SERVICE SPECIFICATION

PURCHASE UNIT CODE: DSSCLT
SERVICE NAME: Community Liaison Team (CLT)

Philosophy Statement

The aim of Disability Support Services 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", "people" or 'Service Users' 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 co-ordination 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 NIDCA eligible civil population who are not subject to Court order.

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

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

- Regional Intellectual Disability Secure Services (RIDSS). (Hospital level forensic assessment)

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

This specification defines the Community Liaison Team component of the framework. Inpatient assessment, triage and longer stay components are defined in a separate specification.

2 SERVICE OBJECTIVES

2.1 General

The role of the CLT is primarily to maintain and improve service delivery and thereby prevent regression into more intensive levels of service provision. The role is defined primarily by consultation and liaison with support agencies but may also include some direct clinical care provision.

Services will be delivered to all providers of service to NIDCA funded service users and include, but are not limited to:

- Clinical advice and support

- Intervention and planning for NIDCA-eligible service users. Intervention and planning will include current community support staff e.g. Care Manager or NIDCA staff

- Transition planning for NIDCA-eligible service users transferring out of RIDSS services

- Liaison with Regional Forensic Services/Court staff

- Care Management services and specialist assessments for Care Recipients or proposed Care Recipients under ID(CC&R) Act.

3 SERVICE USERS

3.1 Inclusions

Services will be provided for NIDCA eligible people with an intellectual disability:

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

  or

- Who are being transferred under appropriate sections of the ID(CC&R) Act. Inclusions are defined by the nature of the bed purchased.

  or

- Who either with or in the absence of Court orders show behaviour (with or without a mental health disorder) that poses a serious risk of physical harm to themselves or others.

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3.2 Exclusions

Service users not covered under this service specification are those with an intellectual disability who are not NIDCA eligible and/ or may also:

- Require assessments and interventions funded by other agencies (e.g. assessments under 38 of the Mental Health Act)
- Require an assessment solely as a result of a mental health need (these assessments are contracted for by District Health Boards (DHB's) through mental health assessment services or community mental health teams)

3.3 Interface With Mental Health

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

4 ACCESS

People will access the framework of services including CLT services based on their assessed level of need and service required as defined by NIDCA:

- Those requiring support as a result of Court proceedings
- Those undergoing assessment under the ID(CC&R) Act possibly being placed in short-term assessment beds in all regions
- Those transitioning from medium to long-term placements i.e. moving from the national secure units
- Care Recipients and the civil population receiving NIDCA services, both within RIDSAS and Mainstream service providers.

4.1 Referrals

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

From time to time the CLT will be required to respond immediately in support of existing Mental Health Court Liaison staff for potentially eligible people. In this instance the service user shall concurrently be referred to NIDCA.

NIDCA will require evidence of previous attempts to use mainstream services interventions before acting on a referral to CLT. The CLT will prioritise caseloads according to clinical presentation (i.e. risk) and those under Court order will take precedence over civil referrals.

NIDCA will be responsible for ensuring that service users accepted in the service will do so with appropriate eligibility. The type of service provided will reflect the high level of need for personal or public safety, and compliance with any Court orders.

The provider shall accept all referrals from the NIDCA except where there are difficulties because of insufficient capacity or where the service user is assessed by the team to not

warrant this level of service. In these cases the team will advise NIDCA and work with NIDCA to find a solution with the greatest expediency.

4.2 Inter Region Transfers

The Provider must give priority to people within their defined geographic catchments before accepting those from other regions.

The Ministry requires that any transfer of service users between regions occurs with the minimum level of disruption to the service user and the care and rehabilitation plan. This means that information transfer and handovers need to be done well. All transfers will be managed the NIDCA.

4.3 Service Exit

Service users shall exit at a date negotiated between the CLT and NIDCA either upon application to the Court for ID(CC&R) Act order to be ceased, or determination of ineligibility as a result of assessment findings. In addition to the Discharge Planning provisions of the Provider Quality Specification and the Health and Disability Sector Standards any possible transfer or transition to an alternative provider will be discussed and agreed with NIDCA and authorised by the Court where applicable for service users under ID(CC&R) Act. Early transition planning will be required to ensure service users will receive services in the least restrictive environment available to meet their needs.

5 SERVICE COMPONENTS

5.1 Process Descriptions

The emphasis for the CLT is to support the eligible service user and/or the service providers. CLT supports Care Recipients and the civil population and services include, but are not limited to:

- The development and implementation of Care and Rehabilitation plans for proposed Care Recipients under the ID(CC&R) Act when acting as Care Manager, or by advising those who are Care Managers
- Planning and intervention for NIDCA eligible service users including the development of support plans
- Consultation and liaison regarding behaviour management, medication review and management of presenting mental health issues
- Seamless transition and clinical supports for clients transitioning between levels of care.

The service is focused on the eventual integration into mainstream community for each service user. Each service user's progress will be regularly reviewed against their goals for treatment and/or rehabilitation and adjustments made as appropriate. The aim of all intervention should be the goal of reintegration into mainstream community services, however in some instances service provision may be lifelong.

Clinical assessment recommendations will include a range of psychosocial and/or psychiatric treatment strategies to assist service users to regain and/or maintain normal living skills and to achieve optional illness management where appropriate. It is the intention of this service to minimise the likelihood of service users requiring increased levels of care.

5.2 Settings

The CLT is a community focused service. It will however cover a range of environments including residential, supported independent living, family home and vocational settings; Courts and correctional facilities. Inpatient services are required where the service user is in transition or where the team member is designated Care Manager.

5.3 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 Mäori services will be encouraged to maintain links with their tribal affiliations which have been identified through Mäori assessment protocol within NIDCA assessments

5.4 Key Inputs

COMMUNITY CONSULTATION & LIAISON TEAM	**DESCRIPTION**
Function	To provide services to eligible service users in a setting that is as least restrictive as possible but where specialised support is still required. Services will be provided to service users in transition from inpatient services (hospital level secure services or assessment services) to community intellectual disability supported services and to people referred from National Intellectual Care Agency (NIDCA) services for specialist assessment and advice. The service will also provide advice to Courts, prisons during transfers and community support providers regarding individual service users.
Nature of Service	The community based service will assist with the integration of a range of services providing assessment and support to service users. The service functions include, but are not

	limited to: • Assessment diagnosis and participation in management of presenting problems and symptoms, This can include joint assessment and provision of second opinion when requested • Collaborative work on the development and implementation of comprehensive management plans that clearly identify problems and desired outcomes • Regular review of clinical management plans at planned intervals • Provision of information/strategies to support community providers in risk assessment and risk management • Provision of advice to and training of community providers • Supporting community transitions including movement of service users within the region to hospital secure service • Provision of advice to prison staff where a person with intellectual disability is involved • Liaison with mental health services such as Intellectual Disability Dual Diagnosis and existing mental health Forensic Court Liaison. • Provision of advice to Court officers, judges and lawyers • Provision of Care Management function (for service users subject to the ID (CC&R) Act where a team member is appointed by a Care Co-ordinator. (see below) • Liaison with family/and whanau members and with the relevant service providers.
Service provided by	• A multi-disciplinary team of specialist staff with appropriate qualifications, skills and experience e.g. Psychiatry, psychology, forensic nursing, occupational therapy, social work. Strategies may include: • Pharmacotherapy • Psychological therapy • Social treatments

	• Behavioural strategies • Provision of education e.g. about illness, symptoms and the management of symptoms to providers and clients • Social skills training.
Care Management (For Service Users who are proposed to be, or who are subject to, the ID(CC&R) Act)	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 NIDCA Care Co-ordinator. The Care Manager fulfils the functions and duties as set out in the ID(CC&R) Act, including the development of the Care and Rehabilitation Plan and regular review of the Plan 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 Ministry of Health Procedure Manual ID(CC&R) Act 2003 – Guidelines for the role and function of Compulsory Care Co-ordinators 2004 (p11). 1. Development of the Care and Rehabilitation Plan. The Care Manager will work with the Care Recipient and the Care Recipients support network, to develop a Care and Rehabilitation Plan based on the specialist assessment. The Plan will reflect how the Care Recipient will progress to greater independence by developing skills and supports in accordance the their needs and goals. To achieve this the Care Manager will need to complete the following tasks: • Contribute to the Care Recipient 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. 1. When a Care Manager is appointed to the person in RIDSS level services to 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 person's 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 of Health document, Roles and Responsibilities of Care Managers The RIDSS will employ staff who are able to be appointed to the role of Care Managers 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. The RIDSS will develop protocols within its own organisation to ensure there is alignment to its legal and administrative obligations Care Managers will be required to complete a Ministry approved training programme.

6 SERVICE LINKAGES

Providers are required to maintain effective links with other Forensic Mental Health, Dual Diagnosis and Behaviour Support service providers whether within their own geographical catchments or elsewhere. It is critically important that the service providers work together to ensure:

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

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

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

- National Intellectual Disability Care agencies (NIDCA)
- Regional Intellectual Disability Supported Accommodation providers (RIDSAS)
- National Intellectual Disability Secure Services
- Regional Intellectual Disability Secure Services
- Regional Forensic Services
- Court and Correction Services
- Specialist Assessors
- District Inspectors
- Police.

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

- Other general mental health services
- Consumer advocacy services
- Vocationl/ education services
- Mäori organisations
- Other sector agencies.

7. EXCLUSIONS

Not applicable

8. QUALITY REQUIREMENTS

8.1 Service User / Family / And Whanau

Unless otherwise directed by the Court, service users, family and whanau members and advocates should be central to service delivery. This requires:

- The service user be given an opportunity to identify who to include or exclude from their assessment process
- The service user, family and whanau members and advocates be provided information regarding how they can be involved in the processes
- The service users, family and whanau members and advocates be notified of complaint procedures

- Mäori Service Plans focused on removing barriers to access and promoting participation for Mäori service users and their family or whanau including staff development and organisation responsiveness outcomes.

8.2 Complaint And Feedback Systems

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

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

9. PURCHASE UNITS AND REPORTING REQUIREMENTS

PU ID	**PU Short name**	**PU Measure**	**Reporting Requirements**	
			Frequency	**Information**
DSSCLT	Intellectual Disability – Community Consultation and Liaison Team	FTE	Quarterly	**Excluding care management** 1. Number of referrals by month. 2. Number of assessments per month by assessment type: • Specialist Assessments • Behaviour Assessments • Medication Reviews 3. Total number of contacts per month. 4. Total number of community contacts per month. 5. Referrals on waitlist per month. 6. Number of open cases.

				7. Number of discharges.
DSS CLT	Care Management	(1 FTE: 12–15 clients)	Quarterly	8. Numbers referred for care management by month. 9. Numbers of care and rehabilitation plans written by month. 10. Caseload for care management by month. 11. Number of discharges by month. 12. Narrative report including: • Introduction • Service Activity • Critical Incidents • Issues • Highlights • Attachments

9.1 Guidelines

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

- From December 2005 or as the Ministry advises Te Reo Toolkit (published by Ministry of Health.

10. QUALITY MEASURES

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

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
- Mäori Service Plans focused on removing barriers to access and promoting participation for Mäori service users and their family or whanau including staff development and organisation responsiveness outcomes In December 2005 Ministry will publish a Best Practise Framework).

GLOSSARY OF TERMS

ACTS

ID(CC&R) Act: *Refers to the **I**ntellectual **D**isability (**C**ompulsory **C**are and **R**ehabilitation) Act (2003)*

CP(MIP) Act: *Refers to the **C**riminal **P**rocedure (**M**entally **I**mpaired **P**ersons) Act (2003) (replaces Part 7 Criminal Justice Act (1985) (CJA)*

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

MINISTRY FUNDED AGENCIES for NIDCA SERVICES

NIDCA: *National **I**ntellectual **D**isability **C**are **A**gency. This is the administration agency of the legislation. The Care Co-ordinator function sits within NIDCA.*

RIDSAS: ***R**egional **I**ntellectual **D**isability **S**upported **A**ccommodation **S**ervice. These services provide community assessment beds, residential and vocational agencies. The Care Manager function sits within RIDSAS.*

RIDSS: ***R**egional **I**ntellectual **D**isability **S**ecure **S**ervices. Hospital level secure services and assessment beds. RIDSS also provide the Community Liaison Team (CLT) contracts. The Care Manager function sits within RIDSS which functions mainly around transition into or out of hospital level services or prisons, however individual circumstances of the service user will inform the decision around who would best fill this function. (See also Community Liaison Team below)*

OTHER

District Inspector (DI): *Means a person designated under Section 144 (ID(CC&R) Act) as district inspector or deputy district inspector under the ID(CC&R) Act. A District Inspector is a barrister or solicitor whose 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 NIDCA 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 NIDCA who are not Care Recipients under the ID(CC&R) Act. This population would receive services from the Intensive Service Coordinator.*

Community Liaison Team (CLT): *Team of multi disciplinary professionals who offer consultation liaison services to all NIDCA 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 NIDCA eligible service users, both those under the ID(CC&R) Act 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 NIDCA will develop MOUs with providers.*

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

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: Mäori person with a disability.

Intensive Service Co-ordinator: *This is a role developed specifically for service users eligible for NIDCA 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.*

Section7. 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.

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

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

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

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

Section 5. Meaning of Care Recipient and related terms—

(1) "`Care Recipient" means a person who is:

(a) a Special Care Recipient; or

(b) a Care Recipient no longer subject to the criminal justice system.

(2) "`Special Care Recipient" means:

(a) a person who is liable to be detained in a secure facility under an order made under

(i) section 24(2)(b) or section 38(2)(c) or section 44(1) of the Criminal Procedure (Mentally Impaired Persons) Act 2003; or

(ii) section 171(2) of the Summary Proceedings Act 1957; or

(b) *a person who is remanded to a secure facility under an order made under section 23 or section 35 of the Criminal Procedure (Mentally Impaired Persons) Act 2003; or*

(c) *a person who is liable to be detained in a secure facility under an order made under section 34(1)(a)(ii) of the Criminal Procedure (Mentally Impaired Persons) Act 2003 and who has not ceased, under section 69(3), to be a Special Care Recipient; or*

(d) *a person who*

(i) *is liable to be detained in a secure facility under a compulsory care order, made under section 45; and*

(ii) *is also liable to detention under a sentence; and*

(iii) *has not ceased, under section 69(3), to be a Special Care Recipient; or*

(e) *an inmate who is required, under section 35, to stay in a facility; or a person who, in accordance with section 47A(5) of the Mental Health (Compulsory Assessment and Treatment) Act 1992, must be held as a Special Care Recipient.*

(3) ``Care Recipient no longer subject to the criminal justice system'' means a person who

(a) *is, or continues to be, subject to a compulsory care order, made under section 45, but is not, or is no longer, liable to be detained under a sentence; or*

(b) *is subject to an order made under section 25(1)(b) or section 34(1)(b)(ii) of the Criminal Procedure (Mentally Impaired Persons) Act 2003; or*

(c) *is subject to a compulsory care order resulting from the operation of section 69(3) or section 94(1); or*

(d) *is a former special patient who is required, under section 35, to stay in a facility.*

(4) ``Proposed Care Recipient'' means a person—

(a) *who is being assessed under Part 3 or Part 4; or*

(b) *in respect of whom an application for a compulsory care order is pending before the Family Court.*

(5) In Parts 2, 3, and 9, a reference to a Care Recipient includes a reference to a proposed Care Recipient.

(6) ``Care Recipient liable to detention under a sentence'' means a Special Care Recipient to whom subsection (2)(c) or (d) applies.

***Region:** (please see map below)*

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

Section 63. Designation notices relating to secure care

(1) This section applies to every person

(a) *who is a Special Care Recipient; or*

(b) *who is a Care Recipient no longer subject to the criminal justice system and who is required to receive secure care.*

(2) A Care Recipient to whom this section applies must

(a) stay in a secure facility that the co-ordinator designates by written notice given to the Care Recipient and the Care Recipient's Care Manager; and

(b) may not leave the facility without authority given under this Act.

Section 64. Directions relating to supervised care

(1) The co-ordinator may direct a Care Recipient who is required to receive supervised care to stay in a designated facility or in a designated place.

(2) A direction under subsection (1) takes effect when written notice of the direction is given to the Care Recipient and the Care Recipient's Care Manager.

(3) A Care Recipient may be directed, under subsection (1), to stay in a secure facility only for the purpose of receiving care that

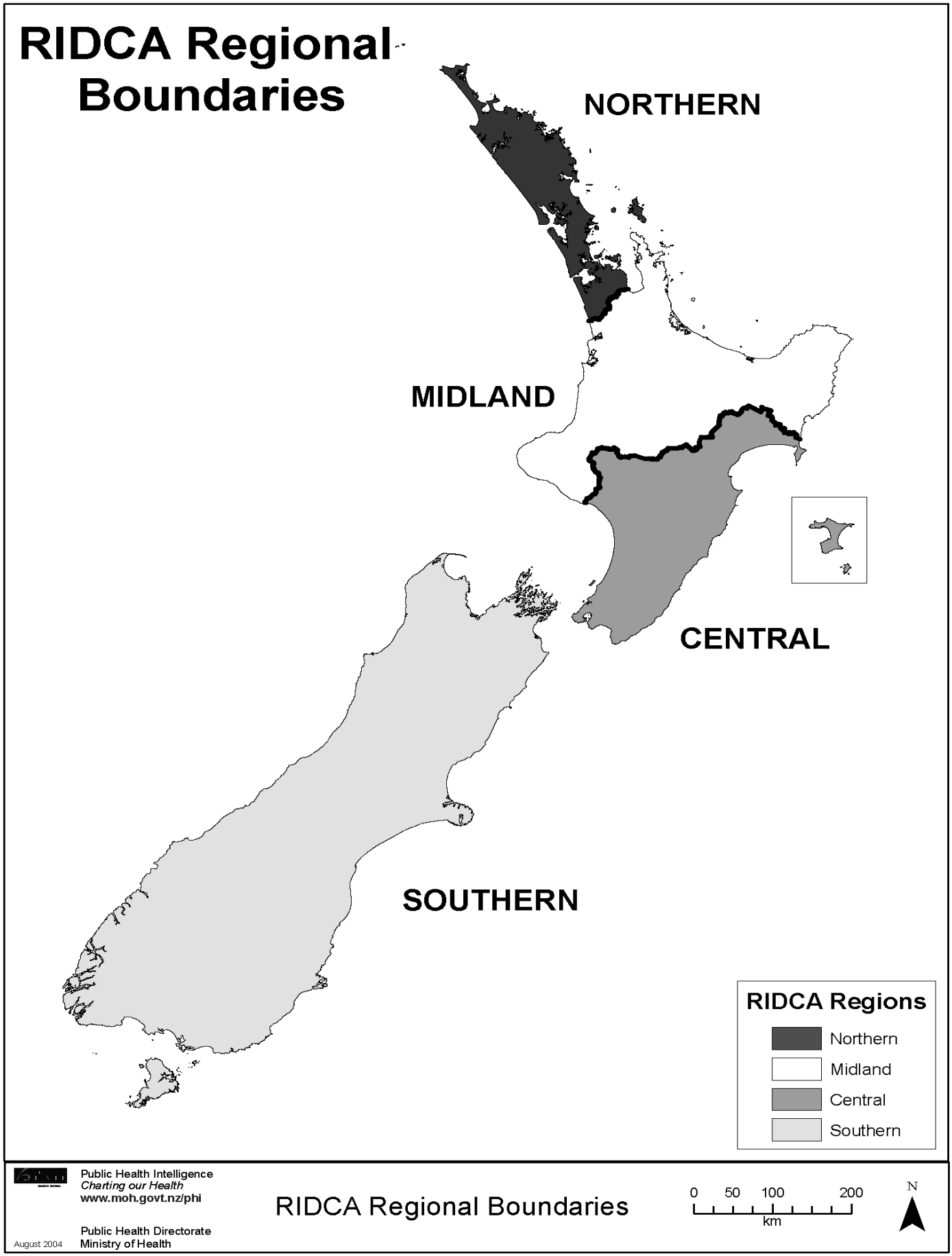
(a) is required to deal with an emergency; and

(b) is of a kind provided for in the Care Recipient's care and rehabilitation plan.

(4) While a direction under subsection (1) is in force, the Care Recipient to whom the direction relates must stay in the facility or place designated by the direction.

(5) If a direction under subsection (1) requires the Care Recipient to stay in a facility, the Care Recipient may not leave the facility without authority given under this Act.

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


RIDCA Regional Boundaries
NORTHERN
MIDLAND
CENTRAL
SOUTHERN
RIDCA Regions
Northern
Midland
Central
Southern
Public Health Intelligence
Charting our Health
www.moh.govt.nz/phi
Public Health Directorate
Ministry of Health
August 2004
RIDCA Regional Boundaries
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N