Disability Support Services

Te Kāwanatanga o Aotearoa
New Zealand Government

Forensic Coordination Service (Intellectual Disability)

Tier 2 Service Specifications

Version 3.0, 1 July 2024

Contents

1. Purpose

This service specification is for the provision of services provided by the Forensic Coordination Service for people with an Intellectual Disability (FCS(ID)). The FCS(ID) is a highly specialised service which provides needs assessment and service coordination for people with an intellectual disability who access the High and Complex Framework (HCF or the Framework). The Framework provides a pathway for offenders with an intellectual disability away from the criminal justice systems towards more appropriate disability services. This service has statutory responsibilities for administering the Intellectual Disability Compulsory Care and Rehabilitation Act (IDCCR Act) and related legislation for people subject to these Acts.

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

Purchase Unit Code: DSSFCS

2. Background

The Framework provides an alternative pathway for offenders with an intellectual disability that provides specialist care and rehabilitation.

Under the Framework, recipients of the service are either:

1. subject to the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act) or the Criminal Procedure (Mentally Impaired Persons) Act 2003 (CPMIP), or
2. under associated legislation, including the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Mental Health Act), or
3. Civil clients, people no longer subject to any legal restrictions and are being supported to transition out of the Framework.

Disability Support Services (DSS) and Ministry of Health - Manatū Hauora (MOH) work together to maintain the connection between the IDCCR Act and the Framework. MOH has statutory responsibility for the IDCCR Act. DSS is responsible for planning and commissioning of services. DSS funds a Framework of interconnected specialised services for people with an intellectual disability placed under the IDCCR Act.

The FCS(ID) works alongside the courts and other referral agencies to coordinate the entrance of eligible people into the Framework. This includes coordinating the care and rehabilitation of people within the Framework, ensuring their rights are upheld, including Enabling Good Lives principles and aspirations, and appropriate progression to enable exit out of the Framework.

The assessment and service coordination provided by the FCS(ID) was previously provided by an agency known as the National Intellectual Disability Care Agency (NIDCA). This service specification replaces the previous agreement with NIDCA. The administrative roles and responsibilities formerly ascribed to NIDCA will now be completed by the FCS(ID).

In addition to these service specifications, the requirements of the FCS(ID) are set out in the IDCCR Act, and a series of related operational guides and policies detailed in Appendix 2.

2.1. Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003

The IDCCR Act, together with the Criminal Procedure (Mentally Impaired Persons) Act 2003 (CPMIP Act), gives the Court powers to order individuals with mental impairment charged with or convicted of an imprisonable offence to accept compulsory care and rehabilitation under the IDCCR Act, or in the case of people with a mental disorder, under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA).

The CPMIP Act permits the Court to make IDCCR Act Compulsory Care Orders for up to three years, and these can be extended by the Family Court if the Care Recipient's behaviour still poses significant risk. The order will direct whether the Care Recipient requires secure or supervised levels of care. Eligible people on a serious charge can be made 'special care recipients' and placed under compulsory care up to a maximum period of 10 years.

The IDCCR Act established four statutory roles:

a. Compulsory Care Coordinators who are responsible for the operational administration of the Act; and,

b. Care Managers who are responsible for oversight of the care and rehabilitation plan to support the needs of a Care Recipient; and,

c. Specialist Assessors who are responsible for assessments to determine eligibility, risk and care and rehabilitation needs; and,

d. Medical Consultants

The IDCCR Act also provides for the designation of District Inspectors who are lawyers appointed under the MH(CAT) Act to safeguard the rights of the Care Recipient subject to a Compulsory Care Order.

The FCS(ID) employs Care Coordinators and Compulsory Care Coordinators. A Compulsory Care Coordinator is appointed to the role by the Director-General of Health and is responsible for the administration duties for Proposed Care Recipients and Care Recipients subject to proceedings of the IDCCR Act. Appointments will be notified in the New Zealand Gazette - Te Kahiti o Aotearoa.

The Director General of Health will determine the terms and conditions under which each Compulsory Care Coordinator is appointed. This includes the geographical region to which the designation applies.

2.2. High and Complex Framework

The IDCCR Act provides for two levels of care:

- Secure Care (Hospital or Community)
- Supervised Care (Community)

The Secure Service Matrix, in Appendix 3, provides details of security levels associated with respective services. FCS(ID) determines eligibility and access for the following Framework services:

a. Regional Intellectual Disability Secure Services (RIDSS) providing hospital level inpatient assessment, triage and longer stay components such as hospital level forensic assessment and long-term placement.

b. National Intellectual Disability Secure Services (NIDSS) providing hospital level forensic assessment and long-term placement for youth (Youth Unit).

c. Regional Intellectual Disability Supported Accommodation Services (RIDSAS) providing community secure, supervised and/or services including vocational services and day activities.

d. Community Liaison Teams which provide clinical specialist support.

All services within the Framework, including FCS(ID) are required to support and participate in service improvement initiatives; for example, supporting the implementation of the High and Complex Framework Operational Strategy 2023-2028.

3. Service description

This section defines the FCS(ID) functions of the High and Complex Framework.

The FCS(ID) is to work closely with Support Service Providers in facilitating supports as a seamless pathway, so that the individual needs of the person are effectively met. This means the FCS(ID) plays a key role in ensuring all service providers work collaboratively for the person.

The FCS(ID) is primarily responsible for the employment of coordinators who fulfil the administrative responsibility of the framework including the employment of people (Compulsory Care Coordinators) designated a statutory function under the IDCCR. They fulfil these responsibilities for people with an intellectual disability defined under the IDCCR Act as:

a. A Proposed Care Recipient; or
b. A Care Recipient; or
c. A Special Care Recipient.

The FCS(ID) also provides coordination to people who are FCS(ID) eligible who may be detained under other legislation, this may include those under the MH(CAT) or other associated legislations and those transitioning out of compulsory care. This group is referred to as *civil clients*, these are people previously defined under one of the above but are no longer subject to any legal restrictions.

While the FCS(ID) is a specialist and distinct NASC service, it should work with NASCs to ensure that where possible, practical, and appropriate, the same systems and process are used. The FCS(ID) must ensure that the core functions, responsibilities, and standards of performance that apply to NASC are also be met by the FCS(ID).

To ensure that no actual or perceived conflict of interest exists, the provision of FCS(ID) functions is separated from the provision of support services. The FCS(ID) provider must either not provide support services other than described in the FCS(ID) specification or must propose and maintain an organisational separation sufficient to avoid conflict of interest.

DSS must be notified in writing of any proposed organisational change that would negatively affect the organisational separation. The proposed change must not be enacted until the FCS(ID) receives approval for the change proposal in writing from DSS.

3.1. Civil clients

Historically the term "civil client" was used broadly to capture all people, supported by the FCS(ID), who were not subject to the IDCCR Act. This has included a small group of people detained under other legislation e.g. MH(CAT). Whilst acknowledging that the FCS(ID) service continues to support people whose care is mandated by other legislation, this service specification seeks to provide direction on the rights and support needs of people who are no longer compelled or directed to receive supports and choose to remain within the service, by consent.

The term 'civil client' now refers to individuals who, while continuing to receive supports from FCS(ID) are no longer under any legal restrictions and are in a process of transitioning into mainstream services.

Civil clients are not required legally to remain within an intellectual disability service. Their aspirations should be central to their support plan and any behaviour plan should place an emphasis on improving their quality of life.

A consent process must be in place and clearly documented. Consent should be understood as ongoing and revisited at all stages.

When coordinating supports with other agencies FCS(ID) will ensure that the legal rights of civil clients are understood and maintained. Civil clients do not have to accept services from the FCS(ID), continued involvement is a choice.

Under the IDDCR Act, only people subject to court orders can be accommodated in Regional Intellectual Disability Secure Services. Civil clients are to be accommodated in Regional Intellectual Disability Supported Accommodation Services.

The aim for FCS(ID) is to provide the support needed to transition the person into mainstream services. As part of the transition process, with the client's consent, the FCS(ID) will work towards transferring the responsibility for future needs assessment and planning to the local NASC.

A priority in providing this support is to reduce the likelihood that the person will require further statutory intervention under the IDCCR Act.

3.2. The FCS(ID) team

The FCS(ID) has a national structure, with a regional presence.

The FCS(ID) is responsible for recruiting, orientating, and maintaining a workforce that has capacity to be meet service demands. This requires a support structure that has capability to provide statutory functions, legal, clinical and managerial oversight.

Specified contractual roles include: a Service Manager, a National Advisor, Compulsory Care Coordinators and Care Coordinators.

The FCS(ID) is required to provide 24 hours cover, with an on-call service.

When recruiting Care Coordinators, the FCS(ID) need to meet the expectations of MOH, who require that Compulsory Care Coordinators are suitably qualified health and disability professionals, with recognised experience working with people with Intellectual Disabilities. The FCS(ID) must also ensure that team attends any training that is mandated by either MOH or DSS.

3.3. Geographic coverage

The statutory functions and designated roles established through the IDCCR Act determine the geographical area for which the Compulsory Care Coordinator is responsible. A Compulsory Care Coordinator can only exercise their statutory functions in the geographic region for which they hold designation. A Compulsory Care Coordinator may hold designation for multiple regions. There are four regional areas (Northern, Midlands, Central and Southern). The regional areas are illustrated in Appendix 4.

The national nature of the FCS(ID) does not alter a Compulsory Care Coordinator's operational or geographic area designation.

The FCS(ID) is responsible for ensuring that there are sufficient Compulsory Care Coordinators to meet the statutory responsibilities and that the workforce comply with the regulatory requirements.

4. Roles within FCS(ID)

4.1. Compulsory Care Coordinator & Care Coordinator

The Compulsory Care Coordinator is responsible for ensuring the comprehensive assessment of the person's support needs and a seamless pathway across a range of services and environments. The Compulsory Care Coordinator appoints other statutory functionaries including the Care Manager and Specialist Assessor for the Proposed Care Recipient. The powers, duties, and responsibilities of Compulsory Care Coordinators are detailed in a guide developed by MOH.

The term Care Coordinator is used generically, applied to both Care Coordinators and Compulsory Care Coordinators. Both are employed by FCS(ID). The distinction being that only Compulsory Care Coordinator hold designations, consistent with section 140 of the IDCCR Act. Care Coordinators have limitations in the duties they can undertake but may progress to becoming a Compulsory Care Coordinator. The process and appointment criteria are detailed in the following guide: Recruitment process for Compulsory Care Coordinators.

The role of the Compulsory Care Coordinator is to oversee and manage the pathway for each person referred by the Court, prisons or forensic services to the FCS(ID) under the IDCCR Act for Proposed Care Recipients, Care Recipients, Special Care Recipients and for Civil clients, where appropriate. This will require the Compulsory Care Coordinator to act with a high level of flexibility and accountability for the completion of key duties, powers, and functions, including:

a. processing applications and referrals,

b. determining the eligibility of people for high and complex needs services,

c. designating a care manager for each referred person,

d. ensuring that people receiving service know their rights and are treated with dignity and respect,

e. arranging specialist assessments and reviews from other Specialist Assessors and other relevant specialists as required e.g., Speech language, occupational therapy and cultural assessments,

f. facilitating the integration of cultural assessment and specialist assessment recommendations within the cultural contexts involved,

g. ensuring that responsibilities in relation to a Rights for Victims of Insane Offenders Act 2021 are met,

h. allocating referrals to care managers to undertake the development of a care and rehabilitation plan,

i. ensuring legal representation is in place for tāngata whaikaha,

j. sign off the care & rehabilitation plan developed by the care manager,

k. monitoring the care & rehabilitation plans developed through 6 monthly reviews or on direction from the court,

l. liaising with support service providers, courts and other government agencies,

m. reporting to the courts as and when required for care recipient under the IDCCR Act,

n. negotiating the person's referrals, outcomes to be achieved and, as appropriate, service packages with support service providers.

o. Provide role specific training, advice, and support for care managers to enable them to fulfil their statutory powers and functions, noting that responsibility for core training, supervision and management of care managers resides with their employer.

The Compulsory Care Coordinator must ensure that in the geographic region they hold designation for:

- There is an on-call system in place to ensure 24-hour cover for the management of compliance with regulation, for example designation or change in residence.

4.2. National Advisor

The role of the National Advisor is to provide specialist technical advice and expertise about the needs of disabled people with intellectual disabilities subject to the IDCCR Act. The role includes representing the FCS(ID) in external forums and meetings and enhancing the capability of the FCS(ID), through provision of coaching and mentoring and quality improvement advice to team members during their day-to-day work. The position description for this role provides a full account of the role and associated expectations. At the discretion of DSS the role may be a part-time position.

The minimum requirements of an individual holding the position are:

a. Intensive knowledge of relevant legislation,

b. Relevant professional qualification (including a current practicing certificate where relevant), such as psychiatry or psychology,

c. Knowledge of the high and complex framework infrastructure and associated services across each region of New Zealand.

As this position is critical to ensuring quality service provision, consistent with the requirements of the IDCCR Act, both the Regulator (MOH) and the Commissioner (DSS) should be part of the recruitment process. Funding for this role is conditional upon DSS approving this appointment.

5. Responsibilities and Functions of the FCS(ID)

The FCS(ID) have responsibility to ensure that the timeframes, duties, functions, and process requirements stipulated in the IDCCR Act, the service specifications, and operational guides are met.

5.1. Timeframes

For Court, Prison and Forensic Referrals

a. The timeframes for Service referrals and transfers are set out in the IDCCR ACT and CPMIP Acts.

b. Initial Assessment process as set out in the IDCCR Act.

The FCS(ID) will ensure assessments are completed and assessors' reports are filed within the timeframes determined by the legislation and the fixture dates set by the Court.

The FCS(ID) is responsible for updating and ensuring the quality of information in Socrates, that data entry into Socrates or other designated system is complete, accurate and inputted at the earliest opportunity, of any court ordered changes no later than 1 working day, all other administrative actions within 3 working days. That information received is reviewed and used to inform service delivery and individual care plans.

That all administrative requirements, defined in the IDCCR Act are undertaken and recorded, consistent with Operational guides.

5.2. Eligibility

The Care Recipient or Proposed Care Recipient is referred to FCS(ID) by the courts.

The FCS(ID) then determines a person's eligibility to access the Framework as per the criteria for intellectual disability described in the IDCCR Act (Section 7 – Meaning of intellectual disability). Only those who meet the criteria can enter the Framework. Eligibility also accords the right to be considered for publicly funded disability support services.

5.3. Inclusions

The FCS(ID) will provide the Services for people with an intellectual disability determined as meeting the following eligibility criteria:

a. Are subject to the provisions under the IDCCR Act, or related legislation including Criminal Procedure (Mentally Impaired Persons Act 2003) CP(MIP) Act , MH(CAT) and Criminal Procedure Act 2011. This includes children, young persons, and adults charged with or convicted of an imprisonable offence. This group are referred to as Proposed Care Recipients or Care Recipients as their services are mandated by the Court. This may include those transferring from Mental Health or prisons in specific circumstances as defined in the IDCCR Act, or

   If the person's intellectual disability has not been established, the FCS(ID) will progress a diagnostic assessment. If an intellectual disability is confirmed the referral may be accepted if all other criteria are met. If an intellectual disability is not present, then the referral must be declined.

b. If required, the FCS(ID) can continue to be involved with a person who is no longer subject to a compulsory care order if the person chooses they want to continue to receive supports from FCS(ID). Involvement is aimed at supporting the person to transition into mainstream services. This group are referred to as civil clients, people not required legally to remain within a service and can choose if they want to continue to receive supports from FCS(ID).

This includes a small group of people who were supported through the Framework prior to the establishment of the IDCCR Act. For as long as their care needs continue to be best met through continued involvement, the oversight of their care and wellbeing remains the responsibility of the FCS(ID).

A flow chart that details the legal framework that informs decisions relating to the person's eligibility and subsequent care journey is detailed in Appendix 5.

5.4. Exclusions

The FCS(ID) will not provide a service for:

a. persons who do not fulfil the entry criteria for FCS(ID) services

b. persons for whom it has been established there is no ongoing intellectual disability

c. persons for whom the presence of an intellectual disability is established but the person:

   i. Requires an assessment solely as a result of a mental health need. These assessments are contracted for by MOH through mental health assessment services or Community Mental Health Teams; or

   ii. has needs more appropriately met by another service's eligibility, for example a transfer under MHCAT or ACC,

d. persons who have needs more appropriately assessed and met by NASC services (according to a principle of least restrictive intervention).

5.5. FCS(ID) Initial (Needs) Assessment

A FCS(ID) initial (needs) assessment is initiated and completed for all eligible tāngata whaikaha, which comply with NASC Guidelines, and Standards for Needs Assessment and FCS(ID) policies and processes. This assessment should be undertaken alongside the person and their whānau so that there is a good understanding of the factors that contributed to their situation and specific personal and cultural support preferences and needs are understood. The assessment process will occur in accordance with all requirements under the IDCCR Act.

If a civil client continues to receive support from FCS(ID) for an extended period, then the initial FCS(ID) assessment process should be repeated, at least, every three years, with annual reviews. Any revisions to information should be agreed by the person and/or their welfare guardian (should the person require support in this process).

For civil clients, on completion of the FCS(ID) initial assessment, the person and the Compulsory Care Coordinator/Coordinator, will agree on the identified goals, disability support needs and how these are to be prioritised. This is the completion of the assessment process, and the person, or if they are unable to, then their welfare guardian will sign the assessment forms to agree that it is an accurate reflection of the assessment that has taken place.

5.6. Assessment for Proposed Care Recipients and Care Recipients Under the IDCC&R Act

For referrals for Proposed Care Recipients the assessor must comply with the assessment process stipulated under Part Three of the IDCCR Act. The Compulsory Care Coordinator will either conduct the FCS(ID) Initial Assessment tasks themselves or delegate to responsibility to another person employed by the FCS(ID).

This Assessment is called the "FCS(ID) initial assessment". This is to prevent confusion over the terminology used for the legislative process and that used in the NASC process. The NASC process references a “Needs Assessment”.

5.7. Specialist Assessment

The Compulsory Care Coordinator will request that a specialist assessor provides reports to meet the requirements of CPMIP Act inquiries for all Proposed Care Recipients and IDCCR Act reviews for Care Recipients. The Specialist Assessors provide a detailed risk formulation that assists the Court in determining the most suitable disposition option and provide additional clinical recommendations. The FCS(ID) is to identify and facilitate access to specialist assessments as required. Details about the role and responsibilities can be found in the deed of appointment and the Guidelines for the Role and Function of Specialist Assessors (under the IDCCR Act 2003) published by the Ministry of Health.

5.8. Cultural Assessment

Cultural Assessment and assessors are covered by the term Specialist Assessors, but cultural assessors are not required to be approved by the Director General of Health.

The Cultural Assessment entails a full assessment of a person's cultural identity and needs. A Cultural Assessment is carried out in parallel with a specialised or Specialist Assessment. It is important to

facilitate the integration of Cultural Assessment and Specialist Assessment recommendations within the cultural contexts involved (including the Deaf culture).

It is important that the cultural and support needs and Specialist Assessments complement each other and have a clear focus on the best outcome for the person and their whānau.

MOH Cultural Assessment Guidelines for Tāngata whaikaha Māori provide guidance on the expertise required, the process for engaging, and the anticipated focus areas.

5.9. Service Coordination

Service Coordination is the process of developing a support package that is consistent with any court orders and done in consultation with the person and their whānau (where appropriate). Coordination is based on the assessed and prioritised needs of the person and is consistent with the Court approved Care and Rehabilitation Plan (CARP). The process should account for the available funding and seek to utilise both funded and non-funded services. Service coordination may be done by the same person who completed the Initial Assessment, but the processes must be discrete from each other.

The wellbeing and safety of the person and others, is central to decisions made; amongst broader factors the following must be considered when determining the appropriateness of a placement:

- the person's gender,
- the person's age. The placement of young people in adult forensic units should only occur if there are appropriate reasons. Compulsory Care Coordinators must be aware of their responsibilities in relation to Article 37(c) of the United Nations Convention on the Rights of the Child,
- proximity of location to the person's whānau and wider established supports,
- The person's cultural needs and the placement's capacity to provide Māori with a culturally supportive environment.

For civil clients the aim is to provide the support needed to transition the person into mainstream services. As part of the transition process, consistent with informed consent processes, the FCS(ID) will work towards transferring the responsibility for future needs assessment and planning to the local NASC.

A priority in providing this support is to reduce the likelihood that the person will require further statutory intervention under the IDCCR Act.

5.10. Reviews and Reassessment

5.10.1. Reviews

The Compulsory Care Coordinator is responsible for ensuring an appropriate timeframe for a review and appropriate processes are established with the person to review their plans. This will be done in accordance with review guidelines and the mandated requirements for the person, court reporting, scheduled reviews, and/or reviews if the person's needs change.

Care Recipients under the IDCCR Act will have court-imposed Reviews that must be delivered.

Unless there is a court-imposed review, detailing a different time frame, Compulsory Care Recipients require a review every 6 months.

Civil clients, require a review at least once every 12 months.

The review process must record progress made towards the person's CARP. Outcome data should be collated in a format that allows for analysis and review. This information should be included in quarterly reporting and available to DSS on request.

As part of the review process feedback about the service, should be sought from recipients of the service.

The review periods for people with particularly high and/or complex needs or those in a crisis period may be considerably shorter and more frequent, as determined by the FCS(ID).

The person and their whānau may at any time seek a review if the Service is not meeting their needs.

5.10.2. Reviews following request or complaint

The FCS(ID) will provide information to all people accessing their service, detailing the procedure by which they may request a review of the outcome of a part, or the whole, of the assessment or service coordination process. Such procedures are to include the following elements:

- The ability to screen out, or resolve through discussion, complaints arising from misunderstandings.
- Further assessment or a new support plan using assessment facilitators or staff members not involved in the previous assessment.

- Access to a second level of review within the FCS(ID) if the person remains dissatisfied.
- The FCS(ID) is required to ensure that the protocol for reviews, is known, monitored and consistently applied.

The above steps will be at the FCS(ID)'s expense. If a complaint still exists, the person may contact DSS. The standard review procedure provided by DSS, at that time, will be followed.

5.10.3. Reassessment

Should the person's need or circumstances undergo significant change, and the support plan no longer meets their needs, a reassessment will be undertaken. The person, the FCS(ID), or Support Service Provider, may request the initiation of a reassessment at any time.

If it is likely that the person's support will change over an identified period, as the result of the care plan addressing underlying issues and/or a reduction in known risk factors, then this would indicate a need for a reassessment. A lack of progress may also suggest the need for a reassessment to determine if alternative supports may be more beneficial for the person.

5.11. Transfers

The FCS(ID) will establish protocols and procedures with NASC organisations and Support Service Providers in all areas of New Zealand to ensure continuity of service for the person both moving into and out of a Support Service Provider's geographic boundary. Such protocols should include but are not limited to:

- A shared understanding of the legal rights of tāngata whaikaha. When working with the person to determine future options they should be supported to understand their rights and (within the scope that legal restrictions allow) ongoing and decision specific consent must be obtained and documented at all stages.
- The timely transfer of relevant information including assessment, service and support planning records to a NASC, noting that all health information is subject to the provisions of the Health Information Privacy Code 2020, including subsequent versions of this document.

- With approval of the person, immediate commencement of services by the new NASC according to the person's transferred Support Plan until such time as a reassessment or review of the Support Plan are undertaken by the new NASC.
- A process for, and agreement on, a transition plan developed by both NASC and FCS(ID) in conjunction with the person. This is particularly important in situations where different services are required and/or where particular services are not available in the new area.
- A process for temporary moves between regions. The FCS(ID) is responsible for ensuring that the person's disability support needs continue to be met while away and as outlined in the Support Plan.
- A process for moves to a geographic or operational area for which the Compulsory Care Coordinator or Care Manager currently responsible for the person does not hold a designation.
- When people receiving service transfer between regions the FCS(ID) must ensure the minimum level of disruption to the implementation of the person's support plan, as detailed in their care and rehabilitation plan.

5.12. Service transition including exit

The FCS(ID) must have a clear process to support people transitioning out of the Framework into the NASC. Protocols should be established with all NASCs to manage these transitions and deal with any issues that may arise from time to time.

Oranga Tamariki - Ministry for Children have responsibility for case management and funding of support packages for children and young people with high and complex behavioural needs. There is a MoU between Oranga Tamariki and Whaikaha, that has transferred to DSS, that informs respective responsibilities for young people with additional support needs, associated with their disability. The FCS(ID) will support transition planning for children and youth who are leaving the case management responsibility of Oranga Tamariki and moving into FCS(ID) services.

The process used for people exiting the Framework services will comply with *The NASC Liaison Guidelines* and DSS operational policy. Please note the DSS policy *Exceptional Circumstances when a Community Residential Support Service Provider requests the Service Exit of a Disabled Person*, does not apply to people receiving support through the FCS(ID).

5.13. NASC Liaison

NASC liaison function aims to support a smooth, well-planned transition for people who no longer need to be supported through the Framework and want to continue to receive disability supports. It also seeks to provide timely support to reduce the likelihood of a person needing to re-enter the Framework. FCS(ID) will provide the following additional support to NASC:

a. Support the NASC to meet the agreed needs of a person to minimise the likelihood that they will require FCS(ID) level services,

b. Support the NASC to develop and maintain linkages with their regional Mental Health Services and other key agencies in relation to specific individuals,

c. Transition people from FCS(ID) level services back to the NASC in accordance with agreed transition plans, when the person chooses to continue accessing support.

The FCS(ID) will ensure there are regular liaison meetings held between regional NASC and regional FCS(ID) team. These can be directly with one NASC or several regional NASCs at one time. A Coordinator from the FCS(ID) will be the dedicated liaison point for each NASC, although advice and support can be sought from any FCS(ID) team member at any time.

5.14. Critical events

Consistent with expectations detailed in both The Health and Disability Services (Safety) Act 2001 and Ngā Paerewa Health and Disability Services Standard NZS 8134:2021, the FCS(ID) is required to promote safe provision of services for people and to actively respond if concerns are raised with them.

Staff across the Framework have a responsibility to ensure that people are safe from harm, abuse, or neglect (including but not limited to physical, emotional, spiritual, cultural, financial, or sexual). The FCS(ID) have a shared responsibility to ensure that risks and harm are identified, recorded, reported and addressed.

The FCS(ID) will provide a 24- hour on-call system for eligible tāngata whaikaha, including those undergoing eligibility assessments, meeting also the legislative requirements of the Compulsory Care Coordinator.

The FCS(ID) will report to MOH, and DSS any critical incident as soon as possible. Any major risk or complaint concerning people under the FCS(ID) management must be notified relevant Ministries as soon as possible but not more than 24 hours after identification or occurrence of the incident.

DSS and the Ministry of Health must also be notified of all instances where young people aged under 18 are placed in an adult unit, or when an adult is placed in a young person's unit.

Guidelines and associated documents required for reporting a critical incident can be found on the respective Ministry's website.

The FCS(ID) has an obligation to escalate concerns that cannot be resolved. The FCS(ID) must have systems and processes in place that guide how issues will be escalated.

5.15. Disability Sector Knowledge

The FCS(ID) has the role of referring to and advising people receiving service and their whānau, of further information. It is expected that general information will be readily available, on but not limited to:

- Eligibility and details of the nature, type and quality of services available through FCS(ID) and services available from other sources.
- Other agencies where further information may be obtained.

The FCS(ID) is not expected to compile and duplicate specific detailed information already available from other disability information agencies in their area. However, the FCS(ID) will maintain effective networks and linkages with a wide range of appropriate organisations resulting in current, reliable information from which to advise and make referrals.

6. Working Collaboratively

6.1. Establishing and Maintaining Service Linkages

The FCS(ID) is required to maintain effective links in all geographic regions for the purpose of:

- Sharing knowledge, ideas and information on the role of FCS(ID),
- Sharing ideas, knowledge and understanding of supports and service options for tāngata whaikaha,
- Undertaking peer reviews as part of a performance management system,
- Ensuring that when people are transferred between regions there is minimum disruption to their goals, risk is minimised, and transfers occur with the interests of the person foremost within available resources,

- Ensuring a coordinated and comprehensive method for accessing information that is relevant and appropriate to the provision of disability support services,
- Supporting individuals by having relevant information for their service needs.

The FCS(ID) will work with the Support Service Providers of high and complex services to ensure that:

a. People receiving service, have access to the full range of services,

b. That the services provided, recognise and value the perspectives of disabled people and whanau, and work with them to address concerns and meet aspirations,

c. Disputes among Support Service Providers are resolved with the minimal possible adverse effect to any tāngata whaikaha,

d. Disputes concerning the service offered to the person are resolved in a timely manner,

e. Any disputes that may escalate to a Critical Incident must be reported to DSS and MOH.

6.2. Disability Sector Linkages

The FCS(ID) is required to demonstrate effective linkages with these Key Agencies or Support Service Providers:

a. RIDSS, NIDSS, RIDSAS, District Inspectors and Community Liaison Team services.

b. Other hospital level Secure Services.

c. Specialised and Specialist Assessors.

d. Care Managers.

e. Needs Assessment and Service coordination organisations (NASC) throughout the geographical region served.

f. Sex offender treatment programmes.

6.3. Intersectoral Linkages

FCS(ID) is required to demonstrate effective linkages with these key agencies or Support Service Providers:

a. Ministry of Health - Manatū Hauora, Director Mental Health and Addiction
b. Behaviour support services
c. Forensic Services
d. Kaupapa Māori organisation and providers
e. The Courts and Department of Corrections, including Court liaison professionals.
f. Community Liaison Teams.
g. NZ Police.
h. Oranga Tamariki and its services (for children and young persons)
i. District Inspectors
j. Services provided by Health New Zealand – Te Whatu Ora (Mental Health Services, Physical Health and Addictions)
k. Office of the Ombudsman
l. Office of the Privacy Commissioner
m. Other supported accommodation Support Service Providers
n. Government Ministries including the Ministry of Disabled People, Education, Health, Social Development, MOE, Justice, and ACC
o. Iwi, hapū, and marae.

The FCS(ID) is required to provide DSS with evidence of the effectiveness of relationships.

6.4. Interface with Mental Health

Disabled people under this service specification may also require the involvement of Health NZ Mental Health services. In all such instances, Mental Health Services and those services specifically for people who have an Intellectual Disability, will work together to achieve the best outcomes for the person.

For those people whose needs are subject to court orders, formal relationships with Forensic services, secure hospital level services and/or Community Mental Health will need to be agreed upon. The FCS(ID) must have processes, in place to support the transfer of eligible people transferring from Mental Health, these processes will be consistent with expectations within the IDCCR Act. For civil clients who may present with co-existing mental illness, Community Mental Health services will be

accessed. Roles and responsibilities of Community Mental Health and the FCS(ID) will be documented and reflected in the person's Support Plan and monitored by the Care Coordinator or Compulsory Care Coordinator.

7. Other Requirements

Legislation

FCS(ID) will be required, to abide by all relevant New Zealand Legislation including but not limited to the following (or current version of the same):

a. Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act)
b. Mental Health (Compulsory Assessment and Treatment) Act 1992 (MH(CAT) Act)
c. Criminal Procedure (Mentally Impaired Persons) Act 2003 (CP(MIP) Act)
d. Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996
e. Health Information Privacy Code 2020
f. Ngā Paerewa Health and Disability Services Standard NZS 8134:2021
g. Protection of Personal and Property Rights Act 1988 (PPPR Act)
h. Oranga Tamariki Act 1989
i. Criminal Procedure Act 2011
j. Privacy Act 2020.
k. Victims' Rights Act 2002
l. Public Records Act 2005
m. New Zealand Public Health and Disability Act 2000 or the Pae Ora (Healthy Futures) Act 2022

Other Guiding Documents

The FCS(ID) are 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 Pacific Health and Disability Action Plan

United Nations Convention on the Rights of the Child

United Nations Convention on the Rights of Persons with Disabilities

Policies/Guidelines/procedures related to administration of the IDCCR Act and wider supports within the HCF, as detailed in Appendix 2.

Any procedures for FCS(ID) service that may be issued by the Ministry of Health ("Manatū Hauora") or DSS in relation to the IDCCR Act.

Other Protocols

The FCS(ID) will observe other protocols and/or memoranda of understanding between the Ministries and other government departments or agencies as and when appropriate and notified to the FCS(ID) by the DSS.

The FCS(ID) will support service initiatives; for example, the implementation of the High and Complex Framework Operational Strategy 2023-2028.

Appendix 1: Definition of terms and acronyms used across the High and Complex Framework

Many of the terms used in this specification are defined in sections 5 through 10 of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act)	
Care and rehabilitation plan	In relation to a care recipient, means the care and rehabilitation plan prepared for the care recipient, under section 24. As defined in section 5 of the IDCCR Act and required by section 24 of the IDCCR Act. Under section 25 of the IDCCR Act they must identify the following matters: (a) the social, cultural, and spiritual needs of the care recipient (b) any medical or psychological treatment that the care recipient requires (c) any requirements for medication needed to manage the care recipient's condition (d) the circumstances in which the care recipient is likely to behave in a manner that endangers the health or safety of the care recipient or of others (e) any aptitudes or skills of the care recipient that should, if practicable, be maintained and encouraged (f) any special concerns or aversions of the care recipient (g) any special dietary needs of the care recipient (h) any other special needs of the care recipient
Care manager	A health professional designated by the Compulsory Care Coordinator under the IDCCR Act for a specific care recipient under section 141 of the IDCCR Act, who is responsible for overseeing the delivery of a care recipient's day-to-day care and support. This includes working with the Care Recipient to develop a Care & Rehabilitation Plan that reflects the support needs of the Care Recipient
Care Programme	As required and defined in section 26 of the IDCCR Act. Every care and rehabilitation plan must set out a care programme for the care recipient that provides for the following matters:

	(a) the objectives of the care proposed to be provided to the care recipient, and the approach or approaches to be followed in achieving those objectives: (b) the general nature of the care proposed to be provided to the care recipient: (c) the degree of security required for the care of the care recipient and for the protection of others.
Care Recipient/Proposed Care Recipient	As defined in section 6 of the IDCCR Act.
Civil clients/service users/Civil population	Previously this referred to all people receiving support from FCS(ID) who were not Care Recipients under the IDCCR Act. In this document the term 'civil client' as been redefined and now specifically refers to individuals who, while continuing to receive supports from FCS(ID) are no longer under any legal restrictions and are in a process of transferring back to mainstream services.
Community Liaison Team (CLT)	Team of multi-disciplinary professionals who, on referral from the FCS(ID) can offer assessment, intervention and consultation liaison services to all individuals determined eligible by the FCS(ID). 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. In the community the role of the CLT is to proactively assist FCS(ID) eligible people, both those under IDCCR Act and the civil population, and the support service providers supporting them.
Compulsory Care Coordinator	A Compulsory Care Coordinator is a health professional appointed by the Director General of Health under section 140 of the IDCCR Act who operates within a particular geographic region. The term Care Coordinator is used generically, applied to both Care Coordinators and Compulsory Care Coordinators. Both are employed by FCS(ID). The distinction being that only Compulsory Care Coordinators are designated
Compulsory care order	A court direction under section 45 of the ID (CC&R) Act or an order made under section 25(1)(b) or section 34(1)(b)(ii) of the Criminal Procedure (Mentally Impaired Persons) Act 2003 (CP(MIP) Act) and includes the order as varied from time to time. The order determines the length of time a person must spend as a care recipient, and the level of security the person is subject to in a hospital or community-based facility.

Court Order	A Compulsory Care Order or an order under section 24(2)(b) or section 34(1)(a)(ii) of the CP(MIP) Act; and includes the order as varied from time to time.
Criminal Procedure (Mentally Impaired Persons) Act (CP(MIP) Act)2003	Refers to the Act that replaced Part 7 Criminal Justice Act 1985 (CJA). Provides the courts with a range of options for the detention, assessment, and care of defendants and offenders with an intellectual disability.
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 Support Service Providers (for example additional staffing, temporary accommodation).
Critical incident	The definition of a critical incident and the reporting responsibilities are detailed on the DSS. DSS Reporting of critical incidents and deaths | Disability Support Services The Outcome Agreement specifies additional reporting requirements required by Ministry of Health -Manatū Hauora and the Care Manager responsibility for reporting to the FCS(ID).
Cultural assessment	As required by section 23 of the IDCCR Act.
Disability Support Services (DSS)	The business unit within MSD responsible for planning, funding and monitoring of disability support services. Disability support services: goods, services, and facilities that are: a. Provided to people with disabilities for their care or support or to promote their independence and participation in society; or b. Provided for purposes related or incidental to the care or support of people with disabilities or to the promotion of the inclusion and participation in society, and independence of such people.
District Inspector (DI)	A barrister or solicitor appointed by the Director-General of Health under section 144 of the IDCCR Act. A District Inspector or Deputy District Inspector role it is to ensure that the rights of disabled people are upheld. They also have an inspection function with respect to service providers and the investigation of complaints.
Enabling Good Lives (EGL)	EGL is a social movement. The EGL approach is about disabled people and their families having the “say so” in their lives, having supports that make things easier and having the ability to influence “the system”.

Facility and Secure Facility	As defined in section 9 of the IDCCR Act. Also note the Secure Service Matrix requirements set out in appendix 3 of this service specification.
Forensic Coordination Service (Intellectual Disability) (FCS(ID))	National agency that determines a person's eligibility for services under the High and Complex Framework, employs compulsory care coordinators, coordinates care recipient referrals and manages placements in hospital or community facilities. Previously known as National Intellectual Disability Care Agency (NIDCA).
High and Complex Framework	The High and Complex Framework (the Framework) is a network of services to support people who are either subject to IDCCR Act or who have previously been subject to it and are now in the process of transitioning into mainstream services.
Intellectual disability	Section 7 of the IDDCR Act provides a legal definition of 'intellectual disability' To align with this, this term is used though out this document.
Intellectual Disability Compulsory Care and Rehabilitation Act 2003 (IDDCR Act)	Statute with the purposes to: - provide courts with appropriate compulsory care and rehabilitation options for persons who have an intellectual disability and who are charged with or convicted of an offence; - Recognise and safeguard the special rights of individuals subject to the Act - Provide 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.
Medical Consultant	A registered medical practitioner designated by the Director General of Health under section 146 of the IDCCR Act.
Ministry of Health (MOH) Manatū Hauora	MOH is the chief steward of the health system. MOH has statutory responsibility for the Intellectual Disability (Compulsory Care and Rehabilitation) Act.
Mental Health (Compulsory Assessment and Treatment) Act 1992 MH(CAT)	Statute setting out the circumstances and conditions required for people to undergo compulsory mental health assessment and treatment, to define the rights of the person and to provide protection for those rights.
National Intellectual Disability Care Agency (NIDCA)	Previous name of Forensic Coordination Service (ID). All functions formerly delivered by NIDCA are delivered through FCS(ID).

National Intellectual Disability Secure Services (NIDSS)	Service that provides hospital level forensic assessment and long-term placement for youth (Youth Unit).
Needs Assessment/Initial Assessment	An initial assessment to determine the needs of tāngata whaikaha. In the case of People detained under a Court Order, the Needs Assessment requirements are set out in Part 3, of the IDCC&R Act.
Needs Assessment and Service Coordination organisation (NASC)	Organisation(s) contracted by DSS to determine a person's eligibility and provide those eligible with a Needs Assessment and Service Coordination for access to DSS funded services and the ongoing suitability of those service to meet a person's needs. NASC providers have budget management responsibility.
Procedures Manual	The Procedures Manual is referred to in several historical documents. This is a hard copy resource that is in the process of being replaced by a kete of digital forms and operational guides. As an interim measure DSS can make a reference copy available of the original procedure's manual.
Re-assessment	A repetition of an Initial/Needs Assessment, where a change in need has occurred and the person's needs require re-assessment.
Region	Geographical regions, as set out in the map attached as Appendix 4 to this Service Specification
Regional Intellectual Disability Care Agency (RIDCA)	RIDCA no longer exists, all functions formerly delivered by RIDCAs initially transferred to NIDCA and are now provided by the FCS(ID).
Regional Intellectual Disability Supervised Accommodation Services (RIDSAS)	These services provide community assessment beds, residential and vocational agencies. The Care Manager function sits within RIDSAS.
Regional Intellectual Disability Secure Services (RIDSS)	Provider of regional hospital level secure services and assessment beds for adults within the HCF, with an appropriate court order. The Care Manager function sits within RIDSS.
Review	The conditions of every care recipient who is subject to a court order must be formally reviewed at times specified in section 77 of the IDCCR Act. Civil clients require this process to be undertaken annually, earlier if required
Secure Care	Is defined in section 5 of the ID(CCR) Act to mean care given to a care recipient who is required to stay in a secure facility.

Specialist Assessment	A specialist clinical assessment in any area of expertise completed by a Health Assessor or Specialist Assessor/Specialist Medical Consultant who is a suitably qualified health or disability professional (and, by convention, are typically designated Specialist assessors). For the purpose of the IDCCR Act or CP(MIP) Act, these assessments will be requested by the FCS(ID) or NASC to establish eligibility and management or planning.
Specialist Assessor	Defined in section 5 of the IDCCR Act. Specialist Assessors' are designated under section 146 of the IDCCR Act.
Special care recipient	As defined in section 6 of the IDCCR Act. A type of care recipient. A person who, due to the very serious nature of their offence, is subject to a longer compulsory care order and liable to (or serving) a term of imprisonment. Special Care Recipients must always receive care and rehabilitation in a secure facility. Their leave must be approved by the Director-General of Health and/or the Minister of Health.
Supervised Care	Supervised care is defined in section 5 of the IDCCR to mean care given to a care recipient who may be directed to stay in a facility or in another place. Section 64 of the IDCCR Act outlines when a care recipient may be directed to receive supervised care.
Support Plan	The equivalent care and rehabilitation plan for Civil Population, outlining support requirements.
Support Service Providers	Organisations that are contracted by DSS to provide services and supports to those people who meet DSS eligibility criteria or engaged by the FCS(ID) provider according to the agreed use of discretionary funding.
Tāngata whaikaha	Tāngata whaikaha is a word created within the Māori disability community, with whaikaha meaning 'to have strength, to have ability, otherly abled, enabled'. This is aligned with terminology used by the sector, with 'Whaikaha' being the name of the Ministry of Disabled People, and with te reo Māori being an official language of New Zealand. 'tāngata whaikaha' is the term used when referring to those receiving intellectual disability services.[1]

[1] Te Reo Hāpai: The Language of Enrichment, https://www.tereohapai.nz/ 5 See https://www.whaikaha.govt.nz/about-us/who-we-are/finding-our-names/

Tāngata whaikaha Māori	Disabled Māori. Tāngata whaikaha means people who are determined to do well.
Te Whatu Ora - Health New Zealand	District Health Boards were disestablished in 2022 and were replaced by Te Whatu Ora - Health New Zealand.
United Nations Convention of the Rights of Persons with Disabilities (UNCRPD)	The United Nations Convention on the Rights of Persons with Disabilities is an international human rights treaty. It sets out what is required to implement existing human rights as they relate to disabled people. In September 2008, the New Zealand Government ratified the CRPD. This means the Government has a duty to protect and promote the human rights of all disabled people.
Whaikaha - Ministry of Disabled People	Whaikaha – Ministry of Disabled People is a standalone government department.

Appendix 2: List of Policies, Procedures and Guidelines

	Document descriptor	Agency Responsible
1.	Bed Utilisation Guidelines (internal)	FCS(ID)
2.	Funding Guidelines (internal)	FCS(ID)
3.	FCS Community Liaison Team Guidelines (internal)	FCS(ID)
4.	NASC Liaison Guidelines (internal)	FCS(ID)
5.	Reporting Guidelines (internal)	FCS(ID)
6.	Supervision Guidelines (internal)	FCS(ID)
7.	Vocational Services Eligibility and Process Guidelines (internal)	FCS(ID)
8.	Eligibility and Process Guidelines (internal)	FCS(ID)
9.	Specialist Assessor Housekeeping Guidelines (internal)	FCS(ID)
10.	Special care recipients (internal)	FCS(ID)
11.	Chain of custody guidelines (internal)	FCS(ID)

12.	Blank CARP Template & sample template	Ministry of Health
13.	Transport guidelines (to be developed)	Ministry of Health
14.	ID Eligibility Guidelines	DSS
15.	Use of close circuit monitoring (to be developed)	DSS
16.	PPP&R in relation to civil clients' guidelines (to be developed)	DSS
17.	Exceptional Circumstances for Service Exit policy	DSS
18.	Prevention and Management of Abuse Guidelines for DSS funded residential services	DSS
19.	IDCCR Act Guidelines including Incidence Reporting & Leave Provisions	Ministry of Health
20.	Statutory Officers' Guidelines: i. Compulsory Care Coordinators ii. Specialist Assessors iii. Care Managers	Ministry of Health

21.	Seclusion and Restrictive Practice guidelines (MHCAT available, IDCCR Act practice guide to be developed)	Ministry of Health
22.	Medication guidelines (to be developed)	Ministry of Health
23.	District Inspector Guidelines	Ministry of Health
24.	Cultural Assessment Guidelines	Ministry of Health
25.	Victim's Rights Guidelines	Ministry of Health
26.	Special Patients and Restricted Patients: Guidelines for Regional Forensic Mental Health Services | Ministry of Health NZ	Ministry of Health
27.	2023 Guidelines for reducing and eliminating seclusion and restraint under the mental health (Compulsory Assessment and Treatment) Act 1992	Ministry of Health

Appendix 3: Secure Matrix

PROCEDURAL SECURITY* (Policy and Practice for Controlling Risk)		Community Supervised (Supervised Order)	Community Secure (Secure Order)	Cottages/stepdown (Secure order)	Hospital Secure (Secure Order)
Lines of Responsibility (Management Arrangements)	**Management Resources**	Ensure clear lines of reporting and responsibilities			
	Weekly Monitoring	Weekly monitoring after entry into service, time within service, transfer, and transition			
	Legal Compliance	Ensure compliance with legal and regulatory requirements			
	Inter-Agency Relationships	Ensure maintenance and enhancement of inter-agency relationships and boundaries.			

RELATIONAL SECURITY (Staffing and Relationships)		**Community Supervised** (Supervised Order)	**Community Secure** (Secure Order)	**Cottages/stepdown** (Secure order)	**Hospital Secure** (Secure Order)
Quantitative: The staff to patient ratio and amount of time spent face to face.	**Quantitative**	Ability to have wake night staff 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. Appropriate staffing levels to account for whereabouts of service user 24 hours per day. Staff / service user ratio adequate to meet the rehabilitation requirements of each individual care recipient. Sufficient staffing levels to manage service user risk and maintain operational integrity of service. Ability to facilitate community access with appropriate staffing levels.	24 hr Rostered Staffing. Appropriate staffing levels to account for whereabouts of service user 24 hours per day. Staff / service user ratio adequate to meet the rehabilitation requirements of each individual care recipient. Sufficient staffing levels to manage service user risk and maintain operational integrity of service. Ability to facilitate community access with appropriate staffing levels e.g. 2:1 escort.

RELATIONAL SECURITY (Staffing and Relationships)		**Community Supervised** (Supervised Order)	**Community Secure** (Secure Order)	**Cottages/stepdown** (Secure order)	**Hospital Secure** (Secure Order)
Qualitative: The balance between intrusiveness and openness; trust between care recipients and professionals.	**Qualitative**	Ability to form rehabilitative relationship with client group essential. Access by referral to specific disciplines via community services.	Ability to form rehabilitative relationship with client group CARP. Predominantly non-professional scopes of practice.	Immediate access to registered health care professionals including Registered Nurses & Medical Staff. Ready access to full scope of Multi-Disciplinary Team (MDT). Ability to form therapeutic relationship with client group essential. Facilitated access to community services consistent with a care recipient care and rehabilitation plan. Clinical team trained in assessment and management of risk, de-	Immediate access to registered health care professionals including Registered Nurses & Medical Staff. Ready access to full scope of MDT. Ability to form therapeutic relationship with client group essential. Facilitated access to community services consistent with a care recipient care and rehabilitation plan. Clinical team trained in assessment and management of risk, de-escalation and Safe Practice Effective
	Restraint	Trained in calming and breakaway techniques. Facilitated access to community services consistent with a care recipient care and rehabilitation plan. The support team trained in assessment and management of risk, de-escalation, or approved equivalent.	Planned access to specific disciplines via community services. Trained in an approved de-escalation restraint programme in accordance with NZ Standards Facilitated access to community services consistent with a care recipient care and rehabilitation plan.		

RELATIONAL SECURITY (Staffing and Relationships)		Community Supervised (Supervised Order)	Community Secure (Secure Order)	Cottages/stepdown (Secure order)	Hospital Secure (Secure Order)
			The support team trained in assessment and management of risk, de-escalation, or approved equivalent.	escalation, or approved equivalent.	Communication (SPEC) or approved equivalent. Clinical team trained in management of service users in seclusion
	Reviews	Daily by Staff At least monthly by clinical team (internal) 6 monthly by MDT (external) + FCS-ID 6 monthly Regular/meaningful whānau engagement, communication, and updates.	Daily by Staff Weekly by internal clinical team Mthly by MDT + FCS-ID 6 monthly Regular/meaningful whānau engagement, communication, and updates.	Daily by registered health care professionals. Formal MDT review schedule in place, including 3 monthly case conferences involving all stakeholders. FCS-ID 6 monthly reviews. Regular/meaningful whānau engagement, communication, and updates.	Daily by registered health care professionals. Formal MDT review schedule in place, including 3 monthly case conferences involving all stakeholders. FCS-ID 6 monthly reviews. Regular/meaningful whānau engagement, communication, and updates.

RELATIONAL SECURITY (Staffing and Relationships)		**Community Supervised** (Supervised Order)	**Community Secure** (Secure Order)	**Cottages/stepdown** (Secure order)	**Hospital Secure** (Secure Order)
	Interface between agencies	Established communication schedule with DSS and MoH. Interface between FCS-ID on progress of care recipients. Liaison with District Inspectors as required.	Established communication schedule with DSS and MoH. Interface between FCS-ID on progress of care recipients. Liaison with District Inspectors as required.	Established communication schedule with DSS and MoH. Interface between FCS-ID on progress of care recipients. Liaison with District Inspectors as required.	Established communication schedule with DSS and MoH. Interface between FCS-ID on progress of care recipients. Liaison with District Inspectors as required.

ENVIRONMENTAL SECURITY (Building and Fixings)		Community Supervised (Supervised Order)	Community Secure (Secure Order)	Cottages/stepdown (Secure order)	Hospital Secure (Secure Order)
This includes the design and maintenance of the estate and fittings, including the staff to operate them (technical staff)	**General Dwelling**[2]	Lockable External Doors	Locked External Doors Locked/ Limited Opening Windows	Facility[3] to have features designed to replicate those available in the community whilst minimising risk of unauthorised leave. Built to high standard with durable materials. Anti-ligature fixtures/fittings	Facility to have particular features that are designed to prevent persons required to stay in the facility from leaving the facility without authority; and is operated in accordance with systems that are designed to achieve that purpose. Built to high standard with durable materials. Anti-ligature fixtures/fittings
	Entry	Ability for staff to monitor Entry and exit	Single point entry / exit Controlled	Single point entry / exit with ability for staff to monitor	Single point entry/exit that is monitored.

[2] Procedural security: Detailed elements for services in this section would likely be found in each organisation's internal policy and practice guidelines.
[3] Facility: The definition of facility is that used in section 9 of the ID(CC&R) Act. 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).

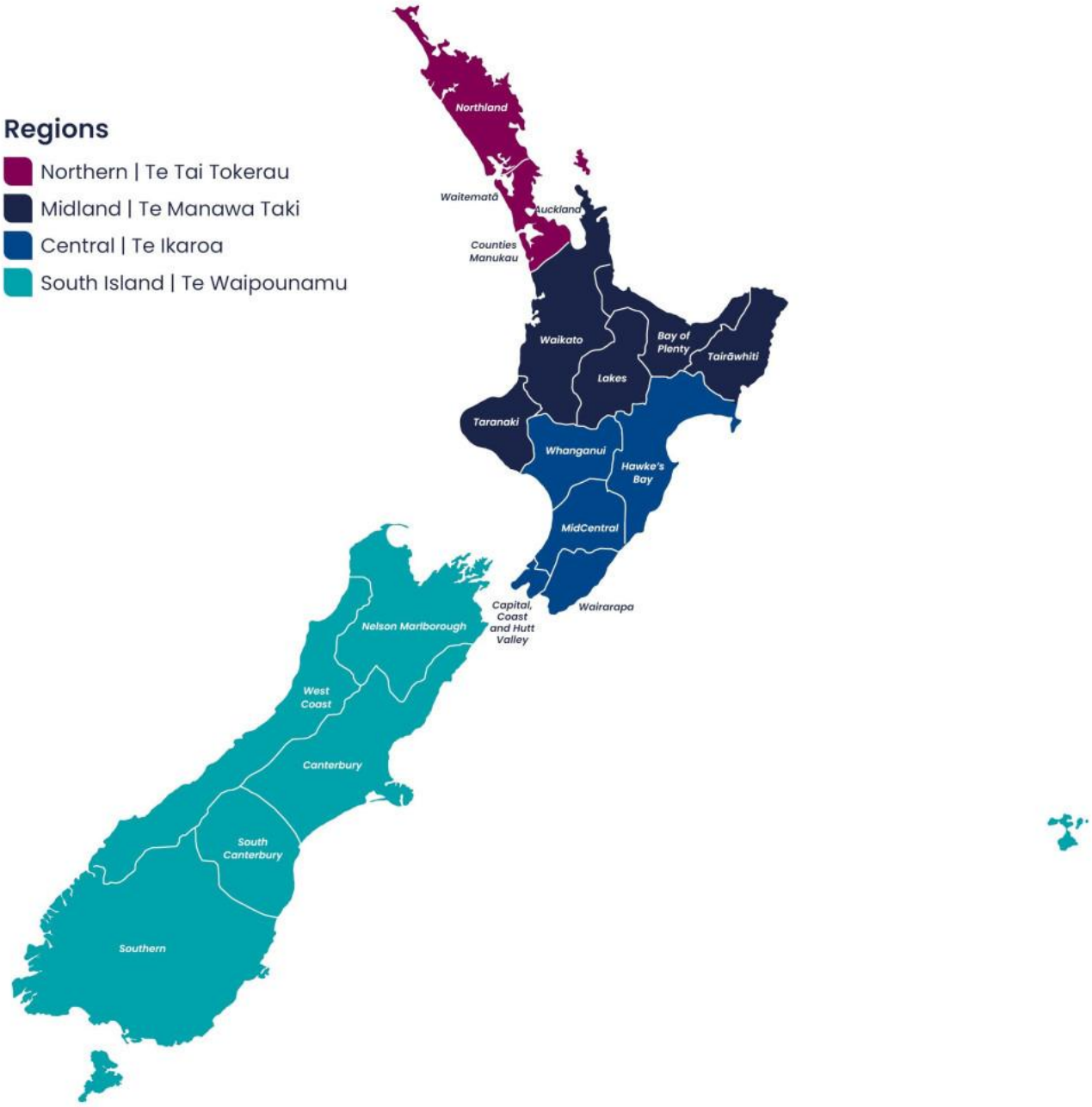
ENVIRONMENTAL SECURITY (Building and Fixings)		**Community Supervised** **(Supervised Order)**	**Community Secure** **(Secure Order)**	**Cottages/stepdown** **(Secure order)**	**Hospital Secure** **(Secure Order)**
					Vehicle air lock
	Windows	Safety Glass (where appropriate) Limited opening	Safety glass (where appropriate) Limited opening Alarmed	Safety glass (where appropriate) Limited opening	Safety glass (where appropriate) Limited opening
	External Doors	Robust lockable (Custodial)	Robust lockable (Custodial)	Robust lockable (Custodial)	Door air lock system Robust (Custodial)
	Internal Doors	Solid core (Robust)	Solid core (Robust)	Solid core (Robust)	Solid core (Robust)
	Seclusion	Low Stimulus Areas (No planned seclusion provision)	Low Stimulus Areas (No planned seclusion provision)	Ability to provide low stimulus area if required. (No seclusion provision)	Purpose built seclusion rooms appropriately designated, including low stimulus areas
	Observation Systems	Dwelling allows easy observation including	Designed to allow staff observation and	Designed to allow staff observation of service user at all times	Designed to allow staff observation and

ENVIRONMENTAL SECURITY (Building and Fixings)		**Community Supervised** **(Supervised Order)**	**Community Secure** **(Secure Order)**	**Cottages/stepdown** **(Secure order)**	**Hospital Secure** **(Secure Order)**
		private areas (when required)	interaction at all times if required		interaction at all times if required CCTV (or equivalent) Entry & Access security control
	Alarm Systems (building)	Ability to alarm egress Meets FENZ requirements	Meets FENZ requirements	Meets FENZ requirements	Meets FENZ requirements
	Alarm Systems (Personal)	Staff Personal Alarms available	Staff Personal Alarms available	Wall Mounted Alarms Staff Tracking Ability	Staff Fully Alarmed Staff Tracking Ability
	Sprinklers	Meets FENZ requirements	Meets FENZ requirements	Meets FENZ requirements	Meets FENZ requirements
	Outdoor	All-weather outdoor space	All-weather outdoor space	All-weather outdoor space	All-weather outdoor space

ENVIRONMENTAL SECURITY (Building and Fixings)		**Community Supervised** **(Supervised Order)**	**Community Secure** **(Secure Order)**	**Cottages/stepdown** **(Secure order)**	**Hospital Secure** **(Secure Order)**
	Perimeter	Lockable gate (where required) Fenced	Perimeter Fencing - Climb resistant to the maximum allowed height with privacy planting as appropriate.	Escape resistant	Escape resistant

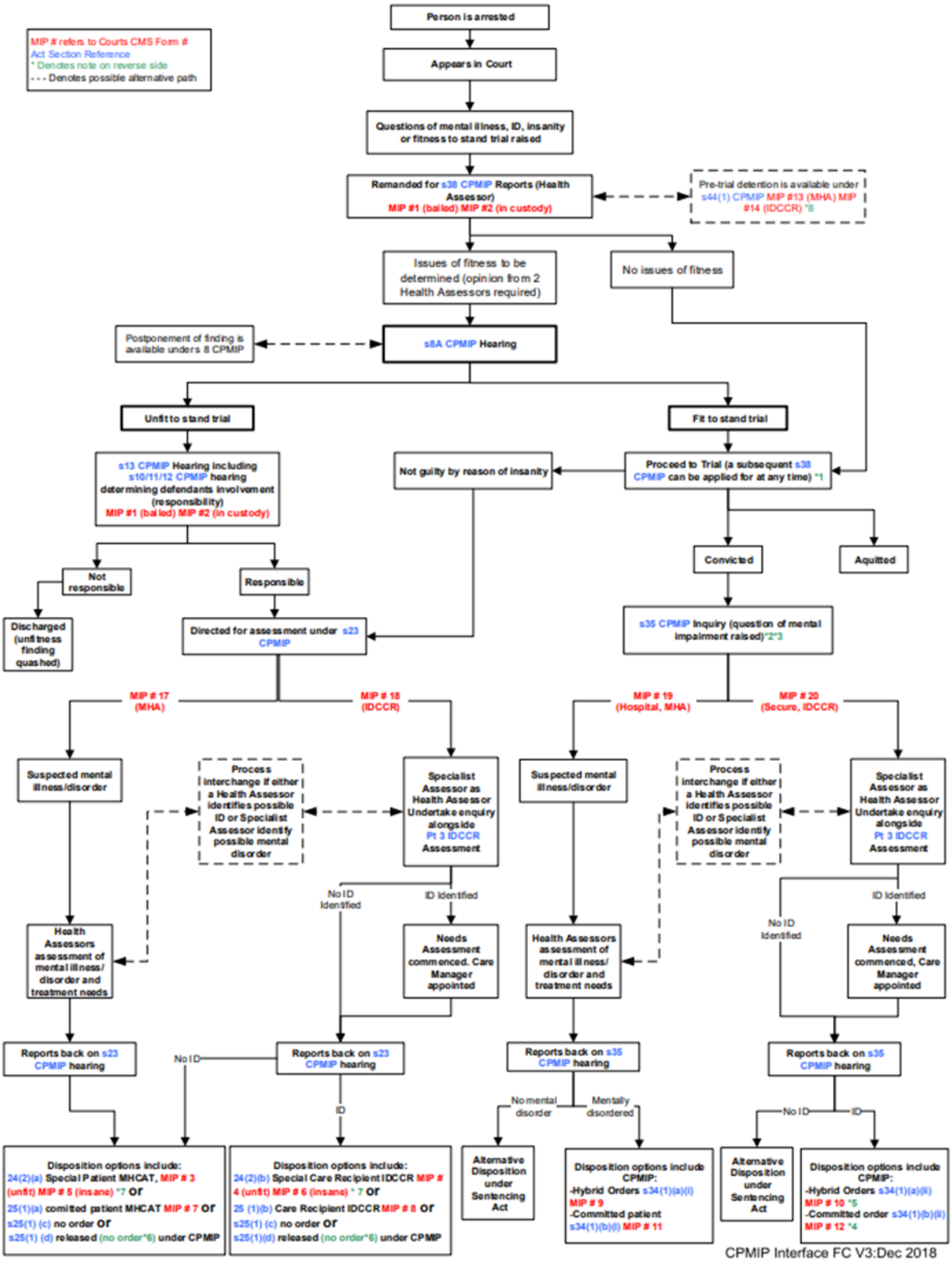
Appendix 4: Regional map[4]

The FCS(ID) operate across 4 regions: Northern, Midlands, Central and Southern.



[4] Map – Health New Zealand | Te Whatu Ora

Appendix 5: Interface Flowchart Describing the Interactions Between Relevant Acts



Explanatory texts on next page

Explanatory text (interface flowchart)

Note 1

s38 assessment can be called for at any time during court proceedings including once a verdict has been arrived at, but prior to sentencing.

Note 2

Please note that there are 2 Section 34 orders:

1. MIP19- MHA
2. MIP20 - IDCCR

Please do not edit these forms. If in doubt, court liaison staff should be able to assist.

Copies of orders to be sent to:

- MIP19's - to Director of Institution (via Forensic Court Liaison)
- MIP20's - to the Director of the Residential Service (to go with client) and emailed to Care Co-ordinator (list)

Note 3

If person is suspected of having an ID, s35 enquiry must include IDCCR eligibility and then part 3 assessments.

Note 4

Please note transitional provisions s47 CPMIP.

Note 5

Please note, Judges are required to specify length of order: s37 CP(MIP) and s46 ID(CC&R).

Court staff - please insert date.

Note 6

No order required as no sentence, or the person is alternatively disposed.

Note 7

There are 2 disposition options: s24(2)a (as a special patient) and s24(2)b (as a special care recipient) - unfit and insane. Both have separate MIP # forms.

Note 8

MIP note: pre-trial detention is also possible under s44(1). These people will go back to hearing.

Note 9

s171(2) Summary Proceeding Act also allows for the possible detention pending trial or sentence.