

## SERVICE SPECIFICATION

**PURCHASE UNIT CODE: DSSRIDSA**

**SERVICE NAME:** Regional Intellectual Disability Supported Accommodation Service (RIDSAS)

### Philosophy Statement

The aim of Health and Disability National Services Directorate (HDNSD)) 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) has developed a framework of interconnected 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 residential support and agency interface. The definition of eligible service users includes those covered by the provisions of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (ID(CC&R) Act) and the Regional Intellectual Disability Care Agency (RIDCA) eligible civil population who are not subject to an (IDCC&R) court order.

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 co-ordination 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.
- National Intellectual Disability Secure Services (NIDSS) Hospital level forensic assessment and long term placement
- Regional Intellectual Disability Secure Services (RIDSS) (Hospital level assessment and long term placement)

- Attached to the RIDSS but with a community focus are Community Liaison Teams (CLT).

The RIDSAS service is described in this specification. The RIDSAS will be required to provide regional coverage generally through a network of providers. (See Glossary for regional boundaries).

## 2 SERVICE OBJECTIVES

### 2.1 General

Providers of services for RIDCA-eligible individuals will work collaboratively and co-operatively together.

RIDSAS will provide support at the level necessary for people to have a safe and satisfying home life. Accommodation and/or service provided may be deemed secure or supervised in accordance with the court order and Care and Rehabilitation plan or individual plan and may be for assessment purposes or for placement.

Access to RIDSAS is through RIDCA and the nature of the service required may be defined

- a) through the ID(CC&R) Act by the courts, or:
- b) through RIDCA service agreements.

Where the service user is a Care Recipient under the ID(CC&R) Act, the RIDCA will have ensured specialist assessment is undertaken and a Care Plan proscribed, the RIDSAS provider will generally have been a contributor to the Care Plan.

If the placement is for assessment, such assessment will be undertaken (by the specialist assessor appointed by the RIDCA) during the time of that placement.

The range of services provided by RIDSAS includes:

- **Residential Accommodation** (group home) / individual care package

This service provides 24-hour support in a home shared by no more than 5 service users.

- **Assessment Beds**

These beds are managed through RIDCA to enable it to respond immediately to court directions for placement for assessment. However RIDCA is required to prioritise service access and departure and will utilise the service as it deems appropriate. Assessment beds are funded on a capacity basis in order to ensure that they are available when required by RIDCA.

Excluded from this service are:

- individuals from other residential facilities who require a period of respite, and
- individuals who do not require an assessment for the purposes of assessment for the High & Complex Framework.

Responsibility for the assessment process will be defined by RIDCA.

- **Life Skills and Day Activity Services**

These are for service users not able to attend life skills and day programmes delivered by generic disability service providers, or who require additional provision for their safe and appropriate attendance. These may be purchased from the accommodation service or separately from another provider.

It is expected that the RIDSAS will either deliver life skills and day activity programmes according to the agreed Individual Plan or Care and Rehabilitation Plan, and will also work with other providers to assist the service user in accessing activities, educational and employment opportunities with appropriate support and funding from external sources according to the service user's Individual Plan and with the agreement of the RIDCA.

For people in life skills and day activity services and are under provisions of the ID(CC&R) Act, each service user will have a Care and Rehabilitation Plan prepared by a Care Manager, setting out the range of supports and services for each person as detailed in the ID(CC&R) Act.

## **2.2 Māori Health**

The three strategic goals are:

- Increased Māori participation at all levels of the health sector e.g.-governance, service delivery, policy development, identifying and overcoming barriers to entry (access).
- Targeted funding of services to achieve health gains for Māori, eg. working in partnership with the Ministry to develop services that are responsive to the needs of Māori.
- Targeted Māori Provider and Workforce development eg working in partnership with the Ministry to develop services that are responsive to the needs of Māori, staff development.

The Māori Health Policy and requirements are outlined in the General Terms and Conditions Provider Quality Specifications. The Provider is required to develop a plan demonstrating its ability to meet these requirements. The plan needs to be initiated within a timeframe agreed with the provider and the Ministry.

## **3. SERVICE USERS**

### **3.1 Inclusions**

RIDSAS service provision is for those service users with an intellectual disability and whom RIDCA has assessed as meeting the following criteria.

- 3.1.1** Are subject to the provision of the ID(CC&R) Act. This service is not age specific i.e. children and young people who are charged with or convicted of an imprisonable offence may be included, but the incidence of this is expected to be low. This group are referred to as Care Recipients because their services have been mandated by the Court.
- 3.1.2** Are adults, aged 17 years and over exhibiting behaviour that poses a serious risk of physical harm to themselves or others and access is limited or prevented not only to

ordinary opportunities and facilities, but also to mainstream disability support services. This group are referred to as the civil population because they are not under compulsory care orders and are receiving a RIDSAS level service. (see Glossary).

### **3.2 Exclusions**

RIDSAS will not provide a service in the absence of referral from RIDCA.

### **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 expects that in all such instances providers will work together to achieve the best outcomes for the service user.

- For those people whose needs are subject to Court orders, not exclusively but including the ID(CC&R) Act, Mental Health (Compulsory Assessment & Treatment) Act 1992 ((MH)CAT) and Criminal Procedure (Mentally Impaired Persons) Act 2003 (CP(MIP). This is not intended to include individuals being assessed under Sec 35. This is the responsibility of Forensic Mental Health Services). Formal relationships with Forensic Services and/or Community Mental Health will need to be agreed upon by both providers. This would be for the provision of assessment and review related to reports to the Court and for all other specialist assistance available to meet the service users needs.
- For those whose needs are not subject to court orders who may present with an associated mental illness, Community Mental Health services will be accessed. Roles and responsibilities of Mental Health and Disability Services will be documented and reflected in Individual Plans monitored by the Intensive Service Co-ordinator of the RIDCA.

## **4. ACCESS**

### **4.1 Referrals**

The RIDCA will manage all referrals to the service. Any referrals from any other source received shall be redirected to the RIDCA.

The provider shall accept all referrals from the RIDCA. Where there are difficulties accepting a service user because of insufficient capacity, compatibility or preparation requirements, the provider is expected to work with the RIDCA to find a solution. This will not apply to court ordered assessments into RIDSAS assessment beds where vacancies exist in the capacity of those beds.

The level and type of service the service user receives will reflect the individual service user's support needs and be agreed with the Care Co-ordinator (if the person is subject to the ID(CC&R) Act, or if not subject to the ID(CC&R) Act, or the Intensive Service Co-ordinator for an individual who has civil status.

### **4.2 Inter Region Transfers**

RIDSAS will, in the first instance, provide service in the geographical catchment area that is defined in the geographical boundaries map attached as Appendix . RIDCA will manage referrals from other regions and negotiate placements within RIDSAS. RIDCA must give

priority to people within their defined geographic catchment area before accepting those from other regions.

The Ministry requires that any transfer of service users between regions occur 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. All transfers will be via RIDCA.

### **4.3 Service Exit**

In addition to the Discharge Planning provisions of the Provider Quality Specifications and the Health and Disability Sector Standards, any possible transfer to an alternate provider or other accommodation will be discussed and agreed with the Intensive Service Co-ordinator or Care Co-ordinator if the service user is subject to the ID(CC&R) Act within the RIDCA. Service exit must adhere to the Ministry of Health *Guideline for the transfer of RIDCA clients to NASC, 2006*.

Where a service user requires admission to a Mental Health setting, Intellectual Disability Secure Service or other specialist service, the Care Co-ordinator or Care Manager will facilitate this, depending on the requirements under the ID(CC&R) Act and the next working day the Care Co-ordinator will make the notifications to the Ministry.

The provider will notify the following on the death of any service user:

- Family/whanau or advocate immediately
- The RIDCA immediately
- The Ministry through the next information reporting (invoicing) cycle, unless the death has not occurred naturally, in which case reporting is to be immediate
- If service user is a Care Recipient, using the correct procedure as outlined in the Procedure Manual Intellectual Disability Compulsory Care and Rehabilitation Act 2003.

## **5 SERVICE COMPONENTS**

### **5.1 Process Descriptions**

#### **5.1.1 Individual Planning**

The following requirements are in addition to those specified in the Provider Quality Specifications and the Health and Disability Sector Standards.

#### **Care Recipients**

The provider will adhere to the provisions of the ID(CC&R) Act for all Care Recipients. The Care Manager will develop and implement a Care and Rehabilitation Plan based on the individual's support needs and legal requirements. The Care Manager will ensure all reviews required under the ID(CC&R) Act are completed. The RIDCA Care Coordinator will sign off all Care and Rehabilitation Plans and reviews.

- **Civil Population**

The provider will ensure each service user has an Individual Plan developed in conjunction with the RIDCA Intensive Service Co-ordinator and as appropriate with the service user's family and whanau/advocate.

**a) The Individual Plan**

The Individual Plan will be reviewed at least 3 monthly or when there is a significant change in the service user's needs. It will be formally reviewed through co-ordination of the Intensive Service Manager every 6 months.

An Individual Plan should include:

- The service user's short and long term goals and timeframes for achievement
- The supports activities and inputs required to achieve the goals
- Family/whanau/friends/advocate involvement
- Skills attained
- Recognition of Māori and other cultural aspects
- Assignment of responsibilities for implementing goals
- Acknowledgement of risk factors in achievement of service user goals
- Transition of goal setting.

**b) Habilitation/Rehabilitation Programmes**

Specific treatment, learning based or rehabilitation programmes will be provided to address goals in the Individual Plan. The provider shall ensure appropriate habilitation/rehabilitation activities and programmes are provided and monitored by persons appropriately skilled to administer them. The provider will also work with the RIDCA to ensure access to services additional to those provided by the RIDSAS as appropriate e.g. alcohol and drug treatment, sexual offender treatment, counselling, mental health support, educational, behaviour support services etc. The provider will work actively with the RIDCA, Community Liaison teams and community services in the planning and implementation of transition strategies.

**c) Risk Management**

The Provider Risk Management Plan shall address matters such as:

- The safety and security of the service user, flatmates and fellow house members, members of the public and staff which are home or away from home. There will be times when responsibility transfers to another provider e.g. vocational service. Such transfers must be documented and clearly agreed in advance with RIDCA and other provider. Risk Management Plans must meet legal requirements of Court orders

applying to the service user and Occupational Safety and Health requirements

- Agreed strategies for managing challenging behaviour
- Agreed strategies for management of crisis and incidents. These should be documented and include appropriate responses taken
- Appropriate relationships and communication in crisis situations with family/whanau/advocates/neighbours/other household members.

**d) Behaviour Support**

The Provider will:

- Ensure that behavioural support is addressed in the service users Individual Plan or Care and Rehabilitation Plan
- Support the development and implementation of programmes by other relevant specialist services
- Ensure that staff are trained and able to contribute to and implement behaviour support programme.

**e) Protocols**

RIDSAS will develop and maintain protocols with the RIDSS and RIDCA and mainstream services as appropriate. This is important to ensure that:

- Information is shared
- Service planning, transition planning and discharge planning occur in a timely manner.

**f) Natural Supports**

- 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.
- In addition to consideration and identification of the funded services that will benefit Hunga Haua, providers should include natural supports during assessment, support service planning and implementation with Hunga Haua 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.

Wherever possible Māori services will be encouraged to maintain links with their tribal affiliations which have been identified through Māori assessment protocol within RIDCA assessments.

### **5.1.2 Care Management (For Service Users Subject to ID(CC&R) Act)**

In addition the processes described above, persons subject to the ID(CC&R) Act (Care Recipients), will also have a Care Manager appointed to them. The appointment will be made by the RIDCA Care Co-ordinator.

The role of Care Manager is to fulfil the functions and duties as set out in the ID(CC&R) Act, including working with the Care Recipient's to develop a Care and Rehabilitation Plan that reflects the Care Recipient's needs and goals. To achieve this the Care Manager will need to complete the following tasks:

- Contribute to the Care Recipient's support needs assessment
- Work with others to develop a comprehensive understanding of the Care Recipient's needs
- Develop a Care and Rehabilitation Plan
- Provide information to the Care Recipient on all their rights
- Liaise with providers and other agencies to ensure that the Care and Rehabilitation Plan can be implemented
- Convene or participate in meetings as required with the Care Recipient and those involved in the development and/or implementation of a Care and Rehabilitation Plan
- Ensure that all aspects of the Care and Rehabilitation Plan are co-ordinated and that the roles and responsibilities of providers are understood on a day to day basis
- Providing ongoing support to the service user, their network and providers
- Seek approval of the Care and Rehabilitation Plan from the Care Recipient's Care Co-ordinator
- Monitor the service user's progress according to the Care and Rehabilitation Plan and adjust the Plan as required with the agreement of the Care Co-ordinator and within the confines of the Order
- Co-ordinate the review of the Care and Rehabilitation Plan, including working with the Specialist Assessor
- Engage in tasks as outlined in the Ministry document, "Roles and Responsibilities of Care Managers" (Ministry Procedure Manual ID(CC&R) Act 2003)

### 5.1.3 Intensive Service Management

The role of intensive service management is to work with the Civil population to:

- Contribute to the service user's support needs assessment
- Work with others to develop a comprehensive understanding of the service user's needs
- Develop an individual plan
- Provide information to the service user on all their rights
- Liaise with providers and other agencies to ensure that the individual plan can be implemented
- Convene or participate in meetings as required with the service user and those involved in the development and/or implementation of the individual plan
- Ensure that all aspects of the individual plan are co-ordinated and that the roles and responsibilities of providers are understood on a day to day basis
- Providing ongoing support to the service user, their network and providers
- Monitor the service user's progress according to the individual plan and adjust the plan as required with the agreement of the RIDCA
- Co-ordinate the review of the individual plan.

### 5.1.4 Transition Management

The role of transition management is to work with the Civil population and those under ID(CC&R) Act orders to transition services users; from Regional Intellectual Disability Secure Services (RIDSS) to RIDSAS<sup>1</sup> and from RIDSAS to mainstream disability support services. To achieve this the following tasks will need to be completed:

- Work with the RIDCA and others to determine at what stage the individual no longer requires a RIDSAS level service and is ready to transition to mainstream services
- Develop, in conjunction with the RIDCA and others, a comprehensive transition plan
- Convene or participate in transition meetings as required with the service user and those involved in the development and/or implementation of the transition plan
- Ensure all aspects of the transition plan are co-ordinated and the roles and responsibilities of all providers are understood

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<sup>1</sup> Please note that it is the responsibility of the RIDSS to lead the transition process for clients exiting RIDSS. The RIDSAS transition management function is to work with the RIDSS to receive the client in to RIDSAS services in accordance with the agreed transition plan.

- Provide ongoing support to the service user, their network and other providers prior to and after their transition. The period of time for this involvement will be outlined in the service user's transition plan. The transition plan will also outline the time requirements for a formal review of the transition plan.
- Monitor the service user's progress in accordance with the transition plan and adjust the plan as required with the agreement of the RIDCA

## 5.2 Interventions and Programmes

The Provider will make available and/or provide access to activities and programmes specifically to address service user needs as identified in the Individual Plans developed by the RIDSAS and Care and Rehabilitation Plans. Content and format of programmes and interventions will be accessible to the service user, for Māori service users, e.g. practising Te Reo.

There will be multidisciplinary input into the development, oversight and review of interventions and programmes.

## 5.3 Service Levels

### 5.3.1 Residential Accommodation

<b>Function</b>	To provide community based residential services for people requiring 24-hour intensive support.
<b>Nature of the Service</b>	<p>This is a community-based service. Homes will be safe and comfortable, shared by no more than 5 service users. Houses with 5 or more residents will require the appropriate certification. Variation to the number of people per house (above 5) is to be approved on a situation by situation basis with the Ministry. Each service user will have his or her own bedroom, except for couples who choose to share. There will be no identifying features (signage) on the house or vehicles to denote the house/vehicle as different from others.</p> <p>Furnishings will reflect age and appropriate living environments, particularly in the lounge and living areas. Where possible and appropriate, service users will be encouraged to have personal belongings. Where not appropriate this will be stated in the Individual Plan.</p> <p><b>Planned breaks from the service</b></p> <p>The service users' need for planned breaks from the service will have been considered and planned for as part of the individual planning process. The leave provisions under the ID(CC&amp;R) Act will be adhered to for all Care Recipients.</p> <p><u>Civil Population</u></p> <p>Each service user will have an identified Intensive Service Manager. An individual plan will be developed with each service user and his/her intensive service manager, in conjunction with the RIDCA Intensive Service Co-ordinator. Service users will progress to greater independence by developing skill and supports, in accordance with their Individual Plan.</p>

### Care Recipient

Each Care Recipient or proposed Care Recipient (i.e. subject to a court order under the ID(CC&R) Act) will have an identified Care Manager appointed by the RIDCA Care Co-ordinator. The Care Manager will develop a Care and Rehabilitation Plan reflecting how Care Recipients will progress to greater independence by developing skills and supports in accordance with their Care and Rehabilitation Plan. Care and Rehabilitation plans will be regularly reviewed as set out in the ID(CC&R) Act.

Any changes to the Care and Rehabilitation Plan must be in accordance with the court order or an application be made to the Care Co-ordinator to apply to the court to vary the court order. (Section 28 ID(CC&R) Act and see also the Ministry Procedure Manual ID(CC&R) Act 2003 – Guidelines for the role and function of compulsory Care Co-ordinators 2004 page 11.

Within the home the provider encourage service users to:

- Participate as fully as they are able in household tasks e.g. cleaning, meal preparation, shopping etc
- Take responsibility for household management decisions and activities

Outside the home service users will be:

- Encouraged to participate in age appropriate and valued social and community activities
- Encouraged to learn skills to enable maximum use of community amenities.

Services provided include:

- Support
- Training and education
- Implementation of programmes aimed at increasing independence
- Input and participation into the development of Individual Care Plans and programmes
- Working collaboratively with other providers
- Close observation, maintenance of safety through proactive intervention.

The Provider will ensure secure, physically safe internal and external environments that meet the particular requirements of service users and comply with court orders for Care Recipients. Staffing levels, behavioural management techniques and alternative activities are considered primary means for providing physical safety of service users.

The Provider will ensure secure care when required and legally authorised by the courts, including measures that may limit or alert the provider to movement from the property.

The home will provide 24-hour intensive and active support. The service will be flexible in the provision of night-time support i.e. whether awake or sleepover staff are needed will depend on the needs of the service user as defined in IP or Care and Rehabilitation plan.

<p><b>Staff</b> <b>(Refer 5.6)</b></p>	<p>The service is provided by a mix of clinical staff (professionally qualified eg nurses, psychologists, occupational therapists), senior staff with relevant expertise and support workers. There must be a sufficient number of clinical staff to ensure that there is 24-hour access and support.</p> <p>The minimum requirement is for 8 hours of direct availability per day and on call for the remainder.</p> <p>Support workers will be trained to an acceptable standard.</p> <p>Each service will employ Care Managers who will be able to be designated to that role for each Care Recipient by the RIDCA Care Co-ordinator. The Care Manager will retain legal responsibility for Care Recipients as set out in the ID(CC&amp;R) Act.</p> <p>Care Managers will be required to hold a relevant health and disability qualification.</p>
<p><b>Key Processes</b></p>	<p>Persons accessing this service can expect, as a minimum, to access advocacy, assessment, care management (if a Care Recipient), intensive service management, transition management, discharge planning, hotel services including, and where appropriate, legal compliance, management of risks, peer support, collaborative service delivery, treatment, rehabilitation.</p>

### 5.3.2 Assessment Beds

<p><b>Function</b></p>	<p>To provide residential support services for people on short notice from the RIDCA for assessment purposes. This service is capacity purchased in recognition that it needs to be available at all times.</p>
<p><b>Nature of the Service</b></p>	<p>An identified number of beds will be available for use by RIDCA for accommodation for those who require assessment. Referrals will always be by RIDCA. Some may come through RIDCA at the direction of the Court and for the civil population on the judgement of the RIDCA. While beds do not need to be in a specific location they must be available and adequately staffed with little advance notice.</p> <p>The service will consist of short term placement in either supervised or secure accommodation.</p> <p>In general assessment periods should take no longer than approximately 30 days. Assessment beds will not to be used for long term placement.</p> <p>The service will be prioritised by RIDCA. A crisis may indicate the need for a change in existing circumstances. The RIDSAS will contact the Care Co-ordinator ID(CC&amp;R)/Intensive Service Co-ordinator (Civil Population) to address any issues that the crisis may have highlighted as these become apparent.</p> <p>The RIDCA are expected to manage the entry and exit of the beds to accommodate need. When circumstances occur where the volume of beds needed is above the capacity purchased, the provider may negotiate with the RIDCA to provide further beds.</p> <p>Each service user will have an identified key worker for the period of time they are in the service. If they are a proposed Care recipient they will have a</p>

	<p>designated Care Manager.</p> <p>The service includes the supply of hotel services where required.</p>
<b>Staff (Refer 5.6)</b>	<p>The service is provided by staff with appropriate qualifications, competencies and experience in working with people whose behavioural needs are high and complex.</p> <p>Support workers will be trained to an acceptable standard.</p>
<b>Key Processes</b>	<p>Service users accessing this service can expect as a minimum to be able to access advocacy, assessment, care management (where appropriate), intensive service management, transition management, discharge planning, hotel services, legal compliance, management of risks, peer support and collaborative service delivery.</p> <p>The provider should ensure that when the service users receive emergency support in existing accommodation, the effect on any other service user is minimised.</p>

### 5.3.3 Life Skills and Day Activity Services

<b>Function</b>	<p>To provide support services that assist service users to participate in activities that will develop skills and experience for employment and stimulating meaningful occupation or participation in other meaningful activities, including community participation.</p>
<b>Nature of the Service</b>	<p>The life skills and day activity service provides service users (including Care Recipients) with the support, stimulation, training and assistance necessary to develop skills and gain experience related to work and meaningful activity.</p> <p>These services will promote community involvement through the activities provided.</p> <p>These services will provide a flexible and varied programme of activities, determined largely by the individual needs of each service user/Care Recipient, and will provide a safe environment of mutual support and information exchange.</p> <p>The style of the services will be such that:</p> <ul style="list-style-type: none"> <li>• There is an emphasis on supporting and building the strengths of each individual</li> <li>• There is an emphasis on meaningful and valued skill development</li> <li>• The particular needs of Māori and Pacific Island people are met by the provision of culturally derived and appropriate skills programmes</li> <li>• Options and activities are age and gender appropriate.</li> </ul> <p>Each service user will have a key worker for the period she/he is accessing the services. The key worker will work with the service user/Care Recipient to</p>

	<p>develop an Individual Plan in conjunction with Intensive Service Co-ordinator (for those not subject to a Compulsory Care Order) or the Care Manager (for Care Recipients subject to a Compulsory Care Order). This will describe the individual's goals, activities to be undertaken and the outcomes sought through these activities.</p> <p>The Intensive Service Co-ordinator or Care Manager will sign off the Individual Plan. The Individual Plan will be reviewed every 3 months or sooner if there is a change in the need</p>
<b>Key processes</b>	<p>The service users/Care Recipients accessing these services can expect as a minimum to be able to access all of the following processes:</p> <p>Advocacy, assessment, case management where appropriate, discharge planning, legal compliance, management of risk, peer support, service handover, vocational support, treatment and rehabilitation.</p>
<b>Access</b>	<p>Access to life skills and day activity funding will be through RIDCA. The provider should not assume that people living in RIDSAS would be requiring a Life Skills Day Activities service from that RIDSAS. Service users will access the option that is best able to meet their individual needs as described in their Care Plan. The RIDSAS provider may provide staffing support to ensure safe and meaningful attendance at a programme.</p>

#### 5.4 Equipment

The provider will supply standard (non-customised) equipment necessary to meet needs including equipment for general use including commodes, rails, raised toilet seats, shower stools, adjustable beds, hoists and chairs in group home settings.

#### 5.5 Facilities

The provider will meet the requirements as set in the Provider Quality Specifications of Health and Disability Sector Standards.

#### 5.6 Key Inputs

##### Staffing

The provider will have sufficient staff to provide a level of service to meet the service users' assessed needs. Staff will have received training that enables them to deliver a service in keeping with the national best practice indicators.

Staff composition and competencies will reflect the needs of service users served. The provider will have staff with significant competency in understanding and addressing the needs of people with high and complex behavioural needs and ensuring that the skills base is readily available to support workers and family and available to influence planning and delivery. This will include staff who have undertaken relevant training from a range of professional disciplines e.g. health, behavioural and social sciences. Where the Provider does not have specialist staff to address specific service user/Care Recipient needs, it will be expected to develop service linkages to facilitate access to that expertise.

It is expected that the provider maintain an active commitment to staff development, including family, whanau as appropriate with training. Staff development should be used as a means to enrich relationships with other providers and related sectors.

Core competencies of support workers should include but not be limited to the areas of disability, knowledge, values (social theories of disability, integration, least restrictive alternative, the right to live in the community), service user-centred services, cultural needs and cultural awareness, physical care of people, augmentative communication, communication skills and behavioural management and particular needs of service users as they change.

The provider will actively encourage, promote and develop Māori staff, to be employed at all levels of the service to reflect the service user population.

### **Care Recipients**

For Care Recipients the provider will be required to employ staff competent to carry out the duties, powers and functions of the Care Manager as specified in the ID(CC&R) Act. Care Managers will be designated by the RIDCA Care Co-ordinator and required to hold a relevant health and disability qualification.

## **6 SERVICE LINKAGES**

It is critically important that RIDSAS and the other providers work together to ensure that:

- Service users have access to the full range of services
- Disputes among providers concerning service coverage are resolved without adversely affecting any service user
- Disputes among providers concerning the course of treatment of any service user are resolved in a timely manner
- Regional coverage is provided.

RIDSAS is required to demonstrate effective linkages with these key agencies or Providers:

- RIDCA
- Community Liaison Teams
- Other supported accommodation providers
- Behaviour support services
- Hospital level secure services
- Dual diagnosis services
- Court and Corrections services
- Vocational services and day programmes
- Child, Youth and Family services

- Forensic Services
- Specialist Assessors
- District Inspectors
- Local Police.

There are a range of other services with whom linkages must also be established:

- Māori primary and community care services
- Other appropriate Māori organisations
- Other general Mental Health services
- Generic NASC agencies
- Consumer advocacy services
- Vocational services
- Other sector agencies.

The Ministry requires the RIDSAS to provide evidence of the effectiveness of relationships, particularly with RIDCA, other RIDSAS and RIDSS providers. The existence of and adherence to protocols between providers of these services will be an area for audit.

## **7 EXCLUSIONS (services not covered in this specification)**

The following items are excluded from the negotiated contract price. These services may be purchased by the Ministry through a separate service agreement or by another service funder. The provider is required to ensure the service user has access to:

- Specialist Behaviour Support Services (otherwise contracted by the Ministry). However, RIDSAS systems and staff are expected to provide higher levels of behavioural expertise in order to appropriately manage and support the client group
- Mental Health services
- Specialised assessment services including assessment for individual equipment via an appropriate specialist equipment/seating service. The assessment and supply of specialist equipment for individual use is through the Equipment Management Service (EMS)
- Customised equipment accessed through personal health services or accredited assessors such as wheelchairs modified for an individuals use accessed through EMS
- The provision of equipment, assistive devices, medical and incontinence supplies/aids or services that relate to conditions covered by personal health services that are funded through the personal health care budget except where these have been specified in the contract. However the service continues to be responsible for ensuring the service user has access to these services

- Vocational and/or educational services as funded through Work and Income or Ministry of Education
- Where the service is not funded for 24 hour support e.g.. supported independent living, other day programmes funded by the Ministry of Health
- Specialist dental services that are funded by personal health budget of the District Health Board (DHB)
- Other personal health services such as district nursing.

### **Individual service user responsibility**

The following items are the responsibility of the individual service user. They are excluded from the negotiated contract price:

- Clothing and personal toiletries, other than ordinary household supplies. However the provider is responsible for ensuring the service user, next of kin or agent as required purchases these items consistent with the preferences of the individual service user
- Telephone call charges for toll calls made by the person
- Services such as hairdressers. However, the service is responsible for ensuring that the service users have access to these services
- Transport costs to individual social functions and family visits outside their local communities
- General Practitioner visits to GP surgery. Where there are additional fees as a result of GP home visits (because of safety concerns) the provider is expected to meet this cost. There may be circumstances where it is in the interests of the service user's physical well-being for payment responsibility to rest with the provider. The need for such variation will arise when the service user is subject to the ID(CC&R) Act and will be detailed (including costs) in the Care and Rehabilitation Plan and signed off by the RIDCA Care Co-ordinator
- Pharmaceutical part-changes. However the provider is responsible for ensuring the service user has access to full entitlements related to high use of medical services.

## **8 QUALITY REQUIREMENTS**

The Provider is required to comply with the MOH General Contract Terms, the MOH Provider Quality Specifications and where appropriate the Health & Disability Standards NZS 8134. It is expected that providers will meet best practice standards and meet practice guidelines that exist on relevant issues e.g.:

- Administration of Psychotropic Medication
- Restraint Minimisation.

In accordance with the Provider Quality Service Specifications other quality indicators will be incorporated as part of your internal evaluation and service development plan.

These include:

1. Adaptability of the service to respond to new research developments and policy guidelines in the intellectual disability field. It is also expected that there is development in best practice programmes for strategies to increase the inclusion of people with disabilities in the day to day management of their home environment
2. Development of professional relationships with referrers
3. Comprehensiveness of the programme to cater for diversity amongst residents
4. Maintenance of service user records to reflect clear, current, accurate and complete information.

## 9 PURCHASE UNITS

Services will be purchased according to the level of need and type of service required by the service user as assessed by the RIDCA.

Purchase Unit Code	Purchase Unit	Measure	Purchase Measure Definition	Unit	Purchase Unit Definition
DSSCMGR	Care Manager	FTE	1 FTE: 8 Care Recipients*		Care Manager
	Intensive Service Management	FTE	1 FTE: 10 Civil Clients *		Intensive Service Manager
	Transition Management				Transition Management
DSSRDSA	Emergency/Assessment beds	Beds			
DSSRDSA	Secure services**	Beds			As defined by court: Care Recipients only
DSSRDSA	Supervised Services**	Beds			For Care Recipients not subject to secure placement and the civil population
DSSRDSA	High and complex Life Skills and Day Activity Services	Half days	A half day is regarded as programme or activity for 3 hours but cover will be given for lunch when a person is attending a full day session		Life Skills and Day Activity Services may include attendance in a service operated by the provider; a programme external to the provider; or staffing support to attend a

				programme.
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\* This number is estimated. Ratios may increase/decrease once evaluated by the Ministry.

\*\* Secure and Supervised as defined by the Ministry during the term of this contract.

Services will report at 6 monthly intervals using the Performance monitoring Templates which will be supplied on the reporting requirements detailed below. The templates supplied will require a monthly information breakdown.

The following purchase units and reporting requirements apply to this service. Reporting requirements have not been finalised and may be subject to alteration during the term of this contract.

## 10 REPORTING REQUIREMENTS

PU ID	PU Short Name	Reporting requirements	
		Frequency	Information
DSSRIDSA	High and complex residential services	6 monthly	<b>Volume Reporting Requirements</b> <ol style="list-style-type: none"> <li>1. Number of new referrals to residential services by month <ul style="list-style-type: none"> <li>• Secure</li> <li>• Supervised</li> <li>• Civil</li> </ul> </li> <li>2. Number of residential service users on waiting list (waiting to access services) by month <ul style="list-style-type: none"> <li>• Secure</li> <li>• Supervised</li> <li>• Civil</li> </ul> </li> <li>3. Average time in days from when referral first received to when residential service user receives service</li> <li>4. Total number of residential service users by month <ul style="list-style-type: none"> <li>• Secure</li> <li>• Supervised</li> <li>• Civil</li> </ul> </li> <li>5. Total number of occupied residential bed days per month <ul style="list-style-type: none"> <li>• Secure</li> <li>• Supervised</li> <li>• Civil</li> </ul> </li> </ol>
DSSRIDSA	Emergency/Assessment beds	6 monthly	<ol style="list-style-type: none"> <li>6. Total number of contracted Emergency/Assessment beds</li> <li>7. Total number of occupied Emergency/Assessment bed days by month</li> <li>8. Total number of</li> </ol>

			Emergency/Assessment service users by month
DSSRIDSA	High and complex Life Skills and Day Activity Services	6 monthly	9. Numbers of Day Activity service users in programmes per month 10. Average time in days from when referral first received, to when service user receives Day Activity service 11. Number of Day Activity sessions delivered per month
		6 Monthly	12. Narrative report as per section 12.1

**NB:**

Narrative reports can be submitted at any time if there are issues that you wish to raise e.g: un-met need.

The report for each period is due by the 20<sup>th</sup> of the month following the end of the 6 month period. Delays beyond this date will be notified to us:

The periods for reporting are:

1 July to 31 December - due by 20 January

1 January to 30 June - due by 20 July

Throughout the term of agreement where the agreement begins or ends part way though a period, the report will be for part of the period that falls within the term of agreement.

You shall forward your completed Performance Monitoring Returns to:

The Monitoring Team  
HealthPAC  
Ministry of Health  
Private Bag 1942  
Dunedin

## **11 OTHER REQUIREMENTS**

### **11.1 Legislation**

RIDSAS provider will be required, under the terms of contract to abide by all relevant New Zealand legislation including but not limited to:

- Intellectual Disability (Compulsory Care & Rehabilitation) Act (2003)
- Mental Health (Compulsory Assessment and Treatment) Act (1992)
- Criminal Procedure (Mentally Impaired Persons) Act (2003)
- Victim Rights Crimes Act (2002).

### **11.2 Guidelines**

The RIDSAS 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 Practice NZ8141
- From December 2005 or as Ministry advises: Best Practice Framework for people working with Hunga Hāua (published by Ministry of Health)
- From December 2005 or as Ministry advises: Te Reo Resource Toolkit (published by Ministry of Health).
- *Guideline for the transfer of RIDCA clients to NASC, 2006*, Ministry of Health

### **11.3 Other Protocols**

The provider will also observe other protocols and/or Memoranda of Understanding (MOU) negotiated between the Ministry and other government departments and agencies.

## 12 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. Report may be sent via email.

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.

### 12.1 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 Practice Framework).

### 12.2 Certification

All homes for five or more people must be certified by the Ministry of Health under the Health and Disability Services (Safety) Act 2001.

All homes are required to meet all relevant New Zealand Legislation

## 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) :** *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)) as district inspector or deputy district inspector under the ID(CC&R) Act. A District Inspector is a barrister or solicitor whose role 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. However, they may be under other orders (outline these).

**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) *s 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 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 CP(MIP) Act, these assessments will be requested by the RIDCA or NASC to establish eligibility and management or planning.*