In the matter of the Commissions of Inquiry Act 1950

Commissions of Inquiry Order (No. 4) 2015

Barrett Adolescent Centre Commission of Inquiry

AFFIDAVIT

Dr Anthony O'Connell, c/- Avant Law, Company Director, solemnly and sincerely affirms and declares]:

In response to further queries raised in the Notice to Give Information in a Written Statement dated 24 December 2015: I say:

Attachment "AOC-1" is a copy of a Requirement to Give Information in a Written Statement dated 8 December 2015 (Notice) directed to me from the Barrett Adolescent Centre Commission of Inquiry and received under cover of a letter from the Commission dated 8 December 2015 and notified to me by the Department of Health on 9 December 2015. This Statement is provided in response to the Notice.

Background and experience

Question 1 – Outline your current professional role/s, qualifications and memberships. Please provide a copy of your current/most recent curriculum vitae.

1. In response to question 1, I advise I am currently employed as National Adviser (Health) by KPMG Australia. I joined KPMG in March 2015.

   My qualifications are:

   (a) Bachelor of Medicine and Bachelor of Surgery (Honours, University of Sydney) 1977;

Signed: . [redacted] Taken by: .. [redacted]

LINDA MARY WHITFORD
A Justice of the Peace in and for the State of New South Wales
Registration Number 107866

~~Solicitor~~/Justice of the Peace

Avant Law Pty Ltd
Level 11
100 Wickham Street
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[redacted]
Ref: HPM:1507295-00

(b) Fellow of the Australian and New Zealand College of Anaesthesia;

(c) Fellow of the College of Intensive Care Medicine of Australasia;

(d) Graduate of the Australian Institute of Company Directors 2010;

(e) Honorary Fellow of the Australasian College of Health Service Management 2012;

(f) Memberships: none, other than the above fellowships.

A copy of my current Curriculum Vitae is attached marked AOC-2.

Question 2 – The Commission understands that you held the position of Director General Queensland Health from June 2011 to September 2013. Could you explain whether and to what extent that is accurate? And, with respect to your role in that position, please:
(a) Outline your key responsibilities, including working and reporting relationships and the branches (or areas) which fell within your responsibility
(b) Detail your role and responsibilities with respect to the operation and/or management of the Barrett Adolescent Centre (BAC); and
(c) Provide a copy of your position description.

2. In response to question 2(a), I say I held the position of Director-General of Queensland Health from June 2011 to August 15, 2013. The role fundamentally changed on 01-Jul-2012 when the Hospital and Health Services (HHSs) came into existence as Statutory Bodies. In this role:

(a) My key responsibilities and relationships were:

(i) Responsibilities prior to 01-Jul-2012: To act as the Chief Executive of Queensland Health, an agency of the Queensland Government which contained 182 hospitals, 85,000 staff and had a budget of $12 billion. All DDGs and hospital district CEOs reported directly to me.

(ii) Responsibilities after 01-Jul-2012: To act as the Chief Executive of the Department of Health, which had a System Manager role. Operational responsibility for the frontline delivery of health services was devolved to the HHSs.

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(iii) Relationships: I reported to the Minister for Health and to the Premier of Queensland. Prior to 01-Jul-2012 all Deputy Directors-General and the CEOs of the health districts reported to me. After 01-Jul-2012, only the Deputy Directors-General reported directly to me, while the CEOs of the HHSs reported to (and were employed by) the Boards of the HHSs.

(iv) Areas within my responsibility: Prior to 01-Jul-2012 all Divisions of the entity including the Health Districts were within my responsibility, whereas after 01-Jul-2012 only the functions of the Department of Health were within my responsibility.

(b) At no time while I was Director-General (D-G) did I have direct responsibility for the frontline clinical activities in the Barrett Adolescent Centre (BAC). I had an indirect responsibility for the general standards of quality and safety within public health facilities in the state, and for the employment of the staff of Queensland Health, which included staff of the BAC.

(c) A copy of my position description is attached marked AOC-3

Question 3 – Identify and provide details of all other positions and appointments (permanent, temporary or acting) held by you in Queensland Health which are not already detailed in response to question 2 above.

3. In response to question 3, I also held the position of Chief Executive Officer of the Centre for Healthcare Improvement, a Deputy Director-General (DDG) equivalent position within Queensland Health from Aug 2009 to Jun 2011. This role was responsible for elective surgery and Emergency Department performance, quality and safety, organizational culture, simulation training, clinician engagement, and health research.

Replacement Unit for the BAC

Question 4 – Outline the nature and extent of your involvement (if any) in the planning of the 15-bed Adolescent Extended Mental Health Treatment Unit at Redlands Hospital (the Redlands unit). In particular, explain the nature and extent of your involvement, and the relevant date(s).

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4. In response to question 4, I say my involvement in the planning for the Redlands Unit was limited to a high-level role during the last eleven months of the planning for the unit i.e. up until the decision to cease the project. That high-level role included receiving briefing notes and noting issues. The planning had been underway for four years before I became D-G. The main direct responsibility for planning this facility was delegated to the head of Mental Health (regarding clinical aspects and models of care) and to the DDG responsible for Infrastructure for non-clinical aspects of the infrastructure development. After 01-Jul-2012, the direct responsibility for the Redlands campus fell to the Metro South HHS (its Board and CEO).

Question 5 –Was funding for the relocation or replacement of the BAC provided for in the* Queensland Plan for Mental Health 2007-17 *(the QPMH)? If so, was the funding for a relocation of the BAC included in the initiative identified on page 18 of the QPMH as* "$121.55 million to expand the range of acute and treatment beds by providing 140 new beds and to upgrade existing services to meet contemporary standards ..."? *If not, identify the specific funding allocation in the QPMH.

5. In response to question 5, I say as the QPMH 2007-2017 (TOC-1) was written four years before I became D-G and two years before I came to Queensland from NSW. The details in the published Plan do not make it clear what the specific breakdown of the infrastructure expenditure was. I am therefore unclear as to exactly how much money was allocated to BAC in that Plan. The Plan does not make specific mention of either BAC or the Redlands Unit. Nevertheless, it is clear that the reference to $121.55m on p18 of the Plan refers to "upgrading existing services to meet contemporary standards". As the Plan covers a ten-year period, what is "contemporary" would vary considerably over time. I expect that funding for relocation or replacement of the BAC would have been reconsidered each year as part of the State Budget process, since the project had not yet commenced and allocations for infrastructure in the Budget are not necessarily fixed over a multi-year timeline.

Question 6 – Provide details of the capital allocation to fund the relocation or the replacements of the BAC for the Redlands unit. In particular, how much was allocated in each annual budget between the financial year 2007-2008 and the financial year 2012-2013. Identify the relevant budget papers.

6. In response to question 6, I say that in the short time available to me to answer the Commission's questions, and because this question covers a significant period when I did not live in Queensland, I am unable to provide details as requested. My previous employer (Queensland Health) has not provided me with any documents other than

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access to my archived emails (i.e. emails from the time I was employed there). Those emails do not contain details of annual budget breakdowns. The current DDG responsible for Infrastructure or the current D-G may be able to provide those details.

Question 7 – As at May 2012, provide details of what steps had been taken to build the Redlands unit and what steps were yet to be taken.

7. In response to question 7, I say that as at May 2012,

   (a) the steps taken to build the Redlands Unit included planning for the unit (including identification of the Redlands site as the preferred option for replacement of BAC - which had been determined by the Australian Council on Health Care Standards to be in need of urgent replacement), commencement of a Preliminary Infrastructure Plan and appointment of Arup Pty Ltd to complete a parking study and discussions with relevant stakeholders including the Mater Hospital.

   (b) I am aware that as at 9 October 2011 the construction of the Redlands Unit had not yet gone to tender. My understanding is that the steps yet to be taken as at May 2012 included approval from local council, approval by the relevant DDG to commence and actual commencement of the build.

Question 8 – Look at the 29 June 2011 document entitled "Queensland Mental Health Capital Program". That document is a table of figures and in the column entitled "Barrett Centre Adolescent Extended Treatment Unit (15)"the figures are: $10,291,637, $5,836,795, $2,763,011 and $18,891,443. Explain each of those figures. And state whether funding of $16,128,432 was available for the Redlands unit and whether the then estimated total cost of that project was $18,891,443.

8. In response to question 8, I say that regarding the table of figures in the Queensland Mental Health Capital Program (TOC-2): this document was finalised three weeks after I commenced acting as D-G. I was not involved in the process by which these amounts were calculated. Nevertheless, the four figures mentioned in the question are explained in their respective column headings: $10,291,637 was allocated in Budget Paper 3 in 2010/11, $5,836,795 was endorsed in addition to the previous allocation, the current estimate of the cost of the project (as at 29-Jun-2011) was $18,891,443, which left a funding shortfall of $2,763,011. $16,128,432 was available at the time, but clearly the funding shortfall needed to either be found elsewhere or else the costs associated with the build otherwise reduced.

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Question 9 – Look at a Briefing Note to the then Minister for Health, Geoff Wilson cleared on 16 August 2011. As at 16 August 2011 had the land at Lot 30 Weippen Street, Cleveland been partially allocated to the relocation of the BAC, with the rest proposed for future hospital expansion.

9. In response to question 9, I say the Briefing note to the then Minister of 16-Aug-2011 (TOC-3) states that land at Lot 30 Weippin Street had been partially allocated to relocation of BAC, with the remainder of the land proposed for future Redland Hospital expansion.

Decision Not to Proceed with Redlands

Question 10 – Explain your involvement in the decision to not proceed with the development of the Redlands unit. In particular:

a. ***When was the decision made and by whom, and in what circumstances;***
b. ***If the decision was made by the Minister, was it on your recommendation;***
c. ***Identify who else had involvement and/or input into the decision and any person or persons who recommended the decision;***
d. ***State the reason(s) why the Redlands unit did not proceed;***
e. ***Explain the relevance (if any) of the Interim Report of the Independent Commission of Audit into the Queensland's Financial Position, Public Sector Service Delivery and Infrastructure Program (the Costello Commission of Audit) dated June 2012 to that decision;***
f. ***Explain the relevance (if any) of the "Fiscal Repair Strategy" on the decision;***
g. ***Explain your knowledge of the redirection of the capital allocation (including by whom, and to where and when, and on whose advice).***

10. In response to question 10, I say that my recollection of the decision to not proceed with the Redlands Unit is that it was:

(a) made over a period of time as a result of consultations between various stakeholders, including the QH executive, with the most relevant circumstances being:

(i) extended land acquisition timeframes which meant that the timely and efficient running of this capital project were compromised;

(ii) delays in confirming the model of service delivery to inform the Project Definition/Schematic Design;

(iii) challenges with the low-lying site at a time of sensitivity to Health facilities being flood-prone;

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(iv) budgetary constraints;

(v) the requirement to complete a preliminary infrastructure plan for the site under the requirements of the Sustainable Planning Act 2009 Community Infrastructure Designation (CID) process requiring QH to meet the Vegetation Protection and Koala Conservation State Planning Regulatory provisions (implemented after the land was acquired); and

(vi) most importantly, an emerging clinical preference to care for patients currently treated in the BAC in more community-based "closer-to-home" models of care, rather than in an institutionalised model.

(b) The decision was reached as an agreement between those ultimately responsible for practical application of state and national mental health policy, having regard to matters such as the delays which had occurred in the project, the difficulties with complying with the vegetation and koala protection provisions, the shortfall in the available funds and estimated cost of completion, the standard of clinical care in the publicly funded health system, and the sensible allocation of funds in a tight fiscal environment. To be specific the decision was made by the Minister of the day following the receipt of advice from me as the D-G who in turn received advice from the relevant DDGs, the Chief Health Officer and the local hospital group. In the Briefing Note of 03-May-2012 (TOC-4), the Chief Health Officer asked me to approve the cessation of the project, which I did. I then passed this Note to the Minister of the Day for noting and approval.

(c) Other parties involved in the development of the decision were the DDGs responsible for infrastructure, finance, clinical models of care, mental health, and the CEO (and later Board) of the hospital group, in this case Metro South Health District and later HHS.

(d) The main reasons the Redlands unit did not proceed are as set out above in paragraph 13(a) (which is my answer to question 10a).

(e) The relevance of the Commission of Audit to the decision was that it influenced the overall fiscal environment in which Government agencies worked. Before the Commission of Audit, Queensland Health had an underlying deficit which had

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been worsening over the previous five years, reaching an overspend of approximately $291 million in the 2010-11 year.

(f) The Fiscal Repair Strategy influenced the budgetary environment in which Government agencies worked after the Commission of Audit, however, even if there had not been a Commission of Audit, the Redlands Unit would not have been progressed because the other reasons cited above warranted ceasing the project.

(g) All commitments of expenditure by Queensland Health were reconsidered as part of the development of the Fiscal Repair Strategy and subsequent budgets. It is not possible to identify a single item of capital expenditure that occurred as a result of the decision to not progress with the Redlands Unit.

May 2012 Briefing Note

Question 11 – Look at the Briefing Note for Approval to you as Director General (the May 2012 Briefing Note) dated 3 May 2012 and signed by you on 16 May 2012. As to the May 2012 Briefing Note:

a. ***Explain the "anticipated capital funding shortfall of $3.1 million for the regional health HHF projects, relating to Information Communications Technology (ICT), escalation and land acquisition."***
b. ***Explain the HHF projects: what were they, and why were they "critical in the reform of Queensland mental health services."***
c. ***Explain whether you, or your office, had decided where the balance of the "potential cost saving resulting from the cessation of the 15 bed RAETU" was going to be allocated (after payment of the shortfall of $3.1million) and, if so, explain where and identify the relevant documents;***
d. ***Explain the "cessation of the 15-bed RAETU which has been funded under Stage 1 of the Queensland Plan for Mental Health 2007-17" and, in particular, state whether the RAETU was the Redlands unit;***
e. ***Explain the reasons for your approval of the cessation of the "15-bed RAETU" and, in particular:***
    i. ***Identify any reports, discussion papers, or any other documents relied on by you in deciding to give your approval to cease the "15-bed RAETU";***
    ii. ***State what, if any, "sunk" or wasted costs you identified or calculated would be incurred by reason of the cessation for the "15-bed RAETU";***
    iii. ***Identify any oral reports (dated, persons) given to you which you relied on, or which influenced your approval to cease the "15-bed RAETU" and state the substance of each oral report;***
    iv. ***State whether, before or at the time of giving your approval to cease the "RAETU", you reconsidered or analysed the reasons for the Redlands unit, or the reasons for the funding of the relocation of the BAC in the***

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QPMH and, if so, the documents and reasoning relevant to that reconsideration or analysis;

f. State whether, before or at the time of giving your approval of the cessation of the "15-bed RAETU, you considered what care arrangements were to be put in place for the BAC patients in the future and, if so, identify those care arrangements and the relevant documents;

g. State whether, before or an the time of giving your approval of the cessation of the "15-bed RAETU", you took into account:

- ***i. The redevelopment of The Park campus;***
- ***ii. When Kuranda and EFTRU were scheduled to open;***
- ***iii. Whether, in the redevelopment of The Park it was always anticipated that the BAC would not remain on the campus;***

h. Explain whether there was any consultation with stakeholders prior to or at the time of giving your approval and, if so give details of the consultation (dated, persons/entities, documents);

i. Explain whether you, or your office, or any person within the department, sought or obtained any child and adolescent psychiatric advice, or other expert advice, prior to giving your approval and, if so, provide a copy or give details;

j. Whether any consideration was given to work done by Professor Crompton and others to develop a Model of Service for Redlands, and whether that Model of Service could be implemented elsewhere.

11. In response to question 11, I say that regarding the Briefing Note signed by me on 16 May 2012 (TOC-4):

(a) The "anticipated capital funding shortfall of $3.1 million": I am unable to provide a breakdown of which areas in the regional MH HHF projects were the source of the various components of the shortfall.

(b) HHF projects: these are projects funded from Commonwealth infrastructure funds. The HHF program commenced in Jan 2009 and was designed to supplement state funding of health infrastructure. Commonwealth funding was and still is a vital supplement to State funding for Infrastructure.

(c) Allocation of potential savings: each year the various savings that could be identified and the costs associated with new priorities was assessed, and budgets for projects tailored to the available funds. It is not possible to identify a single project that benefited from any identified savings.

(d) The "cessation of the 15-bed RAETU":

(i) The RAETU is the Redlands Unit;

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(ii) My understanding is that the RAETU was funded under QPMH stage 1, but the exact allocation is not clear from the QPMH document. This planning document was developed years before I came to Queensland.

(e) Reasons for my approval of the cessation of the RAETU:

(i) Documents relied upon by me: the Briefing Note.

(ii) The types of sunk costs generated by cessation of the project include costs of the various planning elements, the parking study, any architectural drawings or plans already produced. The monetary value of these costs are not available to me to provide at this time. Against these sunk costs are the costs of continuing with the project in the absence of the various approvals required, and the cost of the actual construction once completed.

(iii) Oral reports: none that I can recall.

(iv) Reconsideration: the original reason for investment in the RAETU was very clear to me, but this was now irrelevant given the subsequent considerations that swayed the decision to discontinue the project.

(f) Care arrangements: at the time of the cessation of the RAETU, alternative arrangements for BAC clients had yet to be developed. At the time it was decided to cease the Redlands project it was not necessary to have an alternative developed as the intention was to develop alternatives for care before BAC was finally closed i.e. while it continued to operate.

(g) Other considerations:

(i) Redevelopment of the Park was not taken into consideration;

(ii) Scheduled opening of Kuranda and EFTRU were not taken into consideration;

(iii) Anticipation as to whether BAC would remain on the Park site was not taken into consideration.

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(h) Consultation with stakeholders: the Briefing Note describes the consultations which occurred at points 8 and 9 of the Note.

(i) Expert advice sought: As D-G I relied on advice given to me by the relevant DDGs, each of whom sought advice from content experts relevant to various aspects of the project. The authors of the Briefing Note carried out necessary consultations and considered that cessation of the project was appropriate. I considered that their reasons for the recommendation were justifiable.

(j) Work done by Professor Crompton: I am not aware of whether consultations before the Briefing Note included Professor Crompton or others involved in the work to develop a "model of service".

<u>August 2012 Briefing Note</u>

Question 12 – On 17 August 2012, you signed a Briefing note for Approval (the August 2012 Briefing Note) noting the planned strategy to improve infrastructure in rural hospitals using (amongst other funding sources) the money from the cessation of the Replacement Adolescent Extended Treatment Unit, Redlands. This Briefing Note was then progressed to the Minister for Health, Mr Lawrence Springborg, who gave his approval on 28 August 2012. Look at the August 2012 Briefing Note:

a. ***What was the "planned strategy for the targeted rectification of the prioritised infrastructure issues and subsequent planning for 12 rural hospitals" and identify any documents that recorded that "planned strategy";***
b. ***Identify the 12 rural hospitals referred to, and the "infrastructure issues", and the "subsequent planning";***
c. ***Explain the reasons for your signing the August 2012 Briefing Note and, in particular:***
    i. ***Identify any reports, discussion papers, or any other documents relied on by you in deciding to sign the August 2012 Briefing Note;***
    ii. ***State what, if any, "sunk" or wasted costs you identified or calculated would be incurred by reason of the cessation of the Replacement Adolescent Extended Treatment Unit, Redlands;***
    iii. ***Identify any oral reports (date, persons) given to you which you relied on or which influenced your decision to sign the August 2012 Briefing Note and state the substance of each oral report;***
    iv. ***State whether, before or at the time of signing, you re-considered or analysed the reasons for the Redlands unit, or the reasons for the funding of the relocation of the BAC in the QPMH and, if so the documents and reasoning relevant to that reconsideration or analysis;***
d. ***State whether, before or at the time of signing the August 2012 Briefing Note, you considered what care arrangements were to be put in place for the BAC patients in the future and, if so, identify those care arrangements and the relevant documents;***

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e. State whether, before or at the time of signing the August 2012 Briefing Note, you took into account:

i. The redevelopment of The Park campus;

ii. When the Kuranda Unit and EFTRU were scheduled to open;

iii. Whether, in the redevelopment of The Park it was always anticipated that the BAC would not remain on the campus;

f. Explain whether there was any consultation with stakeholders prior to or at the time of signing the August 2012 Briefing Note and, if so, give details of the consultation (dated, persons/entities, documents);

g. Explain whether you, or your office, or any person within the department, sought or obtained any child or adolescent psychiatric advice, or other expert advice prior to signing the August 2012 Briefing Note for approval and, if so, provide a copy or give details;

h. Whether any consideration was given to work done by Professor Crompton and others to develop a Model of Service for Redlands, and whether that Model of Service could be implemented elsewhere.

12. In response to question 12, I say that Dr Jeanette Young, who was Acting Director-General at the time, signed the Briefing Note on 17-Aug-2012. I did not sign it. At the time, as Acting D-G, she possessed all the powers and responsibilities of the D-G role:

(a) The "planned strategy for the targeted rectification of the prioritized infrastructure issues": I am currently not aware of the strategy;

(b) The 12 rural hospitals: I am currently not aware of which hospitals were involved;

(c) As I did not sign/approve this Briefing Note I am unable to answer this question;

(d) Care arrangements: at the time of the Briefing Note, alternative care arrangements had not been confirmed regarding BAC patients. This was something which it was anticipated would occur in the future;

(e) As I did not sign this Briefing Note I am unable to answer this question;

(f) As I did not sign this Briefing Note I am unable to answer this question;

(g) As I did not sign this Briefing Note I am unable to answer this question;

(h) Work done by Professor Crompton: I am not aware of whether consideration was given to the work of Professor Compton as I have no recollection nor documents to allow me to answer this question.

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After the Decision Not to Proceed with Redlands

Question 13 – Once the decision was made not to proceed with the Redlands unit, explain whether:

a. ***Consideration was ever given to the following alternatives (and, if so, when and by whom and in what circumstances, and outline the reason(s) why/why not)):***
   - ***i. An alternative site for a Tier 3 service; and/or***
   - ***ii. Implementation of the Model of Service prepared for Redlands at the BAC or elsewhere; and/or***
   - ***iii. Refurbishment of the BAC;***

b.A decision had already been made (and, if so, by whom and when) that a Tier 3 facility would not be developed and (if yes, the basis of that decision).

13. In response to question 13, I say that once the decision was made not to proceed with the Redlands unit:

    (a) Consideration of alternatives: the intention was that the development of a replacement service for the BAC would be undertaken by the relevant services (a combination of WMHHS and CHQHHS and MHAODB) based on appropriate expert advice with input/assistance/funding from corporate Queensland Health. I do not believe that refurbishment of the BAC was ever considered an option given the concern about having an adult forensic medical unit situated next to the BAC;

    (b) Specifically regarding a Tier 3 facility: I do not believe that a decision had already been made that a Tier 3 facility would not be developed. My recollection is that the development of the type of services to treat the type of patient who would be admitted to the BAC was still to be undertaken at the time the decision was made not to proceed with the Redlands unit.

Question 14 – Once the decision was made not to proceed with the Redlands unit, to what projects or other initiatives were those funds (both capital and operating) originally allocated to the Redlands unit actually re-allocated and spent.

14. In response to question 14, I say with respect to the allocation of funds that savings identified in each budget year were pooled and used to address emerging budgetary pressures. It is not possible to identify one project to which savings from the RAETU were applied.

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Question 15 – At the time when the decision was made not to proceed with the Redlands unit, who had authority to establish an alternative Tier 3 service (had this option been progressed and a location identified)? If so explain the details.

15. In response to question 15, I say that the development of services to treat the type of patient who would be admitted to the BAC was the responsibility of the WMHHS together with CHQHHS with input from MHAODB. The authority to establish an alternative Tier 3 service would therefore belong to the HHSs in consultation with the Department.

July 2013 Briefing Note

Question 16 – On or about 8 July 2013 Ms Dwyer prepared a "Brief Note for Noting" addressed to you as the Director-General (the July 2013 Briefing note). Look at the July 2013 Briefing Note:

- ***a. Did you see and/or sign the July 2013 Briefing Note, or a document in substantially the same terms? If so provide a copy?***
- ***b. Did you see and/or read the report or the recommendations for the ECRG referred to in the July 2013 Briefing Note?***
- ***c. Was the July 2013 Briefing note, or a document in substantially the same terms, submitted to Minister Springborg?***
- ***d. If you saw and signed or agreed with the July 2013 Briefing Note, please explain the reasons for your signing and agreeing with that Briefing Note. In particular:***
  - ***i. Identify any reports, discussion papers, or any other documents relied on by you in deciding to sign or agree;***
  - ***ii. Identify any oral reports (date, persons, substance) given to you which you relied on or which influenced your decision to sign or agree with the July 2013 Briefing Note;***
  - ***iii. State whether, before or at the time of signing or agreeing, you reconsidered or analysed the reasons for the closure of the BAC and, if so, the documents and reasoning relevant to that reconsideration or analysis;***
  - ***iv. State whether before or at the time of signing or agreeing, you considered what care arrangements were to be put in place for the BAC patients in the future and, if so, identify those care arrangements and the relevant documents;***
  - ***v. State whether, before or at the time of signing or agreeing, you took any steps to ensure that there were one or more appropriate facilities for the BAC patients, and future patients who might otherwise have been admitted to the BAC and, if so, identify those steps and the relevant documents;***
- ***e. Explain whether there was any consultation with the stakeholders prior to or at the time of signing and, if so, give details of the consultation (dates, persons/entities, documents);***
- ***f. Explain whether you, or your office, or any person within the department, sought or obtained any child and adolescent psychiatric advice, or other expert***

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advice prior to signing the Briefing Note for Approval and, if so, provide a copy or give details.

16. In response to question 16, I say with respect to the Briefing Note by Ms Dwyer:

(a) Did I see or sign the Briefing Note?: I cannot specifically recall seeing the Note, and do not have a copy signed by me, so am unable to say whether I saw it;

(b) The Report of the ECRG: I cannot recall seeing the Report;

(c) Submission to Minister Springborg: I am unaware of whether the Note was progressed to the Minister;

(d) I am not in possession of a copy of the Briefing Note signed by me, and so am unable to confirm if I eventually did sign this note. I am therefore unable to answer this question fully. Nevertheless, the Briefing Note is for the purpose of the D-G to note the proposed actions by the West Moreton HHS, which had the authority and clinical responsibility to make these decisions. The note is therefore not asking the D-G's approval for the HHS to proceed with its intentions; it is merely providing information given the sensitive nature of the issue. The Note clearly states that the "Board approved the closure of BAC dependent on alternative appropriate care provisions for the adolescent target group". My interpretation of this sentence would be that WMHHS would not close the BAC until it was reassured that those alternatives were in place. I was aware that the development of those alternatives would take time. I was not being asked to approve the BAC closure at that time, nor being reassured that alternatives for care were already in place.

(e) The operational responsibility for provision of health services and consultation with stakeholders regarding changes to health services was that of the WMHHS (its Board and CEO).

(f) I did not seek expert adolescent psychiatric advice at the time of this Briefing Note as there were no immediate plans to close the BAC and the exact nature of alternative care provisions had not been delineated. Further as already noted the briefing note was one for my noting not for my approval.

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Question 17 – With respect to the BAC:

a. During financial years 2010 to 2014, how was the BAC funded (include detail of the nature of the funding, and any changes in financial responsibility throughout this period (and explain when those changes occurred and what they involved));

b. How did the amount of funding required for the BAC compare as against that required for the community care models of care;

c. What were the financial implications for a state-wide facility being located within a Hospital and Health Service district and, in particular, within:

i. The West Moreton Hospital and Health Services; and/or

ii. The Metro South Hospital and Health Service (i.e. the Redlands unit).

17. Regarding the BAC:

(a) BAC funding 2010-2014: I was only D-G for the full 2011-12 and 2012-13 financial years. Funds for West Moreton hospital group were received from QH according to the budgeted allocation for the hospital group. This allocation was to the health service district prior to 01-Jul-2012 according to block funding formulae, and to the WMHHS after 01-Jul-2012 according to a mix of block and activity-based funding allocations. The total amount of funds provided to the hospital group was comprised of funds from a number of streams: both commonwealth funding and state funding, in the form of purchased Weighted Activity Units and other labelled funds.

(b) I am unable to provide an accurate comparison of the relative costs of care in institutionalised and community-based care, though I note that the quality of care received and obtaining the greatest benefit for patients for the money spent is more important than just which costs less.

(c) Financial implications of location of a statewide service being located within a HHS district: funding for a statewide service requires the development of formulae that allow for use of the service by patients from across the state. Once the capital cost is expended to build a unit, there are no financial implications arising out of whether the facility is located within the WMHHS or within the Metro South HHS (e.g. the Redlands unit).

<u>November 2013 Briefing Note</u>

Question 18 – The Commission is in possession of a Briefing Note for your signature dated 28 November 2012 with the subject, "Approval to close Barrett Adolescent

Signed: [redacted] Taken by: .... [redacted] ...

Soliciter/Justice of the Peace

Centre, the Park for Mental Health" (the November 2013 Briefing Note). The Commission has another version of this Briefing Note on which there is a notation by Michael Cleary and "Miranda" on page 1. There is a notation on that second version to this effect: "Hi Michael, Mental Health has advised that it is their understanding that West Moreton HHS is now taking the lead in relation to the future of the Barrett Adolescent Centre and this briefing note is cancelled...".

a. Explain the notation "this briefing note is cancelled";

b. Explain the circumstances in which you received the November 2013 Briefing Note (if you received it);

c. Did you sign a version of this Briefing Note? If so, please provide a copy;

d. Identify and provide details of the full name and position of "Miranda" as at 28 November 2012.

18. In response to question 18, I note that the question initially refers to a briefing note of 28 November 2012, then later refers to the November 2013 briefing note. On the assumption the later references in question 18 contain typographical error and should refer to a briefing note of November 2012, I say with respect to Documents TOC-7 and TOC-8 (which is TOC-7 with a notation superimposed):

(a) The notation "this briefing note is cancelled" would mean that the Note is not to progress to the D-G in its current form, or possibly ever at all.

(b) I have no record of whether I ever received the briefing note.

(c) I have no record of signing the briefing note, and it is unlikely that I did as the briefing note was cancelled, i.e. not progressed to the D-G.

(d) I am not aware of who Miranda is. I suggest this question be put to Michael Cleary.

<u>Date of Closure</u>

Question 19 – Explain the nature and extent of your involvement and/or input into the decision that the closure date for the BAC was to be January 2014. In the event you had direct involvement and/or input into the decision that the closure date for the BAC was to be January 2014, give details of:

a. The extent and/or nature of your involvement and/or input into the decision and the names and position of those other persons involved in making the decision;

b. The reasons (s) as to why January 2014 was chosen for the closure of BAC;

c. On what date the decision as to the closure date was made;

d. Any consultation with experts and/or stakeholders (and when), and the nature of the consultation;

Signed: . [redacted] Taken by: ... [redacted] ..

~~Solicitor~~/Justice of the Peace

e. What advice/views were given by those experts and stakeholders prior to the decision, and how influential each of the perspectives was to your decision-making and/or input into the decision;

f. The existence of any flexibility with respect to the January 2014 closure date, once set, or any reviews mechanisms; and

g. How, when and to whom, you communicated the decision as to the closure date (and for what purpose).

19. In response to question 19, I say that regarding planned closure in Jan-2014: I had no input to the decision to plan for a January 2014 closure. I had left the role of D-G five months prior to that date. At the time I left the role, my understanding was that alternative care locations and models needed to be developed in order for a satisfactory transfer of patients out of BAC. Certainly it was my opinion at the time I left the role of D-G that it was important to confirm alternatives before closure of BAC.

Question 20 – In the event you did not have any direct involvement and/or input into the decision that the BAC's closure date was to be January 2014, explain:

a. On what date, how, and from whom, you became aware of the decision that the closure date would be January 2014;

b. Any reason(s) for the closure date that were communicated to you and from whom, by what means, and on what date; and

c. The extent to which you were aware of the existence of any flexibility with respect to the closure date of any review mechanisms (and the source of that understanding).

20. In response to question 20, I say that I did not have direct involvement in the planning for a January 2014 closure date (as I left the role of D-G five months before that date):

(a) I am unaware of when the January 2014 date was selected;

(b) I have no communications regarding a January 2014 closure date;

(c) As I was not party to the final decision as to closure date, I am unable to provide commentary on flexibility in the arrangements.

Question 21 – Did you consider the January 2014 closure date to be appropriate and outline the reason(s) why/why not?

21. In response to question 21, I say that I am unable to comment on the appropriateness of a decision taken after I had left the D-G role, as I am not privy to information on what alternative models of care or other considerations were involved in the decision.

Question 22 – Did you facilitate or attend any meetings regarding the closure of the BAC and, if so, with whom and on what date(s), and for what purpose?

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Solicitor/Justice of the Peace

22. In response to question 22, I say that I am in possession of emails that are meeting requests from the CEO of WMHHS to discuss BAC (scheduled for 14:30 on Jun 17, 2013 and for 15:15 on Jun 14, 2013). I am unaware of whether these meetings took place, whether one is a rescheduling of the other, or who attended the meetings. I have kept no personal notes relating to my time as D-G in Queensland Health.

Question 23 – Detail and processes that you were involved in (or were otherwise aware of), with respect to communicating the closure decision to parents of BAC patients (and their families) and BAC staff, and the nature of your involvements (and when).

23. In response to question 23, I say that I was not directly involved in the communication plan for closure of BAC, as this was the responsibility of the WMHHS.

Question 24 – Did you or your office communicate with the Department of Education and Training regarding the proposed closure of the BAC school? If 'yes', give details.

24. In response to question 24, I say that I have no records or recollection of any communication with the Department of Education and Training (DET) regarding the proposed closure of BAC. This communication would not necessarily have been sent to me for approval or notice.

Question 25 – Did you become aware of the requirement for the Department of Education and Training to give notice of a certain duration regarding the proposed closure of a School? If so, explain the requirement and when you became aware of that requirement.

25. In response to question 25, I say that I am not and was not aware of notice of a certain duration being required by DET.

Queensland Plan for Mental Health

Question 26 – Explain the relevance (if any) of the QPMH to:

a. The development of the plan to construct the Redlands unit;
b. The decision not to proceed with the Redlands unit;
c. The decision to close the BAC;
d. The decision to close the BAC by January 2014;
e. The decision to announce the closure of the BAC on 6 August 2013;
f. Consideration (or lack of consideration) of replacement Tier 3 service at an alternative location.

26. In response to question 26, I say that regarding the QPMH:

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(a) At the time it was written in 2007, the QPMH reflected intent to "expand the range of acute and extended treatment beds", and by implication to construct facilities such as the Redlands Unit, though the Redlands Unit is not specifically mentioned in the Plan. Nevertheless, the Plan also gave priority to community-based care, better use of the Primary Care sector, and better co-ordination of care.

(b) All health delivery plans in Australian state Health Departments, especially those which span a decade, are of necessity high-level documents that can only state general intentions and are likely to be modified the more detail they possess or the more time that passes since the plan is communicated, as the environment in which health care delivery occurs has a large number of variables that are not necessarily predictable.

(c) The decision to close the BAC: is consistent with the principles espoused in the QPMH, namely establishing a statewide model of service, enhancing and developing the continuum of mental health treatment, giving emphasis to community-based care, better use of the Primary Care sector, promoting resilience and recovery, and better co-ordination of care.

(d) The decision to close the BAC by Jan 2014: I cannot comment on this issue, as I am unaware of the factors taken into consideration by the authorities that made the decision to close the BAC at that time.

(e) The relevance of the QPMH to the decision to announce the closure of BAC on 6 Aug 2013: I cannot comment on this issue as I was not involved in the decision to announce the closure of the BAC on 6 August 2013.

(f) Consideration of a replacement Tier 3 service: is not specifically referenced in the QPMH.

Question 27 – The QMPH refers to "Core Mental Health Services". Provide details as to:

a. The criteria for being a "core mental health service", and the implications of being (or not being) classified as a "core mental health service" (and provide copies of any applicable policy document(s));

b. Whether the BAC was a "core mental health service" and the reasons (s) why/why not; and

Signed: . [redacted] Taken by: ..... [redacted]

Solicitor/Justice of the Peace

c. Whether the BAC was considered to be "hospital treatment" based on the type of care provided (inpatient subacute bed-based intensive treatment and rehabilitation services), and the reason(s) why/why not (and provide copies of any applicable policy document(s)).

27. In response to question 27, I say with respect to the QPMH reference to "core mental health services":

(a) I am not in possession of documents that define the criteria for a "core mental health service" nor am I familiar with the term, so am unable to provide a response to this question;

(b) I am not aware of whether BAC met the definition of a "core mental health service" for the reason noted in my answer to question 27(a);

(c) Whether BAC was considered to be hospital treatment: this question is best addressed to WMHHS and the Director of Mental Health (as the service providing the treatment and the person overseeing mental health services in general, respectively) are best placed to explain how services are categorised.

Question 28 – Explain the relevance (if any) of the "National Mental Health Service Planning Framework" on decisions made with respect to the Redlands unit and/or the BAC, and state whether you received a copy of the framework (and from whom, on what date, and for what purpose) (and provide a copy).

28. In response to question 28, I say in relation to the relevance of "National Mental Health Service Planning Framework" to decisions made with respect to the Redlands unit and the BAC, I understood decisions with respect to the Redlands unit and the BAC were being made by reference to all relevant national mental health plans and frame work. I am unable to say when I received a copy of the plan or when or from who but expect that I did receive a copy in preparation for a national health meeting.

The Park

Question 29 – Explain the relevance (if any) of the redevelopment of The Park as an adult forensic facility and/or the scheduled openings of the Kuranda Unit and EFTRU facility, to:

a. The initial plan to decommission the BAC and build the Redlands unit;
b. The decision to not proceed with the Redlands unit;
c. The decision to close the BAC;
d. The decision to close the BAC by January 2014; and
e. The decision to announce the closure of the BAC on 6 August 2013.

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Solicitor/Justice of the Peace

29. In response to question 29, I say that in relation to the relevance of redevelopment of the Park as an adult forensic facility and/or the scheduled openings of the Kuranda unit and the EFRTU facility to:

(a) The initial plan to decommission the BAC and build the Redlands unit - I cannot comment on the relevance of the redevelopment of The Park and/or the scheduled openings of the Kuranda Unit and EFRTU facility to the initial plan to decommission the BAC and build the Redlands unit as this occurred before my involvement in Queensland Health;

(b) The decision to not proceed with the Redlands unit – I am not aware that the redevelopment of The Park and/or the scheduled openings of the Kuranda Unit and EFRTU facility was relevant to the decision to not proceed with the Redlands unit, the reasons for which are set out in my answer to question 19 above;

(c) The decision to close BAC – this is a matter which is best addressed to WMHHS and the Director MHAODB as they were together the entities who had responsibility for and made the decision. I believe from available information that a relevant factor in the ultimate decision to close BAC was the desire to extricate vulnerable adolescent patients from exposure to forensic adult MH patients;

(d) The decision to close BAC by January 2014 – I was not involved in the choice of closure date so am unable to answer this question;

(e) The decision to announce the closure of BAC on 6 August 2013 – I was not involved in the decision about when to announce the closure of BAC so I cannot answer this question.

Statewide Services

Question 30 – The Commission understands that the BAC provided a statewide mental health service. Provide details of:

a. Statewide service plans relevant to the BAC (and provide copies);

b. State and National policies, plans and protocols, relevant to the management and operation of the BAC (and provide copies);

c. The relationship between the BAC, the Hospital and Health Services (HHS) AND THE Department of Health, including, but not limited to:

i. Roles in relation to accountability, oversight and responsibility for the BAC;

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ii. Responsibility and development and management of a statewide service, including which entity has the power to cease a statewide service;

iii. How statewide mental health services were planned for and overseen by Queensland Health (and provide copies of any documented framework and/or planning documents);

iv. The role of a Hospital and Health Service with respect to a statewide service and, in particular, the extent of control they have over the service (if any);

v. The role of the Mental Health Alcohol and Other Drug Branch with respect to the BAC.

30. In response to question 30, I say that the details of:

(a) Relevant State-wide service plans: I no longer have ready access to these documents.

(b) State and National policies: I no longer have ready access to these documents.

(c) Relationship between BAC, HHS and Department of Health:

i. Roles regarding accountability, oversight, and responsibility for BAC: the WMHHS had responsibility for the day-to-day operations of the BAC: the front-line operation of the BAC was the responsibility of the hospital management and the WMHHS executive, reporting after 01-Jul-2012 to the WMHHS Board. Since WMHHS was host for the state-wide service for the type of adolescent mental health patients historically nursed at BAC, WMHHS was responsible for the delivery of the service and interactions with HHSs that sent patients to and received from the BAC. The Department of Health through its Mental Health Branch was responsible for state-wide policy on Mental Health and for working with infrastructure branch and finance branch regarding non-clinical issues that could not be dealt with solely by WMHHS.

ii. Responsibility for development of a state-wide service: the WMHHS had responsibility for delivery of the state-wide service that BAC provided, and for cooperation with relevant HHSs that would receive patients transferred out of the BAC. State-wide services were developed through a consultative process between the Department of

Signed: .. [redacted] Taken by: ..... [redacted]

Solicitor/Justice of the Peace

Health and the relevant HHSs. The Department provided assistance to the HHSs in these tasks in its role as System Manager.

iii. How state-wide services were planned for and overseen by QH: prior to 01 Jul 2012 QH had established the various state-wide services in collaboration with the host Districts. After 01 Jul 2012 the HHSs hosting state-wide services were responsible for their efficient operation and to collaborate with other HHSs and the Department with regard to compliance with state-wide policies, obligations, reporting and service development. In its role as System Manager, QH conducts a state-wide service planning function which entails review, planning, establishment and evaluation of state-wide services in collaboration with host and client HHSs.

iv. Role of HHS regarding state-wide services: this is answered in paragraph 33c(iii).

v. Role of the MHAOD Branch with respect to BAC: MHAOD Branch provided a conduit for communication between the WMHHS and the relevant DDG, provision of expert advice to WMHHS and a monitoring role with regard to performance of the mental health services across the state.

Question 31 – The Commission understands that a number of statewide clinical networks sit within Queensland Health, one of which is the Mental Health Clinical Network. Provide details as to:

a. The role and function of the Mental Health Clinical Network and, in particular, with respect to the BAC (prior to its closure);

b. The role of the Mental Health Clinical Network (and any other Clinical Networks) with respect to approving the model of care at BAC;

c. Any concerns raised between the financial years 2010 to 2013 with respect to the model of care at the BAC (and provide details as to by whom, when and what steps (if any) were taken to address those concerns); and

d. Whether the Mental Health Clinical Network was responsible for approving (or otherwise having oversight over) the model of care in place at the BAC prior to its closure (and if so, provide details as to the nature and extent of the approval and oversight).

31. In response to question 31, I say that MH Clinical Network (MHCN):

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(a) Role and function of MHCN, in respect to BAC: the Network has no direct responsibility for individual mental health services, but rather acts as a high-level adviser to the MHAOD Branch, relevant DDG, D-G and Minister with regard to mental health issues in the state.

(b) Role of MHCN regarding approving model of care at BAC: my understanding of how Clinical Networks worked during my time as D-G was that they did not see themselves as being empowered to approve individual models of care in individual institutions, but rather to develop consensus across the state on the best ways to manage patients' journeys in their particular discipline.

(c) Concerns between 2010 and 2013 with respect to model of care at BAC: I did not directly receive concerns regarding the model of care.

(d) Responsibility of MHCN for approval of models of care: MHCN had a role in developing consensus models; ultimately individual clinicians determined how they treated patients.

<u>ECRG & Planning Group</u>

Question 32 – The Commission understands that in around November 2012, an Expert Clinical Reference Group (the ECRG) was formed to make recommendations with respect to models of care for mental health treatment and rehabilitation for adolescents in Queensland. With respect to the ECRG:

a. Explain the nature and extend of your involvement in the formation of the ECRG, including but not limited to, the selection of its members (and the basis for their selection);

b. Explain the nature and extent of your involvement in the formation and role of the ECRG. In particular, provide details of:

- ***i. The function of the ECRG and the function of the report to be prepared by the ECRG;***
- ***ii. The development of the Terms of Reference, the scope and functions of the ECRG and the material to be considered by the ECRG;***
- ***iii. Any input or direction given by you (or on your behalf) to the ECRG (or its members);***
- ***iv. Any consultation by you (or carried out on your behalf) with the ECRG (or its members); and***
- ***v. Any oversight and/or monitoring role which you played with respect to the ECRG.***

c. Provide details of the purpose of the ECRG and, in particular, the relationship between the ECRG and the Barrett Adolescent Strategy Project Plan (as prepared by West Moreton Hospital and Health Service);

Signed: [redacted] Taken by: ..... [redacted]
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d. Did you receive a copy of the ECRG report and, if so, when and how and what action did you take in response?

32. In response to question 32, I say that regarding ECRG formation:

(a) I have no recollection of being involved in establishing the ECRG nor selecting its members.

(b) As I was not involved in the establishment of the ECRG I am unable to answer this question.

(c) I have no recollection about nor documentation explaining the purpose of the ECRG nor the relationship between the ECRG and the Barrett Adolescent Strategy Project Plan and am therefore unable to answer this question;

(d) I cannot recall receiving a copy of the ECRG report.

Question 33 – did you accept or reject the recommendations made by the ECRG in its report?

33. In response to question 33, I say that I cannot recall whether I was given the opportunity to accept/reject the ECRG recommendations. In any event the closure of the BAC was a WMHHS responsibility (in conjunction with MHAODB and CHQ HHS) and the response to recommendations was a matter for those entities;

Question 34 – In its report, the ECRG found inpatient extended treatment and rehabilitation care (Tier 3) to be an essential service component. The ECRG further found that "interim service provision if BAC closes and Tier 3 is not available is associated with risk". With respect to these findings by the ECRG, explain:

a. Whether the option of a Tier 3 service was ever reconsidered/revisited, following receipt of this recommendation by the ECRG (and the reasons why/why not);

b. In the event the option of a Tier 3 service was reconsidered/revisited, the nature of that consideration, who was involved and when (and provide the relevant documents);

c. The reasons(s) why a Tier 3 was not developed or implemented, given the findings of the ECRG that Tier 3 was an essential service component;

d. Whether you took any steps in relation to the risk identified by the ECRG.

34. In response to question 34, I say that I cannot recall the recommendations of the ECRG and cannot therefore provide answers to this question.

Question 35 – The Commission understands that the ECRG was overseen by a Planning Group. With respect to the Planning Group:

Signed: . Taken by: .....

~~Solicitor~~/Justice of the Peace

a. Explain the nature and extent of your involvement with respect to the formation of the Planning Group and the selection of its members;

b. Identify any officers of Queensland Health involved in the formation of the Planning Group and the selection of its members;

c. Explain the nature and extent of your involvement, and the involvement of senior officers of Queensland Health, in the functions of the Planning Group. In particular, provide details as to:

- ***i. The development of any Terms of Reference, the Scope and functions of the Planning Group and the material to be considered by the Planning Group;***
- ***ii. Any input or direction given by you (or on your behalf) to the Planning Group (or its members);***
- ***iii. Any consultation by you (or carried out on your behalf) with the planning Group (or its members); and***
- ***iv. Any oversight and/or monitoring role which you, or senior offices of Queensland Health, played with respect to the Planning Group***

d. State when you received a copy of the Planning Group report and outline by what means and for what purpose (and any steps taken by you as a result).

35. In response to question 35, I say that regarding a Planning Group: I was not involved in the establishment and member selection for a Planning Group, nor have any recollection of receiving a copy of its report or any other involvement with the planning group.

Question 36 – As noted above, in its report ECRG found a Tier 3 to be "an essential service component" and recommended that a Tier 3 be prioritised. In its report, the Planning Group accepted this recommendation by the ECRG "with considerations". These considerations were described as follows:

> ***Further work is needed to detail the service model for a Tier 3. Models involving a statewide, clinical bed-based service (such as the Barrett Adolescent Centre) are not considered contemporary within the National Mental Health Service Planning Framework (in draft). However, there are alternative bed-based models involving clinical and non-clinical service components (e.g., Y-PARC in Victoria) that can be developed in Queensland to meet the requirement of this recommendation. Contestability reforms in Queensland may allow for this service component to be provider agnostic.***

With respect to the above extract, explain:

a. What further work (if any) has been undertaken in Queensland "to details the service model for a tier 3" (and provide details as to when and by whom and the status of that work);

b. Whether you considered a statewide, clinical bed-based service to be contemporary within the National Mental Health Service Planning Framework and the reason(s) why/why not;

c. Any steps taken to develop and/or implement alternative bed-based models involving clinical and non-clinical service components such as, but not limited to, Y-PARC (and provide details as to when and by whom and the status); and

d. Your understanding of the meaning of: "Contestability reforms in Queensland may allow for his service component to be provider agnostic".

Signed: [redacted] Taken by: ..... [redacted] ..

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36. In response to question 36, I say that regarding Tier 3 as "an essential service":

(a) I left the role of D-G five months before the BAC closed and so am unaware of what work has been done to develop detail of a service model for Tier 3 services.

(b) I am of the opinion that for a state-wide MH service to be consistent with the NMHSPF it should have an appropriate mix of bed-based and community-based care models, as determined by consultation between the frontline clinicians and the state health authorities, and patient and family feedback, amongst other matters.

(c) I am not aware of what steps to develop alternative models were taken after I left my role as D-G. The head of Mental Health in QH would be better able to describe what early discussions had occurred at an inter-district/departmental level to develop alternative models in the time before I left the role of D-G.

(d) "Contestability reforms in Queensland may allow for this service component to be provider agnostic": During my time as D-G under the Newman Queensland Government, contestability was being explored in all agencies. Contestability is the examination of what the current costs of service delivery are, whether different ways of providing the service are more efficient or provide better value for money, and whether private or not-for-profit non-government providers can provide services more efficiently. This quoted sentence refers to the possibility that providers other than QH may be able to provide the required alternative services.

Question 37 – In its report, the ECRG found "interim service provision if BAC closes and Tier 3 is not available is associated with risk". With respect to this finding, the ECRG recommended (together with other matters) that "safe, high quality service provision for adolescents requiring extended treatment and rehabilitation requires a Tier 3 service alternative to be available in a timely manner if BAC is closed". The Planning Group's recommendation with respect to the ECRG's recommendation was – "Accept". With respect to these matters, outline:

a. What are the "safe, high quality services" for adolescents requiring extended treatment and rehabilitation" which are an alternative to a Tier 3 service (and provide details as to when they were implemented and what they involve); and

b. The basis upon which the alternative was assessed as being a "safe, high quality" service (and by whom and by what means, and what it involves).

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Solicitor/Justice of the Peace

37. In response to question 37, I say that with respect to safe interim service provision: I left the role of D-G five months before the BAC closed and so am unable to describe what alternative safe high quality services were established before the BAC was closed.

Working Groups/Committees/Relationships

Question 38 –Provide details of any other committees or group you were a member of, or had involvement or input into the formation of, with respect to the operation and/or closure of the BAC, the option of the Redlands Unit, and the redevelopment of The Park and/or the development or implementation of Adolescent Extended Treatment and Rehabilitation service options.

38. In response to question 38, I say that the only group that I was a member of that was involved with receiving reports regarding and making decisions regarding BAC, Redlands Unit and the Redevelopment of the Park was the Executive of the Department of Health. This executive comprised the DDGs and was chaired by myself.

Question 39 – The Commission understands that the following working groups/committees were in existence at around the time when decisions were being made within Queensland Health with respect to the BAC:

- ***a. Barrett Adolescent Centre Strategy Planning Group;***
- ***b. The Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy Steering Committee;***
- ***c. Chief Executive and Department of Health Oversight Committee;***
- ***d. Service Option Implementation Working Group;***
- ***e. Barrett Adolescent Centre Consumer Transition Working Group;***
- ***f. Financial and Workforce Planning Working Group; and***
- ***g. Young People's Extended Treatment and Rehabilitation Initiative (YPETRI) Governance Committee.***

With respect to each of these groups/committee (and any other groups/committees of which you are aware, which concerned the BAC), provide details as to:

- ***a. The role and function of the group (both generally and also in respect of the BAC specifically);***
- ***b. The circumstances and purpose for which each was established (and by whom and the period for which they operated; and***
- ***c. The nature and extent of your involvement and/or input (and when).***

39. In response to question 39, I say in relation to the various working groups identified: I was not a member of any of these groups listed in the question, and do not have access to their roles, functions, purpose, nor period of operation.

Question 40 – Explain the relationships between:

- ***a. Queensland Health and West Moreton Hospital and Health Service; and***

Signed: [redacted] Taken by: ..... [redacted]

Solicitor/Justice of the Peace

b. Queensland Health and Children's Health Queensland Hospital and Health Service;

With respect to:
a. The operation and management of the BAC;
b. Alternatives to the BAC;
c. Redevelopment of The Park.

40. In response to question 40, I say that regarding relationships:

(a) Between QH and WMHHS: This relationship is described in the Act which came into force on 01 Jul 2012 that brought the HHSs into existence as statutory bodies. QH is the System Manager of the Queensland Public Hospital system and the purchaser of services provided by the HHSs. It provides high-level policy and strategy with regard to state-wide services, facilitation of innovation and research, monitoring of performance, and is the employer of the majority of staff in the system. The HHS is a statutory body governed by a Board that has ultimate responsibility for the delivery of services to the population of the district it serves. The executive of the HHS is employed by the Board. WMHHS has responsibility for the provision of services which are for the local population and for the smooth transfer of patients to state-wide services hosted by other HHSs. WMHHS is responsible for the operation of any state-wide services which it hosts. WMHHS is responsible for local planning of services and for consistency with state-wide policies for infrastructure and service developments within the HHS. In this sense, WMHHS was responsible for the redevelopment of the Park and yet would be required to work cooperatively with the Department with regard to any additional funding that was required, compliance with state-wide policies, and support from the Infrastructure Branch in the Department.

(b) Between QH and CHQHHS: This relationship is described in the Act that came into force on 01 Jul 2012 that brought the HHSs into existence as statutory bodies. QH is the System Manager of the Queensland Public Hospital system and the purchaser of services provided by the HHSs. It provides high-level policy and strategy with regard to state-wide services, facilitation of innovation and research, monitoring of performance, and is the employer of the majority of staff in the system. The HHS is a statutory body governed by a Board that has ultimate responsibility for the delivery of services to the population of the district it

Signed: . [redacted] Taken by: ..... [redacted]
Solicitor/Justice of the Peace

serves. The executive of the HHS is employed by the Board. During my time as D-G I did not see CHQHHS as responsible for BAC, but that it had a role in working with the Department of Health and other HHSs to ensure smooth development of services for paediatric and adolescent patients and the transfer of patients to its own services on closure of BAC. CHQHHS had no responsibility for the redevelopment of the Park. I saw the CHQHHS as having a facilitating role in developing alternative models of care for patients of the BAC throughout Queensland.

Transition Arrangements

Question 41 – The Commission is aware that from November 2012 until January 2014 a number of BAC patients were transitioned to alternative care arrangements. With respect to the Transition Clients:

- ***a. Who was responsible for redeveloping the transition arrangements for the Transition Clients, and what were those transition arrangements;***
- ***b. Who had the monitoring or oversight role for the transition arrangements for the Transition Clients;***
- ***c. Provide details as to how transition arrangements were developed, including but not limited to, and consultation(s) with Transition Clients and/or their families, friends or carers (and the date and detail of such consultation(s));***
- ***d. Explain the nature and extent of your role with respect to Transition Clients. In particular, detail your involvement in developing, managing and implementing transition arrangements (including, but not limited to, identifying, assessing and planning for care, support, service quality and safety risks);***
- ***e. What feedback or advice did your receive (and from whom and when) in relation to the progression of the transitioning arrangements for the Transition Clients;***
- ***f. Did you meet with any of the BAC transition clients or their families/carers in relation to their transition from the BAC and, if so, when and for what purpose;***
- ***g. Advise whether there were any transition plans to review the transition arrangements and outline what such review involved (and when and how it occurred).***

41. In response to question 41, I say that regarding transition clients:

(a) During my time as D-G I saw it as the responsibility of the frontline clinicians in the BAC and the receiving HHS MH services (supported by the Executives of the relevant HHSs and MH Branch of the Department of Health) to develop and smooth the transition arrangements for clients moving out of BAC.

(b) Ultimately, the receiving HHS had responsibility to ensure that clients transferred in to their services received adequate and safe care once the transfer was accepted.

Signed: [redacted] aken by: ... [redacted]

Solicitor/Justice of the Peace

(c) I was not responsible for transition arrangements and so cannot describe them. Further, largely the patients moving out of BAC due to its closure were transferred in the months after I left the employ of QH.

(d) I had no direct role in supervising transition of clients.

(e) I received no feedback on the transition arrangements, noting again that largely transfer occurred after I left the employ of QH.

(f) I did not meet with transition clients nor their families. I would see such interaction as inappropriate as I had no direct operational responsibility for MH service provision, and anyway, the majority of transfers would have occurred after I left employ of QH.

(g) I am not aware of transition plans for clients.

Question 42 – Did you have any discussions with the medical or other staff at receiving alternative services regarding the Transition Clients transitional arrangements, transition plans, treatment plans, clinical and education needs or other matters? If so, explain the nature of these discussions, including the date on which they occurred, with whom and for what purpose.

42. In response to question 42, I say that I had no discussions with medical or other staff regarding transition arrangements. I was never approached to engage with these staff.

Question 43 – Were you aware of any concerns regarding the transition of any Transition Clients from the BAC to an alternative service provider? If so:

a. Detail any such concern;
b. If there were concerns, stat who were these concerns expressed by and to whom;
c. On what date and by what means did you become aware of these concerns; and
d. What steps, if any, did you cause to be undertaken as a result of any such concerns.

43. In response to question 43, I say that I was not aware during my time as DG of any concerns regarding transition arrangements.

Question 44 – The Commission understands that your Deputy (Dr Michael Cleary) was a member of the Chief Executive and Department of Health Oversight Committee. With respect to this Committee:

a. What was your involvement in this Committee? Did Dr Cleary report to you following these meetings?
b. Explain the function and responsibilities of the Committee with respect to the BAC including, but not limited to:

Signed: [redacted] Taken by: [redacted]
Solicitor/Justice of the Peace

i. The decision to close the BAC;
ii. The date for closure of the BAC;
iii. The BAC School;
iv. Staff at BAC and the BAC School;
v. The arrangements made for Transition Clients; and
vi. The development and implementation of service options.

44. In response to question 44, I say that regarding Oversight Committee:

(a) Up to the cessation of my employment as DG, I was not involved in oversight committees. I do not recollect or have any documents indicating that Dr Cleary reported to me about the meetings of an Oversight Committee.

(b) I am not aware of the specific functions of the Committee. These were not submitted to me for approval.

BAC Staff

Question 45 – Detail the nature of your involvement with respect to communication with staff of the BAC about the possible (or actual) closure of the BAC. In particular, state when this communication occurred, what it involved and any input/decision you received with respect to the content of the communication (and from whom and when).

45. In response to question 45, I say that communication with staff about the closure of BAC was appropriately delegated to the executive of the WMHHS. I therefore had no involvement in it.

Question 46 – With respect to the Barrett School, explain the nature and extent of your involvement in meeting and/or communicating with staff or officers of the Department of Education or the Minister of Education (including when and the purpose and content of the communication, and any action taken by yourself as a result).

46. In response to question 46, I say that I was not involved in any communication with DET staff regarding closure of the school.

Future Service Delivery

Question 47 – Provide details of any meetings, contact, telephone discussions, written communication and correspondence (including electronic) you had regarding the future service delivery of mental health services by the BAC (i.e. proposed service delivery in lieu of the BAC) and the date(s) when this occurred and with whom.

Signed: . [redacted] Taken by: . [redacted]
Solicitor/Justice of the Peace

47. In response to question 47, I say that I have no additional documentation of discussions regarding future service delivery other than that cited above.

Question 48 – The Commission understands that you were the Director-General of Queensland Health from June 011 to September 2013. To the extent that you are able from your knowledge gained in that position:

- ***a. What was the Queensland Health's proposed model of service delivery for children and adolescents who previously met the criteria for admission of the BAC;***
- ***b. Were additional funds allocated to Child and Youth Mental Health Services (CYMHS) across Queensland upon the closure of the BAC; how much of the funding for the BAC was re-allocated to CYMHS across Queensland;***
- ***c. What framework was developed for the delivery of non-specialist mental health care (i.e. support, care and community access) to adolescents in Queensland at risk and previously in need of a 'tier 3' service;***
- ***d. Were any arrangements with non-government organisations entered into for the delivery of these services. If so, what organisations were contacted with a view to providing the delivery of these services. Were any arrangements entered into with these organisations;***
- ***e. Was any training in the area of child and adolescent mental health offered, developed or provided to these non-government organisations;***
- ***f. Was any additional training offered, developed or provided for Queensland Health staff in relation to child and adolescent mental health issues upon the closure of the BAC;***
- ***g. Were there any proposals or plans in place within Queensland Health for the development of a new adolescent extended treatment tier 3 facility in place in lieu of the BAC;***
- ***h. Did you meet with anyone regarding the future delivery of child and adolescent mental health services with respect to the delivery of services previously offered by the BAC. If so, who did you meet with and what did you discuss. What were the outcomes of these meetings; and***
- ***i. Were any non-governmental residential rehabilitation service organisations contacted to provide additional services to at risk child and adolescents, was additional funding provided to these organisations, and what were the arrangements made with these organisation.***

48. In response to question 48, I say that regarding my knowledge of:

(a) Proposed model of service delivery: my understanding was that psychiatrists in the receiving hospitals and community-based services would provide a level of support to in-patients of BAC that met the clinical requirements of the patients. The exact nature of the model of care would be determined by the expert clinicians directly responsible for the patients, and tailored to their needs.

(b) I was not D-G when the BAC closed, so am unable to answer this question.

Signed: [redacted] Taken by: [redacted]

Solicitor/Justice of the Peace

(c) I was not D-G when the BAC closed, so am unable to answer this question.

(d) I was not D-G when the BAC closed, so am unable to answer this question.

(e) I was not D-G when the BAC closed, so am unable to answer this question.

(f) I was not D-G when the BAC closed, so am unable to answer this question.

(g) I was not D-G when the BAC closed, so am unable to answer this question.

(h) I was not D-G when the BAC closed, so am unable to answer this question.

(i) I was not D-G when the BAC closed, so am unable to answer this question.

Outline

Question 49 –Outline and elaborate upon any information or knowledge (and the source of that knowledge) that you have relevant to the Commission's Term of Reference.

49. In response to question 49, I say that I have no other knowledge of relevance to the Commission's Terms of Reference.

Question 50 – Identify and exhibit all documents in your custody or control that are referred to in your witness statement.

50. In response to question 50, I say that the following documents are attached to this statement:

(a) AOC – I - the requirement notice from the Commission;

(b) AOC- 2 .- my current CV

(c) AOC – 3 – my position description as DG for Queensland Health.

Signed: [redacted] Taken by: ..... [redacted]

~~Solicitor~~/Justice of the Peace

51. All the facts and circumstances herein deposed to are within my own knowledge save where such are stated to be from information only and my means of knowledge and source of such information appear on the face of this my affidavit.

Affirmed by Dr Anthony O'Connell on sixth January 2016,
at Epping NSW in the presence of:

[redacted] .....
Deponent

.....
Justice of the Peace/~~Solicitor~~

LINDA MARY WHITFORD
A Justice of the Peace in and for
the State of New South Wales
Registration Number 107866

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

INDEX TO EXHIBITS

Exhibit No	Exhibit description	Page numbers
AOC – 1	The requirement notice from the Commission	1 – 96
AOC – 2	Current CV	97 – 99
AOC – 3	My position description as DG for Queensland Health	100 – 102

In reply please quote: QHD/20151208

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Mr Paul Lack
Team Leader and Instructing Solicitor
Barrett Centre Commission of Inquiry – State Representation
Crown Law
State Law Building
50 Ann Street
BRISBANE QLD 4000

By email to: [redacted]

Dear Mr Lack

REQUIREMENT TO GIVE INFORMATION IN A WRITTEN STATEMENT TO THE BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

Please find enclosed a notice requiring your client, **Dr Tony O'Connell**, to give information in a written statement to the Barrett Adolescent Centre Commission of Inquiry ("the Commission") established pursuant to the *Commissions of Inquiry Order (No. 4) 2015*.

Dr O'Connell's statement is to be provided to the Commission on or before **4:00pm, Monday 21 December 2015** at the place and in the manner specified in the notice. To this end, we refer you to paragraph 19 of the Commission's Practice Guideline 01/2015, which can be located on the Commission's website: www.barrettinquiry.qld.gov.au.

Where your client's statement refers to and identifies a BAC patient or a family member, we ask that you contact the writer to obtain an identification code so that the patient or family member is otherwise not able to be identified. Generally, the Commission will not publish material or documents that identify or may lead to the identification of former patients or their family members. Please refer to the Commission's Practice Guidelines, the Confidentiality Protocol dated 12/10/15 and the Order to Prohibit Publication of Evidence dated 15/10/15, all of which can be located on the Commission's website: www.barrettinquiry.qld.gov.au.

Documents annexed to witness statements should not be redacted in any way. These documents will be redacted by Commission staff before publication, in accordance with the Confidentiality Protocol.

If in addition your client wishes to apply for an order that the statement or any part of the statement should be confidential then they should apply to the Commissioner for an order under Part G of the Practice Guidelines.

If you require further information or clarification, please contact me on (07) 3239 6031.

Yours sincerely

Ashley Hill
Executive Director
Barrett Adolescent Centre Commission of Inquiry
08/12/2015

BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

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

REQUIREMENT TO GIVE INFORMATION IN A WRITTEN STATEMENT

To: Dr Tony O'Connell

Of: c/- Crown Solicitor, by email to [redacted]

I, the Honourable MARGARET WILSON QC, Commissioner, appointed pursuant to *Commissions of Inquiry Order (No. 4) 2015* to inquire into certain matters pertaining to the Barrett Adolescent Centre ("the Commission") require you to give a written statement to the Commission pursuant to section 5(1)(d) of the *Commissions of Inquiry Act 1950* in regard to your knowledge of the matters set out in the Schedule annexed hereto.

YOU MUST COMPLY WITH THIS REQUIREMENT BY:

Giving a written statement prepared either in affidavit form or verified as a statutory declaration under the *Oaths Act 1867* to the Commission on or before **4:00pm, Monday 21 December 2015**, by delivering it to the Commission at Level 10, 179 North Quay, Brisbane.

A copy of the written statement must also be provided electronically either by: email at mail@barrettinquiry.qld.gov.au (in the subject line please include "Requirement for Written Statement"); or via the Commission's website at www.barrettinquiry.qld.gov.au (confidential information should be provided via the Commission's secure website).

If you believe that you have a reasonable excuse for not complying with this notice, for the purposes of section 5(2)(b) of the *Commissions of Inquiry Act 1950* you will need to provide evidence to the Commission in that regard by the due date specified above.

DATED this 8th day of December 2015

[redacted]

The Hon Margaret Wilson QC
Commissioner
Barrett Adolescent Centre Commission of Inquiry

SCHEDULE

Background and Experience

1. Outline your current professional role/s, qualifications and memberships. Please provide a copy of your current/most recent curriculum vitae.

2. The Commission understands that you held the position of Director General Queensland Health from June 2011 to September 2013. Can you explain whether and to what extent that is accurate? And, with respect to your role in that position, please:

   a. outline your key responsibilities, including working and reporting relationships and the branches (or areas) which fell within your responsibility;

   b. detail your role and responsibilities with respect to the operation and/or management of the Barrett Adolescent Centre (**BAC**); and

   c. provide a copy of your position description.

3. Identify and provide details of all other positions and appointments (permanent, temporary or acting) held by you in Queensland Health which are not already detailed in response to question 2 above.

Replacement Unit for the BAC

4. Outline the nature and extent of your involvement (if any) in the planning of the 15-Bed Adolescent Extended Mental Health Treatment Unit at Redlands Hospital (**the Redlands unit**). In particular, explain the nature and extent of your involvement, and the relevant date(s).

5. Was funding for the relocation or replacement of the BAC provided for in the *Queensland Plan for Mental Health 2007-17*[1] (**the QPMH**)? If so, was the funding for a relocation of the BAC included in the initiative identified on page 18 of the QPMH as *"$121.55 million to expand the range of acute and treatment beds by providing 140 new*

[1] A copy is attached and marked TOC-1.

beds and to upgrade existing services to meet contemporary standards..."? If not, identify the specific funding allocation in the QPMH.

6. Provide details of the capital allocation to fund the relocation or the replacement of the BAC or for the Redlands unit. In particular, how much was allocated in each annual budget between the financial year 2007-2008 and the financial year 2012-2013. Identify the relevant budget papers.

7. As at May 2012, provide details of what steps had been taken to build the Redlands unit and what steps were yet to be taken.

8. Look at the 29 June 2011 document entitled *"Queensland Mental Health Capital Program"*.[2] That document is a table of figures and in the column entitled *"Barrett Centre Adolescent Extended Treatment Unit (15)"* the figures are: $10,291,637, $5,836,795, $2,763,011 and $18,891,443. Explain each of those figures. And state whether funding of $16,128,432 was available for the Redlands unit and whether the then estimated total cost of that project was $18,891,443.

9. Look at a Briefing Note to the then Minister for Health, Geoff Wilson cleared on 16 August 2011.[3] As at 16 August 2011 had the land at Lot 30 Weippin Street, Cleveland been partially allocated to the relocation of the BAC, with the rest proposed for future hospital expansion?

Decision Not to Proceed with Redlands

10. Explain your involvement in the decision to not proceed with the development of the Redlands unit. In particular:

    a. when was the decision made and by whom, and in what circumstances?

    b. if the decision was made by the Minister, was it on your recommendation?

[2] A copy is attached and marked TOC-2.
[3] A copy is attached and marked TOC-3.

c. identify who else had involvement and/or input into the decision and any person or persons who recommended the decision;

d. state the reason(s) why the Redlands unit did not proceed;

e. explain the relevance (if any) of the *Interim Report of the Independent Commission of Audit into Queensland's Financial Position, Public Sector Service Delivery and Infrastructure Program* (the Costello Commission of Audit) dated June 2012 to that decision;

f. explain the relevance (if any) of the *"Fiscal Repair Strategy"* on the decision;

g. explain your knowledge of the redirection of the capital allocation (including by whom, and to where and when, and on whose advice).

May 2012 Briefing Note

11. Look at the Briefing Note for Approval to you as Director General (the **May 2012 Briefing Note**) dated 3 May 2012 and signed by you on 16 May 2012.[4] As to the May 2012 Briefing Note:

a. Explain the *"anticipated capital funding shortfall of $3.1 million for the regional mental health HHF projects, relating to Information Communications Technology (ICT), escalation and land acquisition."*

b. Explain the HHF projects: what were they, and why were they *"critical in the reform of Queensland mental health services."*

c. Explain whether you, or your office, had decided where the balance of the *"potential cost saving resulting from the cessation of the 15 bed RAETU"* was going to be allocated (after payment of the shortfall of $3.1 million) and, if so, explain where and identify the relevant documents;

[4] A copy is attached and marked TOC-4.

d. Explain the *"cessation of the 15-bed RAETU which has been funded under Stage 1 of the Queensland Plan for Mental Health 2007-17"* and, in particular, state whether the RAETU was the Redlands unit;

e. Explain the reasons for your approval of the cessation of the *'15-bed RAETU'* and, in particular:

i. identify any reports, discussion papers, or any other documents relied on by you in deciding to give your approval to cease the *'15-bed RAETU'*;

ii. state what, if any, 'sunk' or wasted costs you identified or calculated would be incurred by reason of the cessation of the *'15-bed RAETU'*;

iii. identify any oral reports (dates, persons) given to you which you relied on, or which influenced your approval to cease the *'15-bed RAETU'* and state the substance of each oral report;

iv. state whether, before or at the time of giving your approval to cease the *'RAETU'*, you re-considered or analysed the reasons for the Redlands unit, or the reasons for the funding of the relocation of the BAC in the QPMH and, if so, the documents and reasoning relevant to that reconsideration or analysis;

f. state whether, before or at the time of giving your approval of the cessation of the *'15-bed RAETU'*, you considered what care arrangements were to be put in place for the BAC patients in the future and, if so, identify those care arrangements and the relevant documents;

g. state whether, before or at the time of giving your approval of the cessation of the *'15-bed RAETU'*, you took into account:

i. the redevelopment of The Park campus;

ii. when Kuranda and EFTRU were scheduled to open;

iii. whether, in the redevelopment of The Park it was always anticipated that the BAC would not remain on the campus;

h. explain whether there was any consultation with stakeholders prior to or at the time of giving your approval and, if so, give details of the consultation (dates, persons/entities, documents);

i. explain whether you, or your office, or any person within the department, sought or obtained any child and adolescent psychiatric advice, or other expert advice, prior to giving your approval and, if so, provide a copy or give details;

j. whether any consideration was given to work done by Professor Crompton and others to develop a Model of Service for Redlands, and whether that Model of Service could be implemented elsewhere.

August 2012 Briefing Note

12. On 17 August 2012, you signed a Briefing Note for Approval (the **August 2012 Briefing Note**) noting the planned strategy to improve infrastructure in rural hospitals using (amongst other funding sources) the money from the cessation of the Replacement Adolescent Extended Treatment Unit, Redlands. This Briefing Note was then progressed to the Minister for Health, Mr Lawrence Springborg, who gave his approval on 28 August 2012.[5] Look at the August 2012 Briefing Note:

a. What was the "*planned strategy for the targeted rectification of the prioritised infrastructure issues and subsequent planning for 12 rural hospitals*" and identify any documents that recorded that "*planned strategy*";

b. Identify the 12 rural hospitals referred to, and the "*infrastructure issues*", and the "*subsequent planning*";

[5] A copy is attached and marked TOC-5.

c. Explain the reasons for your signing the August 2012 Briefing Note and, in particular:

i. identify any reports, discussion papers, or any other documents relied on by you in deciding to sign the August 2012 Briefing Note;

ii. state what, if any, 'sunk' or wasted costs you identified or calculated would be incurred by reason of the cessation of the Replacement Adolescent Extended Treatment Unit, Redlands;

iii. identify any oral reports (date, persons) given to you which you relied on or which influenced your decision to sign the August 2012 Briefing Note and state the substance of each oral report;

iv. state whether, before or at the time of signing, you re-considered or analysed the reasons for the Redlands unit, or the reasons for the funding of the relocation of the BAC in the QPMH and, if so, the documents and reasoning relevant to that reconsideration or analysis;

d. state whether, before or at the time of signing the August 2012 Briefing Note, you considered what care arrangements were to be put in place for the BAC patients in the future and, if so, identify those care arrangements and the relevant documents;

e. state whether, before or at the time of signing the August 2012 Briefing Note, you took into account:

i. the redevelopment of The Park campus;

ii. when the Kuranda Unit and EFTRU were scheduled to open;

iii. whether, in the redevelopment of The Park it was always anticipated that the BAC would not remain on the campus;

f. explain whether there was any consultation with stakeholders prior to or at the time of signing the August 2012 Briefing Note and, if so, give details of the consultation (dates, persons/entities, documents);

g. explain whether you, or your office, or any person within the department, sought or obtained any child and adolescent psychiatric advice, or other expert advice prior to signing the August 2012 Briefing Note for Approval and, if so, provide a copy or give details;

h. whether any consideration was given to work done by Professor Crompton and others to develop a Model of Service for Redlands, and whether that Model of Service could be implemented elsewhere.

After the Decision Not to Proceed with Redlands

13. Once the decision was made not to proceed with the Redlands unit, explain whether:

a. consideration was ever given to the following alternatives (and, if so, when and by whom and in what circumstances, and outline the reason(s) why/why not)):

i. an alternative site for a Tier 3 service; and/or

ii. implementation of the Model of Service prepared for Redlands at the BAC or elsewhere; and/or

iii. refurbishment of the BAC;

b. a decision had already been made (and, if so, by whom and when) that a Tier 3 facility would not be developed and (if yes, the basis of that decision).

14. Once the decision was made not to proceed with the Redlands unit, to what projects or other initiatives were those funds (both capital and operating) originally allocated to the Redlands unit actually re-allocated and spent.

15. At the time when the decision was made not to proceed with the Redlands unit, who had authority to establish an alternative Tier 3 service (had this option been progressed and a location identified)? If so, explain the details.

July 2013 Briefing Note

16. On or about 8 July 2013 Ms Dwyer prepared a '*Briefing Note for Noting*' addressed to you as the Director-General (the **July 2013 Briefing Note**).[6] Look at the July 2013 Briefing Note :

a. Did you see and/or sign the July 2013 Briefing Note, or a document in substantially the same terms? If so provide a copy?

b. Did you see and/or read the report or the recommendations of the ECRG referred to in the July 2013 Briefing Note?

c. Was the July 2013 Briefing Note, or a document in substantially the same terms, submitted to Minister Springborg?

d. If you saw and signed or agreed with the July 2013 Briefing Note, please explain the reasons for your signing and agreeing with that Briefing Note. In particular:

i. identify any reports, discussion papers, or any other documents relied on by you in deciding to sign or agree;

ii. identify any oral reports (date, persons, substance) given to you which you relied on or which influenced your decision to sign or agree with the July 2013 Briefing Note;

iii. state whether, before or at the time of signing or agreeing, you re-considered or analysed the reasons for the closure of the BAC and, if so, the documents and reasoning relevant to that reconsideration or analysis;

[6] A copy is attached and marked TOC-6.

iv. state whether, before or at the time of signing or agreeing, you considered what care arrangements were to be put in place for the BAC patients in the future and, if so, identify those care arrangements and the relevant documents;

v. state whether, before or at the time of signing or agreeing, you took any steps to ensure that there were one or more appropriate facilities for the BAC patients, and future patients who might otherwise have been admitted to the BAC and, if so, identify those steps and the relevant documents;

e. Explain whether there was any consultation with stakeholders prior to or at the time of signing and, if so, give details of the consultation (dates, persons/entities, documents);

f. Explain whether you, or your office, or any person within the department, sought or obtained any child and adolescent psychiatric advice, or other expert advice prior to signing the Briefing Note for Approval and, if so, provide a copy or give details.

17. With respect to the BAC:

a. during financial years 2010 to 2014, how was the BAC funded (include detail of the nature of that funding, and any changes in financial responsibility throughout this period (and explain when those changes occurred and what they involved));

b. how did the amount of funding required for the BAC compare as against that required for community care models of care;

c. what were the financial implications for a state-wide facility being located within a Hospital and Health Service district and, in particular, within:

i. the West Moreton Hospital and Health Service; and/or

ii. the Metro South Hospital and Health Service (i.e. the Redlands unit).

November 2013 Briefing Note

18. The Commission is in possession of a Briefing Note for your signature dated 28 November 2012 with the subject, *'Approval to close Barrett Adolescent Centre, the Park for Mental Health'* (the **November 2013 Briefing Note**).[7] The Commission has another version of this Briefing Note on which there is a notation by Michael Cleary and 'Miranda' on page 1.[8] There is a notation on that second version to this effect: *'Hi Michael, Mental Health has advised that it is their understanding that West Moreton HHS is now taking the lead in relation to the future of the Barrett Adolescent Centre and this briefing note is cancelled...'*:

    a. Explain the notation *'this briefing note is cancelled'*;

    b. Explain the circumstances in which you received the November 2013 Briefing Note (if you received it);

    c. Did you sign a version of this Briefing Note? If so, please provide a copy;

    d. Identify and provide details of the full name and position of *'Miranda'* as at 28 November 2012.

Date of Closure

19. Explain the nature and extent of your involvement and/or input into the decision that the closure date for the BAC was to be January 2014. In the event you had direct involvement and/or input into the decision that the closure date for the BAC was to be January 2014, give details of:

    a. the extent and/or nature of your involvement and/or input into the decision and the names and positions of those other persons involved in making the decision;

    b. the reason(s) as to why January 2014 was chosen for the closure of BAC;

[7] A copy is attached and marked TOC-7.
[8] A copy is attached and marked TOC-8.

c. on what date the decision as to the closure date was made;

d. any consultation with experts and/or stakeholders (and when), and the nature of the consultation;

e. what advice/views were given by those experts and stakeholders prior to the decision, and how influential each of the perspectives was to your decision-making and/or input into the decision;

f. the existence of any flexibility with respect to the January 2014 closure date, once set, or any review mechanisms; and

g. how, when and to whom, you communicated the decision as to the closure date (and for what purpose).

20. In the event you did not have any direct involvement and/or input into the decision that the BAC's closure date was to be January 2014, explain:

a. on what date, how, and from whom, you became aware of the decision that the closure date would be January 2014;

b. any reason(s) for the closure date that were communicated to you and from whom, by what means, and on what date; and

c. the extent to which you were aware of the existence of any flexibility with respect to the closure date or any review mechanisms (and the source of that understanding).

21. Did you consider the January 2014 closure date to be appropriate and outline the reason(s) why/why not?

22. Did you facilitate or attend any meetings regarding the closure of the BAC and, if so, with whom and on what date(s), and for what purpose?

23. Detail any processes that you were involved in (or were otherwise aware of), with respect to communicating the closure decision to parents of BAC patients (and their families) and BAC staff, and the nature of your involvement (and when).

24. Did you or your office communicate with the Department of Education and Training regarding the proposed closure of the BAC school? If 'yes', give details.

25. Did you become aware of the requirement for the Department of Education and Training to give notice of a certain duration regarding the proposed closure of a school? If so, explain the requirement and when you became aware of that requirement.

Queensland Plan for Mental Health

26. Explain the relevance (if any) of the QPMH to:

    a. the development of the plan to construct the Redlands unit;

    b. the decision not to proceed with the Redlands unit;

    c. the decision to close the BAC;

    d. the decision to close the BAC by January 2014;

    e. the decision to announce the closure of the BAC on 6 August 2013;

    f. consideration (or lack of consideration) of a replacement Tier 3 service at an alternative location.

27. The QPMH refers to *"Core Mental Health Services"*. Provide details as to:

    a. the criteria for being a *"core mental health service"*, and the implications of being (or not being) classified as a *"core mental health service"* (and provide copies of any applicable policy document(s));

    b. whether the BAC was a *"core mental health service"* and the reason(s) why/why not; and

c. whether the BAC was considered to be *"hospital treatment"* based on the type of care provided (inpatient subacute bed-based intensive treatment and rehabilitation services), and the reason(s) why/why not (and provide copies of any applicable policy document(s)).

28. Explain the relevance (if any) of the *"National Mental Health Service Planning Framework"* on decisions made with respect to the Redlands unit and/or the BAC, and state whether you received a copy of the framework (and from whom, on what date, and for what purpose) (and provide a copy).

The Park

29. Explain the relevance (if any) of the redevelopment of The Park as an adult forensic facility and/or the scheduled openings of the Kuranda Unit and EFTRU facility, to:

a. the initial plan to decommission the BAC and build the Redlands unit;

b. the decision to not proceed with the Redlands unit;

c. the decision to close the BAC;

d. the decision to close the BAC by January 2014; and

e. the decision to announce the closure of the BAC on 6 August 2013.

Statewide Services

30. The Commission understands that the BAC provided a statewide mental health service. Provide details of:

a. statewide service plans relevant to the BAC (and provide copies);

b. State and National policies, plans and protocols, relevant to the management and operation of the BAC (and provide copies);

c. the relationship between the BAC, the Hospital and Health Services (HHS) and the Department of Health, including, but not limited to:

i. roles in relation to accountability, oversight and responsibility for the BAC;

ii. responsibility for the development and management of a statewide service, including which entity has the power to cease a statewide service;

iii. how statewide mental health services were planned for and overseen by Queensland Health (and provide copies of any documented framework and/or planning documents);

iv. the role of a Hospital and Health Service with respect to a statewide service and, in particular, the extent of control they have over the service (if any);

v. the role of the Mental Health Alcohol and Other Drugs Branch with respect to the BAC.

31. The Commission understands that a number of statewide clinical networks sit within Queensland Health, one of which is the Mental Health Clinical Network. Provide details as to:

a. the role and function of the Mental Health Clinical Network and, in particular, with respect to the BAC (prior to its closure);

b. the role of the Mental Health Clinical Network (and any other Clinical Networks) with respect to approving the model of care at BAC;

c. any concerns raised between financial years 2010 to 2013 with respect to the model of care at the BAC (and provide details as to by whom, when and what steps (if any)were taken to address those concerns); and

d. whether the Mental Health Clinical Network was responsible for approving (or otherwise having oversight over) the model of care in place at the BAC prior to its

closure (and if so, provide details as to the nature and extent of the approval and oversight).

ECRG & Planning Group

32. The Commission understands that in around November 2012, an Expert Clinical Reference Group (the **ECRG**) was formed to make recommendations with respect to models of care for mental health treatment and rehabilitation for adolescents in Queensland. With respect to the ECRG:

a. explain the nature and extent of your involvement in the formation of the ECRG, including but not limited to, the selection of its members (and the basis for their selection);

b. explain the nature and extent of your involvement in the formation and role of the ECRG. In particular, provide details of:

i. the function of the ECRG and the function of the report to be prepared by the ECRG;

ii. the development of the Terms of Reference, the scope and functions of the ECRG and the material to be considered by the ECRG;

iii. any input or direction given by you (or on your behalf) to the ECRG (or its members);

iv. any consultation by you (or carried out on your behalf) with the ECRG (or its members); and

v. any oversight and/or monitoring role which you played with respect to the ECRG;

c. provide details of the purpose of the ECRG and, in particular, the relationship between the ECRG and the Barrett Adolescent Strategy Project Plan (as prepared by West Moreton Hospital and Health Service);

d. did you receive a copy of the ECRG report and, if so, when and how, and what action did you take in response?

33. Did you accept or reject the recommendations made by the ECRG in its report?

34. In its report, the ECRG found inpatient extended treatment and rehabilitation care (Tier 3) to be an essential service component. The ECRG further found that "*interim service provision if BAC closes and Tier 3 is not available is associated with risk*". With respect to these findings by the ECRG, explain:

a. whether the option of a Tier 3 service was ever reconsidered/revisited, following receipt of this recommendation by the ECRG (and the reasons why/why not);

b. in the event the option of a Tier 3 service was reconsidered/revisited, the nature of that consideration, who was involved and when (and provide the relevant documents);

c. the reason(s) why a Tier 3 service was not developed or implemented, given the findings of the ECRG that Tier 3 was an essential service component;

d. whether you took any steps in relation to the risk identified by the ECRG.

35. The Commission understands that the ECRG was overseen by a Planning Group. With respect to the Planning Group:

a. explain the nature and extent of your involvement with respect to the formation of the Planning Group and the selection of its members;

b. identify any officers of Queensland Health involved in the formation of the Planning Group and the selection of its members;

c. explain the nature and extent of your involvement, and the involvement of senior officers of Queensland Health, in the functions of the Planning Group. In particular, provide details as to:

i. the development of any Terms of Reference, the scope and functions of the Planning Group and the material to be considered by the Planning Group;

ii. any input or direction given by you (or on your behalf) to the Planning Group (or its members);

iii. any consultation by you (or carried out on your behalf) with the Planning Group (or its members); and

iv. any oversight and/or monitoring role which you, or senior officers of Queensland Health, played with respect to the Planning Group;

d. state when you received a copy of the Planning Group report and outline by what means and for what purpose (and any steps taken by you as a result).

36. As noted above, in its report, the ECRG found a Tier 3 to be *"an essential service component"* and recommended that a Tier 3 be prioritised. In its report, the Planning Group accepted this recommendation by the ECRG *"with considerations"*. These considerations were described as follows:

> *Further work is needed to detail the service model for a Tier 3. Models involving a statewide, clinical bed-based service (such as the Barrett Adolescent Centre) are not considered contemporary within the National Mental Health Service Planning Framework (in draft). However, there are alternative bed-based models Involving clinical and non-clinical service components (e.g., Y-PARC in Victoria) that can be developed in Queensland to meet the requirement of this recommendation. Contestability reforms in Queensland may allow for this service component to be provider agnostic.*

With respect to the above extract, explain:

a. what further work (if any) has been undertaken in Queensland *"to detail the service model for a tier 3"* (and provide details as to when and by whom and the status of that work);

b. whether you considered a statewide, clinical bed-based service to be contemporary within the National Mental Health Service Planning Framework and the reason(s) why/why not;

c. any steps taken to develop and/or implement alternative bed-based models involving clinical and non-clinical service components such as, but not limited to, Y-PARC (and provide details as to when and by whom and the status); and

d. your understanding of the meaning of: *"Contestability reforms in Queensland may allow for this service component to be provider agnostic"*.

37. In its report, the ECRG found *"interim service provision if BAC closes and Tier 3 is not available is associated with risk"*. With respect to this finding, the ECRG recommended (together with other matters) that *"safe, high quality service provision for adolescents requiring extended treatment and rehabilitation requires a Tier 3 service alternative to be available in a timely manner if BAC is closed"*. The Planning Group's recommendation with respect to the ECRG's recommendation was - *"Accept"*. With respect to these matters, outline:

a. what are the *"safe, high quality services"* for *"adolescents requiring extended treatment and rehabilitation"* which are an alternative to a tier 3 service (and provide details as to when they were implemented and what they involve); and

b. the basis upon which the alternative was assessed as being a *"safe, high quality"* service (and by whom and by what means, and what it involves).

Working Groups/Committees/Relationships

38. Provide details of any other committees or groups you were a member of, or had involvement or input into the formation of, with respect to the operation and/or closure of the BAC, the option of the Redlands unit, and the redevelopment of The Park and/or the development or implementation of Adolescent Extended Treatment and Rehabilitation service options.

39. The Commission understands that the following working groups/committees were in existence at around the time when decisions were being made within Queensland Health with respect to the BAC:

    a. Barrett Adolescent Centre Strategy Planning Group;

    b. The Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy Steering Committee;

    c. Chief Executive and Department of Health Oversight Committee;

    d. Service Option Implementation Working Group;

    e. Barrett Adolescent Centre Consumer Transition Working Group;

    f. Financial and Workforce Planning Working Group; and

    g. Young People's Extended Treatment and Rehabilitation Initiative (YPETRI) Governance Committee.

    With respect to each of these groups/committees (and any other groups/committees of which you are aware, which concerned the BAC), provide details as to:

    a. the role and function of the group (both generally and also in respect of the BAC specifically);

    b. the circumstances and purpose for which each was established (and by whom and the period for which they operated; and

    c. the nature and extent of your involvement and/or input (and when).

40. Explain the relationships between:

    a. Queensland Health **and** West Moreton Hospital and Health Service; and

    b. Queensland Health **and** Children's Health Queensland Hospital and Health Service;

With respect to:

a. the operation and management of the BAC;

b. alternatives to the BAC;

c. redevelopment of The Park.

Transition Arrangements

41. The Commission is aware that from November 2012 until January 2014 a number of BAC patients were transitioned to alternative care arrangements. With respect to the Transition Clients:

a. who was responsible for developing the transition arrangements for the Transition Clients, and what were those transition arrangements;

b. who had the monitoring or oversight role for the transition arrangements for the Transition Clients;

c. provide details as to how transition arrangements were developed, including but not limited to, any consultation(s) with Transition Clients and/or their families, friends or carers (and the date and detail of such consultation(s));

d. explain the nature and extent of your role with respect to Transition Clients. In particular, detail your involvement in developing, managing and implementing transition arrangements (including, but not limited to, identifying, assessing and planning for care, support, service quality and safety risks);

e. what feedback or advice did you receive (and from whom and when) in relation to the progression of the transitioning arrangements for the Transition Clients;

f. did you meet with any of the BAC transition clients or their families / carers in relation to their transition from the BAC and, if so, when and for what purpose;

g. advise whether there were any transition plans to review the transition arrangements and outline what such review involved (and when and how it occurred).

42. Did you have any discussions with the medical or other staff at receiving alternative services regarding the Transition Clients' transitional arrangements, transition plans, treatment plans, clinical and educational needs or other matters? If so, explain the nature of these discussions, including the date on which they occurred, with whom and for what purpose.

43. Were you aware of any concerns regarding the transition of any Transition Clients from the BAC to an alternative service provider? If so:

a. detail any such concerns;

b. if there were concerns, state who were these concerns expressed by and to whom;

c. on what date and by what means did you become aware of these concerns; and

d. what steps, if any, did you cause to be undertaken as a result of any such concerns.

44. The Commission understands that your Deputy (Dr Michael Cleary) was a member of the Chief Executive and Department of Health Oversight Committee. With respect to this Committee:

a. What was your involvement in this Committee? Did Dr Cleary report to you following these meetings?

b. Explain the function and responsibilities of the Committee with respect to the BAC including, but not limited to:

i. the decision to close the BAC;

ii. the date for closure of the BAC;

iii. the BAC School;

iv. staff of BAC and the BAC School;

v. the arrangements made for Transition Clients; and

vi. the development and implementation of service options.

BAC Staff

45. Detail the nature of your involvement with respect to communication with staff of the BAC about the possible (or actual) closure of the BAC. In particular, state when this communication occurred, what it involved and any input/decision you received with respect to the content of the communication (and from whom and when).

46. With respect to the Barrett School, explain the nature and extent of your involvement in meeting and/or communicating with staff or officers of the Department of Education or the Minister for Education (including when and the purpose and content of the communication, and any action taken by yourself as a result).

Future Service Delivery

47. Provide details of any meetings, contact, telephone discussions, written communication and correspondence (including electronic) you had regarding the future service delivery of mental health services to adolescents in Queensland who previously met the criteria for the delivery of services by the BAC (i.e. proposed service delivery in lieu of the BAC) and the date(s) when this occurred and with whom.

48. The Commission understands that you were the Director-General of Queensland Health from June 2011 to September 2013. To the extent that you are able from your knowledge gained in that position:

a. what was Queensland Health's proposed model of service delivery for children and adolescents who previously met the criteria for admission at the BAC;

b. were additional funds allocated to Child and Youth Mental Health Services (**CYMHS**) across Queensland upon the closure of the BAC; how much of the funding for the BAC was re-allocated to CYMHS across Queensland;

c. what framework was developed for the delivery of non-specialist mental health care (i.e. support, care and community access) to adolescents in Queensland at risk and previously in need of a 'tier 3' service;

d. were any agreements with non-government organisations entered into for the delivery of these services. If so, what organisations were contacted with a view to providing the delivery of these services. Were any agreements entered into with these organisations;

e. was any training in the area of child and adolescent mental health offered, developed or provided to these non-government organisations;

f. was any additional training offered, developed or provided for Queensland Health staff in relation to child and adolescent mental health issues upon closure of the BAC;

g. were there any proposals or plans in place within Queensland Health for the development of a new adolescent extended treatment tier 3 facility in place in lieu of the BAC;

h. did you meet with anyone regarding the future delivery of child and adolescent mental health services with respect to the delivery of services previously offered by the BAC. If so, who did you meet with and what did you discuss. What were the outcomes of these meetings; and

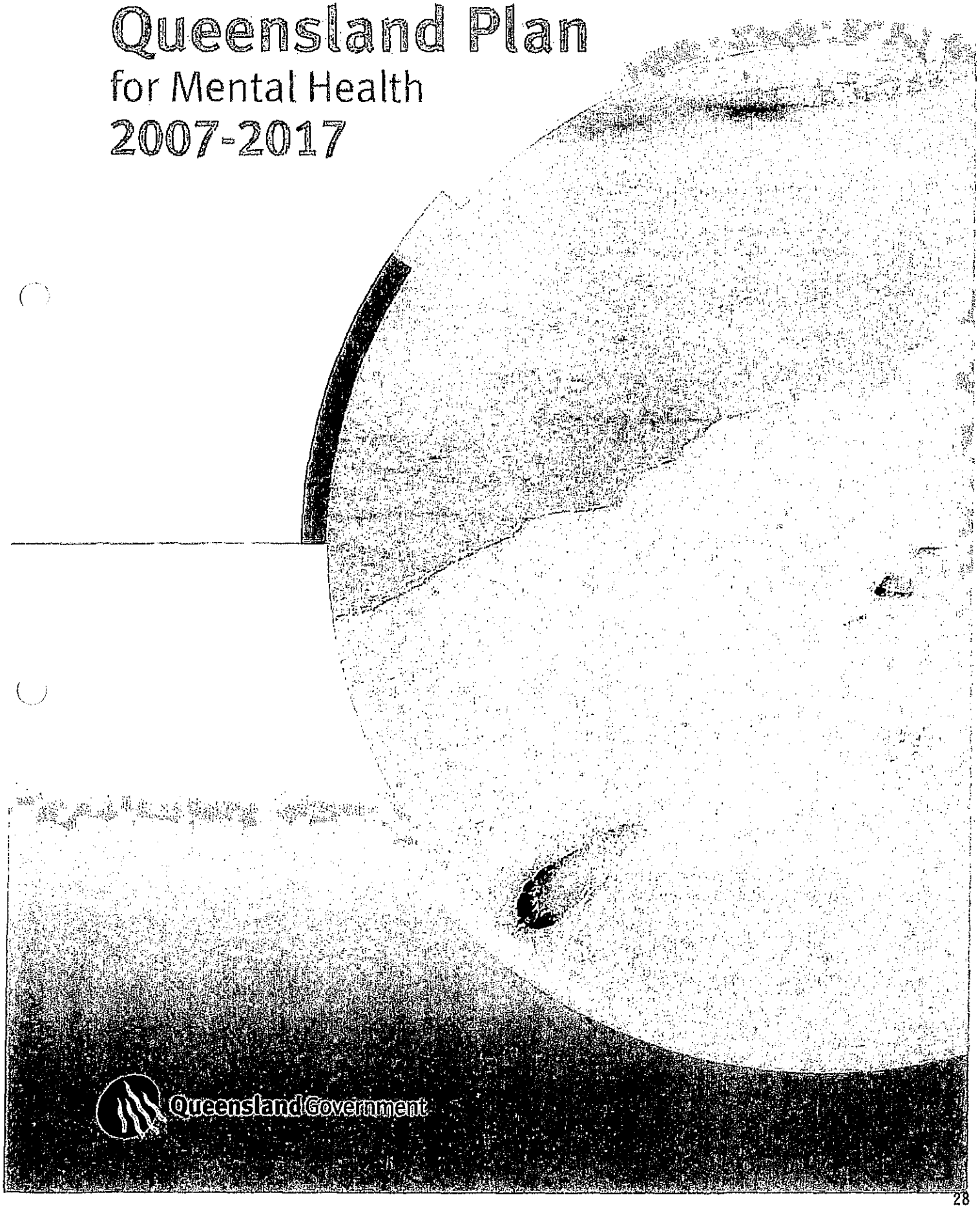
i. were any non-governmental residential rehabilitation service organisations contacted to provide additional services to at risk child and adolescents, was additional funding provided to these organisations, and what were the arrangements made with these organisations.

Other

49. Outline and elaborate upon any other information or knowledge (and the source of that knowledge) that you have relevant to the Commission's Term of Reference.

50. Identify and exhibit all documents in your custody or control that are referred to in your witness statement.

Queensland Plan
for Mental Health
2007-2017



Queensland Government

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Message from the Minister for Health

I am very pleased to present the *Queensland Plan for Mental Health 2007-2017*. The plan outlines priorities for the reform and development of mental health care over the next ten years.

The demand for treatment and support for people with mental illness continues to grow. Currently one in five adult Australians experience a mental illness in any one year. Depression is predicted to rise from the fourth to the second greatest cause of global disease burden over the next twenty years.

As part of the 2007-08 State Budget the Queensland Government committed a record $528.8 million over four years to improve Queensland's mental health system. This unprecedented level of funding, the largest investment in mental health in Queensland's history, reflects the Government's deep commitment to delivering a better quality of life for people who live with mental illness, their families and carers.

In 2008-09 a further $88.63 million has been allocated over four years to continue implementation of this Plan bringing the total Government commitment since July 2007 to $617.43 million.

The *Queensland Plan for Mental Health 2007-2017* provides a blueprint for reform and will inform future investment in mental health services across the State. The directions outlined in the Plan establish a framework for the development of a more responsive system of services to better meet the needs of people who live with a mental illness.

Public mental health services will continue to play a major role, with the contribution of other sectors involved in the delivery of mental health care clearly highlighted. There is a much stronger role for non-government organisations, and major contributions from all levels of government.

The *Queensland Plan for Mental Health 2007-2017* has been informed by extensive consultations undertaken with mental health consumers, carers, service providers and key stakeholders.

Five priority areas for action have been identified. These priorities position mental health services to be better able to respond to existing and future demand for care, by building on the strengths of the current system, developing an appropriate mix and level of services and implementing new and innovative approaches to consumer and carer needs.

The priorities are:

- promotion, prevention and early intervention
- improving and integrating the care system
- participation in the community
- coordinating care
  workforce, information, quality and safety.

Effective partnerships around mental health care are essential. Improving collaboration between the public sector, private sector, non-government organisations, other agencies and departments and the broader community to respond to the needs of people who live with a mental illness, their families and carers is a prime aspect of the *Queensland Plan for Mental Health 2007-2017*. The reform of mental health care over the next ten years relies on these partnerships and the participation of the broader community.

I look forward to working with you as we further develop and implement our vision for mental health in Queensland.

Stephen Robertson MP
Minister for Health

Contents

1. A vision for mental health

Throughout the world, mental disorders are common, affecting more than 20% of all people at some time during their lives. Mental health problems are universal, being experienced by people of all countries, by women and men of any age and socioeconomic status, and in urban and rural environments.

Mental disorders are the largest single cause of disability within Australia accounting for nearly 30% of the burden of non-fatal disease. In Queensland, it is estimated that 16.6% of the population is affected by mental disorders in any one year (further detail provided below).

A complex interplay of biological, psychological, social, economic and environmental factors influence mental health. This is true for all Queensland people, but has particular significance for some population groups, especially Aboriginal and Torres Strait Islander people who view social and emotional wellbeing holistically. Mental health status also influences access to various community resources and capacity to participate in society.

Meeting the mental health needs of Queensland's rapidly growing population poses challenges for governments, policy makers, researchers, service providers and communities. Queensland remains one of the fastest growing states in Australia with the population predicted to grow from 4 million to 5.6 million by 2026.

Mental illness in Queensland

- It is estimated that 16.6% of the Queensland population is affected by mental disorders in any one year (excluding dementia and alcohol and drug-related disorders, except where co-existing with another mental disorder).
- The figure rises to about 22% when alcohol and drug-related conditions are included.
- Anxiety-related and depressive disorders are the most prevalent, affecting approximately 7% and 6% of the population within any year respectively.
- Almost 2.5% of Queensland people experience severe mental disorders. About half of this group have a psychotic disorder and the remainder experience major depression or severe anxiety disorders and disabling forms of other disorders such as anorexia nervosa.
- Approximately 4.5% have a mental disorder of moderate severity, including depression, generalised anxiety disorder, post-traumatic stress disorder and panic disorder/agoraphobia.
- A further 9.6% have a disorder of mild severity and are at risk of recurring or continuing mental disorders.

Queensland Health, 2007*

** Australian and International sources have been used as Queensland-specific prevalence data of comparable coverage and quality are not available.*

While public mental health services in Queensland have undergone significant development in the last decade, there is a growing recognition that mental health is not solely the responsibility of the mental health treatment sector. Other sectors, in particular housing, disability and employment, play important roles in an individual's mental health and wellbeing, and on the broader social health of the community.

Each of these sectors together with education and training, child safety, police and emergency services, corrections and justice and community services, have a key role in maximising the mental health of Queenslanders.

The vision of the *Queensland Plan for Mental Health 2007-2017* is to facilitate access to a comprehensive, recovery-oriented mental health system that improves mental health for Queenslanders. The Plan aims to develop a coordinated approach that provides a full range of services that:

- promote mental health and wellbeing
- where possible prevent mental health problems and mental illness
- reduce the impact of mental illness on individuals, their families and the community
- promote recovery and build resilience
- enable people who live with a mental illness to participate meaningfully in society.

The mental health sector needs to build stronger partnerships with consumers, families, carers, and government and non-government services to achieve better outcomes for Queenslanders.

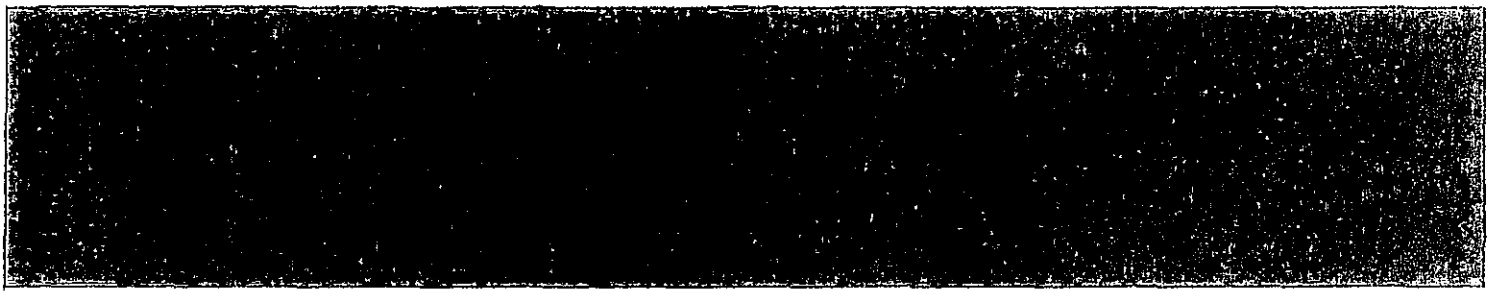
The delivery of recovery-oriented services is central to the Plan. Recovery is an emerging paradigm that has significant implications for people with a mental illness, families, carers and service providers. Recovery refers to a person's improved capacity to lead a fulfilled life that is not dominated by illness and treatment. The recovery approach does not focus on reduced symptoms or need for treatment alone, but on the person experiencing improved quality of life and higher levels of functioning despite their illness.

Recovery is an individual's journey toward a new and valued sense of identity, role and purpose outside the boundaries of mental illness. Recovery-oriented services assist an individual to live well despite any limitations resulting from their mental illness, its treatment, and personal or environmental conditions.

Recovery means that over time, individuals come to terms with their illness, learning how to accept and move beyond it. They learn to believe in themselves, identify strengths as well as limitations and find purpose and enjoyment in their lives, despite their illness. Services supporting individuals with mental illness have to focus on the potential for growth within the individual and acknowledge that individuals with mental illness are active participants in the recovery process.

Recovery acknowledges that having a mental illness does not necessarily mean life long deterioration. People with a mental illness are recognised as whole, equal and contributing members of our community, with the same needs and aspirations as anyone else. As a result, when working to facilitate recovery, the basic elements of citizenship need to be considered, such as ability to live independently, form social relationships and access employment opportunities. In doing this it is important that all relevant stakeholders adopt and are supportive of recovery-oriented service provision.

Sharing Responsibility for Recovery: creating and sustaining recovery-oriented systems of care for mental health. Queensland Health, 2005



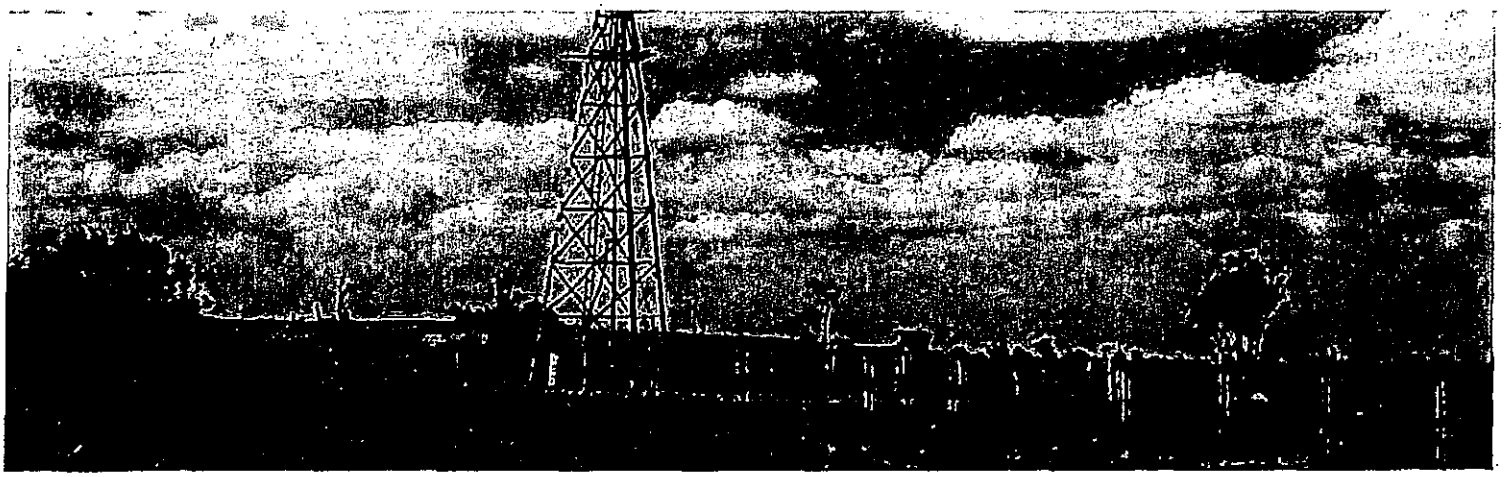
People living with mental illness can and do recover to live productive lives in their communities. Recovery emphasises the need for a comprehensive community-based service system that works to address the full impact of mental illness. The improvement of mental health treatment services in isolation will not address all the issues related to the support of people with mental illness and their recovery.

There is growing recognition that a whole-of-government, whole-of-community approach is necessary to reduce the prevalence and impact of mental health problems and mental illness. The *Queensland Plan for Mental Health 2007-2017* brings together the sectors that impact on the mental health of individuals, their families, carers and communities.

The Plan recognises that a range of sectors including housing, education, training, employment, community support, health, corrections, justice, disability, police, emergency services and child safety have important roles to play in promoting mental health and reducing the impact of mental health problems and mental illness. A stronger role is envisaged for the non-government sector as a key partner in delivering comprehensive community based care and support.

Working collaboratively, these sectors have an important role to play in promoting the mental health and wellbeing of the general population, and assisting with the recovery of those experiencing mental health problems and mental illness.

The vision of the Queensland Mental Health Plan 2007-2017 is to facilitate access to a comprehensive, recovery-oriented mental health system that improves mental health for Queenslanders.



2. Achievements to date

The Queensland Government is building a better mental health system by improving the quality, range and access to mental health services. In October 2005, as part of the *Health Action Plan*, $201 million was allocated over five years to boost mental health services in Queensland. Beginning in July 2006 this funding was used to:

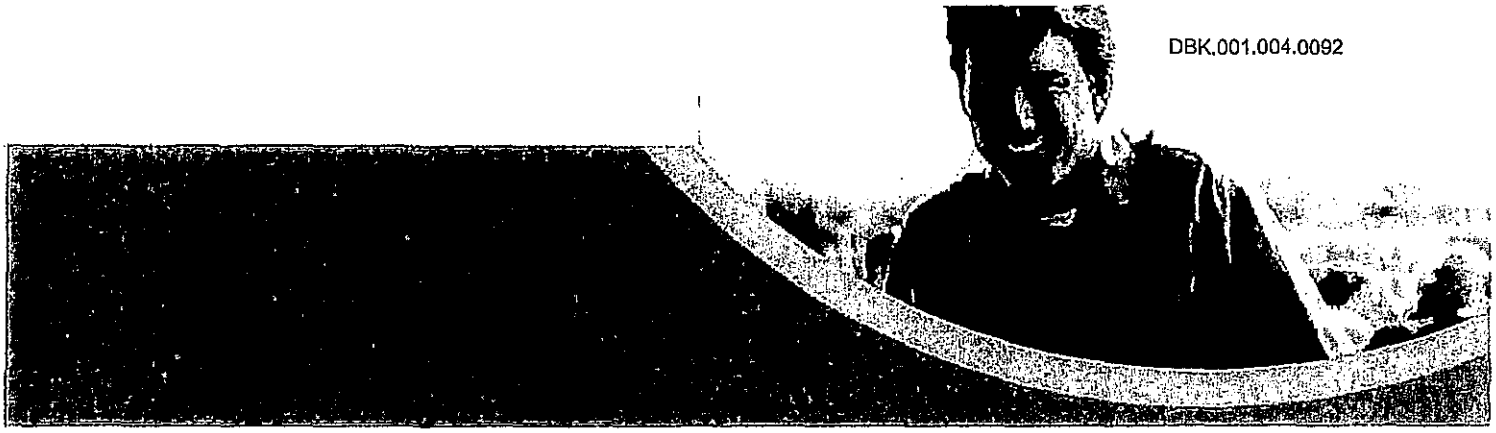
Increase mental health service capacity throughout Queensland

- Across Queensland, 193.5 new positions were established at a cost of $18 million per year. These new positions have increased access to community mental health services for people with mental illness by reducing waiting times and case loads.
- Forensic mental health services were expanded to improve services to people with mental illness who have been in contact with the criminal justice system. Specialised community forensic and court liaison services were enhanced with an additional 27 positions at a cost of $3.16 million per year. This included the creation of the position of Director of Forensic Mental Health Services to provide statewide leadership and oversight of forensic mental health services.
- Additional funding of $11.62 million per year was provided to assist in reducing pressure on existing services by increasing resources in Emergency Departments, acute inpatient treatment settings and other areas of significant demand.

Build the capacity of the non-government sector to support people with mental illness in the community

- Funding to community organisations was increased by $5 million per year, including grants to 18 non-government organisations across Queensland to provide independent living skills and social support services to people with mental illness living in the community.

In recognition of the substantial social and economic impact of mental illness on individuals, families and the wider community, the Queensland Government committed to the Council of Australian Governments (COAG) *National Action Plan on Mental Health 2006-2011* ('the NAP') as part of the continued reform of mental health services in Australia. The initial commitment of $366.2 million announced in July 2006 included the $201 million provided under the *Health Action Plan* and a range of other mental health-specific initiatives funded within Queensland Health and other government departments.



In addition to the *Health Action Plan* enhancements previously listed, major initiatives funded in the initial COAG commitment include:

- the Housing and Support Program as a collaborative service initiative between the Department of Housing, Queensland Health, Disability Services Queensland and the Department of Communities. This program provides coordinated social housing, clinical treatment and non-clinical support to enable people with moderate to severe mental illness and psychiatric disability to live successfully in the community. The program included a $20 million capital investment from the Department of Housing with clinical and disability support services funded by Queensland Health and Disability Services Queensland. A total of 80 supported social housing places were provided in 2006-07.
- development of service delivery hubs in a range of locations to provide integrated services to people in high areas of need. These included Early Years Service Centres, Blueprint for the Bush Service Delivery Hubs and Indigenous Domestic and Family Violence Counselling Services established by the Department of Communities. These hubs are designed to provide a comprehensive range of services, including mental health services, with a focus on children and families, rural communities, and Aboriginal and Torres Strait Islander people.

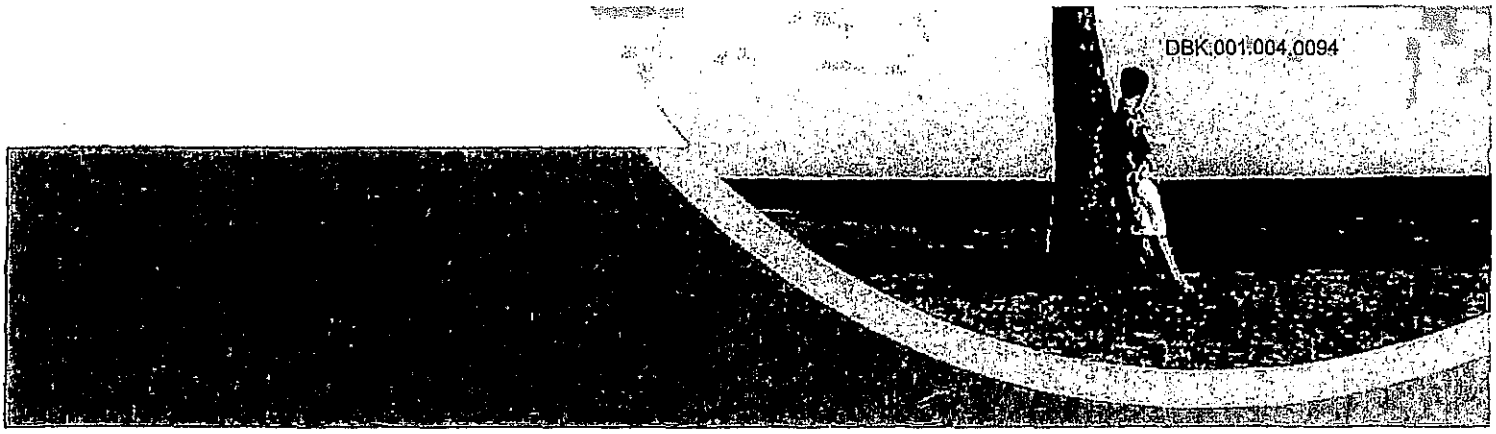
During 2006, Queensland Health also provided $640,000 to seven Divisions of General Practice across Queensland for the implementation of the 'Partners in Mind' framework. This approach, which has been agreed between Queensland Health and General Practice Queensland, will establish a better integrated primary mental health care sector.

The 2007-08 Queensland State Budget provided an additional commitment of $528.8 million over four years to expand the initial Queensland COAG mental health initiatives. This brings the total new investment in mental health by the Queensland Government to $895 million over the five years from 2006-11. This funding and the broad program of mental health reform are the focus of this Plan and are outlined in detail in Chapter 6.

These commitments will enable further development of the substantial network of District Mental Health Services, other government and non-government services in Queensland.

Currently the mental health inpatient system consists of more than 1,400 beds. During 2007-08, District Mental Health Services provided over 374,000 days of inpatient care. In addition, more than 2,000 staff were employed within community mental health services, and for the first time delivered more than 1.1 million occasions of services to Queenslanders with mental illness living in the community.

The Queensland Government is building a better mental health system by improving the quality, range and access to mental health services.



Public mental health services are provided in each of the 20 Queensland Health Service Districts. They deliver specialised assessment, clinical treatment and rehabilitation services to reduce symptoms of mental illness and facilitate recovery. These services focus primarily on providing care to Queenslanders who experience the most severe forms of mental illness and behavioural disturbance, including those who are subject to the provisions of the *Mental Health Act 2000*.

Public mental health services work in collaboration with primary health and private sector health providers. ***Primary health care providers*** include general practitioners, community health workers, nurses, allied health professionals, school health nurses, counsellors and community support groups. Their role includes assisting individuals with mental health problems and facilitating access to specialist public and private mental health services when required.

Private mental health services are delivered by psychiatrists, mental health nurses, clinical psychologists, social workers, occupational therapists and other allied health professionals with expertise in mental health care. They provide a broad range of services largely through office-based private practice and inpatient care within private hospitals, including dedicated private psychiatric hospitals.

Non-government organisations include not-for-profit community agencies, consumer, family and carer groups and other community-based services that provide a range of treatment, disability support and care services, which complement both public and private mental health services. Non-government organisations are the primary providers of psychiatric disability support for people with mental illness and play an important role in promoting and maintaining mental health and wellbeing.

All sectors, including public mental health services, other government agencies and non-government organisations are involved in identifying and intervening early with people who are at risk of developing mental illness and facilitating timely and effective recovery-oriented pathways to care. Key groups requiring particular attention in ***mental health prevention and early intervention*** include children of parents with mental illness, children and youth who have experienced, or are at risk of abuse/neglect, and young people displaying behaviour disturbances, and their families.

A safe environment, adequate income, meaningful social and occupational roles, secure housing, higher levels of education and social support are all associated with better mental health and wellbeing. Queensland Government departments are actively working together to deliver programs that aim to strengthen mental health and promote recovery, across the spectrum of interventions. Ensuring mental health services respond as effectively as possible to the needs of consumers, families, carers, and the broader Queensland community requires effective coordination and collaboration between these sectors and across the spectrum of interventions.

From July 2007, responsibility for funding of mental health services that are contracted from the non-government sector was transferred from Queensland Health to Disability Services Queensland (DSQ). This shift aligns responsibility for the development, implementation and management of mental health programs delivered through the non-government sector with other programs administered by DSQ in the community sector.

4. Purpose and scope of the Queensland Plan for Mental Health 2007-2017

The *Queensland Plan for Mental Health 2007-2017* provides a blueprint for reform of mental health care over the next ten years. It identifies interventions to be delivered by the different sectors to provide a system which is responsive to the needs of consumers, families and carers. This will reduce the burden of mental illness on individuals, families and the community. The Plan provides a framework which balances increases in the capacity of public mental health services against an expanded and strengthened role for non-government services and other areas of government. Collaboration and partnerships between these multiple stakeholders is pivotal in protecting the mental health of the Queensland community and supporting recovery for people living with mental illness.

Mission:

To provide a comprehensive, resilience and recovery-based mental health system across Queensland, with emphasis upon promotion, prevention and early intervention.

The scope of the *Queensland Plan for Mental Health 2007-2017* has been influenced by the framework provided by the *National Mental Health Strategy* and Queensland Government policies and plans including:

- *National Mental Health Policy 1992*
- *National Mental Health Plan 1993-1998*
- *Second National Mental Health Plan 1998-2003*
- *National Mental Health Plan 2003-2008*
- *Council of Australian Governments National Action Plan for Mental Health 2006-2011*
- *Mental Health Statement of Rights and Responsibilities (1991)*
- *National Standards for Mental Health Services (1996)*
- *National Mental Health Information Priorities 2nd Edition*
- *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000*
- *National Practice Standards for the Mental Health Workforce (2002)*
- *National Action Plan on Perinatal Mental Health*
- *Aboriginal and Torres Strait Islander Social and Emotional Well-being Framework 2004-2009*
- *Key Performance Indicators for Australian Public Mental Health Services (2004)*
- *National Safety Priorities in Mental Health: A National Plan for Reducing Harm (2005)*
- *Ten Year Mental Health Strategy for Queensland (1996)*
- *Queensland Forensic Mental Health Policy 2002*
- *Queensland Mental Health Strategic Plan 2003-2008*
- *Queensland Health Systems Review (Forster, 2005)*
- *Queensland Health Action Plan 2005*
- *Queensland Statewide Health Services Plan 2007-2017*
- *Queensland Health Strategic Plan 2007-12*
- *Queensland Health Disability Services Plan 2007-12*
- *Queensland Plan for Multicultural Health 2007-2017.*

The *Queensland Plan for Mental Health 2007-2017* also builds on the recommendations of two key reports. The first, *Promoting Balance in the forensic mental health system - Final Report - Review of the Queensland Mental Health Act 2000.* The Review was charged with examining the efficacy of provisions in the *Mental Health Act 2000* and administrative arrangements relating to victims, as well as assessing whether associated arrangements achieve an appropriate balance between community safety considerations and the provision of rehabilitation to forensic patients.

The Queensland Government Response to the Final Report - Review of the Queensland Mental Health Act 2000, details strategies to implement the Review recommendations.

The second, *Achieving Balance: The Report of the Queensland Review of Fatal Mental Health Sentinel Events,* is being implemented during the life of this Plan and will form the basis of the development of a mental health safety plan.

Planning parameters used in the development of the *Queensland Plan for Mental Health 2007-2017* were drawn from the information paper *Planning Estimates and Technical Notes for Queensland Mental Health Services*, prepared for the Mental Health Branch, Queensland Health.

5. Principles

The *Queensland Plan for Mental Health 2007-2017* articulates six principles to guide and support reform. Mental health intervention, care and service delivery across all sectors in Queensland should align with these principles.

Principle 1 – Consumer and carer participation

Consumers, families and carers are actively involved in all aspects of the mental health system

The mental health system will support active participation of consumers, families and carers in all aspects of activity including policy development and implementation, service planning and delivery, and research to ensure mental health care is oriented to meeting the specific needs of individuals.

Principle 2 – Resilience and recovery

The mental health system promotes resilience and recovery

Mental health care will be provided within an operational framework that promotes resilience and recovery.

Principle 3 – Social inclusion

The mental health system is community-oriented, comprehensive, integrated and socially inclusive

Consumers, their families and carers will have access to a comprehensive community-based system of treatment, care and support that promotes recovery and works in a positive manner to address the impact of mental illness.

Principle 4 – Collaboration and partnerships

Cooperation, collaboration and partnerships are key elements of the mental health system

The mental health system will operate through inter-sectoral cooperation, collaboration and partnerships with a range of stakeholders including consumers, families and carers.

Principle 5 – Promotion, prevention and early intervention

Promotion, prevention and early intervention are integral to the mental health system

Promotion, prevention and early intervention (PPEI) will occur at the population, group and individual level, to build individual and community resilience and wellbeing, effectively target key risk and protective factors, and facilitate early intervention.

Principle 6 – Evidence-based

Mental health care is evidence-based, prioritising quality and safety

High quality services will be accessible and responsive, informed by research and evidence of best practice, provided by a suitably skilled and supported workforce, and deliver improved outcomes to people living with mental illness, their families and carers, and the wider community.

The principles that underpin the *Queensland Plan for Mental Health 2007-2017* are in addition to the principles articulated within the United Nations *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, the *National Mental Health Strategy* and the Queensland *Mental Health Act 2000*.

These frameworks encompass fundamental rights and responsibilities for all people who have a mental illness, including the following:

- People with mental illness are entitled to respect for their basic human rights, confidentiality, and must be able to participate in decisions made about them.
- The specific cultural, religious and language needs of individuals must be respected.
- Treatment should only be provided where it promotes or maintains the person's mental health, and should impose the least restriction on their rights possible with due regard for the safety of the person and others.

6. The reform agenda – improving mental health for Queenslanders

Five priorities guide the reform of the mental health system. These priorities will inform the investment over the period 2007-2017. These priorities and the associated strategies are consistent with the COAG *National Action Plan for Mental Health 2006-2011*.

The needs of consumers, families and carers drive each of the priorities. The involvement of consumers, families and carers in these areas will be instrumental in achieving change. Strengthening the mechanisms through which consumers, families and carers can influence reform of the Queensland mental health system in meaningful and effective ways must occur within each priority and all aspects of activity.

The five priorities have application across the spectrum of intervention and cover both clinical and non-clinical aspects of care. All components of the system are necessary for the system to function effectively. Development of a detailed service model that identifies target levels of resources required for each service component is a key objective of the Plan, to ensure achievement of a balanced system over the next ten years.

These targets will be based on interpretation of trends in national and international planning and reflect best available knowledge at this point in time. The targets cover all components of priority areas and will be continually tested against experience as new services are developed. Ongoing developments in mental health care at the international and national level will be taken into consideration, in association with identification and analysis of local community needs.

The Queensland Plan for Mental Health 2007–2017
Priorities for reform

Promotion, prevention and early intervention	Strengthen collaborative action to: · build individual and community resilience and wellbeing · effectively target key risk and protective factors · facilitate early intervention in known high risk groups for mental illness.
Improving and integrating the care system	Enhance and develop the continuum of clinical mental health treatment and care for consumers, families and carers. This system will promote resilience and recovery.
Participation in the community	Build capacity to assist and support people with mental illness to live full and meaningful lives in the community.
Coordinating care	Facilitate the linkage of a range of services to provide an integrated system of care to consumers, families and carers.
Workforce, information quality and safety	Enhance and strengthen the capacity of services to provide high quality, safe and evidence-based mental health care.

Mental health promotion, prevention and early intervention

Strengthen collaborative action to:
- ***build individual and community resilience and wellbeing***
- ***effectively target key risk and protective factors***
- ***facilitate early intervention in known high risk groups for mental illness.***

Key actions
- Establish statewide leadership through the Queensland Centre for Mental Health Promotion Prevention and Early Intervention (PPEI)
- Improve mental health literacy and capacity in non-clinical workers in key government and non-government services
- Strengthen responses for perinatal and infant mental health
- Reduce suicide risk and mortality within Queensland communities, within identified high risk groups such as Aboriginal and Torres Strait Islander populations, rural communities, and young people

Promotion, prevention and early intervention (PPEI) activities are vital elements in reducing the burden of disease associated with mental health problems and illness, and managing future demand for mental health services. PPEI addresses the health and wellbeing of the entire population, including all levels of mental health need within the community, and requires the contribution of a wide range of government and non-government agencies. Strengthening partnerships with these agencies and building their capacity to effectively contribute to the mental health and wellbeing of all Queenslanders is a priority.

Development of strategic partnerships across the government and non-government sectors aimed at improving mental health literacy, reducing stigma and discrimination experienced by people affected by mental illness, and targeting risk and protective factors for the prevention of high prevalence disorders is essential. Building supportive and inclusive environments, and resilient individuals and communities are also important tasks in promoting mental health into the future. Public mental health services play an important role in mental health PPEI through partnerships focused on intervening early with high risk groups and delivery of recovery-oriented services.

Actions for 2007-11

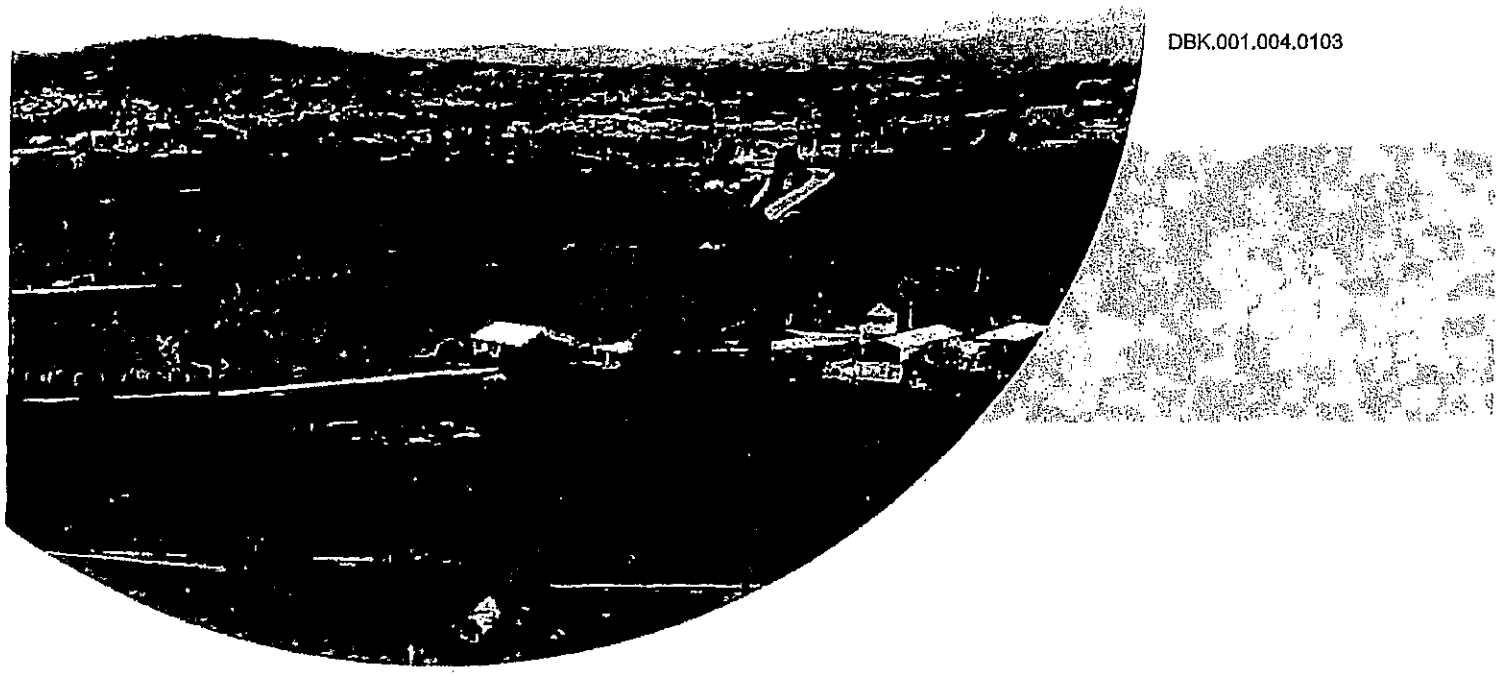
An additional $9.35 million will be provided over four years to support activities which will build mental health promotion, prevention and early intervention capacity.

The Queensland Government will implement initiatives focused on enhancing and promoting mental health and wellbeing, preventing mental illness and providing early intervention, including:

- $5.47 million to establish the Queensland Centre for Mental Health Promotion, Prevention and Early Intervention to lead the development and implementation of a statewide framework for mental health promotion, prevention and early intervention including:
  - establishing the *beyondblue* Queensland Chapter to engage with the National Depression Initiative to promote recognition and early access to treatment for depression
  - improving mental health literacy and access to mental health first aid training for non-clinical workers in key government and non-government services
  - raising community awareness about mental illness, and reducing stigma and discrimination
  - promoting the use of innovative technologies in mental health promotion activities.

- $2.91 million to support the ongoing development of cross-sectoral strategies, partnerships and agreements targeted at reducing suicide risk and associated mortality, including:
  - dedicated strategies to reduce suicide risk and mortality with a focus on specific high risk groups including Aboriginal and Torres Strait Islander populations, rural communities, and young people
  - development of a risk management framework for the detection and management of suicide risk
  - development of mechanisms to review all available information in relation to people who suicide in Queensland
  - increased capacity to follow-up people presenting to Emergency Departments with deliberate self-harm or attempted suicide.
- $0.97 million to establish a hub of expertise in perinatal and infant mental health to provide co-case management, consultation, liaison, and support to public mental health services and the broader community sector.
- Providing training to health workers in hospital, community health and primary health care settings on psychosocial risk assessment, screening and pathways into care consistent with the *National Action Plan on Perinatal Mental Health.*
- Establishing processes for the early detection and psychosocial support of children of parents with mental illness.
- Establishing collaborative processes and interdepartmental partnerships to improve mental health problems in children and young people within education, justice and child protection settings.
- Developing partnerships and increasing access to education and training initiatives to enhance the capacity of the aged care sector to prevent and intervene early in mental health problems and reduce social isolation.
- Developing and implementing early detection and intervention with children and young people including enhanced consultation liaison, improved referral pathways, and training for school support personnel and other key providers such as youth support coordinators, child safety workers, and youth justice workers.

  Establishing programs that build individual and community resilience and capacity, including those targeting Aboriginal and Torres Strait Islander populations, people from Culturally and Linguistically Diverse backgrounds, and other high risk groups.



Outcomes by 2011

These initiatives will strengthen the capacity to promote mental health and wellbeing and to prevent and minimise the risk of mental illness developing, especially in high risk populations. By 2011 the Queensland Government will have delivered the following outcomes:

- established a statewide framework for mental health promotion, prevention and early intervention
- implemented a range of targeted, evidence-based mental health promotion, prevention and early intervention programs across government, non-government and community sectors
- implemented models to ensure early detection of 'at risk' populations
- improved the capacity to build community resilience to mental illness
- improved the response to suicide risk behaviours and the management of suicide risk.

Outcomes by 2017

By 2017, the Queensland Government will have:

- delivered whole-of-population mental health PPEI initiatives across government, non-government, and community sectors
  improved community awareness, understanding and attitudes towards mental health and mental illness
- established collaborative, evidence-based, mental health and early intervention initiatives across the lifespan
- established collaborative, evidence-based mental health prevention and early intervention to targeted high risk groups
- implemented and evaluated a comprehensive approach to suicide prevention and suicide risk management
- developed collaborative initiatives to address the mental health needs of specific communities and targeted populations.

Promotion, prevention and early intervention activities are vital in reducing the burden of disease associated with mental health problems and issues.

Integrating and improving the care system

Enhance and develop the continuum of clinical mental health treatment and care for consumers, families and carers. This system promotes resilience and recovery.

Key actions

Strengthen consumer, family and carer participation in mental health services

- Establish a statewide model of service to facilitate integrated service delivery across child and youth, adult, older persons, statewide and specialised mental health services
- Increase the capacity of community and inpatient mental health services to deliver high quality, responsive, consumer-focused care
- Build collaborative links with primary health and private sector providers to ensure effective links between services and efficient use of resources

Access to the right care and support at the appropriate time is important for people living with mental illness. A range of inter-connected clinical and community service options are required. These need to be responsive to the needs of people with mental illness, promote resilience and recovery, and facilitate positive outcomes.

Primary health, private and public mental health treatment services are all engaged in the delivery of assessment and treatment. Together they contribute to a spectrum of services required to meet the needs of people with mental health problems and mental illness. Close collaboration between providers will minimise the risk of duplication, service gaps and disconnections across the continuum of care.

The Plan focuses on fostering partnerships and improving linkages between services provided within and across the primary health, public and private specialist mental health sectors. It aims to improve access, support optimal care across all service levels and ensure effective use of specialised treatment resources. Innovative approaches to achieve improved continuity of care are proposed.

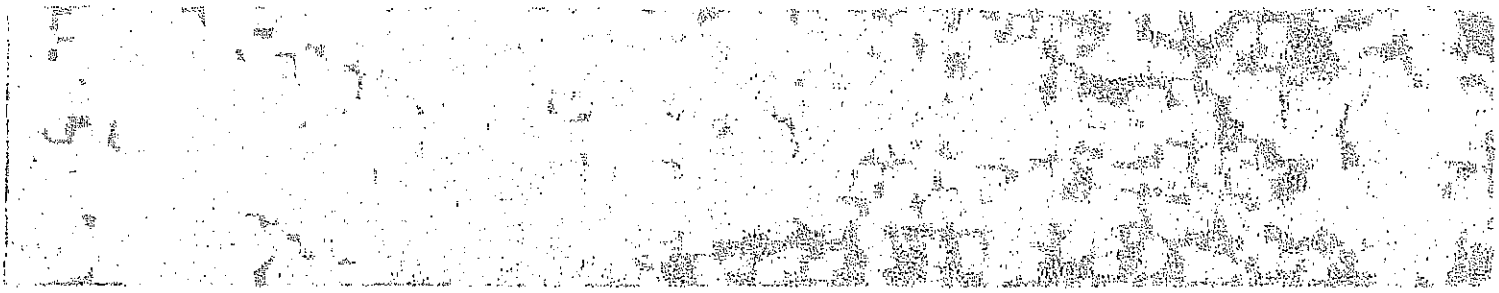
Actions for 2007-11

An additional $345.8 million will be provided over four years to further expand mental health treatment and service capacity across sectors.

Consumer and carer participation

The Queensland Government will implement initiatives focused on enhancing the capacity of consumers and carers to be actively involved in mental health service planning and delivery. This includes:

- $2.97 million to employ additional Consumer Consultants to provide support to consumers and to improve consumer engagement within mental health services
- developing a Queensland Government Consumer, Family and Carer Participation Policy
- establishing a statewide Consumer and Carer Coordinator position to coordinate consumer and carer service development initiatives and participation
- providing education and training to consumers, families and carers, mental health service providers and government and non-government staff to enable informed participation by consumers and carers in service delivery.



Primary and private sector mental health care
The Queensland Government will support the development of a coordinated framework for the delivery of primary and private mental health care. This includes:

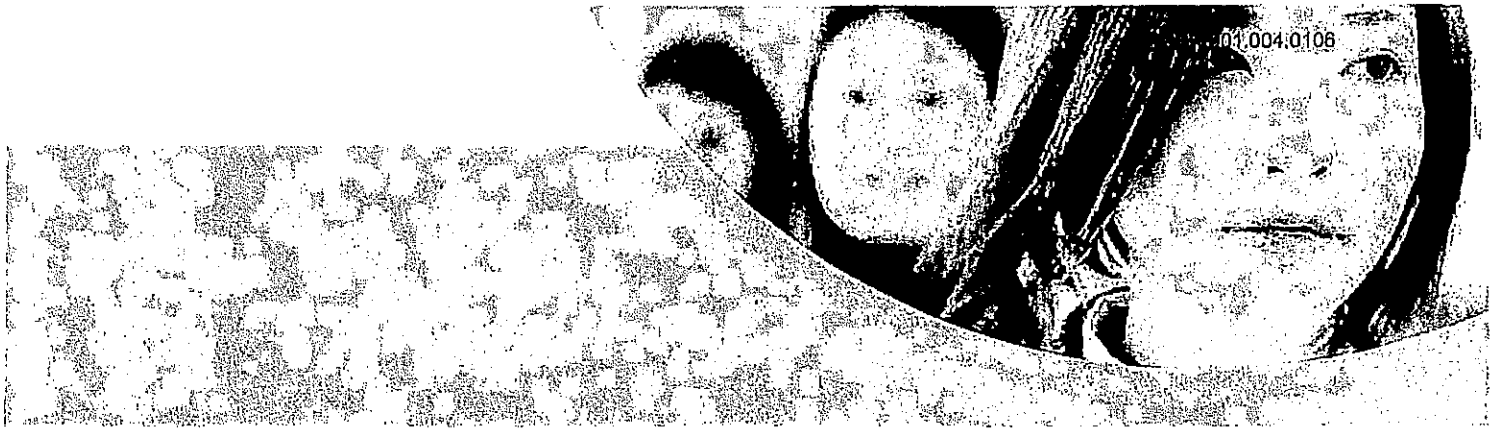
- $3.24 million to employ additional Primary Care Liaison Coordinators to improve coordination of services between primary health care and public mental health service providers.
- $1.42 million to support the implementation of the 'Partners in Mind' framework and its integration with the Queensland Primary Mental Health Care Collaborative and community health services.
- establishing a forum for the public and private mental health sectors to collaborate and implement a plan for alignment of the two sectors with the aim of achieving a continuum of care for consumers moving between them. This would include communication protocols for access and reporting.
- delivering programs of collaborative care between general practitioners, other primary care providers and mental health professionals, particularly in rural and remote areas.

Public mental health care
The Queensland Government will implement initiatives focused on expanding mental health care. This includes:

- $37.78 million for 100 additional clinicians to provide child and youth community mental health services
- $9.44 million for 22 additional clinicians to provide adult community mental health services
- $18.7 million for 46 additional clinicians to provide older persons community mental health services
- $11.55 million for 25 additional clinicians to provide mobile intensive treatment services to consumers with complex needs living in the community
- $27.47 million for 60 additional clinicians to provide extended hours community-based emergency triage and brief acute treatment
- $9.63 million for 18 additional consultation liaison clinicians to support early assessment, treatment and referral of mental health consumers
- $10.5 million to employ 27 additional clinicians to provide tertiary statewide forensic services including, child and youth community forensic outreach, prison mental health, and court liaison services
- $5.7 million to employ 26 additional administrative staff to support clinicians working in community mental health services
- $15.32 million to expand district service and development capacity by establishing additional clinical leaders, supervisors and other staff to manage legislative, quality and safety activity.

Mental health services to people receiving care in acute, extended and community mental health settings will be improved by providing:

- $121.55 million to expand the range of acute and extended treatment beds by providing 140 new beds and to upgrade existing services to meet contemporary standards. This is in addition to the services being provided as part of the development of the new Gold Coast, Sunshine Coast and the Queensland Children's Hospitals.



- standardised service models and protocols for core public mental health service functions, including entry criteria, case management and inter-sectoral collaboration.
- protocols for inter-hospital transfers and referrals to Queensland Health Service Districts providing specialist services.

Mental health services to people in **rural and remote** areas will be improved by providing:

- $2.36 million to develop a service model for rural and remote mental health services in collaboration with the Centre for Rural and Remote Mental Health Queensland, and to develop innovative mechanisms to improve recruitment, retention and development of mental health staff in rural and remote areas
- Programs developed in collaboration with the Centre for Rural and Remote Mental Health Queensland and the Queensland Centre for Mental Health Promotion Prevention and Early Intervention to promote mental health and prevent the development of mental health problems in rural and remote communities.

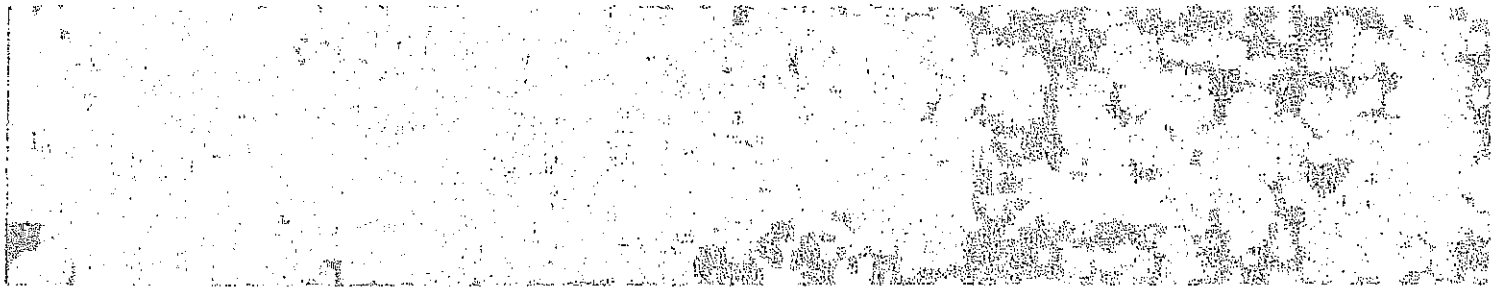
Mental health services to people from an **Aboriginal and Torres Strait Islander** background will be improved by providing:

- $5.15 million to employ additional Aboriginal and Torres Strait Islander mental health workers to provide assessment, treatment and care to people with a mental illness who are from an Aboriginal and Torres Strait Islander background
- a specialist hub of expertise to provide leadership and oversight of development of service models, workforce and partnerships in collaboration with the Centre for Rural and Remote Mental Health Queensland. The specialist hub will provide support to Aboriginal and Torres Strait Islander workers in the development and delivery of clinical services.

Mental health services to people from a **culturally and linguistically diverse** background will be improved by providing:

- $1.8 million for additional clinicians to provide transcultural mental health services. These clinicians will help to improve the capability of mental health services to respond to the needs of people with a mental illness from a culturally and linguistically diverse background.
- programs to increase mental health literacy and reduce stigma and discrimination in culturally and linguistically diverse communities.
support to the Queensland Transcultural Mental Health Centre in implementing the mental health components of the *Queensland Plan for Multicultural Health 2007-12*.

Access to the right care and support at the appropriate time is important for people living with mental illness.



Mental health care for people who have a co-existing mental illness and **drug and alcohol problem** will be improved by providing:

- $2.92 million to establish dual diagnosis coordinators to facilitate the provision of coordination between mental health and drug and alcohol services, and to provide training and skill development for mental health services
- statewide guidelines for mental health services to ensure routine screening of all consumers for drug and alcohol problems and the provision of brief therapeutic interventions.

Initiatives are being progressed by Queensland Health, the Department of Justice and Attorney-General, and the Mental Health Review Tribunal to improve management of **people with mental illness who commit serious offences** and to increase support for victims of violent offences committed by people who are found of unsound mind or unfit for trial under the *Mental Health Act 2000.*

Initiatives include:

- $0.8 million to improve community and stakeholder understanding of the forensic mental health system as part of the recommendations from the Review of the *Mental Health Act 2000* by developing mental health literacy materials, culturally targeted resources and a media professionals' package.
- $29.18 million to enhance clinical services for adult forensic mental health consumers and to improve risk management practices. Funding will:
  - establish 35 additional positions
  - improve specialist and district based forensic services and increase the number of Indigenous mental health workers
  - provide risk management training and monitor and report on compliance with forensic mental health policy and legislation.
- $10.24 million to establish a statewide Victim Support Service and a Victim Information Register.
- $13.34 million to improve the forensic legal processes related to the Mental Health Court and the Mental Health Review Tribunal.

There will be ongoing liaison with Queensland Corrective Services in relation to victims of serving sentence prisoners. The benefits of Queensland Health providing ongoing support, liaison and service provision to offenders with mental illness is acknowledged. This cross departmental relationship is essential to the continued health and wellbeing of offenders accessing health care within any Queensland Corrective Services centre.

The Queensland Government will improve the provision of mental health services to people who have **complex mental health** needs by providing:

- $0.97 million to employ additional positions to boost the capacity to coordinate services for people with complex needs related to intellectual disability and mental illness
- $2.71 million to establish positions to build capacity to provide assessment and treatment for people with eating disorders in the community
- $1.12 million to establish positions to enhance the capacity to provide assessment and treatment for people with mental illness and a visual or hearing impairment
- additional funds to Disability Services Queensland to employ clinicians to provide services for people with an intellectual disability and mental illness, as part of the response to the recommendations of the Hon. W.J. Carter's review and resulting report *Challenging Behaviour and Disability: A Targeted Response.*

Outcomes by 2011

These initiatives will enhance service delivery and expand the range of services provided to meet the needs of a growing population. By 2011, the Queensland Government will have delivered the following outcomes:

- Improved consumer and carer representation at all levels of mental health activity and decision making.
- Implemented a coordinated framework for the delivery of primary, private and public mental health services.
- Expanded community public mental health services with the employment of additional clinical staff across child and youth, adult and older person services in the community. By 2011 the number of clinical staff employed in community public mental health services is expected to increase by 21%. This increase will mean that there will be 48 full time staff per 100,000 of the total population. This represents an estimated progress of up to 68% towards achievement of a ten year target rate of 70 full time equivalent staff per 100,000 population.
- Expanded access and capacity to deliver specialist mental health care services for people within special populations or with complex needs.
- Expanded and improved the infrastructure of hospital and community based inpatient services towards a ten year target of 40 beds per 100,000 total population for acute and extended inpatient services.

Outcomes by 2017

By 2017, the Queensland Government will have:

Public mental health services

- increased effective consumer, family and carer participation in public mental health services
- provided effective consumer and carer advisory systems
- facilitated cross-sector care for consumers, families and carers
- established a consistent model of service provision for the delivery of mental health services
- expanded the capacity of community mental health services
- provided sufficient mental health inpatient beds that reflect contemporary standards and population needs
- improved access and entry to mental health care for consumers, families and carers
- improved capacity to provide comprehensive mental health care to children and young people aged 15-25
- improved capacity to respond to mental health needs of older persons
  Improved capacity to provide mental health services to people in rural and remote areas
- improved capacity to respond to the mental health needs of Aboriginal and Torres Strait Islander people
- increased capacity to deliver Forensic Mental Health Services
- provided effective models of mental health service delivery to people with a mental illness and drug and alcohol problems (dual diagnosis)
- provided culturally appropriate responsive services to people from culturally and linguistically diverse backgrounds
- strengthened delivery of consultation-liaison services across Queensland
- provided a continuum of care for people with eating disorders

- strengthened local capacity to provide specialist mental health care to people who are deaf and/or blind
- strengthened local capacity to provide specialist mental health care to people with intellectual disability
- strengthened local capacity to provide specialist mental health care to people with acquired brain injury
- strengthened local capacity to provide specialist mental health care to people with severe mood disorders
- expanded capacity to respond to people with mental illness who are homeless.

Primary Care

- developed planning and leadership for cross-sector primary mental health care
- strengthened partnership processes between primary, private, public and non-government providers of mental health care.

Private Sector Mental Health Care

- engaged private, primary and community sectors in local-level planning with public mental health services
- established greater collaboration between private psychiatrists, primary care services and public mental health services.

The Plan focuses on fostering partnerships and improving linkages between services provided within and across the primary health, public and private specialist mental health sectors.

PRIORITY 2

Participation in the community

Build capacity to assist and support people with mental illness to live full and meaningful lives in the community

Key actions

- Increase access to non-clinical recovery-focused services delivered through the non-government sector
- Expand access to supported housing and accommodation services for people with mental illness
- Increase capacity of Government agencies to support recovery of people with mental illness across a range of services

People living with mental illness require a range of services to strengthen their community engagement and improve quality of life. Stable housing, income support, education and employment are all vital for recovery, and require access to a range of government and non-government services.

The non-government and community sectors have a key role in providing non-clinical, personal care and other flexible supports to people living with mental illness, families and carers. Close partnerships will be required between Queensland Health, Disability Services Queensland and other government agencies, to ensure availability of the range of services required by people with mental illness within the community.

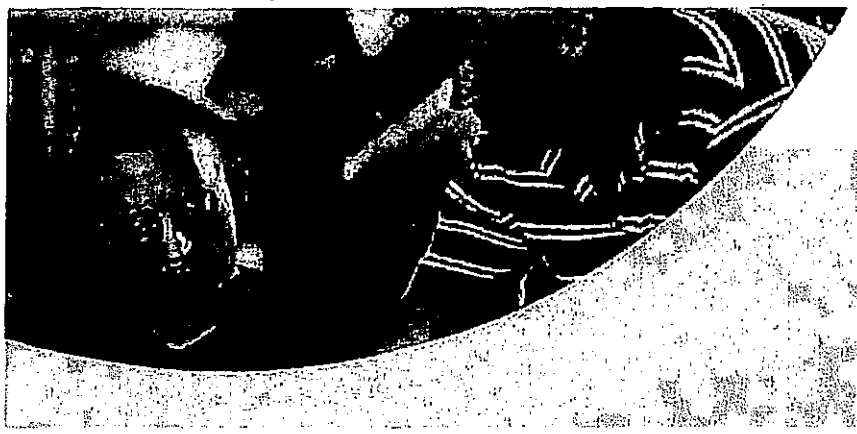
Actions for 2007-11

An additional $98.09 million will be provided over four years to develop and implement programs that will increase access to community based services. These include:

Accommodation and personal support

The Queensland Government will expand the continuum of supported housing and accommodation available to people with mental illness in the community. Disability Services Queensland will purchase non-government sector services to provide non-clinical personal support and accommodation to mental health consumers and their families. Initiatives include:

- $35.64 million to purchase a range of accommodation and personal support services, including:
  - new residential recovery places to provide ongoing assessment, treatment and rehabilitation with the goal of assisting people to live successfully in the community
  - additional personal support packages to provide non-clinical support to people with varying levels of psychiatric disability living in the community in hostels, boarding houses, or in their own homes.
  - Additional places for consumer operated crisis and respite services to provide short-term accommodation, up to a maximum of three months, for those in need of respite, or emergency and crisis support.
  - Non-clinical personal support for people with a mental illness transitioning from corrective facilities to accommodation in the community.
- The Department of Housing, Disability Services Queensland and Queensland Health will expand the Housing and Support Program:
  - $40 million to provide additional housing places for people with a severe mental illness who have moderate to high support needs. Eligibility criteria will require the person to be homeless or in acute



or extended treatment facilities, eligible for social housing and unable to maintain current housing arrangements without adequate support.

- $22.45 million to provide non-clinical personal support to people with a severe mental illness who have moderate to high support needs and are living in social housing. Personal support services may include assistance with activities of daily living and practical support to access programs and services, which help to maintain optimal mental health functioning and promote recovery.

Vocational rehabilitation

The Queensland Government will support the implementation of initiatives to improve the engagement of people with a mental illness in vocational rehabilitation and employment, including:

- developing, implementing and evaluating a model of vocational rehabilitation which collocates an employment specialist within a mental health service
- establishing initiatives to foster the increased involvement of people with a mental illness in training, educational and employment readiness opportunities
- collaborating with non-government sector organisations to develop and provide a range of consumer-run vocational rehabilitation programs.

People living with mental illness need a range of services to strengthen their community engagement and improve quality of life.

Interagency coordination

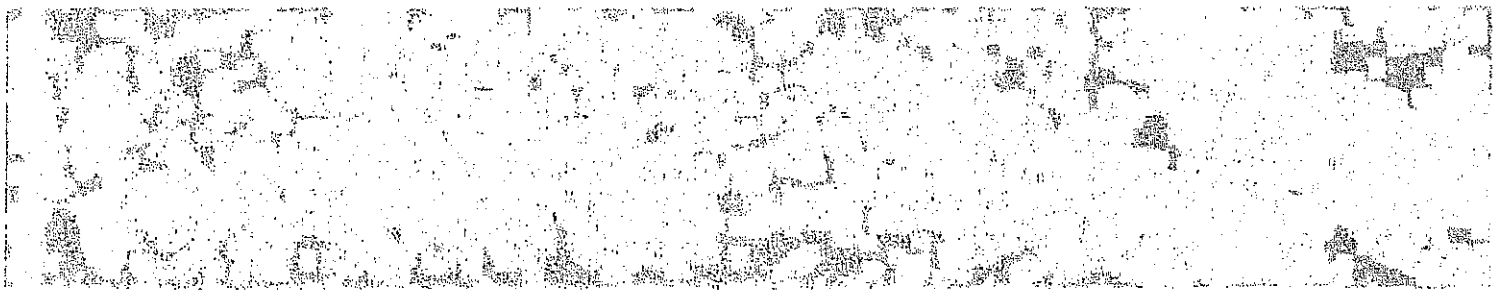
The Queensland Government will support cross-sector collaboration to:

- develop and implement a strategic plan for the mental health non-government sector in Queensland, which enhances workforce capacity and infrastructure, service quality and review, and research, evaluation and outcome reporting
- develop and implement local cross-agency operational protocols and guidelines; local partnership agreements; and cross-agency education and professional development initiatives
- continue to implement and develop the Mental Health Intervention Program to improve collaborative responses between the Queensland Police Service, Emergency Services and public mental health services.

Outcomes by 2011

Investment of funds will improve the range of care and support for consumers living in the community. By 2011, the Queensland Government will have delivered the following outcomes:

- provided and maintained an expanded range of non-clinical personal support and accommodation aimed at assisting people with a mental illness to live a meaningful life in the community
- improved inter-sectoral collaboration in the delivery of programs to assist people with a mental illness to live and participate in the community.



Outcomes by 2017

By 2017, the Queensland Government will have:

- strengthened the capacity of non-government organisations to deliver a range of quality mental health services that promote recovery
- expanded the range of community-based supported housing and accommodation options for people with mental illness
- expanded non-government sector services for consumers, carers and families
- strengthened non-government capacity and government services in the criminal justice system
- increased vocational rehabilitation for people with mental illness
- improved access to education, training and employment opportunities for people with mental illness
- increased understanding of mental illness in non-government and government employees
- expanded mental health initiatives for police, mental health and emergency services.
- expanded cross-government capacity to provide a coordinated statewide mental health and psychosocial disaster response and enhanced participation in the community recovery response.
- improved the capacity of the non-government sector to deliver a range of mental health services in the community, towards a ten year target rate of:
  - 15 places per 100,000 population for residential recovery programs
  - 35 places per 100,000 population for supported social housing
  - 35 packages per 100,000 population for support to people with a mental illness living in hostels and private homes
  - 3 places per 100,000 population for crisis and respite services.

The Queensland Government will expand the continuum of supported housing and accommodation available to people with mental illness in the community.

Coordinating care

Facilitate the linkage of a range of services to provide an integrated system of care to consumers, families and carers

Key actions

- Strengthen partnerships and collaborative initiatives between Government agencies to address mental health service priorities
- Establish Service Integration Coordinators to improve service integration across government and non-government providers
- Implement processes at the local level to support collaborative, coordinated care across government and non-government agencies and improve outcomes for people with mental illness and complex care needs

Commitment to coordinated care for people with mental illness and complex needs is a priority. The various elements of service provided to people with mental illness by organisations and services across sectors need to be integrated to ensure the best outcomes are achieved. A collaborative approach will minimise the risk of people of all ages including youth, falling through gaps in the service system and allow the various services to work together as inter-related parts of a single system of care.

Actions for 2007-11

$4.77 million in funds will be provided over four years to strengthen the capacity to coordinate care for consumers with complex needs living in the community. This funding will support the establishment of Service Integration Coordinator positions across Queensland.

Service Integration Coordinator positions will be responsible for:

- improving care planning, communication and continuity across agencies
- overseeing processes for linking core service needs
- ensuring efficient utilisation of resources.

Queensland government agencies will work in partnership to develop coordinated responses to disasters to minimise psychological impact and facilitate community recovery, including increasing the availability of training and professional staff development.

In addition an Interagency Action Plan for an integrated human services framework to better respond to the needs of people with mental illness, their families and carers will be developed. Initially this plan will focus on people who are at risk of, or are experiencing social exclusion.

Outcomes by 2011

Investment of funds to support these initiatives will improve the coordination of care and support for consumers living in the community. By 2011, the Queensland Government will have delivered the following outcomes:

- Improved capacity for people with a severe mental illness to successfully live in the community
- Improved access to a range of support services and care for people with a severe mental illness in the community
- Improved capacity for effective inter-sectoral collaboration to assist people with mental illness to access appropriate support and care in the community

- reduced the number of people with severe and persistent mental illness and psychiatric disability who currently fall through the gaps in service provision
- improved the degree to which people with a mental illness are socially included and able to participate in the community.

Outcomes by 2017

By 2017, the Queensland Government will have:

- established governance of mental health across sectors, and other levels of government
- strengthened capacity for cross-sector collaboration between providers of mental health care at the local level.

The various elements of service provided to people with mental illness by organisations and services across sectors needs to be integrated.

PRIORITY 5

Workforce, information, quality and safety

Enhance and strengthen the capacity of services to provide high quality, safe and evidence-based mental health care

Key actions

- Increase availability of a skilled mental health workforce
- Improve access to mental health service information, including information on consumer perceptions of care, to inform service evaluation and planning
- Improve delivery of safe, high quality care through effective quality improvement processes
- Increase access to evidence from research to inform mental health service delivery and development

The capacity to provide high quality services is essential to the delivery of a contemporary mental health care system, and relies on the use of evidence-based care to produce measurable improvements for consumers, carers and families. The quality agenda focuses on workforce development, information management, quality and safety initiatives, and research development. These are essential to the delivery of high quality care into the future.

Actions for 2007-11

An additional $70.82 million will be provided over four years to expand and develop the mental health workforce to ensure the provision of high quality, safe public mental health services, and to continue developing mental health research and information management capacity. This funding includes $43 million from the Queensland Government to replace Commonwealth funded projects expiring in 2007-08.

Workforce development

The Queensland Government will implement initiatives focused on developing workforce capacity to deliver mental health programs. This includes:

- $2.41 million to develop and implement a range of strategies to recruit mental health staff. These include undergraduate marketing initiatives, targeted scholarships and incentives for people to enter the mental health workforce.
- $3.06 million to provide a range of ongoing support to assist with retaining mental health staff. This includes orientation programs and supervision models for allied health and nursing.
- $0.69 million to improve workplace culture and leadership, including programs to provide support to professional supervisors and team leaders.
- $0.67 million to provide staff training and education through the Queensland Centre for Mental Health Learning including implementation of recovery training for mental health staff.
- $0.46 million to provide support to develop the non-government sector workforce.
- Additional positions in the Queensland Centre for Mental Health Learning to improve risk assessment and management skills as part of the implementation of the recommendations from the Review of the *Mental Health Act 2000.*

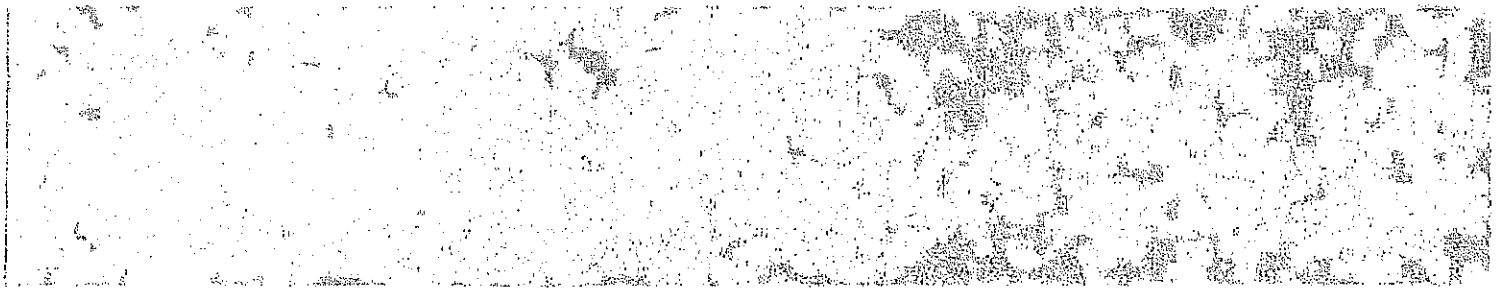
- Enhancing the statewide role of the Queensland Centre for Mental Health Learning in the provision of mental health training initiatives for staff, consumers, family, and carers across public, private and community sectors.
- Developing a Workforce Development and Innovation Plan, which is consistent with the *National Practice Standards for the Mental Health Workforce*, including:
  - development of Clinical Practice Guidelines
  - development of standardised multidisciplinary training and education curriculum and modules based on the *National Practice Standards for the Mental Health Workforce*, for delivery by specialist educational units.

Information management

The Queensland Government will support the further development of Queensland Health information management systems to support quality mental health service delivery and reform. This includes:

- $16.4 million to establish the Consumer Integrated Mental Health Application (CIMHA), which will enhance access to clinical and service information needed to support service delivery and evaluation
- $2.16 million to more effectively utilise information in clinical practice, service planning and policy development
- $1.2 million to establish and maintain a data reporting repository
- developing and implementing strategies to improve access to mental health information
- implementing routine reporting of key performance indicators to guide service improvement activities and facilitate performance monitoring
- building infrastructure to enable the linking of mental health data sets at the client and service levels to better inform planning, funding, evaluation and development of models of best practice
- developing a health planning model for mental health based on prevalence and service utilisation data.

The quality agenda focuses on workforce development, information management, quality and safety initiatives, and research development



Quality and safety

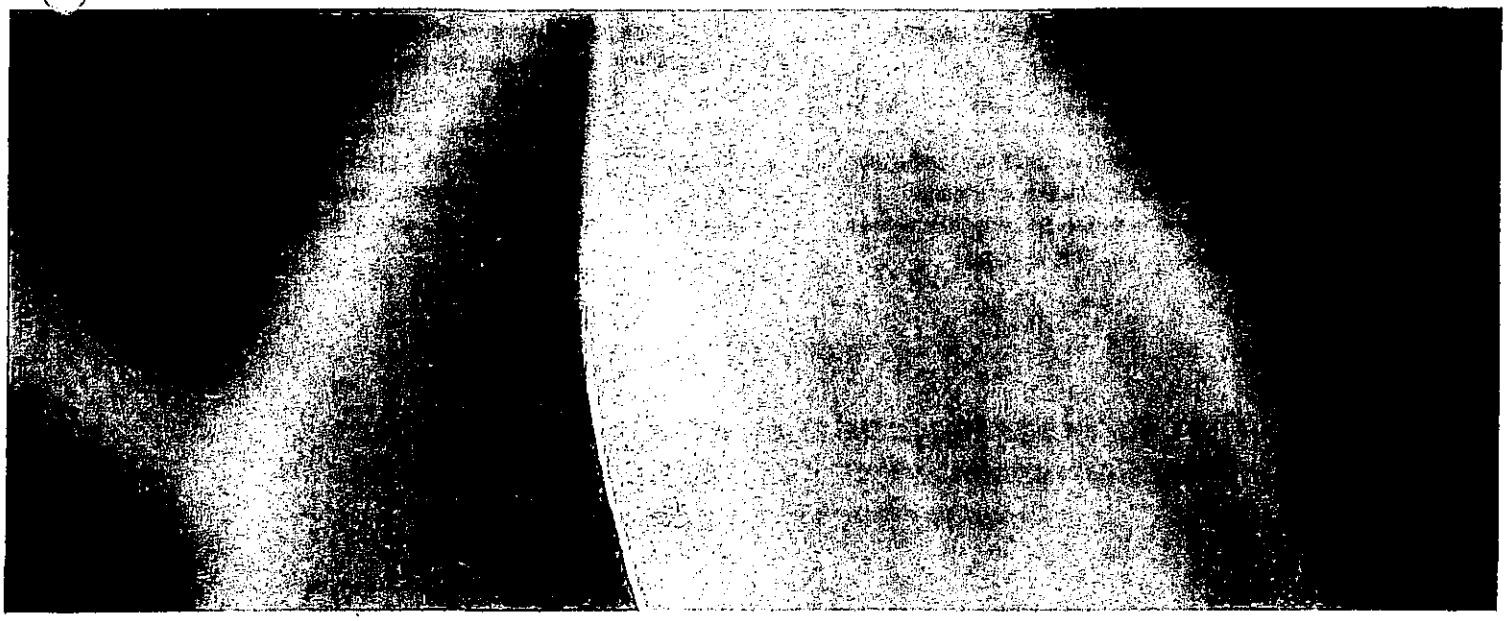
The Queensland Government will continue to develop and improve quality and safety systems in collaboration with consumers, carers and families, government and non-government service providers. This work will include:

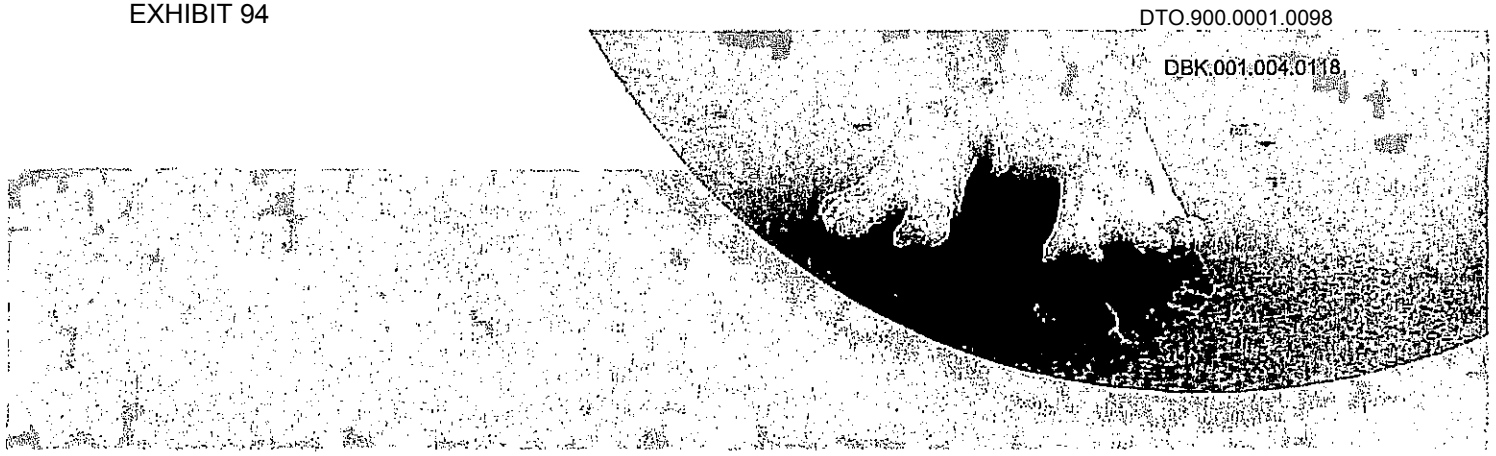
- the development and implementation of a comprehensive Quality and Safety Plan which is aligned to *National Standards for Mental Health Services* and is consistent with the *National Safety Priorities in Mental Health: the National Plan for Reducing Harm*
- establishment of a system of clinical audit that engages services in ongoing review and quality improvement
- finalisation of implementation of the key recommendations in:
  - *Achieving Balance: Report of the Queensland Review of Fatal Mental Health Sentinel Events (2005)*
  - *Promoting balance in the forensic mental health system – Final Report – Review of the Queensland Mental Health Act 2000.*

Mental health research

The Queensland Government will continue to support mental health research and particularly, the application of research to clinical practice. This includes:

- $0.77 million to develop a statewide framework for mental health research which supports the translation of evidence and innovation into improved day-to-day services for consumers, their families and carers
- collaborating with appropriate research bodies
- exploring increased funding for scholarships that promote the translation of evidence into practice.





Outcomes by 2011

Investment of funds to support workforce development and the provision of quality and safe mental health services will improve services for consumers, carers and their families. By 2011, the Queensland Government will have delivered the following outcomes:

- developed sustainable mechanisms to recruit and retain an adequate mental health workforce
- improved workforce development and support to ensure ongoing capability of mental health staff to deliver services
- developed and maintained effective leadership support for professional supervisors and operational leaders
- improved the use of information by clinicians and organisations in day-to-day clinical practice and service improvement initiatives
- developed and maintained the appropriate technology, infrastructure and resources to support mental health information management
- implemented and maintained effective quality and safety systems to ensure proactive identification of safety risks
- developed strategic links between the mental health workforce in public mental health services and the non-government sector workforce.

Outcomes by 2017

By 2017, the Queensland Government will have:

Workforce development

- developed and implemented a range of innovative recruitment and retention strategies for public mental health services
- developed and implemented new roles and new ways of using the skills and expertise of the mental health workforce
- engaged key stakeholders in mental health workforce planning and development.

Information management

- provided relevant and timely information to consumers, carers, mental health service providers and the community
- provided appropriate information and support to inform quality mental health service delivery and reform
- provided the technology, infrastructure, and resources that meet Queensland's mental health information needs
- established a quality and safety governance structure for mental health care across Queensland
- enhanced safety and minimised harm to consumers, the mental health workforce and the broader community
- engaged mental health stakeholders in quality and safety systems.

Research

- established statewide mechanisms to ensure that all key stakeholders contribute to, and benefit from mental health research.

7. Conclusion

The *Queensland Plan for Mental Health 2007-2017* sets a broad agenda to guide the reform and development of mental health services across the State, providing strategic and operational direction to mental health services. The Plan informs development, delivery and investment in mental health services.

It outlines a staged approach to reform and looks to the future as Queensland progresses towards a genuinely collaborative and supportive mental health system. Progressive implementation of the Plan will see Queensland establish a broader base for mental health intervention, while simultaneously moving towards a stronger focus on promotion and prevention, as well as establishing a consumer-driven, recovery-focused service delivery system.

Implementation of the *Queensland Plan for Mental Health 2007-2017* will be overseen by the Mental Health Interdepartmental Committee. The Director of Mental Health will be responsible for coordinating regular reporting that will be detailed in Queensland Health's Agency Service Delivery Statement, the annual Queensland Health Performance Report and a report to Cabinet.

An evaluation framework is being developed that considers progress towards identified goals and objectives at multiple levels:

- at the individual level in regard to the outcomes for consumers and carers, and the delivery and achievements of specific programs
- at the organisational and resource management level
- at the state level in regard to systems development, coordination and collaborative achievements
- within the National COAG evaluation framework.

This Plan will remain current for ten years. It will be reviewed and updated every two years. The benefits and outcomes of initial reforms will assist in shaping further mental health improvements in Queensland throughout this period.

The Queensland Plan for Mental Health 2007-2017 sets a broad agenda to guide the reform and development of mental health services across the State.

Feedback and contact details

We welcome your feedback on the *Queensland Plan for Mental Health 2007–2017.*

Please send feedback to mhb@health.qld.gov.au

or you can contact:

The Director
Mental Health Branch
Queensland Health
GPO Box 48
Brisbane Q 4001

Further copies of the *Queensland Plan for Mental Health 2007–2017* are available:

- electronically, on the Queensland Health Internet site at www.health.qld.gov.au/mentalhealth
- printed copies available by telephoning 1800 989 451.


Queensland Government

QUEENSLAND MENTAL HEALTH CAPITAL PROGRAM
29 JUNE 2011

Project Funding Explaination	BP3 2010/11	Additional $27.142 million budget endorsed since BP3.	Funding Shortfall	Current Total Estimated Cost
Bayside Community Care Unit (39)	$ 9,550,312	$ 706,676	$ -	$ 10,256,988
Logan Acute Mental Health Unit (36)	$ 15,447,817	$ -	$ -	$ 15,447,817
Logan Community Care Unit (37)	$ 9,025,000	$ -	$ -	$ 9,025,000
Mackay Acute Care Unit Now being delivered under Mackay Redevelopment	$ 2,550,000	$ -	$ -	$ 2,550,000
Princess Alexandra Hospital Community Care Unit (32) DP approval 13/1/10 BR043359	$ 10,460,000	$ 86,533	$ -	$ 10,546,533
dcliffe/Caboolture Acute Mental Health (29)	$ 22,431,356	$ -	$ -	$ 10,647,727
Redcliffe/Caboolture Medium Secure Mental Health (28) As at July 2010 incorporated into report 29		$ -	$ -	$ 11,783,629
Rockhampton 4 Psycho-geriatric Beds Being delivered under Rockhampton Redevelopment	$ 562,000	$ -	$ -	$ 562,000
Nambour Psycho-geriatric Extended Treatment Beds Completed	$ -	$ -	$ -	$ -
Toowoomba Child & Youth Mental Health Unit (18)	$ 10,621,902	$ -	$ -	$ 10,621,902
Townsville Extended Treatment Beds Completed	$ 571,454	$ -	$ -	$ 571,454
Townsville Hospital Medium Secure Unit (66)	$ 3,000,000	$ 13,653,236	$ -	$ 16,653,236
Townsville Child & Youth Unit (67)	$ 6,870,496	$ 5,932,404	$ -	$ 12,802,900
est Moreton Community Care Unit (16) (includes Goodna site costs of $862,887)	$ 9,213,000	$ 665,421	$ -	$ 9,878,421
The Park High Secure Unit (14) DP approval 13/1/10 BR043396	$ 7,982,838	$ 121,159	$ -	$ 8,103,997
The Park Forensic Extended Treatment Unit (13)	$ 2,600,000	$ -	$ -	$ 2,600,000
Barrett Centre Adolescent Extended Treatment Unit (15)	$ 10,291,637	$ 5,836,795	$ 2,763,011	$ 18,891,443
QMHP Master Programming/Planning/Reserve	$ 31,188	$ 139,776	$ -	$ 170,964
Total Capital QMHP	**$ 121,209,000**	**$ 27,142,000**	**$ 2,763,011**	**$ 151,114,011**

Minister's Office RecFind No:	
Department RecFind No:	**BR047561**
Division/District:	**HPID**

Briefing Note

The Honourable Geoff Wilson MP
Minister for Health

Requested by: PI001791
Office of the Minister for Health

Date requested: 22 October 2010

Action required by: 11 September 2011

Action required
For approval
For meeting
With correspondence
For information

Other attachments for Ministerial consideration
Speaking points
Draft media release
Ministerial Statement
Question on Notice
Cabinet related document

SUBJECT: 23-31 Weippin Street, Cleveland Land Use

Proposal

That the Minister:

Note the site 23-31 Weippin Street, Cleveland shown as Lot 30 in (Attachment 1) has been partially assigned to the relocation of the 15 Bed Adolescent Extended Treatment Unit (ETU) and School project with the remainder of the land proposed for future Redland Hospital expansion. this may include a multi-storey car park

Note the key findings of the Redland Hospital Parking Study dated 25 October 2010 identified that current demand exceeds supply by 222 parking spaces and that by 2025 an additional 1,495 parking spaces may be required.

Note Planning Branch, Health Planning and Infrastructure Division in partnership with Metro South Health Service District have commenced a Preliminary Infrastructure Plan (PIP) for the Redland Hospital site. The PIP is scheduled to be completed at the end of October 2011 and will inform future requirements for use by Queensland Health of the new Weippin Street site.

Note the Community Infrastructure Designation (CID) process for Redland Hospital has been commenced with an Initial Assessment Report for stakeholder (State and Local Government) consultation having been completed. This process will require recommencement as a consequence of any additional health facilities intended for the site as an outcome of the PIP.

Urgency

1. Routine noting of this brief is required to inform the Minister that the Department seeks to delay seeking a Community Infrastructure Designation (CID) of Redland Hospital including Lot 30 Weippin Street, Cleveland until the PIP has been completed for Redland Hospital.

Background

Redland Hospital Car Parking

2. The shortage of car parking is the single biggest source of staff and patient complaints at the Redland Hospital. Car parking within the Redland Hospital grounds and on street car parking in the local environs is currently free of charge.

3. In May 2009, the Corporation of the Trustees of the Order of the Sisters of Mercy in Queensland (Mater) indicated to Redland Hospital a willingness to enter into discussions for the provision of additional car parking.

Minister's Office RecFind No:	
Department RecFind No:	**BR047561**
Division/District:	**HPID**

4. In July 2009, approval was sought from the former Deputy Director-General, Health Planning and Infrastructure Division (HPID), to enter into exclusive dealing with Mater to negotiate an agreement for the construction and operation of a multi-storey car park on the Redland Hospital campus.

5. A build, own, operate and transfer (BOOT) type arrangement was proposed, where Queensland Health would provide the land, Mater would build the infrastructure and operate the car park for an agreed period, and ownership of the asset would transfer to Queensland Health at the end of the agreement period.

6. Approval was not given to enter into exclusive dealings with Mater as it was deemed inappropriate to negotiate directly with Mater until an analysis of the car parking needs and commercial viability had been undertaken.

7. In January 2010, Arup Pty Ltd was appointed to complete a parking study (refer to Attachment 2). The key findings of the Redland Hospital Parking Study dated 25 October 2010 are:

   - current demand exceeds supply by 222 parking spaces, that there will be a shortfall of 333 car spaces on the Redland Campus by 2012, and an additional 1,495 parking spaces will be required by 2025 (based on growth forecasts of 5 per cent per annum) dependent on the future growth of services at the campus;
   - a multi-level car park is expected to be required before 2025, however, may be required as early as 2012 depending on availability of land for at-grade parking and requirements to meet the Koala Conservation State Planning Regulatory Provisions;
   - remedial works are needed to improve site access and address safety issues such as sight distances for drivers;
   - the external road network, including the intersection of Wellington Road and Weippin Street will require upgrade in the long term to cater for the expected increase in traffic volume; and
   - strategies to encourage increased use of public and active (walking/cycling) transport modes, such as provision of end of trip facilities, should be considered in future planning.

8. [redacted]

9. [redacted]

Redland Hospital Preliminary Infrastructure Plan (PIP)

10. A Health Service Plan for Redland and Wynnum Hospitals was endorsed by the Integrated, Planning and Policy Executive Committee (IPPEC) on 21 February 2011.

11. Development of a PIP for the Redland Hospital site is due for completion in October 2011. The PIP will be informed by the Health Service Plan which will enable planning for future health infrastructure on the site.

12. [redacted]

a. [redacted]

Minister's Office RecFind No:	
Department RecFind No:	BR047561
Division/District:	HPID

b. What other future health infrastructure should be placed on the lot 30 Weippin Street along with the ETU, and consequently included in the Community Infrastructure Designation (CID) application to the site.

c. The proposed multi-storey car park

Adolescent Extended Treatment Unit (ETU)

13. The existing Adolescent ETU and School currently located at The Park – Centre for Mental Health has been identified as being inadequate and unsafe. A review by an Australian Council on Health Care Standards recommended an urgent replacement of this facility.

14. In October 2008, a site options assessment was undertaken of five potential suitable sites for the replacement of the Barrett Adolescent Centre currently located at The Park – Centre for Mental Health at Wacol. The site option paper identified the Redland site as the preferred option for the redevelopment of the 15 Bed Adolescent Extended Treatment Unit and School.

15. On 15 January 2009, BR040033 (Attachment 3) the Deputy Premier, former Minister for Health, approved the purchase of the property adjoining the Redland Hospital, described as Lot 30 on SP106226, 23-31 Weippin Street, Cleveland.

16. Queensland Health acquired Lot 30 on 11 March 2009. The site has been partially assigned to the relocation of the 15 Bed Adolescent ETU and School with the remainder of the land proposed for future Redland Hospital expansion.

17. It would be highly unlikely that any other appropriate sites would be identified now for the Adolescent ETU, which were not already identified and considered previously. Changing the location for the Adolescent ETU at this stage of the project would incur further extensive delays to the project and incur substantial abortive costs for site acquisition, consultation and design fees expended to date.

18. In March 2009, a site designation fee proposal for the new Redland site was received by Queensland Health. However, the designation process was deferred awaiting the outcomes of a review on child and youth mental health model of service delivery for the adolescent service. The model of service delivery was finalised on 22 July 2010 with site planning re-commencing and user group meetings progressing.

19. The Redland 15 Bed Adolescent ETU and School project is currently in the Project Definition and Schematic Design phase. Within the Schematic Design report submitted by Project Services on 17 May 2011 the project cost estimate (Attachment 4) is $18,891,443 (GST exclusive) which is $2,763,011 (GST exclusive) over the $16,128,432 (GST exclusive) budget allocated under the *Queensland Mental Health Capital Works Program*. As the cost estimate is over budget the Schematic Design scope is being reviewed and amended to reduce costs to within the allocated budget.

20. Construction of the Adolescent ETU is expected to commence in October 2012 and reach practical completion by October 2013 as shown in the project master program (Attachment 5). This program allows for Schematic Design review, completion of the Preliminary Infrastructure Plan and Community Infrastructure Designation processes.

Key issues

Minister's Office RecFind No:	
Department RecFind No:	**BR047561**
Division/District:	**HPID**

21. Given a substantial financial outlay of approximately $10.2 million in acquiring the site Queensland Health is seeking to maximise use of the site to attain best value for money and meet the future needs in the delivery of health services to the community.

22. The *Sustainable Planning Act 2009* Community Infrastructure Designation (CID) process requires Queensland Health to meet the Koala Conservation State Planning Regulatory Provisions (KC-SPRP). The final Flora and Fauna Report was provided to Queensland Health on 18 November 2010 and has been used to inform the architect on Schematic Design for the Adolescent ETU (Attachment 6) to minimise koala habitation impacts while maintaining service functionality.

23. The first stage of the CID process for hospital services required preparation of an Initial Assessment Report. This includes a plan of the 15 Bed Adolescent ETU proposed for the site and the responses of stakeholder consultation with local and state government agencies. The responses by Department of Environment and Resource Management indicated concerns about the location of the Adolescent ETU at the back of the site in a denser koala habitat area. The design of the ETU was minimised to reduce impact on koala habitat, plus the rear location allowed for further development on the site.

24. This has identified the need to delay the CID until the outcomes of the PIP are known in October 2011 for the future use of this site for health infrastructure.

25. The CID will be recommenced in November 2011 with completion in mid 2012. As required by legislation a further briefing note will be provided seeking Ministerial approval of the CID of Redland Hospital including Lot 30 Weippin Street, Cleveland.

26. Development of the PIP due for completion in October 2011, will enable planning for car parking, taking into consideration the impact on future health service delivery.

27. Options for addressing the parking shortage include construction of:
    - at-grade car parking on:
        i. 2 Weippin Street (old Fisher Paykel site opposite Hospital);
        ii. Business Park (opposite hospital site);
        iii. 23-31 Weippin Street; and
        iv. current Hospital site;
    - Multi-storey car park on:
        i. current Hospital site; and
        ii. 23-31 Weippin Street.

28. In relation to the options for at-grade car parking:
    - a footprint of approximately one hectare of land would be required for 333 car parking spaces with an estimated cost of $3,265 per space;
    - 2 Weippin Street is privately owned land and is not available to purchase, however, the current owners have indicated a willingness to consider a commercial lease over a one hectare area of land for a two to three year period for at-grade car parking at a cost of approximately $2.5 million for lease of land and development of car park;
    - the Business Park which is opposite the Hospital site is available for two years and could provide 150 car spaces at an approximate cost of $300,000 per annum, which does not include any costs associated that may be associated with any potential Council requirements for pedestrian crossings to the Hospital;

Minister's Office RecFind No:	
Department RecFind No:	BR047561
Division/District:	HPID

- 23-31 Weippin Street a Preliminary Feasibility Study for an at-grade car park at was completed in December 2010 by Project Services to investigate a short term strategy to provide up to 220 on-grade car parks. This study concluded that the site is not suitable for a short term on-grade car park due to significant site constraints with the land, including land fall, easement and a creek; and
- current Hospital site the most cost effective short term option endorsed by the District Chief Executive Officer and supported by Policy Planning and Asset Services is to redesign the existing at grade car parking at the Redland Hospital which would provide an additional 165 car parks as a short term solution. A Deputy Director-General brief has been submitted seeking approval for Emergent Works funds of $436,000 to provide an additional 165 parking spaces as a short term solution.

29. In relation to the options for the multi-storey car parking:
    - a multi-storey car park would require a one hectare footprint and would need to be two to five levels at an estimated cost of $14,200 per space;
    - current Hospital site has not been master planned, has limited space available and construction on site would mean the loss of existing car spaces whilst building takes place;
    - 23-31 Weippin Street whilst this is the preferred option a master plan and land designation are required;
    - following determination of a location for a multi-level car park, a detailed analysis of procurement options will be required to determine the optimum model for procurement, including procurement of the car park through a BOOT or similar arrangement.

Consultation

30. Ongoing consultation has occurred with the Redland Hospital executive team, Metro South Health Service District.

31. The Adolescent Extended Treatment Unit and School Facilities Project Team Meetings have representation from Metro South Health Service District (including Redland Hospital staff), Education Queensland, the Barrett Centre at The Park and Mental Health Alcohol and Other Drugs Directorate.

32. The development of the service model and the planning and design phases for the 15 Bed Adolescent Extended Treatment Unit and School has included consumers and mental health staff.

33. Throughout the completion of the Redland Hospital Parking Study, consultation occurred with key stakeholders from Redland Hospital, Metro South Health Service District, Mater Private Hospital Redland and Health Planning and Infrastructure Division.

34. In relation to car parking, Metro South Health Service District has consulted with Councillor Melva Hobson, Mayor, Redland City Council, and senior Redland City Council planning officers.

Media Implications

35. Issues regarding insufficient parking at the Redland Hospital have the potential to draw negative media.

Financial implications

Minister's Office RecFind No:	
Department RecFind No:	**BR047561**
Division/District:	**HPID**

36. The 15 bed Adolescent ETU and School is funded from the $148.351 million (GST exclusive) Queensland Mental Health Capital Works Program.

37. Funding is not identified in existing funded capital projects to further plan or deliver additional car parking to address the shortfall on campus.

38. A cost estimate for remedial works to improve site access and address safety issues will need to be developed. A source of funding will need to be identified for these works.

39. The Redland Hospital Parking Study provides the following indicative cost estimates for construction of car parking:
    - for at-grade parking, an estimated construction cost of $3,265 per space, which equates to a cost of approximately $1.09 million for a 333 space car park; and
    - for a multi-level car park, an estimated construction cost of $14,200 per space, which equates to a cost of approximately $21.17 million for a 1,491 space car park.

40. Redesigning the existing on-grade car parking has been assessed as being able to provide an additional 165 car parking spaces at an estimated cost of $436,000.

41. In relation to use of 23-31 Weippin Street for car parking, the costs associated with meeting the requirements of the KC–SPRP have not yet been determined.

42. Preliminary Master planning will be funded from the 2011/2012 Master Planning funds in the Capital Acquisition Program.

43. Funding for short term car parking solutions will be requested through Departmental processes.

44. No funding source has been identified for the provision of a long term car parking solution.

Legal implications

45. There are no legal implications.

Elected representative

46. State Government - Mr Peter Dowling MP, Member for Redlands

47. Federal Government - Mr Andrew Laming MP, Member for Bowman

Remedial action

48. Funding will be sought through Departmental processes to address short term car parking.

Attachments

49. Attachment 1: Google site plan.

    Attachment 2: Redland Hospital Parking Study.

    Attachment 3: Copy of BR040033.

    Attachment 4: Adolescent ETU Cost Estimate.

    Attachment 5: Adolescent ETU Master Program.

    Attachment 6: Adolescent ETU Schematic Design.

Minister's Office RecFind No:	
Department RecFind No:	**BR047561**
Division/District:	**HPID**

Recommendation
That the Minister:

Note the site 23-31 Weippin Street, Cleveland shown as Lot 30 in (Attachment 1) has been partially assigned to the relocation of the 15 Bed Adolescent Extended Treatment Unit (ETU) and School project with the remainder of the land proposed for future Redland Hospital expansion.

Note the key findings of the Redland Hospital Parking Study dated 25 October 2010 identified that current demand exceeds supply by 222 parking spaces and that by 2025 an additional 1,495 parking spaces may be required.

Note Planning Branch, Health Planning and Infrastructure Division in partnership with Metro South Health Service District have commenced a Preliminary Infrastructure Plan (PIP) for the Redland Hospital site. The PIP is scheduled to be completed at the end of October 2011 will inform future requirements for use by Queensland Health of the Weippin Street site.

Note the Community Infrastructure Designation (CID) process for Redland Hospital has been commenced with an Initial Assessment Report for stakeholder (State and Local Government) consultation having been completed. This process will require recommencement as a consequence of any additional health facilities intended for the site as an outcome of the PIP.

APPROVED/NOT APPROVED **NOTED** **NOTED**

GEOFF WILSON
Minister for Health

Principal Advisor

Senior Policy Advisor/
Policy Advisor

/ / / / / /

Minister's comments

Author:	**Cleared by:**	**Cleared by:**	**Content verified by:**	**Endorsed by:**
Michelle Walter	Jason Flenley	Glenn Rashleigh	John Glaister	Tony O'Connell
A/Director Statewide Projects	Program Director Capital Delivery Program South	Executive Director	Deputy Director-General	Director-General
Capital Delivery Program South	Health Planning and Infrastructure Division	Capital Delivery Program	Health Planning and Infrastructure Division	
11 August 2011	12 August 2011	16 August 2011		

Minister's Office RecFind No:	
Department RecFind No:	Progressed by PMSU
Division/District:	DCHO
File Ref No:	

Briefing Note for Approval

Director-General

Requested by: Chief Health Officer **Date requested: 3 May 2012** **Action required by:**

SUBJECT: Cessation of the Redlands Adolescent Extended Treatment Unit Capital Program

Proposal

That the Director-General:

Approve the cessation of the Redlands Adolescent Extended Treatment Unit (RAETU) capital program.

Provide this brief to the Minister for noting.

Urgency

1. Critical. A Cabinet Budget Review Committee (CBRC) Submission has been prepared on the *Project Agreements for capital projects approved for Queensland health under the Health and Hospitals Fund 2010 Regional Priority Round* (HHF), and is potentially to be submitted in the week beginning 14 May 2012 – the strength of this CBRC Submission is reliant on the information in this Brief being approved and noted.

Headline Issues

2. The top three issues are:

   - The RAETU capital program has encountered multiple delays to date and has an estimated budget over run of $1,461,224. Additionally, recent sector advice proposes a re-scoping of the clinical service model and governance structure for the Unit.
   - There is an anticipated capital funding shortfall of $3.1 million for the regional mental health HHF projects, relating to Information Communications Technology (ICT), escalation and land acquisition. It is proposed to fund this shortfall through cost savings resulting from the cessation of the 15-bed RAETU which has been funded under Stage 1 of the *Queensland Plan for Mental Health 2007-17* (QPMH).
   - The HHF projects are critical in the reform of Queensland mental health services. The HHF projects focus on building community mental health service infrastructure in regional areas to facilitate a more integrated approach to service delivery in these areas – a key priority in the government's health reform agenda. This investment will address some of the inequities that exist for remote and rural consumers including lack of coordinated, integrated services that are close to their home.

Key Values

3. The key values that apply are the following:

☒ Better service for patients
☒ Improved community health
☒ Valuing Queensland Health employees and empowering its frontline staff
☐ Empowering local communities with a greater say over their hospital and local health services
☒ Value for money for taxpayers
☐ Openness

Minister's Office RecFind No:	
Department RecFind No:	Progressed by PMSU
Division/District:	DCHO
File Ref No:	

Key issues

4. In 2011, $73.5 million in Commonwealth infrastructure funding was announced for eight mental health projects for 134 new mental health beds in regional areas of Queensland, under the HHF including:

    1. **$40.4 million for 69 regional mental health CCU beds** including: 20 bed CCU at Bundaberg; 20 bed CCU at Rockhampton; 24 bed CCU at Toowoomba; and 15 bed CCU at the Sunshine Coast; and

    2. **$33.1 million for 46 beds in regional acute/sub-acute/extended inpatient mental health services** including: 16 older persons extended treatment beds at Toowoomba; eight older persons subacute beds at Maryborough (as part of a 17 bed unit which includes nine acute beds); four bed adult acute unit at Bundaberg; and an 18 bed adult acute unit at Hervey Bay.

5. The HHF projects are complimentary to, but also essential components of, the continuum of care required in a balanced integrated care system. These will expand on the investment in Stage 1 of the QPMH and increase the capacity of the relevant Local Health and Hospital Networks to provide appropriate mental health services, including rehabilitation services, to consumers in regional and remote Queensland.

4. Information and Communication Technology (ICT) costs estimated at $2.5 million were not included in the HHF funding, and the indicative costing for the Bundaberg project included in the HHF applications for land purchase was underestimated by approximately $0.6 million.

5. It is proposed to fund the shortfall (estimated at $3.1 million) of the high priority HHF projects through cost savings resulting from the cessation of the 15-bed RAETU (funded under Stage 1 of the QPMH).

Background

6. The RAETU is one of the 17 projects funded under Stage 1 of the Queensland Mental Health Capital Works Program, and is intended to replace the Barrett Adolescent Centre, which is currently located at The Park Centre for Mental health (The Park).

7. Ceasing the 15-bed RAETU capital program will necessitate a review of the existing adolescent centre at The Park, and should give consideration to the benefits and disadvantages of this model of care. Limited sector consultation supports this review.

Consultation

8. Consultation regarding this Brief has included Health Planning and Infrastructure Division, Queensland Health (QH); limited consultation within the mental health sector; and the Intergovernmental Funding and Policy Coordination Unit, Strategic Policy, Funding and Intergovernmental Relations Branch, QH.

9. Further consultation will be conducted upon approval to proceed.

Minister's Office RecFind No:	
Department RecFind No:	Progressed by PMSU
Division/District:	DCHO
File Ref No:	

Financial Implications

10. The potential cost saving of not proceeding with the RAETU project is $15,150,524 in capital, and $1,824,979 in recurrent operating costs (from 2014-15). These savings can be re-allocated to fund the shortfall associated with the HHF projects.

Legal Implications

11. There are no legal implications.

Attachments

12. Nil.

Minister's Office RecFind No:	
Department RecFind No:	Progressed by PMSU
Division/District:	DCHO
File Ref No:	

Recommendation
That the Director-General:

Approve the cessation of the Redlands Adolescent Extended Treatment Unit (RAETU) capital program.

Provide this brief to the Minister for noting.

APPROVED/NOT APPROVED NOTED

[redacted]

DR TONY O'CONNELL
Director-General

16 / 5 / 12

To Minister's Office for Approval ☑

Director-General's comments

Author:	Cleared by:	Content verified by:
Dr Leanne Geppert	Dr William Kingswell	Dr Jeanette Young
A/Director	Executive Director	Chief Health Officer
MHPIU, MHAODD	MHAODD	Division of the Chief Health Officer
[redacted]		
4 May 2012	4 May 2012	12 May 2012

Minister's Office RecFind No:	
Department RecFind No:	BR054989
Division/District:	HPID/SSS
File Ref No:	HPID02710

BR054989

Briefing Note for Approval

The Honourable Lawrence Springborg MP
Minister for Health

RECEIVED
17 AUG 2012

Requested by: Vajin Peate, Office of the Minister for Health / SDLO | Date requested: 10 August 2012 | Action required by: 17 August 2012

SUBJECT: 12 Rural Infrastructure Projects

Recommendation
That the Minister:

Approve the planned strategy for the targeted rectification of the prioritised infrastructure issues and subsequent planning for 12 rural hospitals.

Note the recommended $41 million funding strategy for 2012-2013 for the rural infrastructure rectifications from the Capital Program, of:

- Cessation of the Sunshine Coast Health Precinct and Caboolture Health Precinct projects;
- Cessation of the Replacement Adolescent Extended Treatment Unit, Redlands project;
- Deferral of the Townsville Medium Secure Rehabilitation Unit refurbishment project until 2013-2014.

Note that a further $10.58 million is being allocated from "Closing the Gap" funding.

Note consultation will occur following approval of the recommended funding strategy.

Note that the 2010 planning at 12 rural hospitals identified infrastructure issues.

Note that the funding strategy identified within existing capital program with minimum expenditure for targeted prioritised infrastructure rectification to improve safety and functionality in the short term.

Note that detailed planning will follow for medium and longer term solutions.

Note that the funding strategy relates to cessation and/or deferral of projects for replacement/collocation of existing services and not service expansion.

APPROVED/NOT APPROVED

[redacted]

LAWRENCE SPRINGBORG
Minister for Health

28 / 8 / 12

NOTED

[redacted]

Chief of Staff

27 / 08 / 12

NOTED

Minister's comments

16 AUG 2012

Minister's Office RecFind No:	
Department RecFind No:	BR054989
Division/District:	HPID/SSS
File Ref No:	HPID02710

URGENT

Briefing Note for Approval

Director-General

Requested by: Vaun Poate, Office of the Minister for Health / SDLO | Date requested: 10 August 2012 | Action required by: 17 August 2012

SUBJECT: 12 Rural Infrastructure Projects

Proposal

That the Director-General:

Note the planned strategy for the targeted rectification of the prioritised infrastructure issues and subsequent planning for 12 rural hospitals.

Note the recommended $41 million funding strategy for 2012-2013 for the rural infrastructure rectifications from the Capital Program, of:

- Cessation of the Sunshine Coast Health Precinct and Caboolture Health Precinct projects;
- Cessation of the Replacement Adolescent Extended Treatment Unit, Redlands project;
- Deferral of the Townsville Medium Secure Rehabilitation Unit refurbishment project until 2013-2014.

Note that a further $10.58 million is being allocated from "Closing the Gap" funding.

Note consultation will occur following approval of the recommended funding strategy.

Provide this brief to the Minister for approval.

Urgency

1. Urgent - as proposed announcement by the Minister on 19 August 2012.

Headline Issues

2. The top issues are:
   - 2010 planning at 12 rural hospitals identified infrastructure issues.
   - Funding strategy identified within existing capital program with minimum expenditure for targeted prioritised infrastructure rectification to improve safety and functionality in the short term.
   - Detailed planning will follow for medium and longer term solutions.
   - Funding strategy relates to cessation and/or deferral of projects for replacement/collocation of existing services and not service expansion.

Key Values

3. The key values that apply are the following:

☒ Better service for patients
☐ Better healthcare in the community
☐ Valuing our employees and empowering its frontline staff
☒ Empowering local communities with a greater say over their hospital and local health services
☒ Value for money for taxpayers
☐ Openness

Minister's Office RecFind No:	
Department RecFind No:	BR054989
Division/District:	HPID/SSS
File Ref No:	HPID02710

Key issues

4. As part of the Preliminary Evaluation for the 12 rural hospitals, an options analysis was undertaken with a focus on meeting their identified service profiles. Using the endorsed service profiles, the following three infrastructure options with associated costs for 2010 (Attachment 1) were developed for each hospital:
   - option 1 – status quo, current health service arrangements and minimal construction work for identified infrastructure risks for continuity of existing services;
   - option 2 – refurbishment or expansion at the existing site; or
   - option 3 – significant redevelopment.

5. An analysis of these options was then undertaken against pre-determined criteria with focus on the service profile. The preferred option for all sites in the medium to long term is Option 2 or Option 3 (Attachment 1).

6. Due to the required time for detailed planning and further consultation including with the Hospital and Health Services (HHS), plus ensuring value for money for any initial funds spent on identified infrastructure issues, planning has progressed around the prioritised requirements based from Option 1. This includes:
   - identification of work completed as identified in Option 1 (Attachment 2)
   - identification of other recently identified infrastructure issues (Attachment 2)
   - development of a list of high priorities for each site to ensure infrastructure is functional and continues to operate safely in the short term (one to three years) until planning and consultation progressed for medium to longer term options (Attachment 3).
   - expenditure following 2012-2013 for rectifications, and cost estimates for the medium to long term solutions of capital redevelopments (Attachment 3).

7. An initial low confidence cost estimate of $51.58 million has been identified for expenditure this financial year. Following further scope finalisation and engineering assessments, there may be variations between the costs at each of the 12 sites.

8. Rectification works are targeted to the higher risk areas of the relevant building codes, for example, fire safety, electrical; and to ensure value for money, for example, replace the unsafe parts of a roof and not total roof when the building may need to be replaced in the medium to long term.

Background

9. Service profiles and infrastructure plans were prepared for the 12 sites (Atherton, Ayr, Biloela, Charleville, Charters Towers, Emerald, Kingaroy, Longreach, Mareeba, Roma, Thursday Island, Sarina) which informed the development of the Preliminary Evaluation, with all completed in 2010 (Attachment 4 BR054344 Service and Infrastructure Planning for Rural and Remote Areas).

10. The current identified capital savings totalling $63.2 million as outlined in the July 2012 Cabinet Budget Review Submission is documented in Attachment 5.

11. In addition to the $63.2 million capital savings, further potential capital savings have been identified totalling $41 million (Attachment 6).

12. These $14 million savings for 2012-2012 relate to cessation or deferral of projects for replacement/collocation of existing services and not service expansion.

Minister's Office RecFind No:	
Department RecFind No:	BR054989
Division/District:	HPID/SSS
File Ref No:	HPID02710

Consultation

13. Some consultation has occurred with the relevant Hospital and Health Services to identify current critical infrastructure issues.

14. Dr Bill Kingswell, Executive Director – Mental Health, Alcohol and other Drugs recommended the cessation of the replacement Adolescent Extended Treatment Unit at Redlands, plus has no objection to the deferral until 2013-2014 of the Townsville Medium Secure Rehabilitation Unit refurbishment project.

Attachments

15. Attachment 1: Recommended Option & Costs
Attachment 2: Option 1 Completed work
Attachment 3: Rural Sites Planning including priorities
Attachment 4: BR054344 Service and Infrastructure Planning for Rural and Remote Areas
Attachment 5: $63.2 million Capital Savings
Attachment 6: $41 million Proposed Capital Savings.

Minister's Office RecFind No:	
Department RecFind No:	BR064989
Division/District:	HPID/SSS
File Ref No:	HPID02710

Recommendation
That the Director-General:

Note the planned strategy for the targeted rectification of the prioritised infrastructure issues and subsequent planning for 12 rural hospitals.

Note the recommended $41 million funding strategy for 2012-2013 for the rural infrastructure rectifications from the Capital Program, of:

- Cessation of the Sunshine Coast Health Precinct and Caboolture Health Precinct projects;
- Cessation of the Replacement Adolescent Extended Treatment Unit, Redlands project;
- Deferral of the Townsville Medium Secure Rehabilitation Unit refurbishment project until 2013-2014.

Note that a further $10.58 million is being allocated from "Closing the Gap" funding.

Note consultation will occur following approval of the recommended funding strategy.

Provide this brief to the Minister for approval.

APPROVED/NOT APPROVED NOTED

[redacted]

~~DR TONY O'CONNELL~~
Director-General

17 / 8 / 12

To Minister's Office for Approval ☒
for Noting ☐

Director-General's comments

Author	Content verified by: (CEO/DDG/Div Head)
Rosemary Hood	Glenn Rashleigh
Director	Chief Health Infrastructure Officer
Health Infrastructure Office	Health Infrastructure Office
[redacted]	
14 August 2012	14 August 2012

Queensland Government

Queensland Health

MEMORANDUM

To: Karen Roach,A/Chief Executive Officer, Townsville Hospital and Health Service

Copies to: Jason Flenley, A/Executive Director, Capital Delivery Program, Health Infrastructure Office

From: Glenn Rashleigh, Chief Health Infrastructure Office, System Support Services

Contact No:

Fax No:

[redacted]

Subject: Deferral of Capital Delivery Project

File Ref: [redacted] Ref-Number

The purpose of this memo is to advise of a decision by government to cancel or defer a small number of capital delivery projects.

This includes the deferral of the Townsville Medium Secure Rehabilitation project until 2013/14.

For further information, please contact Jason Flenley, A/Executive Director, Capital Delivery Program on email [redacted]

Yours sincerely

[redacted]

Glenn Rashleigh
Chief Health Infrastructure Office
System Support Services
Director – Capital Delivery Program
23/08/2012

Department RecFind No:	
Division/HHS:	
File Ref No:	

Briefing Note for Noting

Director-General

Requested by: Lesley Dwyer, Chief Executive, West Moreton Hospital and Health Service **Date requested: 8 July 2013** **Action required by: 15 July 2013**

SUBJECT: Barrett Adolescent Strategy Meeting

Proposal

That the Director-General:

Note a meeting has been scheduled for 4pm on Monday 15 July 2013 between the Minister for Health, Dr Mary Corbett (Chair, West Moreton HHB), Lesley Dwyer (Chief Executive, West Moreton HHS) and Sharon Kelly (Executive Director, Mental Health and Specialised Services, West Moreton HHS) to discuss the next stages of the Barrett Adolescent Strategy.
And
Provide this brief to the Minister for information.

Urgency

1. Urgent. There is growing concern amongst stakeholders of the Barrett Adolescent Strategy, including patients and carers, to receive communication about the future of the Barrett Adolescent Centre (BAC).

Headline Issues

2. The top issues are:
   - The West Moreton Hospital and Health Board considered the recommendations of the Expert Clinical Reference Group on 24 May 2013.
   - West Moreton Hospital and Health Board approved the closure of BAC dependent on alternative, appropriate care provisions for the adolescent target group and the meeting with the Minister for Health.

Blueprint

3. How does this align with the Blueprint for Better Healthcare in Queensland?
   - Providing Queenslanders with value in health services – value for taxpayers money.
   - Better patient care in the community setting, utilising safe, sustainable and responsive service models – delivering best patient care.

Key issues

4. There is significant patient/carer, community, mental health sector and media interest about a decision regarding the future of the BAC.
5. A comprehensive communication plan has been developed.
6. The Department of Health is urgently progressing planning for Youth Prevention and Recovery Care (Y-PARC) services to be established in Queensland by January 2014. This service type would provide an alternative care option for the adolescent target group currently accessing BAC.

Background

7. BAC is a 15-bed inpatient service for adolescent mental health extended treatment and rehabilitation that is located at The Park – Centre for Mental Health (the Park).
8. The BAC cannot continue to provide services due to the Park becoming an adult secure and forensic campus by 2014, and because the capital fabric of BAC is no longer fit-for-purpose. Alternative statewide service options are required.

Department RecFind No:	
Division/HHS:	
File Ref No:	

Consultation

10. Consultation about the proposed next stages of the Strategy and board decision for closure has been limited to Dr Peter Steer, Children's Health Services; and Dr Tony O'Connell Director General, Dr Michael Cleary and Dr Bill Kingswell, Health Services and Clinical Innovation, Department of Health.
11. A short verbal briefing has been provided to the Queensland Commissioner for Mental Health, Dr Lesley van Schoubroeck.
12. Agreement has been reached that the Strategy will be finalised through a partnership between West Moreton HHS, Children's Health Services and the Department of Health.

Attachments

13. Attachment 1: Agenda Barrett Adolescent Strategy.
14. Attachment 2: Issues and Incident Management Plan BAC.

Department RecFind No:	
Division/HHS:	
File Ref No:	

Recommendation
That the Director-General:

Note a meeting has been scheduled for 4pm on Monday 15 July 2013 between the Minister for Health, Dr Mary Corbett (Chair, West Moreton HHB), Lesley Dwyer (Chief Executive, West Moreton HHS) and Sharon Kelly (Executive Director, Mental Health and Specialised Services, West Moreton HHS) to discuss the next stages of the Barrett Adolescent Strategy.
And
Provide this brief to the Minister for information.

APPROVED/NOT APPROVED **NOTED**

DR TONY O'CONNELL
Director-General

/ /

To Minister's Office For Noting ☐

Director-General's comments

Author	Cleared by: (SD/Dir)	Content verified by: (CEO/DDG/Div Head)
Dr Leanne Geppert	Sharon Kelly	Lesley Dwyer
A/Director of Strategy	Executive Director	Chief Executive
Mental Health & Specialised Services, WM HHS	Mental Health & Specialised Services, WM HHS	West Moreton HHS
[redacted] 8 July 2013	<Tel number> <Mob number> 8 July 2013	<Tel number> <Mob number> <Date>

Department RecFind No:	
Division/HHS:	
File Ref No:	

Briefing Note

The Honourable Lawrence Springborg MP
Minister for Health

Requested by: Lesley Dwyer, Chief Executive, West Moreton Hospital and Health Service **Date requested: 8 July 2013** **Action required by: 15 July 2013**

SUBJECT: Barrett Adolescent Strategy Meeting

Recommendation

That the Minister:

Note a meeting has been scheduled for 4pm on Monday 15 July 2013 with the West Moreton Board Chair, Chief Executive and Executive Director of Mental Health to discuss the next stages of the Barrett Adolescent Strategy.

Note The West Moreton Board considered the recommendations of the Expert Clinical Reference Group on 24 May 2013, and approved the closure of the Barrett Adolescent Centre dependent on alternative, appropriate care provisions for the adolescent target group and the meeting with the Minister for Health.

Note There is significant patient/carer, community, mental health sector and media interest about a timely decision regarding the future of the Barrett Adolescent Centre. A comprehensive communication plan has been developed.

Note Consultation about the proposed next stages of the Strategy has been limited to Commissioner for Mental Health, Children's Health Services and Department of Health.

APPROVED/NOT APPROVED **NOTED** **NOTED**

LAWRENCE SPRINGBORG
Minister for Health **Chief of Staff**

/ / / /

Minister's comments

Briefing note rating

1 2 3 4 5

1 = (poorly written, little value, and unclear why brief was submitted). 5 = (concise, key points are explained well, makes sense)

Please Note: All ratings will be recorded and will be used to inform executive performance.

Department RecFind No:	
Division/District:	
File Ref No:	

Briefing Note for Approval

Director-General

Requested by: Dr Michael Cleary **Date requested: 26 October 2012** **Action required by: 01 November 2012**

SUBJECT: Approval to close Barrett Adolescent Centre, The Park Centre for Mental Health

Proposal

That the Director-General:

Approve the closure of the Barrett Adolescent Centre (BAC) in December 2012.
Sign
Note
Or/And
Provide this brief to the Minister for noting.

Urgency

1. Critical: The West Moreton HHS Mental Health Service Executive Director is seeking approval from the West Moreton HHS Board to close the BAC in December 2012.

Headline Issues

2. The top issues are:
   - Service delivered through BAC cannot continue due to the following:
     i. The age and condition of the building has been identified by the Australian Council on Healthcare Standards as unsafe, necessitating urgent replacement.

     ii. Concerns have been raised about the co-location of BAC with adult forensic and secure services delivered by The Park Centre for Mental Health (TPCMH).

     iii. There is a clear policy direction to ensure that young people are treated close to their homes in the least restrictive environment with the minimum possible disruption to their families, educational, social and community networks.

     iv. The average bed occupancy rate for BAC is 43%. This is less than half of the 15 beds currently available in this unit.

Key Values

3. The key values that apply are the following:

☒ Better service for patients
☒ Better healthcare in the community
☐ Valuing our employees and empowering frontline staff
☐ Empowering local communities with a greater say over their hospital and local health services
☒ Value for money for taxpayers
☐ Openness

Key issues

4. The BAC delivers an extended treatment model of care that consists of both extended inpatient and day patient programs including education components. Recent sector advice proposes a re-scoping of the BAC service model and governance structure to ensure a contemporary evidence based model of care is being provided for adolescents with serious mental illness.

Department RecFind No:	
Division/District:	
File Ref No:	

5. Alternative services for this group of consumers will need to be considered immediately and will require a collaborative approach. The short term options to be considered may include the following:
    - Additional day programs attached to current adolescent acute units; and
    - Utilisation of non-government sector services for adolescents; and
    - The use of existing, unoccupied adolescent acute beds will also need to be considered where no other alternatives exist. Currently, acute child and adolescent beds are located in mental health services at the Gold Coast, Logan, Mater Child and Youth, Royal Brisbane and Women's Hospital, Toowoomba and Townsville (opening 2013) mental health services.
6. Longer term planning is required to align with the National Mental Health Service Planning Framework that recommends subacute community based services for adolescents.
7. It is anticipated that the West Moreton HHS will coordinate and facilitate alternative arrangements for adolescents currently accessing BAC services. West Moreton HHS has indicated that they will invite key stakeholders including the Mental Health Alcohol & Other Drugs Branch (MHAODB) to meet in November 2012 to expedite these arrangements.
8. The West Moreton HHS Mental Health Service executive management has commenced high level consultation and planning to progress the closure of BAC by December 2012. A meeting is scheduled on 2 November 2012 with key management staff of BAC to advise of imminent closure.
9. The West Moreton HHS Mental Health Service will use the planned closure of BAC during the Christmas period as a natural progression to permanent closure and will not re-open thereafter.

Background

10. Under the *Queensland Plan for Mental Health 2007-2017 (QPMH),* it was determined that the development of a new model of care for BAC was required. There is some contention in the mental health sector and community around this issue.
11. The Redlands Adolescent Extended Treatment Unit (RAETU), funded under the QPMH, was intended to replace BAC. This project has ceased due to unresolved environmental issues and budget overruns and hence is no longer a sustainable capital works project for Queensland Health.
12. The deinstitutionalisation of services currently provided at TPCMH is part of the reform agenda under the QPMH and will result in only forensic and secure services being provided at the facility.
13. The National Mental Health Policy (2008) articulates that 'non-acute bed-based services should be community based wherever possible.'
14. The National Mental Health Service Planning Framework currently being developed by the Commonwealth Government, due for completion in July 2013 does not include provision for non-acute adolescent inpatient services. The Framework does include subacute community based services for adolescents.

Consultation

15. Consultation has commenced with the Executive Director and Clinical Director of West Moreton HHS Mental Health Service. It is anticipated that the West Moreton HHS will be responsible for the coordination and implementation of change management processes and procedures including all staffing and IR related issues pertinent to the closure of BAC.

16. No formal consultation has occurred with staff of BAC.

17. No consultation has occurred with consumers of BAC and their families.

Financial implications

Department RecFind No:	
Division/District:	
File Ref No:	

18. The operating costs of the BAC for 2011-12 were $4, 264,948. A portion of this funding will be required to meet infrastructure costs at the BAC site until a decision regarding the future use of this site has been made. The remainder of the current operating costs of BAC will be used for alternative adolescent extended treatment services.
19. The cancellation of the RAETU results in recurrent funding savings of $1.8M. This will also be used for alternative adolescent extended treatment options.

Legal implications

20. There are no legal implications

Attachments

21. Nil.

Department RecFind No:	
Division/District:	
File Ref No:	

Recommendation
That the Director-General:

Approve the closure of the Barrett Adolescent Centre (BAC) by December 2012.

Sign
Note
Or/And
Provide this brief to the Minister for noting.

APPROVED/NOT APPROVED **NOTED**

DR TONY O'CONNELL
Director-General

/ /

To Minister's Office for Approval ☐
for Noting ☐

Director-General's comments

Author	Cleared by: (SD/Dir)	Content verified by: (CEO/DDG/Div Head)	Content verified by: (CEO/DDG/Div Head)
<Name>	<Name>	<Name>	
Vaoita Turituri	Dr Leanne Geppert	Dr Bill Kingswell	Dr Michael Cleary
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Senior Project Officer	Director	Executive Director	Deputy Director General
<Unit/HSD>	<Unit/HSD>	<Unit/HSD>	
Intergovernmental Relations & Systems Redesign Unit	Intergovernmental Relations & Systems Redesign Unit	Mental Health Alcohol and Other Drugs Branch	Health Service and Clinical Innovation Division
<Tel number>	<Tel number>	<Tel number>	
	<Date>	<Date>	

HSCID

Dear Miranda,
Thanks for this.
Yes you are correct.
Michael Cleary
28/11/2012

Hi Michael,
Mental Health has advised that it is their understanding that West Moreton HHS is now taking the lead in relation to the future of the Barrett Adolescent Centre and this briefing note is cancelled. Let me know if there is any issue with this

Rgrds
Miranda

Dear Team,

Can we please add a signature box for the CE Ipswich and West Morton HHS so that it is clear that the HHS is seeking this approval.

I would also suggest that we clarify if the Board of the HHS has considered and approved this.

We should also add a section in that indicated that subject to approval being provided that a project and communication plan will be developed and provided to the DG.

Kind regards
Michael Cleary
Friday, 2 November 2012

Briefing Not
Director-General

Requested by:

SUBJECT: Approv ...Health

Proposal
That the Director-G

Approve the cl
~~Sign~~
~~Note~~
~~Or/And~~

Provide this bri

Urgency
1. Critical: The We ...pproval from the West M

Headline Issues
2. The top issues ... Service delivere

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Co ...sic and ...H).

There is a clear policy direction to ensure that young people are treated close to their homes in the least restrictive environment with the minimum possible disruption to their families, educational, social and community networks.

The average bed occupancy rate for BAC is 43%. This is less than half of the 15 beds currently available in this unit.

Key Values
3. The key values that apply are the following:
- ☒ Better service for patients
- ☒ Better healthcare in the community
- ☐ Valuing our employees and empowering frontline staff
- ☐ Empowering local communities with a greater say over their hospital and local health services
- ☒ Value for money for taxpayers
- ☐ Openness

Key issues
4. The BAC delivers an extended treatment model of care that consists of both extended inpatient and day patient programs including education components. Recent sector advice proposes a re-scoping of the BAC service model and governance structure to ensure a contemporary evidence based model of care is being provided for adolescents with serious mental illness.

Department RecFind No:	
Division/District:	**HSCID**
File Ref No:	

5. Alternative services for this group of consumers will need to be considered immediately and will require a collaborative approach. The short term options to be considered may include the following:

   Additional day programs attached to current adolescent acute units; and

   Utilisation of non-government sector services for adolescents; and

   The use of existing, unoccupied adolescent acute beds will also need to be considered where no other alternatives exist. Currently, acute child and adolescent beds are located in mental health services at the Gold Coast, Logan, Mater Child and Youth, Royal Brisbane and Women's Hospital, Toowoomba and Townsville (opening 2013) mental health services.

6. Longer term planning is required to align with the National Mental Health Service Planning Framework that recommends subacute community based services for adolescents.

7. It is anticipated that the West Moreton HHS will coordinate and facilitate alternative arrangements for adolescents currently accessing BAC services. West Moreton HHS hasve indicated that they will invite key stakeholders including the Mental Health Alcohol and& Other Drugs Branch (MHAODB) to meet in November 2012 to expedite these arrangements.

8.
8. The West Moreton HHS Mental Health Service executive management has commenced high level consultation and planning to progress the closure of BAC by December 2012. A meeting is scheduled on 2 November 2012 with key management staff of BAC to advise of imminent closure.

9. The West Moreton HHS Mental Health Service will use the planned closure of BAC during the Christmas period as a natural progression to permanent closure and will not re-open thereafter.

Background

10. Under the *Queensland Plan for Mental Health 2007-2017* (QPMH), it was determined that the development of a new model of care for BAC was required. There is some contention in the mental health sector and community around this issue.

11. The Redlands Adolescent Extended Treatment Unit (RAETU), funded under the QPMH, was intended to replace BAC. This project has ceased due to unresolved environmental issues and budget overruns and hence is no longer a sustainable capital works project for Queensland Health.

12.
12. The deinstitutionalisation of services currently provided at TPCMH is part of the reform agenda under the QPMH and will result in only forensic and secure services being provided at the facility.

13. The National Mental Health Policy (2008) articulates that 'non-acute bed-based services should be community based wherever possible.'

14.
14. The National Mental Health Service Planning Framework currently being developed by the Commonwealth Government, due for completion in July 2013 does not include provision for non-acute adolescent inpatient services. The Framework does include subacute community based services for adolescents.

Department RecFind No:	
Division/District:	**HSCID**
File Ref No:	

Recommendation
That the Director-General:

Approve the closure of the Barrett Adolescent Centre (BAC) by December 2012.

~~Sign~~
~~Note~~
~~Or/And~~
Provide this brief to the Minister for noting.

APPROVED/NOT APPROVED **NOTED**

DR TONY O'CONNELL
Director-General

/ /

To Minister's Office for Approval ☐
for Noting ☐

Director-General's comments

Author	Cleared by:	Cleared by: (SD/Dir)	Content verified by: (CEO/DDG/Div Head)	Content verified by: (CEO/DDG/Div Head)
~~<Name>~~ Vaoita Turituri	Marie Kelly	~~<Name>~~ Dr Leanne Geppert	~~<Name>~~ Dr Bill Kingswell	Dr Michael Cleary
~~<Position>~~ Senior Project Officer	Manager	~~<Position>~~ Director	~~<Position>~~ Executive Director	Deputy Director General
~~<Unit/HSD>~~ Intergovernmental Relations & Systems Redesign Unit, Mental Health, Alcohol and Other Drugs Branch.	Intergovernmental Relations & Systems Redesign Unit, Mental Health, Alcohol and Other Drugs Branch.	~~<Unit/HSD>~~ Intergovernmental Relations & Systems Redesign Unit	~~<Unit/HSD>~~ Mental Health Alcohol and Other Drugs Branch	Health Service and Clinical Innovation Division
[redacted]				
		~~<Date>~~1/11/2012	1/11/2012~~<Date>~~	

CURRICULUM VITAE

Dr Tony O'Connell

MBBS (Hons, Sydney), FANZCA, FCICM, GAICD, FCHSM (Hon)

Current Position: National Advisor (Health), KPMG Australia
Email:
Mobile in Australia:

PROFILE

Dr O'Connell has been a leader within the Australian health care system for two decades, building on a prominent clinical background with hospital experience in Australia's two largest states and internationally, and holding roles in both NSW and QLD Health Departments at the highest executive level. These roles necessitated involvement in national committees and working groups dealing with Commonwealth and State health domains: groups such as COAG as a state negotiator on National Health Reform, NeHTA as a Board Member, AHHA as a Councillor, and AHMAC, with Dr O'Connell being a previous chair of its Community Care & Population Health Principle Committee. AHMAC and its Principle Committees are of course significant contributors to the development of policy and the national regulatory environment in which State Health Departments work.
These roles have given Dr O'Connell an intimate understanding of Commonwealth-State health funding, system performance and monitoring, system stakeholders and drivers, the Primary Care sector and its interface with the acute care sector, Private Health Insurance system and the Pharmaceutical Benefits Scheme.
Dr O'Connell also has a strong track record of delivering transformational change in large health systems in Australia; delivering improvements across the balanced scorecard: quality, safety, financial performance, patient access and flow (in emergency departments, elective surgery and wards) and patient experience. He also has international experience of running a national public hospital system.

National Director Acute Hospitals, Health Service Executive, Republic of Ireland 2014-2015
Responsible for all 50 publicly funded hospitals (statutory and voluntary) in Ireland. Budget €4bn.

Director-General Queensland Health (QH) 2011-2013.
As Chief Executive (D-G) of QH he managed a budget of $12bn and employed 85,000 staff in 182 hospitals. In only the first year in this position he reversed QH's worsening underlying budget position from an underlying deficit of $291M to a surplus position. More importantly, he simultaneously delivered the lowest observed in-hospital mortality in Queensland's history.

Previously functioned at **Deputy Director-General** level in two of Australia's largest state health departments.
Led major state-wide clinical service redesign programs in two Australian states, strategic resource allocation and performance management systems which delivered a turn-around in access performance across NSW in Emergency Departments and best-ever Elective Surgery performance in both QLD and NSW. He has acted as a leading clinician in NSW, chairing a state clinical network for over 12 years and acting as clinical champion for major service reform. He has been medical director of a large intensive care unit and had a busy anaesthetic practice. Able to lead major change at state-wide level while engaging disparate relevant parties.

QUALIFICATIONS

UNIVERSITY & MEDICAL SPECIALIST QUALIFICATIONS

MB, BS (Honours), University of Sydney, 1977
Anaesthetist: Fellow Aust NZ College of Anaesthetists, FANZCA (FFARACS Anaes 1983)
Intensivist: Fellow College of Intensive Care Medicine of Australasia, FCICM (FFARACS Int Care 1988)

OTHER QUALIFICATIONS

Graduate of the Australian Institute of Company Directors Course (Diploma 2010).
Honorary Fellow of the Australasian College of Health Service Management (2012).

RESIDENTIAL BUSINESS COURSES ATTENDED

Harvard Business School, Massachusetts, Leading Excellence in Healthcare Delivery, 2007
Australian Graduate School of Management, Senior Management Course, 2005

OTHER FULL-TIME POSITIONS

2009-2011 CEO, Centre for Healthcare Improvement, QH (Deputy Director-General level position)
2008, A/Deputy Director-General, NSW Health (Responsible for Information Technology, Quality and Safety, Performance Improvement and Data Analysis and Performance Evaluation)
2005-2008 Director, Performance Improvement & Redesign, NSW Health
2004-2005 Director of Access Improvement Program, NSW Health
2002-2004 Head, Paediatric ICU, Children's Hospital at Westmead, NSW

PREVIOUS BOARD APPOINTMENTS

Board Director, National eHealth Transition Authority, Australia 2011-2013
Board Executive Director, Health Service Executive, Ireland, Ministerial appointment 2014-2015
Board Director, National Paediatric Hospital Development Board, Ireland, Ministerial appointment 2014-2015

OTHER RESPONSIBLE POSITIONS

- 2011-2013 Member, Australian Health Ministers Advisory Council
- 2009-2011 Councillor, Australian Healthcare & Hospitals Association
- 1992- 2005, Chairman, NSW Health Critical Care Council
- 1996-2002, Chairman, Medical Advisory Committee, Ambulance Service of NSW
- 1987- 1999, Medical Consultant to the National Poisons Information Service
- 1997-2008, Member, Panel of Examiners for Joint Faculty of Intensive Care Medicine

PUBLICATIONS

- 5 book chapters & 2 books reviews

- 21 articles in medical journals, and 6 published abstracts

Role description

Director-General, Queensland Health

Role title	Director General		
Status	Contract – up to 5 years.	**Closing date**	**15 August 2011**
Organisation	Department of Health	**Contact**	Martin Pick, Amrop Cordiner King
Location	Brisbane	**Telephone**	[redacted]
Classification	Chief Executive		
Total remuneration Value	**From $446,102 to $506,668 per annum** including superannuation and leave loading		

Our challenge

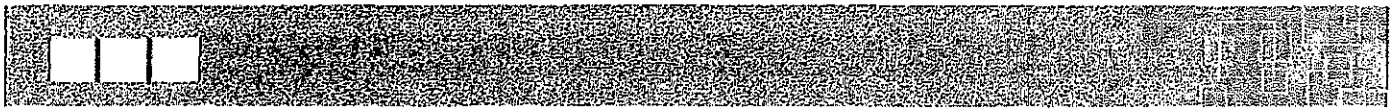
The Office of the Director-General is committed to driving high quality health care and continuous improvement. The challenge, as the main provider of public health services, is the safe provision of quality services across Queensland and across the diversity of needs within the annual budget. Queensland Health has a strong commitment and focus on performance, accountability, openness and transparency.

Queensland Health is committed to providing high quality, safe and sustainable health services to meet the needs of our communities. We cannot meet these challenges alone and will continue to work with partners including other Queensland Government departments, the Australian Government and other agencies, consumers and the private sector to develop collaborative and proactive solutions to meet the health needs of Queenslanders now and into the future.

The strategic challenges are:

- Changing the community's focus to the prevention of illness and maintenance of good health
- Managing the complex process of care delivery ensuring the right services in the right places for the right type of patients
- Building public confidence in the healthcare system
- Providing a seamless transition for patients as they move across healthcare providers and settings
- Achieving a collective and coordinated response across multiple levels and complexities of government
- Attracting and retaining skilled professionals, especially for specialist services and in rural and remote areas
- Ageing building and information and communication technology infrastructure affecting people and information security and accessibility
- Establishing meaningful and measurable outcome indicators for complex health and community services
- Managing the growing demand for services within the economic and financial environment.

The face of healthcare is changing. To help create this change, the Queensland Government is working in partnership with the Australian Government to reform the way our health services will be managed and delivered in the future. A key part of the reform is the development of Local Health and Hospital Networks (LHHNs), which are expected to be operational nationally by 1 July 2012.



Your department

In 2011-12 Queensland's health budget will increase by 10.6 per cent to $11.046 billion. That is a record health budget for Queensland.

Queensland Health is a dynamic organisation committed to providing a range of services aimed at achieving good health and well-being for all Queenslanders. Through a network of 17 Health Service Districts and the Mater Hospitals, Queensland Health delivers a range of integrated services including hospital inpatient, outpatient and emergency services, community and mental health services, aged care services and public health and health promotion programs. Our services are delivered from various locations statewide by approximately 80,000 staff.

The most significant challenge for Queensland Health in the short term will be implementing the Government's reform process and the creation of Local Health and Hospital Networks (LHHNs). The reforms will usher in far-reaching changes to the way in which public health services are managed. The establishment of the LHHNs as statuary bodies and the new role of the department will result in significant changes to structures, processes and people. The benefits of the reform will be:

- Increased efficiency and more sustainable growth in health budget;
- LHHN flexibility to innovate and address local priorities;
- Focus on patient centred care;
- Clinicians, consumers and community are more engaged at local level;
- LHHNs held accountable for performance; and
- Role clarity between system manager and service providers.

Queensland Health values the health and wellbeing of all Queenslanders. We will work with communities to create healthy environments and support behaviors that protect and promote health (like good nutrition and physical activity for example), reduce health risk factors (such as smoking, excessive alcohol consumption and obesity), and improve health outcomes for people living with long-term health conditions.

We recognise that Queenslanders trust us to act in their interests at all times. To fulfill our mission and sustain this trust we share four core values:

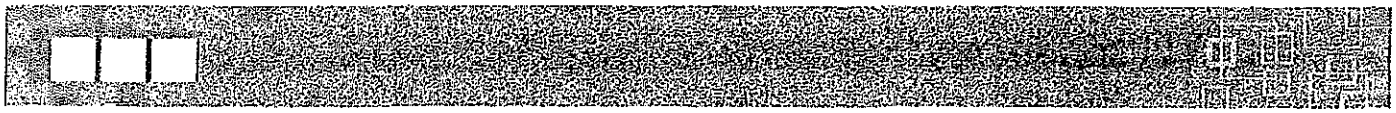
- Caring for people
- Leadership
- Respect
- Integrity

Your opportunity

Accountable to the Premier of Queensland, and reporting to the Minister for Health, the Director General will manage a department committed to contributing to the achievement of giving Queenslanders a reliable quality health system and educating Queenslanders on being a healthy state.

Your key accountabilities

- Lead the reform process for Queensland Health, on behalf of the Government
- Provide superior leadership and strategic direction resulting in efficient and effective delivery of Health services to all Queenslanders which ensure
    - Making Queenslanders healthier.
    - Meeting Queenslanders' healthcare needs safely and sustainably.
    - Reduce health service inequities across Queensland.
    - Develop staff and enhance organisational performance.
    - Foster effective and co-operative relations with Local Government and a network of supported volunteer organisations, advisory bodies and community service organisations.
    - Attract, develop and maintain an ethical, professional and dedicated workforce and volunteer base.



- Ensure openness, transparency and engagement in decision making.

- Provide expert advice to the Minister for Health on matters relating to every day Health issues and high level policy on request and in response to emergent issues.
- Provide leadership to the department's staff and other resources to give effect to relevant legislation, government policy and contemporary best practice.
- Participate in the Community Cabinet meetings, various consultations and negotiations within Queensland, and with equivalent government departments, interstate, on issues within the portfolio responsibilities of the Minister for Health.
- Deliver sound and proper management of the department as the accountable officer under the *Financial Accountability Act 2009*, the *Public Service Act 2008, Health Service Act 1991, Public Service Regulations* and other legislation.
- Drive improved performance and organisational capability within the department to meet service delivery objectives and targets.

Are you the right person for the job?

You will be assessed on your capability and capacity for the following in the context of the accountabilities above. For more information about the Capability and Leadership Framework, please refer to the attached summary sheet provided.

- **Shapes Strategic Thinking**
- **Achieves results**
- **Cultivates productive working relationships**
- **Exemplifies personal drive and integrity**
- **Communicates with influence**

Your working life

You will work in an organisation that values community service, professionalism in performance, integrity and respect for people. You will develop strong working relationships across the department, government and local government and with community groups and private sector stakeholders.

The department is committed to employee professional development, and to maintaining a healthy work–life balance. The department offers its employees generous superannuation, and a range of salary packaging options are available to all staff.

Interested?

Please provide the following information for the panel to assess your suitability:

- A two page statement outlining your suitability for the role.
- A Current CV.

Additional information

- For further information about the work of the department visit www.health.qld.gov.au
- For further information about working for the Queensland Government visit www.qld.gov.au
- All employees of the Department of Health are required to abide by its Code of Conduct.
- Applications from other recruitment agencies will not be accepted.