

Barrett Adolescent Centre Commission of Inquiry

BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

Commissions of Inquiry Act 1950
Section 5(1)(d)

STATEMENT OF IVAN FRKOVIC

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|-----------------------------------|--|
| Name of Witness: | Ivan Frkovic |
| Date of birth: | 27 September 1961 |
| Current address: | Aftercare, 182 Logan Road, Wolloongabba QLD 4102 |
| Occupation: | Deputy Chief Executive Officer, Aftercare |
| Contact details (phone/email): | |
| Statement taken by: | Jessi Whitby, Louise Norman and Mark Lynch |

I **IVAN FRKOVIC** make oath and state as follows:

1. I am the Deputy Chief Executive Officer – National Operations at Aftercare.
2. I have held this role at Aftercare for three and a half years. Prior to that I worked at Queensland Health in a range of senior positions responsible for policy development, funding and mental health services reform. Between 2007 and 2012, I was the Director of the Community Mental Health Branch, Department of Communities responsible for policy development, funding and reform of the non-government mental health sector in QLD. Attached and marked "IF-1" is a copy of my curriculum vitae.

Aftercare

3. Aftercare is one of the oldest mental health organisations in Australia, having been established in 1907 by Emily Paterson as an "aftercare" support service for mainly women discharged from the Gladesville Mental Hospital in Sydney.

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4. Aftercare provides a range of services for people with mental illness, including residential treatment and rehabilitation support to adults, youth and children. Aftercare's services fall into three broad categories:
 - a. **Community-based support services.** Non-clinical psycho-social support for adults, children and young people, and their carers. Psycho-social support includes personalised support with life skills, activities of daily living, social connections, illness self-management, relapse prevention; stable accommodation, and access to vocational and educational opportunities. Examples of these services are the Personal Helpers and Mentors Program (Commonwealth Government funded) and the Community Managed Mental Health Services (Queensland Government funded)
 - b. **Residential services** for young people and adults in Queensland and New South Wales. In Queensland there are two Youth Residential Rehabilitation Units (YRRUs) in Cairns and Greenslopes (catering to 16-21 year olds). There is one Residential Recovery Service for adults in Mackay which is for people stepping down out of hospital. It comprises one 3 bedroom house staffed 24/7; another 3 bedroom share house with day support (this will transition to 5 one bedroom units when QH capital works is completed); and outreach support for up to 12 months. We previously provided a Time Out House Initiative (TOHI) service in Cairns (an early intervention step-up respite residential for up to three months), but the service was converted to a youth residential rehabilitation unit in late 2014.

The New South Wales youth residential model, Kurinda, has more residential places/beds (10) and different levels of support within the facility (described below). The residential provides psychosocial support with the aim of building independence and life skills. All the residentials operated by Aftercare provide the rehabilitation component of an extended treatment and rehabilitation model — that is, the residential rehabilitation of care. The clinical care (the extended treatment component) is provided by public health.
 - c. **Centre-based support services**, including both clinical and non-clinical services. Aftercare operates four Headspace in Queensland (catering to 12-25 year olds), as well as the Headspace Youth Early Psychosis program at Logan (which has been operational for one year, and where we employ a Psychiatrist) and an adult Headspace Service in Ipswich (Floresco).
5. Aftercare is contracted by Western Sydney, Local Health District to provide the Kurinda Adolescent Service ("Kurinda"), a youth residential facility, in Seven Hills, New South Wales. Kurinda is a medium to long term residential service for adolescents and young adults aged 14-24 years old whose primary diagnoses is a mental illness. Low, medium and high support

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levels are provided. The adolescent may be on medication and under treatment of a psychiatrist. An assessment is done upon application for suitability. Kurinda accommodates 10 people; has three levels of intensity of support (2 high support beds; 6 semi-independent beds; and 2 independent living units); and works in conjunction with Headspace and Blacktown Community Mental Health.

6. Aftercare's experience in delivering a Youth Residential Rehabilitation Unit (YRRU) is drawn from the experience of delivering Kurinda for over 20 years, as well the 800-900 individual young people annually who access each of the four Headspace services operated by Aftercare. We also have had, and continue to have, young people (18-20 year olds) coming through our adult services as there are no other options available to them. This learning and experience contributes to our ability to deliver a YRRU.
7. Aftercare does not have experience in delivering Youth Prevention and Recovery Care (YPARC) services. We were not operating in Victoria at the time the YPARCs were established in that State.
8. *I have been asked about the headspace Youth Early Psychosis Program (hYEPP) Aftercare provides at Meadowbrook in Logan.* The program provides recovery oriented, early intervention services to young people aged 12–25 years who are experiencing a first episode of psychosis or are at ultra-high risk of experiencing psychosis. The Meadowbrook program is a part of a 'hub and spoke' model. The 'hub' is the Lives Lived Well Headspace at Southport on the Gold Coast, which provides mobile assessment teams across the region and functional recovery teams. Our Meadowbrook unit is a 'spoke'. We provide continuing care teams in the community. We employ a psychiatrist, psychiatric registrar and a range of clinicians. Although the model is complex, it allows us to manage young people with complex needs and a higher level of acuity. These young people are generally managed in the community.

Challenges for Non-Government Organisations (NGOs)

9. *The Commission has asked about the challenges for NGOs in delivering mental health services.* The primary challenge for the NGO sector is attracting quality staff with relevant qualifications, particularly professional staff (nurses, social workers, psychologists, occupational therapists), given that NGOs are not able to match public service rates of remuneration. Even with the taxation benefits NGOs are able to offer employees through salary sacrificing, the discrepancy in remuneration (typically in the range of \$20–40,000 per annum) makes it difficult for NGOs to be a competitive employer.

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10. Furthermore, the NGO sector tends to be characterised by short-term contracts for the delivery of specific services, some of which are on a pilot or trial basis. As a result, NGOs are generally unable to provide long-term employment contracts, and certainly not the tenure available in the public sector. I believe that the longest contract of service Aftercare has been offered was for three years.
11. The funding available to NGOs to deliver services is limited. I believe this is due to a perception that NGOs can deliver services much cheaper than government agencies. To some extent this perception is correct because of the lower staff remuneration and overhead costs. However for NGOs to deliver services safely and effectively, attract appropriately qualified staff, and manage complex young people with severe mental illness, the overall cost differential is substantial but not as great as generally believed.

The delivery of mental health services by the NGO sector

12. *I have been asked about how NGOs can deliver services differently to health departments and any advantages NGOs have in delivering mental health services.* The approach at Aftercare is to normalise the person's situation and environment as much as possible. In the case of the YRRU program, we try to replicate the environment that a young person might find themselves in the future, in order to equip them to live and thrive in the community.
13. Aftercare focuses on developing the daily living skills of a person with mental illness, rather than focusing only on the illness. This includes developing and managing positive relationships with family, peers, and the person's mental health case manager; managing school, education, and employment; dealing with shopping, cooking & housework etc.; and taking responsibility for managing their illness.
14. Our philosophy is that you can live a successful and fulfilling life with a mental illness. Therefore, our goal is to build and maintain independence. For example, our young people are case managed by Queensland Health — usually the community Child and Youth Mental Health Service clinics (CCYMHS). We work on how the young person will maintain regular contact with their case manager and maintain compliance with their treatment so they can independently manage their mental illness with the support available to them.
15. We avoid a 'hospital mentality'. Hospital is where a young person will go when they are very unwell. There are times when inpatient care (particularly acute inpatient care) is required. But once a person has been stabilised, a hospital environment is not conducive to taking control of ones' life. It is a "sick" or "illness-saturated" environment.

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16. NGOs generally have more flexibility in service delivery which creates opportunities to be more innovative in their approach to care. This is beneficial, given that each patient has unique needs and does not always completely fit suitability criteria or a particular approach. By virtue of being a large bureaucratic organisation, Queensland Health is forced to operate according to its rules and procedures and, as a result, tends to be risk averse. NGOs also have to manage risk, but because we work more intensely with the young person through the different stages of their illness we can provide a greater degree of flexibility and "dignity of risk" with the residential environment.
17. Clients also tend to trust NGOs more because we do not have the power to treat people involuntarily in the same way public mental health services can. Similarly, NGOs are seen as being community focussed rather than hospital focussed. These factors all contribute to developing a positive relationship with our clients.
18. *I have been asked about the concerns that are often expressed by clinicians about the capacity of NGOs to deliver mental health services.* To my knowledge, concerns about NGOs delivering these types of services stem from a historical divide in the provision of services between the NGO and public sectors. Historically, NGOs provided non-clinical services, whilst the public system provided clinical services. These days service provision is more blended, with NGOs like Aftercare, Open Minds and FSG Australia operating in the clinical space as a result of operating Headspace Centres (though not at the acute end). However, the notion remains that NGOs have limited clinical expertise and experience and are not as effective at managing risk (all risks, not just clinical risks).
19. It is fair to say that the staffing profile of NGO-operated services varies according to a range of factors. This includes the model and requirements of the service, the staffing model set by each NGO (different NGOs may establish a different staffing model for the same service) and the recruitment practices of the NGO. In determining the staffing profile for our different programs, including residentials, Aftercare begins by gaining a detailed understanding of the client group, including risk profile, severity of illness, etc. This then enables us to determine the staffing for each program including how many people we need with medical backgrounds; nursing/allied health/clinical backgrounds; para-professional backgrounds; and how many people with lived/peer experience and qualifications. This then informs our budget work up for the program.
20. Our youth residential rehabilitation units have a professional staffing profile even though Aftercare is not required to provide a clinical service. Our Regional Manager for Residential Services in Queensland (manager of the Greenslopes and Cairns YRRUs, and the adult residential service in Mackay), Myf Pitcher, is a social worker with extensive clinical experience in both child and youth, and adult public mental health. A clinical background is a requirement for her role. Each YRRU team leader has allied health qualifications and

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experience. The senior support workers and support workers all have at least vocational qualifications in community work, community mental health work or youth work, but most have allied health professional qualifications. All of our staff have mental health and/or youth work experience.

21. As a result, Aftercare is capable of delivering a range of interventions to different client groups that experience a range of complexities and severity of mental illness. It will take time to shift the perception some clinicians have of NGOs, but I believe we are building our reputation through working effectively with public mental health services.

Aftercare's Youth Residential and Rehabilitation Units (YRRUs) – Greenslopes and Cairns.

22. Aftercare worked closely with Children's Health Queensland to establish the first youth residential rehabilitation unit (YRRU) at Greenslopes. The unit was initially known as YPETRI House because it was established as part of what was known at the time as the Young Person's Extended Treatment and Rehabilitation Initiative (YPETRI). That initiative subsequently became known as the Adolescent Mental Health Extended Treatment Initiative (AMHETI).
23. Aftercare recruited Myfanwy Pitcher from Queensland Health to run the Holiday Day Program over Christmas at the Barrett Adolescent Centre and to establish the Greenslopes YRRU. Ms Pitcher is a social worker with extensive clinical and managerial experience in both the child and youth and adult public mental health sectors, including experience managing two community CYMHS. Ms Pitcher is Aftercare's Queensland Regional Manager, Residential Services and manages the YRRUs at Greenslopes and Cairns, as well as the adult Transitional Recovery Service in Mackay.
24. Aftercare was required to establish the Greenslopes YRRU in early 2014 to align with the AMHETI and to ensure that there were additional options available to young people in SEQ, in addition to the adolescent acute inpatient services. As I note in paragraph 33, the YRRU is an extended residential psychosocial rehabilitation service, and does not provide extended clinical treatment. The treatment component is provided by Queensland Health's child and youth or adult community mental health clinics.
25. The Greenslopes YRRU is based in a domestic house with four bedrooms. One of the bedrooms has two beds, bringing the capacity of the Greenslopes YRRU to five residents.
26. The Greenslopes YRRU commenced operations in March 2014 [REDACTED]
[REDACTED] The unit has progressively increased the number of residents over a number of months with capacity achieved in the second half of 2014.

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27.

28. The Cairns YRRU is also based in a domestic house with capacity for five residents in 5 separate bedrooms. It has been operating at full capacity since January 2015.
29. Aftercare had previously been operating a Time Out House Initiative (TOHI) in Cairns. In the latter half of 2014 Queensland Health decided to convert the TOHI to a YRRU model. In November 2014 the program began a transition to the YRRU model, which commenced in January 2015. I explain the differences between the two models later in this statement.
30. In August 2015, the Queensland Children's Hospital invited tenders for the operation of four YRRUs from January 2016 through to the end of June 2017. Aftercare was awarded the contract to operate the YRRUs at Greenslopes and Cairns. MIND Australia was awarded the tender to establish two new YRRUs in Townsville.
31. The YRRUs are overseen by a Youth Resi Governance Committee ("the governance committee") which includes representatives from Aftercare; MIND Australia; Children's Health Queensland Hospital and Health Service (CHQHSS); the Townsville and Cairns Hospital and Health Services (HHS); and the Mental Health, Alcohol and Other Drugs Branch of the Department of Health. Dr Stephen Stathis from Children's Health Queensland chairs the governance committee.
32. A separate Youth Resi Referral Panel manages referrals for the two YRRUs. Dr Stathis chairs this committee. The panel membership is described in more detail by Ms Pitcher, but includes Aftercare representatives from each YRRU and Children's Health Queensland.

The YRRU model

33. The YRRU is part of the extended treatment and rehabilitation service continuum. The treatment and rehabilitation components of the model are delivered separately, but in a coordinated manner. Aftercare delivers the psycho-social *rehabilitation* component of the model within the YRRU. The clinical services, or the *treatment* component of the model, are delivered by Queensland Health.
34. I believe that there is no problem in delivering the Extender Treatment and Residential Rehabilitation components separately as they have different focus but are complementary.

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35. The YRRUs were never intended to replace the Barrett Adolescent Centre, as YRRUs are not an extended *treatment* facility.
36. Each resident has a HHS mental health case manager. Typically the case managers are based in community CYMHS clinics. However, [REDACTED] residents at the Greenslopes YRRU have been case managed by an Assertive Mobile Youth Outreach Service (AMYOS) team. Those residents case managed by a community CMYHS clinic attend regular meetings with their case manager at the community clinic. However, the YRRU staff liaise with each case manager, generally weekly, to exchange information about the progress and status of each resident to ensure they are being managed appropriately.
37. The YRRU focuses on the rehabilitation aspects of a resident's needs. That is, we focus on restoring a young person's developmental milestones and developing the skills they need to live independently either back in their homes or in other independent accommodation. This is because gaining or regaining independent living skills is an important component of the recovery of a person with mental illness. This is the focus of our Living Skills program.
38. YRRU staff tailor a program according to a young person's own goals and to meet their needs to build independence. The program includes a range of individual and group activities. [REDACTED]
39. [REDACTED]
40. All our young people are required to participate in education or employment, [REDACTED]

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- [REDACTED]
41. Interventions at the family level vary, depending on the circumstances of the young person and their family, and on their goals. Sometimes the issues our young people face stem from the family, which presents a real challenge. [REDACTED]
42. As I have noted above, the YRRU is not a clinical model. Our staff do, however, provide low-level clinical interventions when required. Distress management is a typical example of this. Our staff work with the young people to develop and reinforce their coping strategies and implement the distress management plan developed with their mental health case workers and YRRU key workers.
43. Our staff do have to deal with instances of self-harm by young people in the residences. In any situation requiring medical intervention an ambulance will be called and the young person taken to an emergency department. This is made clear to the young people and they all know that staff will not negotiate in these circumstances.
44. I understand that the Regional Manager for Residential Services in Queensland (Ms Pitcher) has provided more detailed information about the living skills and outreach programs, family interventions and the management of self-harm in her statement.

Resident profile

45. The diagnostic profile of our young people includes those with severe and complex mental health problems and disorders including depression, suicidal ideation, self-harm, and trauma and attachment problems. Some of our young people display borderline personality traits. We do not accept young people with eating disorders that require medical input and stabilisation, or who actively use substances.
46. I would describe our residents as having a moderate level of acuity (meaning that their symptoms are moderate and managed) but with complex psycho-social needs. [REDACTED]

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47. The YRRUs accept referrals for young people aged 16–21 years. We do allow some flexibility in the age for admission, depending on their circumstances and an assessment of whether the young person will fit into the milieu in the house. [REDACTED]
48. [REDACTED]
49. We can manage young people with a high degree of functional impairment so long as they have an ability to manage their basic self-care needs (e.g. showering) and are willing to work with staff to improve their skills and ability to function independently. As part of the referral assessment process we require advice that the young person's prognosis is good, that is that they can improve, even if they have a significant impairment. We accept the advice from the family or case manager.
50. As part of the program, residents must be able to manage public transport to get themselves to their community CYMHS appointments, school or job and other commitments. This is an important aspect of independence. We can provide help initially with things like public transport etc., but this is with a view to the young person learning to manage such things themselves as part of their rehabilitation.
51. The referral pathway for our residents tends to be either from community CYMHS clinics (a "step-up" pathway) or acute inpatient units (a "step down" pathway). Currently we only take referrals for young people case managed by Queensland Health. That is, we do not take private referrals.
52. Given these pathways, the majority of our residents have been case managed in the community by CYMHS clinics. Most have also had a number of planned or unplanned acute inpatient admissions.
53. Since the **Greenslopes YRRU** commenced operations in March 2014, 12 young people have entered the program and eight have exited. The average length of stay has been 9 months (excluding the additional three-month outreach period).
54. Since the **Cairns YRRU** commenced operations in January 2015, eight young people have entered the program and four have exited. The average length of stay is 10 months (excluding the additional three-month outreach period).

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55. There is no formal process for tracking the progress of former residents after the outreach period has concluded. Having said this, most former residents keep in touch with YRRU staff.
56. There has not yet been an evaluation of the service. This is a matter yet to be resolved by the Youth Resi Governance Committee.
57. I understand that the Regional Manager for Residential Services in Queensland has provided more information about the outcomes for some of our residents in her statement.

Staffing profile

58. Queensland Health does not specify the profile of staff required to manage the YRRUs, though in the recent tender Children's Health Queensland did specify 2 full-time equivalent staff members (FTEs) per shift (based on our experience in the Greenslopes YRRU). However, Aftercare has established its own minimum standards for staffing all our services, including the YRRUs. In establishing both of the Youth Residential in QLD, Aftercare consulted with clinicians from the Children's Hospital Queensland on our proposed staffing profile, roster and programs. Most Government tenders that Aftercare has competed for recently have a heavy weighting on cost, this though did not appear as evident in the recent Children's Health Queensland HHS Youth Residential tender. Aftercare has accepted on a number of occasions tender outcomes where we were not selected because of cost. Our primary aim is the provision of quality and safe services to consumers through appropriately qualified and skilled staff and if this means that we are more expensive than other NGOs, then so be it.
59. Aftercare requires that the Regional Manager for Residential Services in Queensland is a qualified and experienced clinician. As I explained earlier in this statement, Ms Pitcher is a social worker with extensive clinical and management experience in both child and adult public mental health.
60. The team leaders must be qualified allied health professionals. The senior support workers and support workers are required to have at least vocational qualifications in community work, community mental health work or youth work. Most of our staff, however, have professional qualifications and significant mental health experience.
61. We can also employ peer support workers who may not be formally qualified (although they may have qualifications relevant to other work). The peer support workers have a different role in the service. They have a lived experience of mental illness and have successfully navigated similar experiences to our residents themselves. They can connect

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with the young people in the YRRUs on their level, and show them that you can recover and have a meaningful life with a mental illness.

62. The cost of providing the YRRU service is approximately [REDACTED] per resident per day. As with most businesses in a service industry, most of our cost base relates to staffing. The qualifications, skills and experience of our staff are key to providing a safe and effective service for our residents, and I believe this is reflected in the outcomes for our residents.
63. I understand that Ms Pitcher has provided more detailed information about the shift arrangements and standard practices across those shifts in her statement.

Conversion of the Cairns TOHI to a YRRU

64. *I have been asked about the conversion of the Cairns Time Out House to a YRRU.* The TOHI was a step-up early intervention service with a funded outreach component. The program provided support to young people aged 15–25 years experiencing the early signs and symptoms of mental illness. There were two support components in the TOHI model:
- a. accommodation for up to three months for young people aged 18–25 years.
 - b. community support for up to three months for young people aged 15–25 years, including linking young people to mental health service providers, accommodation support, employment support and other services.
65. In August 2014, Dr Bill Kingswell and Dr Stephen Stathis from Queensland Health visited the Cairns TOHI. After several months of negotiations it was agreed that we would recruit staff with a higher level of clinical expertise and experience and change the model to a YRRU model. The conversion to the YRRU model did not include the outreach support component of the previous TOHI model. The YRRU model operated from January 2015.
66. In 2013 the ongoing funding for TOHI was nearing completion. Aftercare engaged in intense negotiations at the time with the then Minister of Health, senior bureaucrats in the Department of the Premier and Cabinet (DPC), local Federal MP and the Cairns HHS to secure ongoing funding. An extension to the funding was achieved last minute and TOHI continued operating until it transitioned to the YRRU — this process started in October 2014 and the YRRU commenced operations January 2015.
67. The staffing profile and shift arrangements differ between the two models. The YRRU is more professionally staffed, whereas the TOHI was staffed by vocationally qualified youth workers.

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68. Under the TOHI model there was one staff member per shift. The overnight shift was a sleep-over shift. That is, the staff member was available if needed, but would otherwise sleep overnight. Queensland Health's model of service delivery for the YRRU requires a staffing ratio of 2 full-time staff on every shift per four residents.

Opinion — a statewide model of care for young people with severe and complex mental illness

69. *I have been asked for my opinion on an appropriate continuum of services for young people with severe and complex mental illness and on extended inpatient treatment and rehabilitation models such as that provided by the Barrett Adolescent Centre. Accessible and well-resourced community services, providing both clinical and non-clinical support, are critical to young people experiencing complex and severe mental illness.*
70. I believe that these services should be provided by both public mental health, the private sector where possible, and the NGO sector. At present approximately 85 per cent of overall mental health funding in Queensland and nationally is directed to services provided by public mental health and 15 per cent to the NGO sector. In my opinion, the balance is not right and future investment in mental health should disproportionately favour the NGO sector so that it is able to take more pressure of the public mental health system.
71. For those young people who need a higher level of clinical and psycho-social support, the following continuum of care is, in my opinion, a model that is employed internationally in varying combinations and is supported by the evidence base as being an effective model to treat young people with severe and complex mental health issues:
- An acute inpatient (hospital-based) facility that deals with acute situations, with a maximum length of stay of 10-15 days. There are currently acute adolescent inpatient units at the Royal Brisbane and Women's Hospital, the Lady Cilento Children's Hospital and in Logan, Toowoomba, Townsville and the Gold Coast.
 - Sub-acute extended treatment (community-based) facilities for young people to "step-down" to after an acute inpatient stay, to provide additional intensive clinical support and start the psychosocial rehabilitation process. I believe an appropriate length of stay in these facilities would be 1–3 months. These are YPARC-type facilities. In my opinion, there is a need for half a dozen such facilities around the state that are not located on hospital campus.

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- c. Residential rehabilitation units (YRRUs), also need to be strategically located across the state, to focus on psycho-social rehabilitation. The maximum length of stay would be 12 months. I also think there would be benefit in locating the YRRUs and the YPARC-type facilities in close proximity.
72. Any model needs to be flexible, as no two young people are the same or will respond to treatment in the same way. Each young person needs a unique approach. An example of flexibility is that the YPARCs should not impose a strict length of stay.
73. I note that the size of Queensland presents a geographical challenge in the provision of services. My assessment is that there is a need for YPARC-type facilities in North Queensland (Townsville and/or Cairns); one in Central Queensland (Rockhampton); one North Brisbane (we receive a lot of referrals from Pine Rivers and Caboolture); one in South Brisbane; and one each at the Gold Coast, Ipswich, and Toowoomba.
74. Each of the YPARC's should have a YRRU in close proximity, but not on the same grounds.
75. The YPARC-type facilities and YRRUs both need good links to the acute inpatient units, community mental health and other community-based services.
76. The Barrett Adolescent Centre was on the grounds of a psychiatric facility, and it took young people out of their normal life environment for extended periods (some, I believe, for 2–3 years). I am not aware of any evidence that indicates there is therapeutic benefit from such an extended stay in a hospital environment. While an extended treatment facility is necessary for a small cohort of young people with particularly severe and complex needs, in my opinion it should be a YPARC-type model with an average stay of 28 days, which can be extended up to 3 months.
77. If a young person was then able to step-down again into a YRRU focusing on psycho-social rehabilitation, the overall continuum would provide the extended treatment and rehabilitation that the BAC provided, but in a normalising, rather than illness-saturated, environment. This would prevent institutionalisation and ensure the young person develops the skills, resilience and mindset need to manage their mental illness in their own environment.
78. There may be an argument that a cohort exists that requires extended care beyond the YPARC-type model, though I do not know if that is the case or how large that cohort would be.

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79. Another challenge that needs to be addressed is the young people in adult facilities – the ‘emerging adults’ who transition between child and youth, and adult mental health services. As is evident in other countries (e.g. Canada), there is a need for “emerging adults” services which bridge the divide between our existing segmentations between child and youth and adult services.
80. Finally, in my view there is a general issue with information sharing between the public, private and the NGO sectors, due to issues regarding confidentiality in sharing patient information. For example, YRRU staff are not able to access clinical information about YRRU residents on the Queensland Health Consumer Integrated Mental Health Application (CIMHA) system. We have established manual work-arounds, but as NGOs increasingly deliver services for Queensland Health, I believe that young people would benefit from greater information sharing (with their consent) to avoid repeatedly telling their story and ensure integration of their treatment and rehabilitation.

OATHS ACT 1867 (DECLARATION)

I IVAN FRKOVIC do solemnly and sincerely declare that:

(1) This written statement by me dated 25 February 2016 is true to the best of my knowledge and belief: and

(2) I make this statement knowing that if it were admitted as evidence, I may be liable to prosecution for stating in it anything I know to be false.

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

.....Signature

Taken and declared before me at Woolloongabba this 25 day of February 2016.

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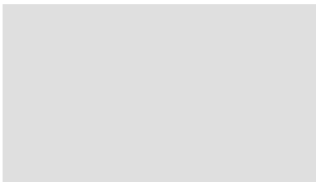
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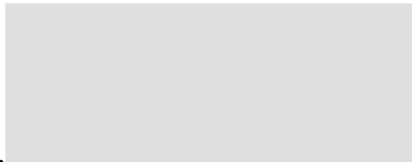
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Bound and marked "IF-1" are the annexures to the Statutory Declaration of IVAN FROKOVIC declared February 2016:

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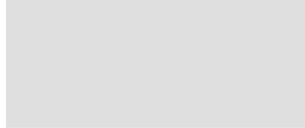
IVAN FRKOVIC

August 2015

PERSONAL DETAILS

NAME: IVAN FRKOVIC

ADDRESS:



TELEPHONE:



E-MAIL



EDUCATION:

1988: Brisbane College of Advanced Education
Associate Diploma in Community Welfare

1991: University of Queensland
Bachelor of Social Work

1999: University of Queensland
Master of Social Welfare Administration and Planning

Commissioner of Declarations

OTHER: Fluent in Croatian

EMPLOYMENT HISTORY

July 2012 – Current:

Aftercare

Deputy Chief Executive Officer National Operations

Responsibilities:

- ◆ Lead, manager and coordinate all Aftercare's operations nationally through eight Regional Managers across Queensland and New South Wales and Service Managers in Victoria and Western Australia.
- ◆ Develop tenders, business cases and expressions of interest for Commonwealth and State Government funding.
- ◆ Grow Revenue, Diversify Revenue Mix; Expand Reach and enhance Reputation.
- ◆ Oversee the development and implementation of all new Aftercare programs and services across Australia.
- ◆ Meet with State and Commonwealth Ministers, Members of Parliament, and Director Generals to advance the reform of mental health services in Australia.
- ◆ Build partnerships, collaboratives and consortia across sectors in Queensland, New South Wales, Western Australia and Victoria.
- ◆ Provide Operational Reports to the Chief Executive Officer and Board every two months.
- ◆ Manage the IT department within Aftercare.
- ◆ Manage the Research and Evaluation agenda within Aftercare, including the routine collection, analysis and reporting on outcomes data.
- ◆ Consult and engage with government and non-government stakeholders and increase broader community awareness through media, public speaking engagements and attendances at community functions about mental health across Australia.
- ◆ Manage and lead Aftercare's transition to the National Disability Insurance Scheme.

Oct 2011 – April 2012:

**Queensland Health
Queensland Mental Health Commission Transition Team**

Project Director

Responsibilities:

- ◆ Support the Government to establish the Queensland Mental Health Commission (QMHC).
- ◆ Establish, support and prepare reports and advice to the QMHC Advisory Committee.
- ◆ Undertake statewide consultations with key stateholders to inform the development of the QMHC.
- ◆ Consult with key stateholders interstate and overseas in relation to the establishment of the QMHC.
- ◆ Prepare Government advice on the roles, functions, governance and guiding principles for the QMHC.
- ◆ Negotiate with Queensland Health and Department of Communities the roles, functions and funding for the QMHC.
- ◆ Write reports, briefs, submissions and discussion papers for the Advisory Committee; Health and Disability Reform CEOs Committee; Ministers and Government.

Sept 2007 – June 2012:

**DEPARTMENT OF COMMUNITIES
Disability and Community Care Services**

Director, Community Mental Health Branch

Responsibilities:

- ◆ Establish the Community Mental Health Branch and build a multi skilled, committed and passionate team.
- ◆ Develop, procure, implement, manage, monitor and evaluate a range of innovative community (NGO) mental health programs state-wide.
- ◆ Lead the development of operational policies and procedures for the Branch and funded programs.
- ◆ Implement cultural change within the agency and within the 100 funded NGO services towards a *Recovery* approach.
- ◆ Provide advice to and accompany the Minister to a range of community and public sector functions, meetings and launches.
- ◆ Provide strategic direction and leadership to the mental health NGO sector in Queensland through leading the development of the *Supporting Recovery: Community Mental Health Services Plan 2011-17*.

- ◆ Represent the department and Minister at various intergovernmental and community meetings, functions, events and conferences at the local, State and national levels.
- ◆ Consult regularly with key stakeholders and develop and maintain effective communication channels with a broad range of key stakeholders including consumers and carers.
- ◆ Prepare ministerial correspondence, briefings, budget submissions, speech notes and media releases.
- ◆ Lead improvements within the Branch and funded non-government organisations through the introduction of outputs based funding and reporting; quality improvement systems; and a performance based culture.
- ◆ Initiate workforce development opportunities; career pathways and succession planning process within the Branch, the Department and with funded non-government organisations.
- ◆ Effectively manage a recurrent budget of approximately \$70 million; \$50 million in capital, \$3 million operational; and approximately 25 staff.

April 2009 – Aug 2009:

DEPARTMENT OF COMMUNITIES
Disability, HACC & Community Mental Health

A/General Manager
HACC & NGO Contracting
(including A/Director – HACC)

Responsibilities

- ◆ Manage the operations of the Home and Community Care Branch; Community Mental Health Branch and Grants Management Branches.
- ◆ Support the implementation of a new financial system in the Grants Management Branch.
- ◆ Provide advice to and accompany the Minister to a range of community and public sector functions, meetings and launches.
- ◆ Provide strategic direction and leadership to the three Branches with over 100 staff.
- ◆ Represent the department and Minister at various intergovernmental and community meetings, functions, events and conferences at the local, State and national levels.
- ◆ Consult regularly with key stakeholders and develop and maintain effective communication channels with a broad range of internal and external stakeholders.
- ◆ Prepare ministerial correspondence, briefings, budget submissions, speech notes and media releases.

- ◆ Participate in Senior Governance mechanisms which set organisational, strategic, workforce and budgetary directions.

June 2006 – Sept 2007:

**DEPARTMENT OF PREMIER & CABINET/
QUEENSLAND HEALTH, MENTAL HEALTH BRANCH**

Manager, COAG Mental Health Reform

Responsibilities:

- ◆ On behalf of the Department of Premier and Cabinet (DPC) and with the support of a cross-government and cross agency governance group, lead the implementation of the Council of Australian Governments (COAG) National Action Plan on Mental Health in Queensland.
- ◆ Compiled Queensland progress reports to COAG annually.
- ◆ Coordinated Commonwealth and State Government agencies responsible for implementing the COAG Action Plan on Mental Health in Queensland.
- ◆ Provided support to DPC as Chair of the Queensland COAG Mental Health Group.
- ◆ Established dialogue between the various Queensland and Australian Government agencies to ensure an integrated approach to implementation of the various initiatives.
- ◆ Established dialogue between the non-government, public and private sector agencies operationalising the various COAG mental health initiatives.
- ◆ Developed and implemented a Care Coordination model as agreed to by COAG for people with severe mental illness and complex care needs.
- ◆ Negotiated policy shifts or alignment between Queensland and Australian Government agencies to minimise services gaps or duplication.
- ◆ Managed the development of a background paper titled *Consumer Choice* targeted at better alignment of the public and private mental health service delivery systems resulting from the new *Better Access* MBS item numbers.
- ◆ Produced the bimonthly QLD COAG Mental Health Group “*Communique*”.

Nov 2005 – June 2006:

**QUEENSLAND HEALTH
MENTAL HEALTH BRANCH**

Manager, Strategic Policy Unit

Responsibilities:

- ◆ Established and facilitated dialogue between the Queensland and Australian Governments and between the non-government, public and private sectors in Queensland to enable an integrated approach to mental health reform.
- ◆ Contributed to the development of National Mental Health Plans; co-lead the development of the *Queensland Plan for Mental Health 2007-17*; and contributed to the development of the *Mental Health Services Planning Estimates*.
- ◆ Represented the department and Minister at various intergovernmental and community meetings, functions, events and conferences at the local, State and national levels.
- ◆ Consulted regularly with key stakeholders and developed and maintained effective communication channels with a broad range of key stakeholders including consumers and carers.
- ◆ Prepared ministerial correspondence, briefings, budget submissions, speech notes and media releases.
- ◆ Negotiated program and funding outcomes with Queensland Treasury, Department of Premier and Cabinet and the Australian Government.
- ◆ Managed Funding and Finances.

Feb 2005 – Nov 2005:

**QUEENSLAND HEALTH
STRATEGIC FUNDING & INVESTMENT BRANCH**

Jul 2005 – Nov 2005:

A/Director, Strategic Revenue Unit

Responsibilities:

- ◆ Managed funding agreements between Queensland Health and Department Veterans Affairs, Q-COMP, Motor Accident Insurance Commission, and other jurisdictions.
- ◆ Serviced Agreement Development with Department of Corrective Services and Australian Defence Force.
- ◆ Prepared the revenue section for the Queensland Government Mini-Budget.
- ◆ Implemented the revenue, co-payment and means testing initiatives identified in the Queensland Health Action Plan 2005.
- ◆ Managed International Business, Exports and International Aid initiatives.
- ◆ Lead and contributed to the Queensland Health Restructure Process.
- ◆ Prepared ministerial correspondence, briefings, budget submissions, speech notes and media releases.

Feb 2005 – Jun 2005: **A/Manager, Commonwealth Funding Team**

Responsibilities:

- ◆ Managed funding agreements between Queensland Health and the Australian Government (AHCA, SPPs).
- ◆ Assessed risk and provided advice to the Minister and Director General on all funding agreements with the Australian Government.
- ◆ Coordinated compliance reporting to the Australian Government.
- ◆ Contributed to the development of a Resource Allocation Framework.
- ◆ Contributed to the development of a Business Case and Economic Evaluation Framework.
- ◆ Prepared ministerial correspondence, briefings, budget submissions, speech notes and media releases.

Feb 2000 – Feb 2005:

**QUEENSLAND HEALTH
MENTAL HEALTH UNIT**

Aug 2004 – Feb 2005:
Aug 2003- Dec 2003:

Manager, Partnership Development Team

Responsibilities:

- ◆ Managed the Mental Health Units partnerships with:
 - Disability Services Queensland
 - Queensland Police
 - Department of Premier and Cabinet
 - Department of Housing
 - Department of Child Safety
 - General Practice
 - Alcohol Tobacco and Other Drugs
 - Public Health Services
 - Department of Corrections
 - Department of Communities
 - Non-Government Organisations
 - Consumers and Carers
- ◆ Developed a partnership framework for mental health which commenced with a loose partnership; moved to a more mutually binding collaboration; and which then lead to full integration.
- ◆ Developed Memorandums of Understanding and Local Partnership Agreements which articulated a common vision;

commitment; investment; accountability and reporting on progress.

- ◆ Developed particularly successful partnerships between mental health services and general practitioners through the *Partners in Mind* initiative; the *Employment Specialist* initiative between Disability Employment Providers and mental health services; between mental health and the police service through the *Mental Health Intervention Project*; between mental health and child safety through the *Evolve Teams*; and mental health, disability services and housing to establish the *Housing and Support Program*.

Jan 2004 – Aug 2004:

July 2002 – Sept 2002:

Acting Manager – Mental Health Unit

Responsibilities:

- ◆ Managed the operations of the Clinical Services Reform Team; the Partnerships Team; the Systems and Outcomes Team; the Mental Health Act & Rights Team; and the Workforce Development Team.
- ◆ Provided strategic direction and leadership to the five teams with over 50 staff.
- ◆ Provided advice to and accompanied the Minister to a range of community and public sector functions, meetings and launches.
- ◆ Represented the department and Minister at various intergovernmental and community meetings, functions, events and conferences at the local, State and national levels.
- ◆ Consulted regularly with key stakeholders and developed and maintained effective communication channels with a broad range of internal and external stakeholders.
- ◆ Prepared ministerial correspondence, briefings, budget submissions, speech notes and media releases.
- ◆ Participated in Senior Governance mechanisms which set organisational, strategic, workforce and budgetary directions.
- ◆ Managed finances and budgets.

Sept 2000 – Aug 2003:

Manager –Services and Structural Reform Team

Responsibilities:

- ◆ Developed and implemented state-wide Policy positions to drive mental health reform in the following areas:
 - Capital Works
 - Older Peoples Mental Health
 - Child and Youth Mental Health
 - Consultation/Liaison Psychiatry
 - Alternatives to Acute Admission
 - Emergency Departments

- Suicide Prevention
- National Standards
- Recovery
- Indigenous Mental Health
- Promotion and Prevention
- Early Intervention
- Deaf & Hearing Impaired
- HIV/AIDS & Mental Health
- Transcultural Mental Health
- Sexual Safety in Mental Health Facilities
- ◆ Provided advice to and accompanied the Minister to a range of community and public sector functions, meeting and launches.
- ◆ Represented the department and Minister at various intergovernmental and community meetings, functions, events and conferences at the local, State and national levels.
- ◆ Consulted regularly with key stakeholders and developed and maintained effective communication channels with a broad range of internal and external stakeholders.
- ◆ Prepared ministerial correspondence, briefings, budget submissions, speech notes and media releases.

May 2000 – Aug 2000:

Principal Policy Officer - Promotion, Prevention & Early Intervention

Responsibilities:

- ◆ Developed and implemented state-wide the Queensland Health Framework for Promotion, Prevention and Early Intervention in Mental Health 2000 targeting:
 - Infants, toddlers and preschoolers 0-4 years
 - Children 5-11 years
 - Young people and young adults 12-25 years
 - Older people and the elderly
 - Individuals, families and communities experiencing adverse life events (loss, grief and bereavement)
 - Rural and remote communities
 - Aboriginal and Torres Strait Islander Communities
 - Culturally and linguistically diverse background communities
 - Consumers, carers and community organisations
 - Health professionals and clinicians
- ◆ Represented the department at various intergovernmental and community meetings, functions, events and conferences at the local, State and national levels.
- ◆ Consulted regularly with key stakeholders and developed and maintained effective communication channels with a broad range of internal and external stakeholders.

- ◆ Prepared ministerial correspondence, briefings, budget submissions, speech notes and media releases.

Feb 2000 – Apr 2000:

Senior Policy Officer - Hospital Redevelopment & Workforce

Responsibilities:

- ◆ Finalised the Queensland Health Mental Health Capital Works Program.
- ◆ Developed and implemented workforce development strategies.
- ◆ Developed models for Mental Health Service Delivery.
- ◆ Provided advice to Director of Mental Health; Director General; and Minister on the progress of the mental health capital works projects.
- ◆ Prepared Ministerial correspondence, briefings, submissions, speech notes and media releases.

Dec 1995 – Feb 2000:

**QUEENSLAND HEALTH
TRANSCULTURAL MENTAL HEALTH CENTRE**

Manager

Responsibilities:

- ◆ Provided clinical consultation and liaison services state-wide
- ◆ Delivered training and professional development sessions to medical and allied health staff.
- ◆ Initiated promotion, prevention and early intervention initiatives in CALD communities.
- ◆ Drove policy implementation and evaluation
- ◆ Managed finances, human resource, projects and change management.
- ◆ Initiated and participated in research.
- ◆ Developed multilingual information and resources.

Feb 1995 - Dec. 1995:

**DEPARTMENT OF SOCIAL SECURITY
Annerley/Stones Corner**

Social Work & Manager Social Work Team

Responsibilities:

- ◆ Staff and Students Supervision
- ◆ Team management
- ◆ Casework

- ◆ Advocacy
- ◆ Community education and liaison
- ◆ Policy analysis and development

Jan 1994 - Jan 1995:

**QUEENSLAND HEALTH
MENTAL HEALTH BRANCH**

Policy Officer

Responsibilities:

- ◆ Policy development
- ◆ Consultation
- ◆ Research/analysis
- ◆ Cost estimation
- ◆ Ministerial briefings, correspondence and submissions
- ◆ Interdepartmental negotiation

Dec 1991 - Jan 1994:

**DEPARTMENT OF SOCIAL SECURITY
Ipswich/Stones Corner
Social Worker**

Responsibilities:

- ◆ Casework
- ◆ Community education and liaison
- ◆ Research

Jun 1993 - Oct 1993:

**DEPARTMENT OF SOCIAL SECURITY
MIGRANT SERVICES UNIT**

Co-ordinator, Migrant Liaison Officer Program

Responsibilities:

- ◆ Staff Supervision
- ◆ Policy implementation and evaluation
- ◆ Community education and liaison
- ◆ Change management
- ◆ Training/Professional Development

1981 - Nov 1990:

**CROATIAN CATHOLIC CENTRE
CROATIAN WELFARE CENTRE**

Co-ordinator

Responsibilities:

- ◆ Manage the centre, staff and students.
- ◆ Report to Board and prepare program, financial and workforce reports to the Board.
- ◆ Initiate community development and education initiatives
- ◆ Write tenders and submission
- ◆ Fundraising
- ◆ Training/professional development
- ◆ Advocacy/negotiation
- ◆ Media interviews

1979 - 1981:

DEPARTMENT OF SOCIAL SECURITY, IPSWICH

Clerical

CASUAL EMPLOYMENT

1999 – 2002:

GRIFFITH UNIVERSITY
Faculty of Nursing & Health
Master of Mental Health Nursing
“Community Needs Assessment”

Lecturer

PUBLICATIONS

Department of Communities. 2011. SUPPORTING RECOVERY – COMMUNITY MENTAL HEALTH SERVICES PLAN 2011-17.

Queensland Health. 2007. QUEENSLAND PLAN FOR MENTAL HEALTH 2007-17.

Aston, A, Chaplow, D, Chettleburg, K, Frkovic, I and Harris C. 2003. INTERNATIONAL MENTAL HEALTH STUDY TOUR REPORT, Wisconsin, USA; Birmingham, UK; Trieste, Italy.

Frkovic, I. 2001. CROATIANS IN QUEENSLAND. 100 Years, 100 Communities – A Century of Contributions. Multicultural Queensland. Department of Premier & Cabinet. Queensland Government.

Frkovic, I. 1999. MENTAL HEALTH POLICY IMPLEMENTATION: AN EVALUATION OF THE PROCESS. Master of Social Welfare Administration and Planning. University of Queensland. (Minor Thesis).

Larson, A., van Kooten-Prasad, M., Manderson, L. & Frkovic, I. 1998. ASSESSING NEEDS FOR MENTAL HEALTH IN CULTURALLY AND LINGUISTICALLY DIVERSE COMMUNITIES: A QUALITATIVE APPROACH (Manual). University of Melbourne.

Ethnic Communities Council Gold Coast. 1997. THE NEED FOR GENTLE WORDS: A Community Needs Assessment of Survivors of Torture and Trauma from Bosnia Living at the Gold Coast. (Co-principal investigator)

Queensland Health. 1995. NON-ENGLISH SPEAKING BACKGROUND MENTAL HEALTH POLICY STATEMENT.

Frkovic, I. 1992. THE YHA MAZE: Youth Homelessness and the Young Homeless Allowance. Department of Social Security, Ipswich.

Frkovic, I. & Randle, D. 1991. CONSOLIDATION OF THE COMMUNITY JUSTICE PROGRAM IN TOOWOOMBA. Queensland Department of Attorney General's Publication.

Frkovic, I. & Grepl, V. 1988. CROATIANS IN QUEENSLAND, Croatian Catholic Centre Publication, Brisbane.

CONFERENCE PAPERS

Frkovic, I and Perry, C. 2015. "Floresco – Its Latin for Flourish". The Mental Health Services Conference (TheMHS), Canberra.

Frkovic, I. 2014. SERVICE INNOVATION AND PARTNERSHIPS, Maximising Social and Economic Participation for those with Mental Illness, Sunshine Coast University. Queensland.

Frkovic, I. 2012. THE PAST & FUTURE OF CONSUMER PARTICIPATION IN QUEENSLAND, Keynote Address, NGAGE Launch, Queensland Alliance, Brisbane

Frkovic, I. 2012. MENTAL HEALTH REFORM IN QUEENSLAND – The Consumer & Carer Contribution. Keynote Address, Consumer & Carer Forum, Gold Coast.

Frkovic, I. 2010. MENTAL HEALTH REFORM IN QUEENSLAND. Keynote Address, Mental Health Summit, Sunshine Coast University, Queensland.

Frkovic, I., Hewitt, C., & Ellis, G. 2009. COMMUNITY MENTAL HEALTH SECTOR – "THINKING OUTSIDE THE SQUARE". Keynote Address, Australian Association of Social Workers - Queensland Conference, Sunshine Coast

Frkovic, I., Villanova, L., & Kelly, M. 2009. MENTAL HEALTH COMMUNITY SECTOR WORKFORCE. Altering States Conference: Reforming the System – Brisbane, Queensland

Frkovic, I. 2007. QUEENSLAND MENTAL HEALTH SERVICE DELIVERY SYSTEM & SOCIAL WORK. Plenary Session, Australian Association of Social Workers - Queensland Conference, Yeppoon, Central Queensland.

Frkovic, I. 2007. FUTURE DIRECTIONS IN MENTAL HEALTH, 8th International Mental Health Conference, Gold Coast, Queensland.

Frkovic, I. 2007. OPENING ADDRESS, New Perspectives and Recent Developments in Recovery Focused Practice Symposium, University of Queensland, Brisbane.

Frkovic, I., Bushell, N. & Harris, D. 2001. MENTAL HEALTH REFORM IN QUEENSLAND – A CONCEPTUAL FRAMEWORK. Paper presented at the Australian & New Zealand Mental Health Services Conference, Wellington, New Zealand.

Frkovic, I. & Nip, P. 1998. BILINGUAL/BICULTURAL CASE-MANAGEMENT MODEL. Paper presented at the Australian & New Zealand Mental Health Services Conference, Hobart.

Larson, A., Frkovic, I., Manderson, L., van Kooten-Prasad, M. 1998. MENTAL HEALTH NEEDS ASSESSMENT IN AUSTRALIA'S CULTURALLY DIVERSE SOCIETY. Paper presented at the Australian & New Zealand Mental Health Services Conference, Hobart.

Frkovic, I. 1998. LOSS: A MULTICULTURAL PERSPECTIVE. Paper presented at the Loss: Unity in Diversity Conference, University of Queensland, Brisbane Exhibition and Convention Centre.

Frkovic, I. 1996. "IMMIGRANTS & POLICY DEVELOPMENT". Paper presented at the Australian & New Zealand Mental Health Services Conference, Brisbane Exhibition and Convention Centre.

JOURNAL ARTICLES

Siskind, D., Harris, M., Buckingham, B., Pirkis, J., Whiteford, H., 2012. PLANNING ESTIMATES FOR THE MENTAL HEALTH COMMUNITY SECTOR, Australian and New Zealand Journal of Psychiatry. *(contributed to the development of the Planning Estimates)*

Larson, A., Frkovic, I., Manderson, L., van Kooten-Prasad, M. 2001. MENTAL HEALTH NEEDS ASSESSMENT IN AUSTRALIA'S CULTURALLY DIVERSE SOCIETY. Transcultural Psychiatry. SAGE Publication.

Giang, J., Dimoska, D., Frkovic, I., Reguera, L. & Turner, G. 2000. POSTCARD FROM ABROAD: Dreams and Realities from the Perspective of the Queensland NESB Consumer & Carer Group. SYNERGY. Autumn 2000.

MINISTERIAL APPOINTMENTS/COMMITTEES/BOARDS

CHAIR WEST MORETON & OXLEY – FLORESCO CENTRE, Governance Steering Committee (2014 - Current)

CHAIR WEST MORETON & OXLEY – PARTNERS IN RECOVERY, Consortium Management Committee (2013 - Current)

ACCESS COMMUNITY SERVICES – Multicultural and Refugee Resettlement Service, Board Member (2013 – Current)

PEACH TREE – PERINATAL WELNESS INC, Board Member.(2012-2014)

QUEENSLAND MENTAL HEALTH COMMISSION - ADVISORY COMMITTEE, Transition Team Member. (Oct 2011 – April 2012)

COMMUNITY MENTAL HEALTH PARTNERSHIP FORUM – Department of Communities cross-sector and cross-government advisory group.(2009 -2011)

HEAD OF SCHOOL ADVISORY COMMITTEE – SCHOOL OF PSYCHOLOGY & COUNSELLING, Faculty of Health, Queensland University of Technology.(2013 - Current)

4th NATIONAL MENTAL HEALTH PLAN IMPLEMENTATION STEERING COMMITTEE – Department of Health and Ageing cross-government and cross-jurisdiction committee.(2010-11)

QUEENSLAND MENTAL HEALTH REFORM COMMITTEE, Cross-government and cross-sector group informing the implementation of the 4th National Mental Health Plan.(2009-12)

COMMUNITY & KEY STAKEHOLDER ADVISORY COMMITTEE, Depart of Social Work, University of Queensland.(2013 - Current)

MENTAL HEALTH ROUNDTABLE 2009 - Convened by Deputy Premier and Minister for Health and Minister for Disability Services and Multicultural Affairs.

MENTAL HEALTH PLAN IMPLEMENTATION STEERING COMMITTEE – Queensland Health (2007-11)

STATEWIDE MENTAL HEALTH NETWORK – Queensland Health (2007-11)

QUEENSLAND PRIMARY MENTAL HEALTH CARE COLLABORATIVE – General Practice Queensland (2007-11)

QUEENSLAND COAG MENTAL HEALTH GROUP (2006-2009) – Department of Premier and Cabinet

MENTAL HEALTH INTERDEPARTMENTAL COMMITTEE (2006-2009) – Department of Premier and Cabinet

HOUSING AND SUPPORT PROGRAM (HASP) STRATEGY GROUP – Interdepartmental Committee comprising Queensland Health, Department of Housing and Disability Services Queensland

COAG REFORM IMPLEMENTATION STEERING COMMITTEE – Policy, Planning and Funding Division, Queensland Health (2006-2007)

JOINT OFFICERS GROUP – Multicultural Mental Health Australia, Department of Health and Ageing (2006-2007)

INTERDEPARTMENTAL STEERING COMMITTEE, Queensland Health – Department of Corrective Services (2005-2006)

JOINT ADVISORY COMMITTEE - Queensland Health and Department of Veterans Affairs (2005)

NATIONAL MENTAL HEALTH WORKING GROUP - HOMELESSNESS AND HOUSING TASKFORCE – Australian Health Ministers Advisory Council (2003 – 2005)

NATIONAL SUICIDE PREVENTION STATE & TERRITORY FORUM – Department of Health and Aged Care (2003-2005)

NATIONAL MULTICULTURAL MENTAL HEALTH POLICY STEERING COMMITTEE – Department of Health and Aged Care (2003 – 2004)

NATIONAL ADVISORY COMMITTEE – MINDMATTERS PLUS, National Guidance and Counsellors Association (2002 – 2005)

COMMONWEALTH TENDER SELECTION COMMITTEE – Australian Transcultural Mental Health Program, Department of Health and Aging (Sept. 2002).

RESIDENTIAL SERVICES STAKEHOLDER ADVISORY COMMITTEE – Department of Communities, Queensland Health representative (2004- 2005)

RESIDENTIAL SERVICES SECTOR COORDINATING COMMITTEE – Department of Communities, Queensland Health representative (2004 – 2005)

QUEENSLAND SUICIDE PREVENTION ADVISORY COMMITTEE – National Suicide Prevention Strategy, Department of Health and Aging (2002 – 2005)

NATIONAL MENTAL HEALTH PROMOTION, PREVENTION and EARLY INTERVENTION WORKING PARTY – Australian Health Ministers Advisory Council, National Mental Health Working Group (2000-2006)

QUEENSLAND GOVERNMENT SUICIDE PREVENTION STEERING COMMITTEE – Queensland Government Suicide Prevention Strategy 2003-2008 (2000-2006)

CENTENARY OF FEDERATION WORKING GROUP, Queensland Youth Suicide Prevention Project, Toowong Private Hospital (2000-2002)

AUSTRALIAN TRANSCULTURAL MENTAL HEALTH NETWORK – Advisory Board member and Queensland Health representative (1995 - 2000)

CURRICULUM COMMITTEE MEMBER. 1998. Southbank Institute of TAFE. Certificate III in Community Services (Mental Health Work – Non-clinical)

CURRICULUM COMMITTEE MEMBER. 1998. University of Queensland and Griffith University. Graduate Diploma in Loss and Grief

MINISTERIAL APPOINTMENTS - Queensland Government's Ethnic Health Advisory Committee (1993) and the Youth Advisory Committee (1988)

CURRICULUM COMMITTEE MEMBER. 1993. Southbank College of TAFE, Interpreting in Mental Health Course

AWARDS

IPPA QUEENSLAND PUBLIC SECTOR EXCELLENCE AWARD (HIGHLY COMMENDED), 2012 Best Practice in State Government – Community Participation Outcomes for People with Mental Illness.

CAIRNS CONSUMER & CARER ADVISORY GROUP, “Professional Contribution Award” 2011.

EXCELLENCE IN PUBLIC SECTOR MANAGEMENT, PREMIERS AWARD, COAG Housing and Support Program, 2008

QUEENSLAND HEALTH, TRANSCULTURAL MENTAL HEALTH CENTRE, “Inaugural Life Time Friend Award” 2006

CROATIAN GOVERNMENT, Red Danice Hrvatske “KATARINA ZRINSKI” 1997

QUEENSLAND GOVERNMENT ETHNIC COMMUNITY SERVICES AWARD 1995

OTHER

2003 International Study Tour on Mental Health – Wisconsin USA, Trieste Italy, Birmingham England.

2013 International Initiative on Mental Health Leadership Exchange – Auckland, New Zealand

2014 International Initiative on Mental Health Leadership Exchange – Chester, England

2015 International Initiative on Mental Health Leadership Exchange – Vancouver, Canada

REFEREES