Oaths Act 1867

Statutory Declaration

QUEENSLAND
TO WIT

WITNESS STATEMENT OF AMELIA JANE CALLAGHAN

I, **AMELIA JANE CALLAGHAN** in the State of Queensland provide this Witness Statement in response to questions (reflected in italics) asked of me by the Barrett Adolescent Centre Commission of Inquiry and do solemnly and sincerely declare as follows:

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

   I am currently the Regional Manager for **headspace** Centres for Aftercare. I have a Bachelor in Social Science - Psychology, a Graduate Diploma in Psychology and a Masters in Social Administration. A copy of my most recent curriculum vitae is attached as Exhibit A.

2. *We understand that you hold (or have held) the position of Headspace State Manager. With respect to this position:*

   a. *state the period during which you have held this position;*

      I was the State Manager for Queensland and Northern Territory for **headspace** National Youth Mental Health Foundation Ltd (**headspace** National Office) from June 2011 to June 2015.

   b. *outline your key role and responsibilities in this position;*

      The key responsibility of the State Manager Queensland and Northern Territory role was to support the ongoing resourcing and development of **headspace** centres in Queensland and Northern Territory.

   c. *provide a copy of your job description.*

      Position description for State Manager QLD and NT attached as Exhibit B.

3. *Provide a broad overview of Headspace's operations and role in the area of adolescent mental health, in particular:*

   a. *detail Headspace's model of care (and provide copies of any relevant documentation);*

headspace National Youth Mental Health Foundation Ltd ABN 26 137 533 843 (**headspace** National Office) provides expertise and delivery of early identification and intervention strategies for young people aged 12-25 years, at risk of developing mental health and associated drug and alcohol problems, or for those already showing early signs of mental health problems or associated drug and alcohol problems. These services are provided through a network of nearly 100 **headspace** centres across Australia, in addition to the **eheadspace** online service, a youth early psychosis program, and the **headspace** school support program. These focus on four core streams of mental health and wellbeing; general health; alcohol and other drug services; and work, school and study services.

The aim of **headspace** is to:

- promote early help seeking by young people 12-25 years old;
- contribute to an increase in the mental health literacy of young people;
- facilitate access to best practice treatment for young people with mental health problems, including those with associated drug and alcohol problems;
- enable better access to allied health services for young people;
- support local, integrated approaches to meeting the needs of young people, particularly those with co morbid mental health and drug and alcohol problems; and
- build the skills and confidence of general practitioners, and other key providers of care and support in the community, in order to provide effective and appropriate mental health services to young people.

b. *state the number and location of Headspace offices in Queensland;*

I am informed by **headspace** National Office that the number and location of **headspace** centres in Queensland are as set out in the document it provided to me, attached as Exhibit C.

c. *state the number and qualification(s) of staff members who work at Headspace offices in Queensland (and provide details of the staffing structure);*

Staff working within the **headspace** centres referred to in question 3(b) above are usually employees and contractors of the "lead agency" which is itself contracted to provide **headspace** services through a grant agreement from **headspace** National Office.

I am informed by **headspace** National Office that staff numbers (expressed as full-time equivalents) in Queensland **headspace** centres as at 30 December 2013

(Q2 FY14), and 30 June 2015 (Q4 FY15) are as set out in the spreadsheet provided to me by **headspace** National Office, attached as Exhibit D.

I am informed by **headspace** National Office that qualifications of staff members who work at **headspace** centres in Queensland are as follows:

Psychiatrists
Minimum - Fellowship with the Royal Australian and New Zealand College of Psychiatrists (FRANZP)
or working as a supervised Registrar/Trainee towards this qualification
Desirable – An additional Certificate of Advanced Training in Child and Adolescent Psychiatry

General Practitioners
Minimum - Fellowship of the Royal Australian College of General Practitioners (RACGP) or
Fellowship of the Australian College of Rural and Remote Medicine (ACRRM)
or working as a supervised Registrar/Trainee towards this qualification

Psychologists
Minimum - Current full registration with the Australian Health Practitioner Regulation Authority (AHPRA)
Psychology Board of Australia

Social Workers
Minimum - Current full membership with the Australian Association of Social Workers (AASW)

Occupational Therapists
Minimum - Current full registration with the Australian Health Practitioner Regulation Authority (AHPRA) –Occupational Therapy Board of Australia

d. provide details of Headspace's funding arrangements and any cost to clients;

headspace National Office oversees the national network, administered through grant agreements for each **headspace** centre. **headspace** National Office provides Commonwealth funding through a grant agreement with the lead agency for each **headspace** centre. This provides establishment funds for the first year, and once operational, funding at a level determined by a formula which takes into account population, catchment size, occasions of service and number of young people seen, region, and market rental rates, and clinical and administrative infrastructure components. In allocating these funds **headspace** must give regard to the operational cost level of an average of $842,000 (GST exclusive) per annum across all **headspace** centres.

Services at a **headspace** centre are either free, or have a low cost. Young people are advised of any costs when they contact the service and they can also ask if there is a cost when they make their appointment.

e. state the average number of persons who receive services from Headspace each year, as well as the average duration of the services they receive;

I am informed by **headspace** National Office that nationally during financial year 2014-15, **headspace** centres serviced 59,047 young people, over 260,768 occasions of service (or sessions/visits) amounting to an average of 4.4 services per young person.

In Queensland, **headspace** centres serviced 11,712 young people, over 47,664 occasions of service (or sessions/visits) during financial year 2014-15. This equated to an average of 4.1 services per young person.

Each session on average is between 45 to 60 minutes.

f. outline the criteria for receipt of services from Headspace and any required referral process(s)/policies (and provide copies);

headspace centres across Australia provide face-to-face information, support and services to young people, aged 12 to 25 years, and their families and friends.

Working on a 'no-wrong-door' policy, the only criterion for accessing a **headspace** service is that the young person is aged between 12 and 25 years for an initial assessment.

In order to receive services from allied health private practitioners located within the **headspace** centre, a young person may be required to obtain a referral from a general practitioner in accordance with the Medicare Benefit Schedule rules.

g. outline the most frequent mental health illness diagnosis/diagnoses given to clients who receive services from Headspace;

I am informed by **headspace** National Office that during financial year 2014-15, young people presented at **headspace** centres nationally with the following primary issues:

Presenting Issue Group	Percent
Mental health and behaviour	76%
Situational	13%
Alcohol or other drugs	3%
Sexual and reproductive health	3%
Physical health	2%
Vocational assistance	2%
Other	1%

Mental health and behaviour issues are further broken down as follows:

Presenting Issue sub-group		
Group	**Issue**	**Percent**
Mental health and behaviour	Depressive symptoms	**28%**
Mental health and behaviour	Anxiety symptoms	**26%**
Mental health and behaviour	Anger issues	**6%**
Mental health and behaviour	Stress related	**6%**
Mental health and behaviour	Suicidal thoughts	**2%**
Mental health and behaviour	Behaviour problems	**2%**

h. outline the target group for Headspace (if any) and state the reason(s) why;

Working on a 'no-wrong-door' policy, the only criteria for initial access to a **headspace** service is that the young person is aged between 12 and 25 years. The focus for ongoing treatment is brief, time limited, early intervention. See also the response to question 3(f) above.

headspace National Office in recent years has launched campaigns and developed approaches to promote the service to "hard to reach" groups or marginalised groups such as Aboriginal and Torres Strait Islanders, LGBTQI, and CALD communities.

i. state whether Headspace focuses its services on any one or more particular mental health illness (including, but not limited to, psychosis and, if so, the reason(s) why)); and

headspace centres across Australia provide face-to-face information, support and services to young people, aged 12 to 25 years, and their families and friends.

headspace is an early intervention service and targets high prevalence disorders such as anxiety and depression.. Refer to the fact sheet entitled "How **headspace** can help" attached as Exhibit E and to the **headspace** website for more information; www.headspace.org.au

j. provide details of any audits/evaluations/assessments carried out in respect of Headspace services (and provide copies).

headspace National Office undertakes internal evaluation activity and has also been externally evaluated. An initial report was completed in 2009 and can be downloaded from the **headspace** website:

http://headspace.org.au/assets/Uploads/Corporate/Publications-and-research/final-independent-evaluation-of-headspace-report.pdf

More recently the Department of Health funded the Social Policy Research Centre to undertake an independent outcome evaluation of **headspace**. I am informed by **headspace** National Office that this evaluation has been completed, and is currently with the Minister for Health, who will determine how widely the report is to be released and associated timing.

headspace National Office undertakes various internal evaluation activities aimed at determining program effectiveness and creating a culture of continuous quality improvement. As an example, **headspace** National Office has developed a **headspace** Best Practice Framework which outlines what is considered to be a best practice approach for **headspace** centres and has helped to inform service improvement activities. This report can be downloaded from the **headspace** website:

http://headspace.org.au/assets/Uploads/Corporate/Publications-and-research/headspace-best-practice-framework-april-2014.pdf

An article entitled 'Changes in psychological distress and psychosocial functioning in young people visiting headspace Centres for mental health problems' was also published in the Medical Journal of Australia 2015; 202 (10): 537-542 and is available at:

https://www.mja.com.au/journal/2015/202/10/changes-psychological-distress-and-psychosocial-functioning-young-people

The article presents results from 24 034 young people accessing **headspace** centres between 1 April 2013 and 31 March 2014.

4. *Explain the relationship (if any) between the operation/funding/services of Headspace and Aftercare.*

headspace National Office has a grant agreement with Aftercare, as the lead agency, for each of the **headspace** centres Aftercare operates. Each grant agreement sets out the operational specifications by which Aftercare will operate the **headspace** centre and agreed funding levels, reporting and milestone payment schedules and specifications. **headspace** National Office overseas the grant agreement to ensure compliance and makes payments to Aftercare in accordance with the agreed milestones and timeframes set out within it. **headspace** grant agreements are standard agreements, in place with each lead agency operating a **headspace** centre.

Aftercare is currently the lead agency for four **headspace** centres in Queensland, and therefore has grant agreements with **headspace** National Office to operate four **headspace** centres as follows:

State	Centre Name	Centre Manager Site Address
QLD	Nundah	1264 Sandgate Road, Nundah QLD 4012
QLD	Ipswich	26 East Street Ipswich QLD 4305
QLD	Woolloongabba	182 Logan Road, Woolloongabba QLD 4102
QLD	Meadowbrook	260 Loganlea Road, Meadowbrook QLD 4131

As a lead agency, Aftercare is responsible for the overall management and operations of these four **headspace** centres, including human resources.

5. *Explain the nature and extent of the relationship/interaction (if any) between the operations and services of Headspace and the operations and services of the Barrett Adolescent Centre (**BAC**), prior to its closure in January 2014.*

There were ten **headspace** centres open in Queensland when the BAC was in operation. At this time, the BAC was a referral option for those **headspace** centres for clients requiring intensive rehabilitation. **headspace** centres could not refer directly to BAC and referrals had to be progressed through the **headspace** centre's local Queensland Health Child and Youth Mental Health Service (QHealth).

I am aware of **headspace** centres ( ) that advocated for a client to be referred to the BAC. There may be other **headspace** centres that had interactions with the BAC prior to closure but to the best of my recollection I have not been informed of these.

There was no relationship or interaction with **headspace** National Office that I am aware of, prior to the closure of the BAC.

Closure of the BAC

6. *On what date, how, from whom, and for what purpose, did you first become aware of the possibility of the BAC being closed?*

I was informed of the possible closure on 23 November 2012, by email from Aileen Colley (Townsville Mackay Medicare Local) who was sharing information and a news article with me in my role as State Manager.

7. *On what date, how, from whom, and for what purpose, did you become aware of the decision to proceed to close the BAC?*

It is my recollection that the Expert Reference Committee was informed by the chair, Leanne Geppert, that the decision to close the BAC had been made. I am not sure of when this occurred, but I believe it was in the early meetings of the Committee.

8. *Outline the nature and extent of your involvement and/or input (if any) (and to your knowledge, that of other staff of Headspace) into the decision to close the BAC. In particular, provide details as to:*

   a. *the circumstances in which you (and, to your knowledge, any staff member of Headspace) had input into the decision (including at whose initiative, and on what date, and for what purpose);*

To the best of my knowledge, it is my understanding that no one from **headspace** National Office was involved in the decision to close the BAC.

b. *your understanding of the reason(s) for the decision to close the BAC (and the source of that understanding, when it was gained and in what context) (and your views in respect of those reasons); and*

It was my understanding that the BAC was closing as there were concerns about the suitability of the location of the facility (being on the same site as an adult high security unit) and that the model may have been outdated and not in line with contemporary and current best practice in youth mental health in Australia and internationally. I gained this understanding through my involvement in the Expert Reference Committee, and these reasons were outlined in the BAC Project Plan emailed to me on 7 December 2012.

I did not have a strong view on the suitability of the location of the facility, given that it had been a long time since I had been on site at the BAC. I was not able to see and assess myself whether there were appropriate measures taken to mitigate any risks associated with having a youth facility at the same location as an adult high security unit. However, there did seem to me to be some validity to the view that it was preferable to not have the two operating near each other, as this would remove all risks that may be associated with co-location.

After the review process undertaken as part of the Expert Clinical Reference Group (ECRG), I personally came to the view that there were better models of service that could be offered as an alternative to the current BAC. This view was not formally endorsed by headspace National Office or the individual centres and no consensus view was sought from headspace National Office or headspace centres.

c. *any alternative options and/or service models (including, but not limited to, a Tier 3 service) that were canvassed in the course of deciding to close the BAC (and by whom and when) and the reason(s) for decisions made in respect of these models.*

While the ECRG and the State Wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy Steering Group (SW AETRS) Committee reviewed models as part of the review and the development of a state wide model of care, I do not know if the West Moreton Hospital and Health Service or the Mental Health Alcohol and Other Drugs Branch also conducted a review of models to assist their decision making in relation to closure.

9. *Outline any concerns held by you (or, to your knowledge, by any staff member of Headspace) with respect to the decision to close the BAC (and any action taken by you, or by Headspace, with respect to those concerns).*

While I originally held concerns about the closure, and I was aware of concerns from some **headspace** centre managers, these concerns seemed to be related to there being no alternative treatment options available for this client group should the BAC close. On 30 November 2012, I emailed Queensland **headspace** centres advising them that:

"I have been asked to sit on a Reference Group around the Barrett Centre for the QHealth MHAOD Branch, meeting on 7th and 11th December. I am keen to represent any view you may have in relation to the Barrett; if you have used this service any feedback you might have, possible alternative models of care, or any other general comments you might want to make in relation to this matter. Please feel free to call or email me if you would like to discuss further. (details below)."

Three Centre representatives replied.

One was the centre manager, (Suzie Lewis) from **headspace** , who stated in an email dated 6 December 2012:

"We have only had one of our young people go to Barrett for treatment. was in great need of an intensive mental health service, having been engaged with multiple community services (both mental health and non mental health) for a long period of time without improvement. We were very happy for this when entered into the Barrett program.

It would be a dreadful loss to the Queensland youth mental health service system should Barrett be closed. I am aware there have been statements made that the young people who need the services of a centre like Barrett could be supported in acute mental health units, or in community treatment – these statements cannot have come from people who understand the severity of the psychopathology present in the young people who are accepted to Barrett. It is frightening to think that that the people who will make the ultimate decision may hold such views.

In the current fiscal climate within Queensland Health, budget cuts will be made. This should not be one of them. No non-government community service will be able to step in and fill the gap that Barrett will leave, nor will any Federal Government funded programs. Responsibility for the care of chronically and severely unwell young people is a State responsibility.

In sum, we cannot state strongly enough our view that the Barrett Adolescent Centre should remain open. "

The second response was from Clinical Manager (Lorraine Dyke) at **headspace** Townsville who on 30 November 2012 forwarded an email from the clinical lead of the Townsville Mackay Medicare Local ATAPS under 12 program that stated:

"My response would be that particularly for regional areas managing/ treating very complex and challenging cases – long stay admission can provide both the intensity and long term treatment that is not otherwise possible and is often needed to change the trajectory of illness/ psychological issues for our young people. Have only ever seen good results with clients returning from Barrett".

The third response was from Ivan Frkovic on 30 November 2012, who stated:

"I am also happy to give you any info that I have about the BAC, its model and also our alternative Time Out House Initiative in Cairns. This service can provide a community based both a step-down (sub-acute 14-18 years residential, day program, and outreach support; and a step-up (early intervention) service for 10-25 years, including day program and outreach support. I can give you more info re this if you need before going to the meeting."

Participating in the ECRG and the Implementation committee was an effort to be able to voice these concerns and attempt to influence future planning in relation to services for young people in Queensland.

10. *Outline the nature and extent of your (or, to your knowledge, any staff member of Headspace's) involvement and/or input into the decision that the closure date for the BAC was to be January 2014. In particular, provide details as to:*

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

    I was informed of the closure date through my involvement in the various committees. I am unsure of when this occurred or how this was communicated initially, but I note that the media release dated 5 August 2013 emailed to me on 30 August 2013 stated:

    "*adolescents requiring extended mental health treatment and rehabilitation will receive services through a new range of contemporary service options from early 2014. Ms Dwyer said the young people who were receiving care from Barrett Adolescent Centre at that time, would be supported to transition to other contemporary care options that best meet their individual needs.*"

    So I was definitely aware from August 2013 that closure was planned to be early in 2014.

    b. *the nature and extent of your (or, to your knowledge, any staff member of Headspace's) involvement and/or input into the decision (and when and at whose initiative);*

    Neither **headspace** National Office, **headspace** centres nor I had any involvement in the decision in relation to the timeline for closure.

    c. *the reason(s) why January 2014 was chosen (and when, and by whom);*

    To the best of my recollection I was not informed of why January 2014 was chosen.

d. *your understanding as to the existence of any flexibility with respect to the closure date; and*

It was my understanding that the decision was already made and that it could not be altered, and that closure in January 2014 was already an improvement on the initial June 2013 closure date proposed in the Project Plan.

e. *any concerns held by you (or, to your knowledge, by any staff member of Headspace) with respect to the closure date (and details of any steps taken by you or Headspace as a result).*

While there was acknowledgment from the outset and at the meetings that the timeframe was very tight, I was informed through the committees that there were a number of separate processes set up to meet these deadlines and that these committees were progressing as required.

For example, the monthly Status Reports for October and December 2013 indicated that all "key areas of focus" were "on track", as indicated by their green status. This included reference to the BAC Clinical Care Transition Panel.

11. *Did you (or, to your knowledge, did any staff member of Headspace) facilitate or attend any meetings regarding the closure of the BAC and, if so, with whom and on what date(s), and for what purpose. Explain the outcome of these meetings.*

I did not attend any meetings regarding the closure of BAC outside of the ECRG and steering committees mentioned elsewhere in this Witness Statement.

I provided a brief update to managers of Queensland **headspace** centres in monthly teleconferences.

I cannot state definitively whether any staff members of **headspace** centres attended any meetings of this nature but to the best of my recollection none were reported to me.

12. *Detail any processes that you were involved in (or, to your knowledge, that any staff member of Headspace were involved in), with respect to communicating the closure decision to parents of BAC patients (and their families), and outline the nature of that involvement (and when and at whose initiative).*

Neither **headspace** National Office, nor I as its representative, had any involvement in communicating the decision to parents of BAC patients.

I am aware that Dr Sandra Radovini, Clinical Director at **headspace** National Office, participated in a meeting with parents on 10 December 2013 but in a private capacity as a consultant and not as a representative of **headspace** National Office.

I cannot state with certainty whether any staff members of **headspace** centres attended any meetings of this nature as the majority of lead agencies operating **headspace** centres were independent third party contractors who were not required to report this to **headspace** National Office. Given their involvement with clients from the BAC, it is possible that staff at **headspace** and may have had contact with family members, however I am not aware of any such meetings having taken place. **headspace** was operated by headspace National Office at the time as an interim measure and I was directly managing it. To the best of my knowledge, staff at **headspace** had no involvement in informing parents.

Expert Clinical Reference Group

13. *The Commission understands that in or around December 2012 you were appointed as a member of an Expert Clinical Reference Group (**ECRG**) with respect to the BAC. In regards to this appointment, provide details as to:*

a. *the circumstances in which you came to be appointed;*

On 28 November 2012, I received an email from Leanne Geppert inviting me to be on the ECRG. I believe I may have had a phone conversation with Leanne around this time to obtain further information. This was followed by a letter from Sharon Kelly dated 3 March 2013.

b. *the period of your appointment;*

The period was somewhat vague. My understanding was that participation was short term (ie. a few months) as there was a sense of urgency given the timeframe to stop services at the BAC site at that time was June 2013. As stated in its Terms of Reference (TOR), the term of the Committee was *"until a recommended model of care is developed"*.

c. *your role and responsibilities as a member of the ECRG;*

My role, as outlined in the TOR, was to:

"*Provide expert clinical advice to promote the development of a contemporary evidence based model of care to meet the needs of adolescent mental health consumers who experience severe and persistent psychiatric symptomatology that significantly interferes with social, emotional, behavioural and psychological functioning and development.*"

My responsibility was to represent the views of **headspace** National Office and the **headspace** centres and to advocate for a model of care that we collectively considered was in the best interests of young people and supported by the latest evidence on good practice.

d. your understanding of the role and function of the ECRG and, in particular:

i. the purpose of the report to be prepared by the ECRG and the recommendations within the report; and

The purpose of the report was to make recommendations to the Planning Group of West Moreton HHS in regards to the model of care. As outlined in the TOR *"The Expert Clinical Reference Group will provide its recommendation regarding contemporary model(s) of care to the planning group as per the Project Plan for the Barrett Adolescent Strategy."*

ii. any constraints placed on the scope and/or function of the ECRG and the content of the report and/or recommendations.

While it was not documented or verbalised specifically, it was my understanding that the report was not to advocate for the continued operation of the BAC in its current form or at its current location.

14. A copy of the Terms of Reference for the ECRG have been produced to the Commission. The ECRG's scope and functions are described in this document as being (in part): "to consider that the model(s) of care will replace the existing statewide services provided by the BAC". Explain your understanding of the meaning of the word "replace" in this sentence.

My understanding was that ''replacement'' was required as the BAC would no longer exist. Further, it was clear that there were no funds to build a new residential facility so advocating for the same model at another location was not feasible.

Hence, although the word "replace" was used, the purpose was to make recommendations on a new model of services that should be available to the client group that were currently being serviced through BAC, but within the current funding limitations.

15. The Minutes of an ECRG meeting held on 27 February 2013 state (in part), as follows:

- *It was noted that in the Planning Group project plan it is stated that the capital allocation previously attached for the rebuild of the BAC is no longer available and BAC will not be built an alternative site.*

- *A point of clarification was therefore sought to determine whether the service model the ECRG is developing should be an 'ideal' or one that takes into account the restrictions of budget.*
- *Agreement that the ECRG will determine an ideal model and alternative models that identify the risks of not including particular components within the ideal. The final model must be within budgetary limits.*

Explain the circumstances in which this matter was raised at the meeting and outline your views in respect of the matters discussed and the outcome documented in the Minutes.

I do not recall the circumstances in which this matter was raised at the meeting and do not have any diary notes to assist my recollection.

While the TOR referred to clients with severe and persistent mental health issues, it was felt that an appropriate model for this client group could only be developed when planned as part of a ''whole of service'' framework. That is, an underlying principle was that if there were appropriate models of service available at each stage of the mental illness continuum (from early intervention to severe and persistent mental illness), there may be less need for an intensive and longer term program such as the BAC in the long term.

In my view, this "whole of service" framework is what was referred to as "ideal" and it was thought that mapping existing services, needs and gaps could then assist with costing future budgetary requirements. Given that the budget for building a new purpose built facility had been redirected, it was also thought that developing a comprehensive model of service elements would also provide an opportunity to advocate for this funding to be returned to youth mental health services or for additional funding to be provided.

16. The Minutes of an ECRG meeting held on 27 March 2013 state (in part), as follows:

- *The Chair spoke to the proposed the [sic] draft service elements table noting only the salient points of the proposed model.*
- *The Planning Group were not provided with a written draft as it has not been discussed by the ECRG.*
- *The Planning Group are purported to be agreeable to the presentation of an ideal model however, some of the elements included in the ideal may not be supported (although may be implemented in the future).*
- *It was reiterated that there is no funding for a capital project and no identified location.*

Explain the circumstances in which this matter was raised at the meeting and outline your views in respect of the matters discussed and the outcome documented in the Minutes.

I do not recall how this was raised. My diary notes from this meeting indicate that I understood that there would be two stages:

1. developing the service elements (ideal) and

2. completing the business model to accompany this to move toward implementation.

See also my response to Question 14.

17. *The ECRG report found inpatient extended treatment and rehabilitation care (tier 3) to be an essential service component and reported that "interim service provision if BAC closes and Tier 3 is not available is associated with risk". The ECRG recommended (in part) that "safe, high quality service provision for adolescents requiring extended treatment and rehabilitation requires a Tier 3 service alternative to be available in a timely manner if BAC is closed". With respect to these findings:*

    a. *elaborate on the reason(s) why the ECRG considered a tier 3 service to be an essential service component;*

    There was acknowledgement that there would still be young people requiring this level of intensive support. This is reflected in the table I emailed to Leanne Geppert on 9 January 2013 mapping client presentations, needs and service examples.

    b. *outline your understanding as to the reason(s) why, given the recommendation of the ECRG, a tier 3 service was not developed and implemented in Queensland (and the source of that knowledge);*

    My interpretation was that a BAC like inpatient model was not supported by the Children's Health Queensland Health and Hospital Service Board and the Qld Health Mental Health and Alcohol and Other Drugs Branch, and secondly there was no funding to implement an alternative Tier 3 state wide model.

    This was reflected in the Planning Group Recommendation reply to the ECRG dated 8 August 2013 which stated:

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

    My diary notes taken during the AMHETI Committee meeting on 10 February 2014 also state:

"Still uncertainty about the need for a bed based service across the State. The Branch is not supporting a bed based..."

c. *outline your understanding as to what "safe, high quality services" for "adolescents requiring extended treatment and rehabilitation" have been implemented as a tier 3 service alternative (and when, by whom and where); and*

It is my understanding that Aftercare residential services at Greenslopes, the Time Out Initiative in Cairns, and subacute beds at Mater Children's Hospital (now closed) and Lady Cilento Children's Hospital could provide treatment and rehabilitation for young people with complex needs.

d. *outline any concerns held by you/Headspace with respect to the failure to develop and implement a tier 3 service in Queensland.*

The need and demand for a Tier 3 inpatient service, if the other recommended service options were available, is still unclear to me. At best it was likely to be a very small group requiring these services, and given that services for young people are best provided close to the family and support networks, it is unlikely that a centralised residential facility like BAC would be able to provide the best response and access for a state as large as Queensland.

While a Tier 3 service was not ready by 1 January 2014, the minutes from the SW AETRS on 10 September 2013 stated:

"AT asked if we are announcing a replacement service from 1st February 2014. JK advised there will be no one singular replacement service but rather a range of services, which we are incrementally working toward. LG advised that there will be additional service options; however, there won't be a bed based option in the short term – this is not possible to deliver in the next 3 months.

For current consumers at BAC, WM HHS will utilise operational funds to support consumers in their home/community until extended service options are in place. JK asked about consumers on the waitlist – it was confirmed that the panel would review the waitlist and provide wrap around services where required. It was agreed that this needed to be communicated to those families and staff by the Clinical Care Panel.

LG noted that some bed-based care is needed; however, not as currently provided at BAC, e.g. 15 beds, 2 years stay. LG also noted that some participants in WG1 queried whether a bed-based option was needed at all. The WG1 forum did raise the need for a multi-disciplinary statewide panel to assess consumer needs to look at a range of options for consumers in the area.

JK raised whether this fits in with Complex Care Coordination, being a similar concept. Other options proposed by WG1 were coordination roles, more Day Program Units, and mobile outreach services."

As noted in the minutes above, there were differing views about whether an inpatient Tier 3 was actually required and whether it was recommended by evidence on good practice with this client group.

In my view, the pressing concern was not limited to Tier 3 alone, but extended to a lack of investment to implement the holistic model of service recommended, covering all stages of mental illness, for a full range of presentations/diagnosis, and providing access to quality care across the entire state of Queensland, while also providing support to families as soon as possible. This was costed out in a document entitled 'Statewide Adolescent Extended Treatment and Rehabilitation Strategy Business Case Summary - Steering Committee Paper January 2014'. For example, the paper indicated that an additional $16.8 million would be required in 2016/17 to implement the full model in Queensland.

18. *The Commission understands that a Planning Group had oversight over the ECRG. Outline:*

a. *the nature of the relationship between the ECRG and the Planning Group, and any interactions between the two groups;*

The ECRG wrote the recommendations to the Planning Group.

I did not know any of the members of the Planning Group. I have an indistinct recollection that some members of the Planning Group may have attended one of the meetings of the ECRG to reply to the recommendations.

Leanne Geppert was largely the conduit of information between the two groups.

b. *the date when you received a copy of the Planning Group recommendations (and from whom, by what means and for what purpose); and*

I was emailed a copy of the Planning Group recommendations on 8 August 2013.

c. *your views in respect of each of the recommendations made by the Planning Group, in so far as they relate to the findings and recommendations of the ECRG.*

Overall I think the recommendations from the Planning Group reflected their thinking on how to take the conceptual elements outlined in the Service Elements document and move them into the next stage of implementation and business planning. This issue is captured in my feedback on the recommendations to the planning group, emailed to Leanne Geppert on 23 April 2013, which stated:

"Having reviewed the emails and the docs I think one of the difficulties is that we are presenting a conceptual model (and in a brief 7 pages!) of an initiative that is complex by nature. The email discussions that are now occurring around things like length of stay, and location of services, funding allocations etc are the beginnings of the next phase of implementation and business planning however due to time constraints these discussions have not occurred in a full and comprehensive manner. My impression is that as a conceptual model there seems to have been agreement generally, & the 'debate' is now about the next level of detail.
I note that the Project Plan provided in Kevin's email outlines the development of an Implementation Plan.as a task of the ECRG, but I don't think we have done this. I think there is another level of Implementation and Business Planning that is still required that will determine the feasibility of what has been suggested and also any financial implications for details such as where new services can be set up, how many beds there can be, staffing profile, length of stay etc. The important question I have is around who will be doing this next stage of work and being involved/consulted in the process?

I don't think the service elements documents lends itself to adding implementation recommendations, but this could be done in some slides? For example an implementation slide could talk about the strengths and concerns of an NGO Accommodation component which seems to be an area of concern for the ECRG or maybe it is simply a point on an implementation slide that says something like' the strengths and risk management concerns of an NGO accommodation component should be fully explored and a risk mitigation plan developed prior to proceeding in development and implementation.' I'm wondering if there is also one slide about Evidence base, even if to note the lack of evidence in some of the areas so that it reflects that we did look at models internationally and interstate etc."

With respect to the ECRG and Planning Group recommendations themselves, I set out my views in the table below.

Recommendation	My view
1. Broader consultation and formal planning processes are essential in guiding the next steps required for service development, acknowledging that services need to align with the National Mental Health Service Planning Framework	Agreed. I think this was also included so that broader representation and views could be sought and also to highlight that structured formal planning would be critical to the success of the transition.
2. Inpatient extended treatment and rehabilitation care (Tier 3) is an essential service component	I agreed with the reply from the Planning Group - that is alternative bed based models could be developed but they did not have to be inpatient.

3. Interim service provision if BAC closes and Tier 3 is not available is associated with risk	I agreed with parts a, b and c however think the recommendation from the ECRG should have read 'tier 3 alternatives'.
4. Duration of treatment – up to 12 months	Agreed. I had concerns that some young people had spent 2 years at the BAC and what this meant for institutionalisation and dependence, however it was felt that alternatives (eg community based step down units) were not available
5. Education resource essential: on-site school for Tiers 2 and 3	I agree that education is a key feature of the recovery model and improving functionality and future prognosis.
6. Residential Service: Important for governance to be with CYMHS; capacity and capability requires further consideration	This was largely in response to a view that NGOs were not skilled enough to provide clinical support to a client group with complex mental health needs. Having worked in a dual diagnosis residential facility run by a NGO service, I did not share this concern but did agree that further consultation on governance was required.
7. Equitable access to AETRS for all adolescents and families is high priority; need to enhance service provision in North Queensland (and regional areas)	Agreed. As mentioned previously, the **headspace** centres in North Queensland were strongly reporting the need for additional services.

19. *Provide details of any other committees or groups you were a member of, or had involvement or input into the formation of, with respect to the closure of the BAC and/or the development or implementation of adolescent extended treatment and rehabilitation service options.*

I was not involved in any other committees or groups.

Transition Arrangements

20. *The Commission is aware that from 2013 up until January 2014, a number of BAC patients were transitioned to alternative care arrangements as a consequence of the impending closure of the BAC (**Transition Clients**). Outline:*

    a. *the nature and extent of your involvement (or, to your knowledge, that of any staff member of Headspace) with respect to the transitioning of Transition Clients from the BAC (and the identity of the relevant Transition Clients). In particular, detail:*

        i. *any relevant service or funding agreements (either pre-existing or entered into during this period) between Headspace and any Queensland government department(s) (and provide a copy);*

        There were no funding agreements either pre-existing or entered into at this time.

        ii. *your (or, to your knowledge, any staff member of Headspace's) involvement in developing managing and implementing transition arrangements (including, but not limited to, identifying, assessing and planning for care, support, service quality and safety risks);*

        I was not involved in any transition arrangements.

        I am aware of one client referred to **headspace** as part of the transition. I believe that information on this process has been provided to the Commission of Inquiry by I was not involved in this transition.

        I am not aware of any other young people referred to other **headspace** centres as part of the transition process, however a number of BAC young people did contact or access **headspace** centres after the formalised transition period.

        iii. *the circumstances in which you (or, to your knowledge, any staff member of Headspace) came to be involved in the transition of Transition Clients;*

        I was not involved in the transition of any clients.

        My understanding is that the BAC referred directly to **headspace** .

iv. *what handover documents you (or, to your knowledge, any staff member of Headspace) received (and from whom and when and for what purpose) in relation to the transitioning arrangements for the Transition Clients;*

I did not receive any handover documents. I believe that any handover documents provided to **headspace** have been provided to the Commission of Inquiry by .

v. *any meetings with Transition Clients or their families / carers in relation to their transition from the BAC and when these meetings occurred and for what purpose, and at whose initiative.*

I did not attend any meetings with clients or families.

I cannot state definitively whether any staff members of **headspace** centres attended any meetings of this nature. However it is my understanding, derived in my capacity as an employee of , that staff from **headspace** met with and had contact with family.

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

It was my understanding from the SW AETRS committee that there was an internal BAC committee coordinating the transition of clients. The minutes from the SW AETRS meeting on 23 September 2013 state:

- *"The BAC Team have started the process of looking at consumer care plans for the future based on individual clinical care needs.*
- *LG has suggested that this WG adopt an approach similar to that of a Complex Needs Panel (involving DETE, Housing, Communities and CYMHS clinical staff) specific to the individual.*
- *Committee agreed to change the name of the WG to BAC Transition Panel*
- *Terms of Reference – raised an issue with confidentiality of consumer identity (specifically in Status Reports, Plans and Risk Management). LG confirmed that any reporting will not identify individuals – this is not about clinical risk to the consumer but rather risks of the initiative, e.g. reduction in bed numbers will create pressure on other service options, etc.*
- *LG proposed to change the Panel membership to include BAC staff in the first instance and to involve other HHS representatives where they are involved in the treatment of a specific individual. The Committee supported this change."*

It was reported to the SW AETRS committee that consultation with families and friends occurred by this Transition Panel, and that there was also a meeting held with families and Dr Sandra Radovini in December 2013. Dr Radovini was not representing **headspace** but as a consultant from the University of Melbourne to discuss the Victorian Intensive Mobile Youth Outreach Service (IMYOS) and how this model works with young people with multiple and complex needs.

c. *whether there were any systems in place to review the transition arrangements, and outline what such review involved (and when and how it occurred).*

I am not familiar with any review systems set up by Qld Health.

With respect to **headspace**, I did not think that any of the existing clients at BAC would be appropriate for referral to **headspace** given **headspace** services are early intervention focused and the majority of **headspace's** service delivery is limited to a maximum of ten sessions under the Better Access Scheme.

I was not informed at any time that clients were referred to **headspace** centres.

Given this, **headspace** did not set up any review mechanisms until August 2014 when I became aware that there were a number of BAC clients that had either been referred or self-referred to **headspace** centres following the closure of the BAC. (Please also see my response to Question 24)

21. *Were you (or, to your knowledge, any staff member of Headspace) aware of any concerns regarding the transition of any Transition Clients from the BAC to an alternative service provider (including, but not limited to, Headspace). If yes:*

a. *detail those concerns;*

Concerns were outlined in handouts provided at the SW AETRS meeting on 4 November 2013. I do not have a copy of those handouts but my recollection is that they reflected two main concerns: a lack of suitable support services for the young people post BAC closure; and a lack of consultation with family members.

b. *state who these concerns were expressed by, to whom, when and for what purpose; and*

Concerns were raised by two parent representatives at the SW AETRS meeting on 4 November 2013.

c. *outline any steps undertaken by you/Headspace as a result of the concerns.*

No steps were taken by me or by **headspace** National Office as a result of the concerns because I had been informed that the Transition Working Group was working on the concerns raised and that appropriate supports would be in place by January 2014 when BAC was due to be closed.

22. *Did you (or, to your knowledge, any staff member of Headspace) have any discussions with the medical or other staff at other receiving services regarding the Transition Clients' transitional arrangements, transition plans, treatment plans, clinical and educational needs or other matters? If so, explain the nature of these discussions, including the date on which they occurred, with whom, for what purpose and at whose initiative.*

I did not have any discussions with staff at other receiving services regarding Transition Clients at the time of the BAC closure.

I did have discussions with staff at **headspace** in August 2014, when I contacted all **headspace** centres to identify centres which were (or had been) seeing BAC clients.

23. *To the extent your response is not already covered by questions 20 to 22 above, provide details of any meetings, discussions or correspondence you (or, to your knowledge, any staff member of Headspace) had, regarding the treatment and care plans, including the ongoing health and wellbeing of the Transition Clients after the closure of the BAC. In particular:*

a. *did you (or, to your knowledge, any staff member of Headspace) meet with any of the Transition Clients or their families/carers. If so, who did you meet, when, and what was discussed;*

I did not meet with any of the Transition Clients or their families.

I am aware that **headspace** had contact with family.

b. *did you (or, to your knowledge, any staff member of Headspace) receive any advice or feedback regarding the transition arrangements for the Transition Clients after the closure of the BAC. If so, what advice or feedback did you receive, when, from whom and for what purpose; and*

I did not receive any advice or feedback regarding Transition Clients.

I believe that any advice or feedback provided to **headspace** would be included in materials already provided to the Commission of Inquiry by Aftercare.

c. *did you (or, to your knowledge, any staff member of Headspace) receive any advice as to the treatment or care plans for the Transition Clients.*

I did not receive any advice as to the treatment or care plans for Transition Clients.

I believe that any advice provided to **headspace** would be included in materials already provided to the Commission of Inquiry by Aftercare.

24. *The Commission understands that in or around late August 2014, you advised Dr Leanne Geppert that you had requested all Queensland Headspace services identify whether they had any ex-BAC patients referred to them at the time of the BAC closure or as part of transition planning. The Commission understands that Headspace identified a total of seven patients and that you requested weekly updates from Headspace services. Outline:*

a. *the purpose and circumstances in which you caused these enquiries to be undertaken;*

The **headspace** School Support team had been involved following the of two BAC clients. From my involvement in that, together with a request for a client file at **headspace** and informal conversations with **headspace** centre managers, I became aware that a number of **headspace** centres had contact with BAC clients since January 2014.

headspace was concerned about BAC clients being referred to **headspace** centres because the persistent and severe nature of the mental health concerns would typically result in these clients being unable to be effectively and appropriately supported within the **headspace** centre. I was also informed by the centre managers that QHealth staff had made contact with **headspace** and **headspace** trying to follow up BAC clients at **headspace** centres. I followed up with the **headspace** centres to assess the level of clinical risk carried by the relevant **headspace** centres, so that they could take steps to minimise the risk of any future of BAC clients accessing **headspace** centres.

b. *the identity of the seven patients and the nature of the services they were receiving (or had received) from Headspace, and when;*

I provided the details in my possession in a brief to the headspace National Office Executive dated 11 August 2014 as follows:

> *"There are 5 headspace Centres that are currently managing young people who were former inpatients at the Barrett Centre, and 2 Centres awaiting additional information to hNO:*

3.1. *There is*

- *had attended for an initial session but could not be re-engaged despite multiple attempts following initial contact. has completed an Incident report for headspace National, which is on the Incidents log for more information.*
- *There is also another client that is actively engaged with headspace , and receives weekly support from headspace funded staff. had not [sic] been initially closed in January but was assertively followed up by the Clinical Lead after hearing of The YP reengaged with the Centre on 25 June 14. was seen by an external psychiatrist on 7.08.14, the Centre had contact with on 8.08.14, has an appt at the Centre next week and is being assertively monitored. The Centre reports they are making good progress with this young person and is well engaged and has started a .*
- *There was an ex Barrett Centre client that had initial contact in August 2013, and last contact in October 2013. visited the Centre a few times before engaging with an ATAPS provided on one occasion. The Centre has actively tried to contact by phone, email and SMS following notification of the other but have been unsuccessful in making contact. This name was passed on to QHealth representatives on 8.08.14 but as was not on their current list it is unclear if they are going to make efforts to follow up.*
- *There is another client that according to QHealth records was in contact with hs , however the Centre has no record of contact of a client by that name.*

3.2. *: There is 1 young person at this Centre, not actively engaged.*

- *This young person attended intake, saw the GP and had one appointment with AOD worker. Multiple efforts have been made to contact the client, including as recent as the 7th August. The current client was reported to be a close friend of the*

3.3. *: There is 1 young person at this Centre, actively engaged.*

- *Previous Day Program at Barrett Centre. Young has weekly appointments with Art Therapist and is booked in for the next month. There have been some ongoing conversations about accessing case manager*

3.4. *: There is 1 young person at this Centre, actively engaged.*

- *year old attends Centre and engages with Dr for self harm, has previously had 4 sessions with psychologist & is now successfully linked in to another counselling service. Last seen at the Centre on Monday 4th August for GP has spoken to YP's on 8 August and reports that is doing well, and will contact is further support is*

needed. This young person's met with the Committee leading up to the Barrett Centre closure.

3.5. *: There is 1 young person at this Centre, actively engaged.*

- *Vanessa Clayworth, Clinical Leader headspace was the Clinical leader at Barrett Centre prior to working at headspace and was actively involved in the development of the Transition Plans for the clients affected by the Barrett Centre closure.*
- *There is one young linked in with this Centre and the Clinical Leader reports that there are currently no risks.*

3.6. *: Possibly one, with limited contact - awaiting confirmation*

- *It is reported that there is one young person in that is likely to have made contact with a number of services including the headspace Centre. It is reported that this person and did not have a close relationship with the three other young people. The hs Centre is going to follow up and get back to hNO early next week.*

3.7. *There are reports that there is one client at headspace Mackay – to be confirmed."*

c. *details of any concerns or risks identified in relation to the and what (if any) steps were undertaken to address these concerns or risks (by Headspace or otherwise);*

There were immediate concerns for one client at **headspace** , and I supported the Clinical Lead at **headspace** to engage and monitor the client. The client was currently under the care of Dr James Scott and was hospitalised in order to contain risk. I had regular phone contact with the Clinical Lead at **headspace** until the acute risk was contained.

For clients that had not been engaged or in recent contact with the **headspace** centre, I asked centre staff to call and assertively follow up in an effort to reengage the client. I offered to provide any support to the centre to assist with this, and also instructed the centre to provide assistance even if it was outside the "brief, early intervention" scope of **headspace's** mandate, given the current elevated risk to those particular young people.

I called the managers at the **headspace** centres regularly over the next few weeks, following up and tracking client status, safety and treatment plans.

I also kept my line manager at **headspace** National Office (Claire Honey, Acting Head of Centres) informed and up to date.

d. *details of all subsequent updates received from Queensland Headspace services (and what was done with these updates); and*

As mentioned above I provided an initial briefing to **headspace** National Office Executive (including the CEO and COO) on 11 August 2014.

Following this, I provided an email update to Sandra Radovini and Claire Honey on 18 August 2014 which contained the update table replicated below:

Centre	
	2 clients: 1. *1 client ( ) that is actively engaged with headspace , and receives weekly support from headspace funded staff. had not [sic] been initially closed in January but was assertively followed up by the Clinical Lead after hearing of The YP reengaged with the Centre on 25 June 14. was seen by an external psychiatrist on 7.08.14, the Centre had contact with on 8.08.14, she has an appt at the Centre next week and is being assertively monitored. The Centre reports they are making good progress with this young person and is well engaged and has started a Was hospitalised last weekend after was informed of the third* 2. *1 , disengaged.*
	1 client: 3. *1 disengaged*
	1 client (year old,) 4. *Has been in contact with our centre on and off since March 2012.* *Notified had been accepted into Barrett in July 2012.* *Entered Barrett in August 2012, closed to headspace September 2012.* *Young person was re-referred to headspace in April 2014 by a Barrett support worker to widen local support network. This was on the understanding remain engaged with CYMHS for mental health needs.* *Young person was offered Art Therapy, which enjoyed*

	When Art Therapy student finished with headspace [redacted], young person was offered support with our Social Work student with goals of working on some practical goals (Getting [redacted] learners license, facilitate referral to PHAMS, support to reconnect with Kid in Mind, relaxation strategies) *Fortnightly sessions being offered currently (non MHCP, student)* *Risk is assessed at each appointment, and a safety plan is in place.*
[redacted]	*1 client:* 5. *Open with GP [redacted]. Receiving counselling elsewhere.*
[redacted] *- Vanessa Clayworth, Clinical Leader headspace [redacted] was the Clinical leader at Barrett Centre prior to working at headspace and was actively involved in the development of the Transition Plans for the clients affected by the Barrett Centre closure*	*2 clients:* 6. *A past Barrett [redacted] year old [redacted] attend session with our GP for the first time last week. [redacted] being managed by [redacted] is chronically high with many past attempts and long history of DSH and engaging in other risk taking behaviours. [redacted] is also a member of our Youth Reference Group; we have liaised with [redacted] Therapist at PAH and agreed that PAH is to manage risk and complete safety planning as they are the primary service provider.* 7. *1 [redacted]: engaged, risk monitored.*
[redacted]	*[redacted] had one YP [redacted] who was closed from the service several months ago who refused to engage. As far as they know [redacted] is well.*
[redacted]	*Have called twice – following up with the Centre (called again today).*

	Suspected contact from a young person - It is reported that this person was [redacted] and did not have a close relationship with the three other young people.

I advised all centre managers to inform me should risk escalate. Given risk appeared to be contained at that time, I did not actively follow up after about 4 weeks had passed and relied on centre managers to inform me should those clients be at risk or if new BAC clients were to present at their centre. No managers informed me of concerns or new BAC clients after this time.

I was also informed that QHealth had been contacting **headspace** centres to follow up BAC clients. Therefore on 18 August 2014 I emailed Steven Stathis at QHealth as follows:

*"**From:** Amelia Callaghan [Callaghan]*
***Sent:** Monday, 18 August 2014 3:15 PM*
***To:** [redacted]*
***Cc:** [redacted]*
***Subject:** re: Barrett Centre clients at headspace Centres*

Hi Stephen,

I'm wondering if I would be able to touch base with you briefly about ex- Barrett Centre clients at headspace Centres? Could you please email me your contact details and I will give you a call?

Following your contact with Marie O'Dea at [redacted] (who reports to me as National Office is currently running this Centre until 1 September), I became aware of other ex-Barrett Centre clients at the time of closure, that are at headspace centres.

To the best of my knowledge:

- *There are 4 Centres that are actively seeing ex Barrett Centre clients [redacted]*
- *There are 2 clients that are still open to headspace Centres, however the Centre [redacted] has been unable to engage or contact despite assertive efforts*
- *One YP made contact with [redacted] and was closed after refusal to engage*
- *Awaiting information from our [redacted] Centre about possible other contact from YP*

I have asked these Centres to actively monitor the risk with these young people, make efforts to actively engage and to notify us if there is any change in risk or

circumstances. Given their elevated risk we are keen to actively support these young people as much as possible.

Just thought it might be good to touch base though and have a quick chat about them, and coordinate our efforts.

I have included Dr Sandra Radovini - Clinical Director headspace National in this email.

Kind regards,
Amelia"

I did not receive a response to this email. I called Leanne Geppert at this time and advised her of the above.

e. *to the extent they are not included in (a) to (d) above, details of all Transition Clients who received services from Headspace (and the nature of the services and the date when they were received).*

There was only one client formally referred to **headspace** as part of the Transition Process. It appears that the remainder were self-referrals or referrals by third parties in the months that followed. With respect to the one client that was part of the transition process, I believe that Aftercare has provided materials to the Commission.

Working Groups / Committees

25. *The Commission understands that you were a member of the State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy. With respect to this group, provide details as to:*

a. *the period for which you were a member of this group and the circumstances in which you were appointed;*

I received an email on 19 August 2013 from Judi Krause inviting me to be on the Steering Committee. I assume that I was invited given my previous involvement in the ECRG, that my role with **headspace** had a state wide and youth specific scope and that I was outside QHealth.

The period of appointment was open ended as outlined in the TOR as follows:

"The Committee is life limited for the duration of development, implementation and evaluation of transition to CHQ. The Chair will advise the Committee

members approximately one month prior to the dissolution of the Steering Committee once the service is mainstreamed."

b. *your role and responsibilities as a member of the group;*

My role and responsibilities as a member of the group were to provide input into the development of mental health services that best met the needs of young people across Queensland. It was also my responsibility to represent **headspace** National Office and to reflect the views of **headspace** centre staff.

c. *the relationship (if any) between this group, the recommendations of the ECRG and/or decisions made about the closure of the BAC;*

A number of members of the ECRG were also on the Steering Committee and were familiar with the recommendations of the ECRG. It was the Steering Committee's responsibility to take the recommendations and overarching principles of the ECRG into consideration when progressing the development of a State wide model.

d. *the role and function of the group and its working and reporting relationships; and*

The role and function was outlined in the TOR as follows:

"The purpose of the Statewide Adolescent Extended Treatment and Rehabilitation Implementation Steering Committee (Steering Committee) is to:

- *Monitor and oversee the implementation of the Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy Project Plan (Project Plan) to ensure that project milestones and key deliverables are met in the required timeframes, and that all accountabilities are fulfilled.*
- *Review and submit any proposed amendments of the Project Plan to the Chief Executive (CE) and Department of Health (DoH) Oversight Committee for approval.*
- *Establish, monitor and oversee the three Working Groups and their associated processes and outputs.*
- *Provide a decision-making, guidance and leadership role with respect to mental health service planning, models of care, staffing issues, financial management and consumer transition associated with the project.*
- *Provide governance of the project risk management process and associated mitigation strategies, and escalate in a timely manner to the CE and DoH Oversight Committee.*
- *Identify roles and responsibilities within the key stakeholder groups regarding information collection and reporting, transition of consumers, re-allocation of funding, including the identification of overlap and related roles.*
- *Prepare a communication plan for endorsement by the CE and DoH Oversight Committee"*

e. *any findings/recommendations/outcomes of the group, in so far as they relate to the BAC and/or adolescent mental health in Queensland.*

Of ten meetings held between 26 August 2013 and 13 January 2014, my records indicate that I was an apology for six of these; I attended by teleconference at two and attended in person at two.

Given that I attended two out of ten meetings in person, and that the two teleconferences I attended were hard to hear and follow over the phone, my ability to comment on findings, recommendations and outcomes is limited. I was also one of a few representatives not from QHealth and some of the matters discussed (eg. financial management) were specific to QHealth and were outside my scope.

In addition, the monthly Status Report for December 2013 indicated that all key areas of focus were "on track" as indicated by their green status.

26. *The Commission understands that you were a member of the Adolescent Mental Health Extended Treatment Initiative Steering Committee. With respect to this group, provide details as to:*

a. *the period for which you were a member of this group and the circumstances in which you were appointed;*

My recollection is not clear with respect to this. I think membership of the AMHETI Steering Committee rolled over from my involvement in the SW AETRI Steering Committee.

The minutes from the SW AETRI Strategy Steering Committee meeting on 28 January 2014 state:

- *"JK advised that CHQ Board Chair wants the initiative name changed to Adolescent Mental Health Extended Treatment Initiative. Documentation will be changed to reflect this."*

As far as I was aware it was the same group, with the same TOR and period, with a name change following this request outlined above.

b. *your role and responsibilities as a member of the group;*

My role and responsibilities as a member of the group were to provide input into the development of mental health services that best met the needs of young people across Queensland. It was also my responsibility to represent **headspace** National Office and reflect the views of **headspace** centre staff.

c. *the relationship (if any) between this group, the recommendations of the ECRG and/or decisions made about the closure of the BAC;*

It was the committee's responsibility to take the recommendations and overarching principles of the ECRG into consideration when developing the model.

d. *the role and function of the group and its working and reporting relationships;*

Please refer to my response to Question 25d.

e. *the "Mindframe" resources/information which the Commission understands you circulated within the group in August 2014; and*

There was discussion at the meeting about media coverage, misinformation contained in the media reports, and concern about the way the deaths were being covered by media. On recommendation from the **headspace** School Support team, I advised the attendees of the Mindframe resources and agreed to circulate them. My recollection is that Steven Stathis was also preparing to meet with the editor of Brisbane Times newspaper and it was thought that the Mindframe resources may have been useful for that.

f. *any findings/recommendations/outcomes of the group, in so far as they relate to the BAC and/or adolescent mental health in Queensland.*

The State wide model of care developed through the Service Options Working Party was slowly being implemented in a staged process dependant on funding. Where elements were not implemented it was due to funding not being available or practical barriers such as not being able to find a suitable premises for the day program.

It seemed to me that QHealth staff were trying to roll out the model to the best of their ability, given the funding constraints and the staged implementation plan.

27. *The Commission understands that you were a member of the Statewide Adolescent Extended Treatment and Rehabilitation Service Options Implementation Working Group Forum. In respect of this group, provide details as to:*

a. *the period for which you were a member of this group and the circumstances in which you were appointed;*

I received an email on 25 September 2013 from Ingrid Adamson stating:

"I apologise for the urgency of this email; however, after speaking with Leanne Geppert yesterday, we felt it was important to see if you might be interested/available to participate in the Service Options Implementation Working Group. The first workshop for this group is being held next Tuesday (again, apologies for the short notice - we are trying to move quickly on this) and below is an email I have sent out to other identified representatives. Are you interested in participating on this Working Group and are you available next Tuesday?"

I joined the group as I believed that it had the greatest potential to impact **headspace** centres and I had a particular desire to advocate for services in North Queensland as requested by **headspace** centres outside of South East Queensland.

While the initial TOR contemplated fortnightly meetings, my recollection is that a workshop was held on 1 October 2013, and then case studies were progressed by email.

Minutes of the SW AETRI Steering Committee meeting on 23 September 2013 state:

"LG advised that the intent to bring the WG1 together as a half day workshop rather than a 1hr fortnightly meeting to expedite work. She advised that, in light of recent events at the Barrett Centre, it is important to progress quickly. The Committee supports this approach."

b. *your role and responsibilities as a member of the group;*

My role and responsibilities as a member of this group were to participate in the workshop and provide feedback on the case studies in order to inform recommendations on the Service Options to the SW AETRI Steering Committee. It was also my responsibility to represent **headspace** National Office and reflect the views of **headspace** centre staff.

c. *the relationship (if any) between this group, the recommendations of the ECRG and/or decisions made about the closure of the BAC;*

The workshop participants were emailed copies of the recommendations on 30 September 2013, prior to their attendance at the workshop on 1 October 2013. Some of the ECRG members were also on this working group.

d. *the role and function of the group and its working and reporting relationships; and*

This group was developing a State wide model of care, taking into account the service elements in the ECRG recommendations and also the group members' own observations about needs and gaps in youth mental health service delivery across the State. This proposed service model could then be costed by the finance

working group for consideration by the Children's Health Queensland HHS Board and the Q Health Mental Health and Alcohol and Other Drugs Branch Executive.

e. *any findings/recommendations/outcomes of the group, in so far as they relate to the BAC and/or adolescent mental health in Queensland.*

As mentioned in my response to Question 17d, there was a range of views represented at this workshop and there was not a consensus that an inpatient Tier 3 unit was needed. It was felt that a range of service options including mobile outreach services, day programs and step up and step down facilities were needed.

28. *Details with respect to any other group of which you were a member, which related (or relates) to the BAC and/or adolescent mental health in Queensland.*

I am a member of the Queensland Mental Health Commission Advisory Council.

Other

29. *State whether you or Headspace intends on providing to the Commission, any written submission relevant to the Commission's Terms of Reference and, if so, the date when you anticipate this will be received.*

I am informed by **headspace** National Office that it does not intend to provide a written submission.

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

I am familiar with the BAC client files for the young people who have accessed services at **headspace** Centres run by Aftercare.

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

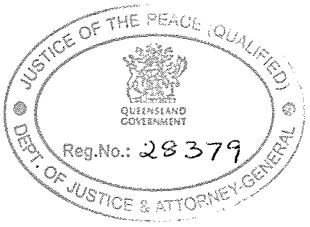
Please refer to the table of Exhibits below.

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

[Signature of person making the declaration]
Declarer

Taken and declared before me at SPRINGWOOD, QLD [insert name of town or city and suburb where witness statement is signed] this 14th [insert date] day of JANUARY [insert month] 2016 [insert year], before me.

JAN PRIEST JP(Qual)



[signature]
Justice of the Peace/Commissioner for Declarations

EXHIBITS to Witness Statement of Amelia Jane CALLAGHAN

Exhibit Number	Description	Question Number
A	Curriculum Vitae of Amelia Jane CALLAGHAN	1
B	Position Description of State Manager QLD and NT role	2c
C	Number and location of **headspace** centres in Queensland	3a
D	Staff numbers in **headspace** centres in Queensland	3c
E	"How **headspace** can help" fact sheet	3i

Amelia Callaghan - Curriculum Vitae

PERSONAL INFORMATION

NAME CALLAGHAN, Amelia

TELEPHONE Mobile [redacted]

EMAIL [redacted]

QUALIFICATIONS

2005	Masters in Social Administration Human Service Management, Social Policy & Counselling concentrations University of Queensland
2000	Graduate Diploma in Psychology University of New England
1998	Certificate 4 in Workplace Training - Category 2
1997	Bachelor of Social Science - Psychology Queensland University of Technology

WORK / PRACTICE HISTORY

September 2015 — **Regional Manager**
headspace Aftercare - Nundah, Ipswich, Woolloongabba and Meadowbrook

July 2015 - current — **Manager**
headspace Meadowbrook
(Primary and Youth Early Psychosis Program)

Responsibility Snapshot

- Provide day-to-day operational & clinical management of headspace Meadowbrook
- 18 staff and 6 private practitioners
- Clinical oversight, Crisis and Incident Management

- Managing complaints
- Establish clinical systems including intake, assessment, case review meetings, treatment programs for individuals, systems for closure & referral
- Ensure programs meet identified funding outcomes, including data collection and pre & post measures
- Establish the new Youth Early Psychosis Program Spoke at headspace Meadowbrook
- Staff management including regular supervision, renegotiating contracts, performance management, redundancy, recruitment and appointment
- Report to the lead agency, the Advisory Group & the Clinical Reference Group
- Development of Service Level Agreements with key stakeholders
- Ensure financial efficiency of the service

2013 – July 2015 **State Manager – QLD, NT (full time)**
headspace National Office

Responsibility Snapshot

- Provide support to headspace Centres in QLD, NT & WA across strategic planning, corporate governance, clinical governance, quality and risk management, financial management and alignment with the National MH Standards.
- Respond to Complaints about headspace Centres
- Work with the Manager to undertake an appropriate review of Level I Critical Incidents at headspace Centres
- Participate in the national Quality, Clinical Risk Committee
- Review clinical governance materials of new headspace Centres and determine whether they are at the appropriate standard required prior to granting approval for the Centre to open
- Coordinate and participate in clinical consultations with the National Clinical Director
- Develop relationships with key Statewide stakeholders in mental health, health and education to drive service reform and facilitate the formation of partnerships for headspace centres and new pathways to care for headspace clients
- Assist with promoting the work of headspace through public speaking, conference presentations and media
- Work collaboratively with the National Centre for Excellence, Service Provider Education and Training and Community Awareness departments including delivery of training programs and webinars
- Work collaboratively with Lead Agencies and Centre Managers to improve performance at centres that experience challenges in meeting targets and/or experience significant operational difficulties
- Actively support integration between headspace Centres and other headspace National clinical programs such as eheadspace, headspace Youth Early Psychosis Program (hYEPP), headspace School Support (hSS) and tele-psychiatry

Achievements Snapshot

- Appointed an Advisory Council member for the Qld Mental Health Commission
- Member by invitation on the QHealth Statewide Adolescent Extended Treatment and Rehabilitation Working Party to develop the Statewide model of care for Child and Youth MH Services

June 2011 – 13 **State Manager – QLD, WA, NT(full time)**
headspace National Office

Sept 2010 – June 11 **Manager – (full time)**
headspace Gold Coast

Responsibility Snapshot

- Provide day-to-day operational & clinical management of headspace Gold Coast
- 7 direct reports, and oversee 16 private practitioners
- Clinical oversight, Crisis and Incident Management
- Managing complaints
- Ensure programs meet identified funding outcomes
- Staff management including regular supervision, renegotiating contracts, performance management, redundancy, recruitment and appointment
- Report to the lead agency and the Advisory Group
- Development of Service Level Agreements with key stakeholders
- Ensure financial efficiency of the service

Achievements Snapshot

- Transition of lead agency from Gold Coast Drug Council to General Practice Gold Coast
- Secured partnership with National brand, UNIT
- Approximately 950 young people through the service every three months
- On average, 8 new referrals a day, 115 new clients each month
- In excess of 2500 young people through the service since opening

Dec 2009 – Aug 10 **Transition Manager – (full time)**
Headspace Gold Coast

Responsibility Snapshot

- Provide day-to-day operational & clinical management of headspace Gold Coast
- Clinical oversight, Crisis and Incident Management
- Ensure services meets identified funding outcomes
- Report to the lead agency (GCDC) and the Advisory Group
- 7 direct reports and completed full staff restructure
- Recruited appropriate staff to the service and performance managed out staff that were not performing their roles
- Managing complaints
- Implement recommendations from the review conducted in November 2009
- Review clinical governance of the service
- Review and ensure financial efficiency of the service
- Staff management including regular supervision, renegotiating contracts, performance management, redundancy, recruitment and appointment

Achievements Snapshot

- Completed restructure of all staffing positions
- Review of budget positions
- Established the Clinical Working Party
- Increase private practice component of the service, including two private psychiatrists

- Increase opening hours to include late night Thursday night (9pm)
- Restructure consortium and redevelop MOU, including convincing QHealth to remain in the initiative.

May 2009 – Aug 09 **Executive Manager – Community Services and the Institute of Studies(full time) Odyssey House Victoria**

Responsibility Snapshot

- Provide day-to-day operational management of Community Services Programs and the Odyssey Institute of Studies
- 8 direct reports, overseeing approx 40 staff members across multiple sites in Victoria
- Ensure financial efficiency of all Community Services & Institute Programs, including development of a Business Plan for the RTO
- Clinical oversight, Crisis and Incident Management
- Review key quality performance indicators related to ISO standards
- Ensure programs meet identified funding outcomes
- Staff management including regular supervision, renegotiating contracts, performance management, redundancy, recruitment and appointment
- Represent and advocate for Community Services programs through membership of the Executive Management Structure

Achievements Snapshot

- Completed annual Strategic Plan for the Community Services and Institute of Studies in line with the 3 year Organisational Plan
- Completed review of all Community Services programs and the Institute of Studies and made recommendations to the CEO

May 2009 - Mar 08 **General Manager – headspace Centres (full time) headspace: National Youth Mental Health Foundation**

Responsibility Snapshot

- $ 32 Million over two and a half years
- Ensure that appropriate assistance and accountability measures were applied to each of the 30 Centres
- Monitor contract deliverables and ensure that Centres were established in line with expectations from headspace National Office

Responsibility Snapshot continued

- Manage the 30 contracts with a range of leading organisations from around the country
- Review submissions for the Youth Development Fund and make recommendations to the Board on funding eligibility
- Manage the project coordinators employed to support the work of the Centres and allocate work responsibilities and duties in accordance with Position Descriptions providing overall direction, support and encouragement

- Manage the Performance Development Framework for staff including the development and maintenance of position descriptions, the formulation and review of annual objectives and the provision of advice on training and career development opportunities.
- Manage the budgets allocated to Centres, ensure that expenditure targets are met and appropriately reported on
- Liaise with legal department regarding non performance of sites against contract deliverables
- Prepare necessary reports for the Foundation Executive, Advisory Board and DoHA
- Attend and report to the headspace Advisory Board
- Assist with promoting the work of headspace through public speaking, conference presentations and media
- Work collaboratively with the Centre for Excellence, Service Provider Education and Training and Community Awareness
- Liaise with headspace managers, consortiums and key stakeholders

Achievements Snapshot

- 5 Collaborative Learning Network events held for headspace Managers
- Development and implementation of the reporting framework
- 30 Youth Mental Health Services established across Australia
- Successful intervention and provision of intensive support in headspace site in WA to prevent non delivery on contract
- Successful execution of the work plan meeting contractual requirements
- Business planning undertaken with all sites

Feb 2008 - Feb 07 **Project Coordinator(full time)**
headspace:
National Youth Mental Health Foundation

Responsibility Snapshot

- Supporting initial establishment of headspace sites in Western Australia, Victoria and Northern Territory
- Prepare reports for the Foundation Executive Committee and Advisory Board
- Assist with promoting the work of headspace through public speaking, conference presentations and media
- Work collaboratively with the Centre for Excellence, Service Provider Education and Training and Community Awareness
- Liaise with headspace managers, consortiums and key stakeholders

Achievements Snapshot

- Development of the Youth Participation Strategy
- Recruitment of young people for the Headspace Youth National Reference Group (HY NRG)
- Representation of headspace at Garma: Indigenous festival

Nov 2005 - Feb 07 **Dual Diagnosis Coordinator(full time)**
Including 3 months as Acting Executive Director through 2006
The Gold Coast Drug Council Inc
(GCDC - Mirikai).

Responsibility Snapshot

- $ 4 Million Budget
- Approx 30 Staff, 40 volunteers
- Direct client load of 115 clients per annum
- Oversee clinical services to in excess of 1000 clients per annum
- 24 hour on call to all clinical services
- Chair Best Practice Steering Committee
- Secondary consultation service
- Established tertiary Student placement and supervision program with Bond University and Griffith University
- Coordinating Psychiatric Clinic and supervising psychiatric services
- Participate in all levels of decision making within GCDC through membership of the Executive Management Structure.
- Participate and represent GCDC on the Gold Coast Complex Needs Assessment Panel

Achievements Snapshot

- Establishment of private medical practice under MBS
- Establishment of private allied health services under MBS
- Establishment of Best Practice Steering Committee
- Participation in RANZCP Depression Logarithm Treatment Mapping Research Program
- Trial of 'Integrated Mind' web based mental health screening
- Funding from Rotary Research Fund for Motivational Interviewing research in collaboration with Griffith University
- QIC standards for AOD
- Establishment of GREAT (Grass Roots Education and Training) collaboration of workforce development budgets and activity across multiple services on Gold Coast including Dept Education, Dept of Youth Justice
- All staff completed Introduction to Psychiatry

June 2005 - Oct 05 Youth Co-morbidity Clinician (full time)
Youth Substance Abuse Service (YSAS)

Nov 2004 - June 05 Psychologist(full time)
Child and Youth Mental Health Service

Nov 2003 - Sept 04 Clinical Manager – 30 hours a week
The Gold Coast Drug Council, Inc (Mirikai)

Responsibility Snapshot

- $ 3.7 Million Budget
- Approx 40 Staff and 30 volunteers
- Approx 1500 Clients per annum
- Clinical oversight, Crisis and Incident Management
- Review key quality performance indicators related to ISO standards
- Ensure programs meet identified funding outcomes
- Staff management including regular supervision, renegotiating contracts, performance management, redundancy, recruitment and appointment

Achievements Snapshot

- Established the Gold Coast Youth AOD Working Party
- Established clinical review and treatment planning processes
- Secured additional funding from the Crime Prevention for DRASTIC Program

Nov 2003 - Sept 04	Private Practice, Broadbeach
April 2003 - Nov 03	Local Co-ordinator 'Building resiliency in Transcultural Adolescent: BRITA' Multicultural Families Organisation
	Contract Work Department of Families (Child Protection)
Feb 2001 - Mar 03	Youth Outreach Coordinator and Counsellor The Gold Coast Drug Council, Inc (Mirikai)
June 2000 - Feb 01	Residential Drug and Alcohol Counsellor Mirikai Therapeutic Community (GCDC)
June 1999 - June 00	Youth Health Worker Youth Health and Education Service (YhES House)
Feb 1998 - June 99	Residential Support Worker The Gold Coast Project for Homeless Youth

C O M M I T T E E S

2014-15	Advisory Council Member Queensland Mental Health Commission
2011-13	Qld Early Psychosis Steering Committee QHealth
2010	Qld Community Mental Health Partnerships Committee Dept of Communities
2007	Member (by invitation) Gold Coast City Council Mayor's Youth Affairs Advisory Board

Position Description

State Manager

Location:	State based appointments
Department:	Centre Support
Level:	Executive Officer - EO1
Employment Type:	Full time, Fixed Term
Approved By:	Liz Burgat
Date Approved:	July 2012
Agreed By:	_____
Date Agreed:	_____

---

1. POSITION SUMMARY

The position will be responsible for supporting the ongoing resourcing and development of the **headspace** centres established across the country. State Manager Positions are allocated to the following locations:

- Victoria and Tasmania
- Western Australia and South Australia
- Queensland and Northern Territory
- New South Wales and Australian Capital Territory

Reporting to the National Manager of Centre Support the State Manager will have responsibility for the strategic development and collaborative support of **headspace** centres both nationally and within their specific location. They will liaise directly with each **headspace** centre to assess areas for service development, explore opportunities for service networking and areas for future development and resourcing. They will develop key relationships with state/territory government and relevant peak bodies in education, vocation and health to drive partnerships and service reform.

As a member of the Centre Support team, the State Managers will work collaboratively with members of the executive, the Board and the Centres to ensure that **headspace** has the best possible chance of meeting its main objective of engaging young people in appropriate care.

2. POSITION CONTEXT

The role is located within the Centre Support team at **headspace** National Office, however will have local offices in their relevant location. The Centre Support team is responsible for assisting and guiding **headspace** Centres to deliver their objectives. The State Manager will report to the National Manager of Centre Support and will work collaboratively with the other State Managers and divisions of **headspace** National Office (hNO) to support consistent systems, service and model development across the potential 90 **headspace** Centres.

3. ORGANISATIONAL INFORMATION

headspace is funded by the Australian Government under the Promoting Better Mental Health – Youth Mental Health Initiative

headspace, *est. 2006, is making a difference to the lives of thousands of young Australians by:*

Giving young Australians the opportunity to seek help early: Thousands of young people have been assisted through our 30 newly established **headspace** centres Australia wide, expanding to 60 by 2014.

Bringing together local health services under the one roof: Reform of local mental health and substance use service systems are being driven by the funding that **headspace** has provided to local communities. Services such as mental health, vocational and alcohol and other drug services come together in our **headspace** centres.

Making it easier for young people and their families to find the information they need: In April 2008, **headspace** launched a new help-seeking website**.** Designed to be youth-friendly and easy to navigate, **headspace*'s*** website is fast becoming the first port of call for people seeking information about youth mental health and wellbeing issues and services within Australia.

Reviewing evidence and interventions to provide Australians with the most up-to-date information on youth health: **headspace*'s*** Centre of Excellence is undertaking a systematic review of Australian and international evidence on interventions for mental health and substance use disorders in young people aged 12-25 years.

Providing opportunities for young people to have input into the development and delivery of headspace services.

Creating awareness and educating young people about how to get help: A successful ongoing social marketing strategy has resulted in **headspace** having a distinct identity and profile in the Australian community.

Training professionals how to work with young people: Professionals from a variety of settings across different **headspace** communities have been provided with training in youth-specific psychosocial assessments and strategies for the effective engagement of young people.

In providing our services we will be:
Compassionate – We are caring, focussed and respectful of others.
Inclusive – We value a diversity of opinion and background.
Responsive – We are agile, flexible and move rapidly.
Passionate – We care about what we do and enjoy what we do.
Leaders – We are innovative, thought leaders and valued partners.

For more information about headspace, please visit www.headspace.org.au

4. KEY RESPONSIBILITIES/OUTCOMES

The allocation of responsibility is approximately 60% centre support, 20% portfolio, 10% state functions and 10% national functions.

The State Manager will be responsible for the ongoing support and resource distribution to the centres by ensuring that appropriate assistance and accountability measures are applied to each of the relevant state sites to ensure that mental health services to young people are enhanced in each of the funded communities. This will include, but not limited to:

- In consultation with the National Manager of Centre Support and the executive team, ensure the strategic plans are aligned nationally with identified action and outcomes.
- Work collaboratively to develop the appropriate mechanisms and tools to assess measure and monitor the delivery of goods and services to the sites.

- Assess the requirements of each centre in consultation with the Centre Manager and lead agency.
- Develop an action plan in consultation with the Centre Manager to ensure **headspace** resources and supports are delivered in an agreed period of time in a structured and timely way.
- Work collaboratively with the Centre Support team and portfolio members to ensure that the appropriate allocation of goods, services, products or expertise is available and delivered to each site.
- The incumbent will be expected to take up a strategic leadership role within the Centre Support team for cross functional topics which support service development nationally. They will work with relevant staff within the team and lead National Office to support the work of the centres. Portfolio areas will be determined upon appointment based on skill mix/area of interest and organisational priorities.
- The State Manager will be responsible for monitoring contract deliverables and ensuring that centres are established in line with expectations from **headspace** National Office.
- Liaise with the Contracts and Compliance Coordinator, Chief Financial Officer and other members of the senior executive to ensure each centre is compliant with its obligations under the funding agreement and budget specifications.
- Manage the performance of the sites against the agreed work plan.
- Develop and lead cross functional teams in order to ensure that all the expertise within the organisation is available to ensure that all supports and resources are of the highest possible standard.
- Work with the Manager of Centre Expansion to orient, mentor and integrate new headspace Centres into the **headspace** initiative.
- The incumbent will prepare necessary reports for the **headspace** Executive, Board and Department of Health and Ageing, as required.
- Lead and participate in major projects to deliver policy reviews, legislative and program proposals; and evaluation of existing programs to address consumer issues and Government priorities.

5. SELECTION CRITERIA

The following criteria must be met for consideration for this position:

5.1 Essential

- A postgraduate qualification in either health or clinical service delivery and business management.
- Highly motivated with exceptional leadership, project management and program management skills.
- Extensive senior management experience in a public and/or private health environment.
- A familiarity with national health organisations and extensive experience with peak State/Territory bodies and authorities.
- Significant experience managing and delivering services to young people.
- A passion for, and knowledge and understanding of, youth mental health and its impact at a community level.
- Understanding of service reform needed and experience in change management principles to support a culture of continuous improvement.
- Knowledge and understanding of current health/mental health policy issues in Australia including its impact on service system reform.
- A proven ability to work within and build effective teams, develop culture and build relationships and strategic partnerships with **headspace** stakeholders including key government, non-government and community partners.
- Exceptional interpersonal, communication and organisational skills with the ability to operate effectively at a national level with a range of individuals as well as organisational stakeholders across a range of sectors, settings and states and territories.
- Capacity to assess and manage risk, problem solve and be able to negotiate successful outcomes in potentially challenging circumstances

- Experience in contract management and the ability to ensure that deliverables are being met by contracted services.
- A capacity to operate in a rapidly changing environment.
- Current Working with Children Check and Federal Police Check.
- A current full drivers licence.

5.2 Desirable

- A background in the provision of direct care.

6. JOB COMPLEXITY, SKILLS, KNOWLEDGE

6.1 Level of Supervision/Independence

- Subject to broad direction and working with a considerable degree of autonomy.
- Will have proven management responsibility for diverse activities and/or staff.
- Responsibility for significant resources.

6.2 Problem Solving and Judgement/Risk

- Fully responsible for the achievement of significant organisational objectives and programs.
- Demonstrated capacity to conceptualise, develop and review major professional, management of administrative policies at the corporate level.
- Responsible for significant high level creative, planning and management functions.
- Provide strategic support and advice at the corporate level, requiring integration of a range of internal and external policies and demands, and an ability to achieve broad objectives operating within complex organisational structures.

6.3 Professional and Organisational Knowledge

- Duties at or above this level typically require a skill level which assumes and requires knowledge or training equivalent to:
    - Proven expertise in the management of significant human and material resources;
    - In addition to, in some areas, postgraduate qualifications and extensive relevant experience.
- Comprehensive knowledge of related programs.
- Expected to bring a multi-perspective understanding to the development, carriage, marketing and implementation of new policies.
- Devise new ways of adapting the organisation's strategies to new, including externally generated demands.

6.4 Breadth of the position

- Complex, significant and high level creative planning, program and managerial functions with clear accountability for program performance.
- Conceptualise, develop and review major policies, objectives and strategies involving high level liaison with internal and external client areas.
- Responsible for programs involving major change which are likely to impact on other areas of the organisation's operations.

6.5 Competencies

Service Delivery, Equity and Diversity, Professional Skills and Ethical Practice

- Philosophies of Practice - applies **headspace** principles of practice to service delivery such as primary health care, client/family centred practice, best practice and evidence based practice and community development
- Strategic and Service Planning
- Service Delivery
- Service Evaluation and Research
- Service Partnerships and Integration
- Cultural Security / Proficiency
- Rural and Remote Context
- Consumer Youth Participation

- Generic Management Skills such as communication and negotiation, teamwork, supervision, delegation, mentoring and coaching, emergent leadership and management and time and workload management
- Self-Care
- Information Management
- Legal and Ethical Practice
- Professional Standards and Competencies
- Consent, Confidentiality and Complaint

Development and Support, Quality and Safety, Clinical Management and Clinical Skills

- Self-Development
- Professional Networks
- Developing Others
- Safe Practice and Risk Management
- Quality Improvement
- Policy and Procedure
- Operational and Strategic Planning
- Client Management Systems
- Evidence Based Practice
- Youth and Family Participation
- Inter-professional Practice
- Consolidation of discipline specific skills
- Consolidation of program specific skills

7. POLICIES AND WORKPLACE PRACTICES

All **headspace** employees are required to acquaint themselves with the organisation's policies and procedures and to abide by them at all times.

It is expected that at all times, employees will:

- be respectful towards the organisation, colleagues, clients and the general public.
- be cognisant with and uphold the objectives and philosophy of **headspace.**
- act collaboratively with all colleagues.
- act in a safe and responsible manner at all times.

Exhibit C
EXHIBIT 32

headspace Centres - Queensland

	Round	Opened	State	Centre Name	Centre Manager Site Address
1	2	2008	QLD	Hervey Bay	Shop 9, Central Plaza3 - 15 Central AvenuePialba QLD 4655
2	2	2008	QLD	Southport	26 Railway St, Southport QLD 4215
3	2	2008	QLD	Townsville	Shop 2, 14 Sporting DriveTownsville QLD 4814
4	2	2008	QLD	Warwick	66 Albion Street, Warwick QLD 4370
5	3	2012	QLD	Cairns	Level 2, 45 Spence Street, Cairns QLD 4870
6	3	2012	QLD	Inala	Shop 53 Inala Plaza, 156 Inala Avenue, Inala QLD 4077
7	3	2012	QLD	Nundah	1264 Sandgate Road, Nundah QLD 4012
8	4	2013	QLD	Ipswich	26 East Street Ipswich QLD 4305
9	4	2013	QLD	Mackay	36 Wood Street, Mackay QLD 4740
10	4	2013	QLD	Maroochydore	1/27 Evans Street, Maroochydore, QLD 4558
11	5	2014	QLD	Mount Isa	West St, Mount Isa QLD 4825
12	5	2014	QLD	Redcliffe	457 Oxley Avenue, Redcliffe QLD 4020
13	5	2014	QLD	Rockhampton	155 Alma Street, Rockhampton QLD 4700
14	5	2014	QLD	Woolloongabba	182 Logan Road, Woolloongabba QLD 4102
15	6	2015	QLD	Meadowbrook	260 Loganlea Road, Meadowbrook QLD 4131
16	6	2015	QLD	Taringa	5 Moorak StreetTaringa QLD 4068
17	6	2015	QLD	Toowoomba	1 Snell St Toowoomba.
18	7	2016	QLD	Caboolture	TBA
19	7	2016	QLD	Capalaba	Office Unit 2/70 Edith St Wynnum QLD
20	7	2016	QLD	Gladstone	roseberry community Services 159 Goondoon St Gladstone 4680 QLD

1/3
AE JP

Centre Manager Postal Address	Centre Main Number
PO Box 1126, Hervey Bay QLD 4655	
PO Box 10204, Southport QLD 4215	
PO Box 4661, Kirwan QLD 4817	
PO Box 346, Warwick QLD 4370	
PO Box 7399, Cairns QLD 4870	
P.O. Box 227, Inala QLD Qld 4077	
PO Box 263, Nundah QLD 4012	
26 East Street, Ipswich, QLD, 4305.	
PO Box 3033, North Mackay QLD 4740	
PO Box 365, Tewantin, Qld, 4565, Australia	
c/- Gidgee Health, PO Box 39, Mount Isa QLD 4825	
PO Box 636, Redcliffe QLD 4020	
PO Box 242, Rockhampton QLD 4700	
PO Box 6042, Buranda QLD 4102	
PO Box 220, Waterford QLD 4131	
c/- headspace Redcliffe PO Box 636, Redcliffe QLD 4020	
PO Box 2397, Toowoomba 4350	
TBA	
Wynnum Post Shop PO Box 94 Wynnum Qld 4178	
Roseberry Community Services PO Box4139 Gladstone 4680 Qld	

Lead Agency
Wesley Mission Brisbane
Lives Lived Well
Northern Australia Primary Health Limited
RHealth
Royal Flying Doctors Service
Accoras
Aftercare
Aftercare
Northern Australia Primary Health Limited trading as Townsville Mackay Medicare Local
United Synergies
Mount Isa Aboriginal Community Controlled Health Service T/A Gidgee Healing
Open Minds Australia
There4u Ltd ABN 76 605 682 979
Aftercare
Aftercare
Open Minds Australia
United Synergies
United Synergies
FSG Australia
Roseberry Community Services

QLD Staffing Profile

Wage Group	Position	2014 Q2 Total	2015 Q4 Total
Clinical	AOD Worker	1.1	0.3
Clinical	Clinical Leader	9.35	15.7
Clinical	Counsellor/MH Worker	3.59	2.8
Clinical	GP	3.8	3.3
Clinical	Indigenous worker	0	1
Clinical	Intake worker	22.52	42.77
Clinical	Intern/Placement	3.13	1.9
Clinical	Nurse	0.2	0
Clinical	Nurse MH/registered	4.23	1.4
Clinical	OT	2	2.52
Clinical	Other	1.81	2.51
Clinical	Practice Manager	9.02	9.8
Clinical	Project Worker	0	0
Clinical	Psychiatrist	0.72	0.55
Clinical	Psychologist	21.31	28.3
Clinical	Registrar	0.28	0
Clinical	Social Worker	1.94	8.75
Clinical	Vocational worker	1.18	0.4
Clinical	Welfare Worker	0.05	0.6
Clinical	Youth Worker	4.53	5.83
Total Clinical		90.76	128.43
Community enga	Community engagement/education	9.62	14.31
Community enga	Other	0.76	2.5
Total Community		10.38	16.81
Management & A	Admin/Reception	16.84	27.13
Management & A	Manager	8.13	10.28
Management & A	Other	0.46	0.68
Total Management & Admin		25.43	38.09
Grant Total		126.57	183.33

Exhibit E
EXHIBIT 32

How headspace can help

headspace is here to help

headspace centres across Australia provide face-to-face information, support and services to young people, aged 12 to 25 years, and their families and friends.

headspace can help you with:

Mental health and wellbeing

headspace can help if you're experiencing significant changes in thoughts, feelings and/or behaviour, if you're being bullied, hurt or harassed or just not feeling yourself.

General health

headspace has youth friendly general practitioners (GPs) and health nurses who can help with any physical health issues. A GP can also help you with issues related to contraception, sexual health, drug or alcohol use, relationship problems or feeling down or upset.

Alcohol and other drug services

If drugs and alcohol are starting to affect things that matter to you, like your mental health, wellbeing or friendships, **headspace** can help.

Work, school and study

headspace work and study specialists can help you if you're struggling at school, unsure what course you want to do, need a hand writing a resume, or if you are searching for a job.

Online and telephone support is also available through **eheadspace**. (There is more information about **eheadspace** over the page.)

headspace centres

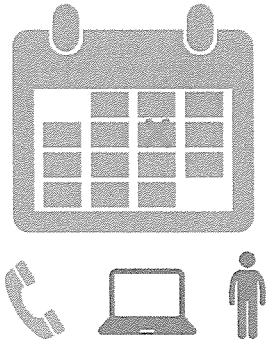
headspace centres help you to access the type of health worker you need. This could be a GP, psychologist, social worker, alcohol and drug worker, counsellor, vocational worker or youth worker. A number of centres also have Aboriginal and Torres Strait Islander health workers, welfare workers and family therapists.

You can visit a **headspace** centre no matter how big or small your problem may seem.

Making an appointment at headspace

It's as simple as phoning or emailing your nearest **headspace** centre to find a time that suits you. You can also ask a friend, teacher, parent, other family member, health worker or community agency to contact **headspace** for you.

Your local **headspace** centre might also have a 'drop in' service where you can visit anytime in their visiting hours. Call your nearest **headspace** centre or check out **headspace.org.au** to find out more about what services are available.



Aged between 12-25 years?

headspace can help if you:

- Are feeling down, stressed or can't stop worrying
- Don't feel like yourself anymore
- Can't deal with school/uni/work or are finding it difficult to concentrate
- Are feeling sick or worried about your health
- Have questions about, or want to cut down on alcohol or other drug use
- Want to talk about sexuality, gender identity or relationships
- Are having difficulties with your family or friends
- Have sexual health issues or want information about contraception
- Are being bullied, hurt or harassed
- Are worried about work or study or if you're having money trouble
- Need someone to talk to.

Getting support can help you to keep you on track at school, study or work, and in your personal and family relationships. The sooner you get help the sooner things can begin to improve for you.

headspace National Youth Mental Health Foundation is funded by the Australian Government Department of Health under the Youth Mental Health Initiative.

Exhibit F.

EXHIBIT 32

How headspace can help

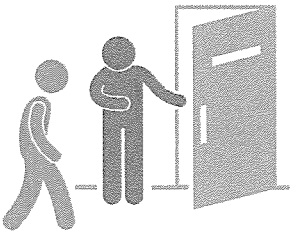
Your first appointment at headspace

Appointments at a **headspace** centre can vary in length but are usually 50 minutes to an hour.

It's okay to feel nervous about getting help for the first time. It can be helpful to bring along a family member, carer or friend to help support you.

You'll probably be asked a lot of questions on your first visit. This is to make sure that all the important issues are covered, and to help develop the best solution for you. As you get to know and trust your **headspace** worker you will probably find that talking about what is going on gets easier.

The appointment is your time. Feel free to ask questions about anything that's on your mind so the **headspace** worker can help you find the best solution, or find the information that you need. It also helps the **headspace** worker to understand what is worrying you.



Cost

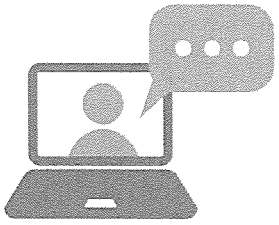
Services at a headspace centre are either free, or have a low cost. You can ask if there is a cost when you make your appointment.

Some services require you to have a referral from a doctor. But don't worry; headspace can help you with this as well.

All eheadspace services are free but if you call from your mobile your usual call charges apply.

eheadspace

If you don't have a **headspace** centre nearby or you don't feel ready to visit a centre, **eheadspace** provides confidential online and telephone support 7 days a week.

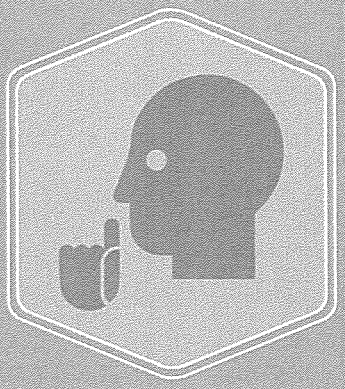


To access **eheadspace** for the first time all you need to do is register at **eheadspace.org.au** or phone **1800 650 890.** You will need to provide some information like your email address, postcode and age. **eheadspace** sessions are generally for 30-60 minutes.

If you are receiving support from a **headspace** centre or another service, **headspace** may ask your permission to speak with your worker to ensure **eheadspace** is providing the best possible support.

Confidentiality

When you talk to a headspace worker what you say is kept confidential. This means nothing you say can be passed on to anyone else without your permission however there are a few exceptions.



If **headspace** is seriously worried about your safety or the safety of someone else they must – by law – try to keep everyone safe.

This means they might have to share their concerns with someone else. Talk to your **headspace** worker about confidentiality to ensure you understand how it works.

If you need immediate medical attention, call 000 or call Lifeline on 13 11 14 or Kids Helpline on 1800 55 1800.

Getting the help that's right for you

When you talk with a **headspace** worker it's important that you feel safe and comfortable – **headspace** will do its best to make sure this happens.

If you do not think your **headspace** visits are working out it is important to ask yourself why. There could be a few reasons: it might be because it is hard to talk about what's on your mind, or it might be that you and your worker are not the right fit. Either way, don't give up. Talk to your worker about how you are feeling and together you can find a way forward.

headspace
National Youth Mental Health Foundation

For more information, to find your nearest headspace centre or for online and telephone support, visit headspace.org.au