The funding figures for specialist AOD services represents only that funding provided through Vote Health and excludes funding from other sources (e.g. Dept. of Corrections).

A PROFILE OF

AOD ALCOHOL & OTHER DRUG Treatment Services

in Aotearoa New Zealand

Unmet mental health and addiction needs are the single largest contributor to poor health and social outcomes at the client, family, whānau and population levels.

- *Invest in the Alcohol & Other Drug sector, especially in NGO services.*
- *Keep building a strong and capable mental health and addiction workforce.*
- *Improve access to Alcohol & Other Drug treatment services.*

SOURCES

1. Mental Health Commission (2012) National Indicators 2011: Measuring Mental Health and Addiction in New Zealand. Mental Health Commission. Wellington. New Zealand.
2. Ministry of Health Mental Health Spend File.
3. Ministry of Health PRIMHD data.
4. National Committee for Addiction Treatment (2011) Addiction treatment is everybody's business. Where to from here? NCAT. Wellington. New Zealand.
5. Oakley Brown, M.A. Wells, E., & Scott, K. M. (Eds.). (2006). Te Rau Hinengaro: The New Zealand Mental Health Survey. Ministry of Health, Wellington.
6. Todd, F.C. (2010) Te Ariari o te Oranga: the Assessment and Management of People with Co-existing Mental Health and Substance Use Problems. Ministry of Health, Wellington.
7. Wells, J.E., Baxter, J. & Schaaf, D. (Eds.). (2007). Substance use disorders in Te Rau Hinengaro: The New Zealand Mental Health Survey. Wellington. Alcohol Advisory Council of New Zealand.
8. Health Workforce New Zealand (2012) Towards the Next Wave of Mental Health and Addiction Services & Capability: Workforce Services Review Report. HWNZ. Wellington.

National Committee for Addiction Treatment

PLATFORM

WHO NEEDS AOD TREATMENT SERVICES?

12.3%[5] of the population will experience a substance use disorder at some stage in their lives.

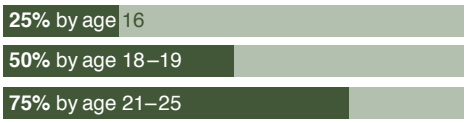
3.5% per year **1.5%** per month

will experience harmful effects from their substance abuse.[5]

150,000[5] **NEW ZEALANDERS** aged 16 and older experience substance use problems that could benefit from an intervention.

Impact on young people

Most people experience the onset of their substance use disorder early in their lives[7]:



People aged 16–24 are the least likely to seek help than any other age group.

82% of pregnant teenagers drank alcohol during pregnancy

Lifetime Prevalency[5]

Aged 16–24 years:

All	18.8%
Māori	33.4%
Pacific	19.6%

All Ages:

All	12.3%
Māori	26.5%
Pacific	17.7%

Impact on whānau, family and friends

At least **four others are negatively affected** by one person's problems with AOD. Addiction problems impact on individuals, whānau, friends, employers, colleagues and communities.

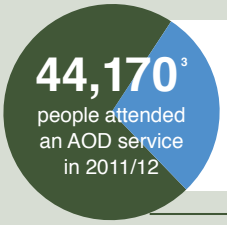
Majority of the people caught up in the criminal justice system have problems with AOD.

Alcohol and other drug abuse, an avoidable health cost, is the sixth highest contributor to the burden of disease in New Zealand .

WHO IS ACCESSING AOD TREATMENT?

The unmet need for help with "substance dependence" is significant.

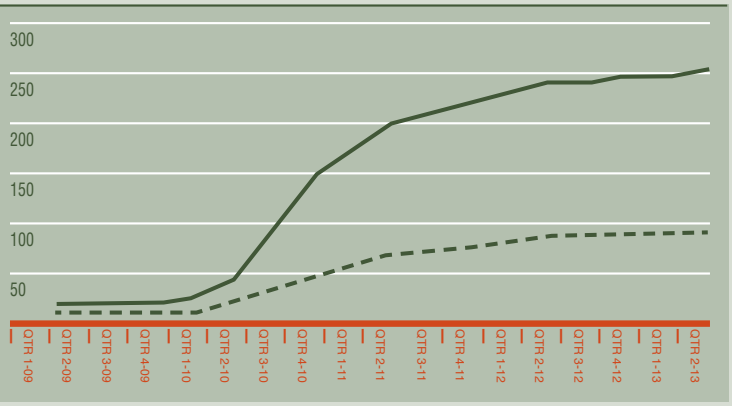
In 2007/08, 1.9% of the population aged 16–64 had wanted help to reduce their alcohol or drug use in the last 12 months, but had not received it, which equates to around 50,000 people.[1]



Less than 1/3[5] of people with a substance use disorder had sought help for their problems in the previous year.

Number of NGOs reporting to PRIMHD, Total and AOD

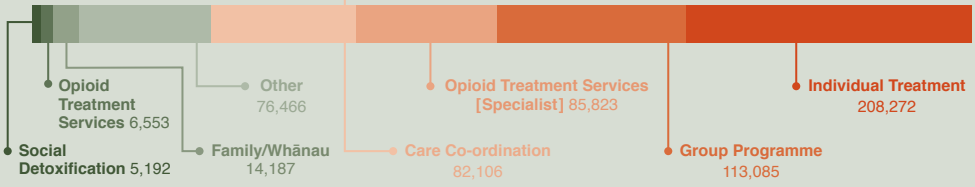
NGOs are now reporting to PRIMHD, which explains the sudden increase in figures from 2009/10.



Median time between Onset and Service Contact

Most people with lifetime substance use disorders tend to take a long time to make contact with treatment services.

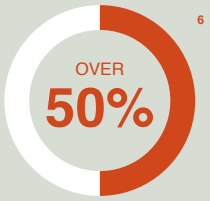
Face-to-face AOD Contacts by Service Type[3]



WHO HAS CO-EXISTING PROBLEMS (CEP)?

OVER **70%**[6] who attend addiction services are likely to have co-existing mental health problems.

People who present to both addiction and mental health services in New Zealand are likely to have co-existing addiction, mental health and gambling problems.



[6]

of people who attend mental health services are likely to have co-existing substance use problems.

[6]

of people who attend a problem gambling service are likely to have a co-existing mental health or substance use problems.

[3]

of people attending mental health or addiction services have more than one diagnosis entered into PRIMHD.

Person-focused services respond to the needs of people with co-existing problems by:

- Screening everybody who comes to the service for co-existing problems.
- Providing brief interventions for mild co-existing problems.
- Providing integrated care alongside specialist services for more complex co-existing problems.
- Entering co-existing problem diagnoses into PRIMHD.

"Any door is the right door."

All mental health and addiction services need to be person-focused to ensure "any door is the right door" for people when they want help. The expectation is that all mental health and addiction services will become CEP capable.

Person-focused treatment

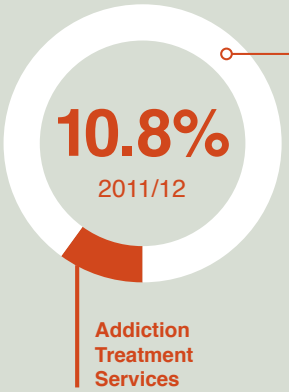
Te Ariari o te Oranga: The Assessment of Management of People with Co-existing Mental Health and Substance Use Problems' (Todd, 2010), provides detailed clinical guidance to services and health professionals and should be used to inform clinical practice.

WHO WORKS IN THE AOD SECTOR?

The addiction workforce in New Zealand is heterogeneous and comprises a range of different disciplines working in a variety of roles and settings.

AOD workers are based in specialist addiction services and in addictions programmes run by non-addictions services.

"People with addictions have a proud history of creating self-help recovery organisations that are self-sustaining. Professional service delivery systems need to maintain close links with the self-help movement to maximise gains."



Mental Health & Addiction Budget

10.8% of the total mental health and addiction budget (2011/12) is spent on addiction services. In the future more people with addiction problems will be managed in primary care and in other settings.

This shift to primary care will mean that the addictions workforce will need to provide more consult liaison services to GPs and to a more generalist workforce.

1,500 PEOPLE

worked in specialist AOD treatment services in 2008.

2008 National Telephone Survey –

The specialist addiction workforce was made up of:

58% Counsellors

16% Social Workers

15% Nurses

2% Psychologists

2% Medical Practitioners

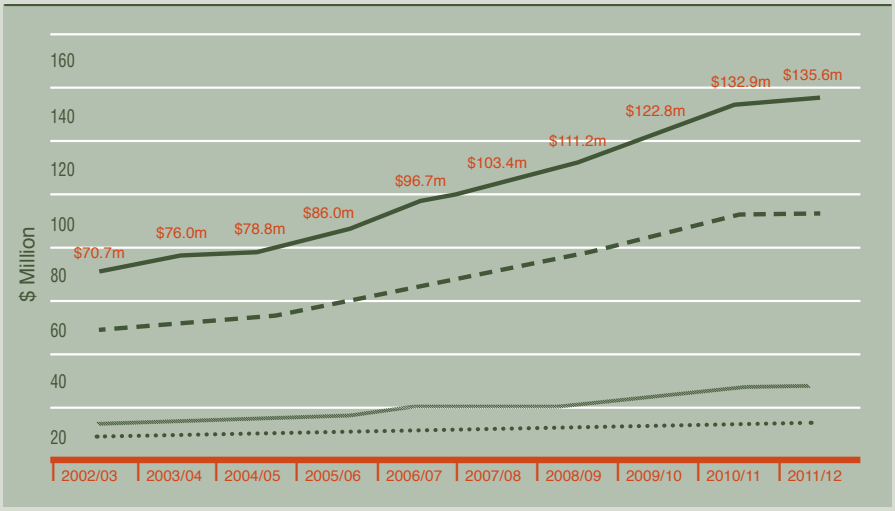
HOW MUCH FUNDING IS GOING INTO THE AOD SECTOR?

$134.7 million

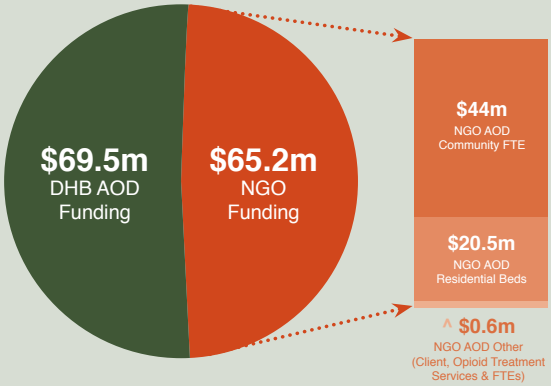
was directed to AOD services in 2011/2012[2]

10.8% of the total funding for mental health & addiction services ($1.25b) went into AOD treatment providers in 2011/12.[2]

Trend from 2002/03–2011/12



By NGO Service – 2011/2012[2]



Health Workforce NZ estimate.[8] (HWNZ)

BY YEAR **2020**

- ↑ 100% increase in demand for health services.
- ↑ 30–40% increase in funding.

WHAT ARE THE OUTCOMES FOR AOD CLIENTS?

Measures of outcome for the population

An effective addiction treatment sector will have a cumulative impact on a range of population health indicators including health, disability, welfare dependence, crime, family violence and education.

The sector needs to develop a system-wide perspective on the client journey. This will require a collaborative approach between health professionals, service users and organisations.

Measures of outcome for the individual clients

The Alcohol and Drug Outcome Measure (ADOM) is a client outcomes measure for people engaged with adult community outpatient alcohol and drug treatment services. ADOM has been developed for the purpose of measuring changes in substance use, aspects of functioning, lifestyle, wellbeing and recovery during the client's engagement with the service.

The ADOM is completed in collaboration between the clinician and the client.

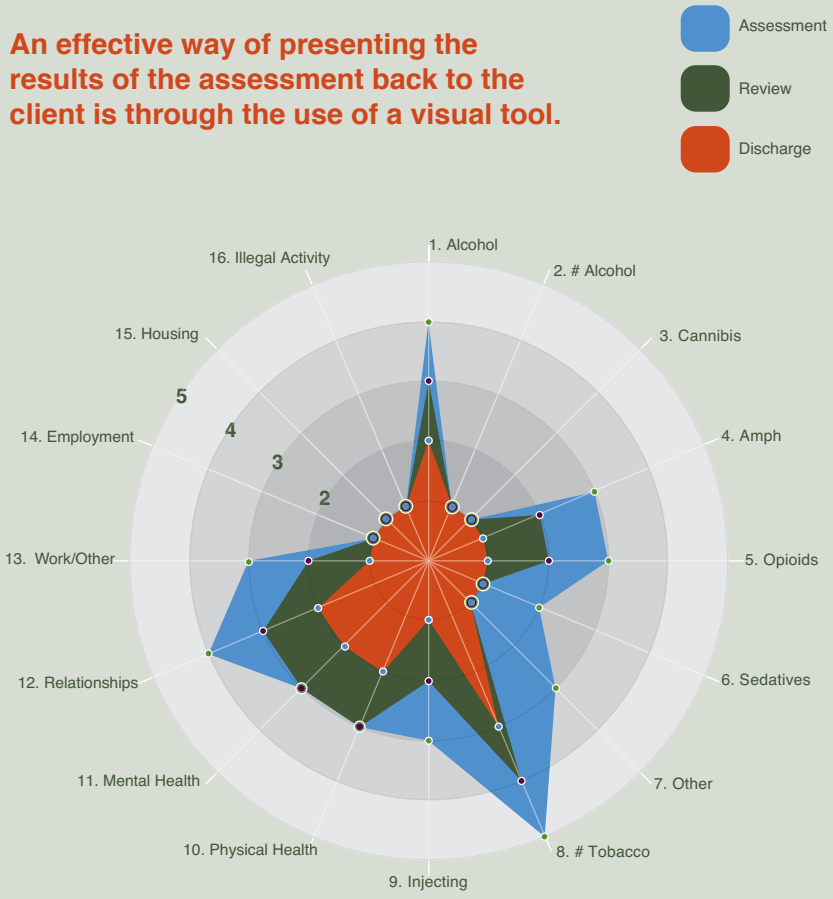
ADOM

Alcohol and Drug Outcome Measure

ADOM implementation within services relies on a number of best practice strategies that have proven to be successful in the pilot sites. These strategies include:

- informed addiction service managers/clinical leaders who will drive the implementation.
- clinician and service level buy-in, that ensures that ADOM is incorporated into best/current clinical practice.
- an ADOM information (data collection and reporting) system in place.
- ADOM trainer(s) trained and resourced to support ongoing implementation with clinicians.

An effective way of presenting the results of the assessment back to the client is through the use of a visual tool.



MORE INFO: *www.matuaraki.org.nz/supporting-workforce/adom*