Submissions of Counsel Assisting on the Draft NMHSPF

Introduction

1. During the course of submissions on 12 April 2016, a question arose regarding the draft National Mental Health Services Planning Framework (NMHSPF). This passage appears in the transcript:

> COMMISSIONER WILSON: Can I foreshadow something. If there is going to be reliance upon the assertion that models involving a statewide clinical bed-based such as the Barrett Adolescent Centre or the Walker centre are not considered contemporary within the National Mental Health Service Planning Framework I'm going to have to have some detailed submissions from Counsel Assisting and from others who are interested in the point as to just how to interpret that framework.[1]

2. The purpose of these submissions is to supply the detailed submissions required by the Commissioner on the interpretation of the draft NMHSPF.

Background to the NMHSPF

3. The Project Charter for the NMHSPF explains the background:

> Both in Australia and internationally, there have been calls for the development of more strategic and coordinated approaches to mental health planning and service delivery. There is currently no nationally agreed approach to the way that mental health services are planned. Planners in States and Territories use their own approaches to this task, which vary considerably in the extent to which they are based on best available evidence. Australia's National Mental Health Strategy has called for each jurisdiction to develop a mix of services appropriate to local population needs, but has not specified targets for services.
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> The 'Fourth National Mental Health Plan - An agenda for collaborative government action in mental health 2009-2014' makes an explicit commitment to developing a national mental health service planning framework that establishes targets for the mix and level of the full range of mental health services, underpinned by innovative funding models.[2]

4. Dr Groves explained that, in the early stages of the development of the Fourth National Mental Health Plan, he, and a number of other State Mental Health Directors, advocated for the development of the NMHSPF. The result was that, when all Health Ministers agreed to the Fourth National Mental Health Plan in September 2009 they agreed to the development of the NMHSPF as one of the foundation actions of the plan.[3]

5. And so, on 20 June 2011 the Commonwealth Government funded a project led by NSW Health, in partnership with Queensland Health, to develop the NMHSPF.[4]

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[1] T27-60.
[2] Exhibit 375, Project Charter dated 27 January 2012 at page 8. Note that this is version 1.03. The earliest version, version 1.00 was dated 30 August 2011.
[3] Exhibit 58, Statement of Aaron Groves dated 21 January 2016, page 34, paras 189 & 190.
[4] Exhibit 375, Project Charter dated 27 January 2012 at page 8.

6. The purpose of the project was, and is, to develop a National Mental Health Service Planning Framework based on the depth of experience of both NSW and Queensland in the development of population-based planning models for mental health, and enhanced by expert input from the various groups established under the project governance structure.[5]

7. As the Project Charter explains, the intention of the NMHSPF was to:

    a. Be based on sound epidemiological data that quantifies the prevalence and distribution of the various mental illnesses, as well as evidence-based guidelines that identify the treatment required for the range of conditions;

    b. Translate this knowledge about illness prevalence and required treatments into resources, measured in terms of the workforce and service components required to establish an adequate service system;

    c. Include delineation of roles and responsibilities across the community, primary and specialist sectors, including the private sector and non-mental health specific services (e.g. aged care, general health services);

    d. Consider the workforce requirements to deliver the range of services;

    e. Include acute, long stay, 'step up/step down' and supported accommodation services, as well as ambulatory and community based services;

    f. Consider the contribution of public, non-government sectors and private mental health service providers;

    g. Clearly differentiate between the needs of children and young people, adults and older people;

    h. Consider socio-demographic factors such as culturally and linguistically diverse groups;

    i. Suggest role definitions and delineations to determine the recommended mix of services with comment on how to address scarcity or mal-distribution in some geographical locations; and

    j. Promote flexible funding models that allow innovation and service substitution to meet specified targets in different delivery contexts.[6]

8. The contracted outputs from the Project include:

    a. The development of a NMHSPF model that can be adapted for use within each Australian jurisdiction that will provide transparency and consistency across all jurisdictions for estimating the need and demand for mental health services - across the continuum of care from prevention and early intervention to the most intensive treatment;

    b. Standardised 'Australian average' estimates of need and demand for a range of agreed mental health services per 100,000 people across the whole age range, and across the continuum of care;

[5] Exhibit 375, Project Charter dated 27 January 2012 at page 9.
[6] Ibid.

c. Estimates of the staffing, beds, and treatment places per 100,000 age-specific population to meet the estimated demand;

d. Estimates of the outputs to be expected from the resources; and

e. A high-level estimate of the gap between current need being met for all jurisdictions, and the resources required to fill that gap.[7]

9. The contracted products from the Project include:

a. Various Project Progress Reports to the Executive Group and the Commonwealth;

b. An Excel workbook with the details of the NMHSPF modelling;

c. A template that individual jurisdictions can adapt to address regional and other variations as needed;

d. Comprehensive documentation of the evidence underlying the parameters used in the model so that it can be modified as new evidence becomes available, and adapted to local evidence (detailed in a 'Technical Manual');

e. A standard reference point for planning information; and

f. An Excel 'calculator' that applies the model to population projections in a convenient manner, and a 'User Manual' for it.

10. The aim of the NMHSPF was to "*better estimate service demand across the service spectrum and across different care environments and will allow jurisdictions to identify service areas requiring investment*."[8]

11. The NMHSPF was to be guided by the following principles:

a. Nationally consistent – The NMHSPF will provide an 'Australian average' estimate of need, demand and resources for the range of agreed mental health services required across the lifespan and across the continuum of care from prevention to tertiary treatment.

b. Flexible and portable – The NMHSPF will be flexible to jurisdictional adaptation, and will be presented in a user friendly format. However, some technical aspects cannot be altered or the validity of the product will be compromised.

c. Not all, but many – To ensure national viability, the NMHSPF will not account for every circumstance or service possibly required by an individual or group, but will allow for more detailed understanding of need for mental health service across a range of service environments.

d. Not who, but what – The NMHSPF will capture the types of care required, but will not define who is best placed to deliver the care. Decisions about service provision will remain the responsibility of each state/ territory and the Australian Government.

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[7] Exhibit 375, Project Charter dated 27 January 2012 at page 10.
[8] Department of Health website page 'National mental Health Service Planning Framework (NMHSPF)' as archived in the National Library of Australia, Australian Government Web Archive; as referred to by the Senate Report: Fourth interim report 'Mental health: a consensus for action', 8 October 2015 at p 49.

e. Evidence and expertise – The NMHSPF will identify what services 'should be' provided in a general mental health service system. Contemporary mental health practice, epidemiological data and working with key stakeholders with diverse expertise will underpin the technical, clinical and social support mechanisms that will form the content of the framework.[9]

12. The Project Charter explained the project's relatively modest ambitions in the context of a mammoth task:

> It would be overly ambitious to expect a 'Rolls Royce' NMHSPF at first pass when the progress to the latest version of the NSW Mental Health Clinical Care and Prevention (MH-CCP) Planning Model has taken over ten years to develop to this point. A project of this significance will require an iterative, or action research, approach to its long-term development. It is the expectation that a 'Toyota Corolla' NMHSPF will be developed under this Project.[10]

Progression of the NMHSPF

2010 to 2013

13. The Commonwealth convened the first meeting of the project in the middle of 2010 at the offices of the NSW Health in North Sydney. Dr Groves attended with other key Queensland Health staff.[11]

14. Project Communiques were produced and distributed to stakeholders in September 2011, February 2012, September 2012 and April 2013.[12]

15. The last of those communiques explained the progress to that point:

> The development of care packages continues with the validation process progressing over the next 3 months. The draft Service Element Descriptions document and taxonomy is also scheduled for final review and endorsement by the project membership in mid year. Finally, the estimator tool will be reviewed by stakeholders and following incorporation of feedback, will be delivered to the Executive Group with all associated documentation at the completion of the Project.
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> Due to the volume and complexity of work generated in the Project, the Project Team have applied to the Department of Health and Ageing for a 3 month extension, suggesting a revised completion date of 30 September 2013.[13]

October 2013

16. In October 2013 there was a final meeting of the NMHSPF Executive which Dr Groves attended. That meeting/workshop introduced the major products which formed components of the NMHSPF.[14] Dr Groves explained what happened next:

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[9] Those 5 messages are part of the Project Charter at page 92 (exhibit 375) and the first Project Communique issued in September 2011; see also the Senate Report: Fourth interim report 'Mental health: a consensus for action', 8 October 2015 at p 49-50.
[10] Exhibit 375, Project Charter dated 27 January 2012 at page 10.
[11] Exhibit 58, Statement of Aaron Groves dated 21 January 2016, page 34, para 193.
[12] Project Communiques, exhibits 378, 975, 977 & 978.
[13] Project Communique 4, exhibit 978.
[14] Exhibit 58, Statement of Aaron Groves dated 21 January 2016, page 35, para 198.

> Following this meeting, the then WA Mental Health Commissioner was provided with a USB drive that contained all the project deliverables as well as a password-protected State-specific Estimator Tool, that could be used under strict conditions for the purpose of informing planning at a jurisdictional level. Together these materials are termed the draft NMHSPF. I have not attached a copy of the draft NMHSPF.

17. As Dr Groves explained, the draft NMHSPF contained the following resources: The Framework Document; the Taxonomy of Services; the Service Element and Activity Descriptions;[15] the complete set of Care Packages; the Technical Manual; and the Estimator Tool.

18. The intellectual property in the draft NMHSPF was held by NSW (with the Commonwealth having an un-restricted perpetual licence).[16] According to Dr Groves, it was NSW's intention, in sharing the draft with the States, that the draft be used in the field as a way of providing important user feedback so that this could be used to refine the draft and ultimately lead to the development of a version for more widespread use once any inaccuracies had been rectified.[17]

19. Thus, the draft NMHSPF was distributed to each of the States either at or shortly after the October 2013 meeting.[18]

Limited Distribution

20. The limited distribution of the draft NMHSPF, and its protection with a password, appears to be a deliberate choice, so that (as Dr Groves explained) some use could be made of the draft, and then it could be refined and developed, and inaccuracies could be rectified, and then there could be more widespread use of the draft. Thus:

    a. On 26 August 2015 the CEO of the National Mental Health Commission told a Senate Committee that the (Commonwealth) Department of Health had declined to provide his Commission with a copy of the NMHSPF.[19]

    b. On 22 December 2015, by email, the (Commonwealth) Department of Health also declined to provide this Commission of Inquiry with access to the NMHSPF saying that:

> The first phase of the NMHSPF Project was completed in mid-2014 with the Executive Group's advice stating that further refinement, validation, sensitivity analysis and testing of the draft NMHSPF was required prior to distribution for use in real world mental health service planning situations. There are recognised technical issues with this version of the NMHSPF. As per the advice provided by Dr Kingswell to you, the intellectual property for the draft NMHSPF is owned by the NSW Government.[20]

    c. In the evidence before this commission, even a medical director as senior as Dr Stathis, the Medical Director of CYMHS, had not read or received a copy of the NMHSPF in 2016 (except for 2 pages).[21]

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[15] See later discussion of an earlier version of this component.
[16] Exhibit 58, Statement of Aaron Groves dated 21 January 2016, page 35, para 201.
[17] Exhibit 58, Statement of Aaron Groves dated 21 January 2016, page 35, para 201.
[18] That is the evidence of Dr Groves; see also the consistent evidence of Professor Kotzé at T23-4.
[19] Exhibit 973, Senate Report: Fourth interim report 'Mental health: a consensus for action', 8 October 2015 at p 50.
[20] Email Commonwealth Department of Health to the Commission dated 22 December 2015; this document is not yet in evidence – a copy of the email will be distributed; note that a copy of the NMHSPF was subsequently provided to the Commission by Dr Kingswell.
[21] T24-30; he appears to have received only documents relating to Step Up Step Down type facilities.

21. The components of the draft NMHSPF comprising the Service Element and Activity Descriptions and the Estimator Tool User Guide are dated October 2013. That is consistent with Dr Groves' evidence that the meeting/workshop took place in October 2013 and that the States were then, either at or subsequent to that meeting/workshop, provided with password-protected versions of the draft NMHSPF.

An Earlier Version

22. Dr Kingswell was a member of the NMHSPF Executive Group. In the course of his evidence before this inquiry, the Commissioner pointed out to that the version of some of the components of the draft NMHSPF were dated October 2013.[22] Dr Kingswell's counsel subsequently produced to the inquiry a November 2012 version of one of the components of the NMHSPF, namely the NMHSPF Service Element and Activity Descriptions.[23] The document control version page describes that document as "*Combined the three EWG[24] draft activity and service element descriptions into one document.*" The equivalent document control version page on the October 2013 version of the same document notes that it is the "*Final First Draft*".

23. In fact, the November 2012 version is quite different from the October 2013 version. This is further discussed below.

2015-2016

24. As at August 2015 the NMHSPF was still in draft. The Senate Committee's Fourth Interim Report explains the situation as at August 2015:

    a. Ms Janet Anderson, First Assistant Secretary of the Health Services Division of the Department of Health explained to the Senate Committee:

        > …the framework exists now, but it is what is known as a beta version. It has had some testing in several jurisdictions, including New South Wales, WA and Queensland. The Mental Health and Drug and Alcohol Principal Committee of AHMAC [the Australian Health Ministers' Advisory Council] has agreed to establish a steering committee to take forward the framework into its further and final stages of development. They are aware of a number of areas where further work is required. It does need some further effort. Apparently there are some technological bugs, which I do not presume to know much about, but they also want to look more closely at some elements of the design model such as the way the care packages are put together. There are further considerations to be given to rural and remote residents in terms of mental health and also to Indigenous communities, and at the far end of all of that there is the need to seek state and territory sign-off to the framework in order for it to be a genuinely national product.

    b. Ms Anderson explained that the 'beta version' was 'a testing model':

        > It is something which is recognised as not yet fully developed but has enough of the moving parts to see how it might apply in real life but in a piloted way. It is not currently being used as a planning model, but it is being tested as if it could be used and to identify things that might need further development. Indeed, that list which I partially rendered is still being developed. There is still the need for

[22] T13-33; T13-34; T13-64.
[23] T13-97 to 98; T25-22; Exhibit 289.
[24] Exhibit 375. The Project Charter explains that, within the governance structure, each Expert Working Group reports to the Modelling Group Chair and Deputy Chair, which, in turn, reports to the NMHSPF Executive Group.

> further identification of the issues to be worked on to move it from its current testing phase into a framework which nine jurisdictions can agree to.

c. Ms Anderson's understanding of the timeframe for progressing the Framework to completion was that approximately another year would be required:

> My understanding is that the expectation of the time frame is that it will take at least 11 or 12 months—probably to the middle of the next calendar year—before this work is completed. A steering committee is being established that is chaired by the Commonwealth and has representation from a number of jurisdictions. It has not yet met, and I think its first meeting will be in September. There is work now underway to establish its specific terms of reference and a work plan which will guide its efforts over the coming 12 months.

d. The fact that the Framework was in 'beta version' was the Department's reason for the framework not being provided to that Commission during its review. Mr Cormack [Deputy Secretary, Strategic Policy and Innovation, Department of Health] argued that:

> [The Framework] is a Commonwealth/state piece of work. It obviously has very significant implications for the way services are planned, designed, delivered and resourced. Any endeavour that requires collaboration across the Commonwealth, state and territory governments on matters that would potentially require changes or increases in their levels of resourcing do require a significant degree of scrutiny within the budget processes of nine jurisdictions. Accordingly, there are appropriate safeguards on the release of unfinished, unapproved work. So it is not unusual for something that is in its development stage within this governance context not to be made more broadly available, particularly as it is subject to change. Whatever version they might have been access at that point in time may not even have been the beta version; it may have been an earlier version. Clearly, things have moved on.[25]

25. There is no suggestion that the NMHSPF is any more advanced at the time of writing. There is no evidence of a final version.

26. It follows that the NMHSPF is a draft in the sense it is unfinished, unapproved, subject to change and has not been made available to the mental health profession (other than to those involved in the process of preparing the NMHSPF).

27. In that context, Professor McGorry's evidence to the inquiry that the NMHSPF was a "work in progress"- even as at March 2016 – is not surprising.

The Role and Utility of the NMHSPF

Use as Part of 'Other Processes'

28. Professor Kotzé explained the role of the NMHSPF:

> So the National Mental Health Service Planning Framework is a decision support tool. **It's merely the start of a service development and planning conversation that then involves a whole lot of other processes**, including stakeholder consultation, but also

[25] Exhibit 973. Senate Report: Fourth interim report 'Mental health: a consensus for action', 8 October 2015 at p 50; see also exhibit 974, the evidence relied on in that report of Ms Janet Anderson, First Assistant Secretary, Health Services Division, Department of Health, Committee Hansard, 26 August 2015, pp 56–57 and Mr Mark Cormack, Deputy Secretary, Strategic Policy and Innovation, Department of Health, Committee Hansard, 26 August 2015, p. 58.

> including a recognition of current context and a sense of future directions that may be achieved over time. So it's not the intention of a model like this that within, you know, a very short period of time you would have extensive repurposing or redirection of its service. It's really about, well, if this is the **general map** that we're seeking to align to, how do we purposely prioritise, use opportunities or identify, perhaps, new sources of funding, etcetera, to align over time what we have with where we think in the future things should go. So in this process that was conducted by the Western Australian Mental Health Commission, it did use, if you like, the technical, more objective science of a mental health service planning, but it **also then went through extensive processes of consultation to identify priorities and identify opportunities**, etcetera.[26] [emphasis added].

Use of the draft NMHSPF in Western Australia

29. As Professor Kotzé explained, the draft NMHSPF was utilised "*for the first time*" in the proposed Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025.[27] Under the heading '*10.4. What the Modelling Tells Us*' are these categories of main bed/service types:[28]

Table A: Relevant Categories under the Western Australian 2015-2025 Plan

Bed/Service Type	Service Description	Age Groups	Length of Stay
Acute Hospital	hospital based inpatient assessment & treatment services for people experiencing severe episodes of mental illness who cannot be adequately treated in a less restrictive environment	Infants, children & adolescents; youth; adults; and older adults	Average length of stay of 14 days
Subacute hospital short stay	hospital based treatment and support in a safe, structured environment for people with unremitting and severe symptoms of mental illness and an associated significant disturbance in behaviour which precludes their receiving treatment in a less restrictive environment	Adults, older adults and a selected number of young people with special needs	Average length of stay of between 35 days and six months
Subacute hospital long stay	hospital based treatment and support in a safe, structured environment for people with unremitting and severe symptoms of mental illness and an associated significant disturbance in behaviour which precludes their living in a less restrictive environment. Programs have a strong focus on safety, security and risk assessment and management. Services include specialist behavioural and symptom management programs, individualised and group programs aimed at maximising individual functioning.	[Not specified]	Average length of stay is 365 days

30. The West Australian 2015-2025 Plan provides that, by the end of 2017, to prepare for the future, the plan aims to convert the Bentley Adolescent Unit into a state-wide 14 bed subacute

[26] T23-11.
[27] Exhibit 315; see also T23-11.
[28] Exhibit 315 at page 49; this list of categories is not an exhaustive list of those listed in the report.

service for youth, that is, for those aged 16 to 24 years of age.[29] Unfortunately, that plan is not clear about whether the subacute service is to be, in the language of the plan, subacute hospital short stay (i.e. average of 35 days to six months) or subacute hospital long stay (i.e. average of 365 days). Attempts by the Commission to obtain further information on the Bentley Adolescent Centre have so far been unsuccessful.

31. It is not clear whether the taxonomy of the West Australian plan fits neatly into the draft NMHSPF. That is because the categories identified in *Table A* above do not neatly match the categories identified in the draft NMHSPF (explained below in *Table B*).

Service Categories in the Draft NMHSPF

32. The draft NMHSPF includes the following categories (called '*service categories*')[30] and the following sub-categories (called '*service elements*'):

Table B: Relevant Service Categories in the draft NMHSPF[31]

Bed/Service Type	**Service Description**	**Age Groups**	**Length of Stay**
Acute Inpatient – Hospital (Service category **2.3.1**)	Acute inpatient treatment is driven primarily by the need to respond to risk associated with a person's symptoms, behavioural disturbance and/or distress which are related to a recent onset or exacerbation of a mental illness. The primary goal of care is reduction in severity of symptoms and/or distress associated with the recent onset or exacerbation of a mental illness. Services are delivered by a multidisciplinary team of health care professionals operating as part of a local integrated mental health service system.[32]	All age groups, including child and youth (0-17) - see service element 2.3.1.2	Acute care average lengths of stay are measured in days or weeks.
Sub-Acute Services (Service Category **2.3.2**)	Comprises 3 elements: Step Up/Step Down Services, Rehabilitation Services, and Intensive Care Services (see the sub-categories – service elements – explained below) Services are provided by multi-disciplinary teams Services are delivered as collaborations between specialist clinical and community support sector services with staff available on site 24 hours a day[33] [*Note: The BAC is noted as an example service*]	Adults and younger people	For younger people: 28 days for SUSD; stays are measured in weeks and months, not years
Step Up/Step Down – Youth Residential (Service Element **2.3.2.1**)	The aim of the service is prevent further deterioration of a person's mental state and associated disability and so reduce the likelihood of admission to an acute inpatient unit (step up). The service also aims to enable early discharge from acute care through the provision of an intensive safe and supportive residential community residential program (step-down). The service aims to provide short term transitional recovery oriented care and support to minimise the trauma and impact of a first episode or relapse of a mental illness.	Youth (12-17) or (16-24)	21 days

[29] The plan itself appears to envisage that 'youth' are those aged from 16 to 24: see the Plan at page 50.
[30] The service categories are identified in yellow and the service elements are identified in green.
[31] These tables do not purport to extract all the features of each service category and service element.
[32] Exhibit 233, page 226.
[33] Exhibit 233, page 252.

Bed/Service Type	Service Description	Age Groups	Length of Stay
	The service takes an integrated approach to clinical recovery and psychosocial interventions with a focus on stabilisation and management of illness, engagement or re-engagement in positive and supportive social, family, educational and vocational connections. Services are located in the community, and delivered in a community residential environment.[34]		
Sub-Acute Intensive Care Service – Hospital (Service Element **2.3.2.5**)	Sub-acute intensive care services provide short to medium term treatment and rehabilitation in a safe, structured environment for people with unremitting and severe symptoms of mental illness and an associated significant disturbance in behaviour which precludes their receiving treatment in a less restrictive environment. Services include, specialist behavioural and symptom management programs, individualised and group rehabilitation programs aimed at maximising individual functioning and minimising the effects of long term care and recovery oriented pre-discharge and community placement planning to support safe transition to more independent living. Sub-acute intensive care services are located on hospital campuses usually operating as a sub-program collocated with non-acute intensive care services.[35]	Adults, older adults and selected young people with special needs.	120 days with an expected maximum stay of less than 180 days (i.e. 6 months)
Non-Acute Extended Treatment Services (Service Category **2.3.3**)	Sub-acute and non-acute bed-based services are part of a spectrum of services and, as such, share some characteristics – for example, a focus on rehabilitation. The key difference is that non-acute services provide care over an extended period – with an expected length of stay in excess of 6 months. People accessing non-acute services present with a relatively stable pattern of clinical symptoms, which may include high levels of severe unremitting symptoms of mental illness and severe levels of need for additional support, resulting in a limited capacity to function independently. The goal is to provide treatment and rehabilitation over an extended period, aimed at promoting personal recovery and reducing difficulties that limit independence. Services are provided over an extended period with an expected length of stay greater than 6 months. Includes treatment and rehabilitation services for people with high intensity needs for clinical care and treatment over an extended period (needs dominated by positive symptoms and associated problems in context of functional disability).	Not specified but there is a comment that: "*Specialist services are generally provided for adults and for older adults. These extended stay programs are not suitable for young people*."	An expected length of stay greater than 6 months.

[34] Exhibit 233, page 255.
[35] Exhibit 233 – page 268. Note the 'Diagnostic Profile' is described as "*Primary diagnoses usually include schizophrenia, psychosis or severe mood illnesses. Also may have complex presentations including issues with personality illness or exacerbations of underlying personality traits, drug and alcohol illnesses, complex trauma and clinically significant deficits in psychosocial functioning. Associated issues of behaviour and risk which indicate a need for rehabilitation include severely disorganised behaviour leading to difficulty in managing activities of daily living, impaired impulse control, vulnerability, ongoing risk of aggression, and significant risk of self-harm.*"

Bed/Service Type	Service Description	Age Groups	Length of Stay
	Includes residential services for people with high intensity needs for psycho-social rehabilitation (needs dominated by functional disabilities in context of unremitting but relatively stable positive symptoms). Services are delivered by multidisciplinary teams operating as part of a local integrated mental health service system. Services are usually delivered as collaborations between specialist clinical and community support services. The person's needs for services are complex and require significantly higher levels of support than can be provided at home or in other non-residential settings.[36]		
Non-Acute – Intensive Care Service – Hospital (Service Element **2.3.3.1**)	Non-acute intensive care services provide medium to long term treatment and rehabilitation in a safe, structured environment for people with unremitting and severe symptoms of mental illness and an associated significant disturbance in behaviour which precludes their living in a less restrictive environment. Services include, specialist behavioural and symptom management programs, individualised and group rehabilitation programs aimed at maximising individual functioning and minimising the effects of long term care and recovery oriented pre-discharge and community placement planning to support safe transition to more independent living.[37]	Adults and selected young people with special needs.	Average LOS[38] - 365 days

Do Barrett, Redlands & Walker fit into the draft NMHSPF?

33. As will be explained below, Dr Kingswell's contention was that the tier 3 proposed by the ECRG was at odds with the draft NMHSPF. However, on a proper reading of the draft NMHSPF, the tier 3 might conceivably fit within either or both of two of those service elements, namely:

    a. Sub-Acute Intensive Care Service – Hospital (Service Element 2.3.2.5).

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

NMHSPF Service Elements 2.3.2.5 & 2.3.3.1

34. It can be seen that the BAC is specifically mentioned as an example service within service category 2.3.2. That suggests that the BAC, or at least services like it, were contemplated as fitting within one of other of the service elements within that service category.

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[36] Exhibit 233 – page 271.
[37] Exhibit 233 – page 273. Note that, as with service element 2.3.2.5, the 'Diagnostic Profile' is described as "*Primary diagnoses usually include schizophrenia, psychosis or severe mood illnesses. Also may have complex presentations including issues with personality illness or exacerbations of underlying personality traits, drug and alcohol illnesses, complex trauma and clinically significant deficits in psychosocial functioning. Associated issues of behaviour and risk which indicate a need for rehabilitation include severely disorganised behaviour leading to difficulty in managing activities of daily living, impaired impulse control, vulnerability, ongoing risk of aggression, and significant risk of self-harm.*"
[38] Length of Stay.

35. It is possible to compare, in a rudimentary way at least, the attributes of the tier 3 proposed by the ECRG in the Service Elements document,[39] and the draft NMHSPF service elements 2.3.2.5 and 2.3.3.1. That is done in the following table:

Table C: Comparison of attributes of ECRG tier 3 and service element 2.3.2.5

Attribute	**ECRG Tier 3**	**Service Element 2.3.2.5**	**Service Element 2.3.3.1**
Location	SE Qld but "*potential site not available at current time*"	Sub-acute intensive care services are located on hospital campuses usually operating as a sub-program collocated with non-acute intensive care services	Sub-acute intensive care services are located on hospital campuses usually operating as a sub-program collocated with non-acute intensive care services
Hours	**24/7**	**24/7**	**24/7**
Target Patients	For young people whose **needs could not be met by Tiers 1 and 2 above**, due to risk, **severity** or need for inpatient extended treatment and care. These young people's needs are not able to be met in an acute setting.	Sub-acute intensive care services provide short to medium term treatment and rehabilitation in a safe, structured environment for people with unremitting and **severe** symptoms of mental illness and an associated significant disturbance in behaviour which precludes their receiving treatment in a **less restrictive environment**.	Sub-acute intensive care services provide short to medium term treatment and rehabilitation in a safe, structured environment for people with unremitting and severe symptoms of mental illness and an associated significant disturbance in behaviour which precludes their receiving treatment in a **less restrictive environment**.
Target age	**13 - 17 years**, with flexibility in upper age limit depending on presenting issue and developmental (as opposed to chronological) age.	Adults, older adults and **selected young people with special needs**.	Adults, older adults and **selected young people with special needs**.
Diagnostic profile	Severe and persistent mental health problems that significantly interfere with social, emotional, behavioural and psychological functioning and development. Treatment refractory/non responsive to treatment - have not been able to remediate with multidisciplinary community, day program or acute inpatient treatment. **Mental illness is persistent and the consumer is a risk**	Primary diagnoses usually include schizophrenia, psychosis or severe mood illnesses. Also may have complex presentations including issues with personality illness or exacerbations of underlying personality traits, drug and alcohol illnesses, complex trauma and clinically significant deficits in psychosocial functioning. Associated issues of behaviour and risk which indicate a need for rehabilitation include severely disorganised	Primary diagnoses usually include schizophrenia, psychosis or severe mood illnesses. Also may have complex presentations including issues with personality illness or exacerbations of underlying personality traits, drug and alcohol illnesses, complex trauma and clinically significant deficits in psychosocial functioning. Associated issues of behaviour and risk which indicate a need for rehabilitation include severely disorganised

[39] Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 822 part of SK-12.

Attribute	ECRG Tier 3	Service Element 2.3.2.5	Service Element 2.3.3.1
	to themselves and/or others. Medium to high level of acuity requiring extended treatment and rehabilitation.	behaviour leading to difficulty in managing activities of daily living, impaired impulse control, vulnerability, ongoing risk of aggression, and **significant risk of self harm**.	behaviour leading to difficulty in managing activities of daily living, impaired impulse control, vulnerability, ongoing risk of aggression, and **significant risk of self harm**.
Average duration of treatment/length of stay	Up to 12 months; flexibility will be essential. There will be wide variation in individual consumer need and their treatment program; length of stay will need to be responsive to this. Young people may be discharged from this Service to a Day Program in their local community.	120 days with an expected maximum stay of less than 180 days (6 months)	365 days
Staffing profile	**Multidisciplinary**, clinical. DETE.	**Multidisciplinary**	**Multidisciplinary**

36. It is difficult to see many substantive differences. Admittedly, there is a difference in the proposed length of stay (6 months for the tier 3 with 6 months and 365 days respectively for the two draft NMHSPF elements). As discussed above, the *Western Australian 2015-2025 Plan*, said to be based for the first time on the draft NMHSPF provides for subacute rather than Non-Acute hospital long stays with an average stay of 365 days (i.e. equivalent to Service Element 2.3.3.1).

37. Similarly, the proposed Redlands site was to be adjacent to a hospital campus with a proposed average length of stay of 6 months.

38. The Walker Centre has a typical 6 month length of stay.[40] Dr Kingswell expressed the view that the Walker Centre was to close and that it only treated psychotic patients. Neither is true.[41]

A Blunt Instrument

39. By its nature, trying to place a particular facility into a specific service category or into a specific service element is a process that necessarily involves a comparison of the specific attributes or features of the particular service (e.g. service type or description, age groups, length of stay),[42] which are likely to vary from service to service, against that described in the draft NMHSPF, which is explicitly an attempt to standardise the description of services nationwide.

[40] Exhibit 63, Statement of Phillip Hazell, 5 November 2015, p 10 para 48; see also T25-13 (Dr Fryer); Dr Stathis' discussions indicated a stay of only 3 months and mostly psychotic patients (T24-60 to 61) but that is contrary to Professor Hazell's evidence.
[41] T24-71 (Stathis); T23-17; Exhibit 63, Statement of Phillip Hazell, 5 November 2015, p 11 para 52-54 (re continuation of Walker).
[42] There are, of course, other features. Not all features are described in the tables above.

40. That process is necessarily a blunt instrument and not susceptible to precision or absolutes. As Dr Kingswell explained:

> This is trying to categorise the services across Australia that are provided by various governments and institutions? So, yes, the document is – it's provider and funder agnostic. So it attempts to capture all of the service elements that you would expect to find for a population.[43]

41. The NMHSPF is likely to be a guide rather than prescriptive, with specific choices and attributes left to the health service involved.[44]

Cautions about the use of the draft NMHSPF

Cautions within the NMHSPF

42. It is important to bear in mind the cautions in the draft NMHSPF itself, namely:

    a. "*the NMHSPF will not account for every circumstance or service possibly required by an individual or group, but will allow for more detailed understanding of need for mental health service across a range of service environments*."

    b. "*The NMHSPF will capture the types of care required, but will not define who is best placed to deliver the care. Decisions about service provision will remain the responsibility of each state/ territory and the Australian Government*." [45]

Other Evidence of Caution

43. Dr Kotzé expressed a similar concern in saying that the draft NMHSPF was "*the general map*" and that other processes were involved.[46] Dr Groves described the draft NMHSP as "*still in its developmental stage*"[47] and Professor McGorry described it as a "*work in progress*".[48]

44. And, of course, the Executive Group for the draft NMHSPF have directly advised this Commission that further refinement, validation, sensitivity analysis and testing of the draft NMHSPF was required prior to its distribution for use in real world mental health service planning situations. They also explained that there are recognised technical issues with this version of the NMHSPF.

45. Another reason for caution is the evidence of Professor Brett McDermott that:

> Much of the policy documentation relating to child and youth mental health has no direct impact on facilities such as the BAC. However, there are national and state principles that are clearly relevant. The most relevant, in my opinion, are the delivery of least restrictive care, access to services close to home, the overarching child and youth principle of developmentally appropriate services (that encourage normalisation rather than pathology), and a commitment to service evaluation.[49]

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[43] T13-35.
[44] See the following discussion.
[45] See exhibit 375, the Project Charter at page 92 and exhibit 378, the first Project Communique issued in September 2011; see also exhibit 973, the Senate Report: Fourth interim report 'Mental health: a consensus for action', 8 October 2015 at pp 49-50.
[46] T23-12 at line 5.
[47] Exhibit 58, Statement of Aaron Groves, 21 January 2016, p 36 para 209.
[48] T18-8.
[49] Exhibit 84, Statement of Brett McDermott, 11 November 2015 at p 30 at para 167.

46. Presumably Professor McDermott's view that much of the policy documentation had no direct impact on facilities such as the BAC was related to the relatively small cohort.

Dr Kingswell's Evidence on the force of the draft NMHSPF

47. That evidence is in contradistinction to Dr Kingswell's evidence.

48. Dr Kingswell's evidence was that the draft NMHSPF assumed some national importance as a planning document. He said that, in part at least, it rendered the *Queensland Plan for Mental Health 2007-2017* (QPMH) as obsolete by 2012.[50] No other evidence suggests that the QPMH was obsolete by 2012.

49. Dr Kingswell was frustrated with the ECRG because:

    a. "*they had been asked to constrain their thinking within the National Mental Health Service's planning framework*" and had failed to do so;

    b. that failure had occurred in a context where the NMHSPF was it "*was important to do so in that that was the policy document of all Australian governments*"[51]

    c. he recalled that he sent the ECRG the National Mental Health Services Planning Framework taxonomy and service element descriptions, and so he was not clear why they did not use that language.[52]

50. However, no other evidence suggests that the draft NMHSPF had become a policy document of all Australian governments. In fact, as explained above, the Commonwealth Department of Health has expressly stated that further refinement, validation, sensitivity analysis and testing of the draft NMHSPF was required prior to its distribution for use in real world mental health service planning situations. They also said there are recognised technical issues with this (October 2003) version of the NMHSPF.[53]

51. And Dr Kingswell's evidence on the point is rather undermined by two points. *First*, if the draft NMHSPF was a policy of all Australian governments it is rather odd that the ECRG did not refer to it. After all, the ECRG comprised a very wide membership, including some very senior clinicians. They are likely to have not referred to it because the limited distribution referred to above meant they did not have access to it.

52. *Second*, Dr Kingswell, after saying he had a clear recollection of the sending the NMHSPF taxonomy to Dr Stathis on behalf of the ECRG,[54] and having said that he thought that the NMHSPF was part of the ECRG's terms of reference,[55] he conceded that:

    a. Dr Stathis was not on the ECRG.[56]

    b. It was possible the draft NMHSPF went to the SWAETRI rather than to the ECRG.[57]

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[50] T13-18 to 19.
[51] T13-23.
[52] T13-19.
[53] See above.
[54] T13-29; see also T13-45: "*Well, I'm sure I provided them to Stephen Stathis. Where they went from there, I don't know*."
[55] T13-45: "*I thought it was in their Terms of Reference that they were to be mindful of the National Mental Health Services Planning Framework*."
[56] T13-82; "*But I am obviously mistaken on that point*."
[57] T13-82.

c. Dr Sadler, who was on the ECRG, he knew that Dr Sadler did not have access to the framework documents by 21 May 2013.[58]

53. In fact, a contemporaneous email dated 11 July 2013, and Dr Stathis' evidence, makes it clear that Dr Stathis did not have a copy of the NMHSPF documents at that time.[59]

54. Dr Kingswell did concede that the NMHSPF was under construction,[60] and had modest ambitions,[61] and was not intended to be exhaustive,[62] and was unable to identify any component of the draft NMHSPF, other than Communiques, which was available to the profession.[63]

55. Dr Kingswell was willing to agree that the estimator tool was in draft and needed a lot of work.[64] He said that otherwise it was a complete document.[65] When shown the watermark on the service elements component to the effect "Draft-in-confidence: not for citation" he was willing to agree that: "*Certain elements, yes [are in draft]. Well you can consider the whole thing in draft, but there are some elements of it that are unlikely to change, large chunks of it that are unlikely to change*."[66]

56. In fact, there were significant changes between the service elements component of the draft NMHSPF in November 2012 when compared with the same component in October 2013.

The November 2012 Version

57. A comparison of the November 2012 version of the service elements shows that the relevant categories are different.

Table D: Comparison of November 2012 and October 2013 Service Elements[67]

October 2013 Service Element[68]	**November 2012 Service Elements**[69]
2.3.2 Service Category – Sub-Acute Services (Residential and Hospital or Nursing Home Based)	1.2 Sub-Acute Services (same 3 categories & also includes BAC as an example service)
2.3.2.1 Service Element – Step Up/Step Down Youth Residential (Target age 12-17 or 16-24; average length of stay: 21 days)	1.2.2 Sub-Acute Step Up/Step Down Service – Youth (Target age 16-24; average length of stay: 28 days)
2.3.2.2 Service Element – Step Up/Step Down Adult Residential	1.2.1 Sub-Acute Step Up/Step Down Service – Adults (similar)
2.3.2.3 Service Element – Rehabilitation Adult and Older Adult (Residential) (not gazetted, adults and	*No similar element (but see next element)*

[58] T13-31.
[59] T24-90.
[60] T13-32.
[61] T13-33.
[62] T13-33; T13-37: "*Well, it – it can't be exhaustive but it – but it is many, not all. And when it says it's not exhaustive, it's not exhaustive because there are significant differences between jurisdictions particularly around…*"
[63] T13-32.
[64] T13-32.
[65] T13-32.
[66] T13-33.
[67] The comparison is limited to bed based sub-acute and non-acute services. There are other differences in the taxonomy.
[68] Ex 232.
[69] Ex 289.

October 2013 Service Element[68]	**November 2012 Service Elements**[69]
older adults, average 120 days with an expected length of stay of no more than 180 days (6 months).	
2.3.2.4 Service Element – Sub-Acute Older Adult 65+ (Hospital) (gazetted, older adults 64+, **35** days)	1.2.3 Sub-Acute Step Up/Step Down Service – Older People (*similar* - gazetted, older adults +64, **30-50** days)
2.3.2.5 Service Element – Sub-Acute Intensive Care Service (Hospital) (gazetted, adults, older adults and selected young people with special needs, 120 days with an expected maximum stay of less than 180 days, i.e. 6 months)	1.2.6 Sub-Acute Intensive Care Services (*similar* - gazetted, adults, older adults and selected young people with special needs, stay of less than 6 months)
No equivalent narrow element –but see above for wide adults, older adults and youth combine element	1.2.4 Sub-Acute Rehabilitation – Youth (not gazetted, young people 13-18, 66 days with a maximum of 6 months)
No equivalent narrow element –but see above for wide adults, older adults and youth combine element	1.2.5 Sub-Acute Rehabilitation – Adults (not gazetted, adults 18 to 64, expected stay of up to 6 months)
2.3.3 Service Category – Non-Acute Extended Treatment Services (Residential and Hospital or Nursing Home Based)	1.3 Non-Acute Services
2.3.3.1 Non Acute Intensive Care Service (Hospital) (365 days)	1.3.1 Non-Acute Intensive Care Services (Hospital) – *similar except the November 2012 version has this as the length of stay*: Average 792 days, median 537 days. 37% of all admissions had a LOS of less than 1 year.

58. That illustrates some differences in the taxonomy from the November 2012 version and the October 2012 version. Presumably Dr Kingswell's evidence (discussed below) that the tier 3 recommended by the ECRG was at odds with the National Mental Health Services Planning Framework is based on the November 2012 version. However, as explained below, there is some difficulty ascertaining exactly why that is so. Certainly, Dr Kingswell's evidence is not clear about it.

59. It is now necessary to turn to Dr Kingswell's use of the draft NMHSPF.

Dr Kingswell's Use of the Draft NMHSPF

Dr Kingswell's Written Evidence

60. Dr Kingswell's written evidence to the inquiry was that, in his view, there were four main reasons why the BAC needed to close, and that he expressed those reasons to other members of the Planning Group.[70] The first of those reasons was:

> The centre had been operated as a therapeutic community for many years and, as such, it was a highly controversial and, some would argue, outdated, model of care. No other jurisdiction in Australia runs a centre where adolescents are hospitalised for years within a standalone psychiatric institution. A number of reviews over the years had

[70] Exhibit 68, Statement of William Kingswell, 21 October 2015, p 7 para 20(v).

> recommended that the BAC be reformed or closed and replaced with alternative services but these had not been actioned.

61. There, in that part of his evidence, Dr Kingswell does not refer to the draft NMHSPF.

62. However, in his email to Dr Stathis on 11 July 2013 Dr Kingswell said:

> The tier 3 recommended by the ECRG is at odds with the National Mental Health Services Planning Framework and will struggle to attract attention in the ABF model priority for state funding.[71]

63. Similarly, on 21 May 2013 Dr Kingswell told Dr Sadler:

> I do not pretend to be a Child trained psychiatrist.
>
> You need to persuade your colleagues on the NMHSPF expert ref grp that this is a model that should prevail.[72]

64. The view that the tier 3 recommended by the ECRG was "*at odds*" with the (draft) NMHSPF is a contention that the ECRG's recommendation was contrary to, or disagreed with, the (draft) NMHSPF.

Dr Cleary's Evidence & Other Evidence

65. Dr Cleary's evidence to the inquiry was that Dr Kingswell advised him that the continuation of the Redlands project was not appropriate for a range of reasons including:

> the proposed unit continued a model of care that was now not considered contemporary. Contemporary models were moving from institutional care to community based care. Dr Kingswell indicated that there was work being undertaken nationally that indicated that institutional models of care were not considered contemporary under the draft 'National Mental Health Service Planning Framework'.[73]

66. Other witnesses appear to have relied on Dr Kingswell's view that the BAC or Redlands models were contrary to the draft NMHSPF. For example, Ms Kelly's email of 8 November 2012, prepared for the purposes of a brief to the Minister's office, states that:

> 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 as per the current model at Barrett. The Framework does include subacute community based services for adolescents
>
> Planning is required to align with the National Mental Health Service Planning Framework that recommends subacute community based services for adolescents[74]

67. Ms Kelly said that she assumes the source of that information was "*someone like Dr Kingswell*".[75]

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[71] Exhibit 759; see also Transcript, William Kingswell, 24 February 2016, p 13-28.
[72] Exhibit 451.
[73] Statement of Michael Cleary, 21 December 2015, p 7 at para 27 (exhibit 40)
[74] Exhibit 437.
[75] T11-33.

Dr Kingswell's Testimony

68. Precisely why Dr Kingswell maintained that the tier 3 proposed by the ECRG was 'at odds' with the draft NMHSPF was never clear from his evidence. When pressed about the issue he appeared to go in three separate directions.

First Direction: The A3 Spreadsheet

69. *First*, when asked about the draft NMHSPF Dr Kingswell referred not to the draft NMHSPF itself but to the A3 spreadsheet which became exhibit 234:

> And so if you **go to the A3** spreadsheet with the taxonomy set out in a flow diagram type form, you will find that what it envisaged for child and youth in the – for adolescents, sorry – what it envisaged for adolescents in the extended treatment space was the Step Up Step Down units.[76] (our emphasis)

70. Similarly:

> All they're saying they're examples of this service which is one of the categories in this framework document? So I think what you need to do is **go to the A3** which I've referred you to and have a look at how the services under youth fall out and you will find that the Barrett Adolescent Centre is not there. The YPARC is there. So all I'm saying is these were the – the services that were available for them to consider as potential models to be included within the service elements. **This document is not telling you that the Barrett Adolescent Centre is a model that would fall out of this framework**.[77] (our emphasis)

71. And again:

> And where do we find that? I'll happily provide you the A3 taxonomy – you know, I'm not sure when.
>
> Alright? I can provide that for you but I can certainly…[78]

72. However, an inspection of the A3 document discloses the service elements referred to above, namely Subacute Intensive Care Service (Hospital). When it was put to Dr Kingswell that that service element he gave this rather lukewarm evidence:

> And the last category Subacute Intensive Care Service (Hospital) – that would cover the Barrett Adolescent Centre? Well, that's not my understanding. My understanding is that it was never envisaged that this sub-category would include and child and youth element.
>
> And where did you get that understanding from? From the planning team.
>
> But we obviously can separately look at the word content of this sub-category, can't we? Well, I'd need to go to the service element descriptor to see what's intended by subacute intensive care service but I was not ever – my attention was never brought to that being intended for adolescents.[79]

73. That evidence makes clear that Dr Kingswell's stance that the tier 3 service elements are not comprehended by the draft NMHSPF because of an understanding he gained from the planning team. He also complains that his attention was never brought to that service element being

[76] T13-35.
[77] T13-37.
[78] T13-38.
[79] T13-48 to 49.

intended for adolescents. In other words, Dr Kingswell's view seems to be based on unspecified conversations and on the fact that he was not told the service element covered adolescents.

Second Direction: Sources

74. *Second*, under friendly cross-examination, Dr Kingswell sought to rely on the sources listed in the service element document:

> No. Two hundred and sixty-eight? This looks like it. Yes.
>
> Can you read that to yourself, please. Not out loud. Just familiarise yourself with it. I understood in your evidence earlier – your evidence was that one would need to look at the descriptor to verify your statements? Yes.
>
> And I'm asking you to look at that and confirm if this is the descriptor? Yes, yes.
>
> And if you look down at the sources – if the witness could be shown the bottom of the document if that's convenient. Are these the sources upon which the model is based? Tell me if I'm wrong? Yes.
>
> And your evidence that the Barrett Centre was no part of the subacute intensive care hospital model is – are you reassured in that view by the absence of that line item in the heading Sources? Yes.
>
> Your evidence is that, in fact, the National Planning Framework Model specifically excluded facilities like the Barrett Centre from the models of care that it endorsed. Is that right? Yes. I think this document is very important. It anticipates young people with psychotic and treatment-resistant illnesses. It anticipates a length of stay of less than six months, and it looks very close to what the Walker unit would be in New South Wales that Dr Hazell runs.
>
> Yes, yes. And why do you draw attention to the target population being persons who have the symptoms that are identified under the – is it the service delivered element that you're looking at? No. I'm so sorry. It's diagnostic profile? Diagnostic profile there.[80]

75. There are two problems with that evidence. The 'sources' listed at page 268 of the October 2013 version of the services element document are plainly the documents relied on by the authors of this section of the draft NMHSPF. Those sources appear confined to secure units and are unlikely to be exhaustive. And Dr Kingswell does not say he read them or how or why those sources demonstrate that the BAC is excluded.

76. And, Dr Kingswell seems to assume that the diagnostic profile only specifies schizophrenia and psychosis. In fact, the diagnostic profile is much wider:

> Primary diagnoses usually include schizophrenia, psychosis or severe mood illnesses. Also may have complex presentations including issues with personality illness or exacerbations of underlying personality traits, drug and alcohol illnesses, complex trauma and clinically significant deficits in psychosocial functioning. Associated issues of behaviour and risk which indicate a need for rehabilitation include severely disorganised behaviour leading to difficulty in managing activities of daily living,

[80] T13-64.

> impaired impulse control, vulnerability, ongoing risk of aggression, and significant risk of self harm.[81]

77. In any event, as Professor Hazell's statement makes clear, the Walker Centre does not just accept patients with schizophrenia and psychosis:

> Patients who are admitted to the Walker unit fall into four main groups. Namely, those with:
>
> (a) unremitting psychosis;
>
> (b) unremitting mood disorder - generally bipolar, rather than unipolar depression;
>
> (c) neurodevelopmental disorders such as autism, usually complicated by intercurrent psychosis or mood disorder; or
>
> (d) unremitting/unrelenting suicidality arising from any cause.
>
> Typically, at any one time, two of the 12 patients of the Walker unit have an emerging borderline personality disorder. Staff try to cap the number of such admissions at two. This is because a higher number of such patients has been shown to create problems in terms of managing the ward milieu.[82]

Third Direction: Stand-alone Hospitals

78. *Third*, Dr Kingswell retreated to what he had understood from others about stand-alone hospitals:

> Yes. I understand? I mean, just keep in mind that I rely on the views of many professionals.
>
> I understand. Yes? But my understanding is that there is a belief within the child and youth sector that enduring personality disorder, particularly when it's associated with significant self-harm and other problematic behaviours, is not well-treated in these services. In fact, it's likely to be worsened by that.
>
> It requires an acute inpatient admission? Well, an acute inpatient admission or perhaps even this where, you know, when there's dislocation from family and social connections that you might need a longer length of stay.
>
> I understand? But institutional care in a stand-alone hospital, I understand from the advice provided to me, is not what people would view as being a appropriate, contemporary model of care.[83]

79. Earlier in his evidence Dr Kingswell said something similar:

> Some patients need to be dealt with in bed-based facilities? Yes. Absolutely. But I'm not – yeah. Absolutely. But you misunderstand. Bed-based facilities can be

[81] Exhibit 233 at page 268.
[82] Exhibit 63, Statement of Phillip Hazell, 5 November 2015, p 8 para 36, 37.
[83] T13-64.

> [T13-38] regional. They don't need to be – you know, the concentration of people in stand-alone hospitals has been criticised by Burdekin forward at every level of government.[84]

80. And so, conspicuous by its absence from Dr Kingswell's evidence is any claim that the draft NMHSPF actually excludes tier 3 facilities. Dr Kingswell was content to justify his views by reference to what he understood from the planning team and from the fact that his attention was never directed to that a service element was intended for adolescents, and perhaps from the 'sources' in the draft NMHSPF, or from what he understood from advice to him about stand-alone hospitals.

81. Others, including Dr Cleary, relied on Dr Kingswell's strong view that the tier 3 facility was 'at odds' with the draft NMHSPF. But, Dr Kingswell's own view certainly does not appear to be based on the draft NMHSPF document itself but is based on illusive conversations with others.

82. Incidentally, Dr Kingswell also seemed to get confused in his evidence regarding the taxonomy:

> And another component of that suite of services is subacute beds? Step Up Step Down and subacute get mixed up in this space. My understanding is that they're the same.[85]

Dr Kotzé and Dr Groves

Dr Groves

83. Dr Groves' evidence is that the BAC as a service type fits within the category of subacute bed-based services (residential and hospital or nursing home based).[86] However, he does note that the model of service requires amendment.

Dr Kotzé

84. Dr Kotzé's evidence is a little less clear.

85. Dr Kotzé also appeared to rely on unspecified conversations in forming an assessment of the BAC:

> So in your statement, when you say that the Barrett Centre was not considered to operate a contemporary model of care, was that your opinion at the time or was this something that had been communicated to you by someone else during the development of the framework? It wasn't my opinion. In developing the framework, there was very detailed consideration of the evidence, but also models currently operating in the jurisdictions so that, for example, there was discussion about units in other states. There were presentations, for example, detailed presentations about some service units. There were site visits conducted by the project team to certain units. So it was during **the process of those discussions**, and a component of the planning process, which was looking at what was currently available, and, if you like, tagging them to particular categories of – of service within the taxonomy. **It was during that process that I came to hear about the Barrett and to understand it was not operating on a contemporary model of care**.

[84] T13-37 to 38.
[85] T13-56.
[86] Exhibit 58, Statement of Aaron Groves, 21 January 2016, p 36 para 211.

> You referred to site visits. Did you have a site visit to the Barrett Centre? No, I didn't. No.
>
> And so your knowledge – you had some knowledge then about the Barrett Centre model of care at the time? As a result of those discussions, yeah.
>
> But only through speaking to ? Yes.
>
> …particular people? Yeah.[87] (our emphasis)

86. Dr Kotzé acknowledged that the BAC was included in the draft NMHSPF as example, but she nevertheless contended that the BAC was not contemporary (Of course, Dr Kingswell had expressed the view to Dr Cleary that the Redlands model, and institutional models, were not considered contemporary under the draft NMHSPF).[88] Dr Kotzé expressed herself in this way:

> So if the Barrett Centre was considered to not operate a contemporary model of care – which is what I understand you say in you statement – why is it included in the framework as an example service in the description for the subacute services service category? What that means is that you could take any service example and find a compartment within the framework to put it, that it's an example of that kind of service. It's not – it doesn't go to the value of that service in providing a contemporary model of care.
>
> Okay. So it's just ? So what it says at a very high level is that is where you would put – that's the compartment you'd assign that service to.[89]

87. Ultimately, Dr Kotzé was prepared to accept that the draft NMHSPF supports a bed-based service:

> Do you agree that the framework doesn't support a bed-based service? Look, it does. I mean, the framework – the framework supports that there are some young people who would benefit from longer stays in hospital. Now, if you just take the Walker Unit, its average length of stay is in the order of 90 days. If you add the leave beds in, it's in the order of 135 days. But its median length of stay, so the middle point of the frequency distribution, is actually 42 days. So, in fact, it recognises – and – and that's recognised within the model. There are some young people who would benefit from that longer – longer stay. What the model – and – and that – and that's, really, most particularly young people with those enduring and relapsing mental illnesses like the psychoses and the affective disorders. What the model – what you won't find in the model is, for example, the very long lengths of stay under the Mental Health Act. You also will not find, for example, long length of stay for people with eating disorders. Now, you have to know where to find that in – in the model, but if you take that particular group you won't find that. You also won't find, for example, extended inpatient stay supported for the group of people who have strong emotional dysregulation, which is the borderline personality disorder group in adult – in adulthood. You wouldn't actually go looking for that in this model. You would find that information, for example, from the NHMRC Guidelines
>
> [T23-18] for Borderline Personality Disorders. So there's quite a lot of unpicking that has to be done beneath the general statements.[90]

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[87] T23-5.
[88] Exhibit 40, Statement of Michael Cleary, 21 December 2015, p 7, para 27.
[89] T23-8.
[90] T23-17 to 18; see also T23-45.

88. Dr Kotzé was concerned about whether particular disorders, such as eating disorders, were covered by the draft NMHSPF, but she accepted the services are part of the taxonomy. [91]

Conclusions

89. The following conclusions can be drawn.

90. In 2012 and 2013 the draft NMNHSPF was a draft that was a work in progress. It remains a draft and not yet a policy document.

91. The document has not yet been released to the profession.

92. The draft will be a guide that is not intended to exhaustively specify the various services which ought to be available, or those which ought not be available.

93. In any event, on a proper reading of the draft NMHSPF, an extended medium length stay sub-acute unit is comprehended by either of these service elements: Sub-Acute Intensive Care Service – Hospital (Service Element 2.3.2.5) or Non-Acute – Intensive Care Service – Hospital (Service Element 2.3.3.1).

94. Dr Kingswell's reliance on the NMHSPF was likely to be based on conversations or assumptions he has made and was misplaced.

[91] Ibid.