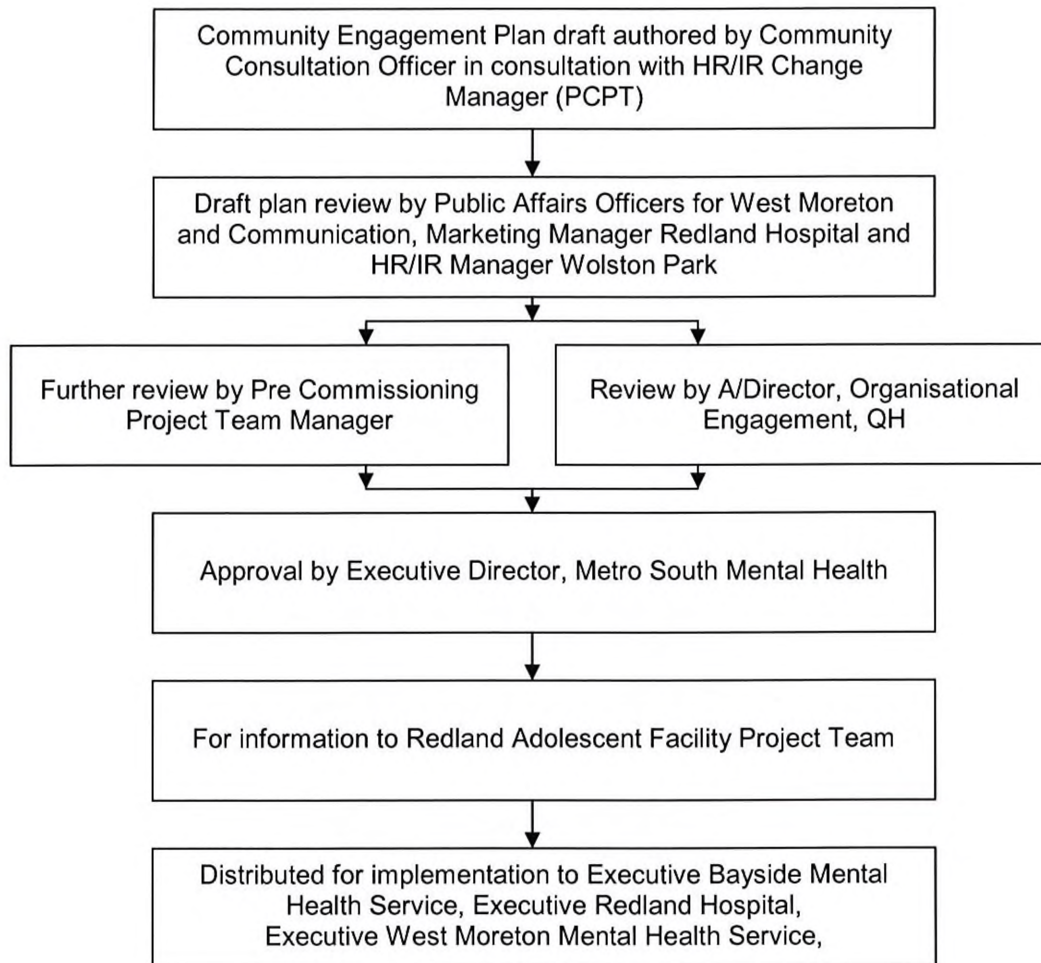
APPROVALS

Approvals confirm the signatories' belief that the following plan is an accurate, complete and reliable indication of the time, effort and resources required to deliver the project scope, with appropriate monitoring and control.

6. Review and approvals process



7. Project Sponsor

In signing, the Project Sponsor confirms support of the project and a willingness and authority to enable the project to deliver the expected outcomes, benefits and deliverables within the stated time and costs set out in this plan.

Signature:		Business Area:	Metro South Mental Health Service
Name:	Associate Professor David Crompton	Date:	
Position:	Executive Director	Contact No:	

David Crompton - Fwd: BAC MOSD Minutes

From: Judi Krause
To: David Crompton; Shirley Wigan
Date: 2/17/2010 3:43 PM
Subject: Fwd: BAC MOSD Minutes
Attachments: BAC MOS Extraordinary meeting minutes 10.02.10.doc

Hi David and Shirley
here is a copy of the minutes from the first meeting for your perusal. Let me know if you have any concerns about the direction the group are taking.
Kind Regards
Judi

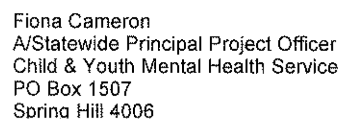
Judi Krause
Acting Executive Director
Child and Youth Mental Health Service (CYMHS)
Children's Health Service District

>>> FionaT Cameron 17/02/2010 2:29 pm >>>
Dear Colleagues

Please find attached the minutes from the meeting on Feb. 10th. Please note the next meeting is Friday 19th Feb. 10-11 at CYMHS, Spring Hill.

Regards Fiona

Fiona Cameron
A/Statewide Principal Project Officer
Child & Youth Mental Health Service
PO Box 1507
Spring Hill 4006



Please consider the environmental impact before printing this email

Meeting to Review Model of Service Delivery (MOSD) for Adolescent Integrated Treatment and Rehabilitation Centre (AITRC)

(formerly known as Barrett Adolescent Centre (BAC))

MINUTES

Chair:	Judi Krause, A/Executive Director, RCH&HSD	**Date:**	10 February 2010
Secretariat:	Fiona Cameron, A/Statewide Principal Project Officer, CYMHS	**Time:**	10:00am – 11:00noon
Venue:	Seminar Room, Institute of Child and Youth Mental Health Services, Spring Hill		
Apologies:	Dr Trevor Sadler, Director, Barrett Adolescent Centre – West Moreton South Burnett District Dr Penny Brassey, Clinical Director, Child and Youth Mental Health, Townsville		
Present:	Fiona Cameron, Statewide Principal Project Officer CYMHS Judi Krause, A/Executive Director, RCH&HSD Erica Lee, Manager, CYMHS Mater, Mater Hospital & Health Service District Dr Brett McDermott, Director, CYMHS Mater, Mater Hospital & Health Service District **Via Teleconference Link** Dr James Scott, Child /Adolescent Psychiatrist ECYMHS & Evolve TS Brisbane North Dr Michael Daubney, Director, CYMHS, Metro South Health Service District		

Agenda Item	Action/Person
Judi gave a brief overview of the task at hand (request by Metro South Management and Mental Health Directorate (Mental Health Plan Implementation Team) to review the MOSD from AITRC in respect to a range of previous reviews that had been undertaken). Judi began discussion by summarising the past reviews of Barrett Adolescent Centre and noting that a recent review (late 2009) had been conducted but the report and recommendations had not been released by the CEO of West Moreton-Darling Downs Health Service District. Discussion took place regarding previous recommendations, issues of concern and key themes of previous reviews: Summary of issues to consider when reviewing MOSD AITRC: • Judi outlined some of the concerns highlighted in previous reviews and key themes from the most recent 2009 review (recommendations unreleased): o safety concerns for clients and staff, a no. of critical incidents and building safety concerns o change of client profile – more acute clients with increased complexity o less referral out options o average length of stay has increased from 4 mths (1994) to 10 mths (2006) o clinical governance structures unclear o lack of integration with local services and broader CYMHS services o concerns regarding the recording of clinical incidents o concerns that the clinical model lacks use of evidence based treatments	

Agenda Item	Action/Person
○ lack of staff training in therapies practiced ○ limited opportunities for staff development in child and adolescent specific education ○ model of care for nursing unclear – (task allocation or functional) not contemporary ○ long waiting times for admission ○ referral criteria / exclusion criteria unclear ○ the need for individualise behaviour management plans ○ treatment evaluation poor ○ staff not experienced in other models of care ○ vague reporting lines ○ inadequate clinical supervision ○ discharge planning challenges/ especially out of home placements for older adolescents ○ poor transition to adult mental health • Judi has spoken with Trevor Sadler in regards to the most recent review conducted in late 2009. Trevor felt that this review was not representative of the range of therapies used at AITRC and did not reflect the scope of the current program. Trevor will access his emails overseas and prepare some information to share with the group at the meeting planned for next week to more clearly articulate the current treatment model. • Model of AITRC 'Toward Recovery' has been presented by Trevor in the past as a framework for treatment and a way of identifying level of impairment. It was felt by the group that this problem solving matrix model (parenting tasks and developmental tasks of adolescence) whilst highly valued does not clearly articulate the AITRC treatment philosophy to those outside of CYMHS. This ambiguity is causing confusion with senior mental health colleagues which has contributed to the need for this further review of the MOSD. • Judi stated that Trevor is concerned that he will be overseas during the current review of the model and had requested this process be put on hold until he returns. This was unable to occur due to MHD/ Metro South determining that the MOSD was an urgent priority and further redevelopment of the Redlands site would not continue until this was addressed. • The task today is to review the key issues in the MOSD that Trevor has drafted to assist in clarifying the model. Themes will be what services are provided, referral pathways, admission inclusion and exclusion criteria, evidence based treatment modalities, staff skill mix and discharge planning frameworks etc. • The current MOSD document lists therapies but there is no particular sense of the continuum of care, the progression of therapies or the client's journey. It was felt this needed to be more clearly defined. • Clinical governance issues discussed. Erica Lee highlighted that AITRC currently is very isolated in clinical governance and reporting structures and that it needs to sit as part of a continuum of care within the broader CYMHS system. The group agreed with this. It was felt this link with a broader CYMHS structure would formalise governance structures establishing clear reporting relationships, enable staff of all disciplines to link into existing staff development, clinical education, clinical supervision and peer support structures. It was also discussed that AITRC should be integrated into the statewide CYMHS model of service.	

Agenda Item	Action/Person

• Discussion re: where AITRC would be best placed under CYMHS continuum of care. It was recommended by the group that line management is undertaken by a well resourced CYMHS service with a proven record of administrating state wide services e.g. Children's Health Service District (CHSD), with the Mater taking this responsibility in the interim period until the establishment of Queensland Children's Hospital in 2014.
 	
• Brett highlighted the need to have AITRC linked into a continuous reform process as per other CYMHS services to ensure contemporary service delivery.
 	
• The group discussed issues around the AITRC including; many anomalies in the model e.g. referrals from private practitioners, long length of stay for some consumers, discharge planning challenges etc. It was determined that referrals to AITRC should be from CYMHS services and not from private practitioners who would not have been able to offer a comprehensive multi-disciplinary approach to community based care. It was agreed by the group that this approach was a minimum pre – entry standard.
 	
• James Scott highlighted that the best treatment gains are often in first 6 months of treatment .James suggested that it would be useful to look at the ***Rivendell*** model in NSW. http://www.sswahs.nsw.gov.au/MHealth/
 	
• Discussion around phases of treatment and group thought 6 months was a reasonable overall time frame for treatment. Suggestions were the initial phase would be focussed on rapport building, developing a therapeutic alliance, risk assessment and developing shared treatment goals, the second phase would involve intensive treatment (evidence based, DBT, IPT-A, trauma focussed CBT etc.) in conjunction with systemic approaches and the third phase would be assertive move toward discharge and re-integration back into the community/ either referring CYMHS team or adult mental health.
 	
• Group discussed the possibility of recommending a multi disciplinary complex case conference process for entry to AIRTC. This panel could consist of senior AITRC staff, key stakeholders from CYMHS and possibly key stakeholders from external agencies. This would assist with commitment of referring agencies for ongoing involvement and assist with consistency and equity of admissions.
 	
Recommendations & Issues for consideration
Clinical Governance:
Recommendation for MOSD to be changed to reflect clinical governance changes to Mater CYMHS in the interim until establishment of QCH.
 	
• **Referrals**:
  o Clarification and consistency needed in referral process.
  o Clarification around what type of clients is suited to the centre.
  o Multi disciplinary complex case conference process for referrals suggested
 	
  • Recommendation for the model to be changed to reflect referrals from CYMHS services only.	

Agenda Item	Action/Person
• Recommendation for model to include multi disciplinary complex case panel process for admission to AITRC or for extension of treatment beyond initial 6 months. • **Treatment**: o How therapies work in a continuum of care? o How does the school operate in the model of care? o Is it evidenced based treatment modalities or is it re parenting? o Clear care pathways to be established. • Concerns around eating disorder clients. Felt that ED clients should not be at AITRC in a model that currently caters for admissions of over 6 months. Concern that there is not the level of expertise needed at Barrett to cater for ED clients as this is a specialised field. It was acknowledged that some rural and remote areas may not be able to access local outpatient support for eating disorders and may require further support from acute facilities or outreach services such as EDOS. • Discussion around AITRC admitting young people with psychosis. It was felt that there are more contemporary community based models of care for this cohort. It was acknowledged that CYMHS may need to be more proactive in linking to early psychosis resources including supported accommodation opportunities for young people with serious mental illness. • Discussion re: current long waiting times for admission precluding admission of either ED or Psychosis • The group agreed that the model of care should focus on a 3-6 month timeframe of admission. Treatments should not extend beyond 6 months unless this case had been re-presented to the complex care panel for extensive review. • Link to support services very important. • Specify more clearly re diagnostic groups and complexity of presentations Group decided there was a need for a meeting next week to review the proposed changes to date in the MOSD and to continue to discuss and integrate further changes. **NEXT MEETING: 9.30 FRIDAY 19TH FEBRUARY 2010 AT CYMHS SPRING HILL.**	Brett McDermott volunteered to co-ordinated the group's suggestions and provide feed back to Fiona Cameron who will integrate these into the service model. Revised Model to be disseminated to group prior to next meeting on 19/02/10.

Redland Adolescent Comms Plan

From: Marisa Stewart

To: Ed_mhsmetrosouth

Date: Tue, 08 Mar 2011 12:27:20 +1100

Attachments: Communication Plan Redland Adolescent ETU March 2011 v2.doc (5.48 MB)

Hi Renee

Please find attached the Redland Adolescent ETU Communication plan.

I require David's feedback on the content and permission to progressing to the Redland Adolescent FPTM committee for their review.

For information - the bulk of the content is fairly generic to all our other comms plans - the Change Communication Action plan table (from page 17 onwards) is the most important part of this document.

Di has also reviewed this doc from a communication point of view and is happy with the content.

Many thanks
Marisa

Marisa Stewart |Community Consultation
Pre Commissioning Project Team
Metro South Mental Health

Nexus Building, Level 2, 96 Mt Gravatt Capalaba Road
Upper Mt Gravatt Qld 4122

Redlands Adolescent Centre

Community engagement strategy — issues and stakeholder audit

Stakeholder	Issue	Strategy	Communication channel/tool	Task/Who
Internal — MHB				
Pre–commissioning Team (PCG)	Teams need to proactively manage stakeholder and community issues and project reputation during construction and commissioning phases	Develop and implement a community engagement strategy	Community Engagement Plan (CEP) template (Note: Include context/background in CEP re history of facility)	Draft CEP prepared by Integrated Communications CEP reviewed and endorsed by PCG and District Public Affairs
	Provide timely and relevant information to key stakeholders	Project team to liaise with project officer from District Public Affairs to implement CEP (Note: Two districts - Darling Downs/West Moreton and Metro South) District public affairs to attend PCG meetings	PCG meetings and/or monthly meeting (PCG representative + District Public Affairs)	Implementation by PCG with assistance from District Public Affairs
	Operational issues/risk management at	Katie Eckersley (KE) [Manager, Bayside Mental Health] + Bayside Mental	Monthly meetings	KE/FM + Bayside Exec

Redlands Adolescent Centre

Community engagement strategy — issues and stakeholder audit

Stakeholder	Issue	Strategy	Communication channel/tool	Task/Who
	Redland Adolescent Centre	Health Exec to meet with Francis Maher (FM) [Project Manager, Pre Commissioning Project Metro South Mental Health] re role/liaison at Redland Adolescent Centre		
	Risk management at The Park	Current model of care under review New model of care needs to be articulated to staff, user groups and media	Working group has been established	David Crompton (DC) [Executive Director, Clinical Services] to organise and Chair on behalf of the Executive Director (ED) Mental Health Branch
	Project website	Create project information landing page on The Park website + link on Mental Health website to project info landing page	Website See also Princess Alexandra Hospital ED website at http://www.health.qld.gov.au/pahospital/	District Public Affairs
Children's Health Services District District Manager (Chief Executive	Interface with Child and Youth Mental Health	Provide timely and relevant information Provide opportunities for	Representation on FPT working group 1:1 meetings as required	FM

Redlands Adolescent Centre

Community engagement strategy — issues and stakeholder audit

Stakeholder	Issue	Strategy	Communication channel/tool	Task/Who
Officer)	Services (CYMHS)	input and feedback Representation on Facility Project Team working group (Note: FPT is overseeing design phase)		
Mental Health Branch—Office of the Executive Director (ED)	Manage issues and project reputation on behalf of the Branch	PCG and District Public Affairs to provide timely and relevant information Mental Health Plan Implementation Team has governance of pre-commissioning activities and reports to ED	Briefings as required 1:1 meetings	DC and John Quinn (JQ)
Darling Downs-West Moreton Health Services District Exec Director (Chris Hodgson) CEO (Pam Lane) Exec Director (Shirley Wigan)	Manage issues and reputation management on behalf of the District Deliver project on time and on budget (financial implications for The Park)	PCG to provide briefings and/or meetings, as required with assistance from District Public Affairs—Darling Downs/West Moreton PCG to forward public correspondence to CEO/ED for noting and/or response Develop and maintain project specific stakeholder database	Briefings 1:1 meetings (catch-ups re hot issues) as req'd Stakeholder database Monthly reports	JQ/FM to provide briefings/meetings as required District public affairs to assist with drafting responses to media and public enquiries

Redlands Adolescent Centre Community engagement strategy — issues and stakeholder audit				
Stakeholder	**Issue**	**Strategy**	**Communication channel/tool**	**Task/Who**
		SW reports monthly to District EMT (Shirley to Pam)		
Metro South Health Services District Exec Director–Assoc. Prof. David Crompton (DC) CEO–Dr David Thiele	Manage issues and reputation management on behalf of the District Deliver project on time and on budget	PCG to provide briefings and/or meetings, as required with assistance from District Public Affairs—Darling Downs/West Moreton PCG to forward public correspondence to CEO/ED for noting and/or response Develop and maintain project specific stakeholder database	Monthly FPT (steering committee – all stakeholders) meeting Briefings 1:1 meetings Stakeholder database	DC Chair FPT JQ/FM to provide briefings/meetings as required District public affairs to assist with drafting responses to media and public enquiries
Directly affected staff—Barrett Adolescent Centre	The Park will become forensic facility and the Barrett Adolescent Centre will be relocated to greenfield site at Redland Hospital HR issues—long term strategy	Change Management Plan to include communications strategy [Joanne King (JK) – Project Director, The Park Redevelopment] Provide timely and relevant information to staff District Public Affairs to liaise with Ian Janke (IJ) [Change Manager, Project Control Team, Metro South Mental	Staff briefings [PCG meets with JK's group + The Park user groups monthly] Project update in staff and District newsletters Project displays at both sites in staff areas Upload information + project contact to website and intranet	PCG to liaise with District Public Affairs + JK + Integrated Communications to develop and implement CEP and supporting collateral Integrated Comms to speak with IJ

Redlands Adolescent Centre Community engagement strategy — issues and stakeholder audit				
Stakeholder	**Issue**	**Strategy**	**Communication channel/tool**	**Task/Who**
	required e.g. relocation; recruitment and retention; potential loss of experienced staff Local transport at Redland	Health) re communications Joanne King (Nursing Director) will be staff contact PCG meets regularly with Joanne	FAQs for staff (site specific) Links to concept and project updates at MHB home page on QHEPS Staff e-alerts from PCG Dedicated url for project e.g www.health.qld.gov.au/ (insert title of project) Key messages re positive benefits of relocation and purpose-built facility	and JK to scope staff comms strategy
Directly affected service providers at current facility, including: ▪ Allied Health ▪ Residential support officers ▪ Teachers ▪ Administration	Change management, including relocation of service Local transport at Redland	As above for staff	As above	As above

Redlands Adolescent Centre

Community engagement strategy — issues and stakeholder audit

Stakeholder	Issue	Strategy	Communication channel/tool	Task/Who
Indirectly affected staff—The Park	HR issues re employment, relocation etc	As above	As above	As above
	Change Management Plan	HR person for West Moreton will be appointed HR to provide direct conduit back to PCG	Align CMP with CEP PCG to provide interface	FM to advise appointee
Potential staff–new Redland facility ▪ Security at new Redland campus ▪ Food services ▪ etc	Transitional and/or recruitment strategy Commissioning plan will be required eg recruitment plan Orientation/education plan Operational plan	Michael Seow (MS) [Manager, Leadership and Corporate Improvement, Mental Health] will implement (Change Management Plan) Liaise with Work4Us and District HR	Information sessions Bulleting boards Displays FAQs Facility tours for relocating and potential staff Onboarding package	MS to liaise with PCG, Integrated Comms and District Public Affairs regarding development and implementation of communication tools to support change management strategy
Government agencies				

Redlands Adolescent Centre

Community engagement strategy — issues and stakeholder audit

Stakeholder	Issue	Strategy	Communication channel/tool	Task/Who
Education Queensland	Relocation (across regions) of services from the Barrett Adolescent Centre to the new facility	Queensland Health (Mental Health Branch) to liaise with Education Queensland to ensure seamless transition of the education facility and services Identify contact/s for project management and receipt of project updates	Representation on FPT Executive briefings, as required Invitation to participate in user group consultation and to attend project workshops, as required Stakeholder database Include teaching staff in HR and engagement strategies	MOU re pre-commissioning activity
Mental Health Review Tribunal	Desire to be kept informed about project during construction	Identify contact for project updates and include on stakeholder database	Database Project information collateral, including updates	PCG
Office of the Child Guardian	Desire to be kept informed about project during construction	Identify contact for project updates and include on stakeholder database	Database Project information collateral, including updates	PCG
Commission for Children and Young People	Desire to be kept informed about project during	Identify contact for project updates and include on stakeholder database	Database Project information collateral, including updates	PCG

Redlands Adolescent Centre

Community engagement strategy — issues and stakeholder audit

Stakeholder	Issue	Strategy	Communication channel/tool	Task/Who
	construction			
Child and Youth Mental Health Services (Redland)	Desire to be kept informed about project during construction	Katie Eckersley (KE) to interface with PCG, Redland Hospital and Darling Downs and West Moreton Public Affairs	Monthly meeting with PCG List on database Project information collateral, including updates	KE/PCG
Union/s	Union support for staff directly affected by relocation and/or closure of existing facility	Change Management Plan Include relevant unions on stakeholder database for receipt of project information and updates PCG to speak to item at Local Consultative Forum meeting and LCG (sub-committee in District)	As per Change Management Plan Briefings, as required 1:1 meetings, as required Union representative on Local Consultative Forum	As per Change Management Plan Local Consultative Forum
User group — consumers and carers	Majority of current consumers won't be affected as duration of treatment at The Park is short	Timely and relevant information Ongoing consultation with consumers and carers association (John will forward copy of initial report to Janet)	Minutes of fortnightly meetings Project updates 1:1 consultation as required Advise care coordinators to encourage carers to seek	PCG to liaise with Directors of Nursing and Clinical Services + District Public Affairs to deliver CEP

Redlands Adolescent Centre **Community engagement strategy — issues and stakeholder audit**				
Stakeholder	**Issue**	**Strategy**	**Communication channel/tool**	**Task/Who**
	term, but new admissions might Relocation and perceived lack of continuity Distance and transport	Might need to consider/review admission criteria close to time of commissioning Incorporate relocation factors into model of care Staff will be front-line ambassadors for new facility with carers	more information or ask to see plans etc; invite input into detailed design Iterative process	
Internal—Queensland Health				
Office of the DP and Minister for Health	Desire for 'no surprises' Avoid negative publicity	Provide timely and relevant information, as required	Briefings, as required	Executive Director, MHB and/or District Executive Director/s with assistance from PCG
Director General, QH	Issues and reputation management	Ensure strategic project management supported by effective communications and stakeholder engagement Provide timely and relevant information	Briefings, as required	Executive Director, MHB and/or District Executive Director/s with assistance from PCG

Redlands Adolescent Centre
Community engagement strategy — issues and stakeholder audit

Stakeholder	Issue	Strategy	Communication channel/tool	Task/Who
		Seek approval by DG for public information collateral, prior to printing and distribution		
Redland Hospital campus—general Brett Bricknell (BB), Executive Director	Collocation with Redland and Mater Private Hospital Redland Integrated community and hospital services Redland Residential Care	Provide timely and relevant information about the project to staff and contractors Display concept and detailed design plans at Redland Hospital and promote at both campuses Promote new facility as part of the government's investment in the upgrade of integrated healthcare services Planning workshop, if required, to seek input into construction mitigation strategies	Information sessions for staff Briefing for Mater Hospital Redland Board Workshops, as required Project information collateral, including, but not limited to: Newsletter (Bayside News) FAQs Open House display (bundle Redland Adolescent Centre with Redland Hospital expansion)	PCG + District Public Affairs + Integrated Communications
Bayside Health Community Council (HCC)	Timely and relevant information	Agenda item at monthly meetings Invitation to Open House	Monthly HCC meetings Project website (tbc)	PCG/KE/BB/JJ

Redlands Adolescent Centre

Community engagement strategy — issues and stakeholder audit

Stakeholder	Issue	Strategy	Communication channel/tool	Task/Who
	Provide opportunity for input			
Local Redland community	Businesses adjoining/ opposite construction site Note: Industrial estate in same street, **including Childcare Centre**	Provide timely and relevant information about the project and construction program (as per Community Engagement Plan and Construction Management Plan) Open House and/or community information session at Redland Hospital Display concept and/or detailed design at Open House and/or information session	Open House and/or community information session Incorporate and promote new facility in plans for Redland Hospital upgrade Staffed public display in local shopping centre Written notification of impacts 1:1 meetings, as required, to seek input into construction mitigation strategies or to resolve issues Letterbox drops Flyers FAQs Display/s—schematic and	PCG + District Public Affairs + Integrated Communications

Redlands Adolescent Centre

Community engagement strategy — issues and stakeholder audit

Stakeholder	Issue	Strategy	Communication channel/tool	Task/Who
			detailed design Link to project information on Redland Hospital and Mental Health websites	
	Cultural Heritage	Liaise with traditional owners (Janet Johnson to advise)	Cultural Heritage Management Plan	PCG
	Announcement about project by Deputy Premier	Include project announcement in MHB Media Opps report (Sharon Broadley, Integ Comms, to liaise with media team)	Media release	PCG to liaise with MHB
Local environmental groups, including, but not limited to, Koala Action Group Queensland Inc.	Environmentally sensitive location Need to safeguard the largest urban koala population in Australia during construction	Adhere to Environmental Management Plan Source local environmental groups and list on database Provide timely and relevant information	Invitation to attend community information session/s Site tours Newsletters Flyers Q&As Display/s—concept and	PCG + District Public Affairs + Integrated Communications

Redlands Adolescent Centre Community engagement strategy — issues and stakeholder audit				
Stakeholder	**Issue**	**Strategy**	**Communication channel/tool**	**Task/Who**
			detailed design Link to project information on Qld Health website	
Other government agencies				
Education Queensland	Staff currently employed at the on-site school Staff relocation across two regions	Provide timely and relevant information Consultation with Education Qld (EQ) [Tahnee to get Kevin Fjeldsoe to provide plan for David] Align HR strategy with EQ strategy Identify contact within EQ to receive project updates List contact details on database Link to project on EQ website Representation on user groups Invitation to attend a	Memorandum of Understanding for partnership arrangements to provide on-site schooling Briefings, including combined agency briefing about concept (tbc) 1:1 meetings, as required Provide project information collateral Stakeholder database Change management workshop/s with existing staff	PCG + District Health Services + District Public Affairs + Integrated Communications

Redlands Adolescent Centre
Community engagement strategy — issues and stakeholder audit

Stakeholder	Issue	Strategy	Communication channel/tool	Task/Who
		combined agency briefing about concept (tbc)		
Department of Child Safety	Need to be kept informed	Provide timely and relevant information Identify contact within DoC to receive project updates List contact details on database Invitation to attend combined agency briefing about concept (tbc)	Provide project information collateral Stakeholder database Combined agency briefing about concept (tbc)	PCG + District Health Services + District Public Affairs
Department of Justice	Need to be kept informed	Provide timely and relevant information Identify contact within department to receive project updates List contact details on database Invitation to attend combined agency briefing about concept (tbc)	Provide project information collateral Stakeholder database Combined agency briefing about concept (tbc)	PCG + District Public Affairs

Redlands Adolescent Centre

Community engagement strategy — issues and stakeholder audit

Stakeholder	Issue	Strategy	Communication channel/tool	Task/Who
Queensland Police	Need to be kept informed	Provide timely and relevant information Identify contact within department to receive project updates List contact details on database Invitation to attend combined agency briefing about concept (tbc)	Provide project information collateral Stakeholder database Combined agency briefing about concept (tbc)	PCG + District Public Affairs
Qld Ambulance	Need to be kept informed Desire for input into design of facility, especially access arrangements	Information about facility and service Liaison re model of service Input into design of facility Martin Davies – MHIP liaison with Emergency Services Community groups/NGO – Helen McIntyre (Service Integration Coordinator)	Invitation to attend combined agency briefing about concept (tbc) Briefing/s as required Project information collateral Stakeholder database	PCG + District Health Services + District Public Affairs
HCC	Local consultative committees (West	Agenda item to inform and update	Invitation to attend combined agency briefing	PCG + District Health Services +

Redlands Adolescent Centre

Community engagement strategy — issues and stakeholder audit

Stakeholder	Issue	Strategy	Communication channel/tool	Task/Who
	Moreton and Bayside) will seek input	Provide timely and relevant information	about concept (tbc) Project information collateral Stakeholder database	District Public Affairs
Elected representatives—all tiers of government				
Hon Paul Lucas MP Local Member – Member for Lytton (Wynnum)	Manage constituency interests and expectations See also previous listing under Internal – Qld Health for the Office of the DP and Minister for Health	Sod turning ceremony Commissioning and launch		
Member for Cleveland – Mark Robinson **Member for Redlands – Peter**	Manage constituency interests and expectations Avoid community backlash about	Provide timely and relevant information Provide briefings, as required (Katie Eckersley + PCG) Supply additional copies of	Briefings, as required Invitation to attend community information session/s Project website	PCG + District Health Services + District Public Affairs

Redlands Adolescent Centre

Community engagement strategy — issues and stakeholder audit

Stakeholder	Issue	Strategy	Communication channel/tool	Task/Who
Dowling LNP **Federal – LNP Andrew Laming** **Mayor, Redland City Council — Councillor Melva E Hobson PSM**	construction of a new local mental health facility	project collateral to electorate offices	Project collateral	
Redland City Council Mayor, Councillor Melva E Hobson PSM	Potential ambassador for project Council planning approvals	Workshops, as required, to finalise design and individual project management plans Incorporate CEP into Project Management Plan	Workshop/s (technical) Meetings, as required Project website Project collateral	PCG + District Health Services + District Public Affairs
	Councillors will monitor project on behalf of their constituents	Provide timely and relevant information Liaise with relevant Council engineers etc in program areas to obtain approvals		
Redland community – general public	Potential community backlash Walking tracks	Staffed display at local shopping centre as part of Redland Hospital Upgrade promotion, if possible (Note: check funding available for	Community events Community forum at Redland Hospital before June 2010 including information about	PCG + District Health Services + District Public Affairs

Redlands Adolescent Centre

Community engagement strategy — issues and stakeholder audit

Stakeholder	Issue	Strategy	Communication channel/tool	Task/Who
	through area Need to proactively manage community perceptions and expectations	community displays under Children's Services budget) Provide accurate and clear information about the facility to dispel fears and myths Develop and promote key messages, including open area – medium security Celebrate project milestones e.g. sod turning + commissioning events Site tours	adolescent centre Feedback survey at initial forum to gauge appropriate communication channels Information sessions – Open House Testimonials Q&As (Janet Johnson to talk with Susan) Key messages Fact sheets Draft media responses and holding statements (Tahnee)	
Directly affected neighbours ▪ Industrial estate ▪ Childcare centre ▪ Mater Private Hospital ▪ etc	Construction and operational impacts	Establish focus groups to advise on specific issues and construction and operational impacts Conduct information sessions – Open House Display concept and detailed design at Redland Hospital	Focus groups to address specific issues Public information sessions Display Community forum Meetings	PCG + District Health Services + District Public Affairs

Redlands Adolescent Centre Community engagement strategy — issues and stakeholder audit				
Stakeholder	**Issue**	**Strategy**	**Communication channel/tool**	**Task/Who**
		Invitation to attend community forum at Redland Hospital before June 2010 1:1 meetings, as required Prior notification of construction impacts via doorknock and/or letterbox drop Provide timely and relevant information, including project updates, fact sheets, website updates etc Develop and maintain stakeholder database, including record of engagement activities and contact Site tours Celebration of project milestones	Doorknock Written notification of impacts via letterbox drop Stakeholder database	
Media	Potential for negative media coverage or	Timely response to enquiries to meet deadlines, if possible Include events in media opps	Media protocol Media responses	Media (Integrated Comms) + PCG + District Health Services + District

Redlands Adolescent Centre Community engagement strategy — issues and stakeholder audit				
Stakeholder	**Issue**	**Strategy**	**Communication channel/tool**	**Task/Who**
	'beat-up'	report Site tours of location of new facility and at various project milestones as part of Redland Hospital upgrade strategy Briefings Good news stories/editorial etc	Media opps report Site tours	Public Affairs

Preparation of Community Engagement Plan (CEP)

Susan will finalise issues matrix and forward to JQ and FM

Marisa Stewart (Pre-commissioning Control Group) will draft CEP

Janet Johnson and Tahnee will review the PCG draft of the CEP

Tahnee is contact for Darling Downs/West Moreton

David Crompton and Aaron Groves will approve the final CEP

Construction timeframes

Construction scheduled to start by 11 Jan 2011

Commissioning anticipated by Oct 2011

EXHIBIT 43

Proposed events

Sod turning ceremony to mark bulk earthworks + official opening — media event Minister

Queensland Health

MEMORANDUM

To:	Lesley Dwyer, Chief Executive Officer, West Moreton Hospital and Health Service Dr Richard Ashby, Chief Executive Officer, Metro South Hospital and Health Service		
Copies to:	Jason Flenley, A/Executive Director, Capital Delivery Program, Health Infrastructure Office		
From:	Glenn Rashleigh, Chief Health Infrastructure Office, System Support Services	**Contact No:** **Fax No:**	
Subject:	Cancellation of Capital Delivery Project		
		File Ref:	SSSC00097 HPI002.770 ~~Ref Number~~

The purpose of this memo is to advise of a decision by government to cancel or defer a small number of capital delivery projects.

This includes the cancellation of the replacement Adolescent Mental Health Unit at Redlands from the current location at Wacol.

For further information, please contact Jason Flenley, A/Executive Director, Capital Delivery Program on email

Yours sincerely

Glenn Rashleigh
Chief Health Infrastructure Office
System Support Services
Director – Capital Delivery Program
28 / 08 /2012

David Crompton

From: Sharon Kelly
Sent: Wednesday, 7 August 2013 11:11 AM
Cc: Bill Kingswell; Leanne Geppert; Marie Kelly; Michael Cleary; Dwyer, Lesley
Subject: progression of the Barrett Adolescent Strategy
Attachments: WMHHS-CHQ BAC 130805.pdf; FAQ BAC.pdf; Expert Clinical Reference Group Recommendations July 2013.pdf

Good morning,

I wish to provide you with further information in regards to the progression of the Barrett Adolescent Strategy following announcements last evening.

The West Moreton Hospital and Health Board considered the documentation put forward by the Planning Group in May 2013 and all seven recommendations made by the Expert Clinical Reference Group (ECRG) with the additional comments from the planning group were accepted. Further key stakeholder consultation was then conducted with the Department of Health, the Queensland Mental Health Commissioner, the Department of Education Training and Employment, and Children's Health Queensland.

The work of the ECRG, the Planning Group and the subsequent consultation process has enabled us to progress the Strategy to the next phase. As identified in an announcement yesterday, adolescents requiring extended mental health treatment and rehabilitation will receive services through a new range of contemporary service options from early 2014. Young people receiving care from Barrett Adolescent Centre at that time will be supported to transition to other contemporary care options that best meet their individual needs.

Importantly, our goal in West Moreton Hospital and Health Service continues to be to ensure that adolescents requiring mental health extended treatment and rehabilitation will receive the most appropriate care for their individual needs. We will also continue to provide information and support as needed to staff at the Barrett Adolescent Centre. The transition process will be managed carefully to ensure that there is no gap to service provision.

For further information about Barrett Adolescent Centre and the planning for new statewide service options in adolescent mental health extended treatment and rehabilitation, please find attached a media statement, a copy of the ECRG recommendations submitted to the West Moreton Hospital and Health Board, and a FAQ sheet.

If you have any further queries, please do not hesitate to contact me on

Regards
Sharon
Sharon Kelly
Executive Director
Mental Health and Specialised Services

West Moreton Hospital and Health Service
T:
E:

The Park - Centre for Mental Health
Administration Building, Cnr Ellerton Drive and Wolston Park Road, Wacol, Qld 4076
Locked Bag 500, Sumner Park BC, Qld 4074

www.health.qld.gov.au

MSS.001.001.0042

EXHIBIT 43

MSS.900.0002.0395

West Moreton Hospital and Health Service

Expert Clinical Reference Group Recommendations

Barrett Adolescent Strategy

July 2013

Adolescent Extended Treatment and Rehabilitation Services (AETRS) Recommendations Submitted to the West Moreton Hospital and Health Board

1. Broader consultation and formal planning processes are essential in guiding the next steps required for service development, acknowledging that services need to align with the National Mental Health Service Planning Framework

ECRG Recommendations	Planning Group Recommendations
a) Further work will be required at a statewide level to translate these concepts into a model of service and to develop implementation and funding plans.	**Accept with the following considerations.** The responsibility for this task at a statewide level sits with the Mental Health Alcohol and Other Drugs Branch and the Children's Health Services. A collaborative partnership is proposed.
b) Formal planning including consultation with stakeholder groups will be required.	**Accept with the following considerations.** This body of work should be incorporated into the statewide planning and implementation process (as above).

2. Inpatient extended treatment and rehabilitation care (Tier 3) is an essential service component

ECRG Recommendation	Planning Group Recommendation
a) A Tier 3 service should be prioritised to provide extended treatment and rehabilitation for adolescents with severe and persistent mental illness.	**Accept with the following considerations.** Further work is needed to detail the service model for a Tier 3. Models involving a statewide, clinical bed-based service (such as the Barrett Adolescent Centre) are not considered contemporary within the National Mental Health Service Planning Framework *(in draft)*. However, there are alternative bed-based models involving clinical and non-clinical service components (e.g., Y-PARC in Victoria) that can be developed in

ECRG Recommendation	Planning Group Recommendation
	Queensland to meet the requirement of this recommendation. Contestability reforms in Queensland may allow for this service component to be provider agnostic.

3. Interim service provision if BAC closes and Tier 3 is not available is associated with risk

ECRG Recommendations	Planning Group Recommendations
a) Safe, high quality service provision for adolescents requiring extended treatment and rehabilitation requires a Tier 3 service alternative to be available in a timely manner if BAC is closed.	**Accept.**
b) Interim service provision for current and 'wait list' consumers of BAC while Tier 3 service options are established must prioritise the needs of each of these individuals and their families/carers. 'Wrap-around care' for each individual will be essential.	**Accept with the following considerations.** While this may be a complex process for some consumers and their individual needs, it was noted that this course of action could start immediately, and that it was feasible. The potential to utilise current BAC operational funds (temporarily) to 'wrap-around' each consumer's return to their local community was noted as a significant benefit. The relevant local community should play a lead role in the discharge of the consumer from BAC and their return to home. The local services need to be consulted around their ability to provide 'wrap-around' care.
c) BAC staff (clinical and educational) must receive individual care and case management if BAC closes, and their specialist skill and knowledge must be recognised and maintained.	**Accept.** The ECRG and the Planning Group strongly supported this recommendation.

4. Duration of treatment

ECRG Recommendation	Planning Group Recommendation
a) 'Up to 12 months' has been identified by the ECRG as a reasonable duration of treatment, but it was noted that this depends on the availability of effective step-down services and a suitable community residence for the young person. It is important to note that like all mental health service provision, there will be a range in the duration of admission.	**Accept with the following considerations.** This issue requires further deliberation within the statewide planning process. The duration of treatment needs some parameters to be set, however, this is primarily a clinical issue that is considered on a case-by-case basis by the treating team and the consumer.

5. Education resource essential: on-site school for Tiers 2 and 3

ECRG Recommendations	Planning Group Recommendations
a) Access to on-site schooling (including suitably qualified educators), is considered essential for Tiers 2 (day programs) and 3. It is the position of the ECRG that a Band 7 Specific Purpose School (provided by Department of Education, Training and Employment) is required for a Tier 3 service.	**Accept with the following considerations.** The Planning Group recommends removing *"Band 7"* from the ECRG recommendation. All educational services need to be evaluated by Department of Education, Training and Employment (DETE) on a case-by-case basis, taking into consideration service model, location, student numbers and complexity. The Planning Group supports the statement that educational resources are essential to adolescent extended treatment and rehabilitation services. The Planning Group recommends consultation with DETE once a statewide model is finalised.

ECRG Recommendations	Planning Group Recommendations
b) As an aside, consideration should also be given to the establishment of a multi-site, statewide education service for children/adolescents in acute units (hub and spoke model).	**Accept with the following consideration.** The Planning Group recommends this statement should be changed to read as: Strong consideration should be given to the establishment of a multi-site, statewide education service for children/adolescents in acute units (hub and spoke model).

6. Residential Service: Important for governance to be with CYMHS; capacity and capability requires further consideration

ECRG Recommendations	Planning Group Recommendations
a) It is considered vital that further consultation and planning is conducted on the best service model for adolescent non-government/private residential and therapeutic services in community mental health. A pilot site is essential.	**Accept with the following consideration.** Note that this service could be provider agnostic.
b) Governance should remain with the local CYMHS or treating mental health team.	**Accept.**
c) It is essential that residential services are staffed adequately and that they have clear service and consumer outcome targets.	**Accept.**

7. Equitable access to AETRS for all adolescents and families is high priority; need to enhance service provision in North Queensland (and regional areas)

ECRG Recommendations	Planning Group Recommendations
a) Local service provision to North Queensland should be addressed immediately by ensuring a full range of CYMHS services are available in Townsville, including a residential community-based service.	**Accept.**
b) If a decision is made to close BAC, this should not be finalised before the range of service options in Townsville are opened and available to consumers and their families/carers.	**Accept.**

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MSS.001.001.0051

EXHIBIT 43

MSS.900.0002.0402

West Moreton Hospital and Health Service
Children's Health Queensland Hospital and Health Service

Media Statement

Queensland Government

6 August 2013

Statewide focus on adolescent mental health

Statewide governance around mental health extended treatment and rehabilitation for adolescents will be moving to Children's Health Queensland.

West Moreton Hospital and Health Service Chief Executive Lesley Dwyer and Children's Health Queensland Chief Executive Dr Peter Steer today said adolescents requiring extended mental health treatment and rehabilitation will receive services through a new range of contemporary service options from early 2014.

Ms Dwyer said the young people who were receiving care from Barrett Adolescent Centre at that time, would be supported to transition to other contemporary care options that best meet their individual needs.

She said West Moreton Hospital and Health Service had heard the voices of staff, consumers and their families, and engaged an expert clinical reference group over the past eight months.

"After taking into consideration the recommendations of the expert clinical reference group and a range of other key issues in national and state mental health service delivery, the West Moreton Hospital and Health Board determined that the Barrett Adolescent Centre is no longer an appropriate model of care for these young people," Ms Dwyer said.

"The board also determined that a number of alternative models will be explored over the coming months under the leadership of Children's Health Queensland.

"It is important to put the safety and individual mental health needs of these adolescents first by providing the most contemporary care options available to us in the most suitable environment.

"It is time for a new statewide model of care. We are also striving to provide services closer to home for these young people, so they can be nearer to their families and social networks," Ms Dwyer said.

Dr Steer said as part of its statewide role to provide healthcare for Queensland's children, Children's Health Queensland would provide the governance for any new model of care.

"This means that we will work closely with West Moreton HHS as well as other hospital and health services and non-government agencies to ensure there are new service options in place by early 2014," Dr Steer said.

"This model of care may include both inpatient and community care components.

"Understanding what options are needed has already begun with the work of the expert clinical reference group, and now we can progress this further and implement the best options for these young people," he said.

"This is a positive step forward for adolescent mental health care in this state," Dr Steer said.

To view the expert clinical reference group recommendations visit http://www.health.qld.gov.au/westmoreton/html/bac/

ENDS

Media contact:

West Moreton Hospital and Health Service –
Children's Health Queensland -

West Moreton Hospital and Health Service

West Moreton Hospital and Health Service	Memorandum		
To:	Executive Directors and Clinical Directors, Mental Health Services		
Copies to:	Mental Health Clinical Clusters		
From:	Executive Director, Mental Health and Specialised Services, West Moreton Hospital and Health Service	**Contact No:**	
		Fax No:	
Subject:	Admissions to Barrett Adolescent Centre		
		File Ref:	Ref Number

As you may be aware the West Moreton Hospital and Health Service (WMHHS) is working towards closing the Barrett Adolescent Centre (BAC) building by the end of January 2014. This is a flexible date that will be responsive to the needs of our consumer group and will be dependent on the availability of ongoing care options for each young person currently at BAC.

WMHHS remains committed to safe, smooth and individually appropriate transitions of care for each young person currently attending BAC. In order to meet this goal, there will be no further admissions to BAC services. This also means that no new referrals will be accepted to the waitlist. WMHHS will be working with the referring Hospital and Health Service to ensure no loss of service provision to those young people currently on the BAC waitlist.

The Children's Health Queensland (CHQ) has commenced work with stakeholders from across the state to develop the future model of adolescent extended treatment and rehabilitation services. Further information about these developments will be provided by CHQ in the near future.

Until then, please contact Dr Stephen Stathis on to discuss any clinical issues for patients who may require extended mental health treatment and rehabilitation, and are unable to be managed within your health service.

If you have any other questions regarding BAC, please contact me on
Additionally for further updates about BAC please visit:
http://qheps.health.qld.gov.au/wm/html/about/projects-planning.htm

Sharon Kelly
Executive Director
Mental Health and Specialised Services
West Moreton Hospital and Health Service
22/10/2013

David Crompton

From: David Crompton
Sent: Thursday, 5 September 2013 7:44 AM
To: Richard Ashby
Subject: Closure Barrett and proposal for adolescent program for MSHHS

Dear Richard
Spoke with senior child psychiatrist involved in developing program. He has looked at Logan ward as interim measure and does not support it.
They appear to have no agreed/finalised view on the model or how should be progressed. He indicated the budget most likely not finalised till October.
If model includes NGO sector by procurement of their services I doubt all done by January given it has taken since April for CCU procurement to get close to completion which I am told should be done by late October. In the middle of all this is the Christmas/new year period.
I suspect some promises made to minister on time frames which cannot be met.

Regards
David
Associate Professor David Crompton OAM
MBBS Grad Dip Soc Sci (Psych)
FRANZCP FAChAM (RACP)
Executive Director
Addiction and Mental Health Services
Metro South HHS
Centre for Neuroscience, Recovery and Mental Health
Diamantina Health Partners

On 05/09/2013, at 6:58 AM, "Richard Ashby wrote:

> Can we get HRT data for PAH Mental ESP looking at changes in ALOS for Schizophrenia and Major Depressive illness to demonstrate the released value .
> Thx
> RA
>
> On 04/09/2013, at 10:29 PM, "David Crompton wrote:
>
>> Dear All
>> I was at a meeting tonight and discussed with Bill Kingswell the WAU conversion.
>> He then tells me that the issues relate to our beds/100,000 vs other HHSs and that our data is incorrect showing PAH occupancy over 100% a lot of the time. He also indicated MSHHS had coded CCU beds had been loaded as acute.

He then suggested the money could be used elsewhere in state which means we risk never getting it and punishing our communities.

I guess a question is do we just open beds even though not use them and manage it another way rather than risk losing dollars but we would not achieve activity targets.

I have attached the data they are using with Bill suggesting the HHS may be providing them incorrect data!
I will make a time to discuss with Robert and Richard next week.

Regards
David
Associate Professor David Crompton OAM
MBBS Grad Dip Soc Sci (Psych)
FRANZCP FAChAM (RACP)
Executive Director
Addiction and Mental Health Services
Metro South HHS
Centre for Neuroscience, Recovery and Mental Health
Diamantina Health Partners

Begin forwarded message:

> **From:** "Bill Kingswell
> **Date:** 4 September 2013 9:13:24 PM AEST
> **To:** "David Crompton"
> **Subject: Fwd: Metro Occupancy over time`**
>
> Begin forwarded message:
>
> > **From:** "Barnaby Kerdel"
> > **Date:** 4 September 2013 4:28:39 PM AEST
> > **To:** "Bill Kingswell"
> > **Subject: Metro Occupancy over time`**
> >
> > Hello Bill,
> >
> > attached is a spreadsheet and graph showing the occupancy for the Metro acute facilities (adult

target population) over 5 years, by month. It's similar to what Kristen gave you, just over a longer period and by month.

The occupancy is calculated on psych patient days reported to Health Statistics Unit through the Monthly Activity Collection, divided by notional bed days based on the number of beds reported annually to us through the Mental Health Establishments Collection. For 13-14, we haven't got new beds data, so I have just repeated 12-13.

Have excluded RedCab for 12-13 because the new beds aren't in there yet. Also excluded TPCH prior to October 2012 because they reported historically reported their medium secure patient days as acute, which gave them silly looking occupancy.

For PAH, we think in 12/13 they engaged in a practice where they would admit incoming mental health patients through an "admitted emergency ward". This is possibly something to do with the NEAT. About 50% of acute patients admitted at PAH came in through this method in 12/13. This may be inflating their occupancy. For a while there they were also coding their CCU patients as acute.

ALl said, I don't think there's much in it except that Logan seems to have reduced paitent days significantly from 2011-12 onwards. But, they are still pretty full.

Barnaby Kerdel
Principal Analyst (Evaluation and Reporting Lead)
Performance Evaluation Analysis and Purchasing Team

Information and Performance Unit | Mental Health Alcohol and Other Drugs Branch
Queensland Health

Level 3, 15 Butterfield Street HERSTON QLD 4006
PO Box 2368 FORTITUDE VALLEY BC QLD 4006

<Metro OCcupancy.xlsx>

Minutes

State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy – Oversight Committee

Date: 15/11/2013 **Time:** 7:00am **Venue:** Teleconference

Chair:	Health Service Chief Executive, CHQ HHS (PS)
Secretariat:	SW AETR Project Manager (IA)
Attendees	Deputy Director General, Health Service and Clinical Innovation Division (MC) Health Service Chief Executive, West Moreton HHS (LD) Executive Director, Mental Health, Metro South HHS (DC) Executive Director, Mental Health Alcohol & Other Drugs Directorate (BK) A/Executive Director, Office of Strategy Management, CHQ HHS (DM) Clinical Director, CYMHS CHQ HHS (SS) A/Director of Strategy, Mental Health and Specialised Services, West Moreton HHS (LG)
Apologies	Health Service Chief Executive, Metro South HHS (RA) Health Service Chief Executive, Townsville HHS (JS)
Observers/ Guests:	Nil

Item No	Topic	Action	Committee member	Due date
1.	**Presentations**			
	Nil	Nil		
2.	**Meeting opening**			
2.1	Welcome and Apologies	Nil	Chair	
2.2	Statement of Conflict/Interest	Nil	Chair	
2.3	Confirmation of Minutes	Nil	Chair	
2.4	Statement of achievements	Below	Chair	
	Business			
3.	**Business Arising from Previous Meetings**			
3.1	Nil			
4.	**Matters for Decision**			
4.1	**CHQ Communications Strategy** • LD noted the need to have close communication with consumers. WM HHS has determined weekly communication is needed. • PS has suggested a Consumer and Parent Reference Group, which will be discussed offline in a meeting between CHQ and WM HHS.	Organise meeting to discuss the establishment of a C&P Reference Group	IA	29/11
	• LG noted the need to include Department of Education in communication plan	Include Dept of Education in Action Plan	IA	18/11
5.	**Matters for Discussion**			
5.1	**Draft SW AETR Service Model** • SS provided an overview of the proposed SW AETR service model • Target age group was raised and it was noted			

Queensland Government

Item No	Topic	Action	Committee member	Due date
	that it needs to be extended beyond 17yo. Moving forward, half of Grade 12 students will be 18yo. Furthermore, the majority of mental health consumers typically repeat a year, extending them to 19yo. Additionally, many young people are not the same development age and may require longer in an adolescent service. The model may need to extend the age group to cater for young people up to the age of 21y.o. LD concurred. • BK noted that there is push to further develop services to the youth sector (16 to 25y.o.). • PS queried whether this is a consideration for the model or if it should be noted separately. • BK noted that three service options proposed target 16y.o. and over, so this age range is accommodated. • BK asked how *headspace* fits into the model. SS said it depends on whether headspace will expand their service to address more than just early psychosis and to include group therapy. • LD enquired on the interface between the subacute bed-based and acute inpatient units. SS noted that a bed-based unit is useful where an adolescent can be released back to the community but not necessarily back home; rather stepping them down from acute inpatient to 24hr care. It is most likely they are not well enough to go home or the home environment may not be supportive for recovery. • BK noted that the model looks like a sensible plan into the future. • LD, LG & Sharon Kelly met with BK to discuss what could be implemented in the interim and that would align with the future plan. • SS noted the quickest options to implement include the Assertive Treatment Services and Day Programs. • WM HHS is looking at establishing a day program with supported accommodation. They have to have something in place by 13th Dec for day program/assertive outreach. • The Committee raised the need to look at appropriate engagement with the Department of Education, emphasising the need to clarify the role of education within a contemporary therapeutic service. • MC stated that he and BK would make an appointment to see the Regional Director to discuss this further. • SS noted that Education's involvement will be added as an element to the Model Overview document. • LG asked if NGO partnerships could be considered across all service options. SS agreed that they could work within most service options with the exception of the subacute bed-based unit. • LD asked if this model will have an impact on	Meet with Education's Regional Director Add Education to Model Overview	MC IA	29/11 17/11

Item No	Topic	Action	Committee member	Due date
	the number of acute inpatient beds in the state. SS said the bed-based unit could act as a step down unit from acute units, freeing up acute unit beds sooner. • It was noted that the Step Up/Step Down (SUSD) units could be delayed. PS noted a risk of removing the SUSD units could be pressure on the length of stay in the bed-based unit. • DC noted that finding appropriately skilled people may be challenging. He noted that Logan has not referred anyone to the BAC in some time – their young people are being treated out in the community with CYMHS support. Logan has asked their CYMHS staff to look at a "family model" for ages up to 25yo. • DC also noted that setting up these services will take a lot longer than anticipated. • LG noted the WM HHS transition plan integrates well with the proposed future model. WM HHS is proposing a phased process commencing with an activity-based program at the BAC (driven by clinical staff working with an NGO). At end of school holidays, WM HHS will then look to establish an Intensive Outreach Team and Day Program, negotiating a new education model to support that. WM HHS is also looking to establish supportive accommodation (comprising 3 or 4 beds) in partnership with an NGO. LD noted that these transitional services will remain in place until the future service options are available. They are not planned to continue past 12 months. • It was agreed that it is important these services fit in with the longer term model of care to ensure smooth transition into future service options. • Metro South have run transitional housing teams and noted that it has been difficult to accommodate people. The Department of Housing have closed two beds for mental health, and Four Walls have made it increasingly difficult to accommodate people. DC recommended active engagement with the Housing, commencing now so that adequate notice is provided to plan for housing options in the future.	Commence engagement with Department of Housing	IA	29/11
	Recommended • PS concluded that three documents are required and must tie together: 1. WM HHS transition plan; 2. Service Overview Model (in more detail) and Implementation Plan, inclusive of business case; 3. An overarching document to bridge the two documents.	Develop: 1. WM HHS transition plan 2. Service Overview Model and Implementation Plan 3. An overarching document	LG IA LG/IA	29/11 20/12 20/12

Item No	Topic	Action	Committee member	Due date
6.	**Standard Agenda Items**			
6.1	**SW AETR Project Budget Status Update** • Noted project expenditure on track			
6.2	**Funding of Future Service Model** • Noted as on track			
6.3	**Communication and Stakeholder Engagement** • Noted in Item 4.1 above			
6.4	**Risk Management** • Nil risks to escalate			
6.5	**Progress of key milestones and deliverables** • Noted as on track			
6.6	**Other Business** • Nil			
7.	**Matters for Noting**			
7.1	**Major correspondence** • Nil			
8.	**For Information**			
8.1	• Nil			
Next meeting: To Be Advised				

ENDORSED BY:

Signature: **Date:** / /13
Name:
Position:

David Crompton

From: David Crompton
Sent: Friday, 15 November 2013 8:36 AM
To: MD05-MetroSouthHSD
Cc: Ed_mhsmetrosouth
Subject: Barrett Adolescent Meeting

Dear Annette
Below are notes from today's meeting for Richard.

Not sure when the next meeting will be.

Barrett Adolescent Meeting

Communication Strategy
Action planned fleshed out:
BAC point out problems with flexibility, especially with those close to patient issues Currently a campaign occurring 16 letters yesterday apparently linked to teachers ??establish parent and friend reference group + one on one Issue of communication with Education Q

Service Model

Dr S Stathis

Population data comparing Qld, NSW, Victoria

Issue of underfunding CYMH for staff aim 14/100,000 Current 8/100,000 Discussion around age groups whether appropriate.
Funding is only approximate
Services:
Assertive community treatment intensive support within local services 2 staff per service Redesign services locally if not enough staff!

Day program
Better motivated young people
Two gps Mater anxious avoidant and males angry, depressed Can be hospital or community based Cost $1.1 to 1.3 million Aim for one at Metro South

Step up Step down model (Y PARC)

Significant NGO involvement
10-12 community
Cost $2.25 million
Age 16+
Look at 2 in SE sector
Role of education in process

Subacute bed based unit
Referral base is broader than one HHS
Weeks or months of admission (max 180 days) aim 3x3 months.
Funding $5 million but they believe cost $4million will be part of Children's Hospital

Quickest set up is Day program and assertive out reach Minister is clear not finish program until replacement service

Residential model
16-21 age group
Need to consent to Rx
Additional support for move to independent living Victoria 17 programs of around 10 per residence Move back to community as soon as possible C&A in reach
1 fte per residence + psychiatrist time $1.1 million NGO support 24 hrs Cost $600,000 ??????
Start SE QLD???

Funding from BAC is around $6 million
Costs outlined so far $18 million

Transition model
From west moreton to HHSs
Holiday program at BAC staff plus NGO
Supported accommodation issues
February 14
Assertive outreach
Day Program
NGO sector

Keep small team to help manage

Raised housing issue with them.
Suggest group to meet with Department of Housing

Three docs need to hang together
Wrap of BAC
Expand models for Long term
Linking document to get going

Risk management document
education
NGO
Procurement time line

Need to look
Start bed stock engagement with department of housing need to ask Michael Cleary to do it.

Regards
David
Associate Professor David Crompton OAM
MBBS Grad Dip Soc Sci (Psych)
FRANZCP FAChAM (RACP)

Executive Director
Addiction and Mental Health Services
Metro South HHS
Diamantina Health Partners
Centre for Neuroscience Recovery Mental Health and Learning

David Crompton

Subject:	Barrett Adolescent Centre Transition Planning
Location:	Sanders Street - TBC
Start:	Thu 24/10/2013 11:00 AM
End:	Thu 24/10/2013 12:00 PM
Show Time As:	Tentative
Recurrence:	(none)
Meeting Status:	Not yet responded
Organizer:	Bernice Holland

Item Type: Appointment
Start Date: Thursday, 24 Oct 2013, 11:00:00am (E. Australia Standard Time)
Duration: 1 Hour
Place: Sanders Street - TBC

Good afternoon

Please be advised that I will confirm the exact address for this meeting tomorrow (Fri 24/10/13).

Frances, I understand that this meeting clashes with another in your diary. I will be in touch to organise a separate meeting for yourself, Darren & Anne to be held within the next week. My aim with this meeting request was to keep you in the loop with the meetings around this subject.

Please do not hesitate to contact me for any further details.

Many thanks

Bernice Holland

Administration Support Officer
Mental Health & Specialised Services

West Moreton Hospital and Health Service

The Park - Centre for Mental Health
Administration Building, Cnr Ellerton Drive and Wolston Park Rd, Wacol, QLD 4076
Locked Bag 500, Sumner Park BC, QLD 4074

www.health.qld.gov.au (http://www.health.qld.gov.au/)

David Crompton

Subject:	Barrett Adolescent Centre Transition Planning discussion
Location:	Royal on The Park - Cnr Alice & Albert Sts Brisbane
Start:	Tue 29/10/2013 5:00 PM
End:	Tue 29/10/2013 5:30 PM
Show Time As:	Tentative
Recurrence:	(none)
Meeting Status:	Not yet responded
Organizer:	Leanne Geppert

Item Type: Appointment
Start Date: Tuesday, 29 Oct 2013, 05:00:00pm (E. Australia Standard Time)
Duration: 30 Mins
Place: Royal on The Park - Cnr Alice & Albert Sts Brisbane

Dear Brett and David
Your time on the phone today was greatly appreciated, as is your offer to meet with us and discuss the issues we are currently facing transitioning in 4 of our most complex cases from BAC into adult community services.

Sharon and I were hoping to catch you after the QMHC Leaders Meeting for about 30 minutes if you don't ming staying back briefly from 5pm.

David, if you are unable to make the QMHC Leaders Meeting, just give me a call when you arrive and I will come out to get you.

Thank you once again, Leanne

Dr Leanne Geppert
A/Director of Strategy
Mental Health & Specialised Services

West Moreton Hospital and Health Service

The Park - Centre for Mental Health

Administration Building, Cnr Ellerton Drive and Wolston Park Rd, Wacol, QLD 4076
Locked Bag 500, Sumner Park BC, QLD 4074

www.health.qld.gov.au (http://www.health.qld.gov.au/)

David Crompton

Subject: BAC consumer transition of care planning meeting
Location: Unit 10, Level 1, 50 - 56 Sanders Street, Upper Mount Gravatt (Conference Room)

Start: Wed 6/11/2013 12:30 PM
End: Wed 6/11/2013 3:30 PM

Recurrence: (none)

Meeting Status: Accepted

Organizer: Renee Robertson
Required Attendees: Leanne Geppert; Ed_mhsmetrosouth; Anne Brennan; Caroline Furlong; Darren Neillie; Laura Johnson; Sharon Kelly; Vanessa Clayworth; Vicki Green; Sean Hatherill; Suneel Chamoli; Roderick Buchner; Carla Piggott; David Crompton; SandersStreet_ConferenceRoom

50-56 Sanders Street, Upper Mo...

Good Afternoon,

As per the e-mail below, please accept this meeting to discuss the progress of the Barrett Adolescent Centre consumer transition of care planning meeting.

Dr Crompton will be attending the first hour, however I have booked longer for further discussion.

Sean – Dr Crompton has advised that he is happy for you to delegate this meeting, should you not be able to attend.

I have attached a map for ease of reference in relation to locate for the building.

Kind Regards,
Renee

From: Leanne Geppert
Sent: Wednesday, 30 October 2013 5:20 PM
To: Renee Robertson; Ed_mhsmetrosouth
Cc: Anne Brennan; Caroline Furlong; Darren Neillie; Laura Johnson; Sharon Kelly; Vanessa Clayworth
Subject: BAC consumer transition of care planning meeting

Hi Renee
Thank you so much for assisting us in prioritising a time in Dr Crompton's schedule to progress the Barrett Adolescent Centre consumer transition of care planning meeting.

If this still suits, please schedule in **Wednesday 6/11/13, 12.30 - 1.30pm at the Conference Room, Sanders St, Mt Gravatt.** Would you mind sending through the full set of venue details?

Attendees from West Moreton HHS will be Dr Anne Brennan (A/Clinical Director of BAC), Vanessa Clayworth (CNC of BAC) and Laura Johnson (Secretariat). Dr Darren Neillie (A/Director Clinical Services) will also try to attend, but may need to t/conf in if the facilities are available.

I have informed Anne and the team of the option to stay beyond 1.30pm with the Metro Sth clinicians (as nominated by David) to finalise the planning arrangements, noting that David will need to leave at 1.30pm.

If there are any changes required, please feel free to give me a call.
Thanks again, Leanne

Dr Leanne Geppert
A/Director of Strategy
Mental Health & Specialised Services

West Moreton Hospital and Health Service

The Park - Centre for Mental Health
Administration Building, Cnr Ellerton Drive and Wolston Park Rd, Wacol, QLD 4076
Locked Bag 500, Sumner Park BC, QLD 4074
www.health.qld.gov.au

David Crompton

From: David Crompton
Sent: Tuesday, 4 February 2014 12:22 PM
To: Suneel Chamoli
Subject: FW: HC002556 - BACtransitionfunding_MS_memo - SIGNED.PDF

Dear Suneel
Fyi please thank all involved
David

A/ Professor David Crompton OAM
SOM UQ and School of Public Health and Social Work QUT MBBS Grad Dip Soc Sci [Psych] FRANZCP FAChAM [RACP]
Executive Director Addiction and Mental Health Services Metro South Hospital and Health Service | Department of Health Centre Neuroscience Mental Health and Recovery Po Box 6046 Upper Mount Gravatt QLD 4122

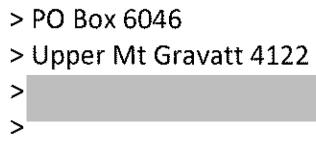
www.health.qld.gov.au/metrosouthmentalhealth

-----Original Message-----
From: Leanne Geppert
Sent: Monday, 3 February 2014 9:00 PM
To: David Crompton
Subject: Re: HC002556 - BACtransitionfunding_MS_memo - SIGNED.PDF

Welcome back David. Hope you had a good break.
Can I say it has been a pleasure working with your staff on this issue - I have passed this on to both Suneel and exec here at West Moreton because your HHS was a standout in the BAC transition processes. So thank you once again.
Happy to provide update re BAC project if you are interested.
Regards leanne

Dr Leanne Geppert
Sent from my iPad

> On 3 Feb 2014, at 6:59 pm, "David Crompton
wrote:
>
>
> Thanks for supporting this Bill.
> Appreciate Leanne's work with our staff.
> <HC002556 - BACtransitionfunding_MS_memo - SIGNED.PDF>
>
>
>
> Regards
> David
> Associate Professor David Crompton OAM SOM UQ and School of Public
> Health and Social Work QUT MBBS Grad Dip Soc Sci (Psych) FRANZCP
> FAChAM (RACP) Executive Director Addiction and Mental Health Services
> Metro South HHS Diamantina Health Partners Centre for Neuroscience
> Recovery Mental Health and Learning
> Ph
> A/H



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> Upper Mt Gravatt 4122
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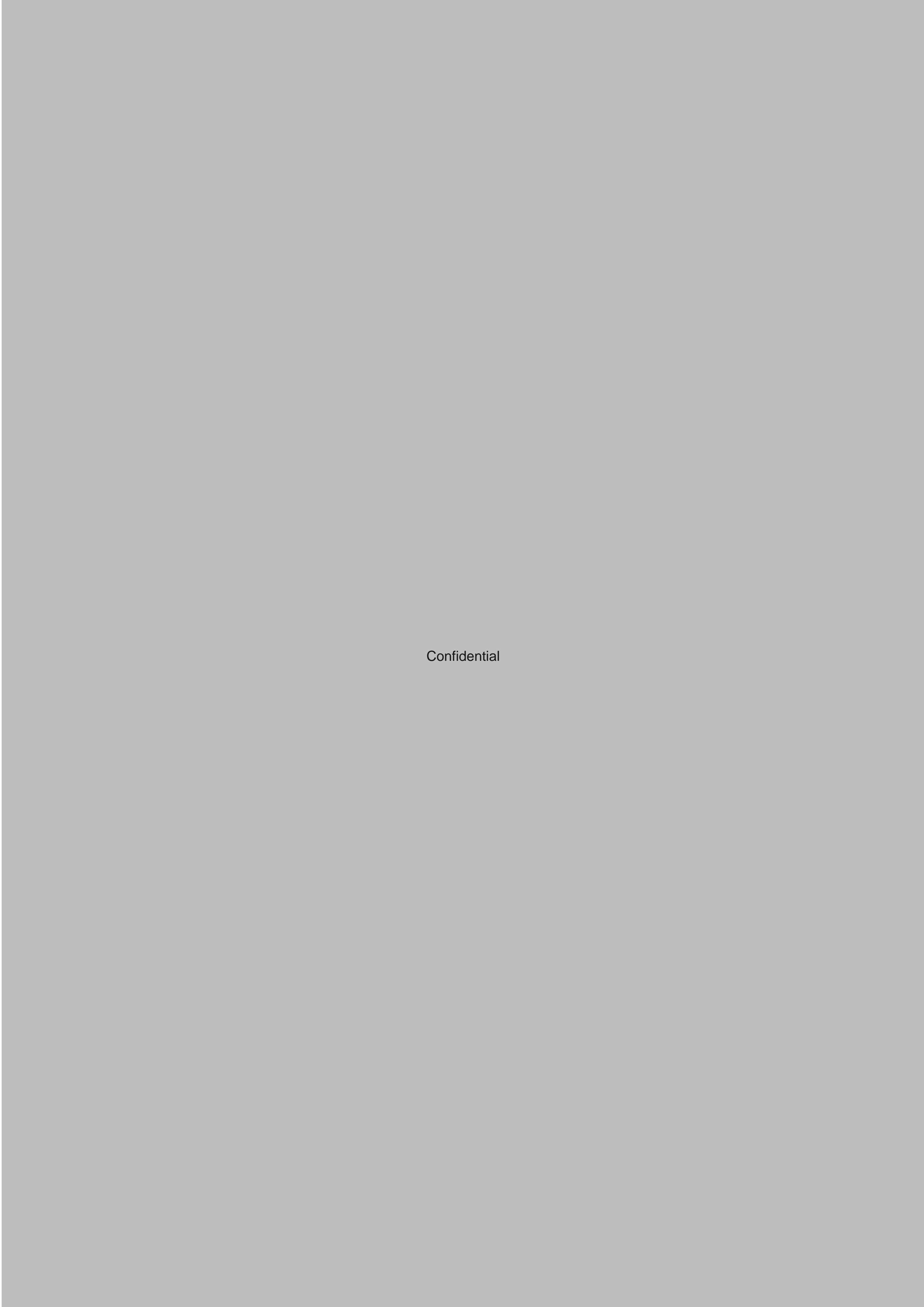

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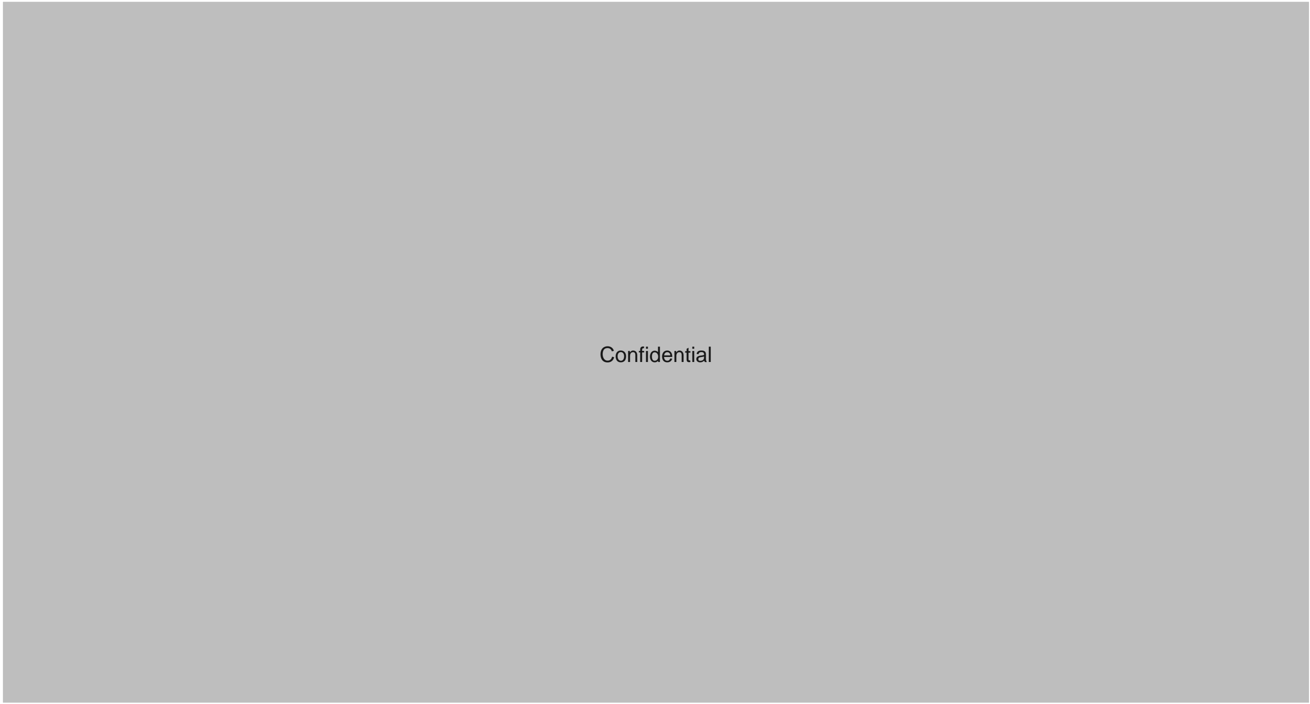

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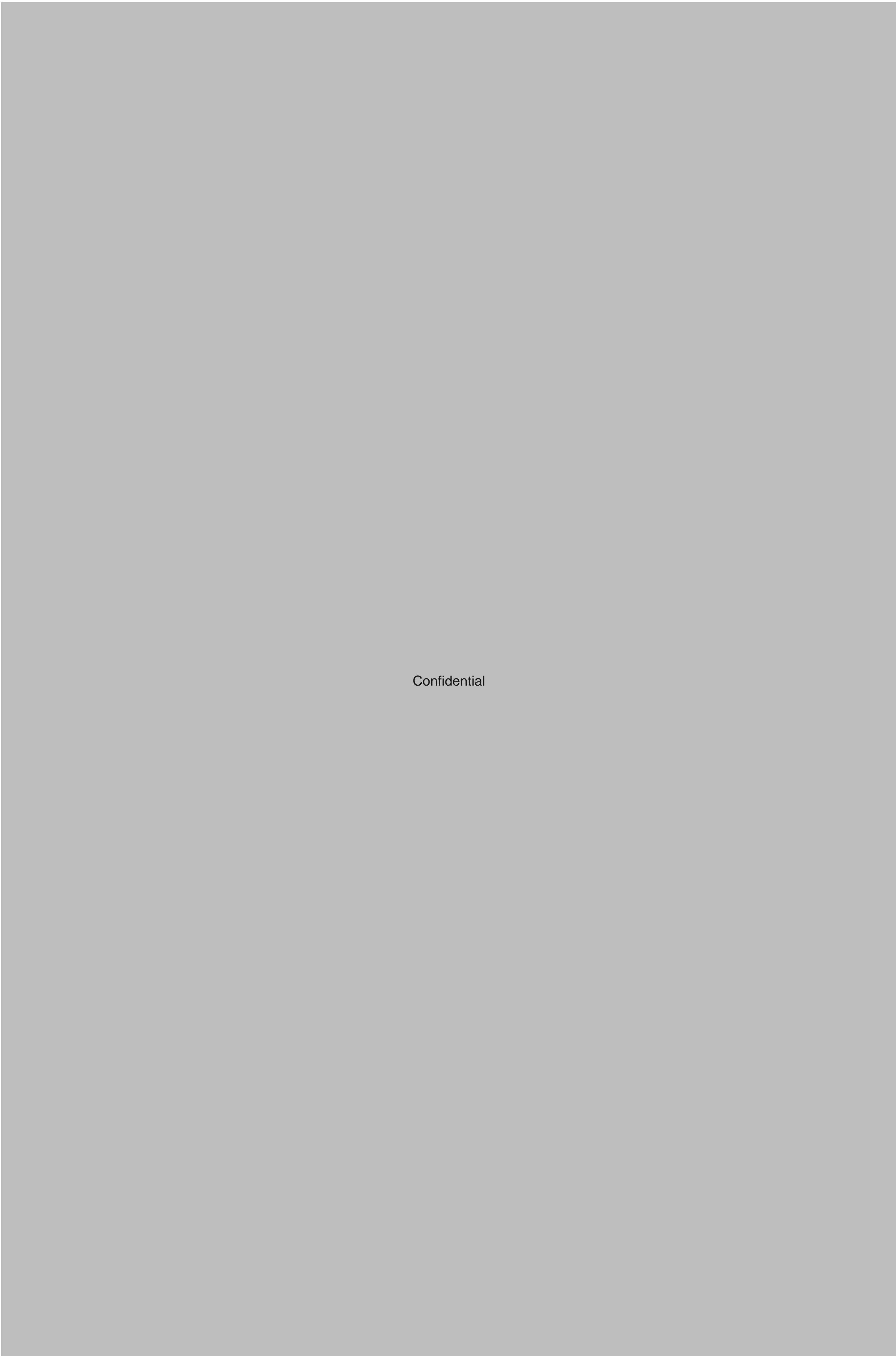

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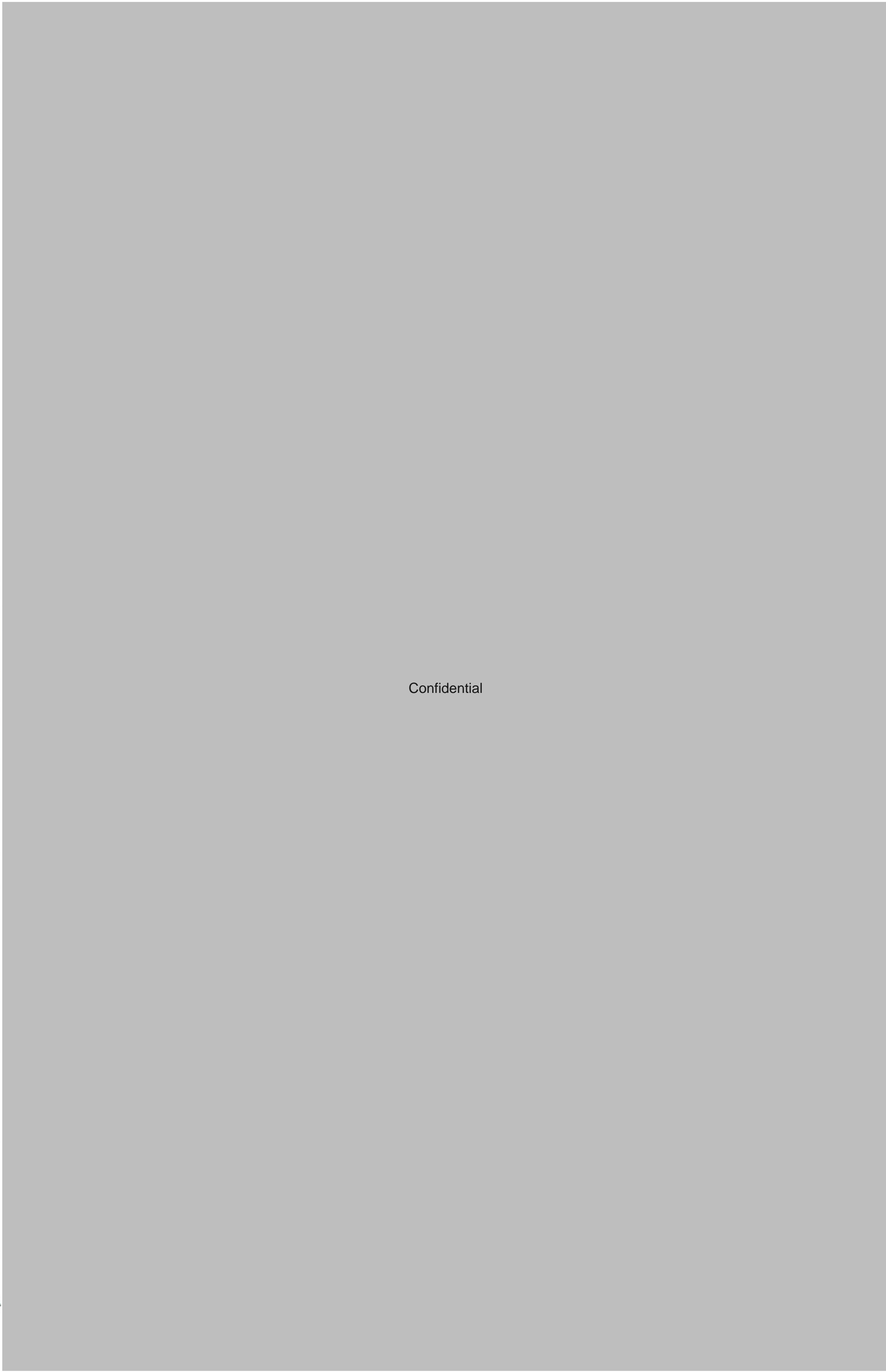

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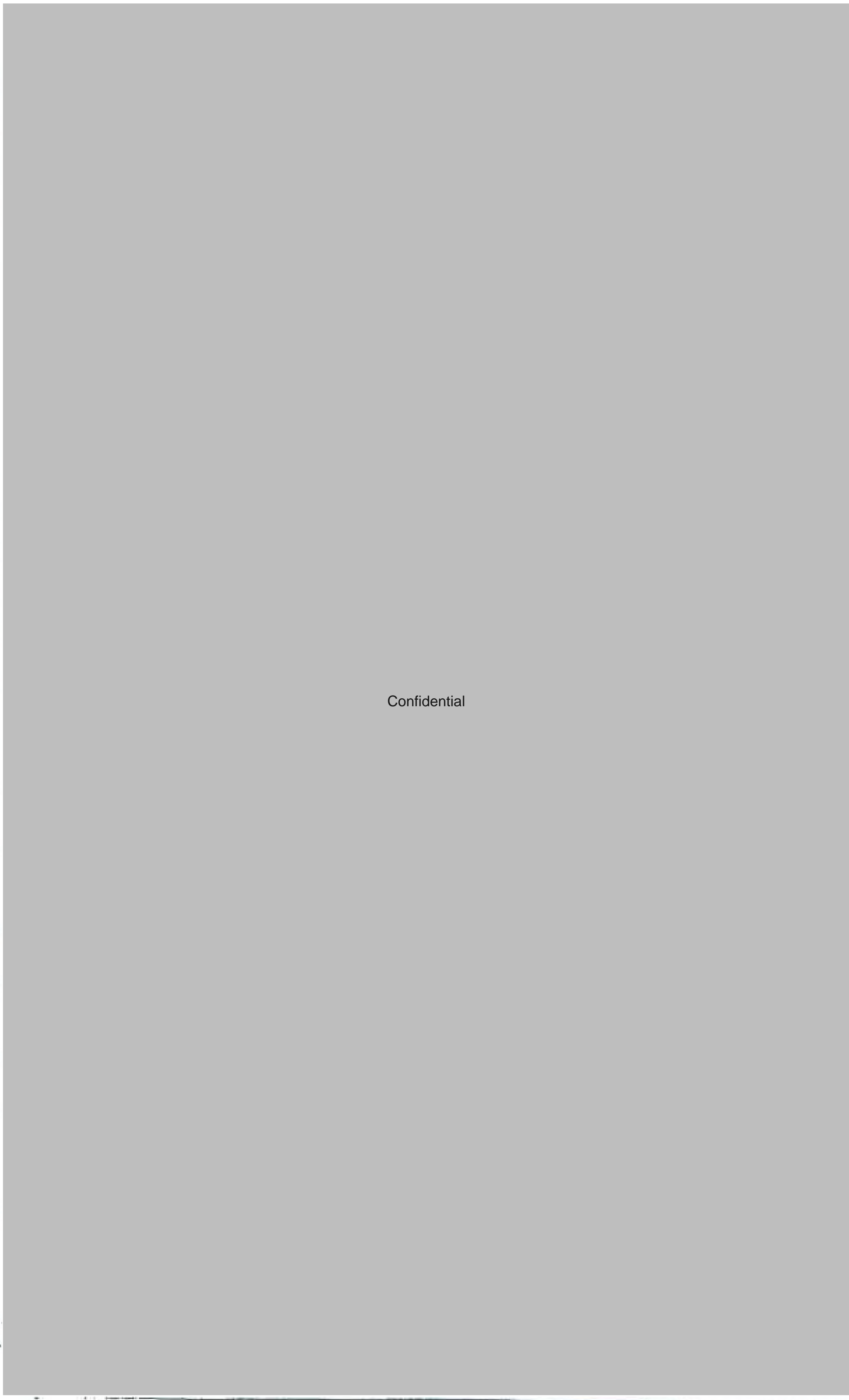

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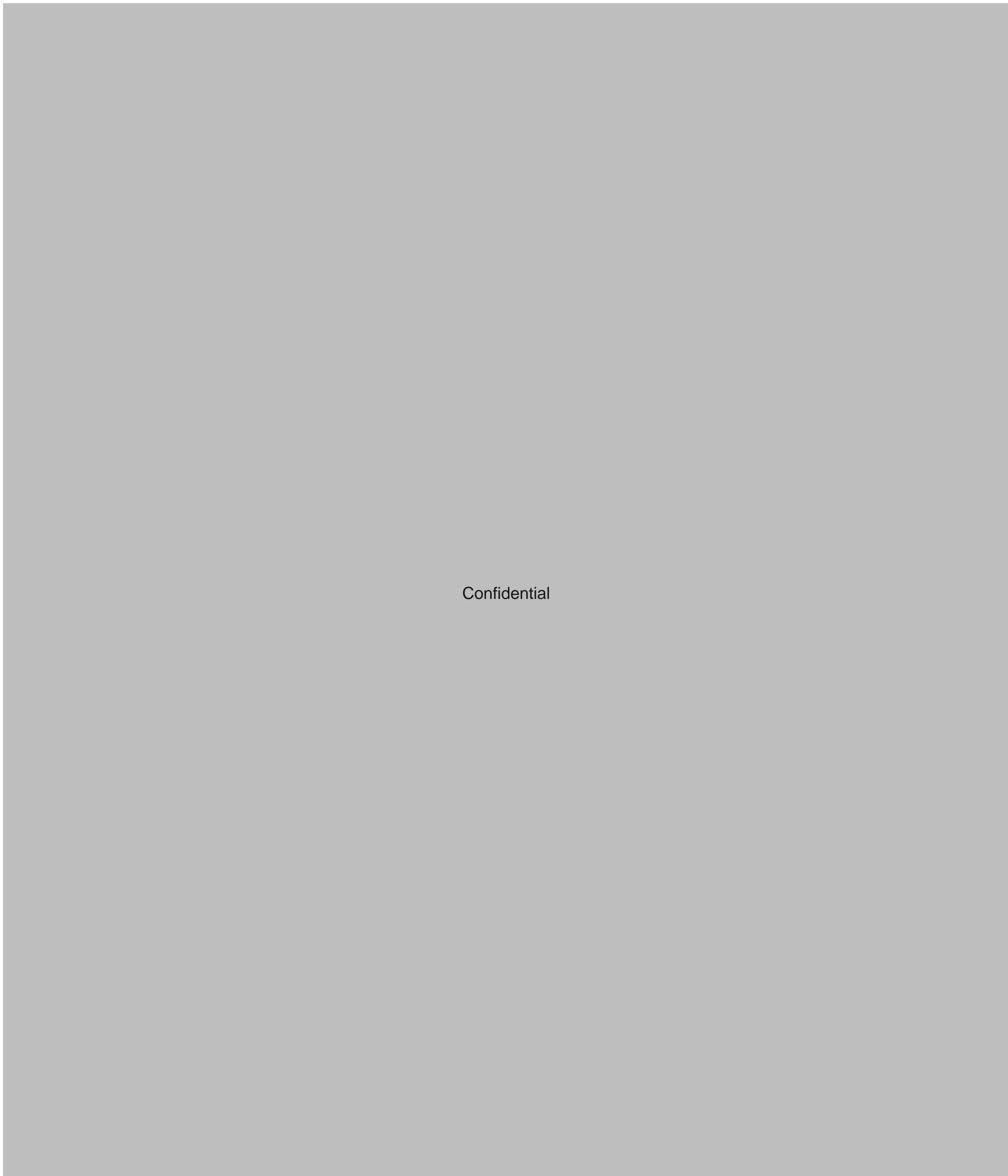

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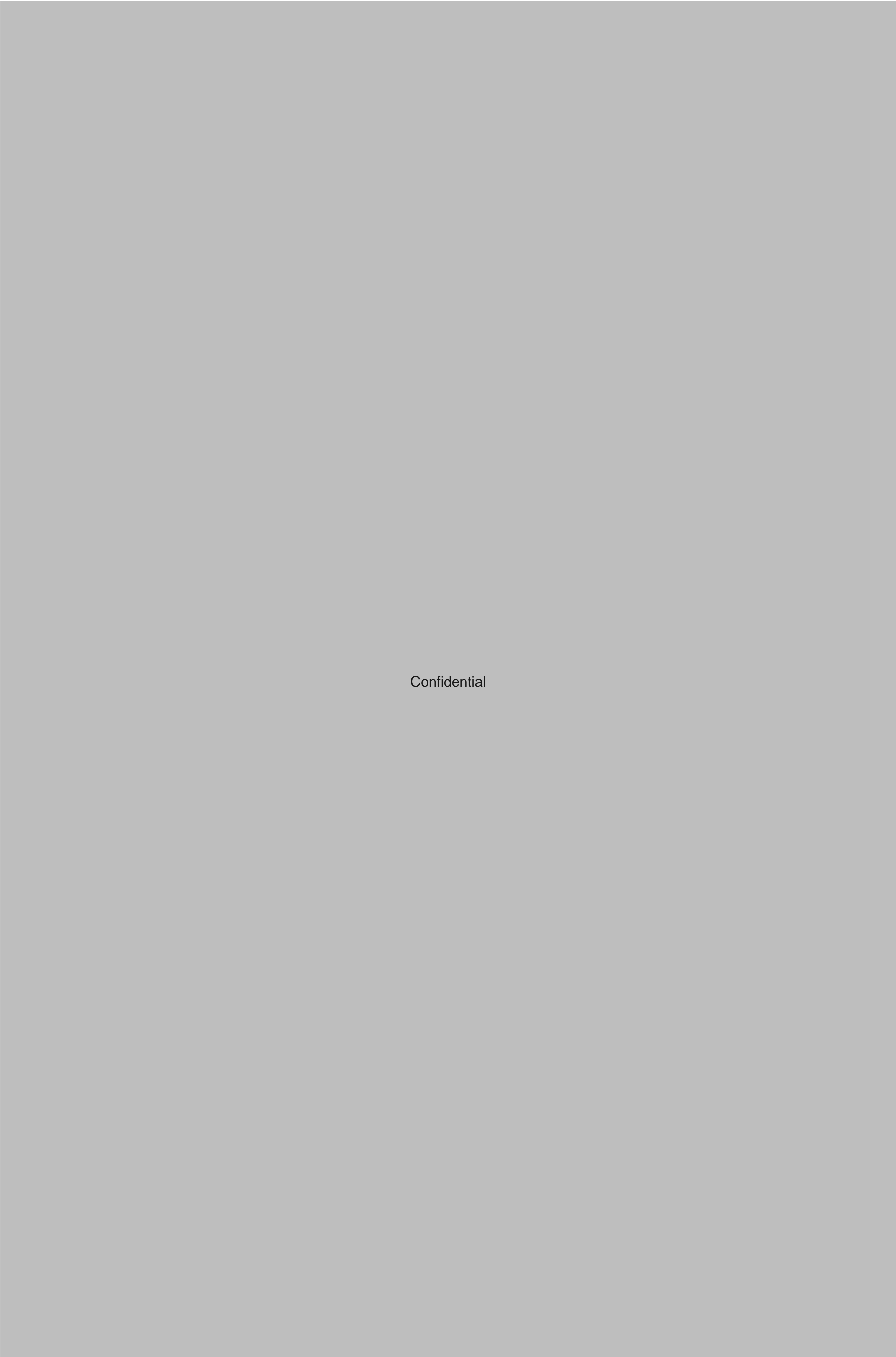
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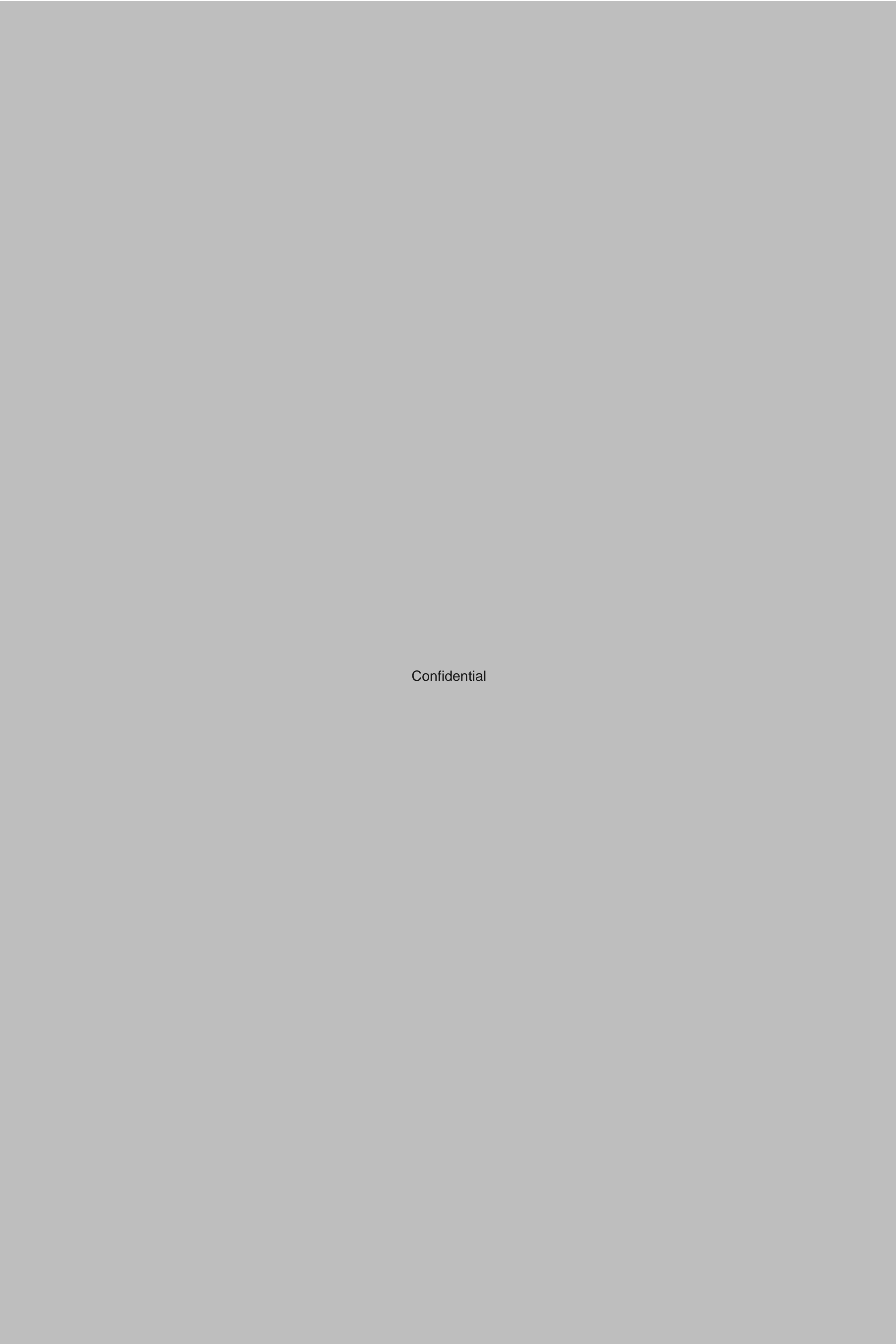
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Terms of Reference

Chief Executive and Department of Health Oversight Committee

1. Purpose

The purpose of the Chief Executive and Department of Health Oversight Committee (CE DoH OC) is to provide strategic leadership and governance for the Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy.

2. Guiding principles

- *Hospital and Health Boards Act 2011*
- *Fourth National Mental Health Plan*
- *Queensland Plan for Mental Health 2007-2017*
- *Mental Health Act 2000*

3. Functions

The functions and objectives of the Oversight Committee include:

- Provision of executive leadership, strategic advice and advocacy in the implementation of Statewide Adolescent Extended Treatment and Rehabilitation (SW AETR) service options.
- To identify the priorities and objectives associated with the development and implementation of SW AETR services, and to endorse plans and actions to achieve these objectives.
- To oversight the development of a contemporary model of care for SW AETR services within the allocated budget.
- To provide a strategic forum to drive a focus on outcomes and achievement of the transition of SW AETR services to CHQ HHS.
- To facilitate expert discussion from key executive around planning, development, and implementation of SW AETR services.
- To oversee the management of strategic risks.
- To monitor overall financial management of the transition of AETR services from West Moreton HHS to CHQ HHS.
- Provision of guidance and oversight for communication and stakeholder planning.
- Provide an escalation point for the resolution of issues and barriers associated with implementation of the SW AETR services.

4. Authority

Members are individually accountable for their delegated responsibility and collectively responsible to contribute to advice provided by the Committee to the Chair in the interests of a whole-of-service position.

Decision Making:

- Decisions made by the Steering Committee will be by majority.
- Where group consensus cannot be reached in relation to critical decisions, the Chair takes the final position

5. Frequency of meetings

Meetings will be held monthly, following the Chief Executive Forums, or as required. The Chair may call additional meetings as necessary to address any matters referred to the Committee or in respect of matters the Committee wishes to pursue within the Term of Reference.

Attendance can be in-person or via teleconference mediums.

The Committee is life limited for the duration of development, implementation and evaluation of transition to CHQ HHS. The Chair will advise the Committee members approximately one month prior to the dissolution of the Oversight Committee.

6. Membership

Dr Peter Steer (Chair)	Health Service Chief Executive, CHQ HHS
Dr Michael Cleary	Deputy Director General, Health Service and Clinical Innovation Division
Mrs Lesley Dwyer	Health Service Chief Executive, West Moreton HHS
Dr Richard Ashby	Health Service Chief Executive, Metro South HHS
Mrs Julia Squire	Health Service Chief Executive, Townsville HHS
Dr Bill Kingswell	Executive Director, Mental Health Alcohol & Other Drugs Directorate
Ms Deb Miller	A/Executive Director, Office of Strategy Management, CHQ HHS
Mr Stephen Stathis	Clinical Director, CYMHS CHQ HHS
Ms Leanne Geppert	A/Director of Strategy, Mental Health and Specialised Services, West Moreton HHS
Ms Ingrid Adamson (Secretariat)	Project Manager, SW AETRS, CHQ HHS

Chair:
The Steering Committee will be chaired by the Health Service Chief Executive, CHQ, or his delegate. The delegate must be suitably briefed prior to the meeting and have the authority to make decisions on behalf of the Chair.

Secretariat:
Secretariat support will be provided by the Project Manager, SW AETRS or an alternate officer nominated by the Chair.

Proxies:
Proxies are not accepted for this Oversight Committee, unless special circumstances apply and specific approval is given for each occasion by the Chair.

Other Participants:
The Chair may request external parties to attend a meeting of the committee. However, such persons do not assume membership or participate in any decision-making processes of the committee.

7. Quorum

A quorum will comprise half of the voting members, including the Chair, plus one.

8. Performance and Reporting

The Secretariat is to circulate an action register to Committee members within three business days of each Committee meeting.

The Secretariat will coordinate the endorsement of status reports and other related advice to be provided, as required, to the Children's Health Queensland Hospital and Health Service Board. Members are expected to respond to out of session invitations to comment on reports and other advice within the timeframes outlined by the Secretariat. If no comment is received from a member, it will be assumed that the member has no concerns with the report/advice and it will be taken as endorsed.

9. Confidentiality

Members must acknowledge and act accordingly in their responsibility to maintain confidentiality of all information that is not in the public domain.

10. Risk Management

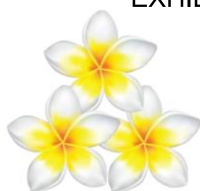
A proactive approach to risk management will underpin the business of this Committee. The Committee will:

- Identify risks and mitigation strategies associated with the implementation of the SW AETR services; and
- Implement processes to enable the Committee to identify, monitor and manage critical risks as they relate to the functions of the Committee.

Document history

Version	Date	Author	Nature of amendment
1.0	18/09/13	Ingrid Adamson	First draft
1.1	19/09/13	Ingrid Adamson	Comments from Deb Miller, A/ED OSM
1.2	23/09/13	Ingrid Adamson	Comments from SW AETR Steering Committee
Final	17/10/13	Ingrid Adamson	Comments from CE DoH Oversight Committee

Previous versions should be recorded and available for audit.



Procedure

Effective from: July 2012
Review Due: July 2013

Procedure No. :	**MSMH.PRO1011\V2\07\2012**
Title:	**Inter-district Transfer of Mental Health Consumers within South Queensland Health Service Districts (SQHSD)**
Purpose:	**This document details the procedure by which mental health consumers of SQHSD receive an efficient, consumer focused transition of care between mental health services within SQHSD.**
Target Audience:	**All Mental Health Professionals**

Procedure for Inter-District Transfer of Mental Health Consumers within South Queensland Health Service District

Definitions:

Queensland Private Health Care Sector	Health Care Services which are not Queensland Health provided
MHS	Mental Health Service
SQHSD	South Queensland Health Service Districts
DOMH	Director of Mental Health
SNFP	Special Notification Forensic Persons
MHA	*Mental Health Act 2000*
CIMHA	Consumer Integrated Mental Health Application

Background:

It is well established that mental health consumers are at an increased risk of harm during periods of transition. SQHSD are committed to an agreed procedure to ensure the comprehensive management of consumer transition between mental health services. This procedure clarifies and standardises the roles, expectations and responsibilities of transferring and receiving services in the management of mental health consumer transitions between services.

Principles:

During the transfer of care of mental health consumers between services:

- The cultural needs of the consumer and their carers will be acknowledged and respected (see Appendix A: Cultural Considerations When Transferring Consumers).
- Mental health services will work collaboratively to ensure a consumer focused transition of care.
- The transfer process, including the time it takes to complete, will be consistent with consumer's recovery / care / treatment plans, e.g. efforts made to support the consumer's ongoing access to their care network if they are from a rural and remote area and are transferred out of area.
- Some transfers of consumer care may require a shared care arrangement for a period of time.

- If a clinical difference of opinion occurs regarding the ongoing management of a consumer transferring between districts, the consultant of the receiving service has the final decision and responsibility for the ongoing care.
- Allowances may be made for consumers who are mental health service employees.

Procedure

Note: Regarding the Transfer of Clinical Information:

The steps required to transfer consumers between services will vary dependent upon the service type the consumer is transferring from and to. For transfers of consumers between all service types, the following (most recent) information is required (when it exists):

- Consumer demographic information form (demographic information generated from CIMHA is also acceptable)
  - Consumer intake form.
  - Consumer assessment form with associated assessment modules attached (for initial assessments: particularly the Family Developmental History and Social Assessment),
  - Recovery Plan. (Note: The recovery plan has 3 sections:
    - 1) recovery plan – consumer focused;
    - 2) individual care / treatment plan – service / duty of care focused;
    - 3) relapse prevention plan).
  - An individual care / treatment plan generated from the care planning module in CIMHA is also acceptable.
- Consumer End of Episode / Discharge Summary.

Clinical documentation should be recorded on the Queensland Health Mental Health standardised suites of clinical documentation forms. Notes written by non Mental Health staff (e.g. Emergency Department clinicians) may be recorded in other formats.

In the event that these forms have never been completed by the transferring service, the Consumer End of Episode / Discharge Summary is mandatory from Inpatient service providers, the intake / assessment information is mandatory from Acute Care Team (ACT) / Emergency Department (ED) services and the Consumer End of Episode / Discharge summary is a minimum requirement from Community Service Providers (including MITT services). These forms therefore **must** be completed by the transferring service prior to transfer unless exceptional circumstances exist (e.g. emergency transfer from rural ED where no after hours mental health staff to complete standard suite of documents).

Documentation in these circumstances must include:

- Risk Screen (if not recorded on intake or assessment form).
- Medical Officer R/V notes if initial Mental Health assessment has not been completed.
- *Mental Health Act 2000* documentation (if applicable).
- Medical Assessment and Clearance.

When possible, the transferring service should forward clinical documentation to the receiving service at least 3 days prior to the transfer of clinical care of the consumer.

Clinical information may be transferred via email or fax. The transferring service must ensure the information has been received by the receiving service and must document in the consumer's medical record that this has occurred.

Note: Regarding Mandatory Steps for Any Transfer of Consumer Care:

The receiving service contact details and follow up appointment details must be noted in the consumer's transferring service medical record prior to transfer. Unless a consumer does not grant permission for mental health service providers to contact their carers and / or families, **prior to the transfer of a consumer's care, the consumer's carers and family should be consulted with regarding the pending transfer of care**.

Transfer of Community Voluntary Mental Health Consumers:

Consumers choosing not to engage with the Community Mental Health Service within their destination District:

- The transferring service will contact the receiving service to advise of the consumer's relocation to the receiving district and, the CIMHA reference number (when available), for information only.
- The transferring service will document contact with receiving service in the consumer's medical record prior to case closure.

Consumers choosing to engage with private sector support services in their destination district:

- With consumer consent the clinical information above will be provided to relevant mental health service provider/s, e.g. GPs, private psychiatrists, NGO's. The transferring service will document contact with the follow up care providers in the consumer's medical record prior to case closure.
- The PSP from the transferring service will contact the consumer, following their relocation, to confirm and document that they have engaged with clinical / support services in their destination district.
- If the consumer has not engaged with clinical / support services as planned, the transferring service PSP will determine if further action is required. If the consumer requires follow up from Queensland Health Services, refer to procedure 1.2 for voluntary consumers and 2.0 for involuntary consumers.

Consumers choosing to engage with the Community Mental Health Service in their destination district:

- The transferring service will contact the receiving service via their intake officer / team leader (rural services), and will forward the information noted above.
- The receiving service intake officer / team leader (rural services) will facilitate the intake process to determine the follow up care which will provided in accordance with local processes (including dissemination of clinical handover information).
- For cases where the consumer is accepted for follow up into a community team (including ACT and MITT) the receiving service follow up team will facilitate PSP face to face contact with the consumer as soon as is required as determined by clinical need, but no later than 14 days. If any consumer has to wait for face to face contact with the receiving service for longer than is clinically acceptable, the transferring service will continue to provide care during the transition period (for up to 14 days, as negotiated between the transferring and receiving services). If it is geographically impractical for the transferring service to provide face to face transition care once the consumer moves into their destination district, the transferring service will maintain telephone or video link transition care as an alternative until the consumer attends their first appointment with the receiving service.

Note: When a consumer is transferred between services following an inpatient episode of care, face to face contact is mandatory within 7 days of discharge from the inpatient unit.

Transfer of Care for Involuntary Mental Health Consumers:

Transfer of care of involuntary consumers under the *Mental Health Act 2000*, who are not forensic consumers:

- The procedure for transfer of care of involuntary consumers under the *Mental Health Act 2000*, who are not forensic consumers, is the same as for voluntary consumers above, with the exceptions that:
  - The appropriate *Mental Health Act 2000* documentation must be transferred. This includes the treatment plan (all consumers) and making contact with the receiving districts *Mental Health Act 2000* Coordinator to advise of transfer and legal status.
  - The consumer's forensic history must be forwarded by the transferring service with the other clinical information required.

  - In the event that the transferring service is providing transition care for up to 14 days, if the consumer breaches the conditions of their treatment plan (e.g. is non compliant with medication), the transferring service will manage this clinical issue during the transition period. If the transferring service requires access to local networks (e.g. emergency services) they may make contact with the receiving service for this information.

Transfer of an involuntary consumer from an inpatient service to a community service:

- For inter-district transfer of an involuntary consumer from an inpatient service to a community service, the following requirements also apply:
  - Consultant to consultant liaison / team leader (rural services) contact is required prior to discharge from the transferring service.
  - If a case manager in the receiving service is not allocated at the time of transfer, the interim PSP is the team leader of the receiving service community team.
  - The Nurse Unit Manager of the transferring service is responsible for liaising with the case manager / team leader of the rural team prior to the consumer transfer, for rural discharges.

Mental Health Act Administrator (MHAA):

- When receiving notification of a transfer of an ITO via CIMHA email facility, the receiving service MHAA will confer with the Team Leader of the relevant team to establish if the transfer process has been completed and the consumer has been accepted to the service.
- When the referral has been accepted the receiving service PSP (usually a case manager) will notify the transferring service team and the receiving service MHAA so transfer of the ITO can be arranged.
- If the transfer is not complete, the receiving service MHAA must inform the transferring service that the ITO is to remain with them until the process is completed.
- If the consumer has been accepted to the receiving service, the ITO must be accepted by the receiving service MHAA.

Transfer of Care for Forensic Mental Health Consumers:

Procedure for forensic consumer under the *Mental Health Act 2000*:

- The procedure for transfer of care of forensic consumer under the *Mental Health Act 2000* is the same for involuntary consumers above, with the exceptions that:
  - The District Forensic Liaison Officers (DFLO) from the transferring and receiving services will be in contact with one another throughout the transfer process.
  - The DFLO from the transferring service will facilitate the transfer from the transferring service end (and therefore will be the person who will be making contact with the receiving service).
  - The DFLO from the transferring service may continue to share care / liaise with the receiving service DFLO regarding the consumer’s care for up to 3 months (as negotiated between the transferring and receiving services dependent upon clinical need). It may be necessary to negotiate a shared care transition plan which includes risk management. The transition plan will provide guidelines to manage issues of non-compliance and indicate who is responsible for managing the consumer should a psychiatric emergency arise. The intention of the transition plan is to ensure: consistency and continuity of care; and that the consumer is suitably monitored and is unable to avoid follow up as a result of not attending appointments, or being absent without leave or frequently moving address. The duration of the transition plan should be for a maximum period of three months and should be ended as soon as the receiving service is clinically confident that they have sufficient understanding of the consumer to no longer require transferring service support.
  - The Statewide Director of Mental Health (DOMH) must authorise (via written authorisation) the transfer of forensic consumers from one AMHS to another AMHS. The transferring AMHS will commence completion of the Request for Transfer – classified / forensic / court order patient form (an authorised Doctor only can complete some sections of this form). This form is then provided to the new AMHS for their completion. On final completion, the form is faxed to the DOMH.

- The DOMH must be satisfied that appropriate follow-up arrangements are in place for the consumer and that the transfer has been accepted by the Clinical Director / Administrator (or equivalent in rural areas) of the receiving service. This includes allocation of an authorised psychiatrist to the consumer prior to the transfer of the order.
- Until the DOMH transfers the order to the new AMHS the transferring AMHS remains responsible for the consumer's treatment as prescribed in the treatment plan, including taking appropriate actions when the consumer is non-compliant with the treatment plan. This will occur with assistance from the receiving service to access local networks if required in geographically isolated areas.
- Additional information which must be forwarded by the transferring service to the receiving service for transfer of forensic consumers includes: last MHRT report – attached treatment plan and LCT provisions; and, summary of forensic issues / outstanding matters (Summary page – Query IPS – CIMHA).

The receiving service may request extra documentation from the transferring service to assist with development of follow up care plans. This may include:
- Medico legal Reports (238 Report, current LCT plan and conditions).
- Crisis Management Plan.
- Relevant Clinical Reports (e.g. Forensic Order Report, CFOS assessment).
- Recent progress notes.

Transfer of care for Special Notification of Forensic Patients (SNFP) Mental Health Consumers:
- The procedure for transfer of care of Special Notification of Forensic Patients (SNFP) under the *Mental Health Act 2000* is the same as for forensic consumers above, with the exceptions that:
  - The Clinical Director (or equivalent) of the transferring service will contact the Clinical Director (or equivalent) of the receiving service to inform them of and discuss the pending transfer.

Transfer of care for Involuntary / Forensic consumers on short term travel:

Note: The *Mental Health Act 2000* Resource Guide, Chapter 8 "Moving and Transfer" does not specifically address the issue of holiday or interim care delivery for persons under the *Mental Health Act 2000* who are holidaying within Queensland away from their treating district. Interstate travel is addressed. Consideration of the consumer's rights must be made when determining appropriate management of this issue.

Key issues to address will include but are not limited to:
- Length of planned holiday period.
- Distance between holiday and home district.
- Conditions of leave.
- Medication prescription and administration.
- Treatment required.
- Social supports required.

According to Forensic Patient Management Policy and Procedures, (Queensland Forensic Mental Health Service), in addition to permanent transfer, Forensic Order movements may be: short term (a couple of nights, for example a holiday); and, regular short terms (e.g. visiting relatives in another district). Regardless of the time length for Forensic Order movement, the following minimum level of information should be provided to the receiving DFLO and District:

- Request for transfer: Classified / Forensic / Court order patient.
- Written Authorisation from DOMH.
- Standardised suite of forms – Consumer Demographics, Copy of Consumer Intake, Consumer Assessment, and Drug Assessment.
- Summary Page – Query IPS (CIMHA).

Transfer of Consumers to a Mental Health Service Inpatient Unit

Consumers presenting to the ED who require inpatient admission and reside in another district:

- Consumers should be treated as close to their home as practicable, to minimise disruption to social networks and functioning.
- All consumers presenting to the ED will be assessed regardless of their district of origin.
- Following the decision that admission is required, the assessing district will contact the consumer's district of origin and notify them of the consumer's presentation and their status.
- Pending bed availability and not withstanding any other agreement between districts, the consumer's district of origin will receive the referral and accept the consumer within a two hour period (between 0800 and 2300hrs). Transport arrangements are the responsibility of the transferring district. Ideally, within the SQHSD metropolitan area, districts will facilitate the acceptance of transfers from 0800hrs to 2000hrs. These transfers should be planned to be completed prior to 2300hrs.
- If there is no bed available at the consumer's district of origin or a safe transfer is not possible at the time, the consumer should be admitted to an appropriate ward and treatment commenced until such time as a bed in the consumer's district of origin becomes available.

The transfer of clinical documentation is to be recorded in the consumer's medical record as noted above.

Consumers presenting to a rural service ED who require inpatient admission:

Note: In 2009, all rural services in South Queensland are part of a district with inpatient beds. However, the service with the inpatient beds may be some distance from the rural service needing to admit a consumer. In the first instance, a rural service should always try and admit consumers to their own district (this is an intra rather than inter district transfer). In circumstances where a rural service is unable to admit consumers to a bed in their own district, a bed in another district receiving service will need to be found and the following applies:

- Following the decision that admission is required, the assessing district will contact the receiving district, through the receiving ACT and notify them of the consumer's presentation, their status and need for admission. The receiving service will make contact with the relevant psychiatrist to confirm and support admission to the inpatient unit. All relevant paperwork related to an involuntary admission (e.g. recommendation and request for assessment forms and request for police escort) will be completed by the onsite medical officer and mental health worker (during business hours).
- Pending bed availability, the receiving district will receive the required material for admission and accept the consumer within a two hour period (between 0800 and 2300hrs). Transport arrangements are the responsibility of the transferring district. Within rural areas transfers should ideally occur during business hours. The above hours are to be seen as flexible and able to be negotiated between services taking into account the needs of the consumer, the availability of human resources and the ability of the transferring service to maintain the safety of the consumer and staff in the facility prior to transfer.
    - If for any reason, the rural transferring service is not able to affect the transfer immediately, the "home" mental health service should put in place strategies to assist in maintaining the consumer safely until the transfer can occur. These strategies would include but not be limited to:
        - Access to a Psychiatric Registrar or Consultant for advice and support.
        - Video-link assessment or review if required.
        - Advice and support about the most appropriate transfer mode.
- If there is no bed available at the receiving district or at other suitable facilities (relevant to CYMHS consumers only) or a safe transfer is not possible at the time and the transferring facility has the capacity to ensure the safety of the consumer and staff, the consumer should be admitted to an appropriate hospital ward and treatment commenced, with consultation from the "home" inpatient psychiatrist until such time as a bed in the receiving inpatient unit becomes available.

Consumers who present or are presented to ED and are on an Authority to Return to another District

- Consumers that are brought to the ED on an Authority to Return from another AMHS are to be assessed upon their presentation.

- It is expected that the service who has issued the Authority to Return document will make available all information to facilitate this assessment.
- If, following assessment the consumer requires admission, refer to section 4.1

Temporary transferring of inpatient care to another district during bed shortage:
- Mental Health Services within the SQHSD have agreed to provide for the temporary care of consumers from other districts when these districts are experiencing bed shortages. Prior to this occurring, the local Mental Health Services should make every attempt to manage the consumers in their local district. Other options to be considered are:
  - Assertive community treatment.
  - “Outlying” appropriate consumers to a medical bed with specialist mental health support in order to make an acute Mental Health bed available.
  - Overnight management of the consumer in the ED, with specialist mental health support.
- The following process is to occur to facilitate all inter-district transfers due to local bed availability shortages
  - The delegated Mental Health Service Bed Manager from the transferring district will make contact with each delegated Mental Health Service Bed Manager within SQHSD to assess availability of beds.
  - Pending bed availability the receiving district will receive the referral and accept the consumer within a two hour period.
  - Documentation to accompany the transfer is as above.
- Inter-district transfers due to bed availability should occur within business hours whenever possible. Transfers outside of business hours are at the discretion of the Consultant on call and must take in to account the availability of medical and nursing staff to safely facilitate the transfer in both transferring and receiving services.
- It is preferable that a consumer requiring inpatient care within an Acute Observation Area (AOA) \ High Dependency Unit (HDU) NOT be transferred to another district, due to the:
  - Acute nature of their mental state.
  - Likelihood of requiring high doses of medication which may compromise their physical health status.
  - Identified benefit of having ready access to their usual treating team.
- The return of persons that have been transferred to another district is to be negotiated between the transferring and receiving services. Factors to be considered should include the consumer’s clinical needs, the consumer’s choice and the consumer’s discharge address. The number of transfers for each consumer should be minimised as much as possible.

Cultural Consideration when Transferring Consumers

Cultural factors of consumer transfer between districts include the cultural sensitivity of the transfer / relocation of a consumer. Mental health staff in both the transferring and receiving services must obtain access to cultural expertise and advice.

Factors to be aware of:
- Locality / community
- Transferring service to liaise with indigenous and culturally and linguistically diverse (CALD) mental health workers.
  - Within their team and with the receiving district
- Social and emotional wellbeing considerations
  - Links to family, friends, elders

Locality / community – When Aboriginal and Torres Strait Islander people are local to a specific area / town / city / suburb cultural protocol states the mental health service will contact the local Aboriginal or Torres Strait Islander community. There are several ways of contacting and involving the Aboriginal and Torres Strait Islander community:
- Through family connection if the consumer has a relative within that particular community
- Consulting the indigenous mental health worker in the receiving district

If the consumer is going to a community that is not well known the indigenous mental health worker must provide orientation for the consumer to the local Aboriginal and Torres Strait Islander community, with the consumer's consent.

Transferring service – It is the responsibility of the clinical team / case manager to notify the indigenous mental health worker in the receiving district of the transfer of the consumer, whether to private or public follow up care. In the event that there is no mental health service in a community, notification to the Aboriginal Medical Service in that community is recommended. The indigenous mental health worker from the transferring service needs to be involved / consulted in the transfer of all indigenous consumers of mental health services.

In addition, the consumer's family, allied person, etc. need to be notified of the transfer between districts, with the consumer's permission. Sometimes family exist in both the transferring district and the receiving district. Consumers need to be orientated to the new district for services and links with Aboriginal and Torres Strait Islander organisations, such as the Aboriginal Medical services; cultural events, activities and meetings; other Queensland Health services and other Queensland Government services.

Social and emotional wellbeing – Following on from this, the consumer's social and emotional needs in the receiving service has to include: family and other relationships; cultural connections / support; other health concerns; housing; income; spirituality; stability of home environment; and, culturally appropriate psycho social interventions and in the areas of: further education; diversional activities; fitness activities; clubs etc.

References and Suggested Reading

Mental Health Act 2000

Version	Date	Prepared by	Comments
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Assertive Mobile Youth Outreach Service
MODEL OF SERVICE

1. What does the Service intend to achieve?

The Assertive Mobile Youth Outreach Service (AMYOS) is one element in the integrated continuum of care for adolescents within Queensland's Hospital and Health Services (HHS) Child and Youth Mental Health Services (CYMHS). Community Child and Youth Mental Health Services (CCYMHS) are generally centre-based and rely on prospective clients and their families to attend a CCYMHS office to access the services provided. Although appropriate for the majority of children and young people with mental health difficulties, and their families, this model of service delivery has proven to be less suitable for a small group of adolescent clients, many of whom have multiple, complex difficulties.

Whilst this group of young people may access mental health care services in periods of crisis, during which they may be responsive to treatment interventions, they are often hard to engage in ongoing mental health care for a variety of reasons including ambivalence about treatment or because of significant practical barriers to attending appointments. Many drop out of treatment until the next crisis, which may see the young person repeatedly presenting to the same services.

Other young people may be in contact with non-mental health service sectors, which may identify that mental health support for their clients would be advantageous, but are unable to facilitate this engagement. This is a high priority if the young person is displaying risk taking and/or highly challenging behaviours, often resulting in the use of Emergency Services and Departments to access mental health support and intervention.

As a group, these young people present a challenge to all youth sector services requiring that services provide a flexible, comprehensive and integrated response to the complexity of their needs. The goal is to ensure every adolescent in need of mental health care will receive the best support and treatment as close to their home and family as possible.

The service model is a family-centred approach that emphasises individual strengths, builds resilience and enhances opportunities for social inclusion. AMYOS operates on the premise that adolescents can and do recover from mental health problems, which is reflected in recovery-oriented treatment and discharge planning.

The key functions of AMYOS are to provide:

- Provide collaborative, system-based care to high risk and difficult to engage adolescents to treat mental illness, reduce emotional distress and promote function within the community.
- Provide intensive, developmentally-appropriate, community-centred, mental health interventions and ongoing assessment for adolescents who require higher intensity services. The overall treatment plan will include risk assessment, crisis/safety planning and management, and rehabilitation and support to recover from mental illness
- Co-ordinate and establish collaborative links with other community service providers, including other health care providers, education, child safety, housing, police, youth justice, and alcohol and other drugs services.
- Facilitate and support the safe transition to more functional or independent living in the community.

The Assertive Mobile Youth Outreach Service functions contribute to:

- Reducing barriers to service attendance.
- Improving engagement of high risk adolescents.
- Providing high quality care to adolescents with a focus on building resilience, fostering individual and family wellbeing, and assisting in the recovery of an appropriate developmental trajectory.
- Reducing CYMHS drop out and crisis re-presentations to Emergency Departments.
- Reducing the need for hospital inpatient admissions.
- Reducing the length of stay when hospitalisation is required.
- Assisting adolescents to maintain hope and progress in their recovery, and to live with mental health issues where such issues persist.
- Supporting adolescents and their families/carers, including facilitating smooth transition to other appropriate services.
- Assisting adolescents to maintain or regain engagement in developmentally appropriate learning or vocational tasks.
- Working with adolescents to develop their personal support systems, and live successfully within their community.

DRAFT

- Decreasing stigma and discrimination within the local community and reducing barriers to social inclusion for adolescents.

AMYOS will be able to:

- Assertively develop meaningful engagement with service users, providing safe, high quality triage, assessment and evidence-based interventions that promote recovery.
- Ensure effective risk assessment and management.
- Provide a service that is sensitive and responsive to service users' cultural, religious, and gender needs.
- Increase stability within the service users' lives, facilitate personal growth, and provide opportunities for personal fulfilment.
- Provide mental health, alcohol, and other drug information, advice and support to adolescents and their families/carers.
- Offer information and advice to other health service providers.
- Establish and promote effective interagency collaborative partnerships internally with CYMHS, other Queensland Health services, other government organisations (Child Safety Services, Youth Justice, Dovetail and other alcohol and other drug services, etc.), Headspace, local health services, and external service providers and stakeholders, including Medicare Locals, General Practitioners (GPs), educational/vocational services, other non-government organisations (NGOs), and community groups.
- Establish a detailed understanding of local resources for the support of adolescents with mental health issues.
- Appropriately involve adolescents and their families/carers in all aspects or support.
- Support/uphold the rights of adolescents to make informed decisions and to actively participate in their recovery.
- Promote and advocate for improved access to general health care services for adolescents.
- Support health promotion, prevention and early intervention strategies for adolescents.
- Link with other Statewide Adolescent Extended Treatment Services to provide a continuum of care for adolescents requiring more intense services.
- Meet the National Standards for Mental Health Services.

2. Who is the Service for?

AMYOS services are available to CYMHS clients who:

- Are generally aged between 13 and 18 years, with flexibility in the upper age limit depending on presenting issues and developmental age.

  And

- Display signs and symptoms of complex and/or severe mental disorder such as:
  - psychosis
  - mood disorder
  - anxiety disorder
  - complex trauma
  - deficits in psychosocial functioning
  - marked social avoidance
  - severely disorganised behaviour characterised by impaired impulse control
  - substance misuse
  - emerging personality vulnerabilities
  - complex disruptive behavioural disorders
  - difficulties managing activities of daily living
  - chronic family dysfunction

  And

- Are considered to be at risk to self and/or others, due to:
  - significant self-harming behaviours
  - suicide attempts and threats
  - challenging behaviours including aggression towards property or others
  - consequences from putting themselves at serious risk of exploitation by others
  - presenting repeatedly in a state of crisis and/or
  - risk of further deterioration to their mental health

  And

- Are difficult to engage through mainstream clinic-based CCYMHS.

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3. What does the Service do?

The key components of Acute Adolescent Inpatient Mental Health Unit are defined here. These components are essential for the effective operation of an Adult Adolescent Inpatient Unit.

Key Component	Key elements	Comments
3.1.0 Working with other service providers	**3.1.1** Strong collaborative partnerships are developed with other local health and mental health service providers.	• Clear and regular contact and communication processes are maintained. • Formal agreements such as memorandums of understanding are developed where required. • Joint planning will occur for the development of programs to better meet the needs of young people and their families/carers. • Advice, education, and support for staff of other services on child and youth mental health issues are provided.
	3.1.2 As specific needs and goals are identified, young people and their families/carers will be assisted in accessing an appropriate range of non-clinical support structures.	• Clients and their families/carers will be involved in collaborative treatment planning. • Collaborative relationships will be developed with key clinical and non-clinical support services, such as housing, welfare, educational and vocational support, child protection, justice, recreational, vocational, and alcohol and other drugs service providers.
	3.1.3 When more than one service provider is involved in service delivery, AMYOS will participate in discussions regarding the young person's care, as required.	• AMYOS will initiate and participate in discussions around which service will adopt the role of lead agency. • Refer: Information sharing between mental health workers, consumers, carers, family and significant others.
	3.1.4 GPs may be involved as the primary service providers for young people across the entire diagnostic range.	• Young people will be encouraged and supported to engage with a GP, if not already, either directly or through other service links.
	3.1.5 There is active engagement with a range of primary health care providers to meet the general health care needs of young people.	• Young people will be encouraged and supported to engage with appropriate primary health care providers, as required.
	3.1.6 Young people receiving treatment in the public, private, and NGO mental health support sectors are supported to continue this engagement.	• Collaborative care agreements will be developed, including the definition of key roles and communication strategies.

Assertive Mobile Youth Outreach Service (AMYOS)

Key Component	Key elements	Comments
	3.1.7 To ensure effective communication, AMYOS will engage the assistance of appropriate services when young people have specific needs (e.g. sensory impairment, transcultural needs).	Relationships will be developed with the following services: • Queensland Health Interpreter Service • Transcultural mental health • Hearing Impaired / Deafness • Indigenous mental health
	3.1.8 AMYOS will develop strong links with local hospital emergency departments, mental health acute response teams, and mental health inpatient units so that service accessibility and crisis planning is supported.	• Partnerships with local mental health services/ teams will be developed and supported. • Refer: Guiding Principles for Admission to Queensland Health Child and Youth Mental Health Acute Inpatient Units, 2010
3.2.0 Referral, access and triage	**3.2.1** All new service referrals will be via a single point of entry through CCYMHS or acute response services, where synergies exist.	• Clear information regarding local referral pathways to CCYMHS/ AMYOS will be available to young people, their families/carers, and other service providers.
	3.2.2 Referrals will be discussed with AMYOS team members.	• AMYOS referrals will be discussed at team meetings and a decision made based on whether they meet the intake criteria. • The capacity of the AMYOS team to accept new referrals will be discussed with the referrer.
	3.2.3 Consent for referral will be obtained.	• Parent/guardian consent to referral to be noted on the intake form. • Young people presenting independently will be asked, where capable, to provide informed consent. The young person will be encouraged to involve parents and/or guardians in knowledge of treatment however; the best interests of the young person are placed above any parental right to be informed, particularly if the young person is deemed Gillick competent. • When a person is referred without his/her knowledge or consent, triage will proceed as clinically indicated, and according to the mental health statement of rights and responsibilities and the *Mental Health ACT 2000.* • Refer: Your rights as an Involuntary Patient, MHA 2000. Available in multilingual brochures.
	3.2.4 Timeframes for assessments by AMYOS will be formulated according to documented risk assessment on the	• This decision will take into account: – the nature of the problem – the acuity and severity of the young person's mental health issues – the complexity of the condition (including comorbidity) – the extent of functional impairment

Key Component	Key elements	Comments
	Consumer Intake Form, capacity to accept new referrals, and other collateral information available on CIMHA.	– the level of distress experienced by the young person and/or family/carers – the availability of other appropriate services – the level of past engagement or predicted level of engagement with services
3.3.0 Assessment	**3.3.1** AMYOS will complete a comprehensive, ongoing assessment with each adolescent. Routine assessments will be timely, reflecting the clinical needs of individual adolescents and their families/carers.	• An ongoing assessment will explore the adolescent's strengths and goals, barriers to improvement, as well as the adolescent and family/carer perception of progress toward recovery goals outlined in the overall care plan, recovery plan, and crisis intervention plan on CIMHA. • Refer: CIMHA Standard Business Processes • Refer: State-wide Standardised Suite of Clinical Documentation • AMYOS will provide or facilitate specialist mental health assessments incorporating, where indicated, psychological, cognitive, functional, vocational, social, and physical aspects of the adolescent's functioning. • Crisis planning will be part of the overall assessment and treatment plan.
	3.3.2 Same day crisis response assessments will be provided.	• AMYOS clinicians will provide crisis response assessments during their rostered working hours. • Outside of these hours the response should align with HHS CYMHS processes commensurate with the Clinical Service Capability Framework for the service. • Crisis management plans need to be readily accessible to workers providing out of hours responses. • Local procedures will need to be developed to provide a safe and consistent approach to conducting home visits in a range of settings to minimise the risk of Workplace Health & Safety incidents.
	3.3.3 Assessments will initiate a discussion of treatment and recovery goals, including the young person's goals, strengths, and capacity for self-management. The assessment will also entail the collection of collateral information from family/carers and other service providers, including GPs and schools.	• A formulation will be developed by the AMYOS team, which will contribute to overall treatment and crisis planning. • The Consumer Care Review Summary and Plan and Crisis Intervention Plan will be updated regularly on CIMHA, following each client and case review. • Refer: State-wide Standardised Suite of Clinical Documentation
	3.3.4 Initial and ongoing assessments will include alcohol and other drugs use.	• Risks identified are incorporated into the Consumer Care Review Summary and Plan and Crisis Intervention Plan. • Detected alcohol and other drug use problems will be incorporated into treatment planning in consultation with the child/young person and family/carers. • Elimination and reduction of cigarette smoking is a focus of treatment, with quit reduction strategies/aids routinely offered to consumers.

Key Component	Key elements	Comments
	3.3.5 Assessment will involve input from all key service providers, family/carers, and significant others where appropriate.	• Relevant information will be sought and recorded with due regard for the young person and family/carers right to Information sharing between mental health workers, consumers, carers, family and significant others.
	3.3.6 Physical and oral health will be routinely assessed, managed, and documented. This may be conducted by a health service provider external to CCYMHS but needs to be considered as part of the CCYMHS assessment. Additional resources, education, and training to improve the physical and oral health management of consumers with mental illness is available on the Activate: Mind and Body website.	• Documented evidence of physical and oral health assessments, or referral, will be recorded on the Physical Examinations Form on CIMHA. • Refer: Physical Examination and Investigations Form • Clinical alerts (e.g. medical conditions, allergies, etc.) must be recorded on CIMHA and the clinical record. • Young people will be actively supported to access primary health care services and health improvement activities. • Refer : General Practice Queensland – A Manual of Mental Health Care in General Practice • A nominated GP must be entered on CIMHA. • Any potential health issues identified will be discussed with the young person, family/carers, and GP or other primary health care provider, where appropriate.
	3.3.7 Risk assessments will be conducted prior to referral, on initial assessment, as clinically indicated in all phases of care provision and prior to transfer or discharge.	• All risk assessments will be recorded on the Risk Screening Tool on CIMHA and will be used to formulate a crisis/risk management plan, developed as part of the overall treatment plan. • Risk management protocols will be consistent with Queensland Health policy. • Refer: Risk Management Policy • Refer: Child Safety Policy • Refer: Risk Screening Tool
	3.3.8 The outcome of assessments will be communicated to the young person, family/carers, and other stakeholders as appropriate, in a timely manner, and with due respect for the young person's right to privacy.	• Crisis assessments will be recorded on CIMHA the same day. • Non-crisis assessments, written or verbal, will be completed within 24-48 hours of assessment. If there are changes with the overall treatment plan or level of risk, then this will be recorded on CIMHA the same day and communicated to relevant stakeholders. • If only verbal communication is provided initially, written communication will be provided within 48 hours. • Efforts will be made to ensure communication of the results of assessments is provided to all relevant stakeholders.
	3.3.9 Child safety concerns will be addressed in accordance with mandatory requirements.	• Refer: Child Safety - home page • Refer: National Framework for Protecting Australia's Children 2009-2020 • Refer: Report of a reasonable suspicion of child abuse and neglect • Refer: Considering and responding to the needs of children for whom a person with a mental illness has care responsibilities

Key Component	Key elements	Comments
	3.3.10 At the time of acceptance to AMYOS, a general information pack about the service will be available for young people and their families/carers.	• Information on AMYOS, compliments/complaints processes, and young person rights and responsibilities will be provided to all young people in an accessible manner. • Refer: Australian Charter of Healthcare Rights
3.4.0 **Clinical Review**	**3.4.1** Team review meetings will be held weekly. Each open case and the individual service plan will be discussed at formal case review meetings at intervals of no longer than two weeks or when indicated.	• Meetings will be attended by the multi-disciplinary team including the AMYOS case manager and consultant psychiatrist either in person or via telehealth. Rural services may be supported by CHQ eCYMHS, if initially unable to recruit to the consultant psychiatry component of the AMYOS, until a local option is available. • There will be an established agenda for discussion of young people, with concise documentation of the content of the discussion and the ongoing plan of care recorded on the Consumer Care and Review Summary and Plan in CIMHA. • Local CYMHS will ensure that appropriate clinical governance structures are in place to enable AMYOS case managers, in collaboration with the treating team, to provide comprehensive assessment and management planning. • A review will provide an in-depth, resilience and recovery-oriented review of the young person. • The opinions and observations of the young person, family/carers, and other service providers/ stakeholders will be included and considered in reviews. • Outcomes of reviews will be discussed with the young person and their family/carers. Any care planning or changes to recovery plans will involve the young person.
	3.4.2 All referrals will be discussed at the next scheduled intake meeting, as soon as possible after referral	• The consultant psychiatrist is the clinical lead. • The consultant psychiatrist, or appropriate medical delegate, will participate in all multidisciplinary team intake meetings. • The consultant psychiatrist, or their delegate, will take responsibility for ensuring that assessments and management plans are adequate and that a process is in place to ensure that any onward referral is completed.
	3.4.3 Ad-hoc reviews will occur as required to review newly accepted young people, to address complex issues or following a critical event.	• A consultant psychiatrist, or appropriate medical delegate, will attend all clinical reviews (in person or via telehealth). • Critical events will be reviewed utilising the clinical management implementation standard. • Refer: Clinical Incident Management Procedure
3.5.0 **Resilience and Recovery Planning**	**3.5.1** A single comprehensive and individualised recovery plan will be developed with every young person, in	• Recovery plans will take into account relevant contributing, maintaining, and protective factors outlined in the case formulation (developed from the comprehensive assessment). • Refer: State-wide Standardised Suite of Clinical

Key Component	Key elements	Comments
	collaboration with their treating CCYMHS team, AMYOS, and other stakeholders involved in the young person's support and service networks.	Documentation • All services delivered by AMYOS are based on the principles of recovery. • AMYOS considers how the concept of recovery applies to young people and their families/carers. • This includes acknowledgement that recovery takes into account developmental process related to adolescence. A greater emphasis is placed on the views and goals of the young person and there is greater involvement of the young person in the plan development and review. Young people from 13 – 18 years of age gain further independence and mastery separate to their family/carers. • Refer: National Standards for Mental Health Services, 2010 • Refer: Sharing responsibility for recovery: creating and sustaining recovery oriented systems of care for mental health • Basic human rights, such as privacy, dignity, choice, anti-discrimination, and confidentiality are recognised, respected, and maintained to the highest degree possible in all clinical interventions.
	3.5.2 The recovery plan is reviewed as needed, and at intervals of no longer than two weeks. Review of progress and planning for future goals, as well as exit from the program, will be integrated into the recovery plan.	• A copy of the most current recovery plan will be located on CIMHA. • A review of the recovery and relapse prevention plan can be initiated by any stakeholder, including team members, consumers, and families/carers. • Reviews of recovery and relapse prevention plans will be performed in collaboration with the young person, families/carers, and relevant other stakeholders. • Where clinically relevant, some components of the review process will include objective measurement tools including but not limited to routine outcome measures. • Refer: State-wide Standardised Suite of Clinical Documentation • Refer: Outcomes measures for mental health services
	3.5.3 Every effort will be made to ensure that recovery planning focuses on the young person's own goals.	• Where conflicting goals exist (e.g. for young people receiving involuntary treatment), this will be clearly outlined in the clinical record and recovery plan, and addressed in a way that is most consistent with the young person's goals and values.
	3.5.4 Recovery planning will be developed in partnership with every young person.	• Young people will contribute as much as possible to every aspect of their recovery plan. • Young people are strongly encouraged to take ownership of their recovery plan. • Any changes to the recovery plan will be discussed and changed in partnership with the young person, their family/carers, and relevant service providers.
3.6.0 Interventions	**3.6.1** Interventions, reviews, and follow up processes will occur in a manner that ensures safety and meets the young	• The extent and type of follow up methods will specifically align with clinical need and acuity levels. • Services will be delivered in the least restrictive environment possible. • AMYOS will proactively provide interventions utilising case management and co-ordination to facilitate

Key Component	Key elements	Comments
	person's individual needs.	assertive engagement and follow up. • AMYOS will provide a flexible response to clients with an ability to meet clients in a non-threatening environment of their choice. • AMYOS will enlist support from current workers who have gained the young persons trust. • Initial contact is carefully planned, drawing on all information available and what has been learnt from the past attempts to engage the young person. • AMYOS clinicians have the capacity to inform clients at a pace and in a way that the young person understands.
	3.6.2 Interventions are guided by assessment and formulation processes, using a developmentally appropriate, biopsychosocial approach, in collaboration with the young person's treating team.	• Interventions will take into consideration the strengths and resilience of the individual, their family, and their community. • The consent of the young person/guardian to disclose information and (where needed) to involve family/carers in treatment planning and delivery will be sought in every case. • Information sharing will occur in every case unless a significant barrier arises, such as inability to gain appropriate lawful consent. • Informed consent is documented in the clinical record, detailing that the young person/guardian understands the treatment plan and that the guardian agrees to support the provision of ongoing care to the young person in the community. • Refer: Information sharing between mental health workers, consumers, carers, family and significant others • Refer: Privacy and Confidentiality Resources webpage • Refer: Consent for the Treatment of Children or Young People Under the Custody or Guardianship of the Director General Department of Communities - Child Safety Services procedure • Identification of family members/carers and their needs is part of the assessment process, and are included in care planning. • Refer: Carers matter webpage • Education and information will be provided to the young person, family/carers, and significant others at all stages of contact with the service. • A shared understanding will be fostered for all aspects of treatment, including risk management, with explicit, documented evidence of the shared understanding in the clinical file/ CIMHA.
	3.6.3 Young people will be supported to access a range of biopsychosocial, developmentally, and culturally appropriate interventions that address the young person's individual needs.	• Evidence-informed interventions to reduce the severity of symptoms and increase resilience to cope with mental health problems will be utilised (e.g. Mentalisation-Based Therapy, Dialectical Behaviour Therapy, family-based interventions, solution-focused therapies, structured problem solving, expressive therapies such as play/art/music, psychoeducation, and psychopharmacological treatments). • Interventions will be based on recovery principles and best practice. • The needs of families, carers, and significant others must be routinely addressed.

Key Component	Key elements	Comments
	Efficacy of treatment and progress will be reviewed and evaluated throughout the episode of care.	• Multidisciplinary input will be provided to optimise consumer recovery. • Consumer and carer support interventions will be included where appropriate. • Interventions will include responsive crisis intervention, relapse prevention strategies, assistance in accessing educational/vocational services, and assistance in accessing psychosocial rehabilitation. • AMYOS will demonstrate a focus on strengths, connectedness, personal involvement, personal choice, empowerment, and increasing confidence in accessing the mental health system and other community services and supports.
	3.6.5 Administration of prescription and non-prescription medications will be supervised in accordance with relevant procedures and guidelines.	• Across all treatment settings, all prescriptions, dispensing, and administration of medicines will comply with Queensland Health policies, guidelines and standards. • Refer: Clinical Guidelines • Refer: Medication Liaison on Discharge Procedure • Refer: Acute sedation guidelines for children and young people (under development) • The psychiatrist responsible for pharmacological treatment will be familiar with national and international best practice standards, and medication will be prescribed in keeping with these standards. • The medication goals of the young person/guardian will be integrated with evidence-based clinical treatment guidelines. • Where needed, strategies focused on medication adherence will be in place. • Monitoring of medication side effects will be routinely conducted and recorded on CIMHA. • Refer: Metabolic Monitoring Form
	3.6.6 Access to interventions to improve the physical health of young people will be facilitated.	• All young people and their families/carers will receive information about physical health issues. • Young people and their families/carers will be supported to access primary health care and health improvement services. • Refer: Activate: mind & body website
3.7.0 Team Approach	**3.7.1** A multi-skilled team approach will be provided.	• The young person and family/carers will be informed of the multidisciplinary approach to mental health care upon entry to AMYOS (and at other times when needed).
	3.7.2 Clear clinical and operational leadership will be provided for the AMYOS team.	• AMYOS staff have will have access to and are encouraged to utilise specialist input (from senior clinical staff) where they need to make significant and complex clinical decisions • Clinical supervision of AMYOS staff should aim to enhance the professional development and competence of each AMYOS clinician, ensure support and guidance, offer leadership and direction, and assist the worker to perform their responsibilities.
	3.7.3 Rosters will be managed to ensure effective use	• AMYOS will operate predominantly Monday-Friday between the hours of 8am-8pm. There is flexibility to extend contact to weekends or after these hours to

Key Component	Key elements	Comments
	of resources and to support staff to work in a safe and effective manner.	meet the recovery-oriented goals within individual treatment plans. • Outside of these hours, the AMYOS team will be required to co-ordinate out-of-hours support for AMYOS clients. This after hours responses should align with local CYMHS processes commensurate with the Clinical Service Capability Framework for the service e.g. through existing CYMHS acute response services (where available), links with adult mental health service Acute Care Teams, etc.
	3.7.4 Specific skills and knowledge will be utilised as appropriate in all aspects of service provision.	• AMYOS staff will have access to peer learning, professional training and development programs, and debriefing and clinical supervision.
3.8 Care Coordination	**3.8.1** Coordination of care is an essential element of an effective service delivery system, ensuring that each young person is able to access the services they need, when they need them, and generally with one identified worker accountable for coordinating service provision.	• A range of agencies will be involved in supporting the young person. • Collaborative relationships will be developed with other service providers, including schools, primary health care, housing, welfare, educational and vocational support, justice and recreational service providers. • Local procedures for evidence-based, case management, including: – Queensland Health Mental Health Case Management Policy Framework: Positive Partnerships to Build Capacity and Enable Recovery [http://qheps.health.qld.gov.au/mentalhealth/docs/casemanage_polstate.pdf]. – Statewide standardised clinical documentation CYMHS user guide [http://qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_user.pdf] – Meeting the needs of children of a person with a mental illness – Child safety policy [http://qheps.health.qld.gov.au/mhalu/documents/policies/child_protect.pdf]. – Early psychosis guidelines (pending) – Perinatal and infant mental health model of service (when available) – Eating disorders model of service(when available)
	3.8.2 All young people will be assigned a case manager upon entry to AMYOS.	• The case manager will be listed as the Principle Service Provider (PSP) on CIMHA. • The consultant psychiatrist will be reflected in CIMHA as the Principle Doctor. • Refer: CIMHA Standard Business Processes • The PSP has primary responsibility for the coordination of care, including working with the young person on goal-setting, recovery, and exit planning.
	3.8.3 Effort will be made to assertively link young people and their families/carers into appropriate services.	• The PSP has the primary responsibility for the coordination of care. • The PSP will develop and maintain relationships with the relevant inpatient treating teams, and negotiate appropriate involvement in inpatient care and discharge planning for the young person.

Key Component	Key elements	Comments
		• The PSP will develop collaborative relationships with other service providers, including schools, primary health care, housing, welfare, educational and vocational support, justice, and recreational service providers. • Collaborative care arrangements are encouraged. • The AMYOS clinician may also be the Other Service Provider (OSP) for CCYMHS or other CYMHS clients, where deemed appropriate.
3.9 Continuity of Care	**3.9.1** Clear information is provided for young people, families/carers, and referral sources about how to contact the service (and/or other supports) across a 24 hour, seven day period.	• This will be documented on CIMHA and in the young person's file. • Service publications and relevant information documents will include this information from a broader perspective. • Documented crisis management plans will be recorded on CIMHA, in the young person's file, and a copy should be given to the young person and their family/carers where appropriate.
	3.9.2 The young person's PSP, treating CYMHS team, and other service providers, will be clearly identified on CIMHA, and communication maintained throughout AMYOS service provision.	• The process for sharing information will be explicitly documented for each young person. • Strategies to ensure continuity of care include good communication, coordination, collaboration, and continual reassessment between the PSP, the young person, family/carers, the young person's treating CCYMHS or other CYMHS team, the AMYOS team, Acute Response Team (where they exist), primary care providers and other service providers. • The team response will be clearly documented in the young person's recovery plan and crisis management plan. • Service links are established with acute care/extended hours teams and local emergency departments to ensure access to acute mental health crisis support outside working hours.
	3.9.3 A team response is provided for planned and crisis interventions, and is not dependent on the PSP's availability.	• Provision of crisis response and intervention occurs during the hours of AMYOS service operation / rostered shifts. • Service links are established with acute care/extended hours teams, and local Emergency Departments to ensure access to acute mental health crisis support outside working hours. • After hours response should align with local CYMHS processes commensurate with the Clinical Service Capability Framework for the service, e.g. through existing CYMHS Acute Response Services (where available), links with adult mental health service Acute Care Teams, etc.
3.10.0 Exit Planning	**3.10.1** Exit planning is considered from first contact with the young person and their family/carers, with support time-limited.	• Exit planning will be a routine component of recovery planning and each review process.

Key Component	Key elements	Comments
	3.10.2 Exit will occur between 3 and 18 months from entry, or when the young person is at a stage of recovery where they have graduated to needing less intensive care and have supports in place to manage in their community.	• The decision to exit a young person is at the discretion of the consultant psychiatrist in consultation with the multidisciplinary team.
	3.10.3 Young people will be exited in a timely manner consistent with the individual recovery plan.	• Families/carers will be routinely directly involved in exit planning wherever possible. • AMYOS will support the young person to arrange appointments with other relevant service providers prior to exit.
	3.10.4 Exit planning will incorporate strategies for relapse prevention, crisis management, and clearly articulated service re-entry processes.	• Relapse patterns and risk assessment/management information will be provided, where available.
	3.10.5 Comprehensive liaison will occur with all other service providers who will contribute to the young person's ongoing care. Wherever possible service providers responsible for the provision of ongoing care will be involved in exit planning.	• Exit letters will indicate relevant information including progress of care, recommendations for ongoing care, and procedures for re-referral. • Follow up direct contact with the young person by their PSP will occur to ensure appropriate linkages have been made and the young person has settled into their community. • A feedback mechanism will be in place so that the receiving team informs the referring team if the consumer fails to attend or if significant problems occur or recur. • A verbal and written handover will be provided on every transfer occasion. • Refer: Consumer End of Episode/Discharge Summary • Discharge Summary will be recorded in CIMHA. • The PSP is responsible for ensuring that discharge summaries are sent to key health service providers (e.g. GP) within 48 hours of exit from AMYOS.
3.11.0 Collection of data, record keeping and documentation	**3.11.1** CCYMHS will enter and review all required information in CIMHA in accordance with approved statewide and district business rules.	• Refer: CIMHA Standard Business Processes
	3.11.2 All referred and open cases will have a designated PSP.	• This will be reflected on CIMHA as the internal contact – PSP.

Key Component	Key elements	Comments
	3.11.3 All open cases will have a designated treating consultant psychiatrist.	• This will be reflected in CIMHA as the internal contact – treating consultant psychiatrist. • Refer: CIMHA Standard Business Processes
	3.11.4 AMYOS will utilise the range of routine outcome measures mandated through the National Outcomes and Casemix Collection (NOCC), including the Health of the Nation Outcomes Scale for Children and Adolescents (HoNOSCA), the Children's Global Assessment Scale (CGAS) and the Strengths and Difficulties Questionnaire (SDQ)	• Routine outcomes data is presented at all formal case reviews and will be an agenda item at relevant meetings. • Results of outcomes are routinely discussed with young people and their families/carers. • Routine outcomes data is used with young people and their families/carers to: – Record details of a young person's symptoms and functioning; – Monitor changes in symptoms and functioning; – Stimulate dialogue about similarities and discrepancies in measures rated by parents, teachers, clinicians and the young person; and – Review progress and plan future goals (to be documented in the Recovery and Relapse Prevention Plan).
	3.11.5 All contacts, clinical processes, and recovery and relapse prevention planning will be documented in the young person's clinical record.	• Progress notes will be consecutive within the clinical record according to date.
	3.11.6 All clinical record keeping will comply with legislative and local policy requirements for the retention and disposal of clinical records.	• Refer: Retention and Disposal of Clinical Records Policy
	3.11.7 Clinical records will be kept legible and up to date, with clearly documented dates, times, author/s (name and title), and clinical progress notes. All documentation will include consumer information labels (or equivalent details).	• Personal and demographic details of the young person, their family/carers, and other health service providers will be kept up to date. • CIMHA will be updated with this information
	3.11.8 Local and statewide auditing processes will monitor the quality of record keeping and	• The written record will align with CIMHA • Mobile or tablet technology will support any increasing application of electronic record keeping. • Refer: National Safety and Quality Health Service Standards

Key Component	Key elements	Comments
	documentation (including written external communications), and support relevant clinician skill development.	
	3.11.9 There will be a single hard copy clinical record for each young person.	
3.12.0 Mental Health Peer Support Services	**3.12.1** All young people and their families/carers will be offered information and assistance to access local peer support services.	• Peer support services may be provided by internal or external services. • Consumer consultants are accessible via local mental health services. • Refer: Consumer, Carer and Family Participation Framework.

4. Related services

The future overarching model of care for CYMHS will include both inpatient and community care options. The care continuum in CYMHS will also include the development of AMYOS teams alongside CCYMHS, acute response services (where they exist), adolescent day programs, adolescent residential rehabilitation units, adolescent step up/step down units, and access to adolescent subacute beds. The specific details and location of these service options are yet to be finalised. Some service options will be available earlier than others, and implementation will be ongoing as funding and resources are made available.

Services are integrated and co-ordinated with partnerships and linkages with other agencies for infants, children, and young people and with specialist mental health services to ensure continuity of care across the service system and through the young person's developmental transitions. Mechanisms for joint planning, developing, and co-ordinating services will be established, including strategic district and area level linkages.

CYMHS adopts a developmentally informed approach, promoting collaboration with relevant government and non-government agencies to maximise outcomes for infants, children, young people, and their families/carers.

AMYOS services will develop service linkages with other services, including but not limited to:

- Other CCYMHS
- Acute response and inpatient services
- Specialist child and youth mental health services (e.g. forensic services, eCYMHS, and Evolve therapeutic services)
- Perinatal and infant mental health services
- Acute and non-acute inpatient and day program child and youth mental health services
- Adult mental health services, including acute care teams
- Alcohol and other drug services
- Specialist health clinics for the target population, e.g. diabetes clinic for children
- Private mental health service providers
- Primary health care providers and networks (including those for Aboriginal and Torres Strait Islander health) and local GPs
- Community pharmacies
- Local educational providers/schools, guidance officers and Ed-LinQ co-ordinators
- Child and family health and developmental services
- Department of Communities (Child Safety Services, Disability Services, and Youth Justice)
- Government and non-government community-based youth and family counselling and parent support services
- Housing and welfare services
- Transcultural and Aboriginal and Torres Strait Islander services

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5. Caseload

Caseload sizes need to consider the complexity of clinical needs presented by an AMYOS client, the flexibility and intensity of the interventions required within the treatment plan, and the liaison required with staff from other internal and external agencies. A significant time commitment is required for each AMYOS client, therefore it is expected that a typical caseload for a full time AMYOS clinician will be between 8 and 10 clients.

The total team caseload will be primarily determined by the capacity of the consultant psychiatrist to provide safe, high quality, clinical governance. The caseload for individual clinicians will be closely monitored to ensure that safe, high quality care can be provided to the consumer at all times. The clinician-to-consumer ratio will be low enough to enable the clinician to provide frequent, intensive consumer contacts, and assertive case management in line with the AMYOS model of service delivery.

Students from all disciplines may participate in case management activities under direct and specified supervision.

6. Workforce

Each AMYOS team will ideally include: 0.2 full-time equivalent (FTE) Child and Adolescent Psychiatrist and two FTE Mental Health Clinicians. CHQ CYMHS will provide statewide coordination for AMYOS across Queensland as outlined in Service Level Agreements with each HHS. This may include provision of additional psychiatry input from the Statewide AMYOS Child and Adolescent Psychiatrists, professional development opportunities, and clinical practice group supervision.

A local CYMHS may choose to add additional clinicians or psychiatry time to the AMYOS team from the CYMHS team to increase service capacity.

The local CYMHS Team Leader will be operationally responsible for AMYOS Teams.

7. Team clinical governance

The AMYOS Consultant Child and Adolescent Psychiatrist will be available to provide clinical governance to the AMYOS service, participate in assessment and intervention, individual treatment planning and review, protocol development, staff supervision, and staff training.

For rural services unable to recruit 0.2 FTE of a Consultant Child and Adolescent Psychiatrist, CHQ CYMHS may be able to initially recruit the psychiatrist to be located in Brisbane and provide input via video conferencing (Statewide AMYOS) until a local option is available.

8. Hours of Operation

AMYOS will operate predominantly Monday-Friday between the hours of 8am-8pm. There is flexibility to extend contact to weekends or after these hours to meet the recovery-oriented goals within individual treatment plans.

Outside of these hours, the AMYOS team will be required to co-ordinate out-of-hours support for AMYOS clients. This after-hours responses should align with local CYMHS processes commensurate with the Clinical Service Capability Framework for the service, e.g.

- Through existing CYMHS Acute Response Services (where available)
- Through links with adult mental health service Acute Care Teams.

In order to ensure effective crisis management, AMYOS clinicians will be expected to develop a crisis management plan for each client as part of the client's treatment plan. The crisis management plan should be developed in collaboration with the young person and his/her system of care. Crisis management plans need to be readily accessible to workers providing out-of-hours response.

9. Staff Training

Staff will be provided with continuing education opportunities, AMYOS local and statewide professional development, local mandatory training, clinical supervision, and other support mechanisms to ensure clinical competence. All training will be based on best practice principles and evidence based treatment guidelines, and underpinned by the Queensland Government's Consumer, Carer and Family Participation Framework.

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Assertive Mobile Youth Outreach Service (AMYOS)

AMYOS teams will have dedicated time and resources for evidence informed clinical education and clinical supervision to enhance the professional development and competence of each AMYOS clinician. Education and training will include a focus on strategies and mechanisms to manage young people with severe and complex mental health issues, who are at risk and difficult to engage in the community.

Education and training should include (but will not be limited to):

- Orientation training for new staff, including information regarding any relevant clinical and operational aspects that may be specific to an individual service
- Promotion, prevention, and early intervention strategies to build resilience and promote recovery and social and emotional wellbeing for young people and their families/carers
- Developmentally appropriate assessment and treatment
- Risk assessment and management, and associated crisis planning and intervention
- Specialist skills for the management of escalating behaviours as a result of trauma, attachment issues, and affect dysregulation
- *Mental Health Act 2000*
- National Standards for Mental Health Services
- Evidenced-informed practice in service delivery
- Consumer-focused care planning
- Routine outcome measurement training
- A range of treatment modalities including individual, group, and family-based therapy
- Child safety services training
- Knowledge of mental health diagnostic classification systems
- Communication and interpersonal processes
- Provisions for the maintenance of discipline-specific core competencies
- Work unit instruction for staff safety (home visits, etc.)
- Cultural capability training
- Supervision skills

Clinical supervision of AMYOS staff should aim to enhance the professional development and competence of each AMYOS clinician, ensure support and guidance, offer leadership and direction, assist the worker to perform their responsibilities, and promote safety. It is crucial that AMYOS staff have access to and are encouraged to utilise:

- Specialist input (from senior clinical staff) where they need to make significant and complex clinical decisions
- Peer learning
- Professional training and development programs
- Debriefing and clinical supervision

10. Research

Staff will be expected to contribute to statewide research and service improvement initiatives.

11. AMYOS functions best when:

- The services are provided by senior mental health clinicians from a range of disciplines, who have advanced skills in engaging and assisting the target group and who are able to work collaboratively with community agencies.
- Clinicians work directly with the young person and systematically with the young person's family/carer/friends, and other service providers to develop wrap around systems of support and care for the young person.
- Care is provided in a flexible outreach approach to provide care in the least restrictive setting possible, as close to their home and family as possible, to maximise engagement with CYMHS services.
- Young people, their families/carers, and other service providers are involved in all aspects of care planning and delivery.
- There is an explicit attitude that young people can and do recover from mental health problems and mental disorders, and that the family or care environment plays an integral role in the recovery of the young person's developmental trajectory.
- Teams are well integrated with other AMYOS teams across the state, local mental health service components, and primary care supports.
- Teams have a good general knowledge of local resources.
- They occupy a stakeholder position in the community in collaboration with CCYMHS, or other CYMHS services, to respond to local issues relevant to mental health service delivery.

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Assertive Mobile Youth Outreach Service (AMYOS)

- Clear roles and strong operational leadership, where the psychiatrist is the clinical lead, are provided.
- There is clear and explicit responsibility for a local population and clear links to specified organisations.
- Clear pathways exist for access to services and onward-referral, as clinically required.
- Crisis plans are developed as part of the overall treatment plan and are readily accessible to workers providing out-of-hours response.
- There is a focus on systems collaboration, consultation, and training.
- Collaborative care arrangements are in place across different service providers, and shared recovery plans and relapse prevention plans are utilised.
- Senior staff, including medical staff, take an active role in fostering the development of clinical skills in less experienced staff.
- Strong internal and external partnerships are established and maintained.
- Caseloads are regularly reviewed and assertively managed.
- All staff are provided with professional support, clinical supervision and training around contemporary evidenced informed care.

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AGREEMENT
FOR THE PROVISION OF SERVICES
between
THE CUSTOMER
and
THE PROVIDER

(Part B – Agreement Schedules)

Schedule A

No.	Part A Reference Clause No.	Agreement – Reference Clause	Details	
1.	1.1	**Customer**	Name:	Children's Health Queensland Hospital and Health Service (CHQ HHS)
			ABN/ACN:	62 254 746 464
			Address:	Level 1, North Tower Royal Children's Hospital Herston QLD 4029
2.	1.1 & 5	**Customer's Authorised Officer**	Name:	Ms Judi Krause Dr Stephen Stathis
			Position:	JK: Divisional Director, Child and Youth Mental Health Service (CYMHS), CHQ HHS SS: Medical Director, CYMHS, CHQ HHS
			Telephone:	
			Facsimile: Email:	
3.	1.1	**Provider**	Name:	HHS to complete
			ABN/ACN:	
			Address:	
			Telephone:	
			Facsimile:	
			Email:	
4.	1.1	**Provider's Authorised Officer**	Name:	HHS to complete
			Position:	
			Telephone:	
			Facsimile:	
			Email:	
5.	1.1 & 3	**Commencement Date**	1st April 2014	
6.	1.1 & 3	**Completion Date**	31 March 2015	

7.	1.1	**Delivery Date/Period**	The service will be delivered in a professional and competent manner throughout duration of the term.	
8.	1.1 & 3	**Term**	Term:	The period of time elapsing between the Commencement Date until Completion Date.
			Optional Extension Period:	Optional 12 month extension period at each annual review date (prior to Completion Date).
9.	1.1 & 9	**Performance of Key Personnel** Are Key Personnel associated with the Agreement?	**Yes** ☐ **No** ☒	
			Name:	
			Qualifications:	
10.	1.1	**Site**	Located in Logan CYMHS Servicing Logan, Bayside, and Beaudesert catchments	
11.	6 & 7	**Provision of the Services**	The Provider agrees to provide the services in a professional and competent manner, and in accordance with the Conditions of this Agreement and these Agreement Schedules.	
12.		*Deliberately blank*	*Deliberately blank*	
13.	6.6	**Provision of the Services – Key Performance Indicators (KPIs) or performance standards**	KPIs for the Partnership • AMYOS clinicians employed by the HHS > 48 weeks across the calendar year • 90% staff attendance at statewide AMYOS training, development and supervision • Caseload kept within maximum limits stipulated in Schedule D: AMYOS Model of Service Proposed KPIs* for the targeted age range of AMYOS (13-18 years): • Delivery of monthly service activity reporting, including o Provision of service (face to face, telephone, etc.) o Third party provision of service • Quarterly KPI performance reporting, including o Rate of preadmission community contact o End of episode discharge summary recorded within 48 hours o Rate of 1-7 day post discharge community contact o Twenty eight day mental health readmission rate o Number of unplanned hospital/DEM presentations o Number of unplanned discharges from CYMHS service *Subject to negotiation upon appointment of statewide teams.	
14.	6.5	**Provision of the Services - Assistance to be provided by the Customer**	**Yes** ☒ **No** ☐ As per Schedule D: AMYOS Model of Service	
15.	1.1 & 16	**Intellectual Property Rights in New Agreement Material** Clause 16.3 applies:	**Yes** ☒ **No** ☐	
16.	1.1 & 16	**Moral Rights**	Not Applicable	
17.	17	**Confidentiality**		

		Is the Service Provider required to obtain from its officers, employees, agents and sub-contractors an executed deed of confidentiality?	**Yes** ☐ **No** ☒	
18.	1.1 & 18	**Privacy & Personal Information** Is the Provider required to obtain from its officers, employees and sub-contractors an executed deed of privacy?	**Yes** ☐ **No** ☒	
19.	22.1(b)	**Insurance – Public Liability** Is Public Liability insurance required? .	**Yes** ☒ **No** ☐ If "**YES**" then please specify the following:	
			Sum Insured:	HHS to complete
			Policy No.:	HHS to complete
			Insurance Provider:	HHS to complete
			Named Insured:	HHS to complete
			Expiry Date of Policy:	HHS to complete
20.	22.1(c)	**Insurance - Professional indemnity** Is Professional Indemnity Insurance required?	**Yes** ☒ **No** ☐ If "**YES**" then please specify the following:	
			Sum Insured:	HHS to complete
			Policy No.:	HHS to complete
			Insurance Provider:	HHS to complete
			Named Insured:	HHS to complete
			Expiry Date of Policy:	HHS to complete
21.	22.1 (c)	Is the Professional Indemnity insurance to be maintained for an alternative period? (i.e. other than seven years after the latter of an Agreement Completion Date or termination of a contract)	**Yes** ☐ **No** ☒	
			Alternative Period:	
22.	22.3	Is the Service Provider a member of a scheme approved under the *Professional Standards Act 2004* (Qld)? *(If "**YES**" please specify and attach a copy of the applicable*	**Yes** ☒ **No** ☐ If Yes, specify the amount of Professional Indemnity Insurance Provided HHS to complete	

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<tr><td></td><td></td><td>scheme).</td><td colspan="2"></td></tr>
<tr><td rowspan="7">23.</td><td rowspan="7">22.1(d)</td><td rowspan="7">Insurance - Other insurances

Is other insurance required?</td><td colspan="2">Yes ☒ No ☐
If "YES" then please specify the following:</td></tr>
<tr><td>Type of insurance:</td><td>HHS to complete
Comprehensive Motor Vehicle Insurance</td></tr>
<tr><td>Sum Insured:</td><td></td></tr>
<tr><td>Policy No.:</td><td></td></tr>
<tr><td>Insurance Provider:</td><td></td></tr>
<tr><td>Named Insured:</td><td></td></tr>
<tr><td>Expiry Date of Policy:</td><td></td></tr>
<tr><td rowspan="5">24</td><td rowspan="5">4 of the Special Conditions</td><td rowspan="5">Quality Assurance</td><td colspan="2">Clause 4A of the Special Conditions in Part A will be applicable unless the form field below is marked with an "X" in which case clause 4B of the Special Conditions in Part A will apply:

Not Applicable ☒</td></tr>
<tr><td colspan="2">Certificate Number:</td></tr>
<tr><td>Period:</td><td></td></tr>
<tr><td>Name of Certifying Party:</td><td></td></tr>
<tr><td>Address:</td><td></td></tr>
<tr><td rowspan="2">25</td><td rowspan="2">1.1 & 30.1(a)</td><td rowspan="2">Notices – Customer's address for Notices</td><td>Facsimile No:

Email Address:</td><td></td></tr>
<tr><td>Address:</td><td>P.O. BOX 1507
Fortitude Valley QLD 4006</td></tr>
<tr><td rowspan="3">26</td><td rowspan="3">1.1 & 30.1(b)</td><td rowspan="3">Notice - Provider's address for Notices</td><td>Facsimile No:</td><td>HHS to complete</td></tr>
<tr><td>Email Address:</td><td>HHS to complete</td></tr>
<tr><td>Address:</td><td>HHS to complete</td></tr>
<tr><td rowspan="2">27</td><td rowspan="2">1.1 & clause 2 of the Special Conditions</td><td rowspan="2">Performance Guarantee

Is a Performance Guarantee required under the Agreement?</td><td colspan="2">Date:</td></tr>
<tr><td>Name of Guarantor:</td><td></td></tr>
</table>

			Yes ☐ **No** ☒	Not required.
28	1.1 & clause 3 of the Special Conditions	**Financial Security** Is a Financial Security required under the Agreement?	Amount:	
			Yes ☐ **No** ☒	
29	Clause 1 of the Special Conditions	**Termination via Notice** Is termination via notice not applicable?	**Not Applicable** ☐	

Schedule B – Specification

1. Background

1.1. The Assertive Mobile Youth Outreach Service (AMYOS) forms part of an integrated continuum of care for young people requiring extended mental health treatment and rehabilitation in Queensland.

1.2. AMYOS are delivered by multidisciplinary teams, who provide ongoing recovery-oriented assessment and assertive treatment and care, aimed at improving the quality of life for young people with complex mental health needs, through intensive, developmentally-appropriate, mobile interventions in a community or residential setting.

1.3. This service aims to assist young people who are high risk and difficult to engage; manage crisis situations; and to reduce the need for inpatient bed-based care.

1.4. The target group for this service is young people (13 to 18 years) who would have previously not engaged with mental health services and have therefore received little to no mental health input, increasing their risk of suicide and other adverse or life-threatening events.

1.5. The AMYOS approach places a strong emphasis on the development of cross-sector partnerships, working with other key service providers in the community to facilitate joint case planning and management for the young people in care.

1.6. Ideally, each AMYOS team would be resourced with a minimum of two full-time employees, supported by dedicated psychiatrists. It is suggested that the team be co-located with the local Community CYMHS, where possible.

2. Purpose

2.1. The aim of this Service Agreement is to ensure that the care of AMYOS consumers, under the operational governance of the Hospital and Health Service, is developed and delivered in partnership with CHQ HHS through reciprocal, appropriate and timely engagement and communication. The shared-care model of service planning and provision needs to be sustainable and ultimately provide a better service for consumers and their families.

2.2. This Service Agreement also serves to highlight the responsibility of the Customer and the Provider to establish and adhere to agreed principles.

2.3. The Customer will retain statewide governance and funding for this service in accordance with CHQ's statewide remit and until such time as these services, which are new to Queensland, are successfully established and well-embedded in the service continuum for adolescent mental health care.

2.4. The Provider will maintain operational governance over the delivery of the service within their catchment and the mental health clinicians delivering that service.

2.5. The Service Agreement is underpinned by the Clinical Services Capability Framework version 3.1 for Children's Services. The Framework recognises that young people require distinct and tailored health services providing care and treatment that is safe and suited to their age and stage of development. It is clearly recognised that the medical, therapeutic, developmental, social and psychosocial needs of young people requiring health services differ from those of adults.

2.6. This agreement will be reviewed at 12 monthly intervals under a negotiated review process, conducted by nominated representatives of the Customer and Provider.

3. Requirements

3.1. The Provider must:

3.1.1. Ensure services are delivered in accordance with Schedule D: AMYOS Model of Service.

3.1.2. Maintain dedicated AMYOS services, as defined by this Service Agreement, for the duration of the Service Agreement.

3.1.3. Recruit to AMYOS positions in the event of a vacancy.

3.1.4. Allocate an appropriate workspace, equipment and adequate resources; including an appropriate clinical environment for videoconferences, where required.

3.1.5. Provide administrative and management support through the Community CYMHS, where the AMYOS team is to be located.

3.1.6. Ensure all AMYOS service activity is captured on CIMHA.

3.1.7. Provide a dedicated vehicle for the AMYOS team, and a satellite phone where the AMYOS team is required to travel to rural, regional, or remote locations to provide services.

3.1.8. Facilitate AMYOS staff attendance at statewide AMYOS training and development, as provided by CHQ (potentially annually or bi-annually).

3.1.9. Facilitate AMYOS staff contribution to local and statewide research and service improvement.

3.2. AMYOS teams will comprise multidisciplinary mental health clinicians, located in the HHS, supported by a network of care providers in their local communities.

3.3. AMYOS clinicians will work as part of both their local HHS service and as part of the statewide AMYOS network.

3.4. Care provided at each HHS may vary depending on infrastructure, available clinical expertise, and local community requirements. It is expected that Providers will work with the Customer to achieve agreed competence and confidence in the services offered.

4. Qualifications, admissions and memberships

4.1.1. The Provider warrants that it has accreditation that meets industry requirements.

5. Tasks

5.1. As per Schedule D: AMYOS Model of Service.

6. Skills transfer

6.1. The Provider will use its best endeavours to impart skills to and instruct the Customer's employees with whom the Provider has contact in the performance of the Services, with a view to increasing and consolidating the skills base within the Customer.

7. Meeting requirements

7.1. The Provider's Authorised Officer must attend service review meetings on an ad hoc basis upon request by CHQ HHS.

8. Reporting requirements

8.1. The Provider must provide the following reports to the Customer:

8.1.1. Monthly Activity Reports within 10 working days of month's end
8.1.2. Quarterly KPIs stipulated in Schedule A Item 13

Schedule C – Pricing

Item 1 – Description of Prices

Description – AMYOS Team	Per Annum Offer Price, up to the amount of (excl. GST)
2.0 x FTE Clinical Nurse Grade 7 and/or Health Practitioner 4 Salaries (inclusive of 15.75% on costs)	$ 248,113
1 x vehicle lease, petrol, and service allowance	$ 12,684
Annual ICT service allowance ($2,500 per person)	$ 5,000
Annual statewide AMYOS training and development allowance ($2,000 per person)	$ 4,000
Total AMYOS Team	**$269,797** per annum
One-off ICT and FFE establishment allowance ($4,000 per person)	**$ 8,000**

Description - AMYOS Psychiatry Support	Offer Price, up to the amount of, (excl. GST) $
0.2 x FTE Psychiatrist (L23) Salary (inclusive of 15.75% on costs and allowances)	$ 68,778
Annual ICT service allowance ($2,500 per person)	$ 2,500
Total Offered Price	**$ 71,278** per annum

Item 2 - Approved Expenses

Nil

Item 3 – Times and Methods for Payment

Description	Detail
Times for submission of Invoices and amounts for milestone payments if applicable.	The HHS is to invoice Children's Health Queensland Hospital and Health Service in arrears on a monthly basis.
Payment methods acceptable to the Service Provider (e.g. cheque, electronic funds transfer, etc).	Electronic funds transfer
Restrictions to apply on the above methods of payment.	N/A

Item 4 - Price Variations

CHQ may, at its absolute discretion, vary this Agreement to request reimbursement of funds allocated where incumbents resign and/or CHQ needs to re-direct the funding elsewhere following, for example, budgetary or position cuts. Consultation and mediation between parties will precede any variations to this Agreement.

Schedule D – AMYOS Model of Service

Refer Attachment A

The Parties to this Agreement have executed the Agreement on the dates set out below.

EXECUTED AS AN AGREEMENT	
EXECUTION BY CUSTOMER:	
Signed for and on behalf of the **State of Queensland** acting through the **Children's Health Queensland Hospital and Health Service**	
by	
………………………………………….………… (insert name of Customer representative)	………………………………………………… (signature of Customer representative)
………………………………………….………… (insert name of Customer representative)	………………………………………………… (signature of Customer representative)
this ……….. day of …………………………2013	
In the presence of:	
……………………………………………………… (insert name of witness)	………………………………………………… (signature of witness)

EXECUTION BY PROVIDER:	
Signed for and on behalf of	
……………………………………………………… **(HHS to complete)** (ABN:)	
in accordance with s.127 of the Corporations Act 2001 (Cth)	
this ……….. day of ……………………………2014	
by	
……………………………………………………… (insert name of Director)	………………………………………………… (signature of Director)
……………………………………………………… (insert name of Director/Secretary)	………………………………………………… (signature of Director/Secretary)
in the presence of	
……………………………………………………… [insert name of witness]	………………………………………………… (signature of witness)

Where an attorney or other agent executes this Contract on behalf of a Contractor, the form of execution must indicate the source of this authority and such authority must be in the form of a Contract and a certified copy thereof provided to the State.

Privacy Statement - The Customer collects Personal Information from the Provider for the purpose of administering the Agreement. This Personal Information may be disclosed to Queensland Government departments or agencies, Queensland Government Bodies, Non-Government Organisations and/or Commonwealth, States or Territories for the purpose of administering the Agreement, or made publicly available in accordance with the requirements of the Queensland Procurement Policy. Personal information will not otherwise be disclosed to any other third party without consent of the Provider, except where authorised or required by law.

CHQ 004/2014 – Adolescent Residential Rehabilitation Unit

AGREEMENT

FOR THE PROVISION OF SERVICES

Between

THE CUSTOMER

and

THE PROVIDER

(Part A- Conditions of Agreement)

THIS AGREEMENT is made:

BETWEEN: The entity specified in Item 1 of Schedule A

('Customer')

AND: The entity specified in Item 3 of Schedule A

('Provider')

BACKGROUND

A. The Customer requires the Services.

B. The Provider has agreed to supply Services to the Customer on the terms of this Agreement.

CONDITIONS OF AGREEMENT

1. DEFINITIONS AND INTERPRETATION

1.1 Definitions

In these Conditions of Agreement, unless the context otherwise requires, the following definitions will apply:

Agreement means a legally binding contract as agreed between the Customer and Provider constituted by the documents specified in clause 2;

Agreement Material means New Agreement Material and Existing Agreement Material;

Agreement Term means the term of this Agreement, as set out in clause 3;

Annual Financial Report means an Annual Financial Report as required be clause 35.1(b);

Approved Expenses means the Provider's expenses (if any) which have been agreed between the Customer and Provider, and approved by the Customer prior to any expenditure being incurred, as specified in Item 2 Schedule D;

Assets includes land, buildings, plant, furniture, computing hardware, vehicles, white goods, kitchen items, photocopiers and other equipment acquired with the Funds for the provision of the Services;

Auditor or Accountant means

(a) for a Provider that is Local Government – the Local Government's accounting officer or chief executive officer as the case may be; or

(b) for other Providers – a member or person eligible to be a member of the Institute of Chartered Accountants in Australia or CPA Australia, who is currently in practice and is not an officer, employee, subcontractor or member of the Organisation.

Business Day means between 9.00am and 5.00pm on a day other than a Saturday, Sunday or public holiday at the Customer's address;

Claim includes (and is not limited to) any claim (whether ascertained or unascertained), action, demand, application, proceeding, judgement, enforcement hearing or enforcement order;

Clients means clients of the type described in the schedules;

Commencement Date means:

(a) the date specified in Item 5 of Schedule A; or

(b) if no date is specified, the date of execution of the Agreement, and if the Agreement is executed by the Parties on different dates, the date the last Party to the Agreement has executed the Agreement.

Completion Date means the date specified in Item 6 of Schedule A or otherwise agreed in writing between the Parties, and includes an extension of that date in accordance clause 3.2;

Conditions of Agreement means these terms and conditions of Agreement and the attached Schedules;

Confidential Information means information of, or supplied by, the Customer that:

(a) is by its nature confidential;

(b) is designated as confidential;

(c) the Provider knows or ought to know is confidential; and includes information;

(d) comprised in or relating to any Intellectual Property Rights of the Customer;

(e) concerning the internal management and structure, personnel, processes and policies, commercial operations, financial arrangements or affairs of the Customer;

(f) that is of actual or potential commercial value to the Customer; and

(g) relating to the clients or suppliers of the Customer;

but does not include information that:

(h) was already in the possession of the Provider and not subject to an obligation of confidentiality

(i) is lawfully received from a third party or independently developed by the Provider; or

(j) is public knowledge other than through a breach of an obligation of confidentiality;

Conflict of Interest means having an interest (whether personal, financial or otherwise) which conflicts or may reasonably be perceived as conflicting with the ability of the Provider to perform its obligations under the Agreement fairly and objectively;

Correctly Rendered Invoice means an invoice:

(a) in which the amount claimed is due for payment in accordance with the Agreement;

(b) in which the amount claimed is correctly calculated in accordance with the Agreement;

(c) which correctly identifies the Services supplied;

(d) which, if GST applies is a valid tax invoice under the GST Legislation; and

(e) which complies with clause 11.4.

Customer means the State of Queensland or other entity specified in Item 1 of Schedule A;

Customers Authorised Officer means the person specified in Item 2 of Schedule A, who is the Customers representative and point of contact for the Agreement;

Deliverable means the Services and any other thing the Provider is required to deliver to the Customer in connection with the Services;

Delivery Date means the date specified in Item 7 of Schedule A in which the Services will be performed by the Provider;

Delivery Period means the period specified in Item 7 of Schedule A in which the Services will be performed by the Provider;

Department of Health means the State of Queensland acting through Queensland Health;

Disability Services means those Disability Services identified in this Agreement and/or any Schedule attached to it relative to the DS NMDS Service Types as defined in the current DS NMDS;

Document includes:

(a) any paper or other material on which there is writing;

(b) any paper or other material on which there are marks, figures, symbols or perforations having a meaning for persons qualified to interpret them;

(c) any article or material from which sounds, images or writings are capable of being reproduced with or without the aid of any other article or device; or

(d) a document in electronic form;

Entitlements include any wages, salary, overtime, allowances, superannuation, leave accruals or any other payment to which the Key Personnel is entitled in respect of the performance of the Services as a result of their relationship with the Provider;

Existing Material means any material which contains Intellectual Property Rights in existence before the Commencement Date;

Exit Strategy means the exit strategy identified in this Agreement which the parties much implement and follow to exit the Agreement;

Financial Security means the unconditional financial security in a form set out in the '*Supplementary Provisions - Conditions of Offer and Conditions of Contract'* document – *'Financial Security'* which is available from the Department of Housing and Public Works' website: *www.hpw.qld.gov.au* under '*Supply and disposal/Government procurement*' or other form of unconditional financial security in a form acceptable to the Customer, as specified in Item 28 of Schedule A;

GST means a goods and services tax imposed by or through the GST Legislation;

GST Amount means the amount of GST payable in respect of any taxable supply under the Agreement, calculated at the rate of GST applicable at the time;

GST Legislation means *A New Tax System (Goods and Services Tax) Act 1999* (Cth) and any related tax imposition law (whether imposing tax as a duty of customs excise or otherwise) and includes any legislation which is enacted to validate, recapture or recoup the tax imposed by any of such laws;

Hospital and Health Service means a Hospital and Health Service established under s 17 of the *Hospital and Health Boards Act 2011* (Qld).

Intellectual Property Rights means all registered and unregistered rights in Australia and throughout the world for:

(a) copyright;

(b) trade or service marks;

(c) designs;

(d) patents;

(e) semiconductors or circuit layouts;

(f) source codes and object codes;

(g) trade , business or company names;

(h) indications of source or appellations of origin;

(i) trade secrets;

(j) know-how and confidential information;

(k) the rights to registration of any of the above; and

(l) the right to bring action for infringement of any of the above,

but excludes Moral Rights;

Key Personnel means the representatives of the Provider specified in Item 9 of Schedule A;

Loss includes (and is not limited to) any loss, liability, tax, prohibition, penalty, fine or expense, including by way of negligence;

Machinery of Government Change means a transfer of responsibility, function or operations, in whole or in part, from a Queensland Government department or agency or Queensland Government Body to another Queensland Government department or agency or Queensland Government Body;

Mater Public means the Mater Misericordiae Health Services Brisbane Ltd ACN 096 708 922 acting under arrangements under the *Mater Public Health Services Act 2008* (Qld);

Moral Rights means the right of integrity of authorship, the right of attribution of authorship and the right not to have authorship falsely attributed, more particularly as conferred by the *Copyright Act 1968* (Cth), and rights of a similar nature anywhere in the world whether existing before, on or after the Commencement Date;

National Disability Agreement (NDA) means the agreement that provides the national framework for the provision of government support to services for people with a disability. The NDA replaces the Commonwealth-State/Territory Disability Agreement (CSTDA);

New Agreement Material means any Intellectual Property Rights in materials which come into existence through the performance of the Services under this Agreement;

Non-Government Organisation or NGO means a body (including a private school), other than a Queensland Government department, agency or Queensland Government Body, which is:

(a) directly or indirectly, partially or entirely funded by the State of Queensland;

(b) a community based, non-profit making organisation performing community services; and/or

(c) another entity, from time to time approved by the State of Queensland acting through the Department of Housing and Public Works - Queensland Government Chief Procurement Office to procure Services in accordance with the Agreement;

Notice means a notice in writing under or in connection with the Agreement from one Party to the other Party; notice

Occurrence means either a single occurrence, or a series of occurrences, which arise out of or in connection with the same circumstances;

Optional Extension Period means a period, or periods, specified as such in Item 8 Schedule A

Party means each of the Customer and the Provider;

Performance and Statistical Reports means performance and statistical reports as required by Clause 36;

Performance Guarantee means the performance guarantee, in a form set out in the '*Supplementary Provisions - Conditions of Offer and Conditions of Contract'* document – *'Performance Guarantee'* which is available from the Department of Housing and Public Works' website: *www.hpw.qld.gov.au* under '*Supply and disposal/Government procurement*'

or other form of performance guarantee in a form acceptable to the Customer, as specified in Item 27 of Schedule A;

Periodic Financial Report means a periodic financial report as required by clause 35;

Personal Information is information or an opinion, including information or an opinion forming part of a database, whether true or not, and whether recorded in a material form or not, about an individual whose identity is apparent, or can reasonably be ascertained, from the information or opinion;

Price and **Pricing** means the itemised prices and/or the price calculated by reference to a schedule of rates payable by the Customer for a Deliverable, as specified in Schedule D and (unless otherwise specified in Schedule C) is exclusive of GST and inclusive of packaging, handling, freight, and all other duties, taxes and charges;

Provider means the entity specified in Item 3 of Schedule A;

Provider's Authorised Officer means the person nominated in Item 4 of Schedule A, being the person nominated by the Provider to oversee and supervise the performance of the Provider's obligations under this Agreement (or other person nominated from time to time by the Provider);

Queensland Government Body means any of:

(a) a body corporate or an unincorporated body established or constituted for a public purpose by the State of Queensland legislation, or an instrument made under that legislation (including a local authority);

(b) a body established by the State of Queensland through the Governor or a Minister; or

(c) an incorporated company over which the State of Queensland exercises control;

Queensland Public Health System (QPHS) means any of:

(a) Department of Health (DoH); or

(b) any division, branch or unit of any Hospital and Health Service and Mater Public;

Records means all material including but not limited to books, documents, information, computer software, equipment, and data stored by any means disclosed, or made available, by the Customer to the Provider in connection with the performance of the Agreement and includes a copy of such material;

Schedule means the schedules which are Part B of the Agreement;

Services means the services described in Part B – Agreement Schedules and any tasks connected with performing those services, and include the individual service items requested by the Customer under the Agreement throughout the Agreement Term.

Services Type means the NMDS classified Services Group of seven (7) categories also known as **Service Groups**: accommodation support; community support; community access; respite; employment; advocacy; information and alternative forms of communication.

Site means the place or places as specified in Item 10 of Schedule A where the Services are to be supplied and/or delivered;

Special Conditions means the additional terms and conditions nominated as applicable in this Part A forming part of this Agreement;

Specifications means the detailed description of the Customer's requirements in Part B – Agreement Schedules; and

Term refer to definition of Agreement Term.

1.2 Interpretation

(a) In these Conditions of Agreement, the index and clause headings have been inserted for ease of reference only and are not intended to affect the meaning or interpretation

of these Conditions of Agreement.

(b) The following rules apply in interpreting these Conditions of Agreement, unless the context otherwise requires:

(i) words importing a gender include the other gender;

(ii) words in the singular include the plural and vice versa;

(iii) all dollar amounts refer to Australian currency;

(iv) a reference to any legislation includes any subordinate legislation made under it and any legislation amending, consolidating or replacing it;

(v) a reference to an entity or person includes an individual, corporation, partnership or other legal entity;

(vi) a party includes its executors, administrators, liquidators, successors and permitted assigns;

(vii) "consent" means prior written consent;

(viii) "in writing" means either by letter, email or facsimile;

(ix) a reference to a clause, attachment or annexure is a reference to a clause, attachment or annexure to these Conditions of Agreement;

(x) if a day on which an act is to be done is a Saturday, Sunday or public holiday in the place where the act is to be done, the act may be done on the next Business Day in that place, unless the Parties agree otherwise;

(xi) if any expression is defined, other grammatical forms of that expression will have corresponding meanings, unless the context otherwise requires;

(xii) a reference to a clause is a reference to all of its sub-clauses;

(xiii) a document or agreement or a provision of a document or agreement, is a reference to that document, agreement or provision as amended, supplemented, replaced or novated; and

(xiv) a Schedule forms part of the document to which it is attached.

2. FORMATION OF AGREEMENT

2.1 The following Documents constitute the entire Agreement between the Customer and Provider:

(a) These Part A Conditions of Agreement, including the Special Conditions;

(b) the Schedules to this Agreement at Part B; and

(c) any annexures or attachments, referred to in these Part A – Agreement Conditions or Part B – Agreement Schedules.

2.2 Subject to clause 2.3, in the event of any conflict between the Documents specified in clause 2.1, the order of precedence to resolve the conflict will be in the above order.

2.3 Any Special Conditions which purport to take away or reduce the entitlements that would otherwise be provided to the Customer under clause 31 are null and void.

2.4 The Agreement supersedes all prior representations, agreements, statements and understandings between the Customer and Provider, whether oral or in writing relating to the subject matter of the Agreement

3. AGREEMENT TERM

3.1 Subject to clauses 3.2 and 3.3, this Agreement will commence on the Commencement Date and, unless terminated sooner pursuant to clause 29, will continue until the Completion Date.

3.2 The Customer may, at its entire discretion, extend the Agreement Term for the Optional Extension Period by Notice to the Provider given at least one month prior to the Completion Date. If the Agreement Term is extended by the Optional Extension Period then the Completion Date will change to the date at the end of the Optional Extension Period and the reference to the right which has been exercised for the Optional Extension Period will be deleted.

3.3 If the Deliverables have not yet been provided to the Customer by the Completion Date, in the entire discretion of the Customer, the Customer may:

(a) extend the Term; or

(b) terminate the Agreement pursuant to clause 29.

3.4 An extension of the Term pursuant to clause 1.1.1(a) will not:

(a) constitute a waiver by the Customer of any other rights it may have under this Agreement or at common law in relation to the Provider's failure to perform the Services by the Completion Date; or

(b) entitle the Provider to recover any payment for any services other than those services which the Provider was contracted to provide by the Completion Date.

4. TRANSFERABILITY / PORTABILITY OF SERVICES

4.1 Notwithstanding any provision of the Agreement, the Customer is entitled, by giving a Notice to the Provider, to freely transfer its rights and responsibilities, including the use of and title to any Services under the Agreement, either in whole or in part, to a Queensland Government department or agency that is part of the same legal entity as the Customer.

4.2 Notwithstanding any provision of the Agreement, the Customer is entitled, by giving a Notice to the Provider, to freely transfer its rights and responsibilities under the Agreement, either in whole or in part, to a Queensland Government department or agency or Queensland Government Body that is not part of the same legal entity as the Customer, but only as a consequence of a Machinery of Government Change.

4.3 If clause 4.2 applies the Provider must execute a deed of novation in a form acceptable to the Customer, and return it to the Customer within five (5) Business Days from receipt of a Notice from the Customer advising of the transfer and requiring the Provider to execute the deed of novation.

4.4 If the Services are transferred in accordance with clause 4.1 or 4.2, the Provider:

(a) must immediately notify the Customer of any reduction in costs, including but not limited to volume discounts, which may occur; and

(b) must notify the Customer of any proposed additional fees for any additional costs directly incurred as a result of the provision of additional overall Services.

4.5 The Provider agrees to negotiate with the Customer in good faith to vary or consolidate the Agreement to:

(a) adjust the Price as a result of the notification of the matters raised in clause 4.4; and/or

(b) comply with any specific requirements of the Customer to which its rights and responsibilities, including the use and title to any Services are, or will be, freely transferred in accordance with clause 4.1 or 4.2.

5. ROLE OF THE CUSTOMER'S AUTHORISED OFFICER

5.1 The Customer's Authorised Officer will be the primary liaison and contact officer between the Customer and the Provider and is authorised to give notices and consents under this Agreement on the Customer's behalf.

5.2 The Provider's Authorised Officer is the primary liaison and contact officer between the Provider and the Customer and is authorised to give notices and consents under this Agreement on the Provider's behalf.

5.3 The Provider's Authorised Officer must:

(a) liaise with and report to the Customer's Authorised Officer about the performance of the Services;

(b) attend meetings with, or provide briefings to, the Customer's Authorised Officer as required from time to time; and

(c) promptly comply with any request or direction given by the Customer's Authorised Officer about the supply and performance of the Services.

6. PROVISION OF THE SERVICES

6.1 The Provider agrees to supply and perform the Services, as an independent contractor, for the Agreement Term in a competent and professional manner.

6.2 The Provider must provide the Services:

(a) on the Delivery Date or during the Delivery Period;

(b) by the milestone dates (if milestones are specified in Item 11 of Schedule A);

(c) by the Completion Date; and

(d) if the Services are periodic or recurrent Services, at the times, intervals and frequency as specified in Item 12 of Schedule A.

6.3 In supplying and performing the Services, the Provider must:

(a) inform itself of the Customer's requirements in respect of the Services;

(b) consult regularly with the Customer and/or Customer's Authorised Officer; and

(c) exercise due skill, care and diligence.

6.4 The Provider must ensure that all Services are of a high quality, professional standard and are fit for purpose.

6.5 The Customer will provide the assistance (if any) described in Item 14 of Schedule A to the Provider.

6.6 If nominated as applicable within Item 13 of Schedule A the Provider must meet the KPIs set out in Schedule A, at the times set out in Schedule A and comply with the following terms:

(a) the Provider must submit any reasonable documentation required by the Customer by notice in writing for the Customer to assess the Provider's performance against the KPIs;

(b) if the Provider fails to meet the KPIs set out in the Schedule then a show cause event will have occurred and the Provider's Authorised Officer must meet with the Customer within 5 days of any Notice to discuss the Provider's plan to remedy its failure to meet the KPIs; and

(c) if the Customer is not satisfied with the Provider's plan the Customer is entitled to proceed to terminate the contract for breach in accordance with clause 29.

7. REQUIREMENTS FOR SERVICES

7.1 All Services provided by the Provider to the Customer in accordance with the Agreement, unless otherwise specified by the Customer, must comply in all aspects with:

(a) the terms of the Agreement, including but not limited to the Specifications;

(b) applicable legislative requirements;

(c) any applicable Government code, policy or guideline; and

(d) any current Australian/New Zealand Standard and where an Australian/New Zealand Standard does not exist, the relevant current International Standard (ISO),

including any that may be introduced or varied during the Agreement Term, which govern the provision of the Services.

8. PROVIDER'S OBLIGATIONS

8.1 The Provider will be responsible for the supply and/or performance of all personnel and/or equipment, necessary for the proper supply of the performance of the Services.

8.2 When supplying and performing the Services, the Provider must:

(a) take all measures to protect people and property;

(b) avoid unnecessary interference with the passage of people and vehicles; and

(c) prevent nuisance and unreasonable noise and disturbance.

8.3 The Provider warrants that:

(a) it has the necessary skills and expertise to complete the Agreement;

(b) it will ensure that the Provider and its officers, employees, agents and sub-contractors (including the Key Personnel) have the necessary skills, the licences, qualifications, certifications, registrations, admissions and memberships required to perform the Services; and

(c) it has obtained or effected all authorisations required in connection with the performance of this Agreement and these authorisations will be in full force and effect on every day of this Agreement and the Provider is not in nor will it be in material default of any of the terms and conditions of the required authorisations during the Term.

9. PERFORMANCE OF SERVICES BY KEY PERSONNEL

9.1 Where the Key Personnel are specified, the Services must be performed by the Key Personnel as specified in Item 9 of Schedule A, unless the Customer has consented otherwise. If the Provider proposes a change to Key Personnel it must submit material about the proposed new Key Personnel to the Customer which is reasonably required by the Customer, including resumes and evidence of qualifications. A person replacing one of the Key Personnel, with the Customer's consent, will be considered to be one of the Key Personnel during the person's engagement to provide the Services.

9.2 The Provider must ensure that the Key Personnel are competent and have the necessary skills and expertise to perform the Services on which they will be engaged.

9.3 The Provider must not, without consent from the Customer:

(a) allow Key Personnel to delegate any part of the Services; or

(b) allocate tasks not connected with the Services to any of the Key Personnel who are engaged on the Services on a full time basis, until the Services allocated to that person have been completed by that person.

9.4 If any of the Key Personnel are not available to perform any of the Services allocated to them, the Provider must immediately:

(a) notify the Customer of the circumstances; and

(b) if so requested by the Customer, arrange for replacement of that person with a person satisfactory to the Customer, at no cost to the Customer.

9.5 The Customer may, on reasonable grounds, give Notice to the Provider to remove any Key Personnel from working on the Services. Upon receipt of such Notice under this clause 9.5, the Provider must, at no cost to the Customer, promptly remove and replace the Key Personnel mentioned in the Notice with a person approved by the Customer.

10. LIST OF SERVICES AND PRICING

10.1 If the Services are provided in accordance with the Agreement, the Customer will:

(a) upon receipt of a Correctly Rendered Invoice, pay the Provider the Price in accordance with clause 11 and Schedule C - Pricing; and

(b) reimburse the Provider for the Approved Expenses, after the Approved Expenses

have been incurred by the Provider.

10.2 The Customer will not be liable to reimburse the Provider for expenses other than the Approved Expenses as specified in Schedule C (if any), unless the Provider has obtained the Customer's consent prior to any expenditure being incurred.

10.3 The Price will be payable in the manner and at the times specified in Schedule C and the Provider must submit a Correctly Rendered Invoice for the Price at the times specified in Schedule C.

10.4 Where the Provider seeks to increase or decrease the Price for the Services it must take into consideration:

(a) movements in the relevant published Australian Bureau of Statistics (ABS) Index (e.g. consumer price or producer price index), as it affects the Services, if specified in Schedule C;

(b) other factors as it affects the Services, if specified in Schedule C; and/or

(c) any variation in any tax, duty or charge as it affects the Services,

the Provider must give Notice to the Customer in accordance with clause 30 and such Notice must include evidence to substantiate the basis of the Price increase or decrease.

10.5 If the Provider's request to increase or decrease the Price for the Services is rejected by the Customer in its absolute discretion, the Agreement will remain unvaried.

10.6 The Provider must notify the Customer of price variations under Schedule C which result in a decrease of the Price within 30 days of the variation. If the Provider fails to do so the Provider must pay to the Customer default interest on any part of the Price paid which exceeds the varied price until that part has been refunded to the Customer. The default interest accrues from day to day at the Reserve Bank of Australia 90 day bank accepted bills rate.

10.7 If the Approved Expenses are travel expenses, the Customer will not pay any amounts in excess of the amounts specified in Directive No 9/11 "Domestic Travelling and Relieving Expenses" and the "Department of Health Travel and Accommodation Policy" as amended from time to time.

10.8 If the Approved Expenses are air travel expenses, the Customer will not pay any amount in excess of the cost of economy class airfares.

11. PAYMENT

11.1 The Customer is not obliged to pay the Provider the Price for any part of the Services until the:

(a) Provider has delivered to the Customer any Deliverables;

(b) Customer has certified that the Deliverables specified in the Correctly Rendered Invoice have been supplied and/or performed in accordance with the Agreement; and

(c) Provider has given the Customer a Correctly Rendered Invoice.

11.2 Despite any previous certification in accordance with clause 1.1.1(b) the Provider must promptly supply or supply again, any part of the promptly perform or perform again, any part of the Services, certified by the Customer as not having been supplied and/or performed in accordance with the Agreement. The Customer may, without limiting any other rights it may have, defer payment for that part of the Services until the Customer is satisfied that the Services have been supplied or supplied again and/or performed or performed again, in accordance with the Agreement.

11.3 The Provider must submit a Correctly Rendered Invoice to the Customer.

11.4 The Correctly Rendered Invoice submitted by the Provider must:

(a) specify the Services and the name of the Customer's Authorised Officer (if applicable);

(b) identify any contract number and specific details pertaining to the Agreement (if applicable);

(c) include sufficient details to allow the Customer to assess progress against milestones (if applicable);

(d) for Services carried out on a time basis, be supported by records of time spent by individuals involved in the Services and verified by the Provider;

(e) itemise Approved Expenses claimed; and

(f) identify any discounts given.

11.5 Upon receipt of a Correctly Rendered Invoice, the Customer may require the Provider to provide additional information or documentary evidence to enable the Customer to determine whether or not an amount is payable.

11.6 A Customer will make payment of a Correctly Rendered Invoice 30 days after the end of the month in which the Correctly Rendered Invoice is received, or if additional information is required by the Customer pursuant to clause 11.4 then 30 days after receipt of the additional information.

11.7 Payment of any amount to the Provider will not constitute an admission by the Customer that the Services have been properly provided in accordance with this Agreement.

11.8 The Customer may deduct from any moneys due to the Provider any sum which is payable by the Provider to the Customer whether or not the Customer's right to payment arises by way of damages, debt, restitution or otherwise and whether or not the factual basis giving rise to the Customer's right to payment arises out of the Agreement, any other contract, or is independent of any contract.

12. GST

12.1 In this clause "adjustment event", "adjustment note", "GST", "supply", "supplier" and "tax invoice" have the same meaning as defined in A New Tax System (Goods and Services Tax) Act 1999 (Cth) ("the GST legislation").

12.2 The Provider acknowledges that in terms of the GST legislation it will, under this Agreement, be a "supplier" and may be required to pay GST to the Commissioner of Taxation.

12.3 The parties agree that the Prices specified under the Agreement are GST exclusive prices.

12.4 The Provider must ensure that all tax invoices and adjustment notes rendered to the Customer under the Agreement are in a format that identifies any GST paid, and which permits the Customer to claim an input tax credit.

12.5 Subject to clause 12.6 for a supply under this Agreement subject to GST, the Customer must pay to the Provider an amount equal to the GST payable for that supply.

12.6 Where a party is required under this Agreement to pay or reimburse an expense or outgoing of another party, the amount to be paid or reimbursed by the first party will be the sum of the amount of the expense or outgoing less any input tax credits in respect of the expense or outgoing to which the other party, or to which the representative member for a GST group of which the other party is a member, is entitled.

12.7 The Provider must issue an adjustment note to the Customer on or before seven days after the occurrence of an adjustment event. The Customer request for an adjustment note shall be deemed to have occurred on the date of the adjustment event. The adjustment note must identify the services relevant to the adjustment event. Adjustment notes issued to the Customer must comply with the requirements of the GST legislation. Where an adjustment event occurs, the amount of GST payable under clause 12.5 will be recalculated to reflect the adjustment event and a payment will be made by the recipient to the supplier or by the supplier to the recipient as the case requires.

12.8 If the amount of GST recovered from the Customer under this Agreement differs, for any reason, from the amount of GST paid or payable by the Provider to the Commissioner of Taxation, including by reason of:

(a) an amendment to the GST legislation;

(b) the issue of or an alteration in a ruling or advice of the Commissioner of Taxation;

(c) a refund of GST to the Provider in respect of any supply made under this Agreement;

(d) a decision of any tribunal or court;

then, subject to obtaining the written approval or instruction from the Customer, the difference in amounts will be paid by or to the Customer as the case may be.

12.9 The Customer is authorised to withhold from payments to the Provider, a subcontractor or worker such amounts as are required under the Pay as You Go (PAYG) system.

13. COMMISSIONS, INCENTIVES AND COLLUSION

13.1 The Provider must not, and must ensure that its officers, employees, agents and/or sub-contractors do not, give or offer anything to the Customer or any officer or employee of the Customer, or to a parent, spouse, child or associate of an officer or employee of the Customer, including any commission, inducement, gift or reward, which could in any way tend or be perceived as attempting to influence the Customer's actions in relation to the Agreement.

13.2 If the Customer discovers at any time during the Agreement Term that the Provider has breached clause 13.1, the Customer may, in addition to any other action, elect to suspend the Agreement in accordance with clause 28 or terminate the Agreement in accordance with clause 29.

13.3 The Provider will make sure that none of:

(a) the Provider;

(b) a related body corporate of the Provider; or

(c) the Personnel of the Provider or a related body corporate of the Provider,

receives any money, payment or thing of value (including any disclosed or undisclosed commission, rebate, allowance or other benefit) relating in any way to the performance of this Agreement unless approved in writing by the Customer, other than payment of salaries, wages and entitlements in the ordinary course of business by an employer to its employees.

14. COLLUSION

14.1 The Provider warrants to the Customer that:

(a) except as is expressly disclosed to the Customer, its Offer was not prepared (and any variations to the Agreement will not be prepared) with any consultation, communication, contract, arrangement or understanding with any competitor (including a contractor under a similar contract with the Customer) regarding:

(i) prices;

(ii) methods, factors or formulas used to calculate prices;

(iii) the intention or decision to submit or not submit an offer (or request a variation) to the Agreement;

(iv) the submission of an offer (or a request for variation) that is non conforming with the terms of the Agreement;

(v) the quality, quantity, specifications or delivery particulars of services (including the Services) to which the Agreement relates; or

(vi) the terms of the Offer (or variation) or a competitor's offer (or variation);

(b) except with the consent of the Customer:

(i) it has not provided any benefit (including money) directly or indirectly to, or entered into any contract, arrangement or understanding to provide any benefit (including money) directly or indirectly, to any competitor (including any

contractor under a similar contract with the Customer) relating in any way to the Agreement;

(ii) it has not received any such benefit directly or indirectly, or entered into any contract, arrangement or understanding to receive any such benefit directly or indirectly from any competitor (including any contractor under a similar Agreement similar contract with the Customer) relating in any way to the Agreement; and

(iii) it will not provide or receive any such benefit;

(c) except as is expressly disclosed to the Customer, it has not consulted, communicated or entered into any contract, arrangement or understanding to provide any benefit (including money), whether directly or indirectly, to a trade, industry or other association (above the published standard fee) relating in any way to the Agreement, nor has it provided, nor will it provide any such benefit;

(d) except as is fully disclosed in the Agreement, at the time of entering into the Agreement, the Provider and all corporations and persons associated with the Provider, including directors and senior management, are not and have never been subject to proceedings relating to anti-competitive conduct in Australia or overseas; and

(e) the Provider will notify the Customer immediately upon becoming aware that the Provider or any corporation or person associated with the Provider, including a director or member of senior management becomes subject to proceedings relating to anti-competitive conduct in Australia or overseas during the Agreement Term by disclosing, at a minimum:

(i) the names of the parties to the proceedings;

(ii) the case number;

(iii) the general nature of the proceedings; and

(iv) the outcome or current status of the proceedings.

14.2 The Provider acknowledges that the Customer has entered into the Agreement in reliance of the warranties in clause 14.1.

14.3 If the Provider breaches clause 14.1, without limiting its rights under the Agreement, the Customer may:

(a) deduct from any moneys due to the Provider under the Agreement, an equivalent sum as an amount due from the Provider to the Customer; and

(b) at its entire discretion terminate the Agreement in accordance with clause 29.3(b) and claim damages for breach of the Agreement.

15. CONFLICT OF INTEREST

15.1 The Provider warrants that, to the best of its knowledge, as at the Commencement Date neither the Provider nor any of its officers, employees, agents and/or sub-contractors (including the Key Personnel) have, or are likely to have, a Conflict of Interest in the performance of the Provider's obligations under the Agreement.

15.2 If a Conflict of Interest or risk of Conflict of Interest arises during the Agreement Term (without limitation, including work undertaken by the Provider for any entity other than the Customer), the Provider must immediately give Notice of the Conflict of Interest, or the risk of it, to the Customer.

15.3 The Provider must:

(a) take all reasonable measures to ensure that its officers, employees, agents and sub-contractors (including the Key Personnel) do not engage in any activity or obtain any interest which is in conflict with the Provider's ability to supply and perform the Services for the Customer in good faith and objectively; and

(b) immediately give Notice to the Customer of any Conflict of Interest relating to the activities or interests of any of its officers, employees, agents and/or sub-contractors (including the Key Personnel).

15.4 Upon receipt of a Notice in accordance with clause 15.2 or 1.1.1(b), or upon the Customer otherwise identifying a Conflict of Interest, the Customer may:

(a) direct the Provider as to how to manage the Conflict of Interest and the Provider must comply with any reasonable direction so given by the Customer;

(b) suspend the Agreement in accordance with clause 28; or

(c) elect to terminate the Agreement in accordance with clause 1.1.1(c).

15.5 If clause 1.1.1(a) or 1.1.1(b) applies, the Provider must give Notice to the Customer when the Conflict of Interest or risk of Conflict of Interest is resolved.

16. INTELLECTUAL PROPERTY RIGHTS AND MORAL RIGHTS

16.1 Title to, and Intellectual Property Rights in, all New Agreement Material will, upon its creation, vest in the Party specified in Item 15 of Schedule A.

16.2 If Item 15 of Schedule A is blank, title to, and Intellectual Property Rights in, New Agreement Material vests in the Customer.

16.3 If Item 15 of Schedule A specifies that this clause 16.3 applies, or if clause 16.2 applies, title to, and Intellectual Property Rights in, New Agreement Material will upon its creation vest in the Customer, and:

(a) the Provider must ensure that during the Agreement Term the New Agreement Material and Records are used, copied, supplied or reproduced only for the purposes of the Agreement; and

(b) after the expiration or sooner termination of the Agreement (or some earlier date if required by the Customer), the Provider must deliver to the Customer, in a format specified by the Customer, all New Agreement Material and Records.

16.4 If Item 15 of Schedule A specifies that this clause 16.4 applies, title to, and Intellectual Property Rights in, New Agreement Material will, upon its creation, vest in the Provider and the Provider grants, and will ensure that relevant third parties grant, to the Customer a paid-up, non-exclusive, non-transferable, irrevocable, perpetual licence (including the right to sub-licence) in respect of the New Agreement Material (and any future development of that New Agreement Material), without additional cost to the Customer to:

(a) use, exploit and otherwise exercise all Intellectual Property Rights, for any purpose of the Customer, the State of Queensland and/or a Queensland Government Body; and

(b) use or exploit (whether commercially or otherwise) for any purpose.

16.5 The Agreement does not affect Intellectual Property Rights in Existing Agreement Material but the Provider grants, and will ensure that relevant third parties grant, to the Customer a paid up, non-exclusive, non-transferable, irrevocable, perpetual licence (including the right to sub-licence) in respect of the Existing Agreement Material but only as part of the Agreement Material (and any future development of the Agreement Material), without additional cost to the Customer to:

(a) use, exploit and otherwise exercise all Intellectual Property Rights for any purpose of the Customer, the State of Queensland and/or a Queensland Government Body; and

(b) use or exploit (whether commercially or otherwise) for any purpose, if clauses 16.2, 16.3 or 1.1.1(b) applies.

16.6 Intellectual Property Rights in Records will remain vested in the Customer.

16.7 If the Provider is an individual, the individual consents to any act or omission done by the Customer in the exercise of the Intellectual Property Rights in the Agreement Material

granted under the Agreement that might otherwise constitute an infringement of the individual's Moral Rights and without limiting this, the individual consents to:

(a) the Customer determining in its entire discretion whether or not the individual will be attributed as author of the Agreement Material comprised in a Deliverable and if the individual will be attributed, that attribution will occur in a manner acceptable to the Customer;

(b) any amendments, deletion, destruction, alteration, relocation or selection of the Agreement Material (or any part thereof) at the entire discretion of the Customer;

(c) the publication or communication, in whole or in part of the Agreement Material; and

(d) any other acts or omissions as specified in Item 16 of Schedule A.

16.8 If the Provider engages an individual, whether an employee, sub-contractor or volunteer, to perform work under the Agreement, the Provider must, prior to allowing that individual to commence work in respect of a Deliverable, obtain from that individual, who is to create New Agreement Material:

(a) all consents, permissions and assignments necessary to enable the Customer to exercise the Intellectual Property Rights granted under the Agreement in full, without impediment or cost to the Customer; and

(b) without limiting clause 1.1.1(a), a consent from the individual to any act or omission by the Customer in the exercise of the Intellectual Property Rights in the Agreement Material granted under the Agreement that might otherwise constitute an infringement of the person's Moral Rights, including a consent to the acts or omissions specified in clause 1.1.1(a) to (d).

17. CONFIDENTIALITY

17.1 The Provider must ensure that Confidential Information is kept confidential and not disclosed to any person except:

(a) to its employees, officers and agents to the extent needed for the performance of this Agreement;

(b) where required by law; or

(c) with the Customer's consent.

17.2 The Provider must not use Confidential Information for any purpose other than performing the obligations under this Agreement, unless required or authorised by Law. Without limiting the foregoing, the Provider acknowledges that it shall not:

(a) exploit the Confidential Information of the Customer;

(b) use the Confidential Information for the Provider's own business purposes without authorisation from the Customer; or

(c) make copies in any format of the Confidential Information without the express authorisation of Customer or in accordance with this Agreement.

17.3 The Provider must:

(a) take all steps necessary to protect the Confidential Information from misuse, loss, and unauthorised access, use, modification or disclosure;

(b) immediately notify the Customer if it becomes aware of any breach of this clause 17, or if a disclosure of Confidential Information is required by law before such disclosure is made;

(c) on the termination or expiration of this Agreement or earlier if requested by the Customer during the term of this Agreement, deliver or destroy (as directed by the Customer) all documents, records or files in its possession or control which contain Confidential Information in accordance with the Customer's instructions; or

(d) if requested by the Customer, obtain from its officers, employees, agents and

contractors a deed of confidentiality in a form acceptable to the Customer.

17.4 For the avoidance of doubt, the Provider warrants that all officers, employees, agents and contractors (including the Key Personnel) involved in performing certain service items will be bound by this clause.

17.5 The Provider acknowledges that:

(a) the value of the Confidential Information of the Customer is such that any award of damages or account of profits may inadequately compensate the Customer in the event of a breach of this Agreement by the Provider; and

(b) without in any way compromising the Customer's right to seek damages or any other form of relief, the Customer may seek and obtain an ex parte, interlocutory or final injunction to prohibit or restrain the Provider or the Provider's officers, employees, agents or contractors, from any breach or threatened breach of this Agreement without the necessity of proving that any actual damage has been sustained or is likely to be sustained by the Customer. The Provider must not, and must ensure that its officers, employees, agents and sub-contractors do not, use or disclose any Confidential Information without the Customer's consent, other than in accordance with this clause 17.

18. PRIVACY AND PERSONAL INFORMATION

18.1 If the Provider collects or has access to or in any way deals with Personal Information in order to provide the Services, the Provider must:

(a) Acknowledge that it is bound by the *Information Privacy Act 2009 (Qld)*;

(b) comply with Parts 2 and 3 of Chapter 2 of the *Information Privacy Act 2009* (Qld) in relation to the discharge of its obligations under the Agreement, as if the Provider was the Customer;

(c) ensure that the Personal Information is protected against loss and against unauthorised access, use, modification, disclosure or other misuse;

(d) not use Personal Information other than for the purposes of the supply of the performance of the Services, unless required or authorised by law;

(e) not disclose Personal Information without the consent of the Customer, unless required or authorised by law;

(f) not transfer Personal Information outside of Australia without the consent of the Customer;

(g) ensure that access to Personal Information is restricted to those of its employees and officers who require access in order to perform their duties under the Agreement;

(h) ensure that its officers and employees do not access, use or disclose Personal Information other than in the performance of their duties under the Agreement;

(i) ensure that its agents and sub-contractors (including the Key Personnel) who have access to Personal Information comply with obligations the same as those imposed on the Provider under this clause 18;

(j) fully co-operate with the Customer to enable the Customer to respond to applications for access to, or amendment of a document containing an individual's Personal Information and to privacy complaints; and

(k) comply with such other privacy and security measures as the Customer reasonably advises the Provider in writing from time to time.

18.2 The Provider must, if specified in Item 18 of Schedule A, or if requested by the Customer during the Agreement Term, obtain from its officers, employees, agent and/or sub-contractors engaged for the purposes of the Agreement, an executed deed of privacy in a form acceptable to the Customer.

18.3 The Provider must immediately notify the Customer on becoming aware of any breach of clause18.1.

19. SECURITY AND ACCESS

19.1 The Provider must, and must ensure that its officers, employees, agents and/or sub-contractors (including the Key Personnel), when entering upon the Customer's premises, dealing with the Customer's employees or members of the public, or using the Customer's facilities, equipment or resources, comply with all applicable rules, policies, standards, codes of conduct, directions and procedures of the Customer, including those relating to security, workplace health and safety and appropriate use of information and communication technology, in a like manner as if they were employees of the Customer.

19.2 The Provider must give the Customer's Authorised Officer and/or any other person authorised in writing by the Customer reasonable access to premises occupied by the Provider where the Services are being produced and/or undertaken and must permit them to inspect any Agreement Material or other material related to the Services.

19.3 The Key Personnel, Customer's Authorised Officer and/or any other person authorised in writing by the Customer must, when attending at the Provider's premises or facilities, comply with all applicable rules, directions and procedures as notified by the Provider, including those relating to security or workplace health and safety, that are in effect at the premises or facilities.

20. LIABILITY

20.1 The liability of a Party to the other Party under the Agreement for loss or damage sustained, will be reduced proportionately to the extent that the loss or damage was caused or contributed to by the other Party's negligence, unlawful act or omission and/or failure to comply with its obligations and responsibilities under and/or in connection with the Agreement or otherwise at law

21. INDEMNITY

21.1 To the fullest extent permitted by law, the Provider indemnifies the Customer for all Loss resulting from any Claim related to:

(a) any act or omission which amounts to a breach of the Provider's obligations under this Agreement; or

(b) any unlawful act or omission connected with the Provider's actual or attempted performance obligations under this Agreement; or

(c) any neglect or default connected with the Provider's actual or attempted performance obligations under this Agreement; or

(d) contravention of any legislative requirement by the Provider, its officers, employees, agents or contractors; or

(e) any Existing Agreement Material or New Agreement Material that:

(i) is used and/or developed by the Provider in connection with the performance of the Services under this Agreement; and

(ii) which is an unauthorised infringement of any Intellectual Property belonging to any third party; and

(f) all costs (including the Customer's internal costs howsoever incurred and solicitor and client legal costs on an indemnity basis) that are reasonably and properly incurred by the Customer because of the Provider's breach of sub-paragraphs (a) - (e).

21.2 The Provider's liability under this clause will be proportionately reduced to the extent that the Customer's officers, employees, agents or contractors contribute to the Loss that is the subject of the Claim.

22. INSURANCE

22.1 The Provider warrants that it will hold and maintain for the Agreement Term the following insurances to cover its obligations under the Agreement:

(a) Workers' Compensation insurance in accordance with the *Workers' Compensation and Rehabilitation Act 2003* (Qld);

(b) Public Liability insurance for the amount specified in Item 19 of Schedule A;

(c) Professional Indemnity insurance if specified in Item 20 of Schedule A for the amount specified in that Schedule in respect of each claim, and which must be maintained by the Provider for a continuous period of seven years, after the latter of the Completion Date or termination of the Agreement, unless otherwise specified in Item 21 of Schedule A; and

(d) any other insurances specified in Item 23 of Schedule A.

22.2 The insurances must be effected with an insurer that is authorised and licensed to operate in Australia.

22.3 The Provider warrants if it is a participating member of a scheme approved under the Professional Standards Act 2004 (Qld) that it will hold and maintain the minimum level of insurance as specified in Item 22 of Schedule A.

22.4 The Provider must, if requested by the Customer, promptly provide a certificate of currency for each insurance policy.

22.5 The Provider warrants that any exclusions and deductibles that may be applicable to the insurance policies that it holds in accordance with this clause 22, will not impact on the Provider's ability to meet any claim or otherwise prejudice the Customer's rights under the Agreement.

22.6 The Provider must immediately advise the Customer if any insurance policy, as required by this clause 22, is materially modified or cancelled.

23. LICENSING REQUIREMENTS

23.1 The Provider warrants that it will hold and maintain all requisite licenses, permits, permissions and/or authorities necessary for the provision of the Services.

23.2 The Provider must, if requested by the Customer, provide evidence of compliance with its obligations under this clause to the satisfaction of the Customer.

24. INDUSTRIAL RELATIONS

24.1 The Customer will not become involved in industrial disputes between the Provider and the Provider's staff unless required to do so by an industrial authority.

24.2 During the periods of industrial disputes of any duration, the Provider will be responsible for continued compliance with its obligations under the Agreement at the Provider's expense.

25. RESOLUTION OF DISPUTES

25.1 If a dispute or difference arises between the Parties in relation to the Agreement or concerning the performance or non-performance by a Party of its obligations under the Agreement, whether raised during the performance of the Deliverables under the Agreement or after the completion of the Deliverables, a Party may give Notice of the dispute to the other Party. The Parties must, if requested by either Party within ten (10) Business Days of receipt of a Notice of dispute by a Party, refer the dispute to mediation before commencement of any litigation, other than for injunctive relief, in relation to the dispute.

25.2 The mediator, the mediator's fees and the mediation rules must be:

(a) mutually agreed upon by the Parties in writing; or

(b) in the absence of agreement, within ten (10) Business Days from receipt of a Notice of a dispute, as determined by the Chairperson of the Queensland Chapter of the Institute of Arbitrators and Mediators Australia.

25.3 The Parties agree to share the costs associated with the mediation in equal shares between them.

25.4 Notwithstanding the existence of a dispute, each Party will continue to perform its obligations under the Agreement where practicable, unless otherwise directed by the Customer.

26. VARIATION

26.1 Except for the circumstances specified in clauses 26.2 and 26.6, the Agreement may only be varied by written agreement between the Parties after the Party requesting the variation has given the other Party a Notice setting out the proposed variation. The Parties must act reasonably and within a reasonable time period in deciding whether to agree to a variation, as requested by the other Party.

26.2 The Customer may vary the terms and conditions of the Agreement by Notice to the Provider, when reasonably required as a result of changes in Government policy.

26.3 Where the terms and conditions of the Agreement are varied as a result of clause 26.2, the Provider must promptly submit in writing to the Customer any proposed variation to the Agreement which is required as a result of this amendment. If the Parties are unable to reach agreement in relation to the Provider's proposed variation, the provisions of clause 25 will apply to resolve the dispute.

26.4 Any variation proposed by the Provider as a consequence of clause 26.1 or 26.3 must be accompanied by evidence to substantiate such proposed variation.

26.5 Despite any other provision of this clause 26, any variation proposed by the Provider which purport to take away or reduce the entitlements of the Customer in accordance with clause 26.3, will be deemed to be rejected by the Customer and the Agreement will remain unvaried.

26.6 The Customer may at any time serve a Notice on the Provider requiring the Provider to decrease or omit the supply of any part of the Services.

26.7 Following issue of that Notice, the Provider will comply with the Notice and immediately take steps necessary to minimise the loss suffered by it as a result of the Notice.

26.8 Where the supply of any part of the Services have been decreased or omitted in accordance with clause 26.6, the Customer will pay the Provider:

(a) for the Services supplied as varied by the Notice in accordance with clause 26; and

(b) any reasonable costs incurred by the Provider which are directly attributable to the reduction in the Services. However, the Customer will not be liable to the Provider for any loss of profits.

27. SUSPENSION OF PAYMENT

27.1 The Customer may suspend payments to the Provider without penalty if the Provider refuses, neglects or fails to supply and/or perform any part of the Agreement, until the Services are performed in the manner acceptable to the Customer and in accordance with the Agreement.

28. SUSPENSION

28.1 The Customer may at any time by Notice, direct the Provider to:

(a) suspend work on the supply of all or any part of the Services for a specified period; or

(b) recommence work on the supply of all or any part of the suspended Services.

28.2 Where the Customer suspends the supply of the Services by Notice in accordance with clause 1.1.1(a):

(a) the Provider must, following receipt of that Notice, immediately take all steps necessary to minimise the loss suffered by the Provider as a result of the suspension, including taking all reasonable steps to prevent or minimise its liabilities to its

suppliers, contractors and sub-contractors;

(b) the Provider and the Customer must negotiate in good faith as to reasonable compensation payable to the Provider for any additional costs that were reasonably and properly incurred by the Provider as a direct result of the suspension but the compensation must not include loss of profit, revenue, goodwill or business opportunities, damage to reputation and any indirect or consequential loss, and, where the suspension is the result of any act or omission of the Provider, the Provider will not be entitled to payment by the Customer of any costs, expenses or any other compensation arising out of such suspension; and

(c) any previously agreed completion dates for the Services will be postponed by a period equivalent to the duration of the suspension.

28.3 Where the Provider commits a breach of the Agreement, the Customer may without limiting any right of action or remedy which has accrued or may accrue in favour of the Customer:

(a) give Notice to the Provider, by a notice of suspension, that the Agreement is suspended in whole or in part from the date specified in the Notice for a nominated period; and

(b) provide the Provider with reasonable directions in relation to subsequent performance of the Agreement.

28.4 The Provider must immediately comply with any reasonable directions given by the Customer, in accordance with clause 1.1.1(b).

28.5 Prior to the period of suspension expiring, the Customer may notify the Provider in writing that the:

(a) period of suspension will cease to be effective from the date specified in the Notice based on the Customer being satisfied that the issues/concerns which gave rise to the suspension have been resolved, upon which, each Party must resume its performance under the Agreement from that date;

(b) period of suspension will be extended for a further period of time specified in the Notice; or

(c) Provider must show cause, pursuant to a Notice issued by the Customer, why the Customer should not terminate the Agreement from the date specified in the Notice.

28.6 If the Customer fails to notify the Provider in writing, in accordance with clause 28.5, the period of suspension will expire at the end of the nominated period and each Party must then resume its performance under the Agreement.

29. TERMINATION

29.1 Without limiting clause 29.3, where the Provider commits any breach of the Agreement, the Customer may by Notice, require the Provider to show cause by the date specified in the Notice, why the Customer should not terminate the Agreement.

29.2 If the Provider fails to show reasonable cause by the date specified in the Notice, then the Customer is entitled, upon Notice to the Provider, to terminate the Agreement.

29.3 The Customer may immediately terminate the Agreement by Notice to the Provider if:

(a) the Provider fails to provide a Performance Guarantee or Financial Security if required under the Special Conditions;

(b) the Customer is satisfied that the Provider has breached any part of clause 14;

(c) the Provider gives Notice in accordance with clause 15.2 or 1.1.1(b) or the Customer otherwise identifies a Conflict of Interest;

(d) the Customer is satisfied that the Provider has breached any part of clause 17 or 18;

(e) the Provider breaches any part of clause 22 or 23; or

(f) the Provider:

(i) becomes insolvent or bankrupt or being a company goes into liquidation or has instituted against it any action or proceeding which has an object or may result in bankruptcy or liquidation;

(ii) has a receiver or a receiver and manager appointed or a mortgage goes into possession of any of its assets or becomes subject to any form of external administration;

(iii) enters into an arrangement with its creditors or otherwise takes advantage of any laws in force in connection with insolvent debtors;

(iv) is wound up, voluntarily or involuntarily; or

(g) the Provider indicates that it is unable or unwilling to complete the Agreement.

29.4 If the Customer terminates the Agreement in accordance with clause 29.2 or 29.3, the termination is without prejudice to any rights of the Customer under the Agreement or at common law, including the right to claim damages for breach of the Agreement.

30. NOTICES

30.1 Any Notice which may be given to or served on either Party under the Agreement must be sent or delivered to the following respective addresses:

(a) for the Customer - as specified in Item 25 of Schedule A; or

(b) for the Provider - as specified in Item 26 of Schedule A,

or such other address as a Party may subsequently notify to the other Party in writing in accordance with this clause.

30.2 Notwithstanding clause 30.1, if the Provider is a company then the Customer may serve a Notice at any time on the Provider’s registered office.

30.3 A Notice to be given or served in accordance with clause 28 or 29 must not be sent via email.

30.4 A Notice will be deemed to be given:

(a) if posted – two (2) Business Days after the date of posting;

(b) if delivered by hand during a Business Day - on the date of delivery;

(c) if faxed - on the date the sender’s facsimile machine notes a complete and successful transmission; or

(d) if emailed - on the date recorded on the device from which the Party sent the email, unless the sending Party receives an automated message that the email has not been delivered;

except that a delivery by hand, fax or email received after 5:00pm (local time of the receiving Party) will be deemed to be given on the next Business Day.

31. RIGHT TO INFORMATION AND DISCLOSURE

31.1 The *Right to Information Act 2009* (Qld) (RTI Act) provides members of the public with a legally enforceable right to access documents held by Queensland Government agencies.

31.2 The RTI Act requires that documents be disclosed upon request, unless the documents are exempt or on balance, disclosure is contrary to the public interest.

31.3 Information relating to the Agreement is potentially subject to disclosure to third parties.

31.4 If disclosure under the RTI Act, and/or general disclosure of information provided by the Provider in connection with the Agreement, would be of concern to the Provider, because it would disclose trade secrets, information of commercial value, the purpose or results of research or other information of a confidential nature, this should be indicated by the Provider at the time of disclosing the information to the Customer. The Customer cannot guarantee that any information provided by the Provider will be protected from disclosure under the RTI Act.

31.5 Despite any other provision of the Agreement, the Customer is entitled to publish on the Department of Housing and Public Works' website: *www.hpw.qld.gov.au* under '*Supply and disposal/Tenders and contracts'* or by any other means, the following details:

(a) the name and address of the Customer;

(b) a description of the Services;

(c) Commencement Date or award date;

(d) value of the Agreement;

(e) name and address of the Provider;

(f) procurement method used; and

(g) where the total value of the Services is $10 million or more, the Customer is entitled to publish the following additional information:

(i) Invitation details;

(ii) Agreement overview; and

(iii) reasons for non-disclosure of procurement results (if applicable).

32. GENERAL PROVISIONS

32.1 **Relationship of the Parties**

(a) The relationship of the Parties under the Agreement is one of principal and contractor and the Provider is not by virtue of the Agreement in partnership or joint venture with the Customer and must not represent itself or allow itself to be represented as a partner, joint venturer, officer or employee of the Customer.

(b) Neither the Provider nor the Key Personnel are entitled to the payment of any Entitlements from the Customer other than the Price.

(c) The Provider is solely responsible for the Entitlements to, or for the benefit of, the Key Personnel and the Customer will not be liable for any failure of the Provider to do so.

32.2 **No Advertising**

(a) The Provider must not:

(i) publish, or allow to be published, any advertising, relating to the awarding of any Agreement by the Customer, in any advertising medium; and

(ii) circulate, or allow to be circulated, any other correspondence for the purpose of promotion in connection with the awarding of the Agreement by the Customer,

without the prior written approval of the Customer.

32.3 **Waiver**

(a) Any failure by a Party at any time to enforce a clause of the Agreement, or any forbearance, delay or indulgence granted by a Party to the other will not constitute a waiver of the Party's rights.

(b) No provision of the Agreement will be deemed to be waived unless that waiver is in writing and signed by the waiving Party.

(c) A waiver by a Party of a breach of any part of the Agreement will not be a waiver of any subsequent breach of the same part nor a waiver of a breach of any other part.

32.4 **No Sub-contracting**

(a) The Provider must not sub-contract the provision of any Services under the Agreement, without the prior consent of the Customer. Any consent given by the Customer to sub-contract:

(i) may be conditional;

(ii) will not operate as an authority to transfer responsibility to the sub-contractor; and

(iii) will not relieve the Provider from any of its liabilities or obligations under the Agreement.

32.5 **Governing Law**

(a) The Agreement is governed by and construed in accordance with the laws of Queensland and the Parties submit to the non-exclusive jurisdiction of the courts of Queensland.

32.6 **Compliance with all Laws**

(a) The Provider must comply with all relevant laws in performing its obligations under the Agreement.

32.7 **Severability**

(a) If any part of the Agreement is determined to be invalid, unlawful or unenforceable, for any reason, then that part, to the extent of the invalidity, unlawfulness or unenforceability, will be severed from the rest of the Agreement and the remaining terms and conditions will continue to be valid and enforceable to the fullest extent permitted by law.

32.8 **Further Assistance**

(a) The Provider must do all things reasonably required by the Customer to give effect to the Agreement.

32.9 **No Assignment**

(a) The Provider must not assign, in whole or in part, its obligations or interest in the Agreement, except with the consent of the Customer.

32.10 **Purchase Orders**

(a) The Customer may from time to time issue the Provider with a purchase order in relation to this Agreement. The parties acknowledge and agree the terms and conditions set out in any purchase order do not apply in so far as they conflict with this Agreement; or takeaway or reduce the entitlements that would otherwise be provided to the Customer under the Agreement.

32.11 **Disclosure by Customer**

(a) The Provider acknowledges that the Customer, its officers, employees, agents and sub-contractors may use and disclose any of the information provided by the Provider about the Provider, the Agreement or the Services to Queensland Government departments or agencies, Queensland Government Bodies, Non-Government Organisations and/or the Commonwealth, States or Territories for any purpose in connection with the administration of the Agreement.

32.12 **Former Public Service Employees**

(a) If the Provider becomes aware that any person who is a former Queensland public service or public sector employee currently within the benefits period of a retirement benefits package is performing the Services, then the Provider must immediately notify the Customer in writing.

32.13 **Counterparts**

(a) This Agreement may be executed in two or more identical copy counterparts, each of which together shall be deemed an original, but all of which together shall constitute one and the same instrument.

(b) In the event that any signature executing this Agreement or any part of this Agreement is delivered by facsimile transmission or by scanned e-mail delivery of a ".pdf" format data file or equivalent, such signature shall create a valid and binding

obligation of the party executing (or on whose behalf such signature is executed) with the same force and effect as if such signature page were an original. For execution under this clause to be valid the entire Agreement upon execution by each individual party must be delivered to the remaining parties.

32.14 **Provision of Services**

(a) The Provider shall remain responsible for the provision of Services and Deliverables in accordance with the Agreement notwithstanding any review or acceptance of the whole or any part of those Services or Deliverables by the Customer.

33. CLAUSES TO SURVIVE TERMINATION

33.1 The following clauses will survive termination or expiration of the Agreement:

(a) clause 1- Definitions and Interpretation;

(b) clause 4 - Transferability/Portability of Services;

(c) clause 10 - List of Services and Pricing;

(d) clause 16 - Intellectual Property Rights and Moral Rights;

(e) clause 17 - Confidentiality;

(f) clause 18 - Privacy and Personal Information;

(g) clause 20 - Liability;

(h) clause 21 - Indemnity;

(i) clause 1.1.1(c) - Insurance;

(j) clause 31 - Right to Information and Disclosure;

(k) clause 31.2 - No Advertising;

(l) clause 32.3 - Waiver;

(m) clause 32.5 - Governing Law; and

(n) clause 32.11 - Disclosure by Customer.

34. FUNDING FROM OTHER SOURCES

34.1 The Provider must immediately notify the Customer in writing if the Provider obtains funding for the Services covered by this Agreement from any other government source (whether Federal Government, State, or Local)

34.2 Upon receipt of notification under clause 34.1, the Customer may at its discretion offset the amount of that other Government funding against any instalment of the Funds, in order to avoid duplication of funding.

34.3 Where the Provider receives 50% or more of its total funding from the Customer and other Queensland Government agencies, the Provider must not advocate for State or Federal legislative change. The Provider must also not include links on their website to other organisations' websites that advocate for State or Federal legislative change.

35. FINANCIAL REPORTING

35.1 The Provider must provide financial reports, including certifications to the Customer as follows:

(a) Periodic Financial Reports in the form set out in Schedule D and must include certifications as set out in Schedule D:

(i) if the Funds are less than $20,000 per annum at the time of signing this Agreement, by 31 January and 31 July of each year, relating to the respective previous six (6) months; or

(ii) if the funds exceed $20,000 per annum, by 30 April, 31 October and 31 January of each year, relating to the respective previous quarter and; unless otherwise stated in Schedule C.

(b) an Annual Financial Report – by 30 September of each year, relating to the previous financial year. The Annual Financial Report must be completed in the form set out in Schedule E and must include certifications as set out in Schedule E.

(c) if the Funds exceed $20,000 per annum, the following documents must be submitted by 30 September of each year, unless otherwise stated by the Customer:

(i) full audited report (both full accounts and individual Income and Expenditure reports) which should include an Auditor's independent declaration; and

(ii) the full audited financial statements (the balance sheet/ notes to accounts/ specific profit and loss for Customer projects and consolidated profit and loss statements/ depreciation schedule if any fixed assets additions/ statement of financial position and the statement of financial performance).

36. PERFORMANCE AND STATISTICAL REPORTING

36.1 The Provider must provide Performance Reports, in the form set out in Schedule E and Statistical Reports to the Customer unless otherwise stated in Schedule C, as follows:

(a) if the Funds are less than $20,000 per annum at the time of signing this Agreement, no Performance or Statistical Reports are required unless otherwise stated in Schedule C.

(b) if the Funds exceed $20,000 per annum:

(i) Performance Reports by 31 July and 31 January of each year, relating to the respective previous six (6) months.

(ii) Statistical Reports by 30 April, 31 July, 31 October and 31 January of each year, relating to the respective previous quarter.

37. REVIEW OF THE SERVICES

37.1 The Provider acknowledges that an independent agency may be appointed by the Customer to review the Services.

37.2 The Provider must co-operate fully with the independent agency in respect of the review.

37.3 The Provider must implement any quality improvement action plan which may result from a review of the Services.

38. ASSETS

38.1 Unless specified in Schedules C and D, the Provider cannot purchase Assets valued more than $5,000.

38.2 Where the Provider is funded for the purchase of Assets valued more than $5,000, as outlined in Schedules C and D, the Provider must record in a register the details of the Assets purchased.

38.3 The register shall contain the following information:

(a) model, engine or stock number and description;

(b) date of purchase and the name of the supplier;

(c) purchase/acquisition price;

(d) depreciation rate (prime cost or diminishing value) as provided under relevant sections of the *Income Tax Assessment Act 1936* and the *Income Tax Assessment Act 1997;*

(e) the effective/useful life of the Asset; and

(f) written down value/book value or adjustable value.

38.4 The Provider must use the Assets for or in connection with the provision of the Services and

for no other purpose.

38.5 The Provider must:

(a) maintain all Assets in good order and condition (including carrying out or arranging for any maintenance or repairs to keep the Asset in working order);

(b) take all reasonable steps to protect Assets against damage or theft; and

(c) take out and maintain insurance in relation to all Assets during the term of this Agreement.

38.6 The Provider must not sell, lease, mortgage, encumber, dispose of, give away or destroy any Assets without the prior written consent of the Customer.

38.7 On the expiration or termination of this Agreement, the Customer requires the Provider to arrange for the return and transfer of all Assets to the Customer (including the signing of any necessary documents) and will otherwise deal with such Assets as directed by the Customer and at the Customer's cost.

38.8 Goods purchased on behalf of individuals and families through Funding are not recognised as departmental assets and are therefore not subject to departmental financial policies related to the management of these assets.

39. ACCESS

39.1 The Provider must allow unrestricted access, including access to any authorised service provider's premises by the Customer's officers and agents to the Provider's land, equipment, buildings, books and records to enable the Customer to:

(a) identify all sources of Funding made to the Provider in relation to the Services;

(b) carry out an audit or inspection in relation to the Services;

(c) review the Services being provided by the Subcontractor; or

(d) otherwise ascertain whether the terms and conditions of this Agreement are being complied with.

39.2 The Provider must, if requested, allow the Customer's officers or agents to attend any meetings of the Management Committee or Board of Directors of the Provider organisation. The Customer will only remain present at any such meetings during discussion of agenda items that relate to the provision of the Services. The Customer will not have any speaking rights at any such meeting and must no interfere with the orderly progress of the meeting.

39.3 The Customer will give at least five (5) business days' notice to the Provider before exercising these access rights and will name any persons requested to be available for interview, unless the Customer has reasonable grounds to suspect fraud or mismanagement.

39.4 The Customer must co-operate with and provide whatever assistance is necessary to enable the customer to exercise its rights under clauses 39.1 and 39.2 and the Provider must not obstruct or hinder the Customer in any way.

39.5 The Provider acknowledges and consents to the customer accessing information about the Provider from any other government source (whether Federal, State or Local Government, or an independent statutory body created under the *Hospital and Health Boards Act 2011 (Qld)),* for the purpose of ensuring that the Provider is complying with the terms and conditions of this Agreement.

SPECIAL CONDITIONS OF CONTRACT

The following Special Conditions of Contract will apply as applicable:

1. AMENDMENT TO CLAUSE 29

1.1 The following clause 29.1A is inserted before clause 29.1, unless nominated as not applicable in Item 29 of Schedule A:

'29.1A The Customer may terminate the Agreement, in whole or in part, for convenience by giving 30 days' Notice or such other reasonable period as determined by the Customer, to the Provider.'

2. ADDITIONAL CLAUSE - PERFORMANCE GUARANTEE

2.1 The Provider must, if specified in Item 27 of Schedule A, or if requested by the Customer during the Agreement Term, arrange within ten (10) Business Days from receipt of a Notice, or such other period agreed between the Parties, for a guarantor, approved by the Customer, to execute the Performance Guarantee in a form acceptable to the Customer.

2.2 The Performance Guarantee will be held as security for the due and proper performance of all obligations of the Provider under the Agreement.

2.3 All charges incurred by the Provider in obtaining, maintaining and releasing the Performance Guarantee in accordance with this clause 2 must be met by the Provider.

2.4 A claim by the Customer against the Provider's Performance Guarantee in relation to the Agreement, will not release the Provider from its obligations in accordance with this clause 2.

2.5 The Customer and Provider may agree to release the Performance Guarantee on terms acceptable to the Customer.

2.6 Notwithstanding clause 2.5, upon termination of the Agreement in accordance with clause 29, the Customer will release the Performance Guarantee to the Provider where the Provider has fully performed and discharged all of its obligations under the Agreement, other than the obligations as specified in clause 33 which will survive the termination of the Agreement.

3. FINANCIAL SECURITY

3.1 The Provider must, if specified in Item 28 of Schedule A, or if requested by the Customer during the Agreement Term, provide within ten (10) Business Days from receipt of a Notice, or such other period agreed between the Parties, a Financial Security in a form acceptable to the Customer.

3.2 The Financial Security must be issued by an Australian domiciled bank, insurance company or other financial institution acceptable to the Customer in its entire discretion.

3.3 The Financial Security is to be held as security for the due and proper performance of all the obligations of the Provider under the Agreement.

3.4 If the Provider fails to properly perform its obligations under the Agreement and the Customer suffers loss or damage arising from, or in connection with, such failure by the Provider, the Customer will be entitled to make a claim upon and to receive payment for any or all such loss or damage (as ascertained and certified by the Customer, but subject to any limitation in clause 20 of the Conditions of Agreement) from the Financial Security. If the Financial Security is not sufficient to meet such payment, the unpaid amount may be recovered from the Provider by the Customer in any appropriate court.

3.5 If any claims are made upon the Financial Security at any time, the Provider must within a period not exceeding 30 days of the claim being made, reinstate the Financial Security to the level required by the Customer in accordance with clause 3.1.

3.6 The Provider must not take nor be entitled to take any action or proceeding to obtain an injunction or otherwise prevent the Customer from making a claim upon or receiving a payment from the Financial Security.

3.7 The Provider agrees that the Customer, whilst exercising its rights in accordance with this clause, will have no liability to the Provider of any nature (whether in negligence or otherwise) for any loss or damage suffered or incurred by the Provider.

3.8 The Customer will release the Financial Security requested in accordance with clause 3.1 to the Provider (or to whom the Provider directs) where:

(a) the Provider has fully performed and discharged all of its obligations under the Agreement (other than the obligations as specified in clause 33, which will survive the termination of the Agreement); and

(b) in the reasonable opinion of the Customer, there is no prospect that money or damages will become owing (whether actually or contingently) by the Provider to the Customer.

3.9 All charges incurred by the Provider in obtaining, maintaining and releasing the Financial Security in accordance with this clause 3 must be met by the Provider.

3.10 If the moneys payable to the Provider under clause 3.8 are insufficient to discharge the liability of the Provider to pay such sum to the Customer, the Customer may have recourse to any Financial Security provided in accordance with this clause.

4. QUALITY ASSURANCE

4.1 Of the following clauses clause 4A will automatically apply unless nominated as not applicable in Item 24 Schedule A, in which case the clauses set out in 4B will apply.

4A. Quality Assurance

4A.1 The Provider must have in place a certified quality assurance system based on Australian Standard AS/NZS/ISO 9001:2010 or an equivalent standard approved in writing by the Customer.

4A.2 Where the quality assurance system is based on a quality system standard other than Australian Standard AS/NZS/ISO 9001:2010, it is the responsibility of the Provider to prove to the Customer's satisfaction that it is equivalent.

4B Quality Assurance

4.2 Where the above clause 38.1 is nominated as not applicable, the following Clause 4B will apply:

4B.1 For this Agreement a certified quality assurance system based on Australian Standard AS/NZS/ISO 9001:2010 or an equivalent standard is a highly desirable but not mandatory requirement.

4B.2 Where the quality assurance system offered is based on a quality system standard other than Australian Standard AS/NZS/ISO 9001:2010, it is the responsibility of the Provider to prove to the Customer's satisfaction that it is equivalent.

5. Special Service Conditions

5.1 Pursuant to Clause 39, Aftercare consents to the Customer and West Moreton Hospital and Health Service (HHS) clinical staff accessing Aftercare premises to support the Services during the Term of the Agreement. The Customer and West Moreton HHS (Mental Health and Specialised Services) will:

(a) identify staff member/s and advise Aftercare by Friday 7 February 2014.

(b) advise Aftercare of any change/s to staff during the Term of the Agreement

5.1 Aftercare, together with the Customer and the West Moreton HHS (Mental Health and Specialised Services) will establish the Governance Committee and Terms of Reference by **Friday 21 February 2014** which will also include representatives from the following:

(a) Child and Family Therapy Unit, Children's Health Queensland HHS

(b) Mental Health Alcohol and Other Drugs Branch, Department of Health

Raylene Archer

From:	David Crompton
Sent:	Tuesday, 9 September 2014 4:52 PM
To:	Richard Ashby
Cc:	Mark Beckett; Danielle Blond
Subject:	Barrett school

Dear Richard
Met with school today. Several teachers and 2 from department.
I ended up hearing about all students from across south east Qld.
I noted some in care of private practitioners and have no contact from any HHS.

However all families and school want more assistance.

I have agreed to organise meetings with individual services to work over care plans.
Also discussed with them accessing supervision.
Have spoken with Stephen Stathis and Judi Krause from metro north and will arrange meeting.

Regards
David
Professor David Crompton OAM
Griffith University
School of human Services and Social Work
SOM UQ and School of Public Health and Social Work QUT
MBBS Grad Dip Soc Sci (Psych)
FRANZCP FAChAM (RACP)
Executive Director Addiction and Mental Health
Metro South Health
Centre Neuroscience Recovery and Mental Health
Diamantina Health Partners

Post Box 6046

Upper Mt Gravatt 4122

http://www.health.qld.gov.au/metrosouthmentalhealth/