

# **Disability Support Services**

## **Tier Two Service Specification**

### **Regional Intellectual Disability Supported Accommodation Service (RIDSAS)**

#### **1. Introduction**

This tier two service specification provides the overarching service specification for all Regional Intellectual Disability Supported Accommodation Service (RIDSAS) Services funded by Disability Support Services (DSS). It should be read in conjunction with the DSS Tier One Service Specification, which details requirements common to all services funded by DSS.

#### **2. Service 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 People includes those covered by the provisions of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (ID(CC&R) Act) and the National Intellectual Disability Care Agency (NIDCA) eligible civil population who are not subject to an (IDCC&R) court order.

The Ministry wishes to purchase the following national and regional network of services:

- a. National Intellectual Disability Care Agency (NIDCA) – a specialist needs assessment and service co-ordination agency. Eligibility for all the following services is defined through NIDCA
- b. Regional Intellectual Disability Supported Accommodation Service (RIDSAS) providing community secure, supervised and/or services including vocational services and day activities.
- c. National Intellectual Disability Secure Services (NIDSS) Hospital level forensic assessment and long term placement
- d. Regional Intellectual Disability Secure Services (RIDSS) (Hospital level assessment and long term placement)

- e. 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. (See Appendix 1 for regional boundaries).

## 2.1 Key terms

The following are definitions of key terms used in this service specification:

Term	Definition
<b>Care Co-ordinator</b>	Means a person who is appointed by the Director General of Health under Section 140 of the ID(CC&R) Act 2003 in a designated geographical area, defined in the appointment. They are also referred to as Compulsory Care Co-ordinator or Co-ordinator under the ID(CC&R) Act. The role is described in section 140 of the ID(CC&R) Act. In general, the role of the Care Co-ordinator is to oversee the operational administration of the Act. They also provide needs assessment and work closely with organisations to ensure specialised services are provided.
<b>Care Manager</b>	Means 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.
<b>Care Recipient</b>	Means persons subject to the ID(CC&R) Act are known as care recipients. Care recipients who are special care recipients must receive secure care, while other care recipients may be eligible for supervised care, that is, care that may be given in a place other than a secure facility.
<b>Civil Client / Population</b>	Means Person / People receiving services coordinated through the NIDCA 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 legal orders.
<b>Community Liaison Team (CLT)</b>	Means a team of multi-disciplinary professionals who offer consultation and liaison services to all NIDCA eligible people. 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 Person will inform the decision around who would best fill this function. In the Community the role of the CLT is to proactively assist NIDCA eligible People, 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 care and rehabilitation programmes.

<b>Term</b>	<b>Definition</b>
<b>CP(MIP) Act</b>	Means the Criminal Procedure (Mentally Impaired Persons) Act (2003) (replaces Part 7 Criminal Justice Act (1985) (CJA))
<b>District Inspector (DI)</b>	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 role it is to ensure a Person's rights are upheld.
<b>ID(CC&amp;R) Act</b>	Means the Intellectual Disability (Compulsory Care and Rehabilitation) Act (2003).
<b>Intellectual Disability</b>	Means the definition used in Section 7 of the ID(CC&R) Act.
<b>Intensive Service Co-ordinator</b>	Means a role developed specifically for People eligible for NIDCA services who are not subject to the 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 Person and the Co-ordinator.
<b>NIDCA</b>	Means the National Intellectual Disability Care Agency. This is the administration agency of the legislation. The Care Co-ordinator function sits within NIDCA.
<b>People/Persons</b>	Means the individual/s using the services described in this specification. (not applied to Secure Services Matrix see Appendix 2).
<b>Region</b>	Means the geographic areas described in the map in Appendix 1.
<b>RIDSAS</b>	Means Regional Intellectual Disability Supported Accommodation Service. These services provide community assessment beds, residential and vocational agencies. The Care Manager function sits within RIDSAS.
<b>RIDSS</b>	Means Regional Intellectual Disability Secure Services. This service provides hospital level secure services and assessment beds. RIDSS also provide the Community Liaison Team (CLT) contracts. A 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 Person will inform the decision around who would best fill this function. (See also Community Liaison Team above.)
<b>Secure Care</b>	Means the definition used in the ID(CC&R) Act (please refer to section 63 and 64 of the ID(CC&R) Act).
<b>Specialist Assessment</b>	Means a specialist clinical assessment completed by Specialist Assessors who will be psychologists or psychiatrists. For the purpose of the ID(CC&R) Act or CP(MIP) Act, these assessments will be requested by the NIDCA or NASC to establish eligibility and management or planning.

### **3. Service Objectives**

#### **3.1 The Provider will:**

- a. Encourage and support People to increase their independence and self-reliance.
- b. Support People to attain and maintain maximum independence, full physical, mental, social, and vocational ability, and full inclusion and participation in all aspects of life.
- c. Ensure People live in an environment that safeguards them from abuse and neglect and ensures their personal security and safety needs are met.
- d. Encourage People to experience opportunities for optimum health, wellbeing, growth and personal development including staff proactively seeking opportunities and experiences for People they support.
- e. Actively support People to integrate in the life of their community and where appropriate to be involved with friends and family, in accordance with their choice and personal goals.
- f. Ensure support staff are well trained and qualified to positively support the Person and meet their needs.
- g. Ensure the Person, and his/her family / whānau / guardians / advocate (with the consent of the Person), have input into all aspects of the service (such as staffing, Individual Planning, and Governance).
- h. Work collaboratively and co-operatively together with Providers of services for NIDCA-eligible Persons.
- i. Provide support at the level necessary for people to have a safe and satisfying home life.

### **4. Service Performance Outcome Measures**

4.1 Performance Measures form part of the Results Based Accountability (RBA) Framework. The Performance Measures in the table below represent key service areas the Purchasing Agency and the Provider will monitor to help assess service delivery. Full Reporting Requirements regarding these measures are detailed in Appendix 3 of the Outcome Agreement. It is anticipated the Performance Measures will evolve over time to reflect Ministry and Purchasing Agency priorities.

4.2 Measures below are detailed in the Performance Measures Data Dictionary, available on the Ministry's website, which defines what the Ministry means by certain key phrases.

	<b>How much</b>	<b>How well</b>	<b>Better off</b>
1.	# of care plans reviewed and signed off by the Person at least once every 6 months	% of care plans reviewed and signed off by the Person at least once every 6 months	
2.			#/% of goals in personal plans achieved
3.		% of frontline staff who have obtained the Level 2 National / NZ Certificate in Health, Disability, and Aged Support	
4.			#/% of Māori who are active participants in their whānau, hapū, iwi and communities
5.			#/% of People who are active participants in their community
6.			#/% of People accessing meaningful employment (including voluntary employment), training or education
7.			#/% of care recipients and civil clients who transition out of NIDCA services
8.			#/% of compulsory care orders that are extended

## 5. Service Eligibility and Entry

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

- a. They are subject to the provision of the ID(CC&R) Act. This group are referred to as Care Recipients because their services have been mandated by the Court. Although 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, there are certain requirements that the RIDSAS and RIDSS providers must adhere to if they are supporting children and young people. These requirements are

governed by the United Nation's Convention on the Rights of the Child (UNCROC).

- b. They 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.

## **5.2 Access Criteria**

- 5.2.1 The NIDCA will manage all referrals to the service. Referrals from any other source received shall be redirected to the NIDCA.
- 5.2.2 Access to RIDSAS is through NIDCA and the nature of the service required may be defined:
  - a. through the ID(CC&R) Act by the courts, or
  - b. through NIDCA service agreements.
- 5.2.3 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. Where the Person is a Care Recipient under the ID(CC&R) Act, the NIDCA 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.
- 5.2.4 If the placement is for assessment, such assessment will be undertaken (by the specialist assessor appointed by the NIDCA) during the time of that placement.
- 5.2.5 The provider shall accept all referrals from the NIDCA. Where there are difficulties accepting a Person because of insufficient capacity, compatibility or preparation requirements, the provider is expected to work with the NIDCA 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.
- 5.2.6 The level and type of service the Person receives will reflect the Person'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, the Intensive Service Co-ordinator (for a Person who has civil status).
- 5.2.7 Access to assessment beds is managed by the NIDCA so that there is available capacity to respond immediately to court directions for placement for assessment. The NIDCA will prioritise service access and departure and

utilise the service as it deems appropriate. When circumstances occur where the volume of beds needed is above the capacity purchased, the provider may negotiate with the NIDCA to provide further beds.

### **5.3 Residential Support Subsidy**

5.3.1 People receiving residential support services who are also receiving a main benefit from Work and Income will generally be required to contribute to the cost of residential support (there are some exceptions).

5.3.2 It is the Provider's responsibility to lodge an application for the Residential Support Subsidy with Work and Income to collect this benefit contribution. The Person has a right to receive their benefit directly and pass on the subsidy to the provider. Alternatively the Person may authorise Work and Income to pay the subsidy directly to the provider.

5.3.3 The provider is required to notify Work and Income within 24 hours of a Person's entrance or exit from the service.

### **5.4 Exclusions**

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

## **6. Service Types**

The range of services provided by RIDSAS includes:

### **6.1 Residential Accommodation Services**

6.1.1 This is a community-based service for people requiring 24-hour intensive support. Homes will be safe and comfortable. Providers will ensure that each house generally accommodates no more than groups of four to six People per house.

6.1.2 Any increase in the number of People per house above six must only occur when approved by the Ministry and involving the NIDCA. Any situation where there are more than six people in a house will be regularly reviewed to ensure it remains appropriate.

6.1.3 The provider will support and encourage People to:

a. Think about who or what their natural supports might be, and to have contact with them, or where no supports exist, to explore the possibilities of developing effective relationships with them. Natural supports include but are not limited to:

- Friends both outside and in the service setting

- Immediate and extended whānau members including hapū and iwi
  - Community activities / groups / education / courses
- b. Participate as fully as they are able in household tasks e.g. cleaning, meal preparation, shopping etc. for the purposes of increasing independence
  - c. Take responsibility for household management decisions and activities
  - d. Participate in age appropriate and valued social and community activities
  - e. Learn skills to enable maximum use of community amenities
  - f. Access training and education
  - g. Attend offender treatment programmes
  - h. Participate in programmes aimed at increasing independence
  - i. Have input into and participate in the development of Individual Care Plans and programmes.
    - Working collaboratively with other providers
    - Close observation, maintenance of safety through proactive intervention.

**6.1.4** The Provider will:

- a. Effectively manage the Person's health, welfare
- b. Support the Person to meet their legal obligations
- c. Work collaboratively with other providers
- d. Closely observe the Person and maintain safety through proactive intervention.

**6.1.5** Persons accessing this service can expect, as a minimum, to access advocacy, assessment, care management (if a Care Recipient) or intensive service management, transition management, discharge planning, hotel services where appropriate, support which is in compliance with legal requirements, management of risks, peer support, collaborative service delivery, treatment and rehabilitation.

**6.2** Assessment Beds

**6.2.1** Assessment beds are used as a short term placement in either supervised or secure accommodation. They are available for People on short notice from the NIDCA for assessment purposes. This service is capacity purchased in recognition that it needs to be available at all times.



- 6.2.2 Referrals will always be made by the NIDCA. Some may come through NIDCA at the Court's direction, and for the Civil Population referral will be on the judgement of the NIDCA. While beds do not need to be in a specific location they must be available and adequately staffed with little advance notice. The NIDCA will 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 NIDCA to provide further beds.
- 6.2.3 Assessment beds are funded on a capacity basis in order to ensure that they are available when required by the NIDCA. Responsibility for the assessment process will be defined by the NIDCA. In general assessment periods should take no longer than approximately 30 days and will not to be used for long term placement. Once a permanent placement is indicated the funding should transfer accordingly.
- 6.2.4 The service will be prioritised by NIDCA. A crisis may indicate the need for a change in existing circumstances. The RIDSAS will contact the Care Co-ordinator (ID(CC&R))/Intensive Service Co-ordinator (Civil Population) to address any issues that the crisis may have highlighted as these become apparent. The provider will ensure that when the Person receives emergency support in existing accommodation, the effect on any other Person is minimised.
- 6.2.5 Each Person accessing an assessment bed will have a keyworker and an identified Intensive Service Coordinator for the period of time they are in the service. If they are a proposed Care recipient they will have a designated Care Manager.
- 6.2.6 The service includes the supply of hotel services where required.
- 6.2.7 People 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 and peer support.
- 6.2.8 Assessment beds do not need to be in a specific location. They must be available and adequately staffed with little advance notice.

### **6.3 Life Skills and Day Activity Services**

- 6.3.1 The life skills and day activity service provides People (including Care Recipients) with the support, stimulation, training and assistance necessary to develop skills and gain experience related to work and meaningful activity.

These services will promote community involvement through the activities provided.

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

6.3.3 The Provider will:

- a. Ensure each Person has a key worker who will be involved in the development of the Individual Plan (in conjunction with the Intensive Service Coordinator for Civil Clients) or the Care and Rehabilitation Plan (in conjunction with the Care Manager for Care Recipients subject to a Compulsory Care Order).
- b. Deliver life skills and day activity programmes according to the agreed Individual Plan or Care and Rehabilitation Plan
- c. Work with other providers to assist the Person in accessing activities, educational and employment opportunities with appropriate support and funding from external sources according to the Person's Individual Plan and with the agreement of the NIDCA
- d. Deliver support services that assist People 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. These services will provide a flexible and varied programme of activities, determined largely by the individual needs of each Person/Care Recipient, and will provide a safe environment of mutual support and information exchange.

6.3.4 The style of the services will be such that:

- a. There is an emphasis on supporting and building the strengths of each Person
- b. There is an emphasis on meaningful and valued skill development
- c. The particular needs of Māori and Pacific Island people are met by the provision of culturally derived and appropriate skills programmes
- d. Options and activities are age and gender appropriate.

6.3.5 The People/Care Recipients accessing these services can expect as a minimum to be able to access all of the following processes: advocacy, assessment, case management where appropriate, discharge planning, legal compliance, management of risk, peer support, service handover, vocational support, treatment and rehabilitation.

- 6.3.6 The provider should not assume that people living in RIDSAS would be requiring a Life Skills Day Activities service from that RIDSAS. People will access the option that is best able to meet their individual needs as described in their Care Plan.

## **7. Service Components**

### **7.1 Planning**

The following requirements are in addition to those specified in the Tier 1 specification and the Health and Disability Sector Standards.

#### **7.1.1. Planning for and with Care Recipients**

- a. Each Care Recipient or Proposed Care Recipient (i.e. subject to a court order under the ID(CCR) Act) will have an identified Care Manager appointed by the NIDCA Care Coordinator.
- b. The Care Manager will:
  - Contribute to the Care Recipient's support needs assessment
  - Work with others to develop a comprehensive understanding of the Care Recipient's needs
  - Provide information to the Care Recipient on their rights
  - Develop a Care and Rehabilitation Plan based on the Care Recipient's support needs and legal requirements, with the involvement of the Person, and where appropriate, their family/ whānau/ guardian/ advocate
  - Ensure the Plan documents how Care Recipients will progress to greater independence by developing skills and supports.
  - 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 Person, their network and providers
  - Seek approval and sign-off of the Care and Rehabilitation Plan from the Care Recipient's Care Co-ordinator
  - Monitor the Person'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)
  - Ensure that all reviews required under the ID(CC&R) Act are completed
  - Ensure that any changes to the Care and Rehabilitation Plan will be in accordance with the court order or an application made to the Care Coordinator to apply to the court to vary the court order (see Section 28 ID(CC&R) Act).
- c. The Provider will ensure that:
- The Care and Rehabilitation Plan is implemented and adheres to the provisions of the ID(CC&R) Act.
  - The leave provisions under the ID(CC&R) Act are adhered to for all Care Recipients. Leave requests should align with the Care Recipient’s leave plan and be part of an identifiable pathway set out in the Care and Rehabilitation Plan.
- d. All People, under provisions of the ID(CC&R) Act, receiving life skills and day activity services will also have a 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.

### **7.1.2. Planning for and with Civil Clients**

Each Civil Client will have an identified Intensive Service Coordinator who will:

- a. Ensure each Civil Client has an Individual Plan developed in conjunction with the NIDCA Intensive Service Coordinator and the Person, and where appropriate, their family/ whānau/ guardian/ advocate. Civil Clients will progress to greater independence by developing skill and support in accordance with their Individual Plan.
- b. Contribute to the Person’s support needs assessment
- c. Work with others to develop a comprehensive understanding of the Person’s needs
- d. Provide information to the Person on their rights
- e. Liaise with providers and other agencies to ensure that the individual plan can be implemented

- f. Convene or participate in meetings as required with the Person and those involved in the development and/or implementation of the individual plan
- g. 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
- h. Providing ongoing support to the Person, their network and providers
- i. Monitor the Person's progress according to the individual plan and adjust the plan as required with the agreement of the NIDCA
- j. Co-ordinate the review of the individual plan.
- k. Ensure the Person's need for planned breaks from the service will have been considered and planned for as part of the Individual Planning process.

The Provider will ensure that the Individual Plan is implemented.

### **7.1.3. Generic Planning Requirements**

The Provider will ensure that:

- a. Each Person will have a key worker for the period she/he is accessing the services. The key worker will work with the Person/Care Recipient to 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).
- b. The Individual Plan and Care and Rehabilitation Plan will be reviewed at least six monthly and/or when there is a significant change in the Person's needs through co-ordination of the Care Manager or of the Care Coordinator or Intensive Service Coordinator as appropriate. The review will involve Specialist Assessor as appropriate.
- c. The Provider will ensure that the Individual Plan and Care and Rehabilitation Plan include:
  - Reason for ID(CC&R) order (care recipients only)
  - Summary of Person's history
  - Any health concerns
  - The Person's short and long term goals and timeframes for achievement
  - The supports activities and inputs required to achieve the goals outcomes sought through these activities (including Life skills and Day activities).
  - 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 Persons goals
- Transition planning
- Behaviour support
- Permitted Leave (Care Recipients only)
- Risk Statements (Care Recipients only).

## **7.2 Risk Management planning**

The Provider's Risk Management Plan shall address matters such as:

- a. The safety and security of the Person, 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 NIDCA and other provider. Risk Management Plans must meet legal requirements of Court orders applying to the Person and Occupational Safety and Health requirements
- b. Agreed strategies for managing challenging behaviour
- c. Agreed strategies for management of crisis and incidents. These should be documented and include appropriate responses taken
- d. Appropriate relationships and communication in crisis situations with family/whānau/advocates/neighbours/other household members.

## **7.3 Rehabilitation Programmes**

7.3.1 The provider shall ensure appropriate habilitation/rehabilitation activities and programmes are provided and monitored by persons appropriately skilled to administer them. These specific support, learning based or rehabilitation programmes will be provided to address Persons' goals in their Individual Plans.

7.3.2 The provider will work with the NIDCA to ensure People have 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 NIDCA, Community Liaison teams and community services in the planning and implementation of transition strategies.

## **7.4 Behaviour Support plan and implementation**

7.4.1 The Provider will support the development and implementation of programmes developed by other relevant specialist services.

7.4.2 When delivering behaviour support the provider will:

- a. Ensure implementation of behavioural management is consistent with relevant Ministry guidelines and policies.
- b. Ensure that challenging behavior is identified early and a referral is initiated to the Specialist Behaviour Support Service or CLT where the provider requires support to manage the behaviour effectively. The Specialist Behaviour Support Service may be consulted for advice outside of a formal referral.
- c. Cooperatively support the Specialist Behaviour Support Service or Dual Diagnosis Service to develop and implement any behaviour support or treatment plan for a Person.
- d. Ensure the home has and operates a policy of using positive behaviour support for managing challenging behaviours that incorporates the principle that a Person's freedom should be restricted only for safety reasons.
- e. Ensure that any behaviour support provided is managed through the use of a formal written plan so that a consistent and supportive approach is demonstrated. The behaviour support plan will be integrated with other planning done by the provider to support the Person.
- f. Ensure the behaviour support plan has the following components:
  - Assessment (including measurement and quantification of the behaviours of concern)
  - Implementation planning (including training of support people)
  - Implementation
  - Review of progress
  - Maintenance.
- g. When a behaviour support plan is implemented, measure progress by gathering the appropriate data (advised by the behaviour support specialist) on the frequency, duration and impact of the behaviours being managed.
- h. Ensure that all staff using the behaviour support plan are trained in how to use the techniques specified in the plan prior to the plan implementation. The provider is required to support training delivered by the Specialist Behaviour Support Service and support staff to apply the skills learned.
- i. Ensure that behaviour support plans are only written by people with specialist skills in behaviour support. Plans must be signed off by a Registered Psychologist who is experienced in the management of

challenging behaviour prior to the behaviour support plan commencing.

## **7.5 Considerations for Māori**

The provider will ensure that:

- a. The needs of Māori are considered in the context of the provision of care and rehabilitation
- b. Cultural assessments are provided under the IDCC&R Act as a mechanism to ensure that the needs of Māori are appropriately assessed and met
- c. The following cultural practices are incorporated into the care and rehabilitation of those who are Māori:
  - Care and rehabilitation provided reflect a holistic model to enhance the cultural perspective on the needs of the person and their whānau through appropriate assessment, care and rehabilitation
  - Culturally appropriate processes are established and maintained through the provision of care and rehabilitation. This may include implementation of Tikanga within support practices or specific focus on cultural activities as part of care and rehabilitation
  - Cultural assessments are undertaken by those also competent in the area of intellectual disability
  - Support the individual with maintaining or re-establishing linkages with iwi, hapū and whānau with consideration of the wishes of the individual.

## **7.6 Interventions and Programmes**

- 7.6.1 The Provider will make available and/or provide access to activities and programmes specifically to address a Person's 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 Person.
- 7.6.2 The Provider will ensure there is multidisciplinary input into the development, oversight and review of interventions and programmes.

## **7.7 Transition Management**

- 7.7.1 The role of transition management is to work with the Civil population and those under ID(CC&R) Act orders to transition services users:



- a. From Regional Intellectual Disability Secure Services (RIDSS) to RIDSAS<sup>1</sup>, and
- b. From RIDSAS to mainstream disability support services.

7.7.2 To achieve this, the Provider will:

- a. Work with the NIDCA and others to determine at what stage the Person no longer requires a RIDSAS level service and is ready to transition to mainstream services
- b. Develop, in conjunction with the NIDCA and others, a comprehensive transition plan
- c. Convene or participate in transition meetings as required with the Person and those involved in the development and/or implementation of the transition plan
- d. Ensure all aspects of the transition plan are co-ordinated and the roles and responsibilities of all providers are understood
- e. Provide ongoing support to the Person, their network and other providers prior to and after their transition. The period of time for this involvement will be outlined in the Person's transition plan. The transition plan will also outline the time requirements for a formal review of the transition plan
- f. Monitor the Person's progress in accordance with the transition plan and adjust the plan as required with the agreement of the NIDCA.

## **8. Key Inputs**

### **8.1 Staffing**

8.1.1 The provider will:

- a. Ensure the service is provided by a mix of clinical staff (professionally qualified e.g. nurses, psychologists, occupational therapists), senior staff with relevant expertise and support workers.
- b. Ensure sufficient staff to provide a level of service to meet the Person's assessed needs.
- c. Ensure staff receive training that enables them to deliver a service in keeping with best practice.

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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.

- d. Ensure staff composition and competencies reflect the needs of People served with a sufficient number of clinical staff to ensure that there is 24-hour access and support.
- e. Employ Care Managers who will be able to be designated to that role for each Care Recipient by the NIDCA Care Co-ordinator. The Care Manager will retain legal responsibility for Care Recipients as set out in the ID(CC&R) Act. Care Managers are required to hold a relevant health and disability and/or social science qualification.
- f. Maintain an active commitment to staff development and training, including family, whanau as appropriate with training. Staff development should be used as a means to enrich relationships with other providers and related sectors.
- g. Ensure where the provider does not have specialist staff to address specific the Person's/Care Recipient's needs that service linkages are developed to facilitate access to that expertise.
- h. Actively encourage, promote and develop Māori staff, to be employed at all levels of the service to reflect the diversity of People in the service.
- i. 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 Person as defined in an Individual Plan or Care and Rehabilitation plan
- j. Where identified by the Care Manager / Care Coordinator, provide staffing support to ensure a Person's safe and meaningful attendance at a programme.

8.1.2 The Provider will have staff who are competent to understand and address the needs of People with high and complex behavioural needs, and ensure this competence is shared with support workers and family and those involved in service 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. Core competencies of support workers include but are not be limited to:

- a. Disability, knowledge, values (social theories of disability, integration, least restrictive alternative, the right to live in the community)
- b. Person-centred services
- c. Cultural needs and cultural awareness
- d. Physical care of people
- e. Augmentative communication

- f. Communication skills and behavioural management including implementation of behaviour support plan
- g. Knowledge of particular needs of People as they change.

8.1.3 The Provider will ensure that staffing levels, behavioural management techniques and alternative activities are the primary means for providing physical safety of People.

## **8.2 Care Manager and intensive Service management**

8.2.1 For Care Recipients the Provider will 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 NIDCA Care Co-ordinator and required to hold a relevant health and disability qualification.

8.2.2 The role of the Care Manager is to fulfil the functions and duties as set out in the ID(CC&R) Act, including working with the Care Recipients to develop a Care and Rehabilitation Plan that reflects the Care Recipient's needs and goals.

8.2.3 Civil Population will also receive intensive care management similar to those under an ID(CC&R) Act order.

8.2.4 The role of the Care Manager and/or Intensive Service Coordinator is to:

- a. Contribute to the Person's support needs assessment
- b. Work with others to develop a comprehensive understanding of the Person's needs
- c. Develop a Care and Rehabilitation Plan and/or Individual Plan
- d. Provide information to the Person on all their rights
- e. Liaise with providers and other agencies to ensure that the Care and Rehabilitation Plan and/or Individual Plan can be implemented
- f. Convene or participate in meetings as required with the Person and those involved in the development and/or implementation of a Care and Rehabilitation Plan and/or Individual Plan
- g. Ensure that all aspects of the Care and Rehabilitation Plan and/or Individual Plan are co-ordinated and that the roles and responsibilities of providers are understood on a day to day basis
- h. Providing ongoing support to the Person, their network and providers

- i. Monitor the Person's progress according to the Care and Rehabilitation Plan and/or Individual Plan and adjust the plans as required with the agreement of the NIDCA.
- j. Co-ordinate the review of the Care and Rehabilitation Plan and/or Individual Plan, including working with any appropriate specialists
- k. Engage in tasks as outlined in the Ministry document, "Roles and Responsibilities of Care Managers" (Ministry Procedure Manual ID(CC&R) Act 2003) (care recipients only)  
<http://www.health.govt.nz/publication/guidelines-role-and-function-care-managers>
- l. For Care Recipients only, seek approval of the Care and Rehabilitation Plan from the Care Recipient's Care Co-ordinator.

### **8.3 Interface with Mental Health**

- 8.3.1 It is expected that many People 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 Person.
- 8.3.2 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 Person's needs.
- 8.3.3 For those whose needs are not subject to court orders who may present with an associated mental illness, the Provider will support the Person to access Community Mental Health services. Roles and responsibilities of Mental Health and Disability Services will be documented and reflected in Individual Plans and monitored by the Intensive Service Co-ordinator of the NIDCA.

### **8.4 Equipment**

- 8.4.1 People eligible for DSS-funded equipment may retain any equipment they have been issued that is intended for their sole use when they move to live in a community residential support home. Any other equipment should be returned to the Equipment Management Services (EMS) provider.
- 8.4.2 If a Person needs new personal equipment while living in community residential support services, they will need to have an assessment and a service request may be made. This assessment must be undertaken by an appropriately accredited EMS Assessor.
- 8.4.3 The equipment must be primarily for the Person's individual use or may be shared with another resident. Factors for consideration are:

- a. The availability or suitability of other equipment within their residential setting to meet the Person's needs
- b. Equipment may have a shared use (e.g. a hoist) where other People living in the same home have similar equipment needs
- c. The impact of the equipment not being provided, such as:
  - Increased level of assistance the Person might require from support staff
  - Risk of deterioration of their functional skills
  - Risk to their personal health and safety such as skin breakdown, development of joint contractures or escalation of challenging behaviour.

8.4.4 When a Person leaves one residential service and moves to another or if they leave community residential support services they can take their equipment to their new home. The Provider will supply equipment necessary for general use by the People in the home.

8.4.5 Refer to the Equipment Manual for further details:

<http://www.health.govt.nz/your-health/services-and-support/disability-services/types-disability-support/equipment-and-modification-services>

8.4.6 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.

## **8.5 Settings**

8.5.1 The provider will meet the requirements as set in the Tier 1 specification and Health and Disability Sector Standards.

8.5.2 The provider will ensure:

- a. Each Person has his, or her, own bedroom.
- b. The home has no identifying features (signage) on the house or vehicles to denote the house/vehicle as different from others.
- c. Furnishings reflect age and appropriate living environments, particularly in the lounge and living areas.
- d. Where possible and appropriate, People are encouraged to have personal belongings. Where not appropriate this will be stated in the Individual Plan. The provider must list all personal items that belong to the Person and keep this inventory on the Person's file.

- e. The home is secure, physically safe internal and the external environments meet the particular requirements of People and comply with court orders for Care Recipients.
- f. The home is suitable (as per the Secure Services Matrix see Appendix 2) and secure care is delivered when required and legally authorised by the courts, including measures that may limit or alert the provider to movement from the property.

## **9. Guidelines / Policies / Legislation**

### **9.1 Legislation**

9.1.1 The Provider will meet all relevant New Zealand legislative and regulatory requirements, including but not limited to:

- a. Certification for homes of five or more People as required under the Health and Disability Services (Safety) Act 2001
- b. For homes of less than five People, the Provider will meet the Home and Community Support Services Standards
- c. Intellectual Disability (Compulsory Care & Rehabilitation) Act (2003)
- d. Mental Health (Compulsory Assessment and Treatment) Act (1992)
- e. Criminal Procedure (Mentally Impaired Persons) Act (2003)
- f. Victim Rights Crimes Act (2002).

### **9.2 Guidelines/ Protocols/Conventions**

9.2.1 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:

- a. 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
  - A Guide to the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, 2004
  - Community Liaison Team Guidelines
  - NASC Liaison Guidelines
  - NIDCA Bed Utilisation Guidelines
  - NIDCA Eligibility Guidelines
  - NIDCA Reporting Guidelines
  - NIDCA Funding Guidelines
  - Care Managers Guidelines
  - Life Skills Day Activity Guidelines

- Cultural Assessment Guidelines
  - b. NZ Standards Restraint Minimisation and Safe Practice NZ8134.2
  - c. The United Nations Convention On The Rights Of Persons With Disabilities
  - d. The United Nations Convention On The Rights Of Children.
- Refer also to <http://www.health.govt.nz/our-work/disability-services/intellectual-disability-compulsory-care-and-rehabilitation-act-2003>

#### 9.2.2 The Provider will:

- a. Develop and maintain protocols with the RIDSS and NIDCA and mainstream services as appropriate, to ensure information is shared and service delivery components occur in a timely manner.
- b. Observe other protocols and/or Memoranda of Understanding (MOU) negotiated between the Ministry and other government departments and agencies.
- c. Ensure all UNCROC requirements, such as age mixing are adhered to.

## 10. Exit Criteria

### 10.1 Inter Region Transfers

10.1.1 The Provider will, in the first instance, provide service in the geographical catchment area that is defined in the geographical boundaries map attached as Appendix 1. NIDCA will manage referrals from other regions and negotiate placements within RIDSAS. NIDCA must give priority to people within their defined geographic catchment area before accepting those from other regions.

10.1.2 The Provider must ensure that any transfer of People between regions occurs with the minimum level of disruption to the Person and their 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 coordinated by the NIDCA.

### 10.2 Service Exit

10.2.1 In addition to the Discharge Planning provisions of the Tier 1 specification and the Health and Disability Sector Standards, any possible transfer to an alternate RIDSAS provider will be discussed and agreed with the Person's respective Intensive Service Co-ordinator or Care Co-ordinator within the NIDCA. Service exit must adhere to the Ministry of Health *Guideline for the transfer of NIDCA clients to NASC, 2006*.

10.2.2 Where a Person 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 Person:

- a. Family/ whānau/ guardian/ advocate immediately
- b. The NIDCA immediately
- c. The Ministry through a critical incident form. This must be within the time frame specified for reporting a critical incident in the Outcome Agreement (as soon as practicable / possible within 24 hours).

## **11. Linkages**

- 11.1 It is critically important that RIDSAS and other providers work together to ensure that:
  - a. People have access to the full range of services they need
  - b. Disputes among providers concerning service coverage are resolved without adversely affecting any Person
  - c. Disputes among providers concerning the course of treatment of any Person are resolved in a timely manner
  - d. Regional coverage is provided.
- 11.2 RIDSAS is required to demonstrate effective linkages with these key agencies or Providers:
  - a. NIDCA
  - b. Community Liaison Teams
  - c. Other supported accommodation providers
  - d. Behaviour support services
  - e. Hospital level secure services
  - f. Dual diagnosis services
  - g. Court and Corrections services
  - h. Vocational services and day programmes
  - i. Child, Youth and Family services
  - j. Forensic Services
  - k. Specialist Assessors
  - l. District Inspectors
  - m. Local Police.
- 11.3 There are a range of other services with which linkages must also be established:



- a. Māori primary and community care services
- b. Other appropriate Māori organisations
- c. Other general Mental Health services
- d. Generic NASC agencies
- e. Consumer advocacy services
- f. Vocational services
- g. Other sector agencies.

11.4 The Provider will maintain, and be expected to provide, evidence of the effectiveness of relationships, particularly with NIDCA, other RIDSAS and RIDSS providers. The existence of and adherence to protocols between providers of these services will be an area for audit.

## **12. Exclusions**

12.1 The following items are excluded from the 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 Person has access to:

- a. Specialist Behaviour Support Services (otherwise contracted by the Ministry). However, RIDSAS systems and staff are expected to provide high levels of behavioural expertise in order to appropriately manage and support the People.
- b. Mental Health services.
- c. 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).
- d. Customised equipment accessed through personal health services or accredited assessors such as wheelchairs modified for a Person's use accessed through EMS.
- e. 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 Person has access to these services.
- f. Vocational and/or educational services as funded through Work and Income or Ministry of Education.

- g. Specialist dental services that are funded by personal health budget of the District Health Board (DHB).
- h. Other personal health services such as district nursing.

12.2 The following items are the responsibility of the Person. They are excluded from the negotiated contract price:

- a. Clothing and personal toiletries, other than ordinary household supplies. However the provider is responsible for ensuring the Person, next of kin or agent as required purchases these items consistent with the preferences of the Person.
- b. Telecommunications charges incurred by the Person
- c. Services such as hairdressers. However, the Provider is responsible for ensuring that People have access to these services.
- d. Transport costs to individual social functions and family visits outside their local communities.
- e. General Practitioner (GP) 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 Person's physical well-being for payment responsibility to rest with the Provider. The need for such variation will arise when the Person 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 NIDCA Care Co-ordinator
- f. Pharmaceutical part-charges. However the Provider is responsible for ensuring the Person has access to full entitlements related to high use of medical services.

### **13 Quality Requirements**

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

- a. Supporting People to hold regular hui or home meetings at least monthly. This meeting can cover anything they choose to discuss, however ideally it will provide an opportunity to talk about People's rights, the service effectiveness and acceptability.
- b. Annual feedback from People and their whānau/ family/ guardian/ advocate that the service is meeting the Person's needs.

13.2 As part of the internal evaluation and service development plan the Provider will be responsible for:

- a. Adaptability of the service to respond to new research developments and policy guidelines in the 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.
- b. Comprehensiveness of the programme to cater for diversity amongst People.
- c. Maintenance of Persons' records to reflect clear, current, accurate and complete information.

## 14 Purchase Units

14.1 Purchase Units are defined in Ministry of Health's Nationwide Service Framework Purchase Unit Data Dictionary. The following table is a summary list of the tier two RIDSAS Purchase Unit Codes associated with this Service.

Purchase Unit Code	Purchase Unit	Measure	Purchase Unit Measure ratio	Purchase Unit Definition
DSSCMGR	Care Manager	FTE	1 FTE: 8 Care Recipients*	Care Manager
	Intensive Service Coordinator	FTE	1 FTE: 10 Civil Clients *	Intensive Service Coordinator
	Transition Management			Transition Management
DSSRIDSA	Emergency/Assessment beds	Beds		
DSSRIDSA	Secure services**	Beds		As defined by court: Care Recipients only
DSSRIDSA	Supervised Services**	Beds		For Care Recipients not subject to secure placement and the civil population
DSSRIDSA	Setup Costs			
DSSRIDSA	Reimbursement Travel/Expenses	n/a		
DSSRIDSA	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 person is	Life Skills and Day Activity Services may include attendance in a service operated by the provider; a programme

Purchase Unit Code	Purchase Unit	Measure	Purchase Unit Measure ratio	Purchase Unit Definition
			attending a full day session	external to the provider; or staffing support to attend a programme.

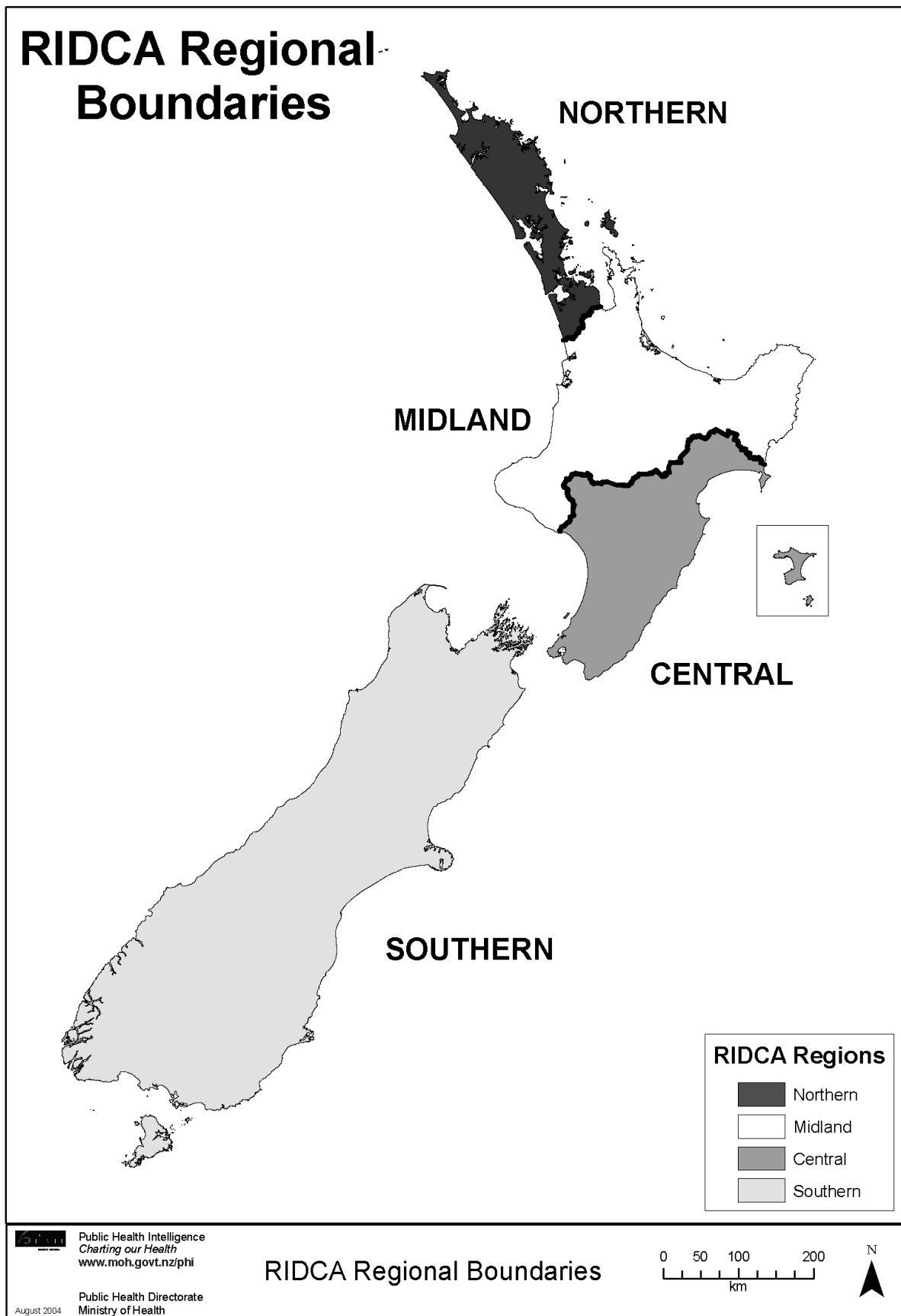
\* This number is estimated. Ratios may increase/decrease once evaluated by the Ministry.

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

## 15 Reporting Requirements

Full Reporting Requirements (including any Provider specific reporting requirements) are included in Appendix 3 of the Outcome Agreement.

## Appendix 1: Geographic region



## Appendix 2: Secure Services Matrix

<b>PROCEDURAL SECURITY</b> (Policy and Practice for Controlling Risk)		<b>Community Supervised</b> (Supervised Order)	<b>Community Secure</b> (Secure Order)	<b>Hospital Secure</b> (Secure Order)
Lines of Responsibility  (Management Arrangements)	<b>Management Resources</b>	Ensure clear lines of reporting and responsibilities		
	<b>Weekly Monitoring</b>	Weekly monitoring and benchmarking of admission transfer and discharge criteria		
	<b>Legal Compliance</b>	Ensure compliance with legal and policy requirements		
	<b>Inter-Agency Relationships</b>	Ensure maintenance and enhancement of inter-agency relationships and boundaries.		
<b>RELATIONAL SECURITY</b> (Staffing and Relationships)		<b>Community Supervised</b> (Supervised Order)	<b>Community Secure</b> (Secure Order)	<b>Hospital Secure</b> (Secure Order)
<b>Quantitative:</b>  The staff to patient ratio and amount of time spent face to face.	<b>Quantitative</b>	Ability to have wake night staff  Adequate to meet the requirements of individual Care and Rehabilitation Plan and manage challenging behaviours 24 hours per day.	Awake Staff at Night  Ability to Escort 2:1 in accordance with Care and Rehabilitation Plan or where appropriate  Adequate to meet the requirements of individual Care and Rehabilitation Plan and observe and manage challenging behaviour 24 hours per day.	24 hr Rostered Staffing  Ability to Escort 2:1 when required  Adequate to meet the requirements of individual Care and Rehabilitation Plan and account for whereabouts 24 hours per day.

<b>Qualitative:</b>  The balance between intrusiveness and openness; trust between patients and professionals.	<b>Qualitative</b>  Ability to form therapeutic relationship with client group essential  Community Based Staffing  Access by referral to specific disciplines via community services.	Ability to form therapeutic relationship with client group essential  Predominantly non-professional Community Based Rostered Staff  Planned Access to specific disciplines via community services.	Ability to form therapeutic relationship with client group essential  Immediate access to predominantly professional nursing and medical care staff  Ready access to full scope of MDT Access to community services by referral by RIDCA
	<b>Restraint</b>  Trained in calming and breakaway techniques	Trained in calming, breakaway and restraint in an approved restraint programme in accordance with NZ Standards	Trained in calming and restraint and use of seclusion
	<b>Reviews</b>  Daily by Staff At least monthly by clinical team (internal) 6 Mthly by MDT (external) + RIDCA 6monthly	Daily by Staff Weekly by internal clinical team Mthly by MDT + RIDCA 6 monthly	Daily by Staff Weekly by MDT Monthly by MDT & CLT + RIDCA 6 monthly

<b>ENVIRONMENTAL SECURITY</b> (Building and Fixings)		<b>Community Supervised</b> (Supervised Order)	<b>Community Secure</b> (Secure Order)	<b>Hospital Secure</b> (Secure Order)
This includes the design and maintenance of the estate and fittings, including the staff to operate them (technical staff)	<b>General Dwelling</b>	Lockable Doors	Locked Doors Locked/ Limited Opening Windows	Escape proof Locked/ Limited Opening Windows
	<b>Entry</b>	Entry and exit monitor-able	Single Point Controlled	Single Point + Vehicle Air Lock
	<b>Windows</b>	Safety Glass (where appropriate) Limited opening	Unbreakable Limited Opening Alarmed	Unbreakable Limited Opening Alarmed
	<b>Doors</b>	Robust Lockable	Robust Lockable	Robust Lockable
	<b>Seclusion</b>	No Specific Structure (No planned seclusion provision)	Low Stimulus Areas (No planned seclusion provision)	Purpose Built Rooms
	<b>Observation Systems</b>	Dwelling allows easy observation including private areas (when required)	Designed to allow staff observation and interaction at all times if required	Designed to allow staff observation and interaction at all times if required CCTV (or equivalent) Entry & Access security control
	<b>Alarm Systems</b>	Ability to alarm egress Fire alarms and/or smoke alarms	Staff Personal Alarms Wall Mounted Alarms Fire Alarms Sprinklers	Fully Alarmed Staff Tracking Ability Fire Alarms Linked to Fire Service Sprinklers
	<b>Outdoor</b>	Outdoor space	Enclosed Courtyard	Internal Courtyard
	<b>Perimeter</b>	Lockable gate (where required) Fenced	Perimeter Fencing - Climb resistant to the maximum allowed height with appropriate Planting	Escape Proof