

Queensland Government Response

Barrett Adolescent Centre Commission of Inquiry Report

Foreword

In coming into office, our Government committed to working closely with all Queenslanders to create jobs and a diverse economy, deliver frontline services, protect the environment and most importantly to build safe, caring and connected communities. Underpinning these directions is a commitment to integrity, accountability and consultation.

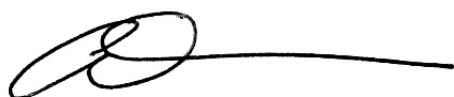
Part of this commitment is a willingness to examine the decisions and processes of government that have a significant impact on Queenslanders. This is about being open and honest with the Queensland community and being willing to learn lessons from the past to improve future services. For this reason the Government committed to an inquiry into the closure of the Barrett Adolescent Centre: a decision which had a significant impact on young people living with complex mental health conditions and their families.

The Government would like to thank the former patients of the Barrett Adolescent Centre and their families for being willing to share their personal stories with the Commission of Inquiry. These can be difficult and confronting conversations to have, without which an effective review would not have been possible. We want to assure the Barrett community that the Government has heard their concerns and will learn the lessons of the past.


It is also important to recognise the impact that the closure and subsequent Inquiry had on current and former staff of Health and Hospital Services and the Department of Health. Our staff come to work each day to do their best for Queenslanders and it is important that we recognise their efforts and treat them with dignity and respect.

The Government would also like to acknowledge the dedication and the thorough manner in which the Commissioner, the Honourable Margaret Wilson QC, and her staff conducted this Inquiry. This Inquiry was a challenging task which required a high level of sensitivity and compassion and we thank the Commissioner for the way in which she presided over the Inquiry and for her report.

Finally this report, its findings and recommendations may cause distress for some people due to their personal circumstances and history. It is important that we support each other through what for some people may be a difficult journey. If you need help or support contact Lifeline: 13 11 14, Beyondblue: 1300 22 4636, Kids Helpline: 1800 55 1800 (24/7 crisis support), or headspace: 1800 650 890. Alternatively please contact 13HEALTH for information and advice.



Anastacia Palaszczuk MP
Premier and Minister for the Arts



Cameron Dick MP
Minister for Health and Minister for Ambulance Services

Background

On 6 August 2013, the then Minister for Health announced that the Barrett Adolescent Centre was to close.

The Barrett Adolescent Centre was Queensland's only long-term residential mental health facility for adolescents at risk of suicide. Following the closure of the centre in January 2014, three former patients died by suspected suicide, which led to widespread community concern about the processes and supports offered to patients around the closure. While it is the Coroner's role to investigate these deaths in detail, these deaths and resulting community concern led the current Government to make an election commitment to establish the Barrett Adolescent Centre Commission of Inquiry (BACCOI).

On 14 September 2015 the Barrett Adolescent Centre Commission of Inquiry (BACCOI) was established. Under the provisions of the *Commissions of Inquiry Act 1950* the Governor in Council appointed the Honourable Margaret Wilson QC (the Commissioner) to make a full and careful inquiry in an open and independent manner with respect to:

- (a) the decision to close the Barrett Adolescent Centre (BAC) announced on 6 August 2013 by the then Minister for Health, including with respect to the cessation of the on-site integrated education program (the closure decision);
- (b) the bases for the closure decision;
- (c) without limiting paragraphs (a) and (b) above—the information, material, advice, processes, considerations and recommendations that related to or informed the closure decision and the decision-making process related to the closure decision;
- (d) for BAC patients transitioned to alternative care arrangements in association with the closure or anticipated closure, whether before or after the closure announcement (transition clients):
 - i. how care, support, service quality and safety risks were identified, assessed, planned for, managed and implemented before and after the closure (transition arrangements); and
 - ii. the adequacy of the transition arrangements;
- (e) the adequacy of the care, support and services that were provided to transition clients and their families;
- (f) the adequacy of support to BAC staff in relation to the closure and transitioning arrangements for transition clients;
- (g) any alternative for the replacement of BAC that was considered, the bases for the alternative not having been adopted, and any other alternatives that ought to have been considered;
- (h) without limiting paragraphs (d)-(g) above—the information, material, advice, processes, considerations and recommendations that related to or informed the transition arrangements and other matters referred to in paragraphs (d)-(g) above;
- (i) whether any contraventions of the Mental Health Act 2000 or other Acts, regulations or directives have occurred with regard to patient safety and confidentiality.

The Commissioner provided the Barrett Adolescent Centre Commission of Inquiry Report (the Report) to the Premier on 24 June 2016.

What has already changed

The Queensland Government recognised that change was needed in how health services were being delivered whilst being mindful that the BACCOI was likely to make specific recommendations regarding mental health services and in particular mental health services for adolescents.

Changes made to date include:

- A new senior leadership team in the Department of Health
- New board appointments across many Hospital and Health Services
- An independent review regarding the Department of Health's structure, governance arrangements and organisational capability has been conducted (The Hunter Review). The Hunter review identified 19 recommendations of which all have been or are being implemented. In response to these recommendations the Department of Health has:
 - Developed *Advancing health 2026* a vision and purpose for Queensland's health system which clearly articulates the importance of a systems leadership approach to achieving improved health outcomes for patients and health care consumers. (Recommendation 1)
 - Established a 'Charter of Responsibility' agreed between the Department of health and Hospital and Health Services setting out agreed roles and responsibilities for each (Recommendation 2)
 - Implemented new governance arrangements for both Queensland's health system and the Department of Health with a System Leadership Executive taking overarching responsibility for the health system (Recommendation 11)
 - Established a system wide risk management framework including escalation procedures, responsibilities and mitigation approaches (Recommendation 12)
 - Completed a review of the current performance management framework (Recommendation 13)
 - Progressed a commitment to re-establish a Patient Safety and Quality Improvement Services with 20 new positions

The Government through the Department of Health has already been working to ensure young people with severe and complex mental illness are supported with appropriate clinical care and treatment.

This has included working with the Children’s Health Queensland Hospital and Health Service to expand the Adolescent Mental Health Extended Treatment Initiative (AHMETI) to deliver adolescent extended treatment (AET) services across the State, so that, when appropriate, young people have the opportunity to stay close to home and remain vitally supported by their friends and family.

The additional AET services established to date include:

- nine Assertive Mobile Youth Outreach Services across Queensland locations;
- a new community based day program in North Brisbane;
- four youth residential rehabilitation services (in Townsville, Greenslopes, and Cairns); and
- availability of sub-acute mental health services for young people at the Lady Cilento Children’s Hospital on demand.

Further AET services currently being established include an additional youth residential rehabilitation service for the north side of Brisbane by December 2016, and a Youth Prevention and Recovery Care (based on the Step Up Step Down Unit model of service), for Cairns to be operational by November 2017.

However, it is recognised there is a small group of young people with very severe and complex mental illness who may require care not able to be offered in the community and may require specialist bed-based care for extended treatment and rehabilitation.

The Report

Given the sensitive and confidential nature of much of the evidence heard by the Barrett Adolescent Centre Commission of Inquiry, the report was presented in two volumes. The first concerns matters relating to the decision to close the Barrett Adolescent Centre, and systemic issues affecting patients. The second relates to individual patients and their transition arrangements and is therefore highly confidential.

The Commissioner recommended that access to the second volume be strictly limited and controlled. Government agrees that access to the second volume should be restricted for those reasons.

Furthermore, consideration of the Commissioner’s advice to Government to reduce the risk of unintended consequences from the release of the report has taken place. As such, the Government, in publicly releasing the first volume of the report, has redacted any personal information that could identify patients or their families, after careful consideration by Government of the need to protect patient confidentiality. The redacted report and

Government response can be found at:

<http://www.thepremier.qld.gov.au/newsroom/barrett-adolescent-centre-report.aspx>.

Summary of Recommendations and Findings, Conclusions and Comments

The Government accepts in principle the six recommendations of the Commission of Inquiry. In summary the recommendations are to:

- Review legislation that establishes the devolved Hospital and Health Service model in Queensland Health;
- Improve Service Agreements Queensland Health uses to contract services provided by Non-Government Organisations;
- Improve the availability and use of evaluations to inform clinical interventions in mental health;
- Consider a new building in south-east Queensland offering a range of mental health services for young people, including bed-based services;
- Improve transitions for adolescents moving into adult services; and
- Improve co-ordination between services designed to support young people who have both an intellectual disability and mental illness.

In addition to the recommendations, the Commission made a number of findings, conclusions and comments. The Commission identifies that overall, the individual patient transition arrangements on the closure of the Barrett were adequate. However, the Commission made criticisms of governance and decision-making processes associated with closing Barrett and cessation of and redirection of funding from the Redlands project.

Queensland Government Response

This table provides a response to the specific recommendations detailed in the Barrett Adolescent Centre Commission of Inquiry Report.

No	Recommendation	Response
1	<p>Review legislation that establishes the devolved Hospital and Health Service model in Queensland Health</p> <p>The Commission recommends that:</p> <p>a. a review of the devolution of responsibilities to Hospital and Health Services under the Hospital and Health Boards Act 2011 (Qld) be undertaken by a</p>	<p>Accepted</p> <p>The Queensland Government will engage an independent party by 30 September 2016 to review the progress of implementation of the Hunter Review with regard to the delivery of statewide services.</p>

	<p>party independent of Queensland Health, the HHSs and the Queensland Mental Health Commission;</p> <p>b. the review be commenced by 30 September 2016; and</p> <p>c. the review be completed within six months of its commencement.</p>	<p>This will include a focus on the functions and role of the Department of Health as a system manager and the role of Hospital and Health Services as statutory bodies with responsibility for delivering statewide services across local communities through service agreements entered into with the Department.</p> <p>This review will be completed by 31 March 2017.</p>
2	<p>Improve Service Agreements Queensland Health uses to contract services provided by Non-Government Organisations</p> <p>The Commission recommends that service agreements be carefully drawn to ensure they deal explicitly and sufficiently with matters such as:</p> <p>a. minimum standards/or staff employed to work in a particular facility;</p> <p>b. which entity may prescribe and monitor compliance with those standards;</p> <p>c. which entity may prescribe the extent and quality of the services to be provided by the NGO;</p> <p>d. which entity may monitor the quality of service delivery and give ongoing directions about it;</p> <p>e. termination of the service agreement, whether by effluxion of time, for breach of contract, because of policy changes, or any other reason.</p>	<p>Accepted</p> <p>The Queensland Government will review the Service Agreement arrangements for all Non-Government Organisations providing health services. This review will focus on the effectiveness of quality and safety provisions, performance monitoring arrangements and the capacity to respond to poor performance or significant events. The review will be completed by June 2017.</p>
3	<p>Improve the availability and use of evaluations to inform clinical interventions in mental health</p> <p>The Commission recommends:</p> <p>a. that the Queensland Centre for Mental Health Research investigate the extent of the clinical evaluation of mental health interventions;</p>	<p>Accepted</p> <p>The Queensland Government will commission the Queensland Centre for Mental Health Research (QCMHR) to identify existing clinical and program evaluation frameworks for extended treatment for adolescents and young</p>

	<p>b. that the extent of clinical evaluation of mental health interventions be referred to the Council of Australian Governments (COAG) for possible development of a coordinated nationwide approach;</p> <p>c. the provision of funding to undertake ongoing in, and where practicable, independent evaluation and research;</p> <p>d. that services and/or independent evaluators be well resourced to enable research results to be published in a timely manner; and</p> <p>e. that service agreements relating to the delivery of Adolescent Mental Health Extended Treatment Initiative (AMHETI) services include a requirement to conduct ongoing evaluation and that this expectation be matched by targeted ongoing funding.</p>	<p>people with severe and complex mental health issues. This will inform the development of an ongoing evaluation process and approach, including data analysis and reporting, across AMHETI services.</p> <p>The Premier will provide the findings and recommendations to COAG for consideration.</p>
4	<p>Consider a new building in south-east Queensland offering a range of mental health services for young people, including bed-based services</p> <p>The Commission recommends that consideration be given to the establishment of a bed-based extended treatment and rehabilitation unit for young people with severe and complex mental illness, as part of an adolescent non-acute mental health facility, on or adjacent to, the campus of a general hospital in South-East Queensland.</p> <p>The Commission envisages that such a facility might encompass:</p> <ul style="list-style-type: none"> • a bed-based extended treatment and rehabilitation unit for 10-15 inpatients • the local day treatment centre (for another 10 patients) • supported accommodation (for day patients) • and be the base for the local AMYOS service 	<p>Accepted</p> <p>The Queensland Government will build a new bed-based treatment facility in south-east Queensland for young people with complex mental health issues, and ensure patients have access to an integrated education/vocational training program.</p> <p>The size, location and model of care provided in this facility will be informed by current research and consultation with health consumers, including families from the former Barrett Adolescent Centre.</p>

	<p>The bed-based extended treatment and rehabilitation unit should have the following features:</p> <ul style="list-style-type: none"> • a non-medicalised environment, at ground level • a multi-disciplinary approach • careful and early discharge planning, from the time of admission • a six month target length of stay • a contemporary suite of interventions • an integrated education/vocational training program • flexibility with upper age limits • admission of young people from all over Queensland. <p>The Commission does not suggest that the BAC should be replicated.</p>	
5	<p>Improve transitions for adolescents moving into adult services</p> <p>The Commission recommends:</p> <ol style="list-style-type: none"> a. that a review of the lack of alignment of adolescent and adult mental health services be undertaken by a party independent of Queensland Health, the HHSs and the Queensland Mental Health Commission; and b. that lack of alignment of adolescent and adult mental health services be referred also to COAG for possible development of a coordinated nationwide approach. 	<p>Accepted</p> <p>The Queensland Government will engage an independent reviewer to review the alignment and transition arrangements between adolescent and adult mental health services.</p> <p>The Premier will provide the findings and recommendations to COAG for consideration.</p>
6	<p>Improve co-ordination between services designed to support young people who have both an intellectual disability and mental illness</p> <p>The Commission endorses the recommendations of the Process Review Report undertaken by the Centre of Excellence for Clinical Innovation and Behaviour Support,</p>	<p>Accepted</p> <p>The Queensland Government will undertake services mapping and review Guidelines for Collaboration between Queensland Health – Mental Health Services, Disability Services</p>

	<p>Department of Communities, Child Safety and Disability Services, namely:</p> <ul style="list-style-type: none"> a. that the Guidelines for Collaboration between Queensland Health – Mental Health Services, Disability Services Queensland and Funded Disability Service Providers be reviewed and revised b. that the need for joint transition planning be addressed c. that comprehensive risk assessment and post-discharge follow up responsibilities of the discharging organisation be included in the joint transition planning <p>The Commission recommends also:</p> <ul style="list-style-type: none"> d. that those Guidelines deal expressly with the respective responsibilities of Queensland Health, Children’s Health Queensland HHS and local Hospital and Health Services in collaborating with Disability Services Queensland and Funded Disability Service Providers e. that a service mapping exercise be undertaken to identify what services are needed 	<p>Queensland and Funded Disability Service Providers.</p> <p>This review will have regard to introduction of the National Disability Insurance Scheme and the role and function of the Department of Health, Hospital and Health Services, the Department of Communities, Child Safety and Disability Services/ National Disability Insurance Agency and Non-government organisations. The revised guidelines will include reference to transition and care-coordination arrangements to ensure continuity of care for clients.</p>
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Queensland Government’s summary of Commission’s Findings, Conclusions and Comments

Governance and decision-making processes

The Commission was critical about governance and decision-making processes, noting no one person or entity assumed responsibility and accountability for the processes of the decision-making about the closure of Barrett.

The Commission also made criticisms regarding systemic issues associated with the cessation of and redirection of funding from the Redlands project, which was originally planned as a replacement facility for Barrett. The Commission found in particular that the decision to close Barrett did not properly assess and analyse relevant factors, particularly in the context of consultation during the relevant briefing processes. The Commission determined that the reasons provided for the decision do not support closure, but rather support the need for a review and update of the appropriate model of care and consideration of a new or replacement facility or location. Other criticisms relate to over-reliance on views of some key

individuals, inadequate briefing notes, record keeping and communication with patients, families and staff.

The Commission found that the former Minister for Health's decision to redirect funding from the Redlands project to address an emergent issue with rural hospitals, was within his discretion to make, but that he had not been adequately advised.

Appropriate consultation with families

The Commission found that consultation with Barrett families and consumers after the closure of Barrett was not ideal. Beyond the involvement of carer and consumer representatives on the ECRG, there was no evidence of any two-way consultation with Barrett families and consumers. There was also no evidence of a process for receiving the views of patients, families and carers, and therefore no scope for those views to influence the decision-making about the Barrett.

Other issues

The Public Service Commission is providing Government with advice in relation to the adverse commentary the Commission made about individual Government employees to assist in determining whether disciplinary or any other action is required to be taken.

Next steps

In the coming months the Government will be developing detailed implementation plans to put into effect the Government's response to the Commission's recommendations.

Effective and inclusive consultation arrangements will be put in place with stakeholders. Health Consumers Queensland will play an important role in supporting these consultation arrangements, and ensuring that a wide range of consumers have a say in future changes resulting from the implementation of the Commission of Inquiry's report recommendations.

Former patients of the Barrett Adolescent Centre and their families will have an important role to play in the consultation processes.

Barrett Adolescent Centre Commission of Inquiry

Terms of Reference

Commissions of Inquiry Order (No. 4) 2015

Short title

1. THIS Order in Council may be cited as the *Commissions of Inquiry Order (No. 4) 2015*.

Commencement

2. THIS Order in Council commences on 14 September 2015.

Appointment of Commission

3. UNDER the provisions of the *Commissions of Inquiry Act 1950* the Governor in Council hereby appoints the Honourable Margaret Wilson QC from 14 September 2015 to make full and careful inquiry in an open and independent manner with respect to the following matters:

- a. the decision to close the Barrett Adolescent Centre (*BAC*) announced on 6 August 2013 by the then Minister for Health, including with respect to the cessation of the on-site integrated education program (the *closure decision*);
- b. the bases for the closure decision;
- c. without limiting paragraphs (a) and (b) above—the information, material, advice, processes, considerations and recommendations that related to or informed the closure decision and the decision-making process related to the closure decision;
- d. for BAC patients transitioned to alternative care arrangements in association with the closure or anticipated closure, whether before or after the closure announcement (*transition clients*):
 - i. how care, support, service quality and safety risks were identified, assessed, planned for, managed and implemented before and after the closure (*transition arrangements*); and
 - ii. the adequacy of the transition arrangements;
- e. the adequacy of the care, support and services that were provided to transition clients and their families;
- f. the adequacy of support to BAC staff in relation to the closure and transitioning arrangements for transition clients;
- g. any alternative for the replacement of BAC that was considered, the bases for the alternative not having been adopted, and any other alternatives that ought to have been considered;
- h. without limiting paragraphs (d)-(g) above—the information, material, advice, processes, considerations and recommendations that related to or informed the transition arrangements and other matters referred to in paragraphs (d)-(g) above;

- i. whether any contraventions of the *Mental Health Act 2000* or other Acts, regulations or directives have occurred with regard to patient safety and confidentiality.

4. THE Commissioner may make any other recommendations arising out of the evidence, considerations or findings of the inquiry in relation to the matters set out in paragraphs 3(a) to (i) above that the Commissioner considers appropriate, including for clinically appropriate models of care for intensive mental health services to young people with severe and complex mental illness.

Commission to report

5. AND directs that the Commissioner make full and faithful report and recommendations on the aforesaid subject matter of inquiry, and transmit the same to the Honourable the Premier by 14 January 2016. [Extended to 24 June, 2016 by *Commissions of Inquiry Amendment Order (No. 3) 2015*, made by the Governor in Council on 10 December 2015.]

Application of Act

6. THE provisions of the *Commissions of Inquiry Act 1950* shall be applicable for the purposes of this inquiry except for section 19C – Authority to use listening devices.

Conduct of Inquiry

7. THE Commissioner may hold public and private hearings in such a manner and in such locations as may be necessary and convenient.

Endnotes

1. Made by the Governor in Council on 16 July 2015.
2. Notified in the Gazette on 17 July 2015.
3. Not required to be laid before the Legislative Assembly.
4. The administering agency is the Department of Justice and Attorney-General.