244227 / 346783/00
Provider No. / Agreement No.

Agreement

between

Waikato DHB

PO Box 934
Waikato Mail Centre
Hamilton 3240

Ph: 07-834 3646
Fax: 07-839 4327

Contact: **Rachel Poaneki**

and

Care NZ (Est 1954) Limited

Community Alcohol & Drug Services

PO Box 9183
Marion Square
Wellington 6141

Ph: 04-384 2085
Fax: 04-385 1516

Contact: **Kathryn Leafe**

CONTENTS OF THIS AGREEMENT

A: SUMMARY

A1 Agreement to Purchase and Provide Services

A1.1 We agree to purchase and you agree to provide services on the terms and conditions set out in the Agreement.

A1.2 The Agreement means all documents included in Part 1 (this document, to be referred to as the Head Agreement), together with Parts 2 and 3 (the documents listed in the Agreement Summary below).

A1.3 The Agreement sets out the entire agreement and understanding between us and supersedes all prior oral or written agreements or arrangements relating to its subject matter.

A2 Duration of the Agreement, and Components of the Agreement

A2.1 Part 2 (the General Terms) will apply for the period specified in the Agreement Summary below, or until terminated in accordance with the Agreement, subject to any rights to review, extend, vary or terminate any of these documents in accordance with the terms of this Agreement.

A2.2 Each Service Schedule will apply for the period specified in Part 3, and shown in the Agreement Summary below, subject to any rights to review, extend, vary or terminate any of these documents in accordance with the terms of this Agreement.

A2.3 The Agreement will automatically terminate upon the expiry of all Service Schedules in Part 3. Notwithstanding any end date given in Part 2 (the General Terms) the terms and conditions of Part 2, including the right to terminate the Agreement or any part of the Agreement, Part 2 (the General Terms) will be deemed to continue as long as there is one or more active Service Schedule in Part 3.

A3 Relative Priorities of the Component Parts of the Agreement

A3.1 In the event of any conflict between the terms of the Provider Specific Terms and Conditions within Part 3 (Service Schedules) and any other part of the Agreement, the terms of the Provider Specific Terms and Conditions within Part 3 (Service Schedules) will have priority.

A3.2 In the event of any conflict between the terms of Part 2 (the General Terms) and Part 3 (the Service Schedules), the terms of the Service Schedules will have priority.

A3.3 In the event of any conflict between the terms of Section B (the Standard Conditions of Agreement) and Section E (the Provider Type Terms and Conditions), the terms of Section E (the Provider Type Terms and Conditions) will have priority.

A4 Enforceability of the Agreement, and its Component Parts

A4.1 If any provision in any of the documents listed in the Agreement Summary below is lawfully held to be illegal, unenforceable or invalid, the determination will not affect the remainder of the relevant document or the Agreement, which will remain in force.

A4.2 If an entire document listed in the Agreement Summary below is lawfully held to be illegal, unenforceable or invalid, the determination will not affect any other documents listed in the summary or the Agreement, which will remain in force.

A4.3 If any provision in any of the documents or an entire document listed in the Agreement Summary below is held to be illegal, unenforceable or invalid, then we agree to take such steps or make such modifications to the provision or document as are necessary to ensure that it is made legal, enforceable or valid. This is in addition to and not in substitution of our rights to give notice of the terms and conditions on which we will make payments to you pursuant to section 88 of the New Zealand Public Health and Disability Act 2000 or otherwise.

A4.4 The above provisions with respect to illegality, unenforceability or invalidity are not to affect any rights validly to terminate any of the documents in the above schedule or the Agreement as a whole in accordance with the terms of the Agreement or otherwise.

A5 Agreement Summary

A5.1 This section lists all documents included in The Agreement. The Agreement comes into effect from the commencement date identified in Part 1 below. This summary will be updated, by an agreement variation, whenever there is a change to this list.

A6 Part 1 – The Head Agreement

Document	Commencement Date
This document	1 July 2013

A7 Part 2 – The General Terms

Document	Document Version No.	Commencement Date	End Date, if specified
Conditions of Agreement	1.0	1 July 2013	30 June 2014
Provider Quality Specifications	1.0	1 July 2013	30 June 2014
Standard Information Specifications	1.0	1 July 2013	30 June 2014
Provider Type Terms and Conditions	1.0	1 July 2013	30 June 2014

A8 Part 3 - The Service Schedules

Service Schedule(s)	Reference/ Version No.	Commencement Date	End date
MHDI48C Child, adolescent and youth alcohol and drug community services - Nursing and/or allied health staff	1.0	1 July 2013	30 June 2014
MHD74C Community based alcohol and other drug specialist services - Nursing and allied staff	1.0	1 July 2013	30 June 2014

A9 Signatures

Please confirm your acceptance of the Agreement by signing where indicated below.

For **Waikato DHB**:

(signature)

Name: Brett Paradine
Position: General Manager Planning & Funding Waikato DHB
Date: 5/7/2013

For **Care NZ (Est 1954) Limited**:

(signature)

Name: K.A. LEAFE
Position: CHIEF EXECUTIVE
Date: 24 JUNE 2013

PART 2: GENERAL TERMS

2. 01 This Part 2 contains all of the parts of the Head Contract, as listed in the Contract Agreement (Agreement Summary).

2. 02 Each of the documents in Part 2 (the Head Contract) form part of the Agreement between us, as defined in the Contract Agreement or in a subsequent Variation to the Contract Agreement, as applicable.

2. 03 Section B -the Standard Conditions of Contract set out the conditions on which our relationship with all our providers is based.

2. 04 Section C -the Provider Quality Specification (PQS) sets out the minimum quality of service required of all our providers. Where appropriate, the PQS also requires providers to meet the Health and Disability Sector Standards. The PQS applies to all Services provided under the Agreement. More detailed and service specific quality requirements are included in the Service Schedules.

2. 05 Section D -the Standard Information Specifications (SIS) sets out information management principles required of all our providers. The SIS applies to all Services provided under the Agreement. More detailed and service specific information requirements are included in the Service Schedules.

B: STANDARD CONDITIONS OF CONTRACT

INTRODUCTION

B1 Standard Conditions

B1.1 Any Agreement you enter into with us will be deemed to include the following Standard Conditions.

B1.2 If however any other terms in the Agreement directly conflict with these Standard Conditions, the other terms will have priority.

B1.3 There is a glossary at the back of these Standard Conditions setting out definitions, interpretations and terms used.

B2 Treaty of Waitangi and Māori Health Statement

B2.1 The Treaty of Waitangi establishes the unique and special relationship between iwi, Māori and the Crown. As a Crown entity the District Health Board considers the Treaty of Waitangi principles of partnership, proactive protection of Māori health interests, co-operation and utmost good faith, to be implicit conditions of the nature in which the internal organisation of the District Health Board responds to Māori Health issues.

B3 Relationship Principles

B3.1 The following values will guide us in all our dealings with each other under the Agreement:

a) Integrity – we will act towards each other honestly and in good faith.

b) Good communication – we will listen, talk and engage with each other openly and promptly including clear and timely written communication.

c) Enablement – we will seek to enable each other to meet our respective objectives and commitments to achieve positive outcomes for communities and consumers of health and disability services.

d) Trust and co-operation – we will work in a co-operative and constructive manner recognising each other's viewpoints and respecting each other's differences.

e) Accountability – we will each recognise the accountabilities that each of us have to our respective and mutual clients and stakeholders.

f) Innovation – we will encourage new approaches and creative solutions to achieve positive outcomes for communities and consumers of health and disability services.

g) Quality improvement – we will work co-operatively with each other to achieve quality health and disability services with positive outcomes for consumers.

MĀORI HEALTH

B4 Māori Health Priority

Both of us will abide by the Māori Health statement set out in clause B2 of these Standard Conditions.

B4.1 You agree that Māori Health is a specifically identified health gain priority area. You must therefore establish and implement a Māori Health policy that reflects that fact. In developing this policy, and without limitation, you must take into account our strategic direction for Māori health in terms of minimum requirements for Māori health based on the Treaty of Waitangi, Crown objectives for Māori health and specific requirements negotiated from time to time with us.

B4.2 You must specify how you intend to implement this policy. In particular, you will identify those services you will deliver as explicit contributions to Māori health gain priorities, how these services will be measured to ascertain what benefit is evident and other additional opportunities that may exist for furthering Māori health gain.

B4.3 On commencement of the Agreement, you must develop your Māori health policy and operational plans after consultation with us, subject to agreement between both of us to our respective responsibilities for ensuring that the plans are adequately resourced within the current levels of funding.

SERVICE PROVISION

B5 Provision of Services

B5.1 You must provide the Services and conduct your practice or business:

a) in a prompt, efficient, professional and ethical manner, and

b) in accordance with all relevant published Strategies issued under the Act; and

c) in accordance with Our obligations, and

d) in accordance with all relevant Law; and

e) from the Commencement Date and then without interruption until the Agreement ends or is ended in accordance with the Agreement.

B5.2 Nothing in the Agreement gives you an exclusive right to provide the Services.

B6 Payments

B6.1

a) we will pay you in accordance with the terms of the Agreement.

b) We will pay you default interest on any payments due to you under the Agreement and in arrears for more than 14 days.

c) You must first have given us an invoice completed in the format required and we must have received it 14 working days before it is due.

d) "Default interest" means interest at the base rate of our bankers calculated from the due date for payment to the date of actual payment, plus the rate of 2 per cent per annum.

e) This clause does not apply to payments due to you in respect of which we have exercised our right of set off (see clause B6.2).

B6.2 We may set off any amounts which you owe us against any payments due by us to you.

B6.3 We may withhold any further payments or portions of payments, where you:

a) have failed to meet any reporting requirements under the agreement,

b) are found to be in breach at the end of an Audit

c) or your sub-contractors do not allow us access under clause "B15.2".

B6.4 In that case payments may be withheld from the date of non-compliance until such time compliance occurs.

B7 Cost and Volume Shifting

B7.1 You must not:

a) act in such a way that increases cost to another provider,

b) be party to any arrangement which results in our effectively having to pay more than once for the supply of the same Services or any component of them,

c) act in such a way that shifts volumes relating to Services being provided separately by you where such volumes have been specifically related to that Service.

B8 Responsibility for Others

B8.1 You will be responsible for all acts and omissions of your employees, agents and subcontractors even if they are done without your knowledge or approval.

B9 Other Arrangements

B9.1 You must not enter into any other contract or arrangement which might prejudice your ability to meet your obligations in the Agreement

B9.2 You may (subject to your obligations in the Agreement), agree to provide Services for any other person.

B10 Subcontracting

B10.1 You may not subcontract any of the Services or part of them without our prior written consent which may not be unreasonably withheld.

B10.2 If we give consent you must comply with any reasonable conditions we impose as part of the consent.

B11 Transfer of your Rights and Obligations

B11.1 You must not transfer any part of your rights or obligations under the Agreement without our prior written consent.

QUALITY ASSURANCE

B12 Quality of Services

B12.1 You must comply with the quality requirements set out in the Agreement.

B13 Information and Reports

B13.1 You must comply with the information requirements set out in the Agreement.

B13.2 You must keep and preserve Records and protect the security of them and make them available to us in accordance with our reasonable instructions.

B13.3 You must take all due care to ensure that in the event of your ceasing to provide the Services, the Records are properly preserved and transferred to us.

B13.4 You must keep proper business records and promptly complete a balance sheet, statement of income and expenditure and cashflows in accordance with accepted accountancy principles at the end of each financial year.

B13.5 We may use any information concerning you:

a) for our own purposes; and

b) for any purposes required by any Minister of the Crown or any Governmental Body.

B13.6 You must report to us in accordance with our reasonable instructions.

B13.7 We may reasonably require you to send reports direct to any Minister of the Crown or any Governmental Body within a time reasonably fixed by us.

B14 Appointment of Auditors

B14.1 We may appoint people to Audit, on our behalf, in relation to any of the matters contained in the Agreement.

B14.2 We will give you prior written notice of the names of the people we have appointed.

B14.3 Both of us must agree to the people we have appointed. You may not refuse where any or all of those people are suitably qualified and have no demonstrable conflict of interest, but your refusal may be based on some other good reason.

B14.4 Those people may take copies of any parts of the Records.

B15 Access for Audit

B15.1 You and your sub-contractors must co-operate with us fully and allow us, or our authorised agents, access to:

a) your premises,

b) all premises where your Records are kept,

c) Service Users and their families,

d) staff, sub-contractors or other personnel used by you in providing the Services,

For the purposes of and during the course of carrying out any Audit.

B15.2 We will ensure that our exercise of access under this clause B15 will not unreasonably disrupt the provision of the Services to Service Users.

B15.3 Notice of Audit

a) we will give you prior notice of any Audit as agreed in any Audit protocols.

b) If we believe that delay will unnecessarily prejudice the interests of any person, we may give you notice of our intention to carry out an Audit within 24 hours.

B15.4 Times for Audit

a) Subject to Clause B15.3b an Audit may be carried out at any time during working hours and at any other reasonable times.

b) You must ensure that the people appointed by us to carry out the Audit have access, during the hours they are entitled to Audit.

B16 Audit Process

B16.1 Subject to clause B23, in carrying out any Audit we may;

a) Access confidential information about any Service User; and

b) Observe the provision or delivery of the Services; and

c) Interview or follow up Service Users and/or their families; and

d) Interview or follow up any staff, sub-contractors or other personnel used by you in providing the Services.

B17 Financial Audit

B17.1 Despite the other provisions in this section B12.1 (Quality Assurance) we may not inspect your accounting system or record of your costs of providing the Services.

a) We may, however, appoint as set out in the Agreement, an independent auditor to Audit;

i. The correctness of the information you give us; and

ii. Your calculations of the cost of supplying the Services; and

iii. Your financial position.

b) The auditor:

i. Must not disclose specific details of your financial position to us; but

ii. May advise us if he or she considers your financial position may prejudice your ability to carry out your obligations under the Agreement.

B17.2 We retain the right to Audit under this Section B12.1 (Quality Assurance) after the Agreement ends but only to the extent that it is relevant to the period during which the Agreement exists.

B18 Insurance

B18.1 You must immediately take out adequate comprehensive insurance throughout the term of the agreement covering your practice or business.

B18.2 You must make sure that all the insurance cover always remains in force for the term of the Agreement or so long thereafter as required for the purposes of the Agreement.

B19 Indemnity

B19.1 You must indemnify us against all claims, damages, penalties or losses (including costs) which we incur as the result of:

a) Your failing to comply with your obligations in the Agreement; or

b) Any act or omission by you or any person for whom you are responsible.

B20 Complaints

B20.1 You must comply with any standards for the Health sector relating to complaints

B20.2 If there is no such standard applicable to you, then you must implement a complaints procedure in accordance with the terms of the Agreement.

B21 Complaints Body

B21.1 You must at all reasonable times co-operate with any Complaints Body and comply with its reasonable requirements.

B21.2 We will advise a Complaints Body of any complaints we receive about you if we believe it is appropriate to do so.

B21.3 We will give you reasonable assistance when we can in respect of any complaints made to the Privacy Commissioner which involve both of us.

B22 Warranties

B22.1 You warrant to us that:

a) All material information given to us by you or on your behalf is correct; and

b) You are not aware of anything which might prevent you from carrying out your obligations under the Agreement.

B22.2

a) The above warranties will be deemed to be repeated on a daily basis from the date of the Agreement and,

b) Your must advise us immediately if at any time either of the warranties is untrue.

B23 Limitation of our Rights

B23.1 Our rights and the rights of others to:

a) Access confidential information about any Service User; and

b) Observe the provisions or delivery of the Services; and

c) Interview or follow up Service Users and/or their families,

Must be either authorised by statute or by a code of practice under the Privacy Act 1993 covering health information held by health agencies or by the informed consent of each Service User concerned. The consents will normally be in writing.

DEALING WITH PROBLEMS

B24 Notification of Problems

B24.1 You must advise us promptly in writing:

a) Of any:

i. changes,

ii. problems,

iii. significant risks,

iv. significant issues,

which materially reduce or affect your ability to provide the Services, or are most likely to do so, including those relating to:

v. any premises used by you,

vi. any equipment you are using,

vii. your key personnel; or

b) if you materially fail to comply with any of your obligations in the Agreement; or

c) of any serious complaints or disputes which directly or indirectly relate to the provision of the Services; or

d) of any issues concerning the Services that might have high media or public interest.

B24.2 We must discuss with each other possible ways of remedying the matters notified. Our discussion or attempted discussions will not however limit any of our rights under the Agreement.

B24.3 You must have in place realistic and reasonable risk management processes and contingency plans to enable you to continue to provide the Services on the occurrence of any of the matters in this clause B24.

B25 Uncontrollable Events

B25.1

a) For the purposes of this Clause B25 an "uncontrollable event" is an event which is beyond the reasonable control of us ("the person claiming"), or an event as set out in Clause B29.4.

b) An uncontrollable event does not include:

i. any risks or event which the person claiming could have prevented or overcome by taking reasonable care including having in place a realistic and reasonable risk management process; or

ii. a lack of funds for any reason.

B25.2 The person claiming will not be in default under the terms of the Agreement if the default is caused by an uncontrollable event.

B25.3 The person claiming must:

a) promptly give written notice to the other specifying:

i. the cause and extent of that person's inability to perform any of the person's obligations; and

ii. the likely duration of the non-performance;

b) in the meantime take all reasonable steps to remedy or reduce the uncontrollable event.

B25.4 Neither of us is obliged to settle any strike, lock out or other industrial disturbance.

B25.5 Performance of any obligation affected by an uncontrollable event must be resumed as soon as reasonably possible after the uncontrollable event ends or its impact is reduced.

B25.6 If you are unable to provide the Services as the result of an uncontrollable event we may make alternative arrangements suitable to us for the supply of the Services during the period that you are unable to supply them after we consult with you.

B25.7 If either of us is unable to perform an obligation under the Agreement for 90 days because of an uncontrollable event, both of us must first Consult and decide to what extent if any the Agreement can be varied and to continue.

B25.8 If we cannot agree that the Agreement may continue, then either of us may cancel the Agreement after giving at least 14 days prior written notice.

B25.9 Clause B34.1 will apply to cancellation of the Agreement under this clause.

B26 We May Remedy Your Failure To Meet Your Obligations

B26.1 If you fail to carry out any of your obligations in the Agreement we may do so on your behalf at your expense and risk.

B26.2 We may do this without giving you notice where the circumstances reasonably require such action. Otherwise, we will give you 7 days notice in writing of our intention to act.

B26.3 All costs we incur in doing so, must be paid by you to us on demand or we may deduct them from moneys which we owe you.

B27 Public Statements, Issues and Advertising

B27.1

a) Neither of us may directly or indirectly criticise the other publicly, without first fully discussing the matters of concern with the other.

b) The discussion must be carried out in good faith and in a co-operative and constructive manner.

c) Nothing in this clause prevents you from discussing any matters of concern with your people being your staff, subcontractors, agents or advisors.

d) Nothing in this clause prevents you from discussing any matters of concern with our people being our staff, subcontractors, agents, advisers or persons to whom we are responsible.

e) If we are unable to resolve any differences then those differences may be referred by either of us to the Dispute Resolution process set out in clause B28.

B27.2 You may use our name or logo only with our prior written consent.

B27.3 The provisions of this clause B27 will remain in force after the Agreement ends.

B28 Dispute Resolution

B28.1 If either of us has any dispute with the other in connection with the Agreement, then:

a) Both of us will use our best endeavours to settle the dispute or difference by agreement between us. Both of us must always act in good faith and co-operate with each other to resolve any disputes, and

b) If the dispute or difference is not settled by agreement between us within 30 days, then, unless both of us agree otherwise:

i. full written particulars of the dispute must be promptly given to the other.

ii. The matter will be referred to mediation in accordance with the Health Sector Mediation and Arbitration Rules 1993 as amended or substituted from time to time. A copy of the Rules are available from the Ministry of Health.

c) neither of us will initiate any litigation during the dispute resolution process outlined in paragraph b) above, unless proceedings are necessary for preserving the party's rights.

d) both of us will continue to comply with all our obligations in the Agreement until the dispute is resolved but payments may be withheld to the extent that they are disputed.

B28.2 Clause B28.1 will not, however, apply to any dispute:

a) concerning any renegotiation of any part of the Agreement,

b) as to whether or not any person is an Eligible Person,

c) directly or indirectly arising from any matter which has been referred to a Complaints Body unless the Complaints Body directs the matter to be resolved in accordance with clause B28.1.

B29 Variations to the Agreement

B29.1 The Agreement may be varied by written agreement signed by both of us.

B29.2 Where the Agreement is for a term exceeding 1 year, we both agree that the Agreement shall be reviewed annually.

B29.3 Variation on requirement by Crown

a) we may require you to vary the Agreement by written notice to you to comply with any requirement imposed on us by the Crown.

b) We will give you as much notice of the requirement and details of the proposed change as possible, to the extent that we are able to do so.

c) Both of us must Consult and decide to what extent if any the Agreement can be varied and continue on that basis.

d) If we cannot agree within 60 days, then either of us may cancel the Agreement after giving at least 30 days prior written notice.

e) You must continue to comply with your obligations under the existing Agreement until any variation of it takes effect.

B29.4 The Agreement will be varied in the event of a disaster, local or national epidemic, emergency or war in accordance with our requirements but this clause is subject to clause B25.

B30 Our Liability

B30.1 Except to the extent that we agree otherwise, we will not be liable to you for any claims, damages, penalties or losses (including costs) which you incur.

ENDING THE AGREEMENT

B31 Notice of Your Future Intentions

B31.1 Before the end of the Agreement you must give a minimum of 3 months notice if:

a) you do not wish to enter into a new agreement with us when the Agreement ends; or

b) you wish to enter into a new agreement with us when the Agreement ends but on materially different terms.

This clause does not mean we must enter into a contract with you when the Agreement ends.

B31.2 You must discuss with us your intentions before giving any notice under clause B31.1.

B31.3 We must give you a minimum of 3 months notice if we do not intend to renew the Agreement, except where Management of Change Protocols may apply.

B32 Your Default and our Right to End the Agreement

B32.1 We may end the Agreement immediately by written notice to you on the occurrence of any of the following events:

a) We have good reason to believe you are unable or will soon become unable to carry out all your material obligations under the Agreement.

i. We must, however, consult with you before ending the Agreement for this reason.

ii. If we believe the health or safety of any person or Population Serviced is at risk we may suspend your provision of the Services while we consult.

b) You have failed to carry out any of your obligations in the Agreement; and

i. the failure is material; and

ii. it cannot be remedied

c) if:

i. you are or adjudged bankrupt; or

ii. you are more than one person, if any of you are adjudged bankrupt; or

iii. you are a company and you are placed in receivership or liquidation.

d) You have failed to carry out any of your obligations in the Agreement and the failure can be remedied by you but you fail to do so within 30 days of your receiving written notice of the default from us.

i. After 30 days from your receiving the notice, so long as the obligation still has not been met, we may instead of ending the Agreement;

ii. At any time vary or withdraw from coverage by this Agreement any of the Services in respect of which you have not met your obligation, either straight away or at any later date, and

iii. Cease payment for any of the services from the date of withdrawal.

iv. You have the same right and must follow the same procedure if we have not met any obligation and you wish to vary or withdraw any of the Services.

v. Any dispute regarding the withdrawal or variation of any of the Services under this paragraph d) must be resolved under clause B28.

B32.2 Nothing in clause B32.1 affects any other rights we may have against you in law of equity.

B33 Our Default and your Right to End the Agreement

B33.1 If we default on any payments which we are not entitled by the Agreement to withhold and we fail to remedy the default within 20 days of your giving us written notice of the default you may do any one or more of the following:

a) cancel the agreement,

b) seek specific performance of the Agreement,

c) seek damages from us,

d) seek penalty interest.

B34 Effect of Ending the Agreement

B34.1 Any cancellation of the Agreement will not affect:

a) the rights or obligations of either of us which have arisen before the Agreements ends; or

b) the operation of any clauses in the Agreement which are expressed or implied to have effect after it ends.

GENERAL

B35 Confidentiality

B35.1

a) except to the extent that these Standard Conditions provide otherwise, neither of us may disclose any Confidential Information to any other person.

b) Both of us acknowledge that the Agreement, but not any Confidential Information, may be published publicly by us through any media including electronically via the Internet.

B35.2 Neither of us will disclose to any third party information which will identify any natural person (as defined in the Privacy Act 1993);

a) without that person's informed consent; or

b) unless authorised by statute, or by a Code of Practice under the Privacy Act 1993 covering Health Information held by Health Agencies.

B35.3. Clause B35.1 does not apply:

a) to terms or information which are or become generally available to the public except as the result of a breach of clause B35.1; or

b) to information which either party is required by law to supply to any person but only to the extent that the law required; or

c) to terms or information disclosed to the professional advisers of either of us or to those involved in a Service User's clinical or care management where disclosure is reasonably necessary for the management; or

d) to information which you are required by the Agreement to disclose or forward to any person.

B35.4 Nothing in clause B35.1 will prevent us from disclosing any terms or information in accordance with any Funding Agreement, or by direction or requirement from the Minister under the Act.

B35.5 Each of us will ensure all Confidential Information is kept secure and is subject to appropriate security and user authorisation procedures and audits.

B36 Governing Law

B36.1 The Agreement is governed by New Zealand law.

B37 Contracts (Privity) Act 1982

B37.1 No other third party may enforce any of the provisions in the Agreement.

B38 Waiver

B38.1 Any waiver by either of us must be in writing duly signed. Each waiver may be relied on for the specific purpose for which it is given.

B38.2 A failure of either one of us to exercise, or a delay by either one of us in exercising, any right given to it under the Agreement, does not mean that the right has been waived.

B39 Entire Agreement

B39.1 Each of us agree that the Agreement sets forth the entire agreement and understanding between both of us and supersedes all prior oral or written agreements or arrangements relating to its subject matter.

B40 Notices

B40.1 Any notice must be in writing and may be served personally or sent by security or registered mail or by facsimile transmission. All notices are to have endorsed on them the contract reference number given to the Agreement.

B40.2 Notices given:

a) personally are served upon delivery;

b) by post (other than airmail) are served three working days after posting;

c) by airmail are served two days after posting;

d) by facsimile are served upon receipt of the correct answer back or receipt code.

B40.3 A notice may be given by an authorised officer, employee or agent of the party giving the notice.

B40.4 The address and facsimile number for each of us shall be as specified in the Agreement or such other address or number as is from time to time notified in writing to the other party.

B41 Relationship of Both of Us

B41.1 Nothing in the Agreement constitutes a partnership or joint venture between both of us or makes you an employee, agent or trustee of ourselves.

B42 Signing the Agreement

B42.1

a) You must satisfy us that the Agreement has been properly signed by you and is a valid and enforceable agreement before we have any obligations to you under the Agreement.

b) We may however waive all or part of this provision with or without conditions by us.

B42.2 If the condition in clause B42.1 is not satisfied or waived by the Commencement Date or any later date we may avoid the Agreement by written notice to you.

B43 Partial Invalidity

B43.1

a) If any provision in the Agreement is lawfully illegal, unenforceable or invalid, the determination will not affect the remainder of the Agreement which will remain in force.

b) This clause does not affect any right of cancellation we may have in the Agreement.

GLOSSARY

B44 Definitions

B44.1 In the Agreement Terms given a meaning in the Glossary have that meaning where the context permits.

B44.2 In the Agreement

a) "We", "us" and "our" means the District Health Board including its permitted consultants, subcontractors, agents, employees and assignees (as the context permits).

b) "You" and "your" means the Provider named in this contract, including its permitted subcontractors, agents, employees and assignees (as the context permits).

c) "Both of us", "each of us", "either of us" and "neither of us" refers to the parties.

B45 Interpretation

B45.1 In the Agreement

a) A reference to a person includes any other entity or association recognised by law and the reverse:

b) Words referring to the singular include the plural and the reverse;

c) Any reference to any of the parties includes that parties' executors, administrators or permitted assigns, or if a company, its successors or permitted assigns or both;

d) Everything expressed or implied in the Agreement which involves more than one person binds and benefits those people jointly and severally;

e) Clause headings are for reference purposes only;

f) A reference to a statute includes:

i. all regulations under that statute; and

ii. all amendments to that statute; and

iii. any statute substituting for it which incorporates any of its provisions.

g) All periods of time or notice exclude the days on which they are given and include the days on which they expire:

h) Working Days – anything required by the Agreement to be done on a day which is not a Working Day may be done on the next Working Day.

B46 Glossary Terms

Expression	Meaning
Act	The New Zealand Public Health & Disability Act 2000
Agreement	The agreement or arrangement between both of us for the provision of any Services and each schedule to that agreement or arrangement and these Standard Conditions of Contract
Audit	Audit includes (without limitation) audit, inspection, evaluation or review of: a) quality, b) service delivery c) performance requirements, d) organisational quality standards, e) information standards and, f) organisational reporting requirements, g) compliance with any of your obligations in relation to the provision of the Services by you.
Commencement Date	The date the Agreement comes into effect
Complaints Body	Any organisation appointed: a) under the Agreement; or b) by both of us by mutual agreement; or c) by a Health Professional Authority; or d) by law to deal with complaints relating to the Services.
Confidential Information	Any information disclosed either before or during the course of the Agreement, by us to you or vice versa that is agreed by both of us as being confidential and which may not be disclosed (subject to any law to the contrary) but excluding the terms of the Agreement.
Consult	a) Each of us must fully state our proposals and views to the other and carefully consider each response to them. b) Each of us must act in good faith and not predetermine any matter. c) Each of us must give the other adequate opportunity to consult any other interested party. The obligation of either of us to Consult will be discharged if the other refuses or fails to Consult.
Crown	The meaning given in the Act.

Eligible Person	Any individual who: a) is in need of the Services; and b) meets the essential eligibility criteria and other criteria, terms and conditions which, in accordance with any direction given under Section 32 of the Act or continued by Section 112(1) of the Act, or any other direction from the Minister, or the Funding Agreement, must be satisfied before that individual may receive any Services purchased by us. c) The Ministry of Health will determine if any individual is an Eligible Person if there is any dispute. "Eligible People" has a corresponding meaning.
End Date	The date the Agreement ends or is ended in accordance with the Agreement.
Funding Agreement	The relevant Crown funding agreement within the meaning of Section 10 of the Act, entered into by us.
Governmental Body	Includes any entity lawfully formed by, or in accordance with any direction of, the Crown or any Minister or officer of the Crown.
GST	Goods and Services Tax under the Goods and Services Tax Act 1985.
Health Professional Authority	Any authority or body that is empowered under and by virtue of any enactment of law, or the rules of any body or organisation, to exercise disciplinary powers in respect of any person who is involved in the supply of Health or Disability Services, or both.
Law	Includes: a) Any legislation, decree, judgement, order or by law; and b) Any rule, protocol, code of ethics or practice or conduct and other ethical or other standards, guidelines and c) Requirements of any Health Professional Authority; and d) Any relevant standards of the New Zealand Standards Association; and e) Any future law.
Management of Change Protocols	Such protocols as may be agreed between us relating to the management of change.
Minister	The Minister of Health.
Ministry	The Ministry of Health (by whatever name known) and any other successor department of state and include the Minister of Health and the Director-General of Health and any of his her or their delegates.
Ministry of Health	Includes any of its legal successors.
DHB	The District Health Board

Our Objectives	Include: a) The objectives listed in Section 22 of the Act, and b) The objectives specified in our statement of intent (as defined in the Act). c) To meet the directions and requirements notified to us under the Act from time to time.
Person	Includes a corporation, incorporated society or other body corporate, firm, government authority, partnership, trust, joint venture, association, state or agency of a state, department of Ministry of Government and a body or other organisation, in each case whether or not having a separate legal identity.
Population Served	Means communities or targeted populations, including Eligible People, for whom Services are or may be provided.
Records	Means without limitation: a) All relevant written and electronically stored material; and b) Includes all relevant records and information held by you and your employees, subcontractors, agents and advisers.
Services	Health Services, or disability services or both as specified in the Agreement.
Service Users	Users of any of the Services.
Standard Conditions	These Standard Conditions of Contract.
Working Day	Any day on which Registered Banks are open for business in New Zealand, relative to your principal place of business.

C: PROVIDER QUALITY SPECIFICATIONS

INTRODUCTION

C1 Relationship Principles

C1.1 The following values will guide us in all our dealings with each other under the Agreement:

a) Integrity -we will act towards each other honestly and in good faith.

b) good communication -we will listen, talk and engage with each other openly and promptly including clear and timely written communication.

c) enablement -we will seek to enable each other to meet our respective objectives and commitments to achieve positive outcomes for communities and consumers of health and disability services.

d) trust and co-operation -we will work in a co-operative and constructive manner recognising each other's viewpoints and respecting each other's differences.

e) accountability -we will each recognise the accountabilities that each of us have to our respective and mutual clients and stakeholder.

f) innovation -we will encourage new approaches and creative solutions to achieve positive outcomes for communities and consumers of health and disability services.

g) quality improvement – we will work co-operatively with each other to achieve quality health and disability services with positive outcomes for consumers.

C2 Quality of Service

C2.1 These Provider Quality Specifications define the quality of service which consumers and populations served under the terms of this contract will receive. Provider quality requirements will in final form be described in three key levels.

a) Health and Disability Sector Standards (H&DS Standards)

b) Provider Quality Specifications (PQS)

c) Service Specific Quality Specifications (SSQS)

C3 Health and Disability Sector Standards (H&Ds Standards)

C3.1 The Health and Disability Sector Standards (H&DS Standards) have been developed to replace several pieces of previous consumer safety legislation. Compliance with them will become mandatory when the Health and Disability Services (Safety) Bill is passed and fully implemented. At that stage compliance with the Standards will replace compliance with the regulations and statutes that apply to hospital in-patient and residential care services. As the standards are implemented the Provider Quality Specifications will be revised to those Standards, and to eliminate repetition.

C4 Provider Quality Specifications (PQS)

C4.1 All providers are required to meet these Provider Quality Specifications (PQS). The PQS have been developed to ensure a common basis for quality among providers of similar services nationally. They focus on key processes and outcomes. The PQS apply to all services provided under the terms of this Contract.

C4.2 These PQS include:

a) specifications for all providers, (Sections C1 – C43 inclusive).

b) facility specifications only for providers who offer services to consumers within premises (C44 and C45).

C4.3 The PQS may be supplemented in contracts by Service Specific Quality Specifications (SSQS) or by specific quality requirements in the Service Specification.

C5 Auditing and Reporting

C5.1 We may, at any time, audit your service against an H&DS Standard (when implemented) or against a PQS or SSQS by asking you to demonstrate compliance with it. This is part of the Provider Quality Improvement Strategy, which may include regular, random and risk based auditing of services. The PQS and SSQS are not, at present, subject to regular reporting unless required elsewhere in the Agreement or as part of any specified Quality Improvement initiative. You are, however, invited to raise with us at any time any concerns you have about your ability to meet these PQS so corrective processes can be put in place. Please see also Clause C11, C12, C16, C17 and C18 of the Standard Conditions and the Schedule or Templates for Information Requirements.

PROVIDER QUALITY SPECIFICATIONS

C6 PQS Apply to all Services

C6.1 You will operate all services covered in this Agreement according to these PQS. You will implement these requirements in a manner that is appropriate for your Organisation, taking into account:

a) requirements of Government Māori Health Policy and Strategies,

b) identified needs of consumers, carers and families,

c) service goals and objectives,

d) parameters of activities,

e) management of risks,

f) any good practice guidelines endorsed by us and by the Ministry of Health,

g) professional standards and codes relevant to your service.

C7 Written Policy, Procedures, Programme, Protocol, Guideline, Information, System or Plan

C7.1 Where, to meet a H&DS Standard or an PQS or SSQS, you need to develop a written policy, procedure, programme, protocol, guideline, information, system or plan etc, you will:

a) develop such a document,

b) demonstrate systems for reviewing and updating all such documents regularly and as required by current performance or risks,

c) demonstrate implementation, through documentation supported as requested through interviews with staff, consumers, and Māori,

d) Demonstrate that staff are adequately informed of the content and the intent of these written documents,

e) provide us with a copy on request.

C8 All Staff Informed

C8.1 You will ensure that:

a) these PQS are attached to each and every service specification contracted by us and delivered by you,

b) employees and sub-contractors are aware of your and their responsibilities for these PQS and relevant Service Specifications as they relate to services provided.

REQUIREMENTS FOR MĀORI

Requirements for Māori, which reflect obligations contained in the Treaty of Waitangi, are specified here and elsewhere in this document.

C9 Services Meet Needs of Māori

C9.1 Your services will meet the diverse needs of Māori, and apply any strategy for Māori Health issued by the Minister.

C10 Māori Participation

C10.1 Māori participation will be integrated at all levels of strategic and service planning, development and implementation within your organisation at governance, management and service delivery levels.

This will include:

a) consultation with, and involvement of, Māori [1] in your strategic, operational and service processes,

b) development of a monitoring strategy in partnership with Māori that reviews and evaluates whether Māori needs are being met by your organisation, including:

i. removal of barriers to accessing your services;

ii. facilitation of the involvement of whanau and others;

iii. integration of Māori values and beliefs, and cultural practices;

iv. availability of Māori staff to reflect the consumer population

v. existence, knowledge and use of referral protocols with Māori service providers in your locality.

[1] Reference to "Māori" includes the development of a relationship with local tangata whenua and if appropriate, regional tangata whenua, Māori staff, Māori providers, and Māori community organisations to achieve the required Māori input.

c) Education and training of staff in Māori values and beliefs and cultural practices, and in the requirements of any Māori Health Strategy,

d) Support and development of a Māori workforce

QUALITY MANAGEMENT

You are required to develop, document, implement and evaluate a transparent system for managing and improving the quality of services to achieve the best outcomes for consumers.

C11 Quality Plan

C11.1 You will have a written, implemented and at least annually reviewed Quality Plan designed to improve outcomes for consumers. This plan may be integrated into your business plan. It will describe how you manage the risks associated with the provision of services. The plan will outline a clear quality strategy and will identify the organisational arrangements to implement it. The plan will be of a size and scope appropriate to the size of your service, and will at least include:

a) an explicit quality philosophy,

b) clear quality objectives,

c) commitment to meeting these and any other relevant Quality Specification and Standards, and guidelines for good practice as appropriate,

d) quality improvement systems,

e) written and implemented systems for monitoring and auditing compliance with your contractual requirements,

f) designated organisational and staff responsibilities,

g) processes for and evidence of consumer input into services and into development of the Quality Plan,

h) processes for sound financial management,

i) how you will address Māori issues including recognition of:

i. Māori participation with Strategic, Governance, Management and Service Delivery planning, implementation and review functions,

ii. Māori as a Government Health Gain priority area,

iii. The Pathways set out in any Māori Health Strategy issued by the Minister,

iv. Māori specific quality specifications,

v. Māori specific monitoring requirements,

vi. Māori service specific requirements.

C12 Employees Registration, Education and Training

C12.1 Employees will be, where relevant, registered with the appropriate statutory body, and will hold a current statutory certificate.

C12.2 Employees will have access to continuing education to support maintenance of professional registration and enhancement of service delivery/clinical practice, and to ensure practice is safe and reflects knowledge of recent developments in service delivery.

C12.3 Your employment policies and practices will support professional career pathway development for Māori health workers; Māori service advisory positions; Māori change management positions, and the recruitment and retention of Māori employees at all levels of the organisation to reflect the consumer population.

C13 Training and Supervision of Assistants and Volunteers.

C13.1 Assistants, volunteers and other relevant support employees will receive training to enable them to provide services safely, and will work only under the supervision and direction of appropriately qualified staff.

C14 Supervision of Trainees.

C14.1 Trainees will be identified and will provide services only under the supervision and direction of appropriately qualified staff.

C15 Performance Management

C15.1 You will have in place a system of performance management for all employees.

C16 Clinical Audit

C16.1 You will have in place clinical audit/peer review processes that incorporate input from relevant health professionals from all services.

C17 Access

C17.1 All eligible people will have fair, reasonable and timely access to effective services within the terms of this agreement. You will define and apply criteria for providing services, including any priority or eligibility criteria agreed between us. You will manage access to services within available resources and according to those criteria. You will maintain records of people who receive services and those who do not, and the criteria by which these decisions are made.

C18 Service Information

C18.1 Potential and current consumers, and referrers, will have access to appropriately presented information in order for eligible people to access your services. This information may be in the form of a brochure and will include at least:

a) the services you offer,

b) the location of those services,

c) the hours the service is available,

d) how to access the service (e. g. whether a referral is required),

e) consumer rights and responsibilities including copy of H&DC Code of Rights, and Complaints Procedure,

f) availability of cultural support,

g) after hours or emergency contact if necessary or appropriate,

h) any other important information in order for people to access your services.

This information will be presented in a manner appropriate to the communication needs of

consumers and communities.

C19 Support for Māori

You will facilitate support from whanau/hapu/iwi; kuia/kaumatua; rongoa practitioners; spiritual advisors; Māori staff and others as appropriate for Māori accessing your service.

ACCEPTABILITY

C20 Consumer Rights

C20.1 Each consumer will receive services in a manner that complies with the Health and Disability Commissioner Act 1994, and with all aspects of the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 (H&DC Code). This will include provision for the:

a) right to be treated with respect for person, privacy and culture,

b) freedom from discrimination, coercion, harassment, and exploitation,

c) right to dignity and independence,

d) right to services of an appropriate standard including legal, professional, ethical,

e) right to effective communication,

f) right to be fully informed,

g) right to make an informed choice and give informed consent,

h) right to support person present,

i) rights in respect of teaching or research,

j) right to complain,

You will make available and known to consumers and visitors to the service the Code of Health and Disability Services Consumers' Rights. You will ensure staff are familiar with and observe their obligations under this Code.

C21 Confidentiality

C21.1 You will disclose information about consumers to any third party only:

a) with the person's informed consent or,

b) in accordance with the Health Information Privacy Code,

c) to assist in effective service provision and achieving positive outcomes for the consumer.

C22 Cultural Values

C22.1 You will deliver services in a culturally appropriate and competent manner, ensuring that the integrity of each consumer's culture is acknowledged and respected. You will take account of the particular needs within the community served in order that there are no barriers to access or communication, and that your services are safe for all people. You will include significant local or service specific ethnic and other cultural groups in assessing satisfaction with services.

C22.2 You will incorporate Māori principles/tikanga into your organisation. These may be explained in the following ways:

Wairua	Spirit or spirituality	A recognition that the Māori view of spirituality is inextricably related to the wellbeing of the Māori consumer
Aroha	Compassionate love	The unconditional acceptance which is the heart of care and support
Turangawaewae	A place to stand	The place the person calls home, where their origins are. Must be identified for all Māori consumers
Whanaungatanga	The extended family	Which takes responsibility for its members and must be informed of where its member is
Tapu/Noa	Sacred/profane	The recognition of the cultural means of social control envisaged in tapu and noa including its implications for practices in working with Māori consumers
Mana	Authority, standing	Service must recognise the mana of Māori consumers
Manaaki	To care for and show respect to	Services show respect for Māori values; traditions and aspirations
Kawa	Protocol of the marae, land, iwi	Determines how things are done in various circumstances. Respect for kawa is very important. If the kawa is not known the tangata whenua should be consulted.

C23 Consumer Advocates

C23.1 You will inform consumers and staff, in a manner appropriate to their communication needs, of their right to have an advocate, including to support the resolution of any complaint. You will allow advocates reasonable access to facilities, consumers, employees and information to enable them to carry out their role as an advocate. You will know of and be able to facilitate access to a Māori advocate for consumers who require this service.

C24 Consumer/Family/Whanau and Referrer Input

C24.1 You will regularly offer consumers/families/whanau and referrers the opportunity to provide feedback as a means of improving the outcomes for consumers. When you obtain feedback from consumers by means of written surveys, you will comply with the Ministry of Health Guidelines for Consumer Surveys. Consumer input will be reflected in the maintenance and improvement of quality of service, both for the individual consumer and across the service as a whole. You will actively seek feedback from Māori by appropriate methods to improve

organisation responsiveness to Māori. When requested you will make available to us the results of such surveys.

C25 Community Involvement

C25.1 You will have in place and follow active processes for consulting with the local community in matters affecting them such as service location and building programmes.

C26 Complaints Procedure

C26.1 You will enable consumers/families/whanau and other people to make complaints through a written and implemented procedure for the identification and management of Complaints. This procedure will meet the H&DC Code requirements and will also ensure that:

a) the complaints procedure itself is made known to and easily understandable by consumers,

b) all parties have the right to be heard,

c) the person handling the complaint is impartial and acts fairly,

d) complaints are handled at the level appropriate to the complexity or gravity of the complaint,

e) any corrective action required following a complaint is undertaken,

f) it sets out the various complaints bodies to whom complaints may be made and the process for doing so. Consumers will further be advised of their right to direct their complaint to the H&D Commissioner and any other relevant complaints body, particularly in the event of non-resolution of a complaint,

g) complaints are handled sensitively with due consideration of cultural or other values,

h) Māori consumers and their whanau will have access to a Māori advocate to support them during the complaints process,

i) consumers who complain, or on whose behalf families/whanau complain, shall continue to receive services which meet all contractual requirements,

j) complaints are regularly monitored by the management of the service and trends identified in order to improve service delivery,

k) it is consistent with any complaints policy as we may notify from time to time.

C27 Personnel Identification

C27.1 Employees, volunteers, students or sub-contractors undertaking or observing service delivery will identify themselves to all consumers and family/whanau.

C28 Ethical Review

C28.1 If you conduct research and innovative procedures or treatments you will have written and implemented policies and procedures for seeking ethical review and advice from a Health and Disability Ethics Committee in accordance with the current "National Standard for Ethics Committees" (or any replacement publication). You will consult with and receive approval from Māori for any research or innovative procedures or treatments which will impact on Māori.

SAFETY AND EFFICIENCY

C29 General Safety Obligation

C29.1 You will protect consumers, visitors and staff from exposure to avoidable/preventable risk and harm.

C30 Risk Management

C30.1 You will have in place well developed processes for:

a) identifying key risks including risks to health and safety,

b) evaluating and prioritising those risks based on their severity, the effectiveness of any controls you have and the probability of occurrence,

c) dealing with those risks and where possible reducing them.

C31 Equipment Maintained

C31.1 You will ensure that equipment used is safe and maintained to comply with safety and use standards.

C32 Infection Control/Environmental and Hygiene Management

C32.1 You will safeguard consumers, staff and visitors from infection. You will have written, implemented and regularly reviewed environmental and hygiene management/infection control policies and procedures which minimise the likelihood of adverse health outcomes arising from infection for consumers, staff and visitors. These will meet any relevant profession-specific requirements and the requirements of the Standard Universal Precautions Guidelines. They will include definitions and will clearly outline the responsibilities of all employees, including immediate action, reporting, monitoring, corrective action, and staff training to meet these responsibilities.

C33 Security

C33.1 You will safeguard consumers, employees and visitors from intrusion and associated risks. You will have written, implemented and reviewed policies and practices relating to security to ensure that buildings, equipment and drugs are secure.

C34 Management of Internal Emergencies and External Disasters

C34.1 You will have written, implemented and reviewed contingency management policies and procedures that minimise the adverse impact of internal emergencies and external or environmental disasters on your consumer, staff and visitors. The policies and procedures will include the processes for working with the organisations who have responsibility for co-ordinating internal and external (environmental) disaster services. These policies and procedures will be linked to your risk management processes.

C35 Incident and Accident Management

C35.1 You will safeguard consumers, staff and visitors from untoward risk arising from avoidable incidents, accidents and hazards. You will have written, implemented and reviewed incident, accident and hazard management policies and procedures which assist in managing safety

and risk. These will include definitions of incidents and accidents and will clearly outline the responsibilities of all employees, including:

a) taking immediate action,

b reporting, monitoring and corrective action to minimise incidents, accidents and hazards, and improve safety,

c) debriefing and staff support as necessary.

C36 Prevention of Abuse and/or Neglect

C36.1 You will safeguard consumers, staff and visitors from abuse, including physical, mental, emotional, financial and sexual maltreatment or neglect. You will have written, implemented and reviewed policy and procedures on preventing, detecting and removing abuse and/or neglect. These will include definitions of abuse and neglect and will clearly outline the responsibilities of all staff who suspect actual or potential abuse, including immediate action, reporting, monitoring and corrective action. You will ensure that relevant employees are able to participate in family, inter-agency or court proceedings to address specific cases of abuse and neglect. These procedures will also include reference to the Complaints Procedure.

EFFECTIVENESS

C37 Entry to Service

C37.1 You will manage consumer entry to your service in a timely, equitable and efficient manner, to meet assessed need.

C38 Plan of Care/Service Plan

C38.1 You will develop for each consumer a written, up to date plan of care/service plan and/or record of treatment which:

a) is based on assessment of his/her individual needs, including cultural needs,

b) includes consultation with the consumer, and,

c) where appropriate, and with the consent of the consumer, includes consultation with the consumer's family/whanau and/or caregivers,

d) contains detail appropriate to the impact of the service on the consumer,

e) facilitates the achievement of appropriate outcomes as defined with the consumer,

f) includes plans for discharge/transfer,

g) provides for referral to and co-ordination with other medical services and links with community, iwi, Māori and other services as necessary.

C39 Service Provision

C39.1 You will deliver to consumers services that meet their individual assessed needs, reflect current good practice, and are co-ordinated to minimise potentially harmful breaks in provision.

C40 Planning Discharge from the Service or Transfer between Services

C40.1 You will collaborate with other services to ensure consumers access all necessary services. When a consumer is transferred or discharged from your services and accesses other appropriate services they will do so without avoidable delay or interruption. You will have written, implemented and reviewed policies and procedures for planning discharge/exit/transfer from your services. These will facilitate appropriate outcomes as defined with the consumer. The policies and procedures will include:

a) defined employees' responsibilities for discharge planning,

b) incorporating discharge planning into the consumer's plan of care/service plan, where appropriate from or before admission,

c) full involvement of the consumer in planning discharge,

d) involvement of family/whanau, including advising them of discharge, as appropriate,

e) assessment and management of any risks associated with the discharge,

f) informing the consumer on their condition, possible future course of this, any risks, emergency contacts, and how to access future treatment, care or support services,

g) where appropriate involving the original referrer and the health professional having ongoing responsibility for the consumer in planning discharge and informing them of confirmed discharge arrangements,

h) a process for monitoring that discharge planning does take place, which includes assessment of the effectiveness of the discharge planning programme.

C41 Where Services are Declined

C41.1 You will have written and implemented policies and procedures to manage the immediate safety of the consumer for whom entry to the service is declined and, where necessary the safety of their immediate family/whanau and the wider community. These include:

C41.2

a) applying agreed criteria for providing services,

b) ensuring all diagnostic steps have been taken to identify serious problems which may require your service,

c) advising the consumer and/or their family/whanau of appropriate alternative services,

d) where appropriate advising the family/whanau or other current services that you have declined service,

e) recording that entry has been declined, giving reasons and other relevant information,

f) having in place processes for providing this information to us.

C42 Death/Tangihanga

C42.1 You will have written and implemented policies and procedures to follow in the event of a death including:

a) immediate action including first aid, calling appropriate emergency services,

b) appropriate and culturally sensitive procedures for notification of next of kin,

c) any necessary certification and documentation including notifying us or the Ministry of Health if required in the Service Specifications,

d) appropriate and culturally competent arrangements, particularly to meet the special needs of Māori, are taken into account in the care of the deceased, until responsibility is accepted by the family or a duly authorised person.

C43 Health Education, Disease Prevention and Health Advice/Counselling

C43.1 You will incorporate within your services, where appropriate, an emphasis on health education, disease prevention and health advice/counselling, and support the goals of The Ministry of Health Strategy "Strengthening Public Health Action" June 1997 or subsequent publications.

FACILITIES

C44 Accessible

C44.1 You will support consumers in accessing your services by the physical design of your facilities. You will make specific provision for consumers with a mobility, sensory or communication disability available and known to consumer. You will make services available to deaf people through the provision of interpreters and devices to assist communication.

C45 Facilities, Maintained

C45.1 You will provide services from safe, well-designed, well-equipped, hygienic and well-maintained premises.

D: STANDARD INFORMATION SPECIFICATION

REPORTING REQUIREMENTS

D1 Information to be reported to the MoH

D1.1 Unless stated otherwise in the Service Schedule, information to be provided to us is to be provided at three monthly intervals in accordance with the timetable below. Where the Agreement begins or ends part way through a quarter, the report will be for that part of the quarter which falls within the term of the Agreement.

Any delays will be notified to The Monitoring Team (see below for details).

D2 Reporting Requirement Timetable

Quarters for Reporting	Due Date
1 January to 31 March	20 April
1 April to 30 June	20 July
1 July to 30 September	20 October
1 October to 31 December	20 January

D3 Forwarding your Completed Report

You shall forward your completed Performance Monitoring Returns to:

The Performance Reporting Team
Sector Services
Ministry of Health
Private Bag 1942
DUNEDIN 9054

Ph: 03-474 8040
Fax: 03-474 8582

Email healthpac_m@moh.govt.nz

PART 3: SERVICE SCHEDULES

3.01 INTRODUCTION

3.01.1 This Part 3 contains each of the Service Schedules listed in the Head Agreement (Agreement Summary).

3.01.2 Each of the Service Schedules in Part 3 form part of the Agreement between us as defined in the Head Agreement or in a subsequent Variation to the Head Agreement, as applicable.

3.01.3 Each Service Schedule contains the Service Specifications and Provider Specific Terms and Conditions associated with the Service.

3.01.4 The Service Specification described the service, and set up quality and information reporting requirements additional to those specified in Part 2 (the General Terms). Note that nationally standard service descriptions may contain details (particularly Purchase Units and Reporting Requirements) which do not apply to all contracts.

3.01.5 The Provider Specific Terms and Conditions detail those elements of the Agreement that are unique to you. This will include payment terms, the term of the Service Schedule, and any details which differ from Part 2 (the General Terms) and/or standard Service Specification/s (including detailed clarification of any parts of the nationally standard service description which do not apply to your contract, and a full list of relevant purchase units, volumes, prices and reporting requirements).

CONTENTS OF EACH SERVICE SCHEDULE WITHIN PART 3

3.02 Service Specifications

3.02.1 Standard national specifications (note this may not be physically contained in the contract but will be made available for Providers in electronic and hardcopy editions for distribution within their organisations).

a) Additional specifications (if appropriate).

3.02.2 Provider Specific Terms and Conditions

a) Introduction
b) Details of all Volumes and Prices which apply to this Service Schedule
c) Reporting Requirements
d) Payment Details
e) Detail of Changes to standard documents

i. Summary of changes to the General Terms (if any)
ii. Summary of additional service specifications (if any)
iii. Summary of changes from standard service specification (if any)

E: PROVIDER SPECIFIC TERMS AND CONDITIONS

INTRODUCTION

E1 Service Details

It is agreed that the following details apply to this Service Schedule.

Legal Entity Name	Care NZ (Est 1954) Limited
Legal Entity Number	244227
Agreement Number	346783 / 00
Agreement Commencement Date	1 July 2013
Agreement End Date	30 June 2014

E2 Standard Documentation

It is agreed that the Service Schedule includes the standard documentation in Part 2 (the General Terms), and the standard service specifications included in this Service Schedule, as amended by any changes (if any) identified below.

It is agreed that the services will be paid for in accordance with the details given in the Payment Details below.

E3 Details of all Purchase Units which apply to this Service Schedule

Purchase Unit (PU ID)	Volume	Unit Price excl. GST (per PU)	Total Price excl. GST (UP x V)	GST Rate (%)	Payment Type
MHDI48C Child, adolescent and youth alcohol and drug community services - Nursing and/or allied health staff	3 Clinical FTE's	$113,317.61	$339,952.83	15	CMS
MHD74C Community based alcohol and other drug specialist services - Nursing and allied staff	3.8 Clinical FTE's pa	$107,021.54	$406,681.85	15	CMS
MHD74C Community based alcohol and other drug specialist services - Nursing and allied staff	4.5 Clinical FTE's pa	$107,953.92	$485,792.64	15	CMS
Total price for the Service Schedule			**$1,232,427.32**		

PAYMENT DETAILS

E4 Price

The price we will pay for the Service you provide is specified above. Note that all prices are exclusive of GST.

E5 Invoicing

We will pay you on the dates set out in the Payment Schedule below for the services you provide in each invoice period so long as we receive a valid GST tax invoice from you. The invoice must meet all legal requirements and must contain the following information:

a) provider name (legal entity name)
b) provider number (legal entity number)
c) provider invoice number
d) agreement number
e) purchase unit number or a description of the service being provided
f) date the invoice is due to be paid/date payment expected
g) dollar amount to be paid
h) period the service was provided
i) volume, if applicable
j) GST rate
k) GST number

If we do not receive an invoice from you by the date specified in the payment schedule below, then we will pay you within 20 days after we receive the invoice.

E6 Payment Schedule

Payments will be made by us on these dates:	On invoices received by us on or before:	For services supplied in the period:	Amount (excl GST)
20 August 2013	5 August 2013	July 2013	$102,702.27
20 September 2013	5 September 2013	August 2013	$102,702.27
21 October 2013	5 October 2013	September 2013	$102,702.27
20 November 2013	5 November 2013	October 2013	$102,702.27
20 December 2013	5 December 2013	November 2013	$102,702.27
20 January 2014	5 January 2014	December 2013	$102,702.27
20 February 2014	5 February 2014	January 2014	$102,702.27
20 March 2014	5 March 2014	February 2014	$102,702.27
22 April 2014	5 April 2014	March 2014	$102,702.27
20 May 2014	5 May 2014	April 2014	$102,702.27
20 June 2014	5 June 2014	May 2014	$102,702.27
21 July 2014	5 July 2014	June 2014	$102,702.35
Total			**$1,232,427.32**

E7 Health Emergency Planning

a) You must develop a Health Emergency Plan to ensure that your clients/patients and staff are provided for during a Health Emergency and ensure that this is reviewed periodically to maintain currency.

b) The plan must identify your response to a worst case scenario pandemic event (40% of the population affected with 2% death rate).

c) A copy of the plan shall be made available to the DHB on request and will be consistent with the DHB's pandemic and emergency plans (available from the DHB).

d) When requested by the DHB you will be involved in processes to ensure that emergency responses are integrated, coordinated and exercised. The level of participation required will be reflective of the nature of the services you provide and the expected roles and services in an emergency situation.

E8 Provider Specific Terms & Conditions

This agreement includes the services purchased via agreements 334029-02 and 337366-01 between Waikato DHB and CareNZ that expired 30 June 2013.

CareNZ will provide Alcohol and Drug Counselling services as detailed in the service specifications for the following:

- Youth Alcohol and Drug Counselling service in Secondary Schools (3 FTE)
- Adult Community Alcohol and Drug service (8.3 FTE) located in:
  - Hamilton,
  - Putaruru,
  - Tokoroa and
  - Matamata.

*The Hamilton service is required to have 4.5 Clinical FTE that focus on providing extended after hours and group therapy to justice referrals (to clarify this service is not exclusively for justice referrals).

Youth Alcohol and Drug counselling service in schools

This is a dedicated service to deliver A&D Counselling service in schools that have been agreed with the Waikato DHB. Priority has been made to service delivery in Waikato based deciles 1-5 Secondary Schools.

Service coverage

Services will be provided to the following schools:

- Taumarunui High School
- Fairfield College
- Fraser High School
- Otorohanga College
- Te Kauwhata College
- Huntly College
- Ngaruawahia High School
- Te Kuiti High School
- Forest View
- Putaruru High
- Tokoroa High School
- Melville High School
- Waihi College
- Hauraki Plains
- Paeroa College

Any variation to the above address/es will be agreed with Waikato DHB prior to moving.

A copy of the service schedule (times and dates) when service will occur for the school year must be provided to Waikato DHB by **31 March** of that year (i.e.; by 31 March 2014 for the 2014 year)

Any change to the named schools where the service will be provided must be advised to CareNZ by 30 September for service the following school year.

Waikato DHB has provided advice to CareNZ that the schools where service is provided is likely to change at 1 January 2014 to align with the intended priority of the service, CareNZ and Waikato DHB will agree service coverage from 1 January 2014 by 30 September 2013.

The service is required to provide 3 FTES per annum – 120 hours per week.

The service programme is to be in line with best practice and suitable for the target youth population. It is expected that the service will promote recovery, wellness and recognition of positive choices through the use of Counselling and Group work.

Training will be made available to school services to enable them to make the earliest identification, effective initial intervention and the referral process of students. Assistance and guidance will be provided in the development of school A&D policies.

Management
CareNZ is responsible for the management of the agreement. Any issues that may arise for CareNZ in regard to their ability to manage the agreement effectively must be notified to the Funder.

CareNZ will work collaboratively with relevant organisations in the Waikato DHB area to ensure the success of the service. Processes must be developed to clarify the relationship of the parties involved.

Operations
CareNZ will document the relationships of CareNZ and key parties to the agreement in regard to:
- Agreed protocols detailed
- Agreed processes and timeframes

The specifics of these will be by agreement between CareNZ and the schools that the service will be delivered from.

Key deliverables
The service is required to:
- Have clear service delivery processes to ensure the effective delivery of the service.
- Have agreements to deliver with identified schools.

Child and youth clusters
CareNZ will enter into MOU with Hamilton Integrated Network, Southern and Hauraki clusters to ensure seamless, continuous service delivery for children and youth.

Specific reporting requirements
CareNZ will provide a report of service for each school at the end of each term and the school year. The report is to include a comprehensive picture of service provision.

Adult Community Alcohol and Drug service

Service coverage
CareNZ will provide Community Drug and Alcohol services to adults in Hamilton, Putaruru, Tokoroa and Matamata. The Hamilton service is required to have 4.5 Clinical FTE that focus on providing

extended after hours and group therapy to justice referrals (to clarify this service is not exclusively for justice referrals).

The service will be available to people who are usually resident in the Waikato DHB area and will be available across the full period of the agreement. Eligible People/Service Users are adults aged 20 or older, with some flexibility based on emotional, physical and social maturity to accept those younger than these age limits should their needs be deemed appropriate and where suitable alternatives are not available.

The adult clinical service must be provided according to:

- MHD74C Community based alcohol and other drug specialist services – Nursing and allied health staff

MHD74C is a tier three service specification. The tier three Community Based Alcohol and other Drug Services specification must be used with the tier one Mental Health and Addiction Specialist Services service specification and is also linked to the tier two Addiction service specifications.

Waikato DHB agrees to the following variation to section 4.1 Entry Criteria in MHD74
Entry criteria
Access may be from any source, including by eligible persons/service users directly or upon referral from primary practitioners, family, caregivers, and community members, and from inpatient or residential services.

When the service is provided:
The service will be available to eligible service users

- Service Hours 8.30 am to 5.00 pm, (Monday to Friday) and see client by appointment in evenings and weekends. (except for the dedicated 4.5 Hamilton service where service hours are: 8.30am to 8pm Tuesday, Wednesday and Thursday. 8.30am to 5pm Monday, Friday and Saturday)
- Service available 52 weeks per year for service delivery (normal after hours arrangements are acceptable for public holidays and the period between Christmas and New Years day).

Any variation to the above hours will be agreed with Waikato DHB prior to commencement.

Where the service is provided:

- Hamilton Clinic - 298 Tristram St, HAMILTON
- Putaruru Clinic - Overdale Community Centre, Overdale Street PUTARURU
- Tokoroa Clinic - Tokoroa Community Centre, Tulloch House, Tokoroa Hospital, Maraetai Road TOKOROA
- Matamata Clinic – Railside by the Green, 41A Hetana Street, MATAMATA

Any variation to the above address/es will be agreed with Waikato DHB prior to moving.

Specific reporting requirements
A copy of the service schedule (FTE, times and days) when service will occur for the period of the agreement must be provided to Waikato DHB by **31 July**. This is to include details of the IOP programme (type of session and when provided).

Background to the 4.5 Hamilton based adult service
Following a successful RFP in 2011 CareNZ agreed to provide Adult Community Drug and Alcohol services as detailed in the service specifications in Hamilton.

CareNZ is required to provide service to a client base in the vicinity of 400 clients per month, 44% of these are expected to identify as Māori. To meet the volume of clients accessing the service it is expected that both individual interventions and group therapies are offered as core components of the service.

A significant number of referrals to service are expected to be via the justice system. CareNZ is required to have effective working relationships with both the local justice and the local alcohol and other drug sector in the Waikato.

The service to be available to eligible service users

- Service Hours: 8.30am to 8pm Tuesday, Wednesday and Thursday. 8.30am to 5pm Monday, Friday and Saturday.

Requirements for the Youth and Adult services

Alcohol and other drug clinical staff qualifications:
Any person employed in an alcohol and other drug (AOD) clinical position funded via this agreement, must meet one of the requirements listed below:

Criteria for a registered AOD practitioner

- Attained an NZQA Level 7 (or higher) AOD specific qualification from an approved learning institute (see below) and also be a current registered Drug and Alcohol Practitioners Association Aotearoa New Zealand (DAPAANZ) Competent Practitioner; or

- Attained an NZQA Level 7 (or higher) non AOD specific qualification and also attained a post graduate AOD qualification from an approved learning institute (see below)and also either;
  - be a current registered DAPAANZ Competent Practitioner; or
  - have a current Drug and Alcohol Nurses of Australasia (DANA) registration for addiction speciality nurses

Criteria for a registered health practitioner working in AOD

- Attained an NZQA Level 7 (or higher) non AOD specific qualification and also be one of the following:
  - Be a registered health professional regulated by the Health Practitioners Competence Assurance Act 2003 (HPCA) and hold a current Annual Practice Certificate (APC); or
  - Be a registered Social Worker as per the Social Workers Registration Act 2003 and hold a current Annual Practice Certificate (APC); or
  - Be a registered NZAC Counsellor (degree level or above) and hold a current Annual Practice Certificate (APC). Note: Midland DHBs are reviewing the acceptance of NZAC as part of accepted clinical criteria for AOD service provision in the region. Staff meeting the above requirements of this section will be acceptable until such time as this review is completed however if criteria are then varied by the funder these staff may require DAPAANZ registration. Refer to 'Midland Accepted AOD qualifications and Learning institutes' section below for NZAC Counsellor Approved Courses.

Present incumbent grand-parenting clause
Present incumbents of clinical AOD positions that have formally been accepted by the funder as meeting clinical qualification requirements immediately prior to the introduction of the new Clinical Alcohol and other Drug clinical staff qualifications requirement may be eligible for transitional arrangements.

Transitional arrangements will allow providers/staff to work towards meeting the new requirements by 30 June 2015. Only transitional arrangements that have been formally agreed between the funder and provider will be valid.

1. Midland accepted AOD qualifications and learning institutes

Midland DHBs have agreed a range of NZQA Level 7 (or higher) AOD specific qualifications, post graduate AOD qualifications and learning institutes in relation to clinical AOD qualifications for AOD which are listed on the appropriate website. Please see the Midland Mental Health and Addictions Network website www.midlandmentalhealthnetwork.co.nz

Overseas qualifications will be considered on a case by case basis with the funder.

Risk management

The Provider will immediately advise the Planning and Funding and Waikato DHB clinical service of significant clinical or service issue that has caused serious harm or has the potential for adverse media comment, and will ensure that a review of the incident is conducted and actions for improvement or to prevent re-occurrence are identified.

A significant clinical or service issue is defined as:
An event which:

- Has resulted in an unanticipated death or major permanent loss of function not related to the natural course of the consumer's illness e.g. suicide;
- Is a major systems failure;
- Has the potential for serious adverse media attention;
- Has resulted in potential or actual harm to a group of consumers, individuals, staff or public; and
- Attempted or alleged sexual abuse or rape.

Employment of staff

Service Providers are to employ staff with appropriate qualifications, skills and experience in meeting the needs of people with serious Mental Health problems/disorders.

The provider must ensure that all staff must be required to list in writing, prior to their employment (as either full or part-time workers) any criminal convictions as part of their job application and that this document is maintained on record.

The provider shall not employ any staff (including any volunteer workers) who to the best of the provider's knowledge has a criminal conviction, relative to the role, for a crime against the person, a crime involving dishonesty or criminal damage, or a sexual offence. The provider shall ensure that an authorised police check is completed as part of the employment process for any person that will be delivering the services to service users. The provider is to ensure all applicants are made aware of the requirement to undertake an authorised criminal check.

Prevention of abuse/neglect

Appropriate safeguards will be put in place to protect consumers, staff and visitors from neglect or abuse, including physical, mental, emotional, financial or sexual maltreatment. You will have written, implemented and reviewed policy and procedures on preventing, detecting and removing abuse and/or neglect. These will include definitions of abuse and neglect and will clearly outline the responsibilities of all staff who suspect actual or potential abuse, including immediate action, reporting, monitoring and corrective action. The procedures will also include reference to the Complaints Procedure.

Support service users in their role as parents/guardians

By 30 June 2014 you will have developed and implemented policy and procedure, on how your service can support service users in your services with their role as parents. The aim of the policy is to positively impact the health status of children, adolescents and youth and their family and/or whānau where a parent/s is experiencing severe mental illness and/or alcohol and/or other drug addiction. Suggested procedure actions could include:

To support parents/caregivers

- services identifying service users who are parents/caregivers and work with them to identify any parenting support they require

- facilitate access to parenting education and support programmes

To support other family members

- assisting access to clinical services where required for other family and/or whānau members
- providing information and education to family members regarding services and resources available to them
- support families and/or whānau members to cope with mental health and/or AOD issues that affect them as a family
- linkage to natural supports and strengths within the family and/or whānau and community as longer-term supports.

Specific to clinical services

- ensure advance plans for acute episodes incorporate consideration of children's, adolescent and youth care, safety, access and visitation during hospitalisation

Smoke free policy

- You are required to have a smoke free policy applying to all their staff, patients/clients, families/whānau and visitors, facilities and vehicles. This is to ensure provision of a smoke free environment for all staff, patients, family/whānau and visitors.
- This policy will also align with the recommendations outlined in the New Zealand Smoking Cessation Guidelines (2007).

Review of services provided against services invoiced

CareNZ will return funding where service provision information indicates under-delivery against purchase units provided on a six-monthly basis.

1. Six-monthly reports
   By 31 January and 31 July of each year, you must provide us with a schedule of the actual volume and description of the purchase units provided by you under this agreement during the previous six months ending 31 December (due 31 January) and 30 June (due 31 July). The schedule must be submitted electronically and as a hard copy and is to include the following details, by purchase unit:
   - Full name of employee
   - Employee's clinical qualifications relevant to position.
   - Start date of employee
   - Leaving or transfer date of employee (if relevant)
   - Each month's average number of hours worked per week per employee relevant to the provision of the purchase unit (i.e. actual service delivery, including relevant administration, staff meetings, training and/or writing up case notes). Hours reported should be inclusive of annual and/or sick leave. A maximum of 40 hours (1.0 FTE) per employee should be reported and should exclude hours not related actual service provision as outlined above.
   - The signature of an appropriate senior representative of the organisation verifying authenticity and accuracy of the information provided on the hard copy submission.

2. Calculating the wash-up
   The following will be used to calculate any potential funding repayable to the DHB:
   (a) The unit price payable per FTE for each purchase unit
   (b) The total value of services actually provided: *[actual FTE provided x (a)]*
   (c) The total amount already invoiced during the period.

   If the total value of services actually provided (b) is less than the total amount already invoiced during the period (c), per purchase unit, then this difference must be repaid to Waikato DHB.

3. Over-delivery of FTE
In the interests of maximising service provision, in situations where there may be over-delivery of a purchase unit within a reported six-month period, this may be considered against an under-delivery of the same purchase unit within the balance of the financial year (1 July – 30 June).

It is noted that this is a capped agreement and that there is no requirement for additional payment if the services provided within the 12-month period exceed the amount in the payment schedule.

4. Recovery of funds
CareNZ will be invoiced for the amount of recovery, as established above. In the event of non-payment of this invoice, Waikato DHB retains the right to offset outstanding monies owing by the provider against future funding payments due to the provider or to follow standard debt recovery processes.

5. Reporting
Forward the wash up report to Waikato DHB electronically (via excel spreadsheet) to support@waikatodhb.health.nz and post signed hard copy to Planning and Funding Support Administrator, Level 3 Hockin Building, PO Box 934, Hamilton 3240.

Wash up process and business rules
Refer to Mental Health 'Wash up" Requirements (updated December 2010) for full outline of the Wash up process and business rules. You can access copies from your Portfolio Manager.

Co-existing problems
As part of our previous agreement the provider was required to be co-existing problems capable by **June 2012.** The provider is required to maintain co-existing capability throughout the period of this agreement.

DHB access to PRIMHD reporting
A requirement of this agreement is that CareNZ agrees to allow access to their NGO PRIMHD Provider Reports, by Waikato DHB Planning and Funding. This will make available a broader set of standard information for future funding and planning decisions.

PRIMHD reporting
National activity and outcomes data collection
- Under this agreement the Care NZ is required to submit all PRIMHD data relating to purchased services to the Information Directorate within 20 days from the end of each calendar month and that it meets all compliance and accuracy requirements.
- ensure that all PRIMHD data is submitted in accordance with the health care user's accurate NHI number and in accordance with the PRIMHD code-set and dataset documentation.
- continue to engage with Waikato DHB in the ongoing management and support of the PRIMHD, as required.
- continue to engage with Waikato DHB to ensure that deadlines agreed with information Directorate for all new compliance requirements/changes are meet.
- Waikato DHB is not moving to the reporting requirements listed as after PRIMHD reporting to Information Directorate, Ministry of Health during the period of this agreement. The provider must therefore comply with both the Tier three Prior to PRIMHD reporting to Information Directorate, Ministry of Health and submit PRIMHD data electronically.

Quarterly narrative reporting
In the narrative section of the quarterly performance monitoring CareNZ will provide a brief report. The following are suggested areas for inclusion:
- Quality initiatives, satisfaction surveys and Health & Disability Standards NZS8134, 2008 compliance reviews
- Implementation, improvement/review of the Maori Health Plan/Policy

- Human Resources issues e.g. vacancies, recruitment and retention risks, training initiatives
- Emerging service risk/s
- Implementation and review of emergency and pandemic planning
- Achievements
- Implementation/use of Lets Get Real and Takarangi Competency Framework
- Any other issues the provider wishes to raise.

Annual accounts

A copy of your annual accounts along with an audit opinion must be provided five months following the end of your financial year.

If you are not required to be audited, a copy of your annual accounts signed as correct by your Board Chairman needs to be submitted within five months following the end of your financial year.

Alternative methods of financial reporting may be agreed with us. These include:

- Confirmation from directors or trustees that audited accounts have been produced and formally considered by your governing body and assurance that your organisation is solvent and able to meet its obligations; or
- Confirmation from bankers of credit worthiness; or
- An auditors certification of solvency and financial viability.

GST

Goods and services Tax under the Goods and Services Tax Act 1985. Subject to this Act, a tax to be known as goods and services tax shall be charged in accordance with the provision of this Act at a rate determined in the Act.

Future measures

You will work with us to understand and agree appropriate output volumes (which may or may not be currently measured in your Performance Monitoring Returns), with a view to including indicative volumes in future agreements.

Relationship meeting

As part of the Waikato DHB commitment to continuous improvement and strengthened relationships with service providers the DHB and the CareNZ will meet monthly to review service delivery. The dates and location of these meetings will be by mutual agreement.

GLOSSARY FOR MENTAL HEALTH AND ADDICTIONS SPECIALIST SERVICES SERVICE SPECIFICATIONS

The definitions in this glossary are consistent with the definitions used in other national documents.

Addiction
Addiction in the context of the mental health and addiction services relates only to alcohol and other drug use and/or problem gambling. It refers to a maladaptive pattern of substance abuse, or problem gambling leading to significant impairment or distress.

Advocacy
Actively advancing or protecting the rights and interests of people with mental illness and/or addiction.

AOD
Alcohol and other drugs

Assessment
A service provider's systematic and ongoing collection of information about a consumer to form an understanding of consumer needs.

Clinical Assessment
Forms the basis for developing a diagnosis and an individualized treatment and support plan with the Service user, their family, whanau and significant others.

Community Service

A service based within the community that maybe delivered in hospital outpatient and/or community settings.

Consultation
Obtaining opinions and views of people affected by potential or proposed changes or developments, in order to consider those views in the decision making process.

Culture
The beliefs, customs, practices, and social behaviour of a particular nation or people, a group of people whose shared beliefs and practices identify the particular place, class, or time to which they belong

Family Inclusiveness
An approach where both the Service users and their family and whanau are involved in the treatment and recovery process

Harm Reduction
Harm reduction focuses on reducing harms associated with addiction, including health, social economic and other harms experienced by individuals, families, communities and society.

Lived Experience
The term refers to having experience of mental illness or addiction

Natural Supports
Natural supports include family whānau, partners, friends, neighbours, colleagues or those from an identified group who help the Service user in his/her recovery

PRIMHD
Programme for the Integration of Mental Health Data

Protective Factors
Supports, strengths and activities that help build resilience

Recovery
Recovery is defined as the ability to live a meaningful and satisfying life in the presence or absence of mental illness or addiction. Recovery in the addiction sector includes a view of both abstinence and

harm minimization perspectives that have evolved over time to represent the individual's view. There is a long and generally held view that in the addiction field recovery involves an expectation/ hope that people can and will recover from their addiction / unwellness, acceptance that recovery is a process not a state of being, and recognition that the recovery is done by the person addicted/affected, in partnership with the services (in the word's widest sense) providing help. A challenge faced by both the mental health and addiction sectors is the ongoing development of the concept and language of recovery.

Relapse Prevention Plan
Relapse prevention plans identify early relapse warning signs of clients. The plan identifies what the client can do for themselves and what the service will do to support the client.

Ideally, each plan will be developed with involvement of clinicians, clients and their significant others. The plan represents an agreement and ownership between parties. Each plan will have varying degrees of complexity depending on the individual. Each client will know of (and ideally have a copy of) their plan.

Residential
The term residential has been replaced by the terms "housing" or "accommodation" dependant on the type of service.

Resilience
Personal and community strengths or skills that enable people to rebound from adversity, trauma, tragedy, loss or other factors, and go on with life with a sense of control, competence, and hope.

Service User
A person who uses specialist mental health or addiction services regardless of level of need. This term is often used interchangeably with consumer and/or tāngata whaiora

Strength based
A treatment approach, that focuses on and helps develop the Service user's strengths. This approach combines both provision of direct services and treatment, along with helping people define or priorities their needs, navigate the system and link into community resources.

Talking Therapies
Talking therapies involve people taking about their problems or issues with trained therapists. They encompass a wide range of psychological and behavioural therapies, including behavioural therapy, cognitive therapy and other types of counselling.

Whanāu
Kuia, koroua, pakeke, rangatahi, tamariki. The use of the term in this document is not limited to traditional definitions, but recognises the wide diversity of families represented within Māori communities.

Whanāu Ora
Māori families achieving their maximum health and wellbeing, and provides an overarching principle for recovery and maintaining wellness.

MENTAL HEALTH AND ADDICTION SERVICES
TIER LEVEL ONE
SERVICE SPECIFICATION

Background

This tier one service specification provides the overarching specification for all specialist mental health and addiction services (the Service). Tier two and tier three service specifications are supplementary to this service specification and provide additional service-specific detail. Please refer to the accompanying glossary for definitions of terms used within the tier one, two and three service specifications.

Eligible people will have timely access to high- quality, trustworthy, responsive mental health and addiction services ranging across the spectrum of promotion and prevention, through to primary, secondary and tertiary services. The specialist mental health and addiction services included in this range of specifications are publicly funded for those who are most severely affected by mental illness or addiction. However, it is recognised that a focus on early intervention strategies will mean specialist services may be delivered to people who are more at risk of developing a severe mental illness or addiction.

Te Tāhuhu - *Improving Mental Health 2005-2015* (Ministry of Health 2005) sets a high-level strategic framework for mental heath and addiction services. The focus is on improving whānau ora, recovery and wellness for people, families, whānau and communities affected by mental illness and addiction. A key step in achieving these goals is through developing a culture of responsiveness where Service users, families, whānau and significant others are actively supported and involved in treatment and recovery.

Social and economic inequalities are associated with poor health outcomes. These inequalities particularly affect Māori and Pacific populations. Te Puāwaiwhero *The Second Māori Mental Health and Addiction National Strategic Framework 2008–2015,* Te Puāwaiwhero, (Ministry of Health 2008) provides the framework for the delivery of mental health and addiction services for Māori. It is expected that all mental health and addiction services will be responsive to the needs of Māori. Services will be designed to facilitate earlier access and choice may be promoted through the development of kaupapa Māori services. New Zealand's growing ethnic diversity means recognition and responsiveness to culture should be integral to treatment and support needs. Concepts to be taken into account in the design and delivery of services include whānau ora, social inclusion; spirituality, the role of family, whānau and social networks, varying perceptions of mental health, wellbeing, resilience and recovery.

Working together is one of the key challenges raised in the policy document *Te Tāhuhu: Improving Mental Health 2005–2015.* In addition to the provision of specialist services, connections with primary care, population health approaches, housing, employment, physical health, and an emphasis on social connectedness and participation all have a significant impact on mental health and wellbeing. It is unlikely that any single provider will deliver the full range of services, therefore all services in the mental health and addiction sector must work collaboratively and co-operatively to provide a well integrated and seamless continuum of care. Effective, robust planning and partnerships within and across health service providers, other government-funded services and private sector service providers are critical in enabling better recovery outcomes for Service users, their family, whānau and communities.

1. Service Definition

Specialist mental health and addiction services are delivered to those eligible people who are most severely affected by mental illness or addiction. Currently the expectation established in the National Mental Health Strategy is that specialist services will be available to three percent of the population. However it is recognised that a focus on early intervention strategies will mean services may be delivered to people who are at greater risk of developing more severe mental illness or addiction. To the extent that funding for specialist mental health and addiction services does not support coverage

for all target populations, it is expected that DHBs will have criteria in place for prioritising the provision of services, to people with the highest level of need.

2. Service Objectives

These following objectives have been developed in collaboration with, and should apply to all specialist mental health and addiction services:

2.1 General

Services will be responsive

Responsive services adapt to meet the unique needs of specific population groups and individuals. This is achieved through being flexible around service delivery settings in both urban and rural areas and adaptable to the Service users' individual circumstances and needs, including cultural and spiritual needs. Services should be age and gender appropriate.

Responsive services focus on recovery, reflect relevant cultural models of health and take into account the clinical and cultural needs of people affected by mental illness and addiction. Services working together will also ensure adequate referrals between mainstream services and those developed to meet the unique needs of specific population groups.

Service delivery should be flexible and responsive to the local situation, national direction and future innovation and evidence.

Where services have smoke-free policies, Service users should be routinely offered advice on how to quit smoking and should have access to appropriate cessation supports, including nicotine replacement therapy (NRT) products.

2.2 Māori Health

An overarching aim of the health and disability sector is the improvement of health outcomes and reduction of health inequalities for Māori. Health providers are expected to provide health services that will contribute to realising this aim. This may be achieved through mechanisms that facilitate Māori access to services, provision of appropriate pathways of care which might include, but are not limited to, matters such as referrals and discharge planning, ensuring that the services are culturally competent and that services are provided that meet the health needs of Māori. It is expected that, where appropriate, there will be Māori participation in the decision making around, and delivery of, the Service.

2.2.1 Responsive to Māori

The overall aim of *Te Puāwaiwhero*, is whānau ora, which is defined as; Māori families achieving their maximum health and wellbeing.

2.3 Responsive to Family and Whānau

Services will acknowledge the particular role the Service user plays in their family and whānau. This may include their role as parents or carers. For most Service users, family and whānau plays a key role in the road to recovery. There are significant clinical, social and economic advantages to providing mental health and addiction services in a family inclusive way. Services need to listen to family and whānau and respond to their specific needs, including providing education on recovery and referral of family and whānau to appropriate support services.

2.4 Recovery Focused

Recovery is defined as the ability to live a meaningful and satisfying life in the presence or absence of mental illness or addiction. Recovery is different for everyone; therefore there should be a range of service models and flexibility of services. For those with addiction problems, recovery is a process whereby Service users are assisted to minimise harms and to maximise wellbeing. Recovery may or may not involve abstinence.

2.5 Foster Resilience

Resilience can be encouraged through a continuous process where individual and family whānau capacities are recognised along with protective factors in the community. Building upon and fostering these factors can help people counter life challenges such as mental illness and/or an addiction. Strength-based approaches help to promote engagement and build resilience.

2.6 Encourage Natural Supports

Supports may include family whānau, partners, friends, neighbours, colleagues or those from an identified group. Mental health and addiction workers will foster relationships with natural supports, as defined and chosen by the Service user, as supports play an important role in building resilience and recovery.

2.7 Promote Independence

Services should support individuals to live as independently as possible within the context of their treatment and support needs, and in an environment that is consistent with these goals.

2.8 Support Service Users to Make Informed Choices

All providers need to ensure information about services is available and easily accessible to Service users and their family and whānau. Service users should be informed of their choices and options for care.

2.9 Reduce Inequalities

Social and economic factors, such as income, poverty, employment, education and housing, have been cited as contributing significantly to mental health and addiction status. It is acknowledged that socioeconomically disadvantaged groups bear a disproportionate burden of risk for mental ill health. This highlights the importance of mental health and addiction services, to co-ordinate and co-operate with other government agencies, such as, housing, employment and education. Responsiveness to infants, children, adolescents and youth is critical to interrupt cycles of mental illness and addiction within families, whānau and communities.

2.10 Promote Seamless and Integrated Services

Service users may be receiving care/treatment for both addiction and mental health issues. Both types of services need to be provided in a seamless way. It is vital that 'any door is the right door' and the mental health and addiction sector must build capacity and capability to respond to co-existing disorders.

Mental health and addiction Service users may also access other services. Services should work together to determine shared care arrangements that best meet the Service user's needs. It is important that those with a mental illness and/or addiction also have their physical health needs met.

Increasing recognition by the Justice system of the need for health interventions for offenders requires mental health and addiction services to interface well with the Justice system. This population is particularly high risk, with a high incidence of co-existing disorders.

2.11 Develop Organisational Governance

Organisational governance structures contribute to the stability and viability of organisations. A strong and active engaged board that is structured to provide fiscal oversight and meet the organisation's governance needs is promoted.

2.12 Develop Workforce

Workforce development needs to be part of the focus for every service. This development involves building the capacity and capability of the Service providers to work in partnership with the Service users. Investment in the development of the mental health and addiction workforce is key to ensuring the delivery of effective services. Integrated care and treatment can be achieved through the establishment of a competent workforce.

Let's get real: Real Skills for people working in Mental Health and Addiction (Ministry of Health 2008) is a framework that describes the essential knowledge, skills and attitudes required to deliver effective mental health and addiction services.

2.13 Value Lived Experience

People with a lived experience of mental illness and addiction offer a unique contribution to services. The important perspective of those with a lived experience should be utilised in the planning and implementation of services. Services should foster a culture that promotes Service users participation and recovery. Real life examples of recovery can offer hope to Service users. Service users should be encouraged into a range of roles, both within consumer-led services and across the continuum of services.

The valuable perspective and experience of family and whānau supporting a loved one with a mental illness and/or addiction should also be seen as an asset within the mental health and addiction workforce.

3. Service Users

A person or people deemed to receive or receiving mental health and /or addiction healthcare, health information, or support services resulting from direct contact with a healthcare provider where the healthcare results in use of resources associated with observation, assessment, diagnosis, consultation, rehabilitation or treatment, ongoing support, education, training, or ensuring or monitoring compliance with relevant legislation. Service users include all eligible people.

Not all patients who are referred or present to the Service are eligible for publicly funded services. Refer to http://www.moh.govt.nz/eligibility for more eligibility information

4. Access

4.1 Entry and Exit Criteria

Referrals to the Service may be made from any source, including self-referral. Some speciality services have specific requirements before accepting a referral. In these circumstances, services need to have clear documented access criteria and protocols, and ensure these are communicated with family, whānau and others making contact with the Service.

On referral (including self-referral), the criteria for assessment is based on the person having a suspected, developing or identifiable mental illness, and/or an addiction problem.

Services may prioritise referrals based on:

- clinical assessment about need and the severity of the mental illness and/or addiction
- the likely impact the mental illness and/or addiction will have on the person's ability to participate in activities of daily living, work, education and community life, and their role as a family and whānau member
- relevant legal requirements including the Mental Health Compulsory Assessment and Treatment (CAT) Act 1992 and Alcoholism and Drug Addiction Act 1966
- the safety of the individual and/or of others such as family members
- patients may exit the Service by transfer, discharge from the Service or death
- the Child Health Strategy (1998), defines a child as being aged from before birth to 14 years, and further identifies that young people up to the age of 18 years should be given care within the most developmentally appropriate services, as young people have specific developmental needs which require that they are cared for in youth appropriate settings. It is also necessary to recognise that the transition to adult services must occur at the appropriate time
- on entry to the Service, the most appropriate course of action will be discussed in consultation with the Service user and their family and whanau. This will be based on needs, strengths,

mental health and /or status and supports. Service users must be informed of their choices and options for care.

4.2 Distance

Services will be delivered locally where possible. DHBs are also expected to have in place arrangements that ensure the people of their DHB area have access to regionally and nationally provided mental health and addiction services.

4.3 Time

When assistance is required under the Mental Health (CAT) Act 1992, 90% of people presenting should be assessed within four hours. DHBs with isolated rural communities will ensure that effective arrangements are in place.

If a person is assessed as needing hospital care under the Mental Health (CAT) Act 1992, 90% should be admitted to a hospital within six hours of being assessed by a doctor or health professional.

The DHB will ensure that crisis services to deal with a critical or urgent mental health and/ or addiction needs will be available to people (regardless of whether or not they come under the Mental Health (CAT) Act) as follows:

- telephone or other remote assistance will be available at all times with minimal delay
- where telephone assistance is insufficient to meet the person's needs, direct contact with a clinician will be provided within four hours; DHBs with isolated rural communities will ensure that effective arrangements are in place
- other services will be arranged when required, including acute inpatient admission and crisis respite.

People are seen and assessed as needing services will receive those services as soon as possible. For some services, there may be a wait before treatment can begin (eg, opioid substitution programmes.)

- Note: until a person is assessed, it will not be known whether they fall under the Mental Health (CAT) Act 1992.

5. Service Components

5.1 Processes

Processes occur as part of a Service user pathway. Processes that include: health education, health promotion, engagement, assessment, diagnosis, treatment, rehabilitation, onward referral, family support, case management, liaison and consultation and ongoing support.

At all stages of this pathway, skilful engagement, consultation and, where appropriate joint care planning between services will be used to ensure the needs of the Service user are identified and responded to. Service users and their family and whānau should be encouraged to participate in evaluation/review at each step. Appropriate risk management procedures should also be put in place for the safety of the Service users, staff and others.

5.1.1 Assessment

Assessment will be appropriate and sufficiently comprehensive for the purpose of the particular service. It forms the basis of the recommended treatment, intervention or support and must be completed by staff with the required competency, knowledge and skills.

The assessment process will vary and take into account individual circumstances and, as well as the Service user, will include agreed family, whānau and support people where practicable. The assessment will take into consideration cultural needs. A full explanation of the process must be provided and reiterated to the Service user and those accompanying them.

The assessment will help develop an initial recovery plan, which will include treatment, intervention or support options, appropriate risk assessment/management and the plan for discharge. Recovery plans will be developed in a collaborative process with Service users, their family and whānau and support networks and address their broader physical, spiritual, social and psychological needs and aspirations. The recovery plan will be discussed with the Service user, and informed consent must be sought. There will be a process in place for reassessment. The assessment process should take into account identification of parental roles and responsibilities. Because the Service users may be linked into several different services, all will contribute to the overall recovery plan.

5.1.2 Treatment, Intervention and Support

Treatment, intervention and/or support are the key focuses for the Service delivery. The models for treatment, intervention and/or support will vary, and are described in further detail in tier two and three specifications.

After the initial assessment, treatment, intervention and/or support options will be recommended specific to the Service users' individual needs and circumstances. The recovery plan will be developed collaboratively with the Service user and, if appropriate, their family and whānau that will identify goals towards discharge and outline supports to assist the person to achieve those goals. It will include early warning signs, wellness maintenance, relapse prevention information and may include advance directives. Recovery plans will address the Service user's broader physical, spiritual, social and psychological needs and aspirations. Recovery plans will be kept current by regular review. Evidence-based, best practice education and information will be proactively provided to Service users and their family and whānau. The Service user will give written informed consent for treatment, intervention and/or support and will receive a copy of their recovery plan.

More positive outcomes occur when people are able to easily access services, and when services show flexibility and encourage Service user participation within clearly communicated and coherent treatment programmes. Information should also be provided about the role of family and whānau and the supports available to them, and other social networks.

5.1.3 Review Process

This is the process of formally reviewing recovery plans, goals and outcomes both with the Service user and in a multi-disciplinary setting. Reviews must occur at a minimum of every six months but the frequency will be determined by the Service user's individual circumstances, for example, their specific goals and the specific role of the service involved. In the addiction sector it is recommended that a review of progress is more frequent, occurring at a minimum of once every four months.

The review will include the Service user and with their consent, their family and whānau. Reviewed outcomes and new treatment goals will be reflected in ongoing recovery plans.

5.1.4 Discharge

Discharge is a planned process that is part of the recovery plan. It should begin from when the service is accessed.[1] Discharge planning must involve Service users and, with their consent, be communicated to all relevant support people. It will include reassessment of risk, the relapse prevention plan and follow-up arrangements. Discharge planning may also include advance directives and will identify medication on discharge and education about this. The Service users, family, whānau and other services and agencies involved should be informed of how to re-engage with the service if required.

A discharge summary will be given to the Service user and, where relevant, the general practitioner/primary care provider and support people.

5.2 Settings

The Service will be provided in the appropriate setting to provide the desired health outcomes. A consideration in determining the settings for the service should include (but not be limited to) issues such as cultural appropriateness, accessibility, gender, age and developmental stage, and the most effective and efficient use of resources. Services may be provided using hospital settings such as inpatient and day hospital, and outpatient settings such as those community based and mobile services.

5.3 Support Services

The following support services, if required, are to be provided as an integral part of the Service and are included in the agreed Purchase Unit price.

- clinical support services such as:
  - laboratory
  - pharmaceutical
  - pathology
- allied health support services such as:
  - dietetic
  - physiotherapy
  - social work and counselling service
  - infection control
- ancillary services such as:
  - sterile supplies department
  - hotel services (laundry and cleaning)
  - maintenance
  - occupational health
  - infection control
- interpreting services (including sign language)
- chaplaincy services
- corporate services such as:
  - human resource department
  - legal
  - finance
  - stores
  - accounts

Additional support services are listed in the appropriate tier two and three service specifications.

5.4 Key Inputs

The key input for mental health and addiction services is the workforce.

5.5 Pacific Health

Pacific peoples share similar risk factors to Māori in terms of health and social inequalities. Te Rau Hinengaro. The New Zealand Mental Health Survey (Ministry of Health 2006) confirms that Pacific peoples experience mental illness at higher levels than the general population. Pacific people are also less likely to access treatment than the total New Zealand population. The service must take account of key strategic frameworks, principles and be relevant to Pacific health needs and identified concerns.

For regions that have significant Pacific populations, the service must link service delivery to the improvement of Pacific health outcomes. Health service providers should also ensure that their service provides a holistic approach to health and wellbeing, assessment and treatment for Pacific peoples. This approach should include focusing on family, relationships, spiritual, physical, language, cultural, emotional and mental dimensions.

5.6 Health for other Ethnic Groups

Mental health and addiction services will be relevant and responsive to the diversity of cultures within local communities. Services will recognise resources, relationships and other protective factors in the community that will empower and promote wellbeing. Services will deliver culturally appropriate care, considering the individual ethnic, spiritual and cultural beliefs of those served.

Service planning, development and delivery will ensure that people are not discriminated against or disadvantaged. Mental health and addiction services will acknowledge that different cultures come with varying perspectives. Mental health and addiction services shall demonstrate effort to recruit staff from different cultures to reflect and match the cultural needs of people from Asian, migrant and refugee backgrounds in the community. Services will take steps to ensure that the mental health and addiction workforce is culturally competent and that qualified interpreters are available to provide maximum access for ethnic/cultural communities.

6. Service Linkages

Service linkages are requirements regarding linkages to other related services and provide a description of such links. The costs of such services are not included in the price of the Service, however, the costs of liaison and linkages with these services are included within the Service Purchase Unit price.

Service Provider	Nature of Linkage	Accountability
Other primary, secondary and tertiary services that the service refers Service users to	Refer and access to skills, expertise and resources within other disciplines ie medical services, surgical services	Referral processes and protocols are in place include mechanisms for shared working where appropriate. Services assist the Service user to access the other services that are required
Supporting services not purchased within this service specification	Provide continuity of care and facilitate access to services that best meet the needs of the Service user	Knowledge of other services within a district maintained Relationship with other providers through stakeholder networks
Publicly funded disability or long term support services for the Service users with co existing disabilities/ conditions who meet other funding streams eligibility criteria such as: Needs assessment and service co-ordination (eg, NASC) Specific support services such as: home and community support; carer support and respite; residential services; supported independent living; habilitation/rehabilitation; other specialist support services, as appropriate Environmental support services (eg, long-term	• Referral and liaison • Consultation • Referral and liaison	• Effective local and regional linkages are in place to facilitate appropriate referrals • Service users needing long-term support services have timely access to individual needs assessment and service coordination services • Service users needing long-term support receive appropriate services across the continuum of care and support to meet their individual needs, within available resources • Service users needing environmental support services

equipment, including specialist assessment services, home modifications) to assist with essential daily activities Information and advisory services (eg, on available services and how to access these)	• Liaison	receive appropriate equipment and environmental modifications • Service users have timely access to appropriately presented information and relevant advice
Local Māori health providers, Māori agencies and community groups	To improve mental health and addiction outcomes and reduce health inequalities for Māori	Local Kaupapa Māori services are strengthened by relationships, networks and cross agency working.
Local Pacific health providers, Pacific agencies and community groups	To improve mental health and addiction outcomes and reduce health inequalities for Pacific people.	Local Pacific services are strengthened by relationships, networks and cross agency working.
Other Government funded social services such as Education, Justice, Police, Social Development eg Work and Income and Child Youth and Family	Alignment of delivery of health services and delivery of other government funded social services to better meet the goals of government strategies and policies from health and related sectors (eg Social Development , Education, Justice, etc) Where children/young people are receiving services from other agencies, the service provider will participate in inter-sectoral collaboration and co-ordination initiatives such as 'Strengthening Families'.	Agreements and protocols regarding obligations of lead providers and collaborative working.
Consumer support groups	Share information with other providers about how to better meet the needs of Service users.	Maintain communication with consumer groups. Support the consumer voice at planning and delivery of services.
Between DHB providers, non-governmental organisations and Primary Health Organisations	Share innovative ideas, solve problems and improve access to services Provide co-ordinated support to people affected by mental illness and/or addiction.	Document agreements in memorandum of understanding (MOU) and protocols.

There will be clear arrangements/protocols/statements describing the accountabilities for access, entry, treatment, care management, exit processes, follow up and information sharing between linked providers.

There will be definitive statements on the boundaries between services and whether these are a matter of clinical judgement or prescribed by regulation/other mechanism.

There will be clear arrangements/protocols/statements describing how the provider will ensure treatment is delegated to the most appropriate person or agency, and which provider is primarily responsible for the care on each occasion.

There will be the requirement for providers to establish dispute resolution processes (depending on the linkage/relationship).

7. Exclusions

Mental illness or addiction often co-exist with other health or social service needs that impact on intervention outcomes. The presence of such needs shall not reduce a Service user's access to mental health and addiction services to which they would otherwise be eligible, but should be a signal that collaboration with another agency or health provider and joint intervention planning/provision is likely to be required.

District Health Boards (DHBs) do not fund services for mental health and addiction when the service or support needs are solely orientated to:

- sexual abuse
- violence and anger
- intellectual disability (including post-head injury), with or without behavioural problems
- learning difficulties
- criminal activities (anti-social behaviours)
- conduct disorder
- parenting difficulties
- relationship issues
- nicotine addiction.

Where people are eligible for services funded under the Injury Prevention, Rehabilitation, and Compensation Act 2001, they are excluded from receiving these services through public funding under Vote: Health.

The following services are not funded mental health and addiction treatment services where they are the sole focus of the intervention. They may be funded through other health funding or, in some cases, by other agencies:

- relationship services
- sexual abuse counselling services
- any counselling interventions not related to mental health and addiction
- psychological testing for educational requirements
- preparation of court reports ordered by the Ministry of Justice, except for those under the Criminal Procedure (Mentally Impaired Persons) **Act** 2003
- preparation of court-ordered reports or parole board reports
- assessments under section 65 of the Land Transport Act 1998
- assessments and reports under section 333 of the Children, Young Persons, and Their Families Act 1989.

8. Quality Requirements

The generic Provider Quality Specification, including the Health and Disability Sector Standards (HDSS) applies to this Service.

The Service must comply with the Provider Quality Standards described in the Operational Policy Framework (OPF) or, as applicable, Crown Funding Agreement Variations, contracts or service level agreements.

Please refer to the OPF for a comprehensive and updated list of standards and legislation that require provider compliance.

8.1 General

It is important that at each stage of the pathway Service users and their family and whānau are able to give feedback on the Service. Regular contract monitoring and auditing will occur and contribute to a continuous quality improvement cycle for all services.

When assessing the quality of the Service to the extent to which the Service has met the following priorities will be considered:

The process of service delivery should ensure:

- the Service user's needs are central
- Service user and wherever possible family / whānau participation
- recognition that many Service users will have parental roles and this will impact on their needs and those of their children
- high-quality mental health and/or addiction care is supported
- compliance with the Health and Disability Sector Standards, National Mental Health Standards and the Alcohol and Other Drug Treatment Sector Standards
- evidence-based best practice is followed.

When selecting the appropriate service specifications required for a Mental Health and/or Addiction service to be purchased, the following steps are taken:

- select tier one Mental Health and Addiction service specification
- consider the most appropriate service type and select one or more tier two service specifications
- consider the Service user needs to be met and the preferred service delivery mode
- select the tier three service specification that best meets these requirements.

(A minimum of three service specifications are required for each contract- a tier one, at least one tier two and a tier three service specification).

9. Purchase Units and Reporting Requirements

The Mental Health Purchase Unit Codes are found in the joint DHB Ministry Nationwide Service Framework Purchase Unit Data Dictionary on **www.nsfl.health.govt.nz**. They are reviewed, agreed and updated annually.

The following four Purchase Units do not have specific mental health and addiction services nationwide service specifications but are covered under this Tier One service specification.

PU Code	Name	Description	PU Unit of Measure
MHFF	Mental Health - flexifund	Service to cover the costs for flexible funding for mental health services in addition to specific services with a unit of measure client, available bed day, occupied bed day or FTE.	Programme
MHQU	Mental Health - quality and audit	Service to cover the costs for quality and auditing of mental health services	Programme
MHWF	Mental Health - workforce	Service to cover the costs for mental health workforce development.	Programme
MHSD	Mental Health - service development	Costs to cover service development projects.	Project

Purchase Units for mental health and addiction services are included at tier three service specification level and reflect the tier one and tier two level components.

9.1 Additional Reporting Requirements

9.1.1 National Collections

Mental Health and Addiction providers will provide data electronically to the Ministry of Health Information Service Directorate via the Programme for the Integration of Mental Health Data (PRIMHD).

A transitional process for all providers to report via PRIMHD is in place.

There will be participation in KPI Benchmarking project as this work is implemented in the sector.

All providers will report on the following:

Workforce

Frequency	Data
Quarterly	Actual FTE's by designated 6 FTE groupings
Quarterly	Staff turnover ratio

To calculate staff turnover ratio:

Numerator	Number of employed staff who have left within the reference period
Denominator	Total number of employed staff within the reference period

9.1.2 Additional Reporting Items for NGO Providers only:

Organisational Governance

Frequency	Data
Six monthly	Number of Board member changes
Six monthly	Number of governance meetings held

9.2.1 Data Definitions and Descriptions

Definition	Description
Admissions	The number of people admitted to the residential/inpatient service during the reporting period. The number of unique clients who have had an inpatient admission within the reporting period. Admission = first activity start date within the referral.
Available Beds	The total number of resourced beds usually available in the facility. NB: This is usually the number of beds funded/resourced and does not mean that the bed is unoccupied.
Available Bed Days	Total number of inpatient beds that are available to be occupied during the period multiplied by the number of days they are available during that period. This would normally be the number of available beds from above multiplied by the number of days in the period. Example: Number of resourced beds x Number of days in the period.

Definition	Description
Available Budget	The total budget available during the reporting period for the service.
Average Length of Stay	Inpatient/Accommodation/Housing- The average number of days between first admission and final discharge for all people "discharged" from the service during the period. If there have been no discharges in the period please enter "N/A". You will only be able to measure this when you have had a client exit your service during this period. Community Services - The average number of days between first contact and final contact for all people "discharged" from the service during the period. Where this cannot be measured, record "not measured". This is calculated as the sum of the total number of calendar days for each client between first contact/admission and final contact/discharge during the reporting period, divided by the total number of clients who have been "discharged" during the reporting period. Each day should be counted even if the service was unavailable eg, public holidays and weekends. The first and last day should be counted. Example: Two clients are discharged, one after 22 days and one after 87 days. Add the days together and then divide by the number of clients discharged – this gives you the average length of stay. 22 + 87 = 109 (days in service) ÷ 2 (clients discharged) = 54.5 days The average length of stay (ALOS) for clients who have had an inpatient or community discharge within the reporting period. Discharge = last activity end date of the referral. Admission = first activity start date within the referral whether it is in the reporting period or not.
Average Length of Time on Waiting List	The Average number of days that people currently on waiting lists for Methadone Treatment Programmes have spent on the waiting list. Count on the last day of the reporting period. The sum of the total number of days between referral and to waiting list and the last day of the reporting period divided by the total number of clients on the waiting list.
Bed Days	Total number of beds that are available and occupied each day in a community residential facility during the reporting period.
Clinical FTE	This is a full time equivalent (see definition of "FTE") staff member with a health professional qualification (including senior medical staff) who directly delivers clinical/therapeutic services to Mental Health consumers. Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team).
Completed Support Needs Assessments	The total number of completed support needs assessments during the period. The assessment process is to meet the "Standards for Needs Assessment for People with Disabilities". All visits and contacts required as part of the Support Needs Assessment are included and are not counted elsewhere. Count of all clients with an activity type code of T10 within the reporting period.
Consultation/Liaison Contacts	A planned discussion (over the phone or face-to-face) with a health professional from outside the service or a professional from another agency,

Definition	Description
	for the purpose of providing specialist advice in relation to a particular person (who is not a current client of the service) with a mental health problem. Count of all clients with an activity type code of T08 within the reporting period.
Consultation/Liaison Training Sessions	Number of education or training sessions provided for people working outside of the service (eg, GPs, Iwi Organisations, School Guidance Counsellors, Police).
Current Client	Any person who is currently receiving assessment, treatment/therapy or support from a service, where the person has been seen by the service within the past three months. Exclude people who have been seen by the service within the past three months but have since been discharged from the service. For inpatient services, this will be the number of people currently in an inpatient in the service, or on trial leave for less than ten days where a bed has been kept available. Unique count of clients without a referral end date during the reporting period, who have had an activity in the last three months (excluding Activity Type = T35).
Day	A day is a 24 hour period beginning immediately after midnight and ending at midnight
Day Attendances	Total number of attendances by non-inpatient consumers at a day programme for assessment, treatment or therapy related to a mental health diagnosis. Count each consumer attendance at the service only once in a day. Attendance of couple, family, or group, only one of whom is a mental health consumer is one attendance. Count of all clients with an activity type code of T23 within the reporting period. Each client to be counted only once per day.
"Day Places" Available	For each day programme offered, multiply the number of places available by the number of days they were available in the period.
Day Programme	A treatment /therapy /skills development programme provided for greater than 3 hours and less than 24 hours. Count of all clients with an activity type code of T22 within the reporting period. Each client to be counted no more than once per programme.
Expenditure (Promotion/Prevention)	The total sum of money spent on this service during the reporting period.
Expenditure with a breakdown of service utilisation **(Community Acute/ Respite Services)**	The total sum of money spent on this service during the reporting period. Each service will be required to report details of the types and volumes of services utilised during the reporting period. The content of these reports is to be negotiated between the funder and each service provider.
Face-to-face Contacts (Groups)	Face-to-face contact between an individual/family and one or more mental health professionals in a group session (Refer to Definition of Terms). Count one contact for each client attending the group session (ie, group session with four clients would be counted as four contacts). Clients counted once only, regardless of numbers of clinicians involved in the

Definition	Description
	activity. Attendance of clients' carer/significant other/whanau not included in the count. Count of all clients with an activity type code of T07 within the reporting period. Each client to be counted no more than once per session.
First Face-to-face Contacts (Individual /Family)	Initial face-to-face contact between an individual/family and a mental health professional regarding an episode of mental illness, a mental health problem or set of problems. The contact is the first assessment contact for this episode or problem, with an individual who is not a current client (refer to definition) of the service in question at the time the referral was received. (T Codes: T32,T36,T42)
Follow-up Face-to-face Contacts (Individual /Family)	All face-to-face contacts between an individual/family and mental health professional which occur after the initial face-to-face contact for this episode, problem or related problems. (T Codes: T32, T36, T42)
FTE	This is a full time equivalent employee (40 hours per week), and is calculated as the total number of hours employed per week (to a maximum of 40 hours per week), divided by 40. For example, where one staff member works 40 hours per week and another works 10 hours per week, the calculation would be: 40/40 + 10/40 = 50/40 = 1.25 FTEs Please note that where an employee (eg, a consultant psychiatrist) has been job-sized as being employed for more than 1.0 FTE (eg, employed as 1.2 FTE for undertaking additional management duties), only 1.0 FTE is to be recorded.
General Hospital Beds	The total number of General Hospital beds in the region on the last day of the period. Count occupied and unoccupied beds.
Group Session	A group session is a psychotherapy/skill development/education programme designed for more than two individuals which lasts between one and three hours.
Group Session Delivered	The total number of group sessions provided during the period.
Hui Held	The total number of Hui held during the period.
Hui Narrative Report	Number of trainees supported/individual training packages developed.
Hui Participants	The total number of attendees participating in Hui held during the period.
Hui Narrative Report (Details of each Hui)	A summarised report of each Hui held during the period, the report should include: • Details of attendees origin eg, HHS, NGO, family/whanau • Location of Hui

Definition	Description
	• Topics of discussion
Inpatient Admissions	The number of people admitted to the inpatient service during the period.
Involuntary Discharges Commenced	The number of clients who have ended involvement with the service during the period, where the decision to end involvement was not made by either the service or the client, eg, justice or prison involvement.
Kaumatua & Taua (Kuia) FTE Staff	Report the total number of FTE Kaumatua and Taua employed by the service. Kaumatua and Taua FTEs are defined as full-time equivalent (see definition of FTE) staff, who are specifically employed to provide guidance and support to the mental health service. Only include those people employed in a specified Kaumatua and Taua position. Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team).
Longest Time on Waiting List	The most days that any one person on the waiting list has spent on that waiting list. Count on the last day of the reporting period.
Maori Advisory FTE staff	Report the total number of FTE (see definition of FTE) Maori Advisory staff (who may or may not hold a professional qualification). Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team).
Maori Training Posts FTE staff	Report the total number of FTE (see definition of FTE) staff specifically employed in Maori Training Posts. Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team).
Methadone Places Available	The number of places available on Methadone Treatment Programmes at one point in time in the period, if the number of people so treated were constant during the period. (Include both GP and Specialist Alcohol and Drug Services.)
Monthly Expenditure for Flexi-Fund with a breakdown of information re: utilisation	A report which provides summary level information regarding utilisation of the Regional Co-ordination Service flexi-fund. This report will provide the following information regarding each individual support package purchased: the type of support purchased, the number of days the support was provided and the cost per day.
Number of FTE staff (Senior Medical)	Report the total number of FTE Senior Medical (SMO) staff employed in the service. Senior Medical FTEs are defined as a full-time equivalent (see definition of FTE) staff who have face-to-face contact in a medical or therapeutic role with clients and who are Registered Medical Practitioners and hold a current practising certificate. Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team). For recording purposes exclude vacant positions.
Number of FTE staff (Junior Medical)	Report the total number of FTE Junior Medical staff employed in the service. Junior Medical FTEs are defined as a full-time equivalent (see definition of FTE) staff who have face-to-face contact in a medical or therapeutic role with clients and who are Registered Medical Practitioners and hold a current

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Definition	Description
	practising certificate. Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team). For recording purposes exclude vacant positions.
Number of FTE staff (Nursing and Allied)	Report the total number of FTE Nursing and allied staff employed in the service. Nursing and allied staff FTEs are defined as a full-time equivalent (see definition of FTE) staff who have face-to-face contact in a medical or therapeutic role with clients and who are Registered Practitioners and hold a current practising certificate or affiliation with a professional body. Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team). For recording purposes exclude vacant positions.
Number of FTE staff (Cultural)	Report the total number of FTE staff employed in cultural specific roles in the service. Cultural staff FTEs are defined as a full-time equivalent (see definition of FTE) staff who have face-to-face contact in a therapeutic or support role with clients and who maybe Registered Practitioners and hold a current practising certificate or registered or regulated by a health or social service professional body and or have demonstrated cultural competencies. Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team). For recording purposes exclude vacant positions.
Number of FTE staff (Maori Mental Health Worker)	Report the total number of FTE Maori Mental Health Workers employed for the service. A Maori Mental Health FTE is defined as full-time equivalent (see definition of FTE) staff member employed specifically to deliver Maori Mental Health services to consumers, whanau or iwi. Only include those people employed in a specific Maori Mental Health position and not Maori staff employed in other clinical positions. Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team). For recording purposes exclude vacant positions.
Number of FTE staff (Medical)	Report the total number of FTE Medical staff employed in the service. Medical FTEs are defined as a full-time equivalent (see definition of FTE) staff who have face-to-face contact in a medical or therapeutic role with clients and who are Registered Medical Practitioners and hold a current practising certificate. Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team). For recording purposes exclude vacant positions.
Number of FTE staff (Nursing)	Report the total number of FTE Nursing staff employed in the service. Nursing FTEs are defined as full-time equivalent (see definition of FTE) staff who have face-to-face contact in a nursing or therapeutic role with clients and who hold a current practising certificates, Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team). For recording purposes exclude vacant positions.
Number of FTE staff (Occupational Therapy)	Report the total number of FTE Occupational Therapy staff employed in the service. Occupational Therapy FTEs are defined as full-time equivalent (see definition of FTE) staff who have face-to-face contact in a occupational therapy or therapeutic/supportive role with clients and are currently registered as Occupational Therapist. Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team). For recording purposes exclude vacant positions.

Definition	Description
Number of FTE staff (Other)	Report the total number of FTEs (see definition of FTE) for the service for 'other staff'. 'Other Staff' include any staff member involved in direct delivery of services to consumers other than medical nursing, psychology, occupational therapy, social work or Maori mental health worker. Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team). For recording purposes exclude vacant positions.
Number of FTE staff (Peer support)	Report the total number of FTE staff employed in specific peer support roles in the service. Peer support staff FTEs are defined as a full-time equivalent (see definition of FTE) staff who have face-to-face contact in a therapeutic or support role with clients and who maybe Registered Practitioners and hold a current practising certificate or registered with and regulated by a health or social service professional body or received a recognised qualification and or training in Peer Support. Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team). For recording purposes exclude vacant positions.
Number of FTE staff (Psychology)	Report the total number of FTE Psychology staff employed in the service. Psychology FTEs are defined as full-time (see definition of FTE) staff who have face-to-face contact in a psychology or therapeutic role with clients and are currently registered as psychologists. Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team). For recording purposes exclude vacant positions.
Number of FTE staff (Social Work)	Report the total number of FTE Social Work staff employed in the service. Social Work FTEs are defined as full-time equivalent (see definition of FTE) who have face-to-face contact in a social work or therapeutic/supportive role with clients and hold a social work qualification. Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team). For recording purposes exclude vacant positions.
Non-Clinical FTE	This is a full time equivalent (see definition of FTE) staff member without a health professional qualification who directly delivers clinical/therapeutic services to Mental Health consumers. Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team). For recording purposes exclude vacant positions.

Definition	Description
Occupied Bed Days	Sum of number of beds that are occupied each day during the period. For reporting purposes, count beds occupied as at 12 midnight each day. Do not count beds reserved for people on formal leave. Formal leave is defined in practice as any planned leave where a person is not physically in the inpatient or residential facility. That is, a bed would not be counted as occupied if the person was on pre-discharge leave, away visiting friends or relations for a period of time, on respite care or transferred to another service temporarily. Example: You have 7 beds but only 6 are occupied, therefore it would be 6 (beds) x No of days in period = Occupied Bed Days.
People Currently on Waiting List	The total number of people who have been assessed as eligible for receiving methadone treatment services and are waiting to begin the programme. Report the number on the waiting list on the last day of the reporting period.
People Receiving Methadone (GP prescribing on Specialist Service Authority)	The total number of people receiving methadone prescribed by GPs under specialist service authority while receiving case management from specialist Alcohol and Drug services on the last day of the working period. (T Code: T19)
People Receiving Methadone (GP Case Management)	The total number of people receiving methadone under GP case management on the last day of the working period.
People Receiving Methadone (Specialist Service Case Management)	The total number of people receiving methadone treatment under specialist Alcohol and Drug service case management on the last day of the reporting period. (Exclude GP prescribing and GP methadone case management.) (T Code: T18)
People Referred Back from GP	Number of people referred to a specialist methadone service by a GP in circumstances where the GP has previously been responsible for providing methadone treatment services to that person. ie, Where the GP has been the "case manager" and requests a specialist methadone service take over this role.
People Supported by this Service at the End of the Period/Month (by NZ Maori, Pacific Island, Other)	The number of current clients (individuals or families) currently receiving services. For definition of 'current client', see above. Although a client may identify as more than one ethnicity, for reporting purposes count them only once. You should prioritise by the Ministry of Health standards ie, NZ Maori, Pacific Island and Other. Example: A client identifies as NZ Maori and Pacific Island. You should count this person only once. They should be reported as NZ Maori. If a client does not identify as any ethnicity then you should enter in Other.
People Supported by this Service	Where provider can count Service users individually, this figure should be the total number of people who have been current clients during the period. Count only once those people who have been discharged and re-entered the service

Definition	Description
during the Period/Month (by NZ Maori, Pacific Island, Other)	during the period or who have used multiple services. Where the provider cannot count Service users once only for recurrent service use or for use of multiple services, record "not measured". Although a client may identify as more than one ethnicity, for reporting purposes count them only once. You should prioritise by the Ministry of Health standards ie, NZ Maori, Pacific Island and Other. Example: A client identifies as NZ Maori and Pacific Island. You should count this person only once. They should be reported as NZ Maori. If a client does not identify as any ethnicity then you should enter in Other.
Planned Discharges	The number of clients who have finished their involvement with the service during the period where the decision to finish involvement with the service was reached by mutual agreement between the client and the service.
Programmes Delivered	The total number of mental health promotion programmes delivered during the period.
Re-admissions	The total number of consumers re-admitted to an inpatient mental health service within twenty eight days of previous discharge, where: • the readmission was not planned at the time of discharge; and • the readmission is to the same service. Count those consumers who are on trial leave for 10 days or more who returned prior to their planned re-admission date.
Senior Medical FTE	This is a full time equivalent (see definition of FTE) senior medical staff member (including DAMHS, but excluding Registrars and House Surgeons) involved in the direct delivery of services to Mental Health consumers. Exclude time that is formally devoted to administrative or management functions (eg, half-time coordination of a community team).
Suicides of Current Clients	The number of suicides of current clients during reporting period. Count only once for users of multiple services.
Transfers to an Inpatient Unit/Off Site Respite	The total number of people transferred from an accommodation service to a mental health inpatient unit or crisis respite service during the reporting period.
Unplanned Discharges - Self Initiated	The number of clients who have ended involvement with the service during the period, where the decision to end involvement was made by the client before the planned therapy/treatment was completed.
Unplanned Discharges - Service Initiated	The number of clients who have ended involvement with the service during the period, where the decision to end involvement was made by the service before the planned therapy/treatment was completed.

MENTAL HEALTH AND ADDICTION SERVICES
ADDICTION SERVICES -
SERVICE SPECIFICATION
TIER LEVEL TWO

The Addiction Services tier two service specification (the Service) is the overarching document for tier three addiction services. It must be used in conjunction with the tier one Mental Health and Addiction Services service specification and be used in conjunction with other tier two service specifications and one of a range of tier level three Addiction service specifications as listed below:

- Addiction – Alcohol and Other Drug Community Support Services
- Addiction – Alcohol and Other Drug Acute Package of Care
- Addiction – Alcohol and Other Drug Day Treatment Programme
- Addiction – Early Intervention Alcohol and Other Drug Service
- Addiction – Intensive Alcohol and Other Drug Service with Accommodation
- Addiction – Managed Withdrawal Home / Community
- Addiction – Managed Withdrawal Inpatient Service
- Child, Adolescent And Youth Alcohol And Other Drug Community Services
- Child, Adolescent And Youth Community Alcohol And Drug Services With Accommodation Component
- Community Based Child, Adolescent And Youth Co-Existing Problems Of Mental Health And Alcohol And / Or Drug Use
- Community Based Child, Adolescent And Youth Co-Existing Problems Of Mental Health And Alcohol And / Or Drug Use
- Child, Adolescent And Youth Planned Respite
- Infant, Child, Adolescent And Youth Crisis Respite Mental Health And Alcohol And Other Drugs / Co Existing Disorders Alcohol.

Its purpose is to define the services and their objectives in the delivery of a range of secondary and tertiary services for people experiencing addiction.

1. Service Definition

The continuum of Addiction services will offer a range of high quality treatment options of varying intensity and delivered in various settings. Treatments will be available and accessible to those who need them. Addiction can often be chronic and relapsing and people may choose to access a variety of different services to meet their needs.

The aim of Addiction services is to support recovery and wellness and minimise the harm that addiction can cause. Although the approaches to achieve recovery and wellness will vary between services, wherever possible treatment approaches should be evidence-based.

2. Service Objectives

2.1 General

The following objectives apply to all Addiction Services:

Supporting recovery

Recovery is about building a satisfying and meaningful life as defined by the person themselves. It is not simply about harm minimisation, but includes a movement towards health, wellbeing and participation in society. Recovery will vary between individuals often taking time to achieve and effort to maintain. The recovery process involves inclusion, or re-entry into society, improved self-identity and the idea of 'giving back' to society and others, such as family members, who may have been adversely affected by the individual's addiction.

Acknowledge and address co-existing problems

Along with addiction, many Service Users may also experience mental health issues. This is evidenced in New Zealand and international literature. Addiction services are expected to respond to these multiple issues. A response might include screening, assessment and then providing a range of responses which may include interventions, co-working or referral. Services should also pay attention to people's general health needs and refer them to health services than can assist with these.

Inclusiveness of family and whānau[1]

Inclusiveness of family and whānau is vital to achieve and maintain successful treatment outcomes. This involves engaging family and whānau in the therapeutic and treatment process; prevention measures to ensure family and whānau members do not also follow the same path of addiction; and providing services to family and whānau members if it becomes apparent that they also have an addiction. Family and whānau involvement in the treatment process will help enhance their knowledge and understanding of how best to respond to the needs of their family member.

A continuum from harm reduction[2] to abstinence

Harm reduction and abstinence approaches occur within a spectrum of treatment approaches for a spectrum of needs (NCAT, 2008). Both abstinence and harm reduction are widely accepted approaches to addiction treatment with both approaches have their place within the continuum. Harm reduction includes policies, programmes, services and actions that work to reduce the health, social and economic harms to individuals, communities and society.

Integrated care

The continuum of addiction and mental health services will likely be delivered by different providers. However these services should appear integrated to the Service User. A competent workforce will allow people to access the right treatment regardless of where they enter the system.

Collaboration

Collaboration between sectors and services is important for addiction services to be effective. Collaboration includes developing capacity and capability to assess and treat co-existing addiction and mental health problems. Collaboration involves working with other health, community and social services, as well as working across government and non-government agencies including Housing, Work and Income New Zealand, Child Youth and Family, Police, Courts and Corrections.

Engagement and access

The prevalence of alcohol and other drug abuse and dependence for males is around double those for females. Māori and Pacific people experience a higher prevalence of addiction and greater problems related to substance use disorder and dependency. The youthfulness of these populations along with relative socioeconomic disadvantage plays key part in this. Services need to engage these populations to assist with reducing the harm caused by addiction. This should include local iwi as a major point of contact and development of relationships to support the reduction in harm caused by addiction within their communities. The prevalence of alcohol and other drug use in gay, lesbian and transgender populations is more than double that of the general population. Services need to engage with these populations to ensure accessibility.

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[1] The definition of family is guided by the Service User. This can include as relatives, whānau, partners, friends or others nominated by the Service User. Whānau is a key component of Maōri identity and the healing process. Whānau can be used to describe groups interconnected by kinship ties, often linked through a common purpose and values.

[2] Also referred to as harm minimisation

Treatment options for young people and their families
Services will provide a range of point of access services for young people and will address their developmental needs and achievements.

Offering choice
Within the boundaries of what is geographically and practically possible, offering choice may include a choice of service providers, treatment models, setting and times that services are delivered.

Treatment must adequately address people's needs, not just their addiction
Increasingly addiction treatment embodies a holistic focus combined with a strengths-based approach, incorporating the strengths of the person and their family and viewing the whole person in the context of what it means to be well for them (NCAT, 2008). This includes Service Users who have dependants.

Continuing care services
Continuing care involves providing ongoing treatment and support so the gains made in treatment are not lost. The importance of continuing care is widely accepted in recognition that there is a high risk of relapse in the period immediately post treatment. All treatment services need to pay attention to ongoing support. Continuing care can include relapse prevention, support groups and individual support for those wishing to maintain the changes they have made in treatment. Access to education or training, advisory services, peer support and social networks and employment support may be included.

Ability to re-engage with services
Addiction problems often involve relapse. In these instances, it is important that mechanisms are in place to allow people to re-enter service immediately if there is a problem with their success in recovery. Service Users and their family and whānau should be made aware of how to re-enter with services if necessary. Services may at times have waiting lists, and these should be managed in conjunction with other services and prioritised according to level of risk.

2.2 Māori Health

Refer to tier one Mental Health and Addiction Services service specification.

3. Service Users

Refer to tier one Mental Health and Addiction Services service specification.

4. Access

4.1 Entry and Exit Criteria
Entry and exit criteria specific to the Service are described in tier three service specifications.

5. Service Components

5.1 Processes

The processes include but are not limited to the following: health education; engagement; assessment; diagnosis; treatment; case management; consultation, advocacy, liaison; support; review process and discharge.

5.2 Settings

The Service may be provided in community, home and hospital based settings.

5.3 Key Inputs

The key input for Addiction Services is the workforce.

5.4. Pacific Health

Refer to tier one Mental Health and Addiction Services service specification

6. Service Linkages

Linkages include, but are not limited to the following:

Service Provider	Nature of Linkage	Accountabilities
Addiction Providers	Facilitate Service access and participation	Liaise with local addiction providers to facilitate accessibility to services and ensure pathways to access are known.
Mental health service providers Primary Care providers	Referral Liaison processes	Establish relationships and referral pathways and liaison processes to promote timely access to services for physical and mental health problems
Other health service providers such as medical services and emergency departments within a general hospital	Liaison processes	Liaise and work with other providers to ensure needs of clients are met, ie, managed withdrawal.

7. Exclusions

Refer to tier one Mental Health and Addiction Services service specification.

8. Quality Requirements

The Service must comply with the Provider Quality Standards described in the Operational Policy Framework or, as applicable, Crown Funding Agreement Variations, contracts or service level agreements.

9. Purchase Units and Reporting Requirements

9.1 Purchase Units are defined in the joint DHB and Ministry's Nationwide Service Framework Purchase Unit Data Dictionary. Specific reporting requirements apply at tier three service specifications.

10. Tier Three Service Specifications

The following service specifications and Purchase Units are for Addiction Services:

Title	PU Code
Community Support Service with Accommodation	MHD53 MHD53C MHD53D MHD53E MHD53F
Opioid Substitution Treatment	MHD69 MHD69A MHD69B MHD69C MHD69D MHD70 MHD70A MHD70B MHD70C MHD70D
Alcohol and other drug consultation and liaison service	MHD71A MHD71B MHD71C MHD71D
Early intervention alcohol and other drug service	MHD72A MHD72B MHD72C MHD72D MHDI72A MHDI72B MHDI72C MHDI72D
Alcohol and other drug- community support	MHD73C MHD73D
Community based alcohol and other drug services	MHD74A MHD74B MHD74C MHD74D MHD74E
Alcohol and other drug day treatment programme	MHD75A MHD75B MHD75C MHD75D
Intensive alcohol and other drug service with accommodation	MHD76 MHD76A MHD76B MHD76C MHD76D
Managed withdrawal- inpatient services	MHD77
Managed withdrawal- home/community	MHD78 MHD78A MHD78B MHD78C MHD78D
Alcohol and other drug acute packages of care	MHD79 MHD79C MHD79D MHD79E

Child, Adolescent And Youth Alcohol And Other Drug Community Services	MHDI48A MHDI48B MHDI48C MHDI48D MHDI48E
Child, Adolescent And Youth Community Alcohol And Drug Services With Accommodation Component	MHDI49 MHDI49C MHDI49D MHDI49E
Community Based Child, Adolescent And Youth Co-Existing Problems Of Mental Health And Alcohol And/Or Drug Use	MHDI50A MHDI50B MHDI50C MHDI50D MHDI50E
Child, Adolescent And Youth Planned Respite Mental Health And Alcohol And Other Drugs/ Co Existing Disorders	MHDI52 MHDI52C MHDI52D MHDI52E MHI52 MHI52C MHI52D MHI52E
Infant, Child, Adolescent And Youth Crisis Respite	MHI42 MHI42C MHI42D MHI42E MHI42F

FOR INFANT, CHILD, ADOLESCENT AND YOUTH MENTAL HEALTH, ALCOHOL AND/OR OTHER DRUGS SERVICES SERVICE SPECIFICATION TIER LEVEL TWO

This tier two service specification for Infant, Child, Adolescent and Youth Mental Health Alcohol and or other Drugs Services (the Service) is linked to tier one Mental Health and Addiction Specialist Services service specification and a range of tier three Infant, Child, Adolescent and Youth service specifications.

This generic tier two service specification is the overarching document for all mental health, alcohol and/or other drugs (addiction) services for infants, children, adolescents and youth. It defines the services and their objectives in the delivery of a range of secondary and tertiary services for infants, children, adolescents and youth, in the mental health and addiction sector. It is recognised that within this age group the service title of 'alcohol and other drugs' is helpful because service users do not identify their alcohol or substance misuse as an addiction. This document should be used in conjunction with the tier one Mental Health and Addiction Specialist Services Specification and the appropriate tier three service description.

Strategies for specialist mental health, alcohol and other drug services for this age group are acknowledged in *Te Tāhuhu – Improving Mental Health 2005–2015* (Ministry of Health 2005) and priorities for development articulated in *Te Raukura: Mental health and alcohol and other drugs: Improving outcomes for children and youth* (Ministry of Health 2007). Service approaches need to be evidence based, integrated and connected, and cross the traditional service boundaries (Mental Health Commission 2007).

Building strengths and resilience for infants, children, adolescents and youth is about first recognising the context of significant adversity in their lives. Second, acknowledging the important wider adaptive systems, such as family, friends and community, that can be harnessed to support individuals within this context. Third, identifying and strengthening protective factors that build resilience. Building resilience in this way may reduce the need or frequency of accessing specialist services.

1. Service Definition

The Infant, Child, Adolescent and Youth Services are specifically developed for and applicable to those up to the twentieth birthday. Adult services are available from age 18 years allowing an overlap that is managed according to the clinical and developmental needs of the individual. Some flexibility will be allowed to manage the transition between child, adolescent and youth services, and adult services through to 25 years (as defined in the individual contract agreement) to best meet the needs of the young person. Services need to establish a mechanism to maintain a developmental focus.

Services are specifically for the following:

- infants, children, adolescents and youth with, or suspected of, having a mental health and/or alcohol and other drug disorder
- infants, children, adolescents and youth with psychological disorders, including severe emotional and behavioural disturbances
- family members/whānau and/or other significant people identified by the child, adolescent or youth (the service user). These people will ordinarily be involved in processes concerning that service user, and will be able to access services as set out in these service specifications unless good reason exists for them not to be involved
- people seeking information about mental ill health, its treatment and prevention, support of people with mental illness, or recognition of problems of mental health and what action to take
- infants, children, adolescents and youth who are affected by a significant other's (parents or carers) mental health and/or addiction problems.

The needs of infants, children, adolescents and youth differ from adults. Therefore age-appropriate services, settings and facilities for this age group are required. An identified service or sub-service

may be offered to adolescents and youth by a dedicated team or sub-team with expertise in the treatment of adolescents and youth. A similar approach may be offered to other age groupings.

However, because not all services that infants, children, adolescents and youth receive are from dedicated child mental health, alcohol and/or other drug teams, it is important this service specification is read in conjunction with the tier one Mental Health and Addiction Specialist Services and tier three Adult Mental Health Services specifications, for example, Crisis Response Services and First Episode Psychosis Services. Where services for infants, children, adolescents and youth are provided from an adult service, the provider will ensure that the needs of this population are met in an-age appropriate manner.

2. Service Objectives

2.1 General

- To support families, whānau and carers in maximising the individual developmental potential and mental health of infants, children, adolescents and youth between the ages of 0–19 years up to their twentieth birthday.
- To establish a strong foundation for ongoing mental health and wellbeing.

2.2 Māori Health

An overarching aim of the health and disability sector is the improvement of health outcomes and reduction of health inequalities for Māori. Health providers are expected to provide health services that will contribute to realising this aim. This may be achieved through mechanisms that facilitate Māori access to services, provision of appropriate pathways of care which might include, but are not limited to:

- matters such as referrals and discharge planning,
- ensuring that the services are culturally competent and
- that services are provided that meet the health needs of Māori.

It is expected that, where appropriate, there will be Māori participation in the decision making around, and delivery of, the Service.

2.3 To be Infant, Child, Adolescent and Youth Centred

- Early, effective, evidence-based age and developmentally appropriate interventions will be provided.
- Treatment will enhance protective factors to promote building resilience and include active management of risk factors.
- The infant, child, adolescent or youth will be treated in a way that acknowledges their needs and given the opportunity to develop their competence in responsible, beneficial and pro-social ways.
- The rights of the infant, child, adolescent or youth will be considered from a developmental perspective and balanced with the rights and responsibilities of family/whānau/carers.

2.4 To Ensure Family and Whānau Participation

- Wherever possible, the relationship between infant, child, adolescent, or youth and parents or guardians, or family and whānau should be maintained and strengthened.
- Full endeavours will be made to obtain the involvement of the parents, guardians or carers, or other significant persons, for provision of any services provided under this service specification.
- Lack of family and whānau involvement should not be a barrier to access for youth who request to access a service confidentially, however, in these cases encouraging family involvement should become a focus of the young person's treatment unless there are clear indications that this would be detrimental to the youth's ongoing wellbeing.

- Parents will be supported to gain the knowledge and skills required to sustain wellness and lead to improvements in quality of life.
- Evidence-based training will assist parents to be coaches, guides and mentors.
- Therapeutic family interventions will be provided when appropriate, and access to interventions will be facilitated.
- Parents will be supported to gain the knowledge and skills required to understand and manage the various stages of their infant, child, adolescent or youth's development.
- Access to support from other health or community services will be facilitated especially for those children of families and whānau at risk of adverse outcomes.

2.5 To Improve Access to Services

- Access to infant, child, adolescent and youth mental health services is generally by referral from primary practitioners, school counsellors, Child, Youth and Family (CYF) Services or professionals in other sectors, such as personal health, disability or education. However, self-referrals or referrals made by family and whānau of the infant, child or adolescent will also be made. It is expected that barriers to access will be identified and strategies put in place to improve access.
- Effective prioritisation processes and waiting list management will assist timely access to services.
- When an assessment identifies needs that cannot be met by the service criteria, the service will provide advice/referral to other services that are resourced to meet those needs.
- Engagement in services by adolescents and youth requires flexibility in venue, appointment timing and methods of service delivery, and that their privacy is respected, for example, in school clinics, Youth One Stop Shops, marae settings and CYF residences.

2.6 To Promote Inclusive Decision-Making

- The wishes of the infant, child, adolescent or youth, so far as those wishes can be reasonably ascertained, should be given such weight as is appropriate in the circumstances having regard to the age, ability, competence and culture of the infant, child, adolescent or youth.
- Wherever possible, the infant, child, adolescent or youth's parents, guardians or carers, or family and whānau should participate in the decision-making processes affecting the infant, child, adolescent or youth.
- Consideration must always be given to how a decision affecting an infant, child, adolescent or youth will affect the welfare of the infant, child, adolescent or youth and their stability.
- There is referral to CYF if there are any care and protection issues.

2.7 To Promote Inter-sector Collaboration

- Services will engage in inter-sector collaboration and co-ordination initiatives such as Strengthening Families, Youth Offending Teams (YOTs) and High and Complex Needs (HCN), where service users are receiving services from a range of agencies.
- Services will recognise the value of supporting children, adolescents and youth in maintaining their attendance at school and/or employment where possible, and will collaborate and liaise with education and employment personnel.
- Service providers will collaborate with the justice and social welfare sectors for maximum effectiveness, especially when service users are accommodated in CYF residences.
- Consultation and liaison across sectors and with other professionals, and provision of information about mental illness to community groups, will be a significant component of the work of mental health services for infants, children, adolescents and youth. For example, participation in Strengthening Families, HCN or Family Group Conferences (FGCs), Care and Protection Resource Panels, inter-agency case management processes or other similar fora is

recognised as beneficial. This may include Primary Health Care Organisations (PHOs), school clinics, CYF, youth services and iwi providers.

- Where possible, services will be provided on site to children, adolescents and youth in CYF residences or Department of Corrections Youth Units.
- For people under 20 years of age with a mental health or substance abuse problem, and a history of offending, it is important that relationships are established with forensic, alcohol and/or other drugs services to ensure joint approaches to care that utilise the expertise of each specialist service. The provider primarily responsible for the care will be negotiated on each occasion.

2.8 To Promote Safe and Age-appropriate Settings and Facilities

- Service settings and facilities will be age appropriate and, where possible, separated from adult services in accordance with United Nations Committee on the Rights of the Child (UNCROC) recommendations.
- Residential services for infants, children, adolescents and youth will undergo an approval process that is consistent with the Approval Standards for Child and Family Support Services and Community Services, and relevant legislation.
- Agreements for, and consent to, out-of-home care for infants, children, adolescents and youth will be consistent with the requirements of the Children, Young Persons, and Their Families Act 1989 including any legislation that supersedes, substitutes or amends this legislation.

3. Service Users

The Service users are eligible infants, children, adolescents and youth up to their 20th birthday.

4. Access

4.1 Entry and Exit Criteria

Entry and exit criteria specific to the Service are described in tier three service specifications.

5. Service Components

5.1 Processes

The processes include but are not limited to the following: assessment; treatment, intervention and support; review process; discharge.

5.2 Settings

Service settings and facilities will be age appropriate and, where possible, separated from adult services in accordance with United Nations Committee on the Rights of the Child (UNCROC) recommendations.

5.3 Key Inputs

The key input for the Service is the workforce.

5.4. Pacific Health

The Service must take account of key strategic frameworks, principles and be relevant to Pacific health needs and identified concerns. For regions that have significant Pacific populations, the service must link service delivery to the improvement of Pacific health outcomes. Overall, the service activity should contribute to reducing inequalities.

6. Service Linkages

Linkages are not limited to those described in tier one Mental Health and Addiction Specialist Services and tier two Adult Mental Health service specifications and include the table below.

Service Provider	Nature of Linkage	Accountabilities
Infant, Child, Adolescent and Youth DHB providers, primary care providers and other agencies	Referral, liaison, consultation	Work with other relevant professionals and agencies in the care of the Service user

7. Exclusions

Refer to the tier one service specification.

8. Quality Requirements

The Service must comply with the Provider Quality Standards described in the Operational Policy Framework or, as applicable, Crown Funding Agreement Variations, contracts or service level agreements.

9. Purchase Units and Reporting Requirements

Purchase Units are defined in the joint DHB and Ministry's Nationwide Service Framework Purchase Unit Data Dictionary. Specific reporting requirements apply at tier one and tier three service specifications, not at tier two service specifications.

10. Tier Three Service Specifications

The following service specifications for infant, child, adolescent and youth are grouped in tier three service specifications under three categories:

- Acute and inpatient services
- Community based clinical treatment and therapy services
- Services to promote resilience, recovery and connectedness

10.1 Acute and Inpatient Services

Title	PU Code
Child, Adolescent And Youth Acute Inpatient Beds	MHI38
Infant, Child, Adolescent And Youth Acute Home based Treatment	MHI39A, MHI39B, MHI39C, MHI39D
Infant, Child, Adolescents And Youth Acute Package Of Care	MHI40, MHI40A, MHI40B, MHI40C, MHI40D, MHI40E, MHIK40
Acute Crisis Intervention Service	MHI41A, MHI41B, MHI41C
Infant, Child, Adolescent And Youth Crisis Respite	MHI42, MHI42C, MHI42D, MHI42E, MHI42F

10.2 Community based clinical treatment and therapy services

Title	PU Code
Infant, Child, Adolescent And Youth Community Mental Health Services	MHI44A, MHI44B, MHI44C, MHI44D, MHI44E, MHI44F, MHIK44A, MHIK44C, MHIK44D
Infant, Child, Adolescent And Youth Day Treatment Services	MHI45A, MHI45B, MHI45C, MHI45D, MHI45E, MHI45F
Child, Adolescent And Youth Intensive Clinical Support Service	MHI46A, MHI46B, MHI46C, MHI46D
Child, Adolescent And Youth Mental Health Community Care With Accommodation Component	MHI47, MHI47C, MHI47D
Child, Adolescent And Youth Alcohol And Other Drug Community Services	MHDI48A, MHDI48B, MHDI48C, MHDI48D, MHDI48E, MHDIK48C
Child, Adolescent And Youth Community Alcohol And Drug Services With Accommodation Component	MHDI49, MHDI49C, MHDI49D, MHDI49E
Community Based Child, Adolescent And Youth Co-Existing Problems Of Mental Health And Alcohol And/Or Drug Use	MHDI50A, MHDI50B, MHDI50C, MHDI50D, MHDI50E
Infant, Child, Adolescent And Youth Services-Needs Assessment And Coordination	MHI51A, MHI51B, MHI51C, MHI51D, MHIK51C, MHIK51D
Child, Adolescent And Youth Planned Respite Mental Health And Alcohol And Other Drugs/ Co Existing Disorders	MHDI52, MHDI52C, MHDI52D, MHDI52E MHI52, MHI52C, MHI52D, MHI52E
Adolescent Youth Forensic Service (*Awaiting Completion*)	MHFI53, MHFI53A, MHFI53B, MHFI53C, MHFI53D

10.3 Services to promote resilience, recovery and connectedness

Title	PU Code
Child, Adolescent And Youth Community Based Day Activity Service	MHI54C, MHI54D, MHI54E
Infant, Child, Adolescent And Youth Community Support Service	MHI55D, MHI55E, MHI55F
Child, Adolescent And Youth Package Of Care	MHI56, MHI56C, MHI56D, MHI56E
Services For Children, Adolescents And Youth Of Parents With A Mental Health Disorder Or Addiction	MHI57C, MHI57D, MHI57E, MHI57F

CHILD, ADOLESCENT AND YOUTH ALCOHOL AND OTHER DRUG – COMMUNITY SERVICES
TIER THREE
SERVICE SPECFICATION
MHDI48A, MHDI48B, MHDI48C, MHDI48D, MHDI48E, MHDIK48A, MHDIK48B, MHDIK48C, MHDIK48D, MHDIK48E

This tier two service specification for Child, Adolescent and Youth Alcohol and Other Drug Community Services (the Service) is linked to tier one Mental Health and Addiction Specialist Services and tier two Infant, Child, Adolescent and Youth service specifications.

1. Service Definition

The Service includes community-based assessment and treatment but is not limited to:

- screening and brief intervention
- comprehensive assessment
- alcohol and other drug treatment, therapy, support and care co-ordination (both individual and group)
- family support and treatment with other interventions as appropriate
- liaison and consultation services to other providers of health services, including mental health services and other agencies that provide services to young people
- community development services.

Consistent with the tier two Infant, Child, Adolescent and Youth Service Specification, each child, adolescent or youth will be offered the interventions that are appropriate according to their age, their developmental needs and assessed need in terms of their drug and alcohol use, related problems and readiness for change. This may include referral to other services or agencies.

It is expected that there will be a reduction in alcohol and other drug related issues.

A recovery plan that includes access to brief intervention for relapse and follow up will be established.

2. Service Objectives

To provide a community-based assessment and treatment service for children, adolescents and youth with alcohol and/or other drug problems and/or dependence.

2.1 Māori Health

An overarching aim of the health and disability sector is the improvement of health outcomes and reduction of health inequalities for Māori. Health providers are expected to provide health services that will contribute to realising this aim. This may be achieved through mechanisms that facilitate Māori access to services, provision of appropriate pathways of care which might include, but are not limited to, matters such as referrals and discharge planning, ensuring that the services are culturally competent and that services are provided that meet the health needs of Māori. It is expected that, where appropriate, there will be Māori participation in the decision making around, and delivery of, the Service.

3. Service Users

The Service users are eligible children, adolescents and youth.

4. Access

4.1 Entry and Exit Criteria

Access may be from any source, including referral by service users directly or upon referral from primary practitioners, family/whānau or carers.

5. Service Components

5.1 Processes

The following processes apply but are not limited to: assessment, treatment, intervention and support, review and discharge.

5.2 Settings

Community based.

5.3 Key Inputs

Services provided by:

a multi-disciplinary team of people with skills and experience in mental health and alcohol and drug intervention, treatment and support, made up of:

- health professionals regulated by the Health Practitioners Competence Assurance Act 2003
- people regulated by a health or social service professional body, people who interact with service users and who are not subjected to regulatory requirements under legislation or by any other means
- staff with appropriate qualifications, competencies, skills and experience, for working with people with alcohol and drug problems/dependence.

6. Service Linkages

Linkages include, but are not limited to the following described in tier one Mental Health and Addiction Specialist Services and tier two Infant, Child, Adolescent and Youth service specifications.

7. Quality Requirements

The Service must comply with the Provider Quality Standards (PQS) described in the Operational Policy Framework (OPF) or, as applicable, Crown Funding Agreement Variations, contracts or service level agreements.

8. Purchase Units and Reporting Requirements

Purchase Units are defined in the joint DHB and Ministry's Nationwide Service Framework Purchase Unit Data Dictionary. The following Purchase Units apply to this Service.

PU Code	PU Description	PU Measure	Reporting Requirements
MHDI48A	Child, adolescent and youth alcohol and drug community services - Senior medical staff	FTE	PRIMHD
MHDI48B	Child, adolescent and youth alcohol and drug community services - Junior medical staff	FTE	PRIMHD
MHDI48C	Child, adolescent and youth alcohol and drug community services – Nursing and/or allied health staff	FTE	PRIMHD

PU Code	PU Description	PU Measure	Reporting Requirements
MHDI48D	Child, adolescent and youth alcohol and drug community services - Non-clinical staff	FTE	PRIMHD
MHDI48E	Child, adolescent and youth alcohol and drug community services - Cultural staff	FTE	PRIMHD
MHDIK48A	Child, adolescent & youth alcohol & drug community services - Kaupapa Maori - Senior medical staff	FTE	PRIMHD
MHDIK48B	Child, adolescent & youth alcohol & drug community services - Kaupapa Maori - Junior medical staff	FTE	PRIMHD
MHDIK48C	Child, adolescent & youth alcohol & drug community services – Kaupapa Māori – Nurses & allied health	FTE	PRIMHD
MHDIK48D	Child, adolescent & youth alcohol & drug community services - Kaupapa Maori - Non-clinical staff	FTE	PRIMHD
MHDIK48E	Child, adolescent & youth alcohol & drug community services - Kaupapa Maori - Cultural staff	FTE	PRIMHD

The Service must comply with the requirements of national data collections PRIMHD.

After PRIMHD Reporting to Information Directorate, Ministry of Health:

Frequency	Data
Monthly	Group sessions delivered
Monthly	Consultation/liaison training sessions
Quarterly	Senior medical FTEs
Quarterly	Junior medical FTE
Quarterly	Nursing and allied FTE
Quarterly	Non clinical FTE
Quarterly	Cultural FTE
Quarterly	Peer support FTE
Quarterly	Staff turnover ratio
Quarterly	Number of suicides of current clients
Six monthly	Number of NGO Board member changes (NGOs only)
Six monthly	Number of NGO Governance meetings held (NGOs only)
Annually	Number. of FTEs in each of these groups: • Medical • Nursing • Psychology • Occupational Therapy • Social Work • Maori Mental Health

	• Other

Prior to PRIMHD Reporting to Information Directorate, Ministry of Health:

Frequency	Data
Monthly	First face-to-face contact with individual/family
Monthly	Follow up face-to-face contact with individual/family
Monthly	Group sessions delivered
Monthly	Face-to-face contact group
Monthly	Consultation/liaison contact
Monthly	Consultation/liaison training sessions
Monthly	Number completed support needs assessments
Monthly	Number of people supported by services at end of period (by NZ Maori, Pacific Island, Other)
Monthly	Number of people supported by services during month (by NZ Maori, Pacific Island, Other)
Quarterly	Senior medical FTE
Quarterly	Junior medical FTE
Quarterly	Nursing and allied FTE
Quarterly	Non clinical FTE
Quarterly	Cultural FTE
Quarterly	Peer support FTE
Quarterly	Staff turnover ratio
Quarterly	Average length of stay
Quarterly	Number of suicides of current clients
Six monthly	Number of NGO Board member changes (NGOs only)
Six monthly	Number of NGO Governance meetings held (NGOs only)
Annually	Number of FTEs in each of these groups: • Medical • Nursing • Psychology • Occupational Therapy • Social Work • Maori Mental Health • Other

ADDICTION SERVICES-
COMMUNITY BASED ALCOHOL AND OTHER DRUG SPECIALIST SERVICES
TIER LEVEL THREE
SERVICE SPECIFICATION
MHD74A, MHD74B, MHD74C, MHD74D, MHD74E

This tier three service specification is for Community Based Alcohol and other Drug Specialist Services (the Service) and must be used with the tier one Mental Health and Addiction Services service specification and is also linked to the tier two Addiction Services service specification.

1. Service Definition

Community based assessment and treatment services that provide, but are not limited to:

- screening and brief intervention
- specialist comprehensive assessment;
- drug and alcohol treatment, therapy, support and case management (both individual, group and inclusive of family and whānau)
- integrated care for those experiencing co-existing problems of addiction and mental health
- ongoing monitoring of symptoms and regular review of progress and treatment
- development of cultural links
- working with family and whānau and offering support and other interventions
- liaison and consultation services to other providers of health services including mental health services and other agencies in contact with people with current or potential substance use problems
- community development services
- referral to other services or agencies where appropriate
- support to enhance recovery and reduce the risk of relapse for example this may include facilitating engagement with a support group.

Each Service user will be offered interventions that are appropriate according to assessed need in terms of their drug and alcohol use, related problems and readiness for change. Where appropriate treatment may include:

- pharmacotherapy and bio-medical interventions
- psychological treatments
- occupational therapy
- social work
- recreational activities
- social skills training
- domestic skills training
- assertiveness and self-esteem building.

Attention will be paid to specific subgroups such as pregnant women with alcohol and other drug problems.

2. Service Objectives

To provide a community or outpatient based assessment and treatment service.

2.1 Māori Health

Refer to the tier one Mental Health and Addiction Services service specification.

3. Service Users

Refer to the tier one Mental Health and Addiction Services service specification.

4. Access

4.1 Entry Criteria

Referral from primary health care, inpatient, community mental health teams, alcohol and other drug services.

5. Service Components

5.1 Processes

The processes include but are not limited to the following: engagement; assessment, information provision, treatment, consultation, liaison, advocacy, support, review process, discharge.

5.2 Settings

The Service may be provided in community, and home based settings.

5.3 Key Inputs

A multi-disciplinary team of people with skills and experience in alcohol and other drug intervention, treatment and support, and who belong in one of the following categories:

- health professionals regulated by the Health Practitioners Competence Assurance Act 2003
- people regulated by the Drug and Alcohol Practitioners Association Aotearoa New Zealand (DAPAANZ) or another health or social service professional body
- people who interact with service users and who are not subjected to regulatory requirements under legislation or by any other means.

5.4. Pacific Health

Refer to tier one Mental Health and Addiction Services service specification

6. Service Linkages

Linkages are as described in Mental Health and Addiction Services tier one and Addiction tier two service specifications

7. Exclusions

Refer to tier one Mental Health and Addiction Services service specification.

8. Quality Requirements

Refer to the tier one Mental Health and Addiction Services service specification.

9. Purchase Units and Reporting Requirements

9.1 Purchase Units are defined in the joint DHB and Ministry's Nationwide Service Framework Purchase Unit Data Dictionary. The following Purchase Units apply to this Service.

PU Code	PU Description	PU Definition	PU Measure	PU Measure Definition	Payment Systems
MHD74A	Community based alcohol and other drug specialist services – Senior medical staff	Community based assessment and treatment services that provide integrated care for those experiencing alcohol and other drug problems and co-existing problems of addiction and mental health. The service is provided by senior medical staff.	FTE	Full-time equivalent staff member (clinical or non-clinical) involved in direct delivery of services to consumers. Exclude time that is formally devoted to administrative or management functions e.g. half-time coordination of a community team.	Sector Services
MHD74B	Community based alcohol and other drug specialist services – Junior medical staff	Community based assessment and treatment services that provide integrated care for those experiencing alcohol and other drug problems and co-existing problems of addiction and mental health. The service is provided by junior medical staff.	FTE	As above.	Sector Services

PU Code	PU Description	PU Definition	PU Measure	PU Measure Definition	Payment Systems
MHD74C	Community based alcohol and other drug specialist services – Nursing and allied health staff	Community based assessment and treatment services that provide integrated care for those experiencing alcohol and other drug problems and co-existing problems of addiction and mental health. The service is provided by nursing and allied heath staff.	FTE	As above.	Sector Services
MHD74D	Community based alcohol and other drug specialist services – Non-clinical staff	Community based assessment and treatment services that provide integrated care for those experiencing alcohol and other drug problems and co-existing problems of addiction and mental health. The service is provided by non-clinical staff.	FTE	As above.	Sector Services
MHD74E	Community based alcohol and other drug specialist services – Cultural staff	Community based assessment and treatment services that provide integrated care for those experiencing alcohol and other drug problems and co-existing problems of addiction and mental health. The service is provided by cultural staff.	FTE	As above..	Sector Services
MHDK74C	Community based alcohol and other drug specialist services – Kaupapa Māori – Nurses & allied health	Community based assessment and treatment services that provide integrated care for those experiencing alcohol and other drug problems and co-existing problems of addiction and mental health. The service is provided by nurses and allied health.	FTE	As above.	Sector Services

PU Code	PU Description	PU Definition	PU Measure	PU Measure Definition	Payment Systems
MHDK74D	Community based alcohol and other drug specialist services – Kaupapa Māori – Non-clinical staff	Community based assessment and treatment services that provide integrated care for those experiencing alcohol and other drug problems and co-existing problems of addiction and mental health. The service is provided by non-clinical staff	FTE	As above.	Sector Services

9.2 Reporting

Details of any additional information to be collected and the frequency of reporting to Sector Services Contract Management System are as specified and documented by the Funder in the Provider Specific Schedule of the contract.

The following information will be reported to:

The Performance Reporting Team, Sector Services
Ministry of Health
Private Bag 1942 Dunedin 9054.
Email performance_reporting@moh.govt.nz.

Reporting to Sector Services, Ministry of Health:

Frequency	Data
Monthly	Group sessions delivered
Monthly	Consultation/liaison training sessions
Quarterly	Senior medical FTEs
Quarterly	Junior medical FTE
Quarterly	Nursing and allied FTE
Quarterly	Non clinical FTE
Quarterly	Cultural FTE
Quarterly	Peer support FTE
Quarterly	Staff turnover ratio
Quarterly	Number of suicides of current clients
Six monthly	Number of NGO Board member changes (NGOs only)
Six monthly	Number of NGO Governance meetings held (NGOs only)
Annually	Number. of FTEs in each of these groups: • Medical • Nursing • Psychology • Occupational Therapy • Social Work • Maori Mental Health • Other