Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF FRANK QUINLAN

I, Frank Quinlan, Federation Executive Director of the Royal Flying Doctor Service of Australia, of Level 2, 10-12 Brisbane Avenue, Barton, ACT 2600, say as follows:

Background

1 I am the Federation Executive Director of the Royal Flying Doctor Service of Australia and have been in this role since November 2019. In my role, I am responsible for advancing the work of Australia's largest aeromedical service and delivering on a range of Commonwealth programs including the provision of mental health services to rural and remote communities across Australia.

2 I started my working life as a youth worker and have extensive experience working in social and community services and health. I have worked for organisations such as the Alcohol and other Drugs Council of Australia, the Australian Medical Association and Catholic Social Services Australia. I also worked for eight years as the Chief Executive Officer of Mental Health Australia, the peak body for mental health organisations in Australia.

3 I hold a number of advisory positions with the Australia Government including as a member of the Australian National Advisory Committee on Alcohol and Drugs.

4 Attached to this statement and marked 'FQ-1' is a copy of my curriculum vitae.

5 I am giving evidence in my professional capacity and not on behalf of any organisations with which I am associated.

Future trends

6 Many of the future trends that will affect mental health are being amplified by the current COVID-19 crisis. Factors such as social isolation, social dislocation and economic inequity, particularly inequality in opportunity, are all likely to undermine the mental health of the community. We are also observing oppositional trends, by which I mean a movement away from traditional community structures that provide people with a feeling of social inclusion, to online ways of engaging within the community. We are in a period of intergenerational change in the way we engage as a community.

7 The mental health literacy among young people is much higher than previous generations. I am lucky enough to be the father of three adult daughters who are 25, 26

Please note that the information presented in this witness statement responds to matters requested by the Royal Commission.

and 28. My daughters and their peers have conversations that are miles beyond anything that me and my friends would have been speaking about at a similar age. This is likely to be a result of a public campaigns focussed on reducing stigma and the work of organisations such as Beyond Blue in relation to depression and ReachOut and Batyr in relation to the work they do specifically with youth. There has also been increased openness from political leaders and other people in the public eye in recent times about their mental health challenges that has led to greater public discourse on these issues. While young people are more open to speaking about their mental health, they are also experiencing higher levels of anxiety and other mental health issues than previous generations. None the less, stigma persists, and help seeking behaviour is often delayed.

8 Australia is in a transformational period where we are moving from the old way of doing things to the new way of doing things. It is not evident yet how that will play out. However, we should not lose sight of the optimism for the future. We have a new generation of young people with a much higher mental health literacy and willingness to speak about emotions that my generation did not have.

9 There are also trends occurring in the mental health consumer movement. Historically, the consumer movement could perhaps have been characterised as a movement predominantly by people who were leaving institutional care that was likely in many cases to have had a traumatic impact on their health. As we look to the future, there is a much broader group of people who might be considered consumers (though unlikely to call themselves that) or “persons of interest” in relation to the mental health system who will also be a part of the discussion about future services and programs.

10 The impact of these trends in relation to their effect on future management of workplaces, management of relationships and future policy setting is exciting. This group of more enlightened people will be moving into positions of influence in many domains which should provide us with hope for the future. The new generations will have expectations that are vastly different, and this is likely to be transformative.

11 It is likely to be the case that current social inequities will be amplified by COVID-19. Flexible working arrangements will be far more difficult for people living in unstable housing or those people for whom home is not a safe place. Some people will be unable to access funded childcare or community or family based childcare arrangements. The reality of home schooling means that some children will be relatively disadvantaged compared to others depending on what their family and social supports are at home. I do not yet see a clear pathway to systemically addressing those inequities to build up the robustness and resilience of the community to a point where we can avoid or manage the stressors that will otherwise cause future demand on the mental health system.

12 The impact of the future trends I have described above means that young people are going to have higher expectations not just about their treatment in a mental health service, but in terms of how they are managed in workplaces and the types of services and supports that will be available to them. They will have higher expectations of the government in providing the types of services required by them, their peers and their families.

Leadership and reform

13 The most fundamental barrier that we face in the mental health system is the short-termism of public policy and the consequential short-termism of public funding. This affects the ability to create leadership that will lead to the implementation of successful and enduring reform in mental health, and the workforce required to deliver it.

14 I have been a provider in an organisation that received funding in three, six and 12 month blocks with no certainty regarding whether the contract would be renewed or not. In the eight years I worked as CEO of Mental Health Australia, there were seven Health Ministers and Mental Health Ministers, and five Prime Ministers. Each of those leaders within their first six months would announce heartfelt commitments to mental health and new approaches, however there were such short-term shifts in policy direction that it was difficult for there to be sustained decision-making. The flow on effect for organisations is that it is very difficult to evaluate whether different approaches are effective or not. This complexity and instability is further compounded once COAG structures are recruited to manage the reform agenda that exists on the cusp of Commonwealth and State and Territory responsibilities. COAG structures to address mental health are essentially moribund, replete with statements of good intent and devoid of funding, outcomes and accountability.

15 Unless we have a national plan, agreement or mechanism that requires governments at national, state and territory level to agree to a particular strategy and to commit long term funding to that same strategy, we are unlikely to achieve enduring reform in mental health.

Collaborative governance

16 The COVID-19 crisis has shown that governments have been able to make collaborative commitments to do things differently in a matter of days. We need to reflect on this before we return to cycles of governance following the crisis where it can take six or 12 months for minute changes to be agreed in arrangements between the government and service providers.

17 Government and service providers (including both NGOs and public sector organisations) need to be regularly sitting at the same table to achieve collaborative governance. In my

experience, the most effective arrangements are ones that involve a forum where policy planning, implementation and monitoring and evaluation is taking place in a genuinely shared environment. This will not be achieved if NGOs are operating in short term agreements and subject to constant tendering processes. Organisations need to be funded to carry out work with recognition by government that professional development and capital renewal of premises and other ancillary costs need to be included in the funding to properly support the work being carried out. Monitoring and evaluation needs to be tested, but not by going out to tender every year. That is an inefficient way of testing the efficiency of arrangements, and is not supported by evidence.

18 Further, both Governments and NGOs themselves need to stop thinking of NGOs as mere "service providers", delivering outcomes for governments in response to contracted requirements. NGOs bring mission, purpose, volunteers and community assets, local connectedness, longevity and persistence, and much, much more to the table. NGOs are at their best when they provide the glue that binds communities, either locally or communities of interest, and too often the delivery of contracted services manifests as benign take-over by governments. NGOs risk being stripped of assets, capability and core purpose. Governments risk dismantling the delicate social fabric that binds communities.

19 It was hoped that primary health networks ('PHN') would achieve effective collaborative governance. However, it is fair to say that they have had mixed results. Some PHNs have essentially become mini governments that are repeating tendering and procurement processes at a local government scale, which appears to only increase the level of resources lost to administration and bureaucracy. We have also observed some PHNs that have embraced a much more collaborative approach to commissioning, co-design of services and co-monitoring of implementation that anybody commissioning services could learn from. For example, Brisbane North adopted a distinctive approach that had considerable success.

Regional commissioning

20 The idea of regional commissioning works if there is a genuine sense of locality and local ownership. Having a PHN that spans an entire state does not capture the sense of what regional commissioning should look like. We need to balance providing the opportunity to have smaller and more local regional plans and input into commissioning decisions, supported by stronger national standards in arrangements and evidence. Local commissioning without national oversight and standards is likely to fail dismally, but similarly national commissioning without appropriate engagement with local communities is also likely to fail.

Workforce change readiness

21 The key challenge in growing and diversifying the existing mental health workforce is attracting the right skills and talent in the current circumstances. Why would someone want to work in an organisation in substandard premises, on a short term contract for low wages and with uncertainty about contract renewal in the next six to 12 months and the risk that the function may be tendered out to another organisation down the road? There should not be any question about why we struggle to attract the mental health workforce that we require. If we are going to support a mental workforce into the future then the question of adequate and secure funding is basic and cannot be avoided.

22 Although I have not worked in public mental health facilities, I get the sense that they are places where people are frequently under resourced and overworked doing some of the most acute frontline work that we could possibly ask them to do, without much expectation that they will receive the required support from community services such as housing an employment services to augment or supplement the care that they are providing. Again, it should not be a surprise that our average workforce age seems to be trending upwards rather than, at a minimum, remaining flat. Until we resolve how to provide people with a secure, safe and appropriate working environment then we will be unable to resolve this issue.

23 The issue of properly resourcing roles also applies to implementing an effective peer workforce. If we simply adopt the approach that a peer workforce is a low grade augmented supplement to other parts of the workforce, then it is likely to fail as well. We need to adopt an approach to our peer workforce which identifies the specific skills and requirements needed based on our evaluation of peer work and commits to properly funding and supporting workers in those roles by providing links to other community support services that they need to be successful in their role.

24 Putting the issues of funding aside, for the workforce to be successful there also needs to be clarity around exactly what roles we need and what our expectations of those roles are. If there is a clear vision laid out for the mental health system with the kinds of workers and skills required to prosecute that system in the future, the rest of the process is almost mathematical in the sense that we can train a certain number of people in a certain amount of time and attract the right people by virtue of wages and working conditions.

Determinants of good mental health

25 Key social determinants of good mental health include housing, employment and trauma. Addressing these three social determinants systematically would go a long way to bolstering the mental health system and a range of other systems such as alcohol and other drugs and family violence.

26 The housing first evidence is fairly clear in demonstrating that having stable, secure and safe housing is a remarkably important start to improving mental health. We need to embrace the idea that this type of systemic change will require longer term supports than are currently being provided.

27 In relation to employment, it appears that over time we have lost the notion of intermediate labour markets. Our government and society need to find ways of funding employment opportunities that are somewhere between unemployment and full-time commercial employment. For instance, I have experienced firsthand the incredible dignity and positive impacts of the Indigenous Rangers program. It has provided many Indigenous people with meaningful employment for the lands they tend. It is a clear example of an intermediate labour market – it is not a commercial activity but it is an activity that has community value and with the right supports and training it provides the program participants with a level of dignity that we often attach to work and a possible pathway to future commercial employment. But programs should acknowledge that not everyone will have the capacity to be successfully employed in purely commercial arrangements.

28 Finding some of these employment opportunities would go a long way towards helping to resolve employment challenges in the market. This is particularly so for people who are at the most disadvantaged end of unemployment and those who have been out of the labour force for a very long time and who do not have pre-existing skills or qualifications that lend themselves to new labour markets. We cannot rely entirely on private employers to bridge that gap; they are partners in the project, but we also must recognise that some people are some way off from being ready for employment on the commercial market.

29 The third aspect is trauma. There is an increasing and emerging awareness that trauma of all kinds, but particularly early childhood trauma, is one of the most significant determinants of subsequent poor mental health. In those circumstances, we need to consider what can be done to avoid early trauma through mechanisms such as the availability of housing, a greater awareness about child sexual abuse and improved institutional and community arrangements to help prevent child sexual abuse. Subsequently, we need to address trauma and provide appropriate therapies for people who experience trauma.

30 Addressing these social determinants is largely a role for government, in partnership with community organisations. I am anxious about the concept that community organisations and non-government organisations are increasingly described by both themselves and by government as service providers. There is an increasing sense that all community organisations do is meet the requirements of the contracts supplied to them by government and that any organisation could provide the service, so it is given to the cheapest bidder. There is a case to be made that community organisations have the capacity to bring a whole raft of things to the table in terms of community engagement,

community fundraising and many other benefits that are difficult to list in a government service contract.

31 The Royal Flying Doctor Service of Australia ('RFDS') is an example of the types of benefits community organisations provide outside of their role in government contracts. The public, both through individual and corporate donations, has essentially purchased our fleet of 77 aircraft – if the government was required to provide these kinds of resources through its contracts it would go broke fairly quickly. However, the benefit of these arrangements is not just financial, the benefit is also that communities have a sense of ownership of our organisation and of being co-investors and critics of the RFDS. Communities raise funds to maintain airstrips and talk to the local members of RFDS, recognising that one day they may be beneficiaries of the service.

32 It is easy to adopt a similar argument in relation to community organisations that provide housing, employment and trauma support services. My fear is that government procurement is becoming a force against community service organisations. Part of the issue, as I mentioned above at paragraph 17, is that government and community organisations need to be sitting at the same table in designing, implementing, evaluating and redesigning programs. The second aspect is that the testing and monitoring needs to be reviewed so that it is not occurring on a yearly or three yearly basis, at best.

33 The idea that has emerged at a Commonwealth level of PHNs being funded on a three year rolling cycle is a very positive opportunity to think about how community organisations are funded. For example, you could appoint staff into positions on a three year basis, and review their performance or that of their program at the 12 month mark which could result in an extension of their role if performance was exceeding expectations or going to plan, or a performance management plan to improve outputs if it was not. Either way, it would provide parties with certainty of contract and the ability to change things in order to ensure the contract is achieving what it seeks to. Programs and staff would then have a clear picture of what the following three years would look like, unlike the current boom and bust cycle.

Service excellence

Mechanisms and structures for ensuring mental health is consistently and fairly prioritised at a service level

34 Historically, mental health programs have not been evaluated in robust and effective ways. To monitor programs effectively requires long time periods and adequate funding. It is not possible to evaluate a program robustly after 12 months, instead what happens is that organisations end up providing their own in-house descriptive evaluations. These serve a purpose, however they are not genuine evaluations with robust data

demonstrating whether programs are meeting service expectations. There are few Commonwealth-funded and state-funded programs that involve appropriate evaluation components.

35 Another key aspect in providing service excellence is having transparency of data. It is generally not clear where government money is being spent and whether it is being spent on mental health or physical health. We have robust accounting principles and arrangements that currently exist in many systems, however, organisations are not being asked to report on the right things and the reporting that does happen is not being adequately used to develop policy and commissioning arrangements.

36 I was a member of the National Targets and Indicators for Mental Health Reform – The COAG Expert Reference Group in 2011 or 2012. The group developed a set of "whole of life" indicators to monitor and evaluate outcomes for consumers of the mental health system. While COAG formally made a commitment to adopt indicators and targets in 2012, this did not involve either a funding commitment or transparent reporting about how these targets would be achieved. Similarly, the national mental health plans that are developed every few years involve reporting processes against the plan, but not outcome or budget reporting.

37 A key reason why effective budget reporting has not been able to be achieved is because we keep producing plans or vision statements without implementation plans attached to them. There needs to be more detail in what plans are going to achieve, what roles different individuals and organisations will have in achieving the intended outcomes and the amount of funding that will be provided to the program. Expectations need to be tied to budget allocations directly. For example, part of the reason that the National Mental Health Service Planning Framework was not taken up further was because the funding for the proposed service model fell severely short of what was required to carry out the model successfully, so the mapping tool was buried.

Embedding innovation cultures and 'cycles of learning' into service structures and environments

38 One way of embedding innovation into service structures and environments is by having longevity in the people who are doing the learning. Having longevity in policy and commissioning arrangements allows learning to occur. By contrast, replacing people every 12 months makes it more difficult to create a learning organisation or a learning environment.

39 While we need to innovate, we also need to provide well known and effective services in adequate numbers to address current demands. Innovation often happens on the fringes of the system which is absolutely welcome – funding should be set aside to seed new

ideas and spark experiments. However, we must also provide people working within the system with enough certainty and stability to learn from their mistakes.

40 The short-term procurement approach pressures people to suppress their learnings, hide mistakes and even hide learnings from each other which is dangerous. The effect of short-term competitive environments, which are often deliberately created by government policy, unsupported by evidence, in order to promote competition and efficiency can be a suppression of learning and innovation because information can become 'market sensitive'. This is not appropriate in the public domain.

Mental health of rural communities in the current COVID-19 crisis

41 It is important that during this pandemic we adopt a population-wide approach to addressing the issues that will arise. However, it is also important to recognise that there are particular groups who face very unique challenges that need to be addressed by our service responses. These groups include Australians living in rural and remote areas, LGBTIQ communities, impoverished Australians, Aboriginal and Torres Strait Islanders and Australians from culturally and linguistically diverse backgrounds.

42 The health disadvantages of rural and remote communities are not unique to mental health – across the spectrum, Australians living in these communities get sicker, have more advanced illness prior to diagnosis and die earlier. This cohort of people experience increased social isolation, often live in challenging circumstances and are currently facing a decline in their workforces as many young people move away to the bright lights of the city rather than taking on the work at family farms. If people are going to remain present in these communities to farm our food and our fibre, to mine our minerals, and to tend traditional lands, we must do more ensure they do not pay such a high price in poorer health outcomes as a result. This must be our social contract.

43 Currently, we are seeing a increasing uptake of telehealth and tele-mental health in rural and remote communities, particularly where communities are shut down in order to appropriately implement physical isolation. Some people have been surprised at how positive the uptake of telehealth and telemedicine has been, which might partly be a reflection of the fact that taking up face to face services for mental health in small communities can be challenging where there is still stigma and discrimination involved. The opportunities for telehealth and telemedicine may be accelerated by these current circumstances in ways that are quite positive.

44 While telehealth provides a lot of opportunities, we also need to ensure that the right infrastructure programs are in place to support its effectiveness into the future. For example, improving rural and remote runways and building telemedicine hubs in communities that have high internet bandwidth and appropriate facilities. It is also

important that we think about the economic recovery of rural and remote communities. For example, increasing tourism in these areas through interesting historic stories or local geographic anomalies and environments. We need to consider how our stimulus investment in economic measures can be used mindfully to build up the resilience, health and future stability of these rural and remote communities.

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print name Frank Quinlan

date 25 May 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT FQ-1

This is the attachment marked 'FQ-1' referred to in the witness statement Frank Quinlan dated 25 May 2020.

CURRICULUM VITAE

Francis Gerard Quinlan

SUMMARY

I have spent my working life trying to advance the common good, particularly for those who face systemic and personal disadvantage.

For the last twenty years I have worked in leadership and executive roles in NGOs, fifteen years as CEO, all national peak bodies, all with complex federations, supporting those receiving and providing services, and advocating on their behalf for changes in public policy and programs.

I now enjoy the benefit of extensive personal, professional, and political networks. I am proud to be known for my integrity, for a balanced and collaborative approach to my work, and for respectful relationships with employees, colleagues, diverse service users, and other stakeholders. My work history demonstrates that this approach has allowed me to establish new initiatives successfully and to achieve transformative change in existing organisations and networks.

WORK HISTORY

Federation Executive Director
Royal Flying Doctor Service of Australia
2019 - present

As Federation Executive Director of the Royal Flying Doctor Service of Australia I work with a Board comprising six directors nominated by each of the member companies of the Royal Flying Doctor Service Federation, and three further independent directors, to ensure the RFDS fulfils its mission and maintains its position as Australia's most reputable charity.

In this role I oversee the functions of the Federation, manage all funding relations with the Commonwealth Government as agent for the Federation, oversee research and advocacy on behalf of better health outcomes for remote and rural residents, and manage the staff and resources of the Federation Company within policy parameters determined by the Board, chair by Mr Nev Power.

Chief Executive Officer
Mental Health Australia
2011 - 2019

Reporting to the Mental Health Australia Ltd Board, I was responsible for 18 staff and all aspects of the operation of Mental Health Australia, Australia's peak non-government organisation advocating for better

mental health for all Australians, better national policy, and improved coordination and quality in the provision of services.

In addition to leading the staff team, I provided advice to a board chaired by Ms Jennifer Westacott, CEO of the Business Council of Australia.

Achievements in this position include:

- Successful advocacy has seen mental health remain high on the Government agenda, with growth in national funding
- Implemented strategic research aimed at influencing the public policy agenda – for example: *Investing to Save*, undertaken on a "low bono" basis by KPMG
- Substantial influence with the Government on the implementation of Primary Health Networks and the National Disability Insurance Scheme
- Strong relationships with both sides of politics and the bureaucracy
- Established Mental Health Australia's first Reconciliation Action Plan
- Substantial growth in membership and member engagement
- Substantially increased MHA turnover with strategic projects and contracts, including significant strategic projects funded voluntarily by members
- Managed successful transition to new Company Limited by Guarantee structure with the support of members and Board, and substantial re-development of the MHA's IT infrastructure, member database, and communication tools
- Reforms managed with very high levels of staff engagement and satisfaction and high staff retention

Executive Director
Catholic Social Services Australia
2004 - 2011

Reporting directly to the Catholic Social Services Australia Board, I was responsible for up to 25 staff and all operations of Australia's peak Catholic welfare organisation, a national office representing the interests of the Catholic social services sector across Australia, including 69 member organisations who employed approximately 10,000 staff. Catholic Social Services Australia influenced national social policy development, social program delivery, and strengthened the national network of Catholic social services.

Achievements in this position include:

- Successfully administered substantial National Employment Services contracts (approximately $40m annually), and Family Services programs held on behalf of the regional members who delivered them locally
- Increased membership by 40%
- Reorganised and substantially strengthened government relations as reflected in the appointment of CSSA representatives, including myself, to various committees and consultative roles for both Labor and Coalition Governments

- Implemented strategic research aimed at influencing the public policy agenda – for example: *Dropping off the Edge*, undertaken by Professor Tony Vinson, which documented geographic and inter-generational disadvantage across Australia
- Contributed to the substantial activities undertaken in coalition with other major NGOs on issues of common interest – for example: commissioning Access Economics to prepare a pre-emptive report on the likely impact of the global financial crisis as the crisis unfolded

Chief Information Officer
Australian Medical Association &
Australasian Medical Publishing Company
2001 – 2004

Responsible for research, policy development, negotiations and advocacy with government regarding policies for improving electronic health systems nationally. Reporting directly to the CEOs and Boards of both companies, I was responsible for strategic direction, change management, and IT infrastructure development across the AMA group of companies.

Achievements in this position include:

- Successful implementation and management of the inaugural Medical Taskforce on Informatics - a collaborative national initiative by the AMA and Royal Specialist Colleges. The Taskforce was established to develop a national strategic plan to support the uptake of new technologies among medical practitioners across Australia, and to negotiate proposed initiatives with government
- Advised AMA senior executive, government, private industry, and a variety of other bodies regarding the likely impact of eHealth strategies on doctors and the general public
- Successfully negotiated across the independent AMA group of companies and AMA state branches in order to integrate complex membership information and data (an outcome sought by the AMA for more than fifteen years)

National Coordinator
General Practice Computing Group
1998 – 2001

Responsible for the implementation of a three-year, $15 million initiative called the General Practice Computer Group that transformed the way GPs in Australia use information systems. This program was a cooperative project, auspiced by the AMA on behalf of the AMA, the RACGP, the Rural Doctors Association of Australia, and the Australian Divisions of General Practice

Achievements in this position include:

- Established and maintained a peak national body pursuing the computerisation of general practice across Australia. Established and supported a Management Committee comprising representatives from disparate groups including the Australian Medical Association, Rural Doctors Association of Australia, the Royal Australian College of General Practitioners,

Australian Divisions of General Practice, the Health Insurance Commission, Health Consumers and the General Practice Partnerships Advisory Council

This program was recognised by the Medical Journal of Australia as one of the ten most significant programs in Australian general practice during the last 100 years.

Program Manager
Alcohol and other Drugs Council of Australia
1994 – 1998

Undertook a broad range of research, development, and policy related activities as a senior staff member in the national peak association representing the interests of non-government organisations in the alcohol and drug field in Australia.

Project Officer

- Implemented an Australian CD ROM information package in non-government alcohol and drug agencies in Sri Lanka, Hong Kong, Malaysia and the Philippines. Trained staff on-site and undertook follow-up evaluation over two years. Project funded through the Australian overseas aid organisation AusAID
- Convened a national forum to examine alternatives to the prosecution of alcohol and drug offenders in Australia. This included the preparation of research and case studies over three years and brought together 50 key stakeholders from Health, Attorney Generals, police and treatment agencies from each state and territory

Program Officer
Australian Drug Foundation
1991 – 1994

Undertook a range of projects and community development activities to identify alcohol-related problems and implemented a range of strategies to address them. The Australian Drug Foundation was at that time the largest NGO working in the drugs area in Victoria.

- Established and provided support to the Alcohol Action Council (AAC). The AAC was a council of eminent community members (including the Director of Public Prosecutions of Victoria, Members of Parliament, representatives of the community and the entertainment industry) whose aim was to promote policy and actions that reduced alcohol-related harm. Media interviews and liaison as required.
- Planned and implemented the evaluation of the first Responsible Serving of Alcohol training offered across the state of Victoria by the Liquor Licensing Commission. Managed project budget, engaged and liaised with external research consultants. Liaised with stakeholders (including police) and steering committee members. Preparation of reports. Recommendations to government regarding changes to serving practices across Victoria.

- Planned, implemented and evaluated community-based harm minimisation projects including community needs assessments, project tendering and budgeting. Liaised with police to develop services related to Police Community Consultative Committees.

Youth Worker
Grassmere Youth Services
1988 - 1991

Developed and implemented programs for disadvantaged young people who were the subject of legal orders.

- Developed, implemented and evaluated programs aimed at supporting disadvantaged young people (mainly young offenders) in long term employment and training. Responsible for the selection and supervision of four staff involved in the delivery of programs. Liaised with a variety of community groups, government departments and local businesses. Prepared submissions for the funding of various programs. As part of Grassmere's management team I planned, implemented and evaluated a range of programs to support disadvantaged young people and their families. These programs included: financial, health, educational, legal, accommodation, recreational and other support.
- Supported a caseload of disadvantaged young people under the care of the courts. Developed and implemented a range of programs to address issues such as homelessness, long-term unemployment, substance abuse, sexual assault, domestic violence and mental health.
- Supervised a caseload of young people who were the subject of legal orders. Provided a range of programs related to employment, finance, health and social integration. Liaised with police and the courts regarding case management plans.

Education

Bachelor of Arts
Monash University
1985 - 1987
Human Geography
Philosophy

Bachelor of Theology
Catholic Theological College
1982 – 1984

Occasional Guest Lecturer
Australian National University
Master of Public Policy program
2009 - 2013

Select Board Appointments and Committees

I provide this select list, in part, to demonstrate that I have been entrusted to various advisory positions by both sides of politics over a substantial period of time.

- **Primary Health Network Mental Health Advisory Panel**
  2017 - 2018
  Co-chair, appointed by Minister Hunt
- **Australian National Advisory Council on Alcohol and Drugs**
  2011 – present
  appointed by Health Ministers
- **National Disability and Carer Advisory Council**
  2016 - present
  Appointed by Minister Prentice
- **Grand Pacific Health**
  2016 – present
  Board Director
  organization delivering primary health care in regional NSW
- **Directions ACT**
  2014 – present
  Board member, now President
- **Ministerial Council on Strategy and Innovation**
  2013
  By invitation of Minister Carr
- **NDIS Expert Group – Eligibility and Assessment**
  2013
  By invitation of Minister Jenny Macklin
- **Not-for-Profit Sector Reform Council**
  2010 - 2011
  By invitation of Minister Tanya Plibersek
- **National Roundtable of Non-Profit Organisations**
  Elected December, 2010
- **Community Response Taskforce**
  2009
  Established by invitation of then Deputy Prime Minister Julia Gillard to respond to the Global Financial Crisis
- **2020 Summit Delegate**
  2008
  Convened by Prime Minister Rudd

OTHER INTERESTS

I enjoy remote 4WD travel throughout Australia. In 2015 I qualified as a recreational pilot (with navigation and passenger endorsement). I was previously qualified as a PADI Rescue Diver and Divemaster. When at home I enjoy sustainable gardening, guitar, and cooking.

In 2020 I will celebrate 30 years married to my wife Jane (a Social Worker), and we have three adult daughters.