

SERVICE SPECIFICATION

PURCHASE UNIT CODE: DSSIDSS

SERVICE NAME: Regional/National Intellectual Disability Secure Services (RIDSS/NIDSS)

Philosophy Statement

The aim of Disability Services Directorate (DSD) is to build on the vision contained in the New Zealand Disability Strategy (NZDS) of a fully inclusive society. New Zealand will be inclusive when people with impairments can say they live in:

‘A society that highly values our lives and continually enhances our full participation.’

With this vision in mind, disability support services aim to promote a person’s quality of life and enable community participation and maximum independence. Services should create linkages that allow a person’s needs to be addressed holistically, in an environment most appropriate to the person with a disability.

Disability support services should ensure that people with impairments have control over their own lives. Support options must be flexible, responsive and needs based. They must focus on the person and where relevant, their family and whanau, and enable people to make real decisions about their own lives.

Note: Subsequent references in this document to “the person” or “people” should be understood as referring to a person/people with impairment(s).

1. DEFINITION

The Ministry of Health (The Ministry) wishes to purchase assessment, triage and community liaison services as part of a national and regional network of services for people with an intellectual disability whose levels of need for behavioural support are high and complex. This definition includes those covered by the provisions of the intellectual disability (Compulsory Care and Rehabilitation) Act 2003 (ID(CC&R) Act)

The Ministry is developing a framework of specialised services for people with an intellectual disability whose levels of need for behavioural support are so complex as to require specialist clinical support and intensive levels of co-ordination and agency interface. The definition of eligible service users includes those covered by the provisions of the ID(CC&R) Act and the RIDCA eligible civil population who are not subject to Court order.

To ensure that there exists the full spectrum of effective and complementary services that succeed in supporting the person with complex needs the Ministry wishes to purchase the following national and regional network of services:

- Regional Intellectual Disability Care Agency (RIDCA) – a specialist needs assessment and service coordination agency. Eligibility for all the following services is defined through RIDCA
- Regional Intellectual Disability Supported Accommodation Service (RIDSAS) providing community secure, supervised and independent supported living accommodation and/or services including vocational services and day activities. Hospital level services provide inpatient assessment, triage and longer stay components:

- National Intellectual Disability Secure Services, (NIDSS) based in Wellington and Auckland (Hospital level high forensic assessment and medium /long term placement)
- Regional Intellectual Disability Secure Services (RIDSS). (Hospital level forensic medium secure assessment beds
- Attached to the RIDSS but with a community focus are Community Liaison Teams (CLT).

This specification defines the assessment, triage and longer stay component of this service. While not all RIDSS will provide national service, both national and regional levels of services are defined below. The Community Consultation and Liaison service is defined in a separate specification.

2. SERVICE OBJECTIVES

2.1 General

RIDSS regional hospital level intellectual disability assessment services purchased in this specification in all regions will provide:

- 24 hour supervision and active support
- Short-term assessment and planning for the period of assessment through referral by Court direction from RIDCA.

NIDSS national hospital level intellectual disability assessment services purchased in this specification in Auckland and Wellington will provide:

- 24 hour supervision and active support
- Short-term assessment and planning for the period of assessment through referral by Court direction from RIDCA
- Assessment for service users requiring secure hospital services (forensic high dependency)
- Medium to long term placement for service users requiring secure hospital services (forensic high/medium dependency).

3. SERVICE USERS

3.1 Inclusions

Services will be provided for people with an intellectual disability who are referred by Court via RIDCA and covered by the provisions of the ID(CC&R) Act, or in some cases by the Criminal Procedure (Mentally Impaired Persons Act 2003) CP(MIP) Act.

Generally service users will be those:

- Whose behaviour has resulted in a breach of law, requiring involvement of criminal justice personnel (including Police, Correction or the Courts)

or

- Who are being transferred under appropriate sections of the Mental Health Act 1992 and who show behaviour that poses a serious risk of physical harm to themselves or others

or

- Who appear to manifest a psychiatric disorder, requiring mental health professional assistance for assessment, treatment or management.

3.2 Exclusions

Service users not covered under this service specification are those with an intellectual disability who:

- Are without an appropriate Court order
- Are not RIDCA - eligible
- Are referred solely for long-term placement.

3.3 Interface With Mental Health

It is expected that many service users under this specification will require the involvement of Mental Health services. The Ministry of Health expects that in all such instances providers will work together to achieve the best outcomes for the service user.

4. ACCESS

People will access services based on the nature of the referral and service required.

1. Those requiring assessment under the ID(CC&R) or CP(MIP) Acts will access short-term assessment beds in all regions.
2. Those requiring medium to long-term placement in hospital secure services will access the national secure units where vacancies allow.

4.1 Referrals

The RIDCA will facilitate all referrals to the service, using the same access criteria as described above. Any other referrals received (including those from Court) should be redirected to the RIDCA.

RIDCA will be responsible for ensuring that service users accepted to the service will do so with appropriate legal authorisation for their placement in that secure service. The type of service provided will reflect the high level of need for personal or public safety, such that the Court orders a secure placement.

The provider is expected to accept all referrals from RIDCA where legal authority for entry exists. Where there are difficulties accepting a service user immediately because of insufficient capacity (for clients using beds over and above the capacity purchased RIDSS level assessment beds in each region), the provider is expected to work with RIDCA to find a solution with the greatest expediency.

4.2 Inter-Region Transfers

The Provider shall, in the first instance, provide services to defined geographical catchments. However the Provider will be required to accept eligible service users from throughout New Zealand up to the capacity number of beds available and purchased by the Ministry. The Provider of assessment beds must give priority to people within their own defined geographic catchments before accepting those from other regions.

The Ministry requires that any transfer of service users between regions occurs with the minimum level of disruption to the service user and the Care and Rehabilitation plan. This means that information transfer and handovers need to be timely and carried out to the highest standard.

NIDSS and RIDSS will co-ordinate with RIDCA for all transfers and discharges. RIDSS will manage all clinical aspects in conjunction with the CLT and the RIDCA appointed Specialist Assessors

4.3 Service Exit

Regional RIDSS will co-ordinate with RIDCA for all transfers and discharges. RIDSS will manage all clinical aspects in conjunction with the CLT and the RIDCA appointed Specialist Assessors. Early transition planning will be required to ensure service users will receive services in the least restrictive environment available to meet their needs balanced with risk management.

4.3.1 Regional Assessment Beds

In addition to the Discharge Planning provisions of the Provider Quality Specification and the Health and Disability Sector Standards, service users will exit at a negotiated date at the direction of the RIDCA. Exit will occur either:

- Upon application to the Court for an order subject to the ID(CC&R) Act

or

- Through determination of ineligibility as a result of assessment findings.

4.3.2 National Secure Units

In addition to the Discharge Planning provisions of the Provider Quality Specification and the Health and Disability Sector Standards any transfer or transition to national secure beds will be discussed and agreed with RIDCA. If the person is subject to the ID(CC&R) Act discharge will be authorised by the Court.

5. SERVICE COMPONENTS

5.1 Processes And Settings

A comprehensive range of hospital based treatment and rehabilitation options will be available to all service users, including but not limited to:

- Occupational therapy
- Social skills training
- Individual counselling and training
- Budgeting
- Domestic Skills
- Assertiveness and self esteem training
- Cultural assessment and development of appropriate cultural links
- Coordination of services
- Nursing, psychology and medical specialists (e.g. psychiatrists, neurologists etc).

Treatment strategies may include:

- Pharmacotherapy
- Psychological therapy
- Social treatments
- Education about illness, symptoms and the management of symptoms.

5.1.2 Natural Supports

In addition to consideration and identification of the funded services that will benefit Hunga Haa, providers should include natural supports during assessment, support service planning and implementation with Hunga Haa and appropriate supports. Natural supports include but are not limited to:

- Friends, both outside and in the service setting
- Immediate and extended whanau members including hapu and iwi
- Community activities/groups
- Community education/courses
- Neighbours
- Workplaces.

The place of natural supports in a person's life is likely to be an important part of managing relationships while in care and during rehabilitation planning. Hunga Haua should be encouraged to think about who or what these supports might be and should be supported to have contact with them, or, where no supports exist, should be supported to explore the possibilities of developing them.

Wherever possible Māori service users will be encouraged to maintain links with their tribal affiliations which can be identified through the māori assessment protocols.

5.1.3 Assessment Beds (regional and national)

The focus of this service will be the facilitation of the assessment process necessary to determine appropriateness for the application to the Court for a compulsory care order under the ID(CC&R) Act.

5.1.4 National Secure Beds

The focus of this services will be the implementation of Care and Rehabilitation Plans (for Care Recipients under the ID(CC&R) Act and eventual integration into the community for each Care Recipient.

Each Care Recipient's progress will be regularly reviewed, as defined by the Court, against their goals for treatment and/or rehabilitation and adjustments made as appropriate.

Clinical treatment options will include a range of psychosocial and medical treatment strategies to assist service users to regain and/or maintain normal living skills and to achieve optional illness management where appropriate.

5.2 KEY INPUTS

<i>Hospital level secure</i>	<i>Description</i>
Function	<p>To provide inpatient care in a secure environment for eligible service users within the level of security required. Levels are defined by level of staffing required together with physical and procedural security. The level of security may be specified as high or medium. This is to ensure that the option of least restrictive alternative can be appropriately applied. Eligible service users will be in need of more intensive assessment and/or acute treatment than can be safely provided in a less secure community or RIDSAS setting.</p> <p>The service will aim to:</p> <ul style="list-style-type: none"> • Provide a safe assessment environment for service users being assessed under the provisions of the ID(CC&R) Act • Improve or maintain the level of functioning in accordance with a documented plan of management that addresses identified problem areas • Manage any co-morbid mental illness

	<p>Enhance the involvement of service users in their own management and planning</p> <ul style="list-style-type: none"> • Utilise a variety of interventions (psychological, social, behavioural, cultural, spiritual, pharmacological) to achieve desired outcomes • Enable access to a range of vocational, recreational and educational programmes and activities • Encourage self care through an environment of accountability and cultural appropriateness • Minimise alienation from/enhance community links and liaison with other mental health teams and disability support services pre discharge/transfer of care • Complete Court reports as required under the CP(MIP) 2003 /ID(CC&R) or other statutes.
Nature of the Service	<ul style="list-style-type: none"> • A secure service providing a high level of 24hour observation and supervision. • Beds will be capacity purchased to ensure that the service can be accessed immediately for service users. Additional beds may be purchased in negotiation with the RIDCA when required.
Key Processes	<ul style="list-style-type: none"> • Service users accessing this service can expect, as a minimum, to be able to access all of the following processes: <p>Advocacy, assessment, case management, discharge planning, hotel services, legal compliance, management of risk, peer support, service handover, support, therapy, treatment and rehabilitation.</p>
Support Service	<ul style="list-style-type: none"> • Access to a number of clinical and financial support services is required. These may include, but not limited to: <ul style="list-style-type: none"> • Laboratory diagnostic services • Pharmacy services • Radiology services • Medical intensive care • Commercial services. • The provider must ensure that the necessary relationships are established with providers of these

	services to ensure their availability to service users as required.
Services provided by	<ul style="list-style-type: none"> • A multi disciplinary team of specialist staff with appropriate qualifications, skills and experience including, but not limited to: Psychiatry, psychology, mental health and intellectual disability nursing, therapy and cultural.

6. SERVICE LINKAGES

Providers are required to maintain effective links with other Forensic Psychiatry and Intellectual Disability service providers whether within their own geographical catchments or elsewhere. It is critically important that the service providers work together to ensure:

- Service users have access to the full range of services
- Disputes amongst providers concerning service coverage are resolved in a timely manner, without adversely affecting any service user
- The efficient and effective use of each service.

Providers must establish working protocols with providers of all other services who are part of the intellectual disability high and complex regional network. Accountability for access, entry, treatment, care management, communication, exit processes, follow-up and information sharing should be clearly stated in protocols, as should dispute resolution processes. All protocols should align to legislative, contractual and Ministry issued guidelines.

In particular, providers are required to demonstrate effective links with the following key agencies or services:

- RIDCA
- RIDSAS providers
- NIDSS
- RIDSS
- Regional Forensic Services
- Court and Correction Services
- Specialist Assessors
- District Inspectors.

There is a range of other services with linkages whom may be required such as:

- Other general mental health services
- Consumer advocacy services
- Vocational / educational services
- Māori organisations
- Other sector agencies.

7. EXCLUSIONS

Not Applicable

8. QUALITY REQUIREMENTS

8.1 Service User / Family And Whanau Involvement

Service users, family and whanau members and advocates should be central to service delivery. This requires:

- The service user be given an opportunity to identify who to include or exclude from their assessment process
- The service user, family and whanau members and advocates be provided information regarding how they can be involved in the processes
- The service users, family and whanau members and advocates be notified of complaint procedures.
- Māori Service Plans focused on removing barriers to access and promoting participation for Māori service users and their family or whanau including staff development and organisation responsiveness outcomes.

8.2 Complaint And Feedback Systems

The Provider will have a set of documented policies/protocols for the following aspects of service delivery:

- Managing disruptive behaviour in the least restrictive way possible
- Medication administration, supervision and review
- Minimising potential risk to service users of physical or sexual abuse from others
- Administration of statutory powers, including restraint and seclusion
- Clinical aspects of personal care
- Security of personal property
- Handling of complaints.

9. PURCHASE UNITS AND REPORTING REQUIREMENTS

PU ID	PU Short name	PU Measure	Reporting requirements	
			Frequency	Information
DSS IDSS	Intellectual Disability – Assessment bed service (forensic)	Bed night	6 monthly	1. Total number of beds 2. Number of occupied beds per month
DSS IDSS	Regional Intellectual Disability Secure Services - beds	Bed night	6 monthly	3. Total number of beds 4. Number of occupied beds per month
DSS IDSS	National Intellectual Disability Secure Services – beds (Units in Auckland and Wellington only)	Bed night	6 monthly	5. Number of occupied beds per month by service users by regional allocation. (Northern/Midland/Central/Southern)

This information should be supplied within seven days after the end of each period, using the Ministry template format. The report for each period is due by the 20th of the month following the end of the period. Delays beyond this date will be notified to us.

The Periods for reporting are:

1 July to 30 September	due by 20 October
1 January to 31 March	due by 20 April

Throughout the term of the agreement

Where the agreement begins or ends part way through a period the report will be for that part of the period that falls within the term of the agreement.

You shall forward your completed Performance Monitoring Returns to:

The Monitoring Team
HealthPAC
Private Bag 1942
Dunedin

Note: When forwarding completed Performance Monitoring Returns electronically, please cc the Ministry of Health Agreement Manager noted on the front of this contract.

9.1 Guidelines

The RIDSS/NIDSS provider will be required to abide by all relevant Policy and Ministry processes and all Ministry issued Guidelines and regulations, forms and procedures, including but not limited to:

- The New Zealand Framework for Disability Service Delivery – August 1994, Ministry of Health.
- The DSD Strategy for Māori Health 1999.
- He Korowai Oranga Māori Health Strategy, 2002 Ministry of Health.
- Ministry of Health policies and Guidelines related to the administration of the ID(CC&R) Act, including the Ministry of Health Procedure Manual: Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003
- DSD Strategy for People with High and Complex Behavioural Needs, 2000.
- New Zealand Disability Strategy 2001.
- NZ Standards Restraint Minimisation and Safe Practise NZ8141
- From December 2005 or as Ministry advises: Best Practise Framework for people working with Hunga Haua (published by Ministry of Health)
- From December 2005 or as Ministry advises: Te Reo Resource Toolkit (published by Ministry of Health)

10. QUALITY MEASURES

All Providers are required to comply with the MOH Provider Quality Specification and are to immediately report to the Ministry of Health any critical incident or crisis that may result in media or political attention or a potential Coroner's Inquest.

In addition to the general quality requirements, the following quality requirements apply to this service:

- Assessment of effectiveness and acceptability of the service through the Hui or regular resident meetings held at least monthly and/or as required.
- Seek feedback at least annually from the Whanau/family and service users that the service is meeting the resident's needs.

10.1 Service Development

The Provider is required to report 6 monthly on the following:

- Planned service development
- Changes in the type and way in which services are delivered

- Critical incidents and events – detailing the circumstances, dates and persons involved and outcomes of incident
- Māori Service Plans focused on removing barriers to access and promoting participation for Māori service users and their family or whanau including staff development and organisation responsiveness outcomes In December 2005 Ministry will publish a Best Practise Framework)

GLOSSARY OF TERMS

ACTS

ID(CC&R) Act: Refers to the *Intellectual Disability (Compulsory Care and Rehabilitation) Act (2003)*

CP(MIP) Act: Refers to the *Criminal Procedure (Mentally Impaired Persons) Act (2003)* (replaces Part 7 Criminal Justice Act (1985) (CJA))

MH(CAT) Act: *Mental Health (Compulsory Assessment and Treatment) Act 1992*

MINISTRY FUNDED AGENCIES for RIDCA SERVICES

RIDCA: *Regional Intellectual Disability Care Agency. This is the administration agency of the legislation. The Care Co-ordinator function sits within RIDCA.*

RIDSAS: *Regional Intellectual Disability Supported Accommodation Service. These services provide community assessment beds, residential and vocational agencies. The Care Manager function sits within RIDSAS.*

RIDSS: *Regional Intellectual Disability Secure Services. Hospital level secure services and assessment beds. RIDSS also provide the Community Liaison Team (CLT) contracts. The Care Manager function sits within RIDSS which functions mainly around transition into or out of hospital level services or prisons, however individual circumstances of the service user will inform the decision around who would best fill this function. (See also Community Liaison Team below)*

OTHER

District Inspector (DI): *Means a person designated under Section 144 ID(CC&R) Act as district inspector or deputy district inspector under the ID(CC&R) Act. A District Inspector is a barrister or solicitor whose job it is to ensure service users' rights are upheld.*

Care Co-ordinator: *(referred to as Compulsory Care Co-ordinator, or Co-ordinator under the ID(CC&R) Act) A person who is appointed by the Director General of Health under Section 40 of the ID(CC&R) Act in a designated geographical area, defined in the appointment. The role is described in section 40. In general, the role of the Care Co-ordinator is to oversee and manage the pathway for each service user referred by the Court, prisons or forensic services to the RIDCA as proposed Care Recipients. This will require the Care Co-ordinator to act with a high level of flexibility and accountability for the completion of key duties, powers and functions.*

Care Manager: *A person appointed by the Care Co-ordinator for a specific Care Recipient under section 141 of the ID(CC&R) Act. In general the role of Care Manager is to fulfil the functions and duties as set out in section 141, including work with the Care Recipient to develop a Care & Rehabilitation Plan that reflects the support needs of the Care Recipient.*

Civil Population: *Those service users receiving services from the RIDCA who are not Care Recipients under the ID(CC&R) Act. This population would receive services from the Intensive Service Coordinator*

Community Liaison Team (CLT): *Team of multi disciplinary professionals who offer consultation liaison services to all RIDCA eligible service users. The CLT has a role within RIDSS and in the community. For RIDSS, the role of the CLT is mainly around transition into or out of hospital level services or prisons. However individual circumstances of the service user will inform the decision around who would best fill this function. In the Community the role of the CLT is to proactively assist RIDCA eligible service users, both those under ID(CC&R) and the civil population, and the providers supporting them. This includes, but is not limited, to supporting the development of and/or maintenance of management and rehabilitation programmes*

Crisis Response: This is defined as a situation requiring immediate action that falls either outside the working hours of agencies who might otherwise (more appropriately) respond, or that requires immediate attention over and above that normally expected of service providers. I.e. Additional staffing, temporary accommodation. The RIDCA will develop MOUs with providers

Cultural Assessor: Required by the ministry for Māori and other cultures as set out in ID(CC&R) Act Section 13 and Section 23 and consistent with Guidelines for Cultural Assessment – Māori, Ministry of Health

Facility: The definition of facility is that used in section 9 of the ID(CC&R) Act.

Section 9. Facility and secure facility

- (1) A "facility" is a place that is used by a service for the purpose of providing care to persons who have an intellectual disability (whether or not the place is also used for other purposes).
- (2) A "secure facility" is a facility that
 - (a) has particular features that are designed to prevent persons required to stay in the facility from leaving the facility without authority; and
 - (b) is operated in accordance with systems that are designed to achieve that purpose.
- (3) A facility that is not a secure facility need not have any particular features and, accordingly, a building (such as a residential house) that is not an institution can be used as such a facility.
- (4) In no case can a prison be used as a facility.
- (5) Subsection (3) is subject to any other enactment.
- (6) *Hunga Haua*: Māori person with a disability.

Intensive Service Co-ordinator: This is a role developed specifically for service users eligible for RIDCA services who are not subject to ID(CC&R) Act. The role provides levels and intensity of service co-ordination usually requiring the involvement of multiple providers and ongoing problem solving. Intensive service co-ordination requires that there be an ongoing relationship between the service user and the co-ordinator.

Intellectual Disability: The definition of intellectual disability is that used in Section 7 of the ID(CC&R) Act.

Section 7. Meaning of intellectual disability

- (1) A person has an intellectual disability if the person has a permanent Impairment that
 - (a) results in significantly sub-average general intelligence; and
 - (b) results in significant deficits in adaptive functioning, as measured by tests generally used by clinicians, in at least 2 of the skills listed in subsection (4); and
 - (c) became apparent during the developmental period of the person.
- (2) Wherever practicable, a person's general intelligence must be assessed by applying standard psychometric tests generally used by clinicians.
- (3) For the purposes of subsection (1)(a), an assessment of a person's general intelligence is indicative of significantly sub-average general intelligence if it results in an intelligence quotient that is expressed

- (a) as 70 or less; and
 - (b) with a confidence level of not less than 95%.
- (4) The skills referred to in subsection (1)(b) are
- (a) communication:
 - (b) self-care:
 - (c) home living:
 - (d) social skills:
 - (e) use of community services:
 - (f) self-direction:
 - (g) health and safety:
 - (h) reading, writing, and arithmetic:
 - (i) leisure and work.
- (5) For the purposes of subsection (1)(c), the developmental period of a person generally finishes when the person turns 18 years.
- (6) This section is subject to section 8.

Māori: Anyone who identifies themselves as Māori and has the endorsement of a recognised kaumatua (respected Māori elder)

Needs Assessment: The terminology in the Act is at times inconsistent with that used in mainstream NASC process. The Act requires needs assessment to be completed near the end of the assessment process as opposed to the more usual NASC process of commencing provision of services with the Needs Assessment. For the purposes of meeting the requirements under the ID(CC&R) Act the procedural manual will make reference to the term 'Initial Assessment Tool' This initial assessment tool is the tool that is usually referred to by mainstream NASC as a "needs assessment. "

In order to remedy the matter of timing within the Act, the executive summary, called "Executive Summary Needs Assessment" is the document that will signal the fulfilment of the needs assessment requirement under Part 3 of the ID(CC&R) Act.

Proposed Care Recipient: The definition is that used in section 5 of the ID(CC&R) Act.

Section 5. Meaning of Care Recipient and related terms

- (1) "Care Recipient" means a person who is—
- (a) a special Care Recipient; or
 - (b) a Care Recipient no longer subject to the criminal justice system.
- (2) "Special Care Recipient" means—
- (a) a person who is liable to be detained in a secure facility under an order made under

- (i) section 24(2)(b) or section 38(2)(c) or section 44(1) of the Criminal Procedure (Mentally Impaired Persons) Act 2003; or
 - (ii) section 171(2) of the Summary Proceedings Act 1957; or
 - (b) a person who is remanded to a secure facility under an order made under section 23 or section 35 of the Criminal Procedure (Mentally Impaired Persons) Act 2003; or
 - (c) a person who is liable to be detained in a secure facility under an order made under section 34(1)(a)(ii) of the Criminal Procedure (Mentally Impaired Persons) Act 2003 and who has not ceased, under section 69(3), to be a special Care Recipient; or
 - (d) a person who
 - (i) is liable to be detained in a secure facility under a compulsory care order, made under section 45; and
 - (ii) is also liable to detention under a sentence; and
 - (iii) has not ceased, under section 69(3), to be a special Care Recipient; or
 - (e) an inmate who is required, under section 35, to stay in a facility; or a person who, in accordance with section 47A(5) of the Mental Health (Compulsory Assessment and Treatment) Act 1992, must be held as a special Care Recipient.
- (3) "Care Recipient no longer subject to the criminal justice system" means a person who
- (a) is, or continues to be, subject to a compulsory care order, made under section 45, but is not, or is no longer, liable to be detained under a sentence; or
 - (b) is subject to an order made under section 25(1)(b) or section 34(1)(b)(ii) of the Criminal Procedure (Mentally Impaired Persons) Act 2003; or
 - (c) is subject to a compulsory care order resulting from the operation of section 69(3) or section 94(1); or
 - (d) is a former special patient who is required, under section 35, to stay in a facility.
- (4) "Proposed Care Recipient" means a person
- (a) who is being assessed under Part 3 or Part 4; or
 - (b) in respect of whom an application for a compulsory care order is pending before the Family Court.
- (5) In Parts 2, 3, and 9, a reference to a Care Recipient includes a reference to a proposed Care Recipient.

- (6) *“Care Recipient liable to detention under a sentence” means a special Care Recipient to whom subsection (2)(c) or (d) applies.*

Region: (please see map below)

Secure Care: *The definition of secure is that used in the ID(CC&R) Act (please refer to section 63 and 64 of the Act).*

Section 63. Designation notices relating to secure care

- (1) *This section applies to every person*
- (a) *who is a special Care Recipient; or*
 - (b) *who is a Care Recipient no longer subject to the criminal justice system and who is required to receive secure care.*
- (2) *A Care Recipient to whom this section applies must—*
- (a) *stay in a secure facility that the co-ordinator designates by written notice given to the Care Recipient and the Care Recipient's care manager; and*
 - (b) *may not leave the facility without authority given under this Act.*

Section 64. Directions relating to supervised care

- (1) *The co-ordinator may direct a Care Recipient who is required to receive supervised care to stay in a designated facility or in a designated place.*
- (2) *A direction under subsection (1) takes effect when written notice of the direction is given to the Care Recipient and the Care Recipient's care manager.*
- (3) *A Care Recipient may be directed, under subsection (1), to stay in a secure facility only for the purpose of receiving care that*
- (a) *is required to deal with an emergency; and*
 - (b) *is of a kind provided for in the Care Recipient's care and rehabilitation plan.*
- (4) *While a direction under subsection (1) is in force, the Care Recipient to whom the direction relates must stay in the facility or place designated by the direction.*
- (5) *If a direction under subsection (1) requires the Care Recipient to stay in a facility, the Care Recipient may not leave the facility without authority given under this Act.*

Specialist Assessment: *A specialist clinical assessment in any area of expertise completed by Specialist Assessors who will be suitably qualified health or disability professionals. For the purpose of the ID(CC&R) Act or the CP(MIP) Act these assessments will be requested by the RIDCA or NASC to establish eligibility and management or planning*

