Disability Support Services

MINISTRY OF SOCIAL DEVELOPMENT
TE MANATŪ WHAKAHIATO ORA

Community Liaison Team (CLT)
Tier 2 Service Specifications

Purchase Unit Code: DSS CLT

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1. Terminology

Appendix 1 provides a detailed summary of current and historical terminology that relates to the High and Complex Framework.

In this service specification, people who are eligible for services under the High and Complex Framework (HCF) are mostly referred to as “the person”, “people “or “individuals”. Consistent with the language used in the IDCCR Act, other terms include “care recipients/proposed care recipients”. “Tāngata whaikaha Māori” is also used when referring to Māori accessing Framework services.

2. Purpose

Disability Support Services (DSS) commission a range of services to ensure a full spectrum of effective and complementary services, that aim to enable eligible people to be supported within the most appropriate environment with the optimum level of support.

This service specification defines the Community Liaison Team’s (CLT) function within the High and Complex Framework (the Framework or HCF). These teams are currently attached to the Regional Intellectual Disability Services (RIDSS) but have a different function and are independently resourced. The CLT is a multi-disciplinary team who offer intervention and consultation liaison services to all individuals determined eligible by the Forensic Coordination Service, Intellectual Disability (FCS(ID)). The CLT has a role within RIDSS and in the community. The FCS(ID) are responsible for all referrals to CLT.

The primary function of the CLT is to provide specialist assessment, intervention, and liaison services to people within the Framework, in community-level facilities. This includes eligible people, both those under IDCCR Act and the civil population, and the support service providers supporting them. Within RIDSS the CLT’s role is mainly around supporting transitions into and out of secure services.

The CLT forms part of a continuum known as the High and Complex Framework (HCF or the Framework). The Framework operationalises the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act) and related legislation; for example, the Criminal Procedure (Mentally Impaired Persons) (CP(MIP) Act) 2003, the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MH(CAT)) and the Criminal Procedure Act 2011. The IDCCR Act recognises individuals with an intellectual disability have different needs to other offenders (including those with a mental health diagnosis) and provides a distinct legislative track for those individuals. It sets out a statutory regime for the compulsory care and rehabilitation of individuals with an intellectual disability charged with or convicted of an offence while recognising and safeguarding their rights. The IDCCR Act makes provision for the appropriate use of different levels of care for individuals who, while no longer subject to the criminal justice system, remain subject to the Act.

The Framework is intended to provide an approach that helps maximise personal autonomy and choice without jeopardising health and safety. The goal is for those supported under the Framework to live a balanced and satisfying life without offending, and to have the greatest possible level of independence.

3. Service Objectives

3.1 General

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

On referral from FCS(ID), services must be delivered to people eligible for FCS(ID) services and to the HCF teams that support them.

4. Eligibility

4.1 Inclusions

CLT involvement is initiated by a referral from the FCS(ID). All people determined eligible for FCS(ID) are eligible for CLT services.

4.2 Exclusions

People not covered under this service specification are those who do not have an intellectual disability and those with an intellectual disability who are not FCS(ID) eligible and/or may also:

- Require assessments and interventions funded by other agencies (e.g. assessments under 38 of the MH(CAT) Act.
- Require an assessment solely because of a medical or mental health need, for which Health NZ – Te Whatu Ora have responsibility.

5. Referrals

The FCS(ID) will facilitate all referrals to the CLT. Any other enquiries received by CLT (including those from Court) shall be directed to the FCS(ID).

The CLT must prioritise caseloads according to clinical presentation (i.e. risk) and those under a Court order must take precedence over civil referrals. On occasion the FCS(ID) may identify a need for immediate support that requires CLT to reprioritise their casework to enable a rapid response.

FCS(ID) are responsible for ensuring that only people with appropriate eligibility are accepted into the service. The CLT must ensure that all people are supported to understand their legal rights. When working with civil clients, CLT must ensure that informed consent is understood as ongoing, given by the person, documented and revisited at all stages of involvement.

5.1 Regional cover

CLT provide national cover, this is provided for through 5 regional teams. CLT must be responsive to referrals across the whole of their designated region.
Appendix 1 shows the 4 geographical regions within which the HCF operates. There is provision for two CLT's within the Southern region.

5.2 Inter Region Transfers

The Ministry requires that any transfer of people between regions occurs with the minimum level of disruption to the person and the implementation of their care and rehabilitation plan (CARP). This means, for example, that information transfer and handovers need to be timely and carried out to the highest standard All transfers must be managed by FCS(ID).

The CLT may be required to support the transition of people moving between services and when needed, between regions.

5.3 Service Exit

People shall exit CLT support at a date negotiated between the CLT and FCS(ID) when intervention is complete or on expiry of the compulsory care order and the person is no longer receiving HCF services. Discharge planning and process must be consistent with the provisions of the Ngā Paerewa Health and Disability Services Standard NZS 8134:2021.

CLT must provide a discharge summary detailing intervention/advice provided. This discharge summary must be shared with the FCS(ID).

Early transition planning will be required to ensure that the person receives services in the least restrictive environment available to meet their needs.

6. Service component.

6.1 Process and settings.

Assessment, advice and intervention must be provided by CLT in accordance with a documented evidence-based model of care, that is person centred, inclusive of a Māori perspective of health & disability and is informed by a clearly articulated disability-centric values base.

Clinical assessment recommendations must provide direction on how the person's environment and team approach can be adapted to reflect individual need, alongside a range of psychosocial and/or psychiatric treatment strategies to assist people to regain, develop and/or maintain normal living skills and to achieve optimal wellbeing. It is the intention of this service to minimise the likelihood of people requiring increased levels of care.

The CLT is a community focused service. It will however cover a range of environments including residential, and vocational settings. Inpatient services are required where the person is in transition or where CLT member is designated Care Manager.

The emphasis for the CLT is to support eligible people and/or the service providers responsible for their care. CLT must provide services to both care recipients/proposed care recipients and the civil population. Services provided to eligible people and the service providers who support them may include, but are not limited to:

- Support and advice on assessment, planning and intervention, including the development of support plans. Intervention and planning must include current community support staff e.g. care manager and/or FCS(ID) staff.
- Assessment diagnosis and participation in management of presenting problems and symptoms, this can include joint assessment and provision of second opinion when requested.
- Liaison with Health NZ's medical and mental health services and existing mental health forensic court liaison staff.
- Clinical advice and support.
- Liaison with whānau members and with the relevant service providers.
- Provision of Care Management function (for people subject to the IDCCR Act) when a team member is designated by a Compulsory Care Coordinator at FCS(ID). This includes the development, implementation, and review of CARPs for care recipients under the IDCCR Act. Care managers are required to fulfil the functions and duties as set out in the IDCCR Act and the MOH guideline
  for care managers.
- Working collaboratively with the person, their whānau and the HCF services to develop and implement comprehensive management plans that clearly identify problems and desired outcomes.
- Provision of advice to and training of community providers.

care.

Group and individual therapy (e.g. social skill training, emotional regulation skills training)

6.2 Workforce

CLT is comprised of a multi-disciplinary team of people who must have appropriate qualifications, registration, skills, and experience in identifying and responding to the needs of offenders who have an intellectual disability. This workforce must be comprised of:

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- Consultation and liaison regarding behaviour concerns, medication review and management of co-existing mental health issues.
- Provision of information/strategies to support community providers in risk assessment and risk management.
- Seamless transition and clinical supports for people transitioning between levels of

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- health professionals regulated by the Health Practitioners Competence Assurance Act 2003

- people regulated by a recognised health or social service professional body.

people who provide support and are supervised by appropriately trained and regulated health professionals.

The CLT must have the ability to meet the person's health and disability care needs, with competence in:

- intellectual disability, psychology, psychiatry and forensic assessment, interventions and treatment.
- the identification and treatment of co-existing disorders, and the identification and referral of other potentially unmet need such as trauma, mental and physical health problems.
- the legislative framework in which they are operating, and the ability to meet the specific legal responsibilities associated with this statutory framework, including the ability to meet the expectations required of Care Managers, to effectively fulfil the functions and duties as set out in the MOH guidelines.

CLT team members who are or may be designated as a care manager must engage in training, related to this statutory role, as required by the FCS(ID), DSS and/or the MOH.

6.3 Model of care

CLT have a role in, working alongside HCF providers, to maintain clinical support which ensures that:

- Each person has a comprehensive clinical formulation (an explanation of the person's behaviour, informed by assessment, based on psychological theory), that seeks to understand their behaviour and emotional responses in the context of their formative, whānau, cultural and current experiences.
- The person's individual clinical formulation informs their care and rehabilitation, and their individual clinical formulation is regularly updated to incorporate an understanding of more recent developments and responses to situations.
- Consideration is given to the persons' quality of life, liberty (as appropriate) and optimising their health and wellbeing, the development of everyday skills required for independence, in addition to reducing the person's risk of reoffending by targeting specific risk factors.

- Each person's plan includes direction on how best to respond when there is a need to gain safe, rapid and effective control in a situation where the person is displaying challenging behaviour. The relevant sections of the CARP must be updated as necessary if there are changes in the management approach in response to challenging incidents. Restrictive methods must only be used as a last resort when all other strategies have failed, and immediate safety is at risk. Advice must be consistent with expectations detailed in Ngā Paerewa Health and Disability Services Standard NZS 8134:2021.
- Post incident analysis must be promoted, to allow a better understanding of factors influencing the person's behaviour and potential solutions so that the person's plan can be revised. Post incident analysis and amended plans must be reported by the Care Manager to the Compulsory Care Coordinator.
- The cultural needs of all people are understood and inform the person's CARP. That, consistent with rights afforded in Te Tiriti o Waitangi, tikanga based models of care, are used, to achieve aspirations and meet needs of tāngata whaikaha Māori.
- Planning and support must value and acknowledge natural supports and help the person to maintain and develop relationships with their whānau and their community.
- Practice and team culture ensures the rights of people are upheld by staff, principles, and practice at all levels.
- There is active involvement of the person in their own management and planning.

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7. Quality and Safeguarding

To be confirmed

8. Service Linkages

CLT is required to maintain effective links with other forensic mental health, dual diagnosis and behaviour support service providers within their own FCS(ID) geographical catchments and elsewhere. It is critically important that the service providers work together to ensure:

- People have access to the full range of appropriate services.
- Disputes amongst providers concerning service coverage are resolved in a timely manner without adversely affecting the support provided to the person.
- The efficient and effective use of each service.

In addition to the care manager role, there are several additional statutory roles, with whom all providers, within the Framework, need to maintain a close working relationship, namely: Compulsory Care Coordinators, District Inspectors, Specialist Assessors and Medical Consultants.

The Provider must establish working protocols with other HCF providers, across the regional network.
The provider must have written protocols that include, but are not limited to:

- the intervention pathway (referral to discharge)
- treatment and care management
- record keeping and information management
- dispute resolution.

All protocols must align to legislative and contractual obligations as well as MOH and MSD/DSS issued guidelines.

8.1 Interface with Mental Health

People may also require the involvement of Health New Zealand. The provider must work with mental health service providers to achieve the best outcomes for the person.

8.2 Other agencies

The provider is required to work collaboratively and effectively with the following key agencies or services:

- The Forensic Coordination Service - Intellectual Disability (FCS(ID))
- Government Ministries including the Ministry of Disabled People, Education, Health, Social Development, Justice, and ACC

- Regional Intellectual Disability Supported Accommodation Service providers (RIDSAS).
- Regional and National Intellectual Disability Secure Services (RIDDS/NIDSS).
- Regional Forensic Services (Court liaison professionals).
- District Inspectors
- The Courts and Department of Corrections.
- Wider services provided by Health New Zealand – Te Whatu Ora (mental health services, physical health and addictions).
- Kaupapa Māori organisation and providers.
- Community Liaison teams.
- NZ Police.
- Oranga Tamariki and its services (for children and young persons).
- Wider disability support and advocacy services.

9. Other requirements

The provider is required to comply with all relevant New Zealand legislation and the guidelines and policies set by the regulator and commissioner, including but not limited to the following (or current version of the same):

- Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act) and it's guidelines and regulations.
- Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHCAT Act) and it's guidelines and regulations.
- Criminal Procedure (Mentally Impaired Persons) Act 2003 (CP(MIP) Act).
- Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996.
- Health Information Privacy Code 2020.
- Ngā Paerewa Health and Disability Services Standard NZS 8134:2021.
- Protection of Personal and Property Rights Act 1988 (PPPR Act).
- Oranga Tamariki Act 1989.
- Criminal Procedure Act 2011.
- Privacy Act 2020.
- Victims' Rights Act 2002.
- Public Records Act 2005.
- New Zealand Public Health and Disability Act 2000 or the Pae Ora (Healthy Futures) Act 2022.

9.1 Other Guiding Documents

The provider is required to comply with all relevant requirements including but not limited to the following (or the current version of same):

- New Zealand Disability Strategy 2016-2026.

- The National Pacific Disability Approach – Atoatoali'o 2025.
- United Nations Convention on the Rights of the Child.
- United Nations Convention on the Rights of Persons with Disabilities.
- The United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
- Whakamaua: Māori Health Action Plan 2020-2025.
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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.

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Appendix 1: Regional map[1]

The CLT provide cover to the whole of the country. There is one team in each of the Northern regions and two teams within the South Isl