

**Community Health Transitional
and Support Services**

**Short Term Residential
Care Services for People
in Contracted
Residential Facilities**

Tier 2 Service Specification

September 2024

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1. Status

Approved to be used for mandatory nationwide description of services to be provided.

MANDATORY ☒ RECOMMENDED ☐

It is compulsory to use this Specification when purchasing services. No Districts should use a local service specification instead of this mandatory specification.

2. Review History

Review History	Date
First Published on Nationwide Service Framework Library	April 2012
Review of: Residential Respite Care Services for Older People in Residential Aged Care Contracted Facilities (January 2010). Amendments: Title name change and update of content including reporting requirements and new Purchase Units, retire HOP213A and HOP213.	April 2012
Amendment: inserted HOP240 reporting requirement previously omitted.	June 2012
Amendment: replaced references to Tier One Rehabilitation and Support Services (now retired) with Tier One Community Health Transitional and Support Services.	April 2013
Amendment: updated reporting requirements, referenced Appendix One.	May 2016
Amendment: corrected PU code descriptions HOP237, HOP238	July 2016
Amendment: reporting table simplified for consistency, replaced 'days' with 'attendances', corrected 2.2 section reference.	June 2017
Moved to Health NZ template. Updated links for PUDD and NSFL only. Amended DHB to become District/Region where appropriate. No other changes to content made.	September 2024
Consideration for next Service Specification Review	Within five years

Note: In September 2024 a small programme of work moved all Service Specifications to Health New Zealand branded templates. No amendments were made to the body text or content of the Service Specification, so references to DHB, Ministry of Health or other pre-2022 reforms vocabulary will still exist. A larger programme of work to review and revise all Service Specifications is planned for late 2024 to early 2025.

Note: Contact the NSF Team, Te Whatu Ora | Health New Zealand to discuss proposed amendments to the service specifications and guidance in developing new or updating and revising existing service specifications. NSF@tewhatuora.govt.nz

The Nationwide Service Framework Library web site can be found [here](#).

3. Introduction

This tier two service specification for Short-term Residential Care Services for people in a contracted residential facility (the Service) is intended for both Health of Older People Service Users and Chronic Health Conditions Service Users of all ages, including children and young people. It is linked to the overarching tier one, Community Health, Transitional and Support Services service specification, which must be used in conjunction with this service specification.

The Service specification is also linked to the tier two District Health Board (DHB) funded Needs Assessment and Coordination Service specification. Where required, this service specification must also be read and comply with the Ministry of Health Certification and the Age Related Residential Care services agreement for eligible Service Users.

3.1 Background

Short-term residential care services (Services) are designed to provide temporary support for eligible people in a contracted residential setting of any size. These services are designed to enable people to live in their home for longer and can improve their health and well-being.

If the eligible person has a main carer¹ the service is designed to provide the main carer with a short break from their caring role, and can improve their health and well-being, enabling the main carer(s) to continue in the caring role.

The Service is delivered by organisations referred to in this document as Service Providers (the Provider), and these organisations are accountable for the quality of the services delivered. This includes the delivery of services that are appropriate to the age, stage and need(s) of the service user, including children and young people.

The Provider will have a philosophy and care delivery system that promotes and maintains Service Users' independence to support their ability to return home. The Provider will:

- have age appropriate expertise in working with people with health and support needs
- have expertise in working with people with chronic health related support needs
- be informed about and understand the requirements of a Service User who wishes to remain living in their own home
- if providing services to people with dementia, have expertise in working with people who have dementia specific needs.

¹ The term 'main carer(s)' is a reference to the person(s) spouse, parent/guardian, family, whānau or friend providing informal support and care for more than four hours a day. The main carer does not have to live with the person supported, as long as the main carer is responsible for supporting their ongoing care and wellbeing – A Guide for Carers: He Aratohu mā ngā Kaitiaki <https://www.msd.govt.nz/documents/what-we-can-do/community/carers/carers-a4-booklet-v8.pdf>

Appendix One is to be used as a guide for District Health Boards contracting for short-term residential care services. It describes where Provider specific components can be added to contracts to further specify the Service, and provides examples.

4. Service Definition

The Service is a 24 hour, seven day a week service (unless otherwise negotiated with the funder) within a contracted facility of any size. The Service provides both planned and emergency (or crisis) short-term residential care to the eligible Service Users and, where relevant, to support their main carer(s). Emergency short-term residential care will be provided when Service Users and / or their main carer(s) are in urgent and immediate need of temporary support. For example it may be due to a family emergency, illness, crisis, or unforeseen event.

5. Service objectives

5.1.1 General

The Service will:

- enable the Service User to have a short-term break
- ensure that a Service User focused approach is central to decision making
- assist Service Users to adapt to ongoing health or support needs
- ensure each Service User maintains their level of functioning and the ability to remain as independent as possible
- ensure staff understand the holistic needs of the Service User
- support the Service User to remain living in their own home, wherever possible including facilitating a smooth transition back home
- support the wellbeing of the Service User's main carer, where relevant, to enable them to continue in their caring role and reduce carer stress
- provide culturally appropriate services
- provide age appropriate services.

5.1.2 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 and provision of appropriate pathways of care, which might include, but are not limited to:

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

Where appropriate, there will be Māori participation in the decision making around, and delivery of, the Service. Providers must recognise Māori realities. The importance of Whānau, Hapu and Iwi structures, and the role the Service User, particularly Koroua and Kuia, plays within these structures. Positive intervention for Māori Service Users can help to introduce healthier lifestyles, change habits and enhance positive social and functional activities.

6. Service Users

People who have been assessed as eligible by the DHB approved needs assessment and service coordination service as requiring short-term residential care services, and who qualify for age appropriate services, such as people:

- aged 65 years of age or older, or
- aged 50 to 64 with age related needs, or
- requiring long term support for chronic health conditions (all ages, including children and young people), or
- fulfil the criteria (as specified by individual DHBs) to enable access to a specific DHB initiative.

People with mental health or addiction needs should have their specific mental health and addiction needs met through mental health services but are not excluded from having their age related or chronic health conditions needs funded through these specifications.

7. Access

7.1 General

The Provider ensures the Service User has been assessed as eligible for the Service, and has sufficient unused short-term residential care days allocated by an approved DHB needs assessment and service coordination service.

The Service User, and where relevant their main carer and their support network, should be involved in the selection of the Provider.

The Provider must advise the Service User of any optional additional charges at the time of arranging the Service, and details must be included in the admission agreement.

Whilst in the Service, the Service User will remain under the care of their own General Practitioner or Nurse Practitioner (GP / NP). If this is not possible, the Provider will ensure access to a GP / NP.

If the Service is provided in an aged residential facility the Registered Nurse will conduct an assessment within 24 hours of admission.

The Provider will use assessment information available from any current assessment (eg, InterRAI HC, Well Child/Tamariki Ora) to inform care planning and prevent duplication of assessment.

The Provider will advise the Service User (or in the case of a child or younger person their main carer) of admission and discharge times.

A Service User may stay longer than their allocated short-term residential care, but will be charged a daily fee, as agreed in advance with the Provider, for the full cost of care for any extra days. This does not apply if the Service User moves into permanent care within the facility as funding may be covered under a different funding stream.

7.2 Entry Criteria

Access to the Service is based on eligibility, as assessed by a DHB approved needs assessment and service coordination service. The level of service provided will be at the level the Service User has been assessed as requiring.

The DHB approved needs assessor will approve the number of care days that can be used by the Service User within a defined period. The Provider and Service User, or where appropriate the main carer (eg. children or young people, people with dementia) will agree a start and end date for each period of short-term care.

7.3 Exit Criteria

Service Users will exit the Service by planned discharge or death.

A Service User (or in the case of a child or younger person their parent or guardian) may choose to leave the residential facility before the agreed end date. In this situation the Provider will make every effort to inform the Referrer and where appropriate the main carer, family or whānau.

8. Service Components

8.1 Settings

The Provider will provide 'home-like', physically safe internal and external environments that are most appropriate for the Service User's age, developmental stage and support needs.

Where required under the Health and Disability Services (Safety) Act 2001, the Provider must have Ministry of Health Certification and meet the Health and Disability Services Standards NZS8134:2008.

Services for children and young people will be provided in a developmentally, behaviourally appropriate environment for them and their families and where best outcomes can be achieved. It is not the intention of the service specification to mix age groups together for services, unless it is in the best interest of the child or young person to do so. Reference should be made to the Ministry of Health's guidance on this matter so that decisions taken by DHBs and their providers are consistent with Article 37(c) United Nations Convention on the Rights of the Child (refer to Appendix 2).

If the Service User is 65 years of age or older, or is 50 to 64 with age related needs, the Service will provide short-term residential care consistent with the standard of care identified in the service specification of the Age-related Residential Care Services Agreement.

8.2 Time

Unless otherwise indicated through a specific funding agreement with the funder, the Service will be available 24 hours a day, seven days a week, including public holidays.

8.3 Costs

Providers will not charge Service Users any part charges for short-term residential care services under this agreement.

A Service User (or in the case of a child or younger person their main carer) may be requested to pay a small contribution towards some activities (eg, a show) when they have:

- had prior notice of such a cost associated with that activity
- a choice as to whether they participate in the activity.

8.4 Processes

8.4.1 Admission Agreement

The Provider must ensure that the Service User, or their main carer or nominated representative (for example, the person with enduring power of attorney for care and welfare), signs an Admission Agreement on the day the Service User commences attending Services at the Providers facility. The admission agreement should be reviewed at each consecutive admission. The Provider must not charge the Service User or any other person for preparing or providing an Admission Agreement.

The Admission Agreement must contain:

- a list of items that are excluded from the Service as set out in 2.2 above.
- an itemised list of each optional additional service offered by the Provider which is not part of the service agreement, and the charge for each optional additional service
- a statement of the right of the Service User (or in the case of a child or younger person their main carer) to:
 - receive short-term residential care without being required to receive and pay for any additional service
 - decide whether to receive any individual additional service
 - at any time decide to receive or cease to receive any individual additional service
- the extent of the Provider's liability for damage or loss of the Service User's personal belongings, including clothing
- provisions relating to the following topics:
 - staffing of the facility
 - safety and personal security of Service Users, and if appropriate protections for children and young people
 - fire protection and emergency management
 - communication with Service Users for whom English is a second language, are deaf, or whose ability to communicate is limited.
- the complaints procedure a Service User (or in the case of a child or younger person their main carer) should follow if they wish to make a complaint about the provider or any of the services received by the Service User, and how to access the Health and Disability Commissioner's Advocacy Service.

8.4.2 Short-term Care Plan

The following requirements are in addition to those specified in the Provider Quality Specifications and Health and Disability Services Standards NZS8134:2008.

The Provider will ensure that each Service User has a written and implemented short-term care plan, and that each Service User has had the opportunity to participate in developing the short-term care plan. Where a Service User has a main carer or is a child or young person the main carer will also be involved in the development of the short-term care plan. Where possible a shared care plan can be used to ensure continuity between community and short-term residential care services. The short-term care plan is agreed with the Service User, and is written in a way that is understood by the Service User.

Where a Service User is unable to participate in developing the short-term care plan, their main carer or nominated representative will identify who can provide information about the Service User's preferences in relation to activities of daily living.

The short-term care plan will:

- identify how the Service User's assessed health and support needs will be met
- be implemented to maximise the Service User's level of physical and social functioning during the period of care
- be updated upon each admission according to the assessed needs of the Service User. The assessment will be documented by the Registered Nurse accountable for the Service User's short-term care plan with input from all relevant people
- reflect pre-existing and/or new directives by the Service User's GP / NP during any period of care
- be available to the Service User's needs assessor for the purpose of reassessing the Service User's care needs
- include strategies and actions to safeguard the Service User
- include length of stay and arrangements for return home
- include dietary needs, allergies (eg. medication, food etc)
- agree administration of provided prescribed medication (eg. antibiotics)
- where appropriate, include details from their care plan while at home
- where appropriate, include the Service User's likes and dislikes
- where appropriate, include arrangements for school attendance or other activities (eg. pool therapy sessions), including transport
- where appropriate, include communication and behavioural support.

The Provider will document:

- baseline information regarding the Service User's health status, abilities and support needs, which is updated, collated and held upon each contact with the Provider
- relevant demographic information which is collected and retained and includes the names of the GP / NP, main carer, family and whānau, unique identification number (NHI), age, ethnicity and the number of short-term residential care days used during each stay.

8.4.3 Access to Health Services

Providers will ensure that:

- if, during a Service User's stay in the Service, the need for personal health services (secondary care) is identified, access to these services is provided in a timely manner
- the Service User will continue to receive and/or have access to community nursing and allied health services.

Accessing health services (including transport) while attending the Service is at the cost of the Service User.

8.4.4 Medications²

Providers will ensure that the following medicine management regime is followed:

- confirm Service User's regular medicines with the Service user or main carer prior to admission
- complete medicines reconciliation on admission
- document in the Service User's file any changes while in care
- notify the main carer and prescriber of any changes to medicines regime
- provide information and/or education as appropriate to the Service User and their main carer
- document information and/or education provided in the Service User's file
- complete medicines reconciliation on discharge and ensure the Service User has access to correct medicines for discharge.

8.4.5 Discharge Planning

The Provider will ensure that:

- a Service User, and where relevant, the Service User's main carer or family and whānau is involved in the discharge planning process
- if there is any change in the Service User's support needs that may affect their requirement for ongoing support services following discharge the provider will send a referral to the DHB approved needs assessment and coordination service at least two days prior to discharge.

If the main carer or family has not arranged for the Service User's return home at the agreed time, this will be reported immediately to the Referrer responsible for the placement as per the agreed Plan.

² From Ministry of Health. 2011. *Medicines Care Guide for Residential Aged Care*. Wellington: Ministry of Health.

8.4.6 Risk Management

The Provider must, as a minimum, document and implement policies, processes and procedures for:

- identifying key risks to health and safety
- evaluating and prioritising those risks based on their severity, the effectiveness of any controls the Provider has and the probability of occurrence
- dealing with those risks and where possible reducing them
- staff recruitment to ensure the safety of Service Users (eg. Police vetting, training for working with children and young people where appropriate)
- minimising the adverse impact of any internal emergencies or external environmental disasters on the Service Users, visitors and staff
- working with the organisations who have responsibility for co-ordinating internal and external (environmental) disaster services
- accident and hazard management that safeguard Service Users, visitors and staff from avoidable incidents, accidents and hazards
- compliance with Infection Prevention and Control Standards NZS8134.3.2008
- requirements of staff if abuse of Service Users is evident or suspected, following the appropriate Family Violence Intervention Guidelines (Child and Partner Abuse or Elder Abuse and Neglect). Where the Service User is a child, it is the Provider's responsibility to notify the DHB and Child, Youth and Family service
- dealing with challenging behaviours – when and how to access support services and when to access reassessment
- development and maintenance of positive relationships with the immediate neighbouring community.

Each risk management policy, process, or procedure developed must include definitions of all incidents and accidents, and must clearly outline the responsibilities of staff, including:

- taking immediate action
- reporting, monitoring and corrective action to minimise incidents, accidents and hazards, and improve safety; and
- debriefing and staff support as necessary.

Key risks include, but are not limited to:

- theft/burglary
- fire
- accidents/incidents
- chemicals incidents, and
- disposal of waste.

A record of any accidents or incidents must be maintained, and crises and major incidents must be notified immediately to Service User's main carer, family or whānau, needs assessment and service coordination service, and GP / NP.

8.5 Behavioural Support

Where the Service User requires Behavioural Support the Provider will:

- ensure that communication and behavioural support is addressed in each Service User's short-term care plan
- work cooperatively with Specialist Behavioural Support Services eg. age appropriate specialists such as dementia advisory services and child development services
- operate a non-aversive policy for managing challenging behaviour which adopts the principle that a person's freedom should be restricted only for safety reasons
- utilise restraint procedures based on the Restraint Minimisation and Safe Practice Standards NZS8134.2.2008.

8.6 Access to Support Services

If a Service User's assessed need requires the services below, the Provider must not preclude the Service User from accessing these services. Any cost associated with access (including transport) is the Service Users responsibility:

- needs assessment and service coordination services
- interpreting services – including sign language
- assessment, treatment and rehabilitation services contracted by the DHB
- primary health care, including Well Child / Tamariki Ora, and district /community nursing services
- ambulatory services
- laboratory services
- diagnostic imaging services
- dental services
- specialist medical services, including paediatric services
- podiatry services that are not prescribed by a Medical Practitioner or Nurse Practitioner
- Māori provider organisations
- Ministry of Social Development services, including Family Start
- social workers
- advocacy services
- supporting voluntary organisations such as Alzheimers New Zealand and Stroke Foundation
- socialisation outside the Service.

9. Service Linkages

Where relevant and appropriate the Provider should be well integrated with other general and specialist services and there should be effective consultation, liaison and referral between services and sub-specialities to maintain continuity of care.

Service Provider	Nature of Linkage	Accountabilities
Advocacy services (including Elder Abuse and Neglect Prevention advocacy services, Health and Disability Commission advocacy)	Referral and consultation	Service Users have timely and appropriate access to advocacy services
Community health services, including professional community services, social workers, district nursing	Referral and consultation	Clinical consultation and referral services that support continuity of care
DHB approved needs assessment and service coordination services	Referral and consultation	Service Users needing reassessment of their support needs have timely access to individual needs assessment and service coordination services
Equipment and Modification Services (eg, Long-term equipment, including specialist assessment services, home modifications) to assist with daily activities	Referral and consultation	Eligible Service Users needing environmental support services receive appropriate equipment and environmental modifications
Information and advisory services (eg, on available services and how to access these eg, Disability and Information Advisory Service, Age Concern, Alzheimers New Zealand)	Referral and consultation	Service Users have timely access to appropriately presented information and relevant advice
Major incident management including Civil Defence	Liaison and coordination of services	Ensure appropriate and timely response in the event of an emergency
Occupational therapy Physiotherapy Speech Language therapists Social workers Podiatry services	Referral and consultation	Clinical consultation and referral services that support continuity of care
Other specialist services	Referral and consultation	Expert clinical consultation and referral services that support continuity of care
Primary care services eg. General Practitioner, Nurse Practitioner	Referral and consultation	Clinical consultation and referral services that support continuity of care

Service Provider	Nature of Linkage	Accountabilities
Public health service, communicable disease programmes, and the Medical Officer of Health	Referral and consultation	Clinical consultation and referral services that support continuity of care
Social support services (eg. benefits, disability allowances, services for senior citizens, children etc)	Referral and consultation	Service Users have access to appropriate social support services for which they are eligible
Social services, counselling, home based support, meals on wheels, community services, new migrant Community Health Workers, accredited visiting services	Referral and consultation	Ongoing support, service coordination that supports continuity of care
Voluntary organisations, eg, Age Concern, Alzheimers New Zealand, Cancer Society, National Heart Foundation	Liaison, consultation and coordination of services	Ensure relevant and accurate information is available to support service delivery
If Applicable:		
Specialist behavioral support teams	Referral and consultation	Clinical consultation and referral services that support continuity of care
Child health services, including Well Child / Tamariki Ora services	Referral and consultation	Clinical consultation and referral services that support continuity of care
Day and / or recreational activities	Referral and consultation	Maintain Service User's access, support seamless service delivery and continuity of care
Disability Support Services (Ministry of Health funded)	Liaison, consultation and coordination of services	Maintain Service Users access, support seamless service delivery and continuity of care
Ethnic and cultural services	Liaison, consultation and coordination of services	Ensure culturally appropriate support is provided
Mental health services	Referral and consultation	Clinical consultation and referral services that support continuity of care
Palliative care - Hospice	Liaison, consultation and coordination of services	Support seamless service delivery and maintain continuity of care

Service Provider	Nature of Linkage	Accountabilities
Schools, education sector, child development services	Liaison, consultation and coordination of services	Maintain Service User's access, support seamless service delivery and continuity of care
Transport services, eg, Total Mobility, to recreational and / or day activities etc. National Travel Assistance	Liaison, consultation and coordination of services	Maintain the Service Users' access

10. Exclusions

10.1 General

The Service is not for Service Users who are receiving short-term residential care services under other public funding arrangements such as ACC or the Ministry of Health (unless formal written agreements have been made for joint funding for individuals with complex needs).

10.2 Exclusions from Service

Unless otherwise indicated through specific agreement with the funder, the Service cost does not include:

- specialised assessment and rehabilitation services – including assessment for, or advice on, rehabilitation and specialised assessment (by accredited assessors) for individualised customised equipment via ACC and Ministry funded Environmental Support Services providers
- customised equipment, accessed through services funded by the relevant DHB or through specialised accredited assessors, such as wheelchairs modified for an individual's use, seating systems for postural support, specialised communication equipment and other customised and personal care and mobility equipment
- the provision of equipment, aids, medical supplies or services that relate to conditions covered by separate funding from the Provider, any DHB, or the Ministry
- services such as those provided by dentists, opticians, audiologists, podiatrists, chaplains, hairdressers, dry cleaners, and solicitors
- clothing and personal toiletries, other than ordinary household supplies. However the Provider is responsible for ensuring that these items are purchased by the Service User, their main carer or family and whānau as required and are consistent with the preferences of individual Service Users
- prescribed pharmaceuticals, including pharmacy dispensing fees or co-payments (note that if emergency supplies are required consideration should be given to achieving this at the least cost to the Service User – local Primary Health Organisation arrangements apply)

- doctors visits (note that if an emergency visit is required, consideration should be given to achieving this at the least cost to the Service User – local Primary Health Organisation arrangements apply)
- services provided by community nursing and allied health services eg, Community Oxygen Therapy
- continence consumables
- dressings for wound care
- any transport
- personal toll calls made by the Service User
- internet access

The Provider must ensure the Service User has access to these items, and should support the Service User to continue to source their consumables as they did prior to accessing short-term residential care. The Provider may supply them to the Service User if they choose to obtain the items from the Provider. The Provider is allowed to charge for these items if the Service User chooses to obtain them in this way, but the Provider must inform the Service User (and if applicable, their main carer) of the cost of items prior to purchasing them. The Provider must not charge the Service User for any items that are otherwise publicly funded.

The Service User is responsible for the safety, security and insurance cover of their own personal belongings, but the Provider must exercise due care and comply with relevant laws.

11. Quality Requirements

11.1 General

The Service must comply with the Provider Quality Standards described in the Operational Policy Framework³ or, as applicable, Crown Funding Agreement Variations, contracts or service level agreements.

11.2 Acceptability

The Service will be acceptable to Service Users and, as appropriate, their main carers, families, and whānau. This will be supported by Service User participation in on-going evaluation of the Service and by feedback contained in annual Service User satisfaction surveys which, where appropriate, include input from main carers, family, and whānau.

11.3 Effectiveness

The Provider will provide feedback to, and discuss any advice or information about the care of the Service User, with the main carer or family and whānau at the end of the placement, as agreed by the Service User.

³ <http://nsfl.health.govt.nz/accountability/operational-policy-framework-0>

11.4 Staff Training

The Provider will be responsible for employing staff for adequate hours for the needs of the Service Users to ensure 24-hour service provision. The Provider will have sufficient trained and experienced staff to provide a level of service relative to the Service User's assessed needs.

The Provider must undertake a planned, documented programme of staff development or in-service education, with at least 8 hours of programmes being provided annually, including courses attended other than at the facility. The Provider must keep a written record of staff attendance at such programmes. The Provider will ensure that the Services are delivered in a culturally appropriate manner. Staff should be able to demonstrate an appropriate level of cultural competence.

Where the Service is regularly provided to Service Users with behavioural support needs the Provider will use opportunities to use strategies of individual behavioural support plans to form the basis of up-skilling staff.

The Provider's staff training must include identification and management of abuse to Service Users. Where child abuse is observed or suspected, child protection agency procedures should be followed. Where elder abuse or neglect is observed or suspected the Family Violence Intervention Guidelines Elder Abuse and Neglect (2007)⁴ should be followed.

12. Purchase Units

Purchase Unit Codes are defined in Health New Zealand's Nationwide Service Framework Purchase Unit Data Dictionary.

The Service must comply with the requirements of national data collections where applicable. The following Purchase Units apply to this Service.

PU Code	PU Description	PU Definition	Unit of Measure
HOP1042	Short-term Residential Care (Day) for People with Main Carer-Residential Facility	Short-term care (between 6 and 8 hours) for older people with a main carer. Care is provided in a residential care facility to enable main carer to have a break from their caring role. Excludes Community Activity Programmes.	Day
HOP1043	Short-term Care for People with Main Carer-Residential Facility Rest Home Level Care	Short-term care for older people with a main carer. Care provided in a residential facility for rest home level care to enable main carer to have a break from their caring role.	Occupied Bed Day
HOP1044	Short-term Care for People with Main Carer-Residential Facility-Hospital Level Care	Short-term care for older people with a main carer. Care provided in a residential facility for hospital level care to enable the main carer to have a break from their caring role.	Occupied Bed Day

⁴ <http://www.health.govt.nz/publication/family-violence-intervention-guidelines-elder-abuse-and-neglect>

PU Code	PU Description	PU Definition	Unit of Measure
HOP1045	Short-term Care for People with Main Carer- Residential Facility- Dementia Level Care	Short-term break for older people with a main carer. Care provided in a residential facility for dementia level care to provide the main carer a break from their caring role.	Occupied Bed Day
HOP1046	Short-term Care for People with Main Carer- Residential Specialised Psycho-geriatric Level Care	Short-term care for older people with a main carer. Care provided in a residential specialised hospital for psycho-geriatric care to provide the main carer a break from their caring role.	Occupied Bed Day
HOP228	Emergency/Unplanned Care for older people- Residential Facility	Emergency/ unplanned short-term care for older people. Care is provided in a residential facility .	Occupied Bed Day
HOP236	Short-term Care (Day) for People without Main Carer- Residential Facility	Short-term care (between 6 and 8 hours) for older people without a main carer. Care is provided in a residential care facility . Excludes Community Activity Programmes)	Day
HOP237	Short-term Care for People without Main Carer- Residential Facility Rest Home Level Care	Short-term care for older people without a main carer. Care is provided in a residential facility for rest home level care to enable them to continue living at home.	Occupied Bed Day
HOP238	Short-term Care for People without Main Carer- Residential Facility Hospital Level Care	Short-term break for older people without a main carer. Care is provided in a residential facility for hospital level care to enable them to continue living at home.	Occupied Bed Day
HOP239	Short-term Care for People without Main Carer- Residential Facility- Dementia Level Care	Short-term care for older people without a main carer. Care provided in an Aged Residential Facility for dementia rest home care to enable them to continue living at home.	Occupied Bed Day
HOP240	Short-term Care for People without Main Carer- Residential Specialised Psycho-geriatric Level Care	Short-term break for older people, without a main carer. Care is provided in a residential specialised hospital for psycho-geriatric level care to enable them to continue living at home.	Occupied Bed Day
CHC0009	Short-term Care (Day) for People with CHC- Residential Facility	Short-term care (between 6 and 8 hours) for people with Chronic Health Conditions (CHC). Care is provided in a residential facility to enable them to continue living at home, and (if applicable) to enable the main carer to take a break from their caring role. Excludes Community Activity Programmes.	Day
CHC0010	Short-term Care for People with CHC- Residential Facility Rest Home Level Care	Short-term care for people with Chronic Health Conditions (CHC). Care is provided in a residential facility for rest home level care to enable them to continue living at home, and (if applicable) to	Occupied Bed Day

PU Code	PU Description	PU Definition	Unit of Measure
		enable the main carer to take a break from their caring role.	
CHC0011	Short-term Care for People with CHC– Residential Facility Hospital Level Care	Short-term care for people with Chronic Health Conditions (CHC). Care is provided in a residential facility for hospital level care to enable them to continue living at home, and (if applicable) to enable the main carer to take a break from their caring role	Occupied Bed Day
CHC0012	Short-term Care for People with CHC and Dementia- Residential Facility Dementia Level Care	Short-term care for people with both Chronic Health Conditions (CHC) and Dementia. Care is provided in a residential facility for dementia level care to enable them to continue living at home, and (if applicable) to enable the main carer to take a break from their caring role.	Occupied Bed Day
CHC0013	Short-term Care for People with CHC- Residential Facility Specialised Psycho-geriatric Level Care	Short-term break for people with Chronic Health Conditions (CHC). Care is provided in in a residential facility specialised hospital for psycho-geriatric level care to enable them to continue living at home, and (if applicable) enable the main carer to take a break from their caring role	Occupied Bed Day
CHC0014	Emergency/Unplanned Short-term Care for People with CHC- Residential Facility	Emergency/ unplanned short-term care for people with Chronic Health Conditions (CHC) Care is provided in a residential facility.	Occupied Bed Day

Unit of Measure	Unit of Measure Definition
	<ul style="list-style-type: none"> Day where care is between 6 to 8 hours. Can also be claimed as half days.
Occupied Bed Day	total number of beds occupied each day over a designated period. For reporting purposes, count beds occupied as at 12 midnight each day. Leave days, when the bed is not occupied at midnight are not counted. Counting formula is discharge date less admission date less leave days.

12.1 Death of Service User

The 24 hours after death will be paid as one day.

Providers will notify the DHB or needs assessment coordination service, of any Service User that dies in their care, with notification of the death including their NHI and date of birth.

13. Reporting Requirements

The reporting information is used by the Provider and Funder to monitor the scope and quality of service delivery. Other local specific reporting requirements for the Service may be specified by the Funder in the agreement Provider Specific Terms and Conditions.

Unless otherwise specified in the agreement, the following reporting information will be emailed to The Performance Reporting Team at: performance_reporting@health.govt.nz

The following information is to be reported as per the Information and Reporting Requirements.

PU Code	Frequency	Reporting Requirements
HOP236 HOP1042	Quarterly	<ol style="list-style-type: none"> 1. number of attendances during the reporting period 2. number of individual Service Users 3. number of Service Users new to the Service 4. number of rejected referrals <p>Narrative Report</p> <ul style="list-style-type: none"> • Feedback from Service Users on their experience. • Summary of complaints and action taken. • Reason for any rejected referrals. • Update on any service issues, including design development and delivery of new initiatives. • Describe any issues including risk management issues. • Identify gaps in service delivery.
HOP228 HOP237 HOP238 HOP239 HOP240 HOP1043 HOP1044 HOP1045 HOP1046	Quarterly	<ol style="list-style-type: none"> 1. number of occupied bed days that your service has been utilised during the reporting period 2. number of individual Service Users 3. number of Service Users new to the Service 4. number of rejected referrals <p>Narrative Report</p> <ul style="list-style-type: none"> • Feedback from Service Users on their experience. • Summary of complaints and action taken. • Reason for any rejected referrals. • Update on any service issues, including design development and delivery of new initiatives. • Describe any issues including risk management issues. • Identify gaps in service delivery.
CHC0009	Quarterly	<ol style="list-style-type: none"> 1. number of days that your service has been utilised during the reporting period 2. number of individual Service Users 3. number of Service Users new to the Service 4. number of rejected referrals <p>Narrative Report</p> <ul style="list-style-type: none"> • Feedback from Service Users on their experience. • Summary of complaints and action taken. • Reason for any rejected referrals. • Update on any service issues, including design development and delivery of new initiatives. • Describe any issues including risk management issues. • Identify gaps in service delivery.

PU Code	Frequency	Reporting Requirements
CHC0010 CHC0011 CHC0012 CHC0013 CHC0014	Quarterly	<ol style="list-style-type: none"> 1. number of occupied bed days that your service has been utilised during the reporting period 2. number of individual Service Users 3. number of Service Users new to the Service 4. number of rejected referrals <p>Narrative Report</p> <ul style="list-style-type: none"> • Feedback from Service Users on their experience. • Summary of complaints and action taken. • Reason for any rejected referrals. • Update on any service issues, including design development and delivery of new initiatives. • Describe any issues including risk management issues. • Identify gaps in service delivery.

14. Reporting Definitions

Term	Explanation
Service Users new to the Service	Service Users who have not ever used this Service before, in this DHB

15. Glossary

Not required

16. Appendices

16.1 Appendix 1: Guidelines for Contracting

Guidelines for Contracting Short-term Residential Care Services for People in Contracted Residential Facilities

Service Users

This service specification covers people of all ages (including children) who require a short-term stay in a residential care setting. It is not the intention of the service specification to mix age groups together for services, but to provide one platform for contracting a range of services. It is essential that services and settings are age appropriate. It is not appropriate for children or young people to receive short-term residential care in an aged residential facility.

Younger adults with early onset dementia should be provided short-term residential care appropriate to their age and needs wherever possible (eg, not within an aged residential care facility). However, there is an understanding that this may not be possible in smaller communities where a limited number of resources are available.

Setting

This service specification is intended to be flexible and cover a range of service models, such as, planned and unplanned respite. Some models already exist (eg, Short-term care in aged residential facilities) and there is potential for DHBs to create new models (eg. holiday homes that allow the carer to take a holiday with the Service User, Dementia specific services etc).

Consumables

Providers are not expected to fund wound care and continence products during a respite stay. Access to these consumables should already be provided to the Service User in the community, or via a ward from hospital. However if the Service User wants superior products they are able to source consumables themselves.

Providers should support the client to continue to source their consumables as they did prior to accessing short-term residential care. If another arrangement is required, this should be reflected in the Provider specific component of the contract.

Private Payers/Carers Support

Although Service Users accessing these services through the Carers Support Subsidy or by private payment are not covered by this service specification the expectation is that Service Users will not receive a lesser service. The Provider is able to take private paying clients as well as DHB funded Service Users and the DHB cannot influence the cost of the service between the Provider and private paying clients, as this is a private agreement. Some Providers may be able to source funding through other avenues eg, fund raising, which they may choose to use to subsidise private paying clients.

Payment for admission and discharge days

There is no longer a calculation for payment of admission and discharge days provided within the service specification. It is the DHB's responsibility to negotiate how the admission and discharge days will be paid. If charging of a part day is agreed, then there is the ability to part charge ($\frac{1}{2}$ or $\frac{1}{4}$) for an occupied bed day. The calculations can be included in the Provider specific component of the contract within the contract (examples: Admission day is charged as $\frac{1}{2}$ a day, and discharge as full day. Admission day is charged as $\frac{1}{2}$ day and discharge day as $\frac{1}{2}$ day. Admission and discharge days are charged as full days).

Staff Expertise and Training

The service specification sets out general training requirements and deliberately does not stipulate qualifications. This enables DHBs to ensure the Provider specific component of the contract contain the appropriate staff expertise and qualifications necessary for the particular service being contracted for, and that all Service Users needs are met.

16.2 Appendix 2: Guidelines for Compliance

Guidelines for Compliance with Non Age-mixing Provisions in Article 37(c) of the United Nations Convention on the Rights of the Child

Preface

These guidelines are to assist DHBs and other service providers in all health and disability residential and in-patient contexts to comply with article 37(c) of the United Nations Convention on the Rights of the Child (UNCROC), which requires that “every child [aged 17 and below] deprived of liberty be separated from adults unless it is considered to be in the child’s best interest not to do so”.

These age-mixing provisions of UNCROC apply to children and youth who are mandatorily detained under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MH (CAT)) or the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCC&R). However, the age-mixing principle is relevant for all children within in-patient and residential settings, therefore these guidelines should be applied to voluntary patients also.

The Ministry of Health recommends that mental health and disability services establish procedures that will ensure compliance with the standards set out in the UNCROC. District Area Mental Health Services and Care Managers should always refer to the Rights sections of the relevant legislation for further guidance on any matter. However, questions or feedback on these guidelines can be directed to the Office of the Director of Mental Health or the IDCC&R Operations Section at the Ministry of Health.

1 Definitions

1.1 Child

UNCROC defines a child as any person under the age of 18 years, unless under the law applicable to the child, maturity is attained earlier (article 1).

1.2 Age-mixing

There are separate adult and young persons in-patient units and residential facilities within, or funded by, DHBs. Disability Services also purchases many services on an age specific basis (i.e. respite). However, residential and secure services are generally purchased for adults, including those under IDCC&R.

Age-mixing refers to the practice of placing a child (under 18 year old) into an adult unit or an adult (18 years or older) into a youth unit. There are special circumstances under which this may be in the child’s best interest.

1.3 Best Interest

The provision that decisions should be based on the best interests of the child (article 3(1)) respects the concept that a child’s wellbeing should be the primary consideration when seeking to protect their rights.

2 UNCROC Principles

- 2.1** Relevant principles are to be found in article 37(c) of UNCROC, which provides that –
- 2.1.1 Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person and in a manner which takes into account the needs of persons of his or her age.
 - 2.1.2 Every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so.
 - 2.1.3 Every child shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances.
- 2.2** The requirements for non-age-mixing also take into account the following provisions; the child's best interests (article 3(1)), clinical safety (patient volumes; sufficient qualified staff to be safe (article 3(3)) and within resources available (article 4).
- 2.3** Article 3(1) provides that in all actions concerning children, the best interests of the child shall be a primary consideration.
- 2.4** Article 3(3) provides that institutions, services and facilities responsible for the care or protection of children are to conform with health and safety standards in particular the number and suitability of staff and supervision.
- 2.5** Article 4 requires that all appropriate measures for the implementation of economic, social and cultural rights within UNCROC be undertaken to the maximum extent of available resources.

3 Relevant legislation

- 3.1** Other relevant legislative principles are to be found in [Part 8, Special provisions relating to children and young persons](#), of the Mental Health (Compulsory Assessment and Treatment) Act 1992 and Part 2 section 12, Principles governing decisions affecting children and young persons, of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (see Appendix 2).
- 3.2** Section 86 and 89 of the MH (CAT) Act provide for a child psychiatrist to conduct assessment examinations and be involved in tribunal reviews for patients under the age of 17 years wherever practicable.
- 3.3** Section 12 of the IDCC&R Act ensures that the welfare of the child is considered in the context of the family and ensures the involvement of the family / whanau in decisions. This section also advocates that the child's wishes are considered and that decisions are implemented within a suitable timeframe. However, section 138 of the IDCC&R Act states that nothing in the Children, Young Persons and Their Families Act 1989 is to be interpreted as limiting the application of the IDCC&R Act.
- 3.4** The Criminal Procedure (Mentally Impaired Persons) Act 2003 covers all those charged with an imprisonable offence and found guilty or unfit to stand trial, or those acquitted on account of insanity. These offenders can be detained under the MH (CAT) or IDCC&R Act in a hospital or secure facility.
- 3.5** In 2005, advice from Crown Law stated that the Criminal Procedure (Mentally Impaired Persons) Act 2003 (CPMIP) and, consequently, the IDCC&R Act could be applied in the Youth Court. This has led to higher numbers of youth being released into services that were predominantly designed for adults, increasing the need for protection of a child's right to separation from adults.

4 Guidance for compliance with Article 37(c)

- 4.1** Article 37(c) of UNCROC requires that “every child deprived of liberty be separated from adults unless it is considered to be in the child’s best interest not to do so”. Therefore, those aged under 18 years should be admitted to facilities specifically designed for children and adolescents, with distinct child-centred staff, personnel, policies and practices.
- 4.2** The Nationwide Service Specifications for Child, Adolescent and Youth Mental Health Services states the age of eligible users as 0-19 years recognising that chronological age may not be the best indicator of service appropriateness. Adult mental health and Alcohol and Other Drug service provision begins at 18 years. The two year overlap allows flexibility to access the most appropriate service based on emotional, physical and social maturity, and clinical need.
- 4.3** The most appropriate service to meet the needs is to be determined clinically by or in conjunction with a child and adolescent specialist. Health services require an agreed mechanism for determining and ensuring access to put this into effect.
- 4.4** Within the context of service flexibility the concept of best interests of the child should be considered paramount (article 3(1)). A youth user may be treated in an adult service if it is thought to better meet their needs than the alternative and an adult may be admitted to a youth unit so long as it is not to the detriment of those children around him / her.
- 4.5** Upholding the right of detained children to separation from adults should not be limited by financial or resource constraints. DHBs should take measures to ensure children are separated from adults to the maximum extent of available resources (article 4). There is a margin of discretion in meeting needs in the most appropriate way and taking steps to progressively realise the right to separation.
- 4.6** A balance must be sought between competing interests for the child. For example, a child’s needs may be better met by providing child and adolescent specialist input to treatment in an adult setting close to family than by admitting the child to a child in-patient unit in another city in circumstances where family could not participate in treatment. Other situations in which age-mixing of children and adults may be appropriate and consistent with UNCROC are:
- a 16- or 17-year-old youth is temporarily admitted to Adult Mental Health Services, when urgent treatment is required and no other options are available, until a bed in a youth facility becomes available
 - a suitably mature 16- or 17-year-old youth is referred to Adult Mental Health Services or an adult residential unit, when no other options are available, to avoid solitary confinement due to low numbers of similar youth
 - a 19-year-old turning 20 in a youth unit is permitted to remain for continuation of treatment if in the person’s best interest and not contrary to younger children’s best interests
 - a vulnerable young adult over 18 years is accepted into a youth mental health unit or residential unit to be more appropriately treated with those who have similar developmental needs
 - where a mother is permitted to keep her infant with her in an adult inpatient setting.
- 4.7** For 15-year-olds when there is no youth in-patient alternative available it would usually be preferable to provide care in a paediatric setting than an adult one.
- 4.8** In all situations it is the interests of the under-18-year-olds that must be protected. In all situations specialist child and adolescent clinicians must be involved in placement decisions and in the child’s treatment as soon as practicable after admission.

5 Best Interests Assessment

- 5.1** In order to comply with article 37(c) of UNCROC, there must be reasonable grounds for deciding that placing a child in a facility that does not allow separation from adults is in their best interests.
- 5.2** Although no conclusive definition can be given, the wellbeing of a child will depend on the individual circumstances of each case; the age, clinical needs and maturity of the child and the nature of the health problems.
- 5.3** Wherever practicable the best interests assessment should be conducted by a specialist child and adolescent psychiatrist or senior child and youth clinician.
- 5.4** To determine a child's best interests, the psychiatrist, specialist assessor or responsible clinician must consider all relevant clinical or personal information. Safety, family and close relationships, developmental and clinical needs and the views of the child are important factors to consider.
- 5.5** These factors provide a checklist to guide clinicians in deciding which, among the available options, better secures the attainment of the child's needs and rights. The weight given to each factor will vary according to the individual child and their situation.

6 Guidance for when age-mixing is considered to be in the best interests of the child

- 6.1** The Ministry of Health expects that, when age-mixing is considered to be in the best interests of the child, certain protective measures are put in place.
- 6.2** Services should have protocols for referral of youth to adult facilities and vice versa that address the priority of needs and joint care or consultation arrangements.
- 6.3** A child and adolescent psychiatrist or senior child and adolescent clinician should be involved in determining whether best interests are met post-assessment and work closely with adult psychiatrists and clinicians during the duration of the admission.
- 6.4** The adult service should ensure access to age appropriate specialist care via other child and adolescent mental health services (CAMHS), Paediatric services or services with expertise in caring for children with disabilities such as Child Development Centres (CDCs).
- 6.5** Appropriate Child, Youth and Family (CYF) services can be consulted to provide support to the child and/or family and should be involved where the child is in CYF care.
- 6.6** The adult service provided will reflect the special needs and safety of these service users, with respect to family, staffing, treatment and provision for parents / whanau / caregivers.
- 6.7** A precautionary plan in age-mixing situations must include awareness of the young person's potential physical, emotional and sexual vulnerability (level of supervision, visiting policies and smoking and other drug use policies may need modification).
- 6.8** The young person will have access to appropriate therapeutic and recreational activities and their educational needs will be met.
- 6.9** The child's links with family / whanau, hapu, iwi, and family group should be managed and maintained through correspondence, visits and video conferencing.
- 6.10** Staff should be made aware of the rights of the young person and additional provisions for those under the age of 17⁵.

⁵ As in Part 8 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

- 6.11** An area of an adult unit should be identified for admissions for young people, under exceptional circumstances, so that in such cases staff members are as familiar as possible with working with these patients.
- 6.12** DHBs and service providers will notify the Ministry of Health of any instances of age-mixing.

7 Reporting requirements

- 7.1** The Ministry of Health must be notified of all instances where a DHB or service provider does not comply with the non-age-mixing requirement, that all those aged 17 or under are separated from adults. This applies to situations where an under 18 year old is placed in an adult unit and when an adult is placed in a young persons unit. The reporting requirements apply to children that are mandatorily detained to meet UNCROC provisions but services should also report on age-mixing of voluntary patients.
- 7.2** The DHB or service provider must be able to provide a comprehensive justification for age-mixing that confirms it is in the best interest of the child and not be restricted by financial aspects. Services should be prepared to provide a robust clinical assessment of the risk and benefits of the situation and the alternative options considered.
- 7.3** Notifications will enable the Ministry of Health to monitor New Zealand's progress with compliance of Article 37(c). The reporting is for information and awareness purposes rather than for investigation.
- 7.4** Disability Services and Directors of Area Mental Health Services have direct reporting responsibility for critical incidents on a quarterly basis, which will include cases of age-mixing.

Best Interests Assessment Checklist

Safety

Fundamental international human rights norms are to protect the right to life and physical safety. Therefore, clinical safety would normally outweigh any other factor.

Considerations for safety include:

- need for secure care
- risk of harm to self or others
- substance use / abuse
- level of supervision required and capacity of service to provide this (staff numbers and competency)
- vulnerability (especially survivors of abuse)
- risk of and from exposure to adult behaviour (eg, sexual behaviour, substance use, psychosis, aggression and restraint of acting-out adult patients)
- level of specialised care by child psychiatrist required (capacity to do this)
- adequacy of facilities for youth (visitation / recreation / privacy), environment that recognises the special physical, cultural, and emotional needs of children and young people.

Family and close relationships

One of the fundamental principles for child and youth mental health is for services to be family centred. Aspects of family and close relationships are likely to be highly important to the welfare of the child, and should be part of the best interest decision process. The

decision to place a child in a geographically removed location from his or her parents should only be taken if their needs cannot be addressed in a closer facility.

Considerations for family and close relationships include:

- proximity to family / caregivers / other support network and options for maintaining therapeutic contact with family
- quality of family relationships and the potential effect of separation
- the views of the family / whānau
- the stability of the family given that intervention into family life should be the minimum necessary to ensure a child's or young person's safety and protection.

Developmental and clinical / treatment needs of the child

Children and youth have unique mental health needs that are different from those of adults. A developmental approach is taken when treating children.

Considerations for developmental and clinical / treatment needs are:

- the social development opportunities / constraints in each option
- learning and educational needs
- intellectual capacity / disability
- ☐ the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child
- available options for mixing young person with clinically similar young adults
- the possible detrimental effects of the alternative (isolation)
- suitability of the clinical treatment model / programme(s) to meet needs (re: age, sex, developmental stage, clinical diagnosis, interest, capability)
- willingness and capacity to engage in the programme
- capacity of programme to meet other health needs
- capacity of programme to meet education needs in an in-patient setting.

Views of the child

A decision that is in the best interests of the child is likely to be that which takes account of the views of the child.

Consider:

- the child's competency to comprehend and assess the implications of the options
- the views of the child, giving due weight in accordance with the age and maturity of the child
- the mental state of the child
- any previous contact the patient or proposed patient has had with other mental health service providers
- the impact of a placement in conflict with the child's views

Relevant Legislation

Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003

Part 2: Principles and general duties

Section 12: Principles governing decisions affecting children and young persons

Whenever a court or a person exercises, or proposes to exercise, a power conferred by or under this Act over a child or young person, the court or person must be guided by any of the following principles that are relevant to the exercise or proposed exercise of the power:

- (a) wherever possible, the family, whanau, hapu, iwi, and family group of the child or young person should participate in the making of decisions affecting the child or young person, and, accordingly, regard should be had to the views of the family, whanau, hapu, iwi, and family group:
- (b) wherever possible, the links of the child or young person with his or her family, whanau, hapu, iwi, and family group should be maintained and strengthened:
- (c) a decision affecting the child or young person may be taken only after consideration of the likely impact of the decision:
 - (i) on the welfare of the child or young person; and
 - (ii) on the stability of the family, whanau, and family group of the child or young person:
- (d) consideration should be given to the wishes of the child or young person, to the extent that those wishes can reasonably be ascertained, and those wishes should be given the weight that is appropriate in the circumstances, having regard to the age, maturity, and culture of the child or young person:
- (e) decisions affecting the child or young person should, whenever practicable, be made and implemented within a time frame that is appropriate to the sense of time of the child or young person.

Section 138: Orders under Children, Young Persons and Their Families Act 1989

An order made under the Children, Young Persons and Their Families Act 1989 in respect of a child or young person does not stop the application of the provisions of this Act to that child or young person.

Mental Health (Compulsory Assessment and Treatment) Act 1992

Part 8: Special provisions relating to children and young persons

Section 85:

Application

In respect of any patient or proposed patient who is under the age of 17 years, the other provisions of this Act shall be read subject to the provisions of this Part.

Section 86:

Assessment examination

Wherever practicable, an assessment examination of a [proposed patient] who is under the age of 17 years shall be conducted by a psychiatrist practising in the field of child psychiatry.

Section 87:

Age of consent

Notwithstanding anything in [section 36 of the Care of Children Act 2004] or any other enactment or rule of law to the contrary, in respect of a patient who has attained the age of 16 years, the consent of a parent or guardian to any assessment or treatment for mental disorder shall not be sufficient consent for the purposes of this Act.

Section 88:

Brain surgery

Notwithstanding anything in Part 5 or section 87 of this Act, brain surgery shall not be performed for mental disorder on any person who is under the age of 17 years.

Section 89:

Membership of Review Tribunal

Wherever practicable, for the purposes of a review by a Review Tribunal of the condition of a patient who is under the age of 17 years, 1 member of the Tribunal shall be a psychiatrist practising in the field of child psychiatry.

Section 90:

Review of patient about to attain age of 17 years

- (1) This section applies to every patient who is subject to a compulsory treatment order and who will attain the age of 17 years before the expiry of the compulsory treatment order.
- (2) Not earlier than 2 months and not later than 1 month before the date on which the patient will attain the age of 17 years, the responsible clinician shall review the patient's condition.
- (3) The provisions of subsections (3) to (9) of section 76, and the succeeding provisions of Part 7, of this Act, so far as they are applicable and with any necessary modifications, shall apply in respect of every review under this section.

United Nations Convention on the Rights of the Child

Article 3

Article 3(1) - In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

Article 3(3) - States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.

Article 4

Article 4 - States Parties shall undertake all appropriate legislative, administrative and other measures for the implementation of the rights recognized in the present Convention. With regard to economic, social and cultural rights, States Parties shall undertake such measures to the maximum extent of