincent's Hospital, Sydney
1993	Bachelor of Nursing Deans Commendation for Outstanding Academic Achievement University of Southern Queensland
2005	Australian Council on Health Care Standards Surveyor
2012	The Medal of the Order of Australia For contribution to mental health service development and reform.

RELEVANT CONSULTANCY WORK

October 2015 to April 2016

Suicide Risk Audit and Prevention Plan
Borallon Training and Correctional Centre
For the Department of Corrective Services
Queensland Government

January to December 2015

Technical advice to support the development of a new State Mental Health Services Plan for Queensland (2016-2021) - QCMHR
For the Executive Director of Mental Health
Queensland Health

July 2015

Models of Care and facility infrastructure review- planning for the development of adult acute inpatient services.
Health Waikato Mental Health Services
For the Chief Executive Officer
Health Waikato District Health Board
Hamilton NZ.

January 2015

Report - Application of the NMHSPF to Commonwealth Funded Primary Mental Health Programs - QCMHR
Department of Health and Ageing
Australian Government

October 2014

Service Review - Public Sector Mental Health Services
South West Queensland Hospital and Health Service
For the Chief Executive Officer
South West Hospital and Health Service
Queensland Health

June 2014

Service Review - Public Sector Mental Health Services
Mackay Hospital and Health Service
For the Chief Executive Officer
Mackay Hospital and Health Service
Queensland Health

January 2014

Review of structure, activity and cost of Public Sector Community Mental Health Services in Queensland
QCMHR
For the Executive Director of Mental Health
Queensland Health

October 2013

Review of service contracting with Community Sector Mental Health Services in Queensland
QCMHR
For the Executive Director of Mental Health
Queensland Health

September 2012 – September 2013

Consultant – Inpatient Services
National Mental Health Service Planning Framework (NMHSPF) Development Project
Department of Health and Ageing
Australian Government

March 2010

Service Development and Change Management Plan - Health
Waikato Mental Health Services
For the Chief Executive Officer
Health Waikato District Health Board

March 2009

Review of Health Waikato Mental Health Services
For the Chief Executive Officer
Health Waikato District Health Board

August 2007

Functional Plan for High Security Forensic Inpatient Services
For the Director of Mental Health
Department of Health, Australian Capital Territory

January 2004

External Review of Psychiatric Rehabilitation and Recovery Services and Programs – Greater Murray Area Health Service
For The Director General
Department of Health, New South Wales

September 2003

External Review - Care and Treatment in NSW Non-Acute Inpatient Mental Health Services (Section 237 of the NSW Mental Health Act - 1990)
For The Director General
Department of Health, New South Wales

April 1999

Forensic Mental Health Services Review for Health Waikato
Department of Health
New Zealand

November 1998

Second and Tertiary Mental Health Service Planning Review: Graylands Hospital, Sir Charles Gardener Hospital, Royal Perth Hospital, Fremantle Hospital
For the Health Department of Western Australia

June 1998

Report to consider extended inpatient secure services for people with mental illness in the Australian Capital Territory, for the Australian Capital Territory Department of Health and Community Services. With Dr Don Spencer and Mr Alan Jones.

RECENT EMPLOYMENT HISTORY

September 2012 to Present
Researcher/Consultant
University of Queensland
Policy and Epidemiology Group
Queensland Centre for Mental Health Research

February 2008 to September 2012
Director – State Mental Health Plan Implementation
Mental Health Branch
Queensland Health

January 2006 to February 2008
Executive Director of Mental Health Services
West Moreton Health Service District
Queensland Health

January 2005 to June 2005 (Secondment)
State Manager – Mental Health
Department of Health and Human Services
Tasmania

April 2004 to October 2004 (Secondment)
Director - Human Resource Development Branch
Queensland Police Service
Brisbane

January 2001 to January 2006
Executive Director and Director of Nursing
The Park – Centre for Mental Health
Wacol

May 1999 to January 2001 (Secondment)
Executive Director
Wolston Park Hospital
Wacol

July 1997 to May 1999 (Secondment)
Manager
State Mental Health Capital Works Project
Mental Health Unit
Corporate Office
Queensland Health

March 1996 to June 1997 (Secondment)
Project Officer
10 Year Mental Health Strategy for Queensland
Mental Health Unit
Queensland Health

5. Project Governance Structure

The Governance Structure to support the Project is outlined in Figure 4 on the follow page.

It should be well noted that the primary contractual relationship for the Project is between the Commonwealth and NSW. Noting that NSW is directly responsible for the Project deliverables, the primacy of the role for the NSW Executive Sponsor/Executive Group Chair, supported by the Project Director, cannot be understated.

To realise the benefits of the NMHSPF, the Project is structured around a number of focussed Project Groups, including the:

- Executive Group
- Project Team
- Modelling Group
- Primary Care / Community / Non Hospital Expert Working Group
- Psychiatric Disability Support, Rehabilitation and Recovery Expert Working Group
- Inpatient/ Hospital Based Service Expert Working Group
- Consumer and Carer Reference Group

The suggested membership and key responsibilities for each Project Group are listed below. The actual Membership, Terms of Reference and Business Rules for each Project Group can be found at Appendices B through G respectively.

5.1 Executive Group

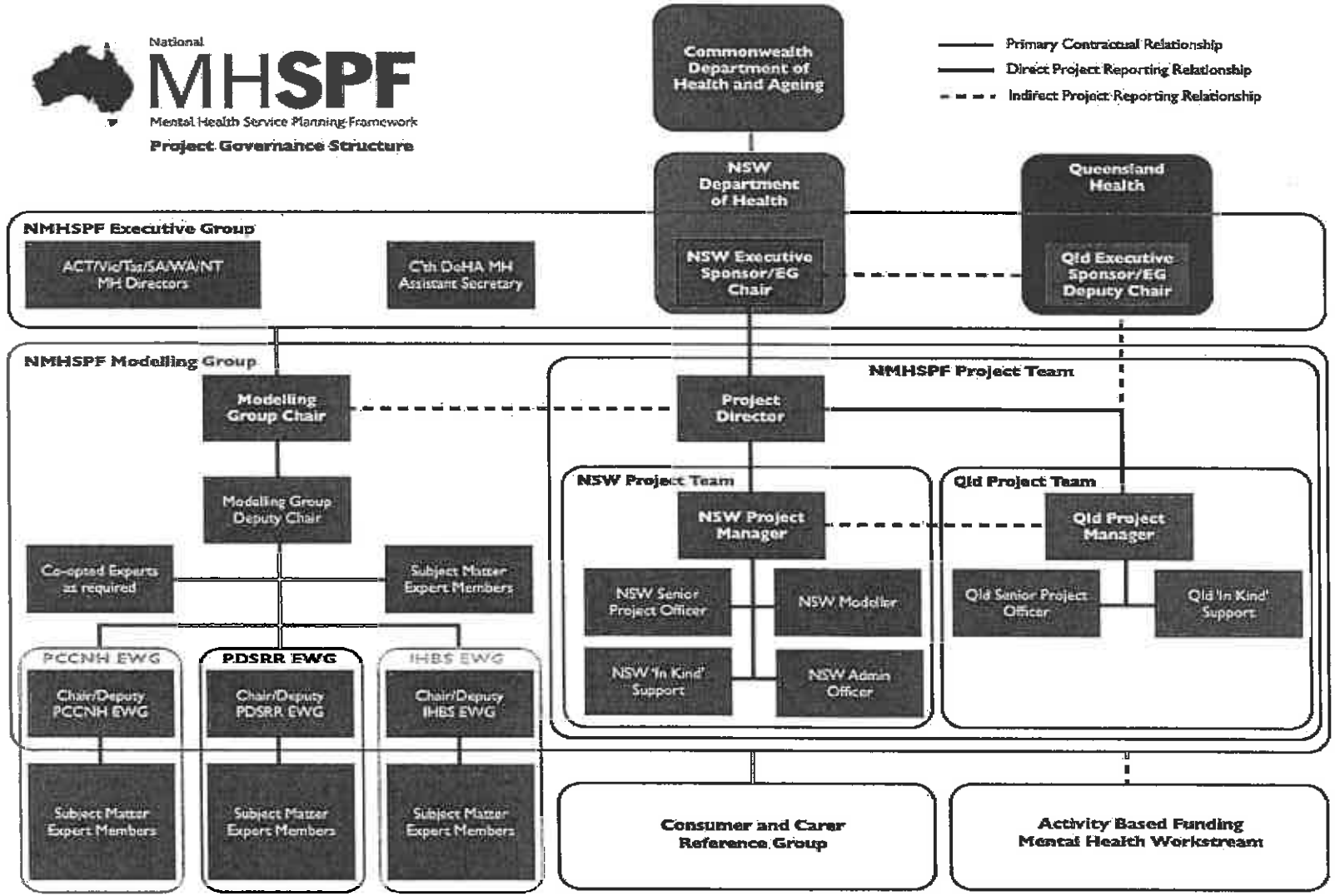
The purpose and the responsibilities of the Executive Group include:

- Oversee funding and provide leadership for the project.
- Ensure the development of a population-based national service planning framework for mental health and to have it endorsed by jurisdictions (NMHSPF V1).
- Receive reports from the modelling work undertaken over the preceding six-month period by the Project Team and Modelling Group. This report will identify areas where decisions or directions are needed.
- Assist with prioritising work to be done by the Project Team.
- Resolve issues that cannot be resolved by the Modelling Group and escalate issues that need to be addressed but cannot be undertaken by the Project Team within the scope of the agreed project.
- Communicate with stakeholders as articulated in the Communications and Marketing Strategy.

The membership of the Executive group includes representatives of the Commonwealth and each jurisdiction's Director of Mental Health.

The actual Membership, Terms of Reference and Business Rules for the Executive Group can be found at Appendix B.

Figure 4: The Project Governance Structure



5.2 Project Team

The purpose and responsibilities of the Project Team include:

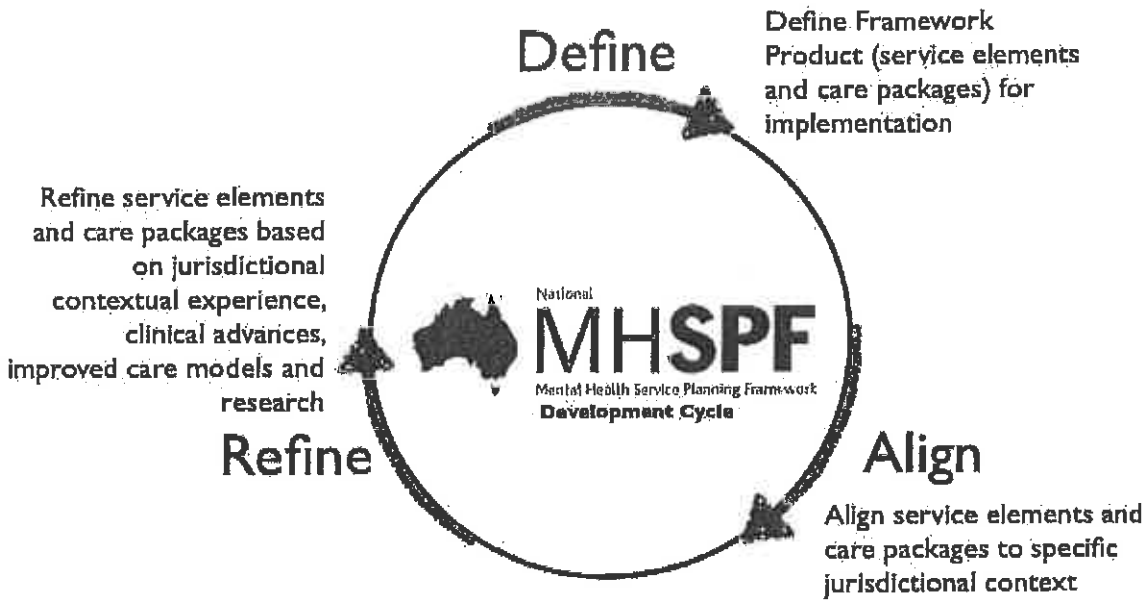
- Build the population-based national service planning framework for mental health and to have it endorsed by jurisdictions.
- Use standard epidemiological, clinical and service use information to estimate the need and demand for services.
- Use clinical evidence and work to gain expert consensus to specify the care packages required by individuals and groups.
- Calculate the resources needed to provide these care packages, for example FTE staff per 100,000 population, and the beds/ treatment places per 100,000 population.
- Arrange meetings, run the Expert Working Groups, write meeting papers, write modelling papers, write reports for the Executive Group, write the final document, etc.
- Coordinate and integrate the input from the three Expert Working Groups.
- Be responsible for providing timely secretariat support and papers for meetings of the Executive Group and the Modelling Group; for conducting modelling in accordance with Executive Group decisions on priorities and options to be considered; and for providing feedback and preparing papers for the Executive Group.
- Other functions for the Project Team throughout the phases of the project will include:
  a. Day to day management of the project;
  b. Managing the project within the agreed budget;
  c. Establishment of, and secretariat support for the various Groups;
  d. Ensuring relevant government employee expertise of the jurisdiction is available to lead and contribute to development of the Framework for the duration of the framework;
  e. Establishing and managing sub-contractual arrangements as required to purchase expertise;
  f. Ensuring appropriate application of intellectual property provisions in existing materials and material developed through the Project;
  g. Working closely with the Executive Group to ensure appropriate engagement between the Executive and all 'specialist' Groups;
  h. Managing State and Territory engagement throughout the project to ensure all jurisdictions are engaged and contribute to development of the Framework;
  i. Develop and implement a consultation strategy agreed to by the Executive Group; and
  j. Ensuring deliverables are developed and produced within agreed timelines and within the project budget.

The membership of the Project Team includes NSW Department of Health and Queensland Health staff identified for the Project, plus additional 'in kind' support.

The actual Membership, Terms of Reference and Business Rules for the Project Team can be found at Appendix C.

The existing NSW planning model has been modified to improve the product over the last 10 years and a similar process is reasonably expected for this Framework. It is the expectation that a Design/Align/Refine cycle will be applied to the Framework for the development of future iterations (refer Figure 3).

Figure 3: Define/Align/Refine development cycle for the NMHSPF



It is the expectation that this Project will have almost completed 1 and 2/3rd cycles to the development of NMHSPF Version 1.

IN SCOPE

Define (existing NSW and Queensland Models; NMHSPF V0)/ **Align** (NMHSPF V0 with jurisdictional populations; identify service gaps)/ **Refine** (NMHSPF V0 based on work of all Project Groups)/ **Define** (NMHSPF V1)/ **Align** (NMHSPF V1 for implementation in jurisdiction-specific context by developing and communicating generic implementation plan).

OUT OF SCOPE

It should be well noted that the Project does not include development of jurisdiction specific implementation plans or the execution of those plans. The Project does not include further work to Align, Refine and Define the NMHSPF.

It is the intention of the Project to develop a Framework that estimates the need and demand for mental health services across all age ranges and across the continuum of care, from prevention and early intervention to the most intensive treatment. The Project Governance Structure identifies that the Modelling Group will require specific expertise in the development of the framework.