Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF MS AMELIA JANE CALLAGHAN

I, Ms Amelia Jane Callaghan, Director of Clinical Service Innovation, at Orygen, of 35 Poplar Road Parkville Victoria 3052, say as follows:

1 I am making this statement on my own behalf.

2 I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

3 In this statement, I use the term 'young people' to refer to those aged between 12 to 25 years.

BACKGROUND

4 My full name is Amelia Jane Callaghan. B.S.S-Psych, GradDipPsych, MSocAdmin.

Qualifications

5 I hold the following qualifications:

(a) Bachelor of Social Science in Psychology;

(b) Graduate Diploma in Psychology; and

(c) Masters in Social Administration.

6 I hold full registration with AHPRA – PSY0000957436.

6 I have been involved in youth services since 1998 and the health sector since 1999, and was first registered as a Psychologist in 2004.

7 Since that time I have had experience working in both mental health services and alcohol and other drug services. I have held Psychologist roles in Child and Youth Mental Health services – Queensland Health, and in community based non-governmental organisation mental health and alcohol and other drug services (**AOD**) services.

8 Since 2007, I have held a variety of roles related to establishing and running headspace Centres, including:

(a) Project Coordinator for the establishment of the first headspace Centres and also led the planning, recruitment and establishment of the first headspace Youth National Reference Group (**HY-NRG**);

(b) General Manager - headspace Centres for headspace National;

(c) Manager at headspace Gold Coast (now headspace Southport);

(d) State Manager for Queensland, the Northern Territory and Western Australia for headspace National;

(e) General Manager - Integrated Service Centres managing seven headspace Centres and the Youth Early Psychosis Program for Aftercare (recently renamed to STRIDE); and

(f) more recently managing the five headspace Centres run by Orygen in my capacity as Director of Clinical Service Innovation.

9 I lived and worked in Victoria in 2005 for approximately 3 months, and again in 2007 for approximately 3 years. On this occasion I have been in Victoria since January 2019. For the remainder of my professional career I was based in Queensland, however I was the State Manager for Northern Territory and Western Australia for headspace for two years, employed by headspace National and visiting Melbourne monthly and the Northern Territory and Western Australia regularly. I also managed services in New South Wales (headspace Miranda and headspace Hurstville, LikeMind Wagga Wagga, LikeMind Orange) for Aftercare for two years.

10 Over the last twenty years, I have been responsible for establishing and implementing a range of integrated service centres such as headspace centres, headspace Youth Early Psychosis (**hYEPP**) service, adult integrated services (Floresco Centres in Queensland and LikeMind in New South Wales), and a child and family based early intervention integrated service centre pilot (The Poppy Centre).

11 I am a passionate advocate for early intervention services aimed at reducing the long term impact of mental illness on children, young people and families.

12 Attached to this statement and marked 'AC-1' is a copy of my Curriculum Vitae.

Current role

13 I am the Director of Clinical Service Innovation at Orygen. I have held this role since January 2019. I am jointly responsible for the strategic development and implementation of Orygen's local clinical service model, including at their five headspace Centres in Craigieburn, Glenroy, Melton, Sunshine and Werribee. This includes joint responsibility

for leading the delivery of Orygen's strategic direction and goals in terms of innovative, evidence-based service models and systems of care. We currently have six innovation projects underway, including developing a new integrated model of service delivery across the Western Melbourne region. A key priority for the design, development and implementation of this work is partnering with, and strengthening, youth and family participation.

14 For the last twelve months I have also being managing the National Programs Team at Orygen. This program provides support and guidance to the headspace Early Psychosis Programs across Australia and also provides support and guidance to the Primary Health Networks nationally in regards to their Youth Enhanced funded services targeting young people with more complex mental health needs. National Programs works to facilitate the translation of evidence based practice into successful implementation in service delivery across Australia, particularly for young people with more moderate to severe mental health presentations.

QUESTIONS FOR PANEL MEMBERS

Question 1: In considering a community-based mental health system over the longer-term (i.e. over 10 years), what is the ideal role and what services should be provided for:

15 Community–based mental health services should offer bio-psychosocial-cultural services across the whole continuum of care, including providing preventative services for those at risk of developing mental ill-health and also support and treatment for mild, moderate and severe mental illness. These services should be available regardless of the person's stage of presentation or psychosocial needs, or where they live. Community-based mental health services should also have the capacity to provide a range of services that can step up and down or be provided through shared care arrangements to best meet the needs of the individual. They should also provide support to families, carers and significant others of the individual requiring assistance.

16 The service components should include:

(a) drawing on the lived experience in design and delivery of services;

(b) a coordinated 'Front End' to facilitate easy and seamless access to services (see paragraphs 57 to 58 below);

(c) integrated service centres to offer a 'menu' of services that individuals can access based on their needs and preferences, in a coordinated and integrated system. This would include mental health, alcohol and other drug services, physical health services, employment/education services and a range of psychosocial support services;

(d) extended response services including assertive outreach, emergency department diversion and post emergency department follow up;

(e) access to acute care including inpatient beds;

(f) access to sub-acute services like Prevention and Recovery Centres (**PARCs**) and Residential Recovery Units (**RRUs**); and

(g) digitally enhanced care options.

17 The underpinning principles should be:

(a) based on meeting the needs of individuals, rather than based on resource limitations. This looks like a 'care matching' approach, rather than 'screening out' individuals from services;

(b) relational and engagement focused;

(c) socially and culturally inclusive;

(d) evidence informed;

(e) trauma informed;

(f) shared decision making; and

(g) family inclusive (using a broad definition of family and carers).

18 The table below summarises my responses to the following questions, however it is not intended to reflect a linear model of service, but more so a 'menu' of service options that young people and their families can access simultaneously, or sequentially and at different levels that adapt to their needs at any given time in a coordinated way facilitated by a key worker whether that be a clinician, care coordinator or peer worker;

Severity of Mental Illness	**'At risk'** **Targeted intervention**	**Mild - Moderate**	**Moderate – High**	**Acute – Suicidal crisis or following a suicide attempt** **Severe mental illness**
Diagnostic Focus	Maintaining Health and Wellbeing	High Prevalence disorders	High & Low prevalence Emerging (Ultra high risk) disorders	High and Low prevalence disorders

Psychosocial complexity	Low to High	Low - Moderate	Low - High	Low – High & Acute
Duration of active episode of care (based on need of Young Person)	Episodic care	10 sessions (~ 3 - 6 months)	6 - 12 months	12 - 24 months
Model of Engagement	Engagement and Monitoring	Care Coordination	Enhanced Care Coordination (including preventative monitoring)	Case Management Assertive outreach
Therapeutic Services available at an Integrated Service Centre with extended operating hours	Physical Health services (GPs, Dieticians, Exercise Physiologists, Personal Trainers etc)	Physical Health services	Physical Health services	Physical Health services including; • Metabolic management • Medication review
	Coping skills, Resilience	Targeted Psychological interventions	Targeted Psychological interventions	Targeted Psychological interventions
	Building mental health literacy	Psychiatrist assessments where indicated	Psychiatric assessment and management	Psychiatrist assessments, monitoring and management
	Respite and family support if required	Family support and psycho-education	Family therapy	Family therapy
	Peer Work			
	Family Peer Work			

a. Adolescents and young people at-risk of developing mental illness?

19 The role of community-based mental health services is to engage and monitor young people within the at-risk group, in order to detect mental illness early. Services also need

to help build resilience and coping skills in young people to proactively build their wellbeing and assist in keeping young people healthy and mentally well.

20 For those young people who are at risk of developing a mental illness, community-based mental health services need to offer psychosocial services, psycho-education, prevention and resilience building and physical health services. It is essential that the services offered are non-stigmatised services that young people can access without the need to identify that anything is 'wrong' with the young person.

21 If a young person is still engaged in a school-based setting, then school-based interventions are important. However, many young people at risk of developing mental illness have difficulty remaining in mainstream schooling. Community-based mental health services should provide psycho-education, physical health programs and support to these young people to remain in education and employment. They should also assist the teacher and school staff to support young people and their families, and facilitate a partnership between the clinicians and the key school staff.

22 For at risk groups, it also is important for community-based services to offer programs which target behavioural programs, such as anger, self-harm or violent behaviour. Many young people, particularly young males, are labelled as having behavioural problems. It is often not recognised that these young people may be at ultra-high risk of developing a mental illness.

23 Community-based mental health services should also provide additional support to young people in out of home care or whose parents or carers who have a mental illness. These young people often miss out on the experiences that other young people have, such as celebrating birthdays, Christmas or attending family based outings. Receiving respite from their family of origin, building healthy and pro-social relationships with others assists these young people to stay well and prevents them from developing a mental illness.

b. Adolescents and young people experiencing mild and moderate illness?

24 Like the headspace model, community-based services should provide services to both young people at risk of developing a mental illness and those who have a mild or moderate illness from a centralised and accessible location. Services are offered in an episodic manner and young people can access as often as they require services.

25 In addition to the focus on health and wellness for young people who are at risk of mental illness, the role for community-based mental health services in relation to those who have mild and moderate illness necessitates more therapeutic interventions.

26 Currently, community-based mental health services could provide more culturally sensitive and appropriate services to young people with a mild or moderate illness. This

is particularly relevant to First Nations and culturally and linguistically diverse young people. Often these young people have to experience a deterioration in their condition before they can receive a culturally appropriate response.

27 Services for young people experiencing mild to moderate should also offer a wide range of services, in addition to mental health services. Employment, education services, health and wellbeing services and working in partnership with local providers to meet local needs should also be included in the service design and delivery.

c. Adolescents and young people living with severe mental illness?

28 Young people living with severe mental illness require more targeted therapeutic intervention and case management.

29 It is important for young people to hear stories of hope from other young people through peer work and for families to also be able to access family peer workers.

30 There is a need to establish youth PARC units, in a similar way to the existing adult PARCs as a step up from community or a step down from inpatient services. Young people can stay in PARCs for approximately 3 months.

31 Currently Youth Residential Recovery Units (**YRRU**) operate in Queensland which provide services to young people who have longer term mental health conditions and require more intensive supports before being able to live independently. Young people with severe illness are often homeless due to their illness and family circumstances. YRRUs provide supported accommodation for up to 12 months to assist the transition to independent living.

d. Adolescents and young people who are experiencing a suicidal crisis or following a suicide attempt?

32 Diversion of young people away from emergency departments is very important. Young people who are experiencing crises often end up in emergency departments for long periods of time. They may self-discharge while waiting to be seen and while they are still at risk. They then have a negative experience of help seeking which can discourage them from seeing further help.

33 Many of the young people who present at emergency departments do not require admission, but do require intensive follow up in the community that is not available in the current system.

34 Additionally, if a young person does present at an emergency department and is discharged, there needs to be a capacity to follow them up intensively in the community.

35 As an alternative to the use of emergency departments, I suggest that the provision of services in an integrated service centre which offers extended operating hours.

36 There is also a need to develop the capacity within services for emergency outreach support. While this support exists on paper, it is often not available in practice. As a result, if a young person is in crisis at 2 am and their carer cannot get them in a car, currently the only options are to call the police or an ambulance to transport the young person to hospital. If the option existed to send a mental health team rather than an emergency services, then that would be a better option.

e. Families and carers of adolescents and young people experiencing challenges to their mental health?

37 Families need to be engaged as active partners in the care of young people from the very start of the process, and continue to be given opportunities to be active partners in the young person's care. There may be scenarios where the young person will not consent to that, and that should be respected but also revisited at key timeframes or milestones in treatment.

38 The needs of families and carers will differ based on the severity of a young person's illness. For young people experiencing mild to moderate illness, services will need to offer families education, including support and strategies. For young people experiencing severe illness, providing additional support to their family in the form of family therapy, peer support or access to support groups is essential.

39 Family therapy is a therapeutic intervention for families of young people with severe mental ill-health. It is not generally used when young people are experiencing mild to moderate illness. Family therapy is intended to respond when the mental wellbeing of the family is impacted by young person's situation. It can also include family mediation in order to sustain the young person living in the home. There is currently no Medicare item number for family therapy, and it needs to be billed under an individual's mental health care plan.

Question 2: What are best-practice examples of community-based mental health care for adolescents and young people? Why do they work well?

40 headspace is a best practice example of a community-based mental health service for the cohort young people with mild to moderate illness. It is also a model which could be expanded on. Some headspace services are co-located with both tertiary and community providers. As a result, some headspace centres are starting to function as a more comprehensive 'one-stop-shop'. They are perceived with less stigma by young people as they offer programs which encourage young people to maintain wellness, such as art

and personal training and social groups. If a young person does become ill, then headspace is seen as a less stigmatised place to access help.

41 There is a need to progress beyond co-location of services to integration. Even in headspace Centres where primary and tertiary services are in the one physical location they are very rarely integrated in their systems or medical records. In practice this means a change of clinician, retelling of their story, having to be discharged from one system to be assessed and registered in another system, all of which can be disruptive to the therapeutic relationship and slow down or stop any therapeutic gains.

42 Another best practice example is the Foundry service in Canada. They use a peer worker model from the outset. A young person who approaches the service will speak to a peer worker. That peer worker will then speak to a clinician. The young person's experience in that model is engaging in the first instance with a peer worker.

43 A lot of young people will only attend a single session, so the challenge is what to do in the one session to be able to offer the best care. The Foundry also uses a brief intervention single session model.

44 The Assertive Mobile Youth Outreach Service (**AMYOS**) operates in Queensland, based on a service that was previously offered in Victoria as the Intensive Mobile Youth Outreach Service (**IMYMOS**). The model for AMYOS is based on delivering services in the community rather than centre-based. The model is ideal for young people who need an assertive approach rather than expecting them to engage with the service at a centre. This is not as relevant to those young people with mild to moderate illness. Proactive outreach is particularly relevant to young people with severe mental illness, who may be psychotic, experiencing chaotic drug use, or have high levels of social needs that mean they are unable to attend a service. It is not just a crisis response service, but is aimed at preventing the young person's situation from requiring a crisis response. It can also reduce the demand on emergency departments.

Question 3: Should services for children, adolescents and youth be streamed by age, and why?

45 Regardless of how services are 'streamed' or grouped there will always be additional criteria that are considered in order to fully understand the individuals needs and subsequently develop a care plan. These include age, severity of mental illness, level of risk, diagnosis, other psychosocial needs, gender, cultural background and functionality. A quality service may be streamed by one of these factors but will then further consider how their care needs to be tailored in relation to the other factors. For example, an individual may attend a women's service but the care they receive will be further defined by their other presenting factors.

46 Services for children and young people should be streamed by age, because children and young people have different needs and developmental considerations to adults and aged persons. Streaming for children and young people increases the likelihood that the individual will receive the right services in a timely and appropriate manner.

47 I think streaming by age for children and young people has more merit than for the adult population, where streaming by other factors like gender, culture, sexuality or psychosocial needs has some merit. For example, the service that someone is likely to attend as an adult is related to how they see their identity, and also how they classify the 'problem' they are experiencing.

48 The grouping I would suggest for children is 0 to 11 years and 12 to 25 years for young people. There is need for further stratification within those services based on differing needs. For example within the 0 to 11 group, the infants aged 0 to 4 present with different developmental and mental health needs than 5 to 11 year old and within the 12 to 25 year olds, 12 to 17 years and 18 to 25 years are often further differentiated into two groups based on the different developmental tasks of those age ranges. Further to that, an individual's needs will also differ depending on their intellectual needs, their understanding and maturity. For example, it may be that a 19 year old and a 15 year old will receive the same service because they have similar needs and levels of maturity. In considering appropriate grouping, gender and cultural needs will also be important.

a. What are the challenges associated with age-based streaming?

49 The challenge would be assuming that all young people of a certain age or age group are heterogeneous and only using age as the criteria for service mapping.

50 Regardless of the criteria used, any grouping needs to not be overly concrete. It must be flexible in response to how people present. If age streamed, there needs to be flexibility at the ends of the age ranges to allow for exceptions in some scenarios where an argument can be made to begin care in this system earlier for pre-12 years or extend it later for post-25 years.

b. Could the aims of aged based streaming be met through alternative means? For example, by streaming based on different criteria.

51 I believe the aims of aged based streaming are to facilitate access to the right services to meet an individual's needs in a timely and appropriate manner. While access can be facilitated through a variety of means, I do not believe grouping under other criteria for children and young people will facilitate the desired aims. For example, while grouping services by gender, culture, diagnosis, stage of onset or severity will facilitate access to services, grouping the services by age encourages help seeking in the first place and

ensure that the different developmental and aged based needs underpin the delivery of service.

52 For example, it is not desirable to stream solely based on diagnosis. Even where individuals have the same diagnosis, interventions will be different based on their age, at different stages of their illness, and diagnosis can change over time. For this reason it is important to group by age, then a service can further stage by secondary criteria like diagnosis.

c. Are there examples of high-quality systems and services that don't use age-based streaming?

53 There are high quality systems that may not be grouped by age in the first instance, but all of them consider age as a primary consideration in treatment mapping at some stage. For example, Primary Care services, emergency departments, homeless services, call lines like Lifeline or KidsHelpLine, all differentiate the clinical intervention by age at some stage closely following initial assessment.

Question 4: How can Victoria better identify and support adolescents and young adults who need extra support for their mental health?

54 To improve identification, it is important to upskill those who are 'first to know' in their communities. That is, school teachers, sports coaches, family members and adults who come in contact with young people and are often the first people that young people will go to for help. The aim is to improve their mental health literacy so that they are able to recognise, identify and provide support to young people who require extra support and know when to refer when specialised support is required.

55 Young people have increasing mental health literacy. However, there remains a need to remove the stigma surrounding mental health. There are two aspects to this. Not only do young people need to know how to maintain their mental health and wellbeing, they also need to be aware of how to access services in the event they need assistance. Young people from our co-design process have told us that it is hard to know where to go to seek help. I believe that in addition to working with 'first to know communities', the development of a digital pathway that links existing services and resources could assist with this.

a. What key changes would you recommend to Victoria's mental health system?

56 A best practice future state would include increased numbers of peer workers and family peer workers. The added complexity in relation to peer work with young people is identifying the key features of a peer worker. For adults, a peer worker is clearly defined as someone with lived experience. However, what is an appropriate peer worker for a

12 year old? Is the defining feature that they are young, or that they have a lived experience of mental illness? Young people may also be reluctant to identify with their own lived experience. For young people there may be space for a support person or youth worker who is also young to fulfil this function, as well as a traditional peer worker role.

57 Another key change would be the redesign of the 'front end'. 'Front end' refers to how young people come in contact with the system, how they are engaged, how we can avoid them being bounced around between services, how their needs are assessed, how decisions are made about their care and how they are then linked seamlessly into that care.

58 At Orygen we are trialling a new coordinated 'front end'. We engaged 15 young people from the West Melbourne region to help us redesign the front end, identify the best approach and how to deliver this service. Three main priorities were identified by those young people:

(a) access to and engagement with a peer worker at the start of engagement with a service (the front end);

(b) culturally appropriate services. The future workforce may require more identified position for First Nations, culturally and linguistically diverse and LGBTQI individuals to lead to a broader socially inclusive workforce; and

(c) a sense of agency and control within their own care, including shared decision making and choice.

59 The young people engaged by Orygen identified they wanted contact with a peer workforce when engaging with the service. Ordinarily a young person starts with the most skilled clinician and de-escalates to a peer worker. However we are trialling starting engagement with peer workers who can escalate to a senior clinician if required. This approach is likely to be controversial. I consider that as long as there is clinical oversight and support behind the peer workers, and training to enable them to recognise when to escalate then it is likely to be successful. I am not aware of such a system in use in Victoria, however it is adopted by the Foundry in Canada.

60 Many young people who can only access primary care currently, have a higher level of need than can be met in that system. This places significant pressure on the primary system. A lot of clinician's time is also spent trying to get young people into tertiary systems that will not accept them. A young person may be referred from headspace to a tertiary provider and back to headspace without receiving any treatment because the services are debating where they should fit, and theoretically either system could provide the service if they had capacity. Currently access is a debate based on resource and

service capacity and severity of symptoms, and not on needs of the young people. The services which can be offered by primary and tertiary care are limited by the funding available. This creates huge gaps in the services available to the missing middle.

61 I consider that a better approach is not a 'no wrong door' approach, but 'every door is the right door'. Services should start with a 'yes' rather than the current model which starts with a 'no' and the presumption that an individual cannot access a service unless they can satisfy the service criteria or threshold that differs across services and across times of the year.

62 To address the missing middle there is a need for further integration between the state and commonwealth funded services. This requires a commitment from both state and federally funded services to work together and to use the different funding sources to create a seamless and collaborative service model rather than a fractured service. To achieve this, funding, governance and information technology systems must integrate across all of the parts of the mental health system.

63 Expanded integrated service centres are also required. There are some integrated services that provide core services. For example, headspace offers primary services, community services, Centrelink, legal assistance and physical health in a single integrated service. However, integrated service centres should build on that foundation and incorporate onsite tertiary services. The tertiary services should not be co- located but integrated into the service centre. Hours of operation need review also with greater flexibility for hours and days of operation.

64 Rather than focusing on 'hubs' which may only provide co-location, the system needs to focus on vertical and horizontal integration. We are developing six integrated service centres in the western region. The challenge is how to coordinate between the integrated service centres and not just within the Centres.

65 At Orygen, we are developing an integrated regional model, to build primary and tertiary services together and use that as a broader model for the state. We have identified the 7 core components that would be required, outlined in paragraph 16.

66 We also need to build on the success of these Centres to offer extended hours, avoid young people presenting to emergency departments, follow up on young people who have been to emergency departments and offer outreach services to respond to crises at home. A hospital in the home service based out of an integrated service centre would be a significant development. It could facilitate a pathway for young people to step down into an integrated service centre.

b. What key changes would you recommend to other service systems that support and engage with vulnerable children and adolescents; for example, schools and family welfare services and the justice system?

67 Young people in out of home care are particularly at risk of mental illness. Child protection systems require increased support to address these needs and need to be fundamentally rethought. Often, child protection services are triaging in response to only the highest level of risk and they cannot respond to the mental health needs of young people that are not at an acute level of risk.

68 Young people who are homeless may be homeless as a result of drug use or mental health issues in their family. They may themselves be showing early signs of more serious mental illness and may have significant trauma. Homelessness services provide housing to these young people but generally do not provide other mental health support. These young people require targeted intervention.

69 There is also a particular need for culturally specific mental health approaches for young people, especially First Nations young people, engaged in the youth justice system. These models should be co-designed with these communities.

Question 5: What are the professional mindsets, capabilities and skills that are needed for working specifically with young people in mental health?

70 Those working with young people require knowledge of the developmental tasks and stages of young people. Workers need to understand what normal development is so that they can identify deviations from that and work with the young people who are exhibiting abnormal behaviour.

71 They also need to understand that the early signs for people in ultra-high risk groups are often mistaken for other things, such as behavioural problems, but are actually a sign of the development of a more serious mental illness. Emerging mental illness can also present differently in young people and adults.

72 Across the age range of 12 to 25 years there is a large difference and there is a challenge finding a workforce that can work across that wide age range. Most clinicians will have a skill base that leans towards either end — that is young children or adults. We need a multi-disciplinary workforce that can adapt the skills needed with children and adults to the young adult population.

73 There is a distinct skill in engaging with young people, particularly those resistant to treatment. There is a distinct skill in re-engaging young people in high-risk categories and there is an art in engaging young people who do not want to engage in treatment in order to build a relationship and establish a therapeutic output.

74 An ability to adjust traditional treatment content to a process that works for young people is also a required skill.

75 Personal characteristics include being calm under pressure, patient, resilient, able to manage stress, emotionally intelligent, and have the ability for self-reflection.

a. How do they compare with the professional mindsets, capabilities and skills that are needed for working with adults?

76 The fundamental knowledge of mental illness and interventions is very similar but the application will be different to accommodate for the developmental and intellectual needs of the young person.

b. What prevents existing workforces from providing optimal care, treatment and support to young people, and what steps can be taken to overcome these factors?

77 A lack of resources and overly cumbersome processes means that the existing workforce is often overloaded and cannot provide optimal care for young people. They are carrying high case-loads, not receiving regular supervision, and some have little access to professional development. The paperwork is aimed at risk management and mitigation rather than the needs of the individuals that we work with. Systems that do not talk to each other, that are not compatible, forms that are mandatory that do not add any value to the clinical intervention also compound the situation.

78 Additional resourcing to reduce case-loads and increase supervision, a review of the existing systems and processes with the aim to remove duplication and an enhancement of digital integration of systems would be a start at addressing this issue.

c. What capabilities and skills are needed within the workforce to better engage with parents and carers of young people as partners in their care, treatment and support?

79 Professionals that work with young people often identify with the young person as the primary client at the expense of the relationship with their families and carers. The workforce needs to understand the importance of working with families particularly in this age group and the additional benefits that can be achieved for the young person and their family.

80 Some professionals also lack skills in engaging families and are uncertain how to manage conflict within families. Increasing clinician's skills and confidence with working with families would also assist.

81 Confidentiality is often used by professionals as a reason to not involve families, while young people are often happy to consent to involving their families in their care. There can be a misunderstanding by professionals around the limits of confidentiality, and how and when to share information with families.

82 Young people under the age of 18 may be 'mature minors' who are able to give consent, and there can also be some scenarios where adults over the age of 18 are unable to give informed consent. Clinicians must be able to understand the negotiation that occurs in relation to young people's responsibility and capacity for consent, and how this relates to family involvement in the young person's care.

d. What are the implications of the required professional mindsets, capabilities and skills you have identified above for the composition, training and deployment of:

i. clinical workforces?

83 Training in working with families, confidentiality and consent would be beneficial.

84 Training in supervision would also be beneficial.

ii. non-clinical workforces?

85 I believe that the addition of more Family Peer Workers at all levels of services would improve the quality of services provided to young people and their families. The family peer workers need to be integrated into the multi-disciplinary team.

86 I also believe that administration staff do not receive the support that they need to assist them to work with this cohort. For example, training like 'Managing challenging conversations', 'Mental Health First Aid', 'ASIST' 'First Aid and 'Culturally appropriate services' has been received positively by our staff.

iii. workforces in other service settings who may identify presenting mental health needs in young people (e.g. education staff)?

87 As mentioned previously in relation to 'first to know' communities, I think additional training in identification and basic support frameworks would assist here.

COMMUNITY MODEL OF CARE*Barriers to the delivery of effective community-based care for adolescents and young people*

88 Some of the key barriers to effective community based care are:

(a) stigma related to help seeking;

(b) a lack of low cost services;

(c) a lack of culturally specific services;

(d) young people not knowing how to access services;

(e) young people being bounced between services and having to repeat their assessment;

(f) limitations on how long young people can access help or not being able to return if they need additional assistance; and

(g) cumbersome processes for entry that require attending multiple locations and services, like having to attain a mental health care plan before being able to access counselling.

89 One of the biggest barriers is demand. If services are only able to treat individuals with high acuity and the remainder of individuals are turned away. In turn, staff often feel overloaded and burdened as a result. The high demand creates a feeling in staff that they never feel like they are doing enough.

90 In relation to the absence of culturally specific services, it is important to recognise that 'mental health' is not a concept that resonates with all cultures. As such, community-based services cannot expect to successfully advertise 'mental health services' to these communities.

91 In regards to what can be done to overcome these barriers, see paragraphs 15 to 36 above.

Best practice responses to support adolescents and young people at risk of suicide or with suicidal ideation

92 Orygen has done a lot of work in responding to suicidal ideation in social media use by young people. Jo Robinson from Orygen is an expert in this area and can offer further suggestions.

93 In this work, the response is offered proactively rather than waiting for a young person to become acutely unwell before looking for an opportunity to intervene.

ALCOHOL AND DRUG USE

Features of a best practice service response for young people with co-occurring mental illness and problematic alcohol and other drug use

94 A best practice response provides AOD and mental health services in the one service setting, in an integrated or shared care model.

95 In a best practice response, the AOD services are full time and not sessional. In headspace, we attempted a co-located service offering sessional alcohol and other drug services and also sessional vocational services and there was no demand for these services. However, what we have seen with the vocational services is that when staff are available at the service full time and integrated into the clinical systems, they are fully booked. I suspect AOD services would be the same. If a dedicated full-time clinician for alcohol and other drugs were integrated into these mental health services they would be fully booked in a short period of time. They could also provide outreach for harder to reach clients that have co-occurring AOD and mental health concerns.

96 The clinical systems of care would be integrated. For example, case reviews would include both AOD and mental health staff as a multidisciplinary team.

97 Ideally mental health staff would be able to provide AOD interventions and AOD staff would be able to provide mental health interventions, so the individual can receive the same quality and standard of care with their 'preferred clinician' without having to transfer across service systems and staff.

98 It is essential to match the care to young people's stage of motivation and readiness for change. For example, a young person may present as having an anxiety disorder but the anxiety is actually the result of them engaging in problematic drug use. An integrated model would be able to work with the young person regardless of what the young person identifies as their primary concern and build a therapeutic relationship that would be able to address the comorbidity over time.

99 It would also be useful for a service to be able to support family members regardless of whether the young person is willing and ready to seek support for their AOD or comorbidity. Educating, supporting and building the skills of family members has long term benefits for the young person regardless of whether the young person is engaged in care at that time. It can also assist the young person to remain in the family home instead of being at risk of homelessness and also assist the young person to remain in school or employment.

Integrated care

100 Integrated care is care that is delivered under the one clinical system including clinical processes like assessment, case reviews and allocations, as well as clinical structures like medical records, quality and safety systems and under clear and documented clinical governance arrangements. It is beyond co-locating with other services and more than collaborative care.

101 How this can be achieved in services for young people is discussed at paragraphs 94 to 99.

Risk factors that make adolescents and young people vulnerable to mental health problems or problematic alcohol or other drug use

102 I think a lot of the risk factors for young people are the same as for adults – family members with mental illness and substance use issues, trauma backgrounds, homelessness, poor socio-economic status and early engagement with the criminal justice system.

103 More unique risk factors for young people include exposure or access to drugs, peer pressure, lack of family engagement or positive role models, domestic violence, social difficulties at school including bullying, academic difficulties at school and undiagnosed mental illness like ADHD.

Mitigating risk factors in adolescents and young people

104 Family support programs and good interventions for adults with addiction who have children can mitigate risk factors in adolescents and young people. This is also discussed at paragraphs 18 to 22.

BARRIERS

Barriers to young people help seeking and engaging with mental health services

105 In addition to stigma surrounding help seeking, young people often do not seek help until quite late as they think that they can do it on their own.

106 Waiting lists also prevent young people from engaging with services, as does the bureaucratic processes of accessing services. When young people want help they want it straight away - they do not want to wait a few days or weeks.

Overcoming barriers to help seeking and engagement

107 Prior to a young person attending a service, there are a number of things that services can do to assist young people to feel safe. Having clear information about services online, having a 'virtual tour' online, offering a range of options for young people around how they would prefer to engage with the service and listening and acting on feedback from young people who have accessed the services helps that service to be more accessible and youth friendly.

108 Our Youth Ambassadors are in the process of developing a booklet that will become an online resource that will assist young people to think through what they would like from the service prior to attending. The resource is called 'Passport to me' and assists young people to identify their goals and preferences in receiving care.

109 Once a young person attends a service, it is common practice to introduce the service, outline what the young person can expect to happen, and explain confidentiality and any limits to confidentiality, and allows space for the young person to ask any questions. All of these activities assist young people to feel safe in terms of knowing what to expect and being able to clarify any concerns they may have.

110 Written information for them to take home with them also assists young people as the initial appointment can be overwhelming sometimes and we have heard feedback that it is helpful to have something that the young person and their family can refer back to later, particularly about the next steps and timeframes.

The importance of family and carer engagement

111 Family and carer engagement is crucial. The nature of accessing services is episodic, however it is families and carers that will provide ongoing care and monitoring.

112 Overall, the mental health sector is so focused on young people that it often forgets to engage the family. As a workforce issue we must change the culture and practice of the workforce to engage families and carers, as discussed at paragraphs 37 to 39.

DIGITAL TECHNOLOGY

Successful digital mental health services, treatments or supports

113 There are a number of digital mental health platforms for young people including eOrygen (Moderated Online Social Therapy (**MOST**)), Synergy, MindSpot and Eheadspace.

Improving access to mental health services and information

114 In my view, the use of digital approaches improve adolescents' and young people's ability to find and use information that helps them to understand their mental health needs would best be done on platforms where young people are already engaged and accessing rather than a separate website or app.

115 There are a range of sites that facilitate information on mental health issues and also mental health services. I would like to see these be more interactive, rather than static information. For example, when you log onto a sales website, there is often a 'pop up' that says 'would you like to talk to someone', or 'how can I help you'. This kind of approach could assist young people to more actively be linked into a service near them, and the information could be shared with the service provider through something like My Health Record with the young person's consent.

116 There are methods already used in general practices where young people can book appointments online or have a home visiting doctor. Some of this technology should be

available in mental health services. You can also already fill in 'screeners' online to help suggest which service you need or which 'diagnosis' might apply. While I am not suggesting online assessments replace clinical services, I am suggesting that screening and engagement can begin on line and streamline young people to the right services and also 'flag' young people at high risk so they can be prioritised to access services earlier.

Digital tools to assist shared decision making

117 There are some examples of shared decision making tools that could be used to help young people with making decision about services, treatment, care and supports but they are not widely used in mental health services.

118 Orygen has previously trialled shared decision making tools with headspace Centres and the Wellcome Trust in UK has also developed shared decision making tools for young people.

Improving care pathways, treatment and supports

119 Information stored in systems that do not talk to each other is a barrier to quality care and is unsafe at times. The interoperability of these systems is paramount and could be a real game changer. They do not need to be on the same digital systems or medical record but the ability to securely share information across platforms would improve the young person's experience of care and the quality of services that can be provided by clinicians based on better access to information.

120 Orygen will be trialling an app that links to the young person's medical record so the young person can control what is shared and with whom. For example, this information would be available to the young person through the app if the young person needed to present to the emergency department or a new general practitioner.

121 Orygen has also developed a Moderated Online Social Therapy (**MOST**) platform to supplement the clinical services delivered face to face. More information is available in Mario Alvarez-Jimenez's statement.

122 Digital interventions could also be used to taper up or taper down services at the beginning of care and toward the discharge and maintenance stages of care.

Quality of services being provided

123 headspace Centres use a survey on ipads that is used to provide feedback on client satisfaction with service at the headspace Centres. There is also a yearly family and carer satisfaction survey that is collected in the same way.

Measurement and feedback loops

124 A common data set across services, including pre and post outcome measures, would be beneficial.

125 Feeding back to young people and their clinicians their results so they can see clinical changes over time would also improve the quality of the service in addition to the experience of the young person.

FORENSIC MENTAL HEALTH

126 I have only had limited experience in delivering youth work with Youth Justice clients in Queensland. I do not have experience delivering forensic mental health services and have not been involved in the delivery at Orygen so I do not think I am well placed to answer these questions. Professor Andrew Chanen from Orygen could assist.

INTERSECTION BETWEEN MENTAL HEALTH AND PHYSICAL HEALTH

127 The key improvements which can be made to the intersection between physical and mental health are in relation to increasing the access to:

(a) general practitioners;

(b) dieticians;

(c) personal trainers and exercise physiologists; and

(d) sexual health practitioners.

128 General practitioners are a great resource for mental health services where they are available. Many medications lead to weight gain and require metabolic management. However, we struggle to attract general practitioners to integrated services under the current funding model. Often young people do not attend appointments. If a young person does not attend an appointment, the general practitioner will not receive a reimbursement. The reimbursement may also be lower than in other settings as general practitioners may need to spend longer with each patient.

129 Dieticians are also an important part of maintaining the physical health of young people with mental illness. A dietician can be accessed through Medicare on a chronic plan, however this does not assist a young person at an early stage of their illness.

130 Young people also respond really well to personal trainers and exercise physiologists. At Orygen we have a gym and young people will attend exercise and boxing groups.

131 Access to sexual health could also be improved for young people accessing mental health services. This would ensure that young people can access testing for sexually transmitted infections and engage in sexual health education.

INNOVATION

New and innovative models for service delivery

132 The system should identify the core components of a best practice, evidence informed and quality model, and then allow flexibility for how these components are delivered locally depending on feedback from young people and their families and adaptations required for local challenges like workforce limitations.

133 It should also provide greater support and guidance in evaluating these innovative approaches and build evaluation into funding models and deliverables.

134 The current approach to funding can encourage competition rather than collaborative models. This can also impact of the culture of delivery within a service. There is a need to consider how governance arrangements can encourage collaborative arrangements.

135 The challenge to reforming the mental health system successfully is often not in the model designed or adopted but in the implementation of that model. Additional implementation supports and sharing of learnings and case studies can assist to avoid implementation challenges.

The role of regulation

136 I think core components of service should be regulated and then audited to ensure compliance. But the method and mode of delivery could be new and innovative.

Facilitating continuous improvement

137 Assessments against fidelity to models, benchmarking against similar services, and measuring against key performance indictors can assist us to move toward more evidence based and quality services.

138 The participation of adolescents and young people in innovative service design development and implementation can be strengthened by building it into deliverables and fund it appropriately.

WORKFORCE

Multi-disciplinary care

139 Underpinning multi-disciplinary care is the need to value the input of each of the different disciplines equally. For example, it requires an acknowledgement that a peer worker's input is just as valuable as a psychiatrist's input. This is fundamentally a shift from the current paradigm of a hierarchy of disciplines and reflects the move from a medical model of health towards a more social model of health.

Consumer-focused care

140 Consumer-focused care requires professionals to value the contribution that a consumer has to offer. It is a shift from being the 'expert' with all the knowledge, to a collaborative approach where everyone is working together. This requires shared decision making and a sense of agency for the individual.

141 I believe that not for profit community based organisations lead in consumer-focused behaviours and practices and approaches to care.

Family-centred care

142 At Orygen we have a family orientated practice offering psycho-education, support, family therapy and family peer work. Essentially this involves families in a way that is meaningful rather than tokenistic so that the family is informed, engaged and a key stakeholder at every step.

Recovery-oriented practice

143 In youth services recovery orientated practice is often known as functional recovery and includes a range of services like education and employment, and a range of individual and group programs focused on life skills, health and wellbeing.

Research awareness and translation

144 Currently, research is often conducted very separately to service delivery. However, at Orygen, our research and service delivery are integrated or at least operating 'side by side', and the workforce are able to see and participate in research being conducted with the young people that they working with. The clinicians are therefore aware of the research being conducted and interventions being trialled. This approach also enables researchers to receive feedback and see any benefits of the trialled interventions, and, as a result, the workforce is more invested in the research results

145 Translation of research into practice is challenging and requires strong leadership and a range of methods including communicating outcomes of research in appropriate ways for clinicians (like guidelines), training in evidence based interventions, ongoing supervision and implementation coaching and building practice into clinical systems and processes.

Improving the safety and wellbeing of staff and service users

146 At Orygen, to minimise the occurrence of harmful incidents, and to respond to the needs of consumers and staff when they do occur, we:

(a) conduct active monitoring of young people's mental health and progress through meetings like case reviews and complex case reviews;

(b) provide proactive support to prevent harm to staff by imposing case load limits. This ensures that young people are able to receive the right amount of service and the clinician can manage the workload;

(c) engage in regular supervision with other clinicians, including discipline specific supervision;

(d) track trends in incidents and complaints and identify opportunities for system and practice changes;

(e) review critical incidents as part of continuous improvement and ensuring staff and consumer safety;

(f) collect feedback from young people and their families;

(g) have clear processes for providing support to staff (clinical and administrative) following the death of any young people or any critical incidents;

(h) offer confidential Employee Assistance Programs to all staff;

(i) practice open disclosure; and

(j) provide opportunities for professional development.

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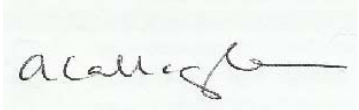

print name Amelia Jane Callaghan

date 05.05.2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT AC-1

This is the attachment marked 'AC-1' referred to in the witness statement of Ms Amelia Jane Callaghan dated 5 May 2020.

Amelia Callaghan - Curriculum Vitae

P E R S O N A L I N F O R M A T I O N

NAME CALLAGHAN, Amelia

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EMAIL amelia.callaghan@orygen.org.au

Q U A L I F I C A T I O N S

AHPRA Registration **PSY0000957436**

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

E M P L O Y M E N T H I S T O R Y

Feb 2019 - current **D i r e c t o r – C l i n i c a l S e r v i c e I n n o v a t i o n**
O r y g e n, N a t l o n a l C e n t r e f o r E x c e l l e n c e I n Y o u t h M e n t a l H e a l t h

Responsibility Snapshot

- Oversight of the five Orygen led Headspace Centres – Craigieburn, Melton, Werribee, Glenroy, Sunshine and Youth Enhanced PHN funded programs
- Management of the National Programs Team supporting headspace Early Psychosis Programs and Youth Enhanced PHN funded services nationally
- Western Melbourne Youth Mental Health Regional Model redesign, implementation and evaluation
- Establishment and Implementation of an Innovation Program for Youth Mental Health

Amelia Callaghan - Curriculum Vitae

Dec 2017 – Dec 2019 **General Manager**
Integrated & Clinical Services
Aftercare

Responsibility Snapshot

- Approximately $20 million per annum
- Approximately 6000 clients across all programs at any time
- Management of Child (0 -11) and Youth (12-25) Programs:
  - 7 headspace Centres (Meadowbrook, Ipswich, Nundah, Woolloongabba, Capalaba, Hurstville, Miranda)
  - Youth Early Psychosis Program (Spoke) at Meadowbrook
  - Individual Placement Support Meadowbrook
  - Impara Indigenous Youth Suicide Prevention Program
  - Redlands Youth Support Program
  - Ipswich Ultra High Risk Program
  - Stafford Child Safety High Support Residential
  - The Poppy Centre Ipswich
- Management of Adult (18-65) Clinical Services:
  - 4 Integrated Service Centres (Floresco Toowoomba, Floresco Ipswich QLD, LikeMind Orange, LikeMind Wagga Wagga NSW)
  - Mental Health Clinical Care and Coordination Program
  - Genesis (Payment by Outcomes Pilot)
  - Extended Response Service (ED Diversion program)
- Leading organisational clinical governance and managing the National Manager of Service Delivery Quality, Safety and Governance

June 2015 – Nov 2017 **Regional Manager**
headspace QLD & The Poppy Centre
Aftercare

Responsibility Snapshot

- Management of 4 headspace Centres in QLD: Meadowbrook, Ipswich, Nundah and Woolloongabba, Youth Early Psychosis Program at Meadowbrook, The Poppy Centre Ipswich, Individual Placement Support, Impara Indigenous Youth Suicide Prevention Program.
- Including strategic planning, corporate governance, clinical governance, quality and risk management, financial management, staff management and alignment with the National MH Standards.
- Develop relationships with key 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 young people
- Monitor compliance with Grant Agreement and meeting of key performance milestones
- Assist with promoting the work of headspace, The Poppy Centre and Aftercare through public speaking, conference presentations and media

2013 – June 2013 **State Manager – QLD, NT**
headspace National Office

Amelia Callaghan - Curriculum Vitae

June 2011 – 13 **State Manager – QLD, WA, NT**
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.
- 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
- Monitor compliance with Grant Agreement and meeting of key performance milestones
- 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
- 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

Sept 2010 – June 11 **Manager –**
headspace Gold Coast

Responsibility Snapshot

- Provide day-to-day operational management of headspace Gold Coast
- 7 direct reports, and oversee 16 private practitioners
- Ensure financial efficiency of the service
- 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

Amelia Callaghan - Curriculum Vitae

Dec 2009 – Aug 10 **Transition Manager – Headspace Gold Coast**

Responsibility Snapshot

- Provide day-to-day operational 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

May 2009 – Aug 09 **Executive Manager – Community Services and the Institute of Studies 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

May 2009 - Mar 08 **General Manager – headspace Centres 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

Amelia Callaghan - Curriculum Vitae

Responsibility Snapshot continued

- Monitor contract deliverables and ensure that Centres were established in line with expectations from headspace National Office
- 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

Feb 2008 - Feb 07 **Project Coordinator**
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
- 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

Amelia Callaghan - Curriculum Vitae

Nov 2005 - Feb 07	Dual Diagnosis Coordinator Including 3 months as Acting Executive Director through 2006 The Gold Coast Drug Council Inc
June 2005 - Oct 05	Youth Co-morbidity Clinician Youth Substance Abuse Service (YSAS)
Nov 2004 - June 05	Psychologist Child and Youth Mental Health Service
Nov 2003 - Sept 04	Clinical Manager – 30 hours a week The Gold Coast Drug Council, Inc (Mirikai)
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