

**A National Strategic
Framework for
Alcohol and Drug Services**

**Published in October 2001 by
the Ministry of Health
Manatū Hauora
Wellington, New Zealand
ISBN 0-478-24381-2 (Book)
ISBN 0-478-24382-0 (Internet)
HP 3444**

**This document is available on the Ministry of Health's Web site:
<http://www.moh.govt.nz>**



MANATŪ HAUORA

Foreword

The Ministry of Health is pleased to release *A National Strategic Framework for Alcohol and Drug Services*. This document was written initially for the Health Funding Authority to provide a national direction for the ongoing development of alcohol and drug¹ treatment services. The action points included were developed after a period of information gathering and consultation and is covered in two separate documents which provide background to this strategy:

- *National Alcohol and Other Drug Services Funding Strategy: Background document*
- *National Alcohol and other Drug Services Funding Strategy: Analysis of Submissions*.

The focus of this national strategic framework is on increasing the capacity of the specialist alcohol and drug treatment sector, both in terms of service delivery and workforce. Workforce development is fundamental to the sector becoming better equipped to meet the ever-increasing demands.

In order to move towards a national alcohol and drug workforce development framework there needs to be better co-ordination and resourcing of alcohol and other drug training. Without a national focus specifically on alcohol and drug workforce development, it is unlikely that many of the other issues identified in the alcohol and drug sector can be progressed.

Implementation of this strategic framework will also involve resource allocation and prioritisation. Given that demand often outstrips availability the Ministry of Health's funding principles will guide the use of the limited resources available to bring services up to the levels required.

This strategy does not address all the problems identified in the alcohol and drug sector. Many of the issues are complex and long-standing and require more discussion than was possible within the scope of this strategy. It is intended that this strategy become a future resource for the Ministry of Health, providers, consumers/tangata whaiora, local communities and DHBs when making future funding and delivery decisions regarding alcohol and drug treatment services. It will assist in prioritising the work that still needs to be done in achieving a high quality professional alcohol and drug treatment sector.

I would like to thank the many people who contributed to this project. The Ministry of Health received considerable help from the National Advisory Group and others in the sector. Those who shared their knowledge, experience and time helped to identify the key issues and shaped the direction outlined in this strategy. The Ministry would especially like to acknowledge the work done by Phillipa Gaines and Terry Huriwai.

Further copies of this strategy, the background document and the analysis of submissions are available on request by contacting Wickliffe (04) 496 2277, who hold Ministry of Health publications or on the Ministry of Health website www.moh.govt.nz.

A handwritten signature in blue ink, appearing to read 'Janice Wilson', with a horizontal line underneath.

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1 Introduction

The Ministry of Health has produced this strategy to assist with the development of alcohol and other drug treatment services for people with substantial to severe substance use related problems.

Many New Zealanders use caffeine through the consumption of tea and coffee whilst significant sections of our population regularly consume alcohol and use tobacco. An increasing number are also using illegal drugs as well as misusing prescription medicines. Untreated substance abuse and dependency have large economic, health and social costs, both to the individual and the wider community. This is most notably reflected in health, social services and criminal justice expenditure. The National Drug Policy (NDP) recognises the continuum of harm associated with substance use and that no single approach or set of strategies can adequately address the possible range of harm.

The goal of this strategy reflects the national goal expressed in the *National Drug Policy* and in *The New Zealand Health Strategy*, 'as far as possible and within available resources, to minimise harm caused by excessive alcohol and other drug use to individuals and the community'. The development of this strategy has been based on the priorities and objectives expressed in the National Drug Policy, *Moving Forward* and the *National Mental Health Funding Plan 1998–2002*.

1.1 Background

Prior to this work, the Health Funding Authority (HFA) completed a background paper that was a 'snapshot' of the alcohol and drug treatment field. That work highlighted key issues and possible future directions for the sector. It was distributed for wider consultation and the results of the consultation have informed the development of this strategy. Both these documents are available.

The following documents provide policy direction relevant to this strategic framework:

- *Moving Forward* (Ministry of Health 1997) clearly positioned alcohol and drug treatment within the mental health structure and highlighted the National Drug Policy as the key related strategy.
- The *National Mental Health Funding Plan 1998–2002* (HFA 1998) – specified a number of targets for the development of alcohol and drug services.

- The *National Drug Policy* (Ministry of Health 1998) and its allied *National Alcohol Strategy 2000–2003* (ALAC 2001) aimed to provide a framework for intersectoral decision-making about where the greatest drug-related harm is occurring and the best means for addressing this. The National Drug Policy also articulated the harm minimisation approaches of supply reduction, preventative demand reduction and targeted harm reduction strategies.
- Government policy that specifically addresses the disparities in health status of Māori and Pacific peoples.
- The *New Zealand Health Strategy* (King 2000) set the platform for the Government's actions on health and signalled a shift towards a population health framework that better recognises that populations are not homogenous in health status, thus providing a focus on tackling inequalities in health.

1.2 Focus of the strategy

The immediate focus of this strategy is on increasing the capacity of the specialist alcohol and drug sector, both in terms of service delivery and workforce. It is one thing to fund more services, quite another to ensure that the workforce is both available and sufficiently trained to deliver appropriate treatment interventions.

Workforce development is fundamental to the sector becoming better equipped to meet increasing demands from inside and outside the sector for more professionalism. In order to move towards a national alcohol and drug workforce development framework, there needs to be better co-ordination and resourcing of alcohol and other drug training. Without a national focus specifically on alcohol and drug workforce development, it is unlikely that many of the other issues identified in the alcohol and drug sector can be progressed.

Within health, resourcing for the continuum of alcohol and drug-related matters primarily comes from the Public Health, Personal Health and Mental Health directorates of the Ministry of Health. The Mental Health Directorate oversees District Health Board funding of alcohol and drug treatment services and related alcohol and drug workforce development.

Currently there is a substantial shortfall in funds available to bring services up to benchmark levels. Implementation of this strategy will involve resource allocation and prioritisation based on the Ministry of Health's funding principles. The following special populations have been prioritised in order of ranking for future service consolidation and development:

- Priority one: Development of Māori-responsive alcohol and drug treatment services, particularly kaupapa Māori services.
- Priority two: Development of Pacific peoples' alcohol and drug treatment services.
- Priority three: Development of specialist child and youth alcohol and drug services.
- Priority four: Development of specialist alcohol and drug treatment services for consumers/tangata whaiora with complex and/or severe needs (for example, co-existing disorders).
- Priority five: Development of the alcohol and drug treatment workforce.

The order of priority reflects the emphasis that funders need to place on developing services for these at-risk groups while consolidating the gains made in other core specialist alcohol and drug services. National and regional planning also needs to ensure equity in resource allocation and take account of the needs and benefits of different services for certain groups.

In setting the above priorities, the strategy focused on alcohol and drug services that offer treatment interventions to the 3 percent of the population with substantial to severe alcohol and drug related problems. Frequent challenges were made at all stages of the development of this funding strategy regarding the applicability of the 3 percent benchmark. Research indicates that substance abuse and dependence figures may be as high as 6 percent for the general population and 8 percent for the Māori population.

However, limiting the focus to those specialist services funded to deliver to the 3 percent of the population with the most severe alcohol and drug related problems over a six-month period is in line with the Ministry's benchmark for access to services. The scope has also been confirmed by the Mental Health Commission, based on its review of current services, as well as by evidence from international epidemiological studies including information related to alcohol and drug abuse. The Ministry of Health accepts targets will continue to be reviewed as part of the National Mental Health Strategy and as additional information and evidence becomes available.

This strategy does not address all the problems identified in the alcohol and drug treatment sector. Many of the issues are complex and longstanding and require more discussion than was possible within the scope of the project. It is intended that this strategy will be a resource for the Ministry of Health, providers, consumers/tangata whaiora, local communities and the DHBs when making future funding and delivery decisions regarding alcohol and drug treatment services. It is envisaged that it will assist in prioritising the work that still needs to be done in achieving a high-quality professional alcohol and drug treatment sector.

Shifting to District Health Boards with a population-based health funding approach creates an opportunity for more integrated service development across primary health care and secondary health care. The problems related to alcohol and drug use cannot be addressed by focusing on specialist treatment services alone. The *Canadian Addiction and Population Health Symposium Report 1999* acknowledged that substance abuse does not neatly fit into a population health

model in that substance abuse and dependence is complex and there is a lack of understanding of all of the contributing factors. Nevertheless, it was felt that addictions have an important place in the model and that it is a useful framework for strengthening intersectoral arrangements and examining trends.

For this reason, both public health and primary health initiatives have been included as an appendix to this document. For the strategy to be effective, it will require collaboration with primary and public health sectors, consumers, providers and other stakeholders including intersectoral initiatives.

Integral to the vision for the strategy is an emphasis on the important role consumers/tangata whaiora play in developing alcohol and drug policy, participating in service planning and monitoring and evaluation.

1.3 The vision for services in the future

The New Zealand Health Strategy is the Government's framework within which District Health Boards and the health sector will operate. It highlights a shift towards a population health framework that better recognises that populations are not homogenous in health status. The population health framework is a way of examining the differences in health status among and within populations. In New Zealand this is particularly important in terms of meeting treatment needs of the tangata whenua, vulnerable and at-risk groups as well as other special populations.

Alcohol and drug-related problems occur within a social context, and there is a growing acknowledgement that factors external to the health care system can and do affect the health and wellbeing of individuals, communities and the population as a whole. We therefore need to be mindful of the complex interrelationship of biological, psychological, cultural and social aspects of alcohol and other drug use when thinking about promoting 'wellness' at one end of the care continuum and developing a range of effective specialist treatment interventions at the other.

There is also a growing recognition that health services need to adapt to meet the needs of consumers/tangata whaiora rather than trying to fit all consumers/tangata whaiora into generic programmes. The challenge for service providers and planners is to design treatment interventions that work for individuals and that are flexible enough to consider and incorporate new ways of reaching at-risk groups. Treatment services need to enhance their professional profile in their local community as high-quality specialist services that offer both treatment services and consultation liaison services within a wider network of primary community health and social services.

Part of this challenge includes the specific formalised involvement of consumers/tangata whaiora in the development of alcohol and drug policy, funding, service planning and evaluation of treatment interventions. With this input we can improve methods of delivering alcohol and

drug services and minimising alcohol and drug related harm.

The following sections cover the vision for alcohol and drug treatment services in New Zealand and the underlying funding principles as they apply to treatment services. They link the objectives of this strategy to the goals and strategic directions of two Government documents: The *National Drug Policy* and *Moving Forward*. Some targets have been included in this strategy, but a more detailed national workplan is required to specifically address the service gaps and to indicate how the objectives can be applied at the district level, regionally and nationally.

1.4 What does 'alcohol and drugs' cover?

Throughout this document, alcohol is acknowledged as another psychoactive substance (hence the term alcohol and other drugs) and, unless otherwise stated, 'drugs' refers to illicit drugs, volatile and other substances used for psychoactive effects, as well as prescription and pharmacy-only drugs used outside of medical or pharmaceutical advice.

Nicotine is one of the most addictive substances, definitely contributes to premature death and health costs, and has been associated with being a gateway drug to illicit drug use. Notwithstanding this, and despite the fact that nicotine tolerance, dependence and withdrawal often require specialist treatment, the definition of 'other drug' does not include tobacco in this strategy. Tobacco is covered by Public Health funding and is also included in the National Drug Policy.

This funding strategy has been prepared for a general audience and contains terms that may not be familiar to a number of readers. Short definitions of some of these key terms are provided in the glossary at the end.

2 National Consistency and Prioritisation

It is important that a wide range of treatment options is available to those with alcohol and drug-related harm, since no one approach can be effective for all consumers/ tangata whaiora. Planning for future services relies on some system of prioritisation given that the demand for services outstrips their availability. The principles guiding prioritisation are:

- **Effectiveness:** funders of services will use the best information available to evaluate the extent to which services are contributing to the goal of minimising harm caused by excessive alcohol and drug use.
- **Cost:** the total economic costs of services, including flow-on effects, will be considered together with the effectiveness of those services to ensure available funding is used to achieve the maximum possible gain in health and independence.
- **Equity:** considerations of equity must be taken into account in decisions about resource allocation, access to services and outcomes for special populations and communities.
- **Māori health:** funders recognise that the Treaty of Waitangi is New Zealand's founding document and that central to the Treaty relationship between Crown and Māori are three key principles: participation, partnership and culturally appropriate practices. These principles translate in practice to Māori being able to define and provide for their own priorities for health.
- **Acceptability:** New Zealanders' expectations and values will be taken into account in the funders' decision-making processes.

The basic principle of prioritisation is that funding should be distributed across the regions according to the needs of the population. This ensures that those groups with the highest level of need receive proportionally more resources than those with less need. The adoption of priority areas does not mean neglect of other areas; rather that priority areas will receive added attention and focus when funding decisions are being made.

That is, the order of priority reflects the emphasis that funders need to place on developing services for these groups while at the same time consolidating the gains made in other core specialist alcohol and drug services.

The special populations that are detailed in the following section reflect the priority groups identified in the relevant policy documents for alcohol and drug treatment. The groups, in order of priority, are as follows:

1. Māori
2. Pacific peoples
3. children and youth
4. people with co-existing disorders
5. offenders with alcohol and drug problems
6. people who are opioid dependent
7. women
8. older people.

These priorities are congruent with those listed in the *National Drug Policy* and *The National Mental Health Funding Plan 1998–2002* and require a parallel commitment to developing a skilled and diverse alcohol and drug treatment workforce.

Recommended actions:

- improve the availability and accessibility of alcohol and drug treatment for the identified priority groups in order of ranking (DHBs)
- DHBs should identify what services are needed regionally, and then locally, given the current service provision. Implementation of this strategy will involve resource allocation and prioritisation with consideration of cost effectiveness, best practice and equity funding principles
- for each priority group, DHBs may also elect to develop services in localities where current expenditure is below the national average (this does not assume that the current national average equates to an acceptable level of service coverage).

3 Service Priorities

Considerable importance has been placed on the need to develop treatment programmes for special populations, those people with common demographic characteristics such as age, gender or ethnicity, or those who share unique functional characteristics such as legal features, clinical features (eg, co-existing disorder) or social status. There are differences within special populations which have implications for treatment outcomes, hence the need for individually matched treatment interventions.

While the development of population-specific services seems to improve access and retention within treatment services for these special populations, there has been a lack of systematic research on their effectiveness.

Continuing to develop separate services for distinct groups of people may not be sustainable within the resources available. An alternative approach suggested involves developing services and a workforce that can individualise interventions and be flexible enough to account for the complex relationship of addictions to population health. Likewise, services need to adapt to growing knowledge about best practice in the treatment of people with substance use related problems.

3.1 Responsiveness to Māori

Objectives and targets

National Objective 2.3 from *Moving Forward*, as well as priority group in National Drug Policy and the Mental Health Funding Plan:

To continue to increase responsiveness to the special needs of Māori, by providing access to both Kaupapa Māori and mainstream programmes.

Target 2.3.1 from *Moving Forward Next Steps*:

By July 2005, 50 percent of Māori adults will have the choice of a mainstream or a Kaupapa Māori community support mental health service.

Desired outcomes

- Mainstream alcohol and drug services improve responsiveness to Māori.
- More kaupapa Māori services and programmes.

There are many issues in common for Māori and non-Māori with alcohol and drug related problems. The socio-cultural contexts in which alcohol and drug problems occur for some Māori can be best addressed by treatment services and interventions that are uniquely Māori. This is supported by those Māori who participated in consultations on future service development, who stated that the barriers to engaging in treatment services would be reduced by dedicated Māori services.

Underlying the development of dedicated services for Māori (and, more recently, of responsive services within mainstream services) has been the belief that improved treatment outcomes are likely. Healing is achieved by working with other Māori and integrating cultural processes and elements in their treatment. For some services, the greater integration of Māori principles, values, beliefs, processes and practices in the treatment has led to an increase in the cultural competence of their workers. For others, it has validated a more holistic approach to treatment through viewing clients in the context of whānau rather than as individuals in isolation, and working to achieve change in a more systematic way.

Iwi and marae-based programmes allow for greater involvement of some whānau and partners and will allow for the development of more responsive services. There is a need to develop a more holistic approach to the alcohol and drug and mental health needs of Māori and to provide a range of specialist alcohol and drug and mental health treatment services, primary care, and linkages to other types of social services. The one-stop shop (or multidisciplinary) concept of service provision promoted by some marae-based services could be a viable option to consider. Similarly, those Māori services that can offer a primary, secondary and tertiary alcohol and drug service could be encouraged.

The development of broader holistic approaches will require appropriate frameworks for evaluating outcomes beyond simply the reduction of symptoms. The National Drug Policy states that substance use problems experienced by Māori are best addressed through targeted approaches developed and delivered by Māori, for Māori. While there is an urgent need to develop more culturally responsive services to meet the needs of Māori with alcohol and drug problems, there is a parallel need to consolidate or possibly reconfigure existing services.

Given the limited resourcing for kaupapa Māori alcohol and drug services, clear criteria are needed to define them. As a minimum, kaupapa Māori alcohol and drug services or programmes need to have mainly Māori staff and clients, have alcohol and drug treatment as their core business, and have ongoing support from local iwi and the Māori community.

There are significant workforce challenges within non-government organisations (NGOs) and hospital services, and within kaupapa Māori and mainstream services, to upskill clinically and culturally. Another factor that assists many Māori-managed programmes is an emphasis on increasing the knowledge, skills and support available to Māori workers in the voluntary and non-clinical support sector. The recent National Māori Alcohol and Drug Summit highlighted this need and called for greater support, particularly for kaumatua and kuia. The NDP also emphasised upskilling 'professionally trained' Māori workers, and recognition of the need for a variety of local approaches rather than a single national approach.

Mainstream alcohol and drug services need to ensure they are responsive to the needs of their Māori consumers. Being bicultural in New Zealand describes an ability to operate and function comfortably in both Māori and non-Māori contexts. However, the categories of 'Māori' and 'non-Māori', while useful, can be oversimplified by failing to consider the diverse realities within both. Treatment services therefore need to appreciate that Māori will have different degrees of understanding and/or knowledge of customary Māori beliefs, values and principles, and of appreciation of contemporary Māori society. Assuming all Māori are the same can create new barriers.

It is crucial that the Māori alcohol and drug workforce (both in kaupapa Māori and mainstream services) continues to develop complementary clinical and cultural training and capacity building.

One challenge for funders is to ensure monitoring and evaluation frameworks and processes are responsive to the diversity of Māori services, communities and tangata whaiora.

Recommended actions:

- continue to ensure that workers can respond to the cultural and substance use issues of Māori (mainstream alcohol and drug service providers)
- develop strategies to support community development initiatives and integration of a range of services that meet the holistic needs of Māori, in urban and rural settings and in hapū/iwi and pan-tribal contexts (DHBs)
- work with Māori treatment provider networks to identify service gaps and needs for Māori (accessing kaupapa Māori and mainstream services) in the different regions (DHBs)
- plan for a range of culturally responsive services to be available in each region for Māori individuals and their whānau who have substance use problems (DHBs)
- increase access to training for Māori generalist and specialist alcohol and drug treatment workers (funders and service providers)
- support research to examine the nature and extent of alcohol and drug problems among Māori (rangatahi particularly), as well as treatment outcomes (research funders)
- develop a quality and audit framework for alcohol and drug services for mainstream and kaupapa Māori providers (Ministry of Health and DHBs). Treaty audits and cultural audits are equally applicable to kaupapa Māori and mainstream services
- develop a culturally responsive framework for outcome evaluation that includes whānau and tangata whaiora (Ministry of Health and DHBs).

3.2 Pacific peoples

Objectives and targets

National Objective 3.8 of *Moving Forward*, as well as priority group in the National Drug Policy and Mental Health Funding Plan:

To improve the responsiveness of mental health services to Pacific peoples.

Target 3.8.1 of *Moving Forward Next Steps*:

By July 2000, the funding/purchasing body will have purchased pilot community based mental health services for Pacific peoples in areas of concentrated Pacific population. These services will be provided by Pacific peoples, either as independent services providers or as teams within mainstream services.

Target 3.8.2 of *Moving Forward Next Steps*:

By July 2000, the funding/purchasing body will have commenced evaluating the responsiveness of mainstream mental health services to Pacific populations.

Desired outcomes

- A comprehensive range of culturally responsive alcohol and drug services which meet Pacific peoples' needs.
- Culturally responsive mainstream services.
- More Pacific alcohol and drug treatment services.

Pacific peoples share a common migration history, but there are many differences in terms of culture, language, recency of residency, and whether individuals are New Zealand-born or island-born. The challenges of providing Pacific alcohol and drug services to this diverse mix and the problems of insufficient capacity were the two significant issues to emerge from the consultation process around the development of this strategy.

A framework for Pacific alcohol and drug treatment services should provide guidelines to best practice, competencies, standards of services, accountability, training requirements, and recruitment, as well as to other elements of service provision such as service accessibility and clients' rights to choose what service to access. The development of appropriate alcohol and drug treatment services for Pacific peoples should not be done in isolation from other health and social services.

Some Pacific alcohol and drug providers have indicated that there is an urgent need for residential care services to cater for Pacific peoples' alcohol and drug problems in areas where there are large numbers needing these services. Residential care is needed for people who require closely supervised detoxification, respite care, or because of the extreme severity of dependence on alcohol or other drugs an intense form of supervised intervention.

There is an argument for the development of memorandums of understanding that deal with the linkages between community NGOs, mental health services, alcohol and drug service providers and the Pacific community. Such formal protocols could help improve the co-ordination of alcohol and other drug services for Pacific peoples, and could provide the means for congruency and consistency in Pacific peoples' access to culturally appropriate services.

It is crucial that the Pacific alcohol and drug workforce receive immediate development in terms of training and capacity building. Pacific providers in alcohol and drug and other related sectors could co-ordinate some degree of primary health care training to staff in generalist settings. Funders such as the Ministry of Health and the DHBs may consider selectively funding specific training programmes for Pacific providers to widen the pool of Pacific alcohol and drug and mental health workers.

Recommended actions:

- further investigate the establishment of alcohol and drug residential detoxification and treatment services for Pacific peoples, prioritising those regions with the largest Pacific populations (DHBs)
- improve and formalise linkages between all relevant services and community organisations involved in alcohol and drug treatment for Pacific peoples (DHBs)
- develop the Pacific alcohol and drug workforce, especially training and capacity building (this could extend to specific training programmes for Pacific providers to widen the pool of Pacific alcohol and drug and mental health workers) (Ministry of Health and DHBs)
- research the prevalence of alcohol and drug use by Pacific young people as well as problems encountered during and after use (Ministry of Health and research funders)
- establish systems to monitor the effectiveness, consistency and quality of the alcohol and drug services provided for Pacific people with alcohol and drug problems (DHBs)
- in areas where Pacific alcohol and drug services are not available, ensure that training is available to staff working with Pacific alcohol and drug clients (DHBs)
- expand the clinical/cultural Pacific peoples' liaison services available to support staff working with Pacific peoples (DHBs)
- initiate a substance abuse awareness campaign for the Pacific community to raise awareness about alcohol and drug use and to raise the profile of the treatment sector among potential Pacific workforce recruits (Ministry of Health and DHBs).

3.3 Children and youth

Objectives and targets

National Objective 3.1 of *Moving Forward*, as well as priority group in National Drug Policy and the Mental Health Funding Plan:

To improve the delivery of mental health services for children and young people with moderate to severe mental health problems.

Desired outcomes

- More specialist child and youth alcohol and drug treatment services and programmes.
- Better-integrated child and youth mental health services and alcohol and drug treatment services.
- More responsive child and youth alcohol and drug services and programmes.

The National Drug Policy identifies children and adolescents as an at-risk population requiring special focus. The policy states that interventions should be delivered with both harm prevention and harm reduction philosophies. There is a need for a nationally co-ordinated youth services strategy that addresses the prevention and reduction of alcohol and drug related harm.

Youth in treatment for alcohol and other drug-related problems are not just younger versions of adults in treatment, and their issues and needs (including safety) differ qualitatively and quantitatively. Many youth are presenting at specialist alcohol and drug treatment services with a raft of problems of which alcohol and drug use is but one, and for a number of reasons they will not be accessing specialist mental health services or specialist child and adolescent mental health services (CAMHS).

For some, youth-specific services or programmes are best able to meet these needs. However, given the diversity of the youth population that can present for treatment, it would be impractical to have specific services for each group. Service providers and planners need to adopt a strategy utilising what is known about special population issues to ensure accessibility, appropriateness and effectiveness at the same time as involving youth and their family/whānau to ascertain their individual needs.

Clearly there is a need for training to support primary health care workers. However, the potential demand for youth services is far higher than could possibly be provided by existing mental health services (including alcohol and drug services). Any attempt to stimulate awareness of the need for treatment-seeking needs to be paralleled by equal efforts in developing adequate treatment and facilities.

Recommended actions:

- expand evidence-based prevention and early intervention strategies for children and youth at risk of substance abuse (DHBs)
- pilot early intervention programmes and review them for effectiveness, with special reference to Māori and Pacific youth with substance abuse issues (DHBs)
- support intersectoral work with relevant social and welfare agencies to develop and implement packages of care, or wraparound services, for children and youth with multiple and/or complex needs (Ministry of Health, DHBs, CYFS and Education)
- support the intersectoral development of wraparound services for children and youth with complex needs through its membership of the Inter Agency Committee on Drugs (Ministry of Health)
- undertake comprehensive alcohol and drug assessments and provide responsive treatment services (specialist youth mental health services)
- provide a consultation/liaison role for children and youth with severe alcohol and drug related problems (specialist hospital-based alcohol and drug services)
- support alcohol and drug youth training initiatives which offer training in the identification and treatment of mental health problems (DHBs)
- support additional training for specialist child and youth mental health workers and other youth workers (NGO and hospital staff) in alcohol and drug assessment and treatment interventions (DHBs)
- base access to youth alcohol and drug residential treatment on clear clinical criteria with adequate after-care provisions (specialist service providers)
- ensure access for youth to enhanced or specialist alcohol and drug services, including detoxification and methadone services (specialist service providers).

3.4 Treatment for people involved in the criminal justice system: objectives and targets

Objectives and targets

National priority group within the National Drug Policy:

Especially relevant to prison inmates and those released from prison.

Desired outcomes

- Convicted offenders with substance use related problems have the same right of access to alcohol and drug treatment services as others in the community.
- Improved case management of offenders with alcohol and other drug-related problems.

Those in the criminal justice system, including the youth justice system, seem to experience disproportionately high levels of alcohol and drug related abuse and dependence compared with most others in the community.

Offenders in the criminal justice system access specialist alcohol and drug treatment services for a comprehensive assessment to confirm a substance dependency problem, a recommended course of treatment (possibly affecting sentence or release from prison) and, if necessary, a referral to an appropriate alcohol and drug treatment intervention.

Mandated treatment does not necessarily mean there is a lack of motivation, and there is evidence to suggest that some offenders do as well in treatment as other consumers/tangata whaiora, despite the element of coercion.

The important issues when considering the development of alcohol and drug treatment services for youth offenders are:

- the growing numbers of young offenders
- the fact that young Māori and Pacific people are over-represented in prison and probation populations
- the need for different treatment for youth with complex problems, including substance abuse/dependence.

Youth offenders often have a number of agencies involved in their care. This requires good co-ordination and liaison and the ability to develop wraparound services to best meet these young peoples' needs.

The gaps for youth offenders with substance abuse include:

- the development of appropriate and sufficient youth forensic services focusing on consulting/ liaison positions, court liaison and community services
- enhanced access to alcohol and drug services, including detoxification and methadone services
- access to specialist programmes that directly address the link between offending and severe substance abuse/dependence.

Recommended actions:

- the Ministry of Health and the Department of Corrections should continue to increase co-ordination and co-operation between the two sectors so that there is a seamless and specific service for those offenders with alcohol and drug use problems, and specifically to examine
 - provision of improved training in the assessment and management of alcohol and drug related issues for those (generalists) working in Corrections settings
 - development of a wider intersectoral approach that establishes systems of care (wraparound services) for people with severe substance abuse problems who are involved with a number of agencies, not just the Department of Corrections
 - development of a more co-ordinated and integrated approach to sentence management, in particular between Community Probation Services and the Public Prison Service and specialist alcohol and drug treatment services in the community.

3.5 Dual diagnosis: substance abuse and mental health disorders

Objectives and targets

National Objective 3.7 of *Moving Forward*, as well as a priority group in the National Drug Policy:

To improve responsiveness and effectiveness of services for people with both a severe mental illness and a drug and alcohol disorder.

Targets 3.72, 3.73 and 3.74 of *Moving Forward Next Steps*:

By July 1999, training in the assessment and management of drug and alcohol disorders will be provided in each major centre for mental health services clinical staff.

By July 2000, training in the assessment and management of mental illness will be provided in each major centre for drug and alcohol clinical staff.

By July 2000, the funding/purchasing body will include, in all contracts for mental health services and drug and alcohol services, specific provisions for a comprehensive assessment of people in either service and for improving liaison and co-ordination between these services.

Desired outcomes

- Consumers/tangata whaiora with co-existing disorders will receive a seamless service that incorporates the skills and experience available from both mental health and alcohol and drug services.

Despite the fact that co-existing disorders (co-morbidity or dual diagnosis) have been the focus of discussion in the mental health and addiction literature over the past decade, there are large gaps in the research, particularly in New Zealand. There needs to be a series of well-constructed outcome studies across the country. The effective management and treatment of people with combined mental health problems and substance use disorders is a major challenge for the mental health sector (including the alcohol and drug sector).

Many presenting at specialist alcohol and drug treatment services have co-existing mental health problems, but although these problems complicate treatment they may not warrant a referral to a specialist mental health team. Similarly, there are increasing numbers in mental health services who have substance use issues which may not warrant referral to an alcohol and drug treatment service.

In both cases, there may not be a referral to a specialist dual diagnosis team.

The capacity and ability of existing services and workers to meet the needs of people with co-existing alcohol and drug and mental health problems needs to be increased.

The principles of an integrated treatment approach are as applicable to case workers in specialist dual-diagnosis teams as to case workers in specialist alcohol and drug settings, where a large number of clients present with co-existing disorders. The difference between the two settings is mainly the level of complexity of presentation.

Recommended actions:

- improve co-ordination of training for the assessment and management of co-existing disorders (service providers)
- promote wider distribution of the guidelines *Assessment and Management of People with Co-existing Substance Use and Mental Health Disorders* (DHBs)
- facilitate the establishment of basic clinical competencies for alcohol and drug workers and those in the wider mental health sector to include the assessment and management of co-existing disorders (DHBs).

3.6 Women

Objectives and targets

A priority group (pregnant women) of the National Drug Policy

Desired outcomes

- Early intervention services will reduce the prevalence of substance misuse in this emerging at-risk population (especially among young women).
- Increased public awareness of the risk of foetal alcohol effects, foetal alcohol syndrome, and alcohol-related issues for women considering pregnancy.
- Increased awareness of child care and protection issues for women with alcohol and other drug use problems in treatment.

Differences between men and women have been found in the development of substance use related problems, treatment seeking and responses to treatment. How these factors affect outcomes is far from clear. There is still little evidence-based practice in work with women who have alcohol and drug problems. Clinical guidelines need to be based on what is known about best practice in general. This very diverse group will present with a wide range of expectations, preferences and treatment needs. Classifying them solely according to gender may increase the possibility of overlooking other critical issues that are more relevant in immediate treatment planning.

However, failing to understand the possible impact of gender may result in inadequate assessment and poor treatment matching. Ensuring that research includes gender analysis, increasing the awareness of women's issues in alcohol and drug treatment, and increasing the range of interventions in accordance with the research literature are ways improve clinical practice.¹

Pregnant women comprise one of the priority groups listed in the National Drug Policy. The possible effects of alcohol and drug use during pregnancy for both the mother and the developing child are well documented. The incidence of alcohol related birth defects is complicated in that it does not require alcohol abuse by the mother during pregnancy for the foetus to be affected, hence the recommendation that women who are pregnant not drink. A greater awareness of the issues and an active prevention strategy could contribute to improving children's health status and wellbeing.

¹ Material on women with alcohol and drug problems was taken from a paper written for Healthlink South by Sandy McLean in her role as co-ordinator of Women's Services.

Women who use opiates have a particular risk of poor pregnancy outcomes. The health of these women and their children could be improved by provision of appropriate health services, including methadone treatment where indicated.

Recommended actions:

- consider the development of women's co-ordinator positions for alcohol and drug services specifically aimed at helping to develop services for women (service providers)
- increase the provision of consistent advice by primary health workers and other community workers, especially for pregnant women and women planning pregnancy (sector-wide activity)
- increase awareness among health workers of foetal alcohol syndrome, foetal alcohol effects and alcohol-related birth defects (ARBD) (sector-wide activity)
- liaise with training providers to ensure professional training covers the welfare of children with parents presenting with significant alcohol and drug problems (Ministry of Health and service providers)
- prioritise the issue of gender-matching assessment and treatment in alcohol and drug treatment research (service providers).

3.7 Opioid dependency

Objectives and targets

National Objective 1.3 of *Moving Forward Next Steps*:

To improve access to methadone treatment for opioid dependent people.

Targets 1.3.1, 1.3.2 and 1.3.3 of *Moving Forward Next Steps*:

By July 1999, 80 percent of people assessed as requiring methadone treatment for opioid dependence will be able to access this treatment within two weeks of assessment.

By July 1999, 50 percent of people receiving methadone treatment will be receiving this treatment through general practice providers.

From July 1999, increases in the provision of methadone treatment will occur throughout the primary health care sector.

Desired outcomes

- Opioid dependent consumers/tangata whaiora that qualify for transfer to GP care are able to receive this service through their GP.
- Reduced waiting lists for both assessment and treatment.
- Improved access for those assessed as requiring this service.

Methadone is considered the most effective treatment option for opiate dependence. Other pharmacotherapies that are being tried elsewhere are being considered for use in New Zealand. People meeting criteria for methadone maintenance treatment (MMT) are generally at the severe end of the continuum of the drug-dependent population. They typically present with a raft of other medical, social and mental health-related problems. Despite increased volumes being funded each year, the demand for methadone treatment exceeds the available treatment places. The number of people receiving methadone treatment has risen from 3,200 in 1998/99 to 3,625 in 2000/01.

It has been argued that MMT is a means of stabilisation in order to improve functioning in a number of dimensions. Given the complexity of their problems, many methadone consumers/tangata whaiora require access to other intervention approaches. Combining psychosocial interventions with the appropriate methadone dose has been found to produce better outcomes.

In terms of management, consumers/tangata whaiora often require co-ordination with other health and social services as well as an integrated treatment planning approach.

Recommended actions:

- review and update the 1996 national protocol for methadone treatment and give consideration to best-practice guidelines (Ministry of Health)
- identify the barriers to GPs offering methadone maintenance treatment, with attention given to enhancing the current system, including workforce development (Ministry of Health and DHBs)
- initiate research into the relevant treatment outcomes for clients treated by GP providers and specialist methadone services (DHBs)
- develop a framework for delivering methadone maintenance treatment for Māori (Ministry of Health and DHBs)
- increase monitoring and auditing of methadone services against the national protocol to ensure national consistency in service standards and clinical policies (Ministry of Health and DHBs)
- consider the approval of alternative pharmacotherapies for the treatment of opioid dependence (Ministry of Health)
- finalise a system for contracting with GPs for the provision of methadone case management for people who are stable and have been referred by secondary methadone treatment services (Ministry of Health and DHBs)
- continue to support workforce development initiatives for the delivery of opioid treatment by GPs in primary health care settings (Ministry of Health)
- evaluate current workforce development initiatives for the delivery of opioid treatment by GPs in the primary care setting (Ministry of Health).

3.8 Older people with substance abuse problems

Objectives and targets

National priority group under *More Services* (National Mental Health Funding Plan)

Desired outcomes

- Improved responsiveness of mainstream mental health and alcohol and drug services for older people.

It has been suggested that many older people who are heavy drinkers present more often at GPs with a range of physical and mental health problems. The perception that older people move more slowly, have poorer balance and have more aches and pains sometimes contributes to alcohol and drug related problems being under-recognised in this setting. Little reliable data exists on alcohol use among older people in New Zealand, but according to overseas studies one-fifth of older people regularly exceed recommended alcohol consumption limits.

Older people have higher rates of prescription drug use (for example, benzodiazepines) and poly-pharmacy than younger age groups. Combined alcohol and prescription medicines may cause problems for older people, even at moderate levels, because of their increased vulnerability to the combined effects.

The growing proportion of older people in the population as a result of demographic changes is likely to lead to an increased need for additional alcohol and drug services. This group can experience difficulty in accessing mental health services (including alcohol and drug services) because of the tendency to refer people aged 65 years and over to aged care services, regardless of their actual needs.

Recommended actions:

- recognise the alcohol and drug treatment needs of older people in service planning (DHBs)
- take measures to make services more accessible to older people (specialist alcohol and drug services).

4 Implementation Issues

The establishment of DHBs offers the alcohol and drug sector an opportunity to increase community awareness of the factors that contribute to addiction and to increase the profile of alcohol and other drug services as a specialist response. Tool kits are being developed by the Ministry of Health to identify the types of actions required under each of the 13 priority population health objectives listed in *The New Zealand Health Strategy* (King 2000). These tool kits will contain baseline data, evidence about best practice and targets for DHBs. The two objectives relevant to the alcohol and drug treatment sector are:

- minimising harm caused by alcohol and other drug use to individuals and the community
- improving the health status of people with severe mental illness.

This funding strategy will link directly into the tool kits for use by the incoming DHBs.

The development of strategic alliances and co-operative working relationships between DHBs (and key stakeholders) is essential for continued progress in mental health services development, and for progress in improving the mental health of Māori. The Mental Health Commission's view is that, for mental health, this will be only be assured if DHBs establish common regional mental health agencies or networks. (Mental Health Commission 2000)

The Mental Health Commission (2000) has recommended to DHBs that they develop regional mental health networks to provide:

- mental health planning and funding for the region
- collaborative approaches to quality improvement, audit and review
- joint workforce development, recruitment and retention initiatives
- increased integration and collaboration across the whole range of services.

The Commission has also recommended that the DHB regional mental health networks establish advisory groups to assist with planning and consultation and to strengthen interagency links. These stakeholder advisory groups are to include representation from Māori, consumers/tangata whaiora, families, as well as NGOs, hospital services and other key community representatives (Mental Health Commission 2000).

Consultation recommended that regional alcohol and drug sector consortiums be established as one of these stakeholder advisory groups. These consortiums could then link with one another and to a national treatment co-ordinating body to help strike a balance between high levels of local consultation and responsiveness and the need for national consistency, and the development of highly specialised regional/national alcohol and drug services.

Throughout the development of this strategy, questions have been asked about the respective roles of the DHBs and the Ministry of Health. The following information is taken from information prepared by Ministry of Health and the previous Health Funding Authority for the incoming DHBs and was intended to assist them in their capability planning. It is not intended to be a summary of all the roles but does answer some of the more commonly asked questions regarding the division of future roles between the DHB and the Ministry of Health.

DHB functions and roles	Ministry of Health roles
Regularly investigate, assess and monitor the health status, and the need for services, of its resident population	
<ul style="list-style-type: none"> • Undertake local needs analysis to inform annual and medium term planning activities • Consult with local communities and providers on strategic plans 	<ul style="list-style-type: none"> • Provide guideline for national consultation framework and methodologies • Provide a national framework and guidelines to support needs analysis • Undertake national-level analysis of changing needs, including in relation to funding, demographics, sector and service developments
Health information	
<ul style="list-style-type: none"> • Input into national data collections • Access national collection data for contract monitoring, needs assessment etc 	<ul style="list-style-type: none"> • Specify data requirements • Maintain national data collections
Contract compliance monitoring and quality audits	
<ul style="list-style-type: none"> • Audit (clinical and Treaty) services contracted by the DHB • Monitor provider performance against service agreements, including compliance and effectiveness audits of providers 	<ul style="list-style-type: none"> • Audit services contracted by the Ministry • Certifies providers against the requirements of the health and disability sector standards

DHB functions and roles	Ministry of Health roles
Service strategy and development	
<ul style="list-style-type: none"> Implement local service approaches informed by national service strategies 	<ul style="list-style-type: none"> Develop national service strategies that encompass best practice, service improvement and development, workforce and pricing elements Support the further development of sector specific standards that complement the requirements of the health and disability sector standards
Sector performance	
<ul style="list-style-type: none"> Responsible for ensuring regional and district service delivery according to the agreed funding plans 	<ul style="list-style-type: none"> Monitor DHB performance according to the funding agreement

Recommended actions:

- support the development of a provider-focused peak organisation (DHBs)
- form a sector stakeholder interest group linked to the regional mental health networks (regional alcohol and drug consortiums). Activities could include the development of an overall treatment system appropriate to their region, co-ordination of service delivery, continuity of care, best practice, consistency and further service development for special populations
- increase the involvement of consumers/tangata whaiora in the planning, development and evaluation of alcohol and other drug treatment services (regional alcohol and drug consortiums).

5 Ensuring High Quality Treatment Services

This strategy focuses on key quality issues that require attention if the performance of alcohol and other drug treatment services is to result in improved health outcomes and a reduction in health disparities for people with substance use related problems.

Objectives and targets

HFA Mental Health Funding Plan:

To improve the quality of drug and alcohol treatment and support services nationally.

National Drug Policy Priority Outcome:

Improve the range, quality and accessibility of effective treatment options.

Desired outcomes

- improved consistency nationally with respect to service access and entry priorities and procedures.

The essential element of an effective treatment system is a co-ordinated and commonly understood system of care. Effective management of those with severe alcohol and drug related problems typically requires considering safety and stabilisation, comprehensive assessment, treatment planning, integrated treatment and assertive case management. Integrated and co-ordinated service delivery addresses some key issues that currently affect the efficient and effective delivery of responsive alcohol and drug treatment services.

Different people have different alcohol and drug problems, and so treatment options for those problems need to be as diverse. An integrated and co-ordinated treatment system is one that identifies people with alcohol and drug use related problems early and provides a level of assessment appropriate for that individual. On the basis of that assessment, the person is matched with the best available intervention and is actively followed up.

The outcomes of an intervention can then be fed back into the system to support current practice. They can also alert services to the possible need for changes in the criteria for matching people to interventions, or changes to the intervention itself, or how it is used to meet consumers/tangata whaiora needs. This model ideally offers the right model at the right time as well as ensuring continuity of care.

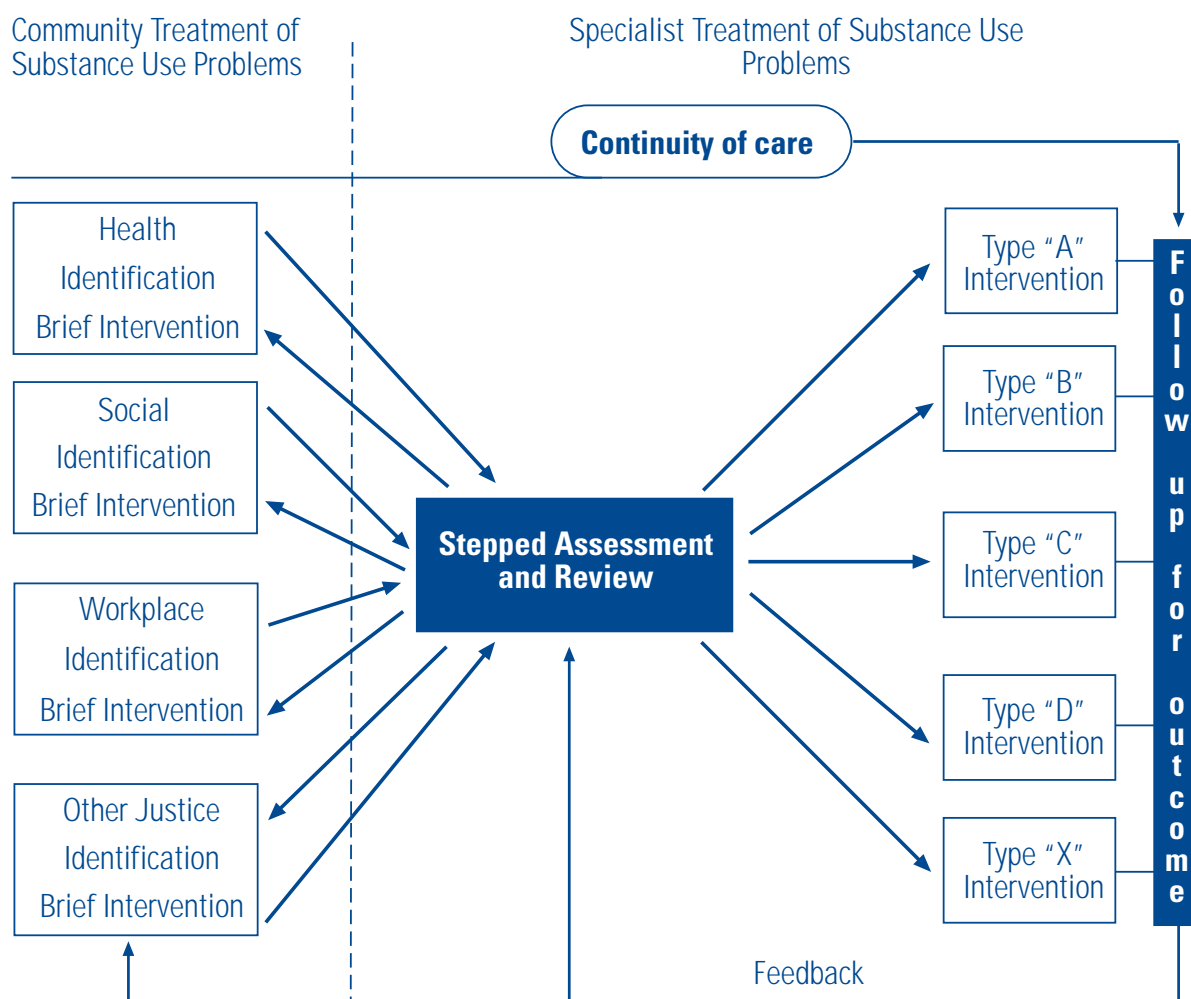
Alcohol and drug treatment systems and services that are not well integrated run the risk of creating service gaps, duplicating service delivery, failing to maximise interventions that require co-ordination with other services, and delivering disjointed or fragmented services.

The Institute of Medicine (1990) has proposed a treatment system model as a means of describing continuity of care. Figure 1 is an adaptation of that model. 'Continuity assurance' can be an individual designated to fulfil this function (a care or case manager), or can be strategies involving structured interrelationships among components of a treatment system.

Ideally, all people seeking services from community agencies should be screened for substance abuse problems and, where appropriate, provided with a brief intervention. People with substantial or severe alcohol and drug problems are referred for a more specialised assessment. It is preferable that consumers/tangata whaiora receive a level of assessment and treatment planning that is matched to the severity of the problem and their level of motivation.

Where treatment is indicated, people are matched to the most appropriate specialised type of intervention (including detoxification or relapse prevention work). The outcome of treatment (including maintenance and after-care) is determined, and feedback of outcome information is used to improve matching guidelines at the assessment/review process as well as back to referrers. Continuity of care is provided to guide individuals throughout the treatment system.

Figure 1: Assuring continuity of care



Adapted from Institute of Medicine 1990, p 330

Case management is a process where consumers/tangata whaiora are provided with the appropriate services in a co-ordinated, effective and efficient manner. This may mean working across services and sectors, the critical factor being continuity of care.

The elements of the system such as assessment, matching, and treatment (eg, detox, residential, reintegration and aftercare) as well as the determination of outcome, can be viewed as the vertical components of care: they occur in more or less serial order and are time limited. Continuity assurance is the horizontal element in the system cutting across the other elements and providing a coherent experience for the individual.

This model relies on the workforce at all levels of the system being able to screen, assess and provide appropriate treatment according to the severity of the alcohol and drug related problem presented to them. A comprehensive training framework that covers the vertical components of care at each point in the continuum of services does not yet exist.

Recommended actions:

- develop regional consortiums to promote the development of an overall treatment system appropriate to a region (alcohol and drug sector). Each consortium could support the co-ordination of service delivery, continuity of care, best practice, consistency and further service development for those sectors of the community currently not accessing services (DHBs)
- develop a nationally consistent treatment system where best practice guidelines and consistent referral criteria inform clinical decisions regarding access and entry to all types of treatment service (DHBs and service providers)
- consider the lack of after-care services in some areas for consumers/tangata whaiora returning to their local communities following residential treatment (regional alcohol and drug consortiums in partnership with the DHBs). The development of a co-ordinated system of care would specifically include a range of readily accessible reintegration/post-treatment support houses or relapse prevention programmes that would support consumers/tangata whaiora to build on the gains that they have made in residential treatment
- promote advances in knowledge regarding what constitutes best practice, which can then be incorporated into alcohol and drug treatment service delivery at the local, regional and national level (alcohol and drug consortiums and DHB regional networks)
- consider the further development of a co-ordinated system of care that is centred on a stepped assessment and case management approach (regional alcohol and drug consortiums and DHBs)
- support the development of an 'accredited clinician' status occupying a specific place in the alcohol and drug career structure (alcohol and drug providers).

6 Service Availability and Access

In health planning, the *availability* of treatment services typically refers to the supply and mix of services relative to the needs of a given individual or community. *Accessibility* is the degree to which the health care system inhibits or facilitates entry to and responsiveness of services when those services are available. Entry to services represents the stage of acceptance into that service. It is assumed that entry is determined on the basis of an assessment that identifies a substance abuse problem and matches that particular person to a specified treatment intervention.

Referral for a specialised alcohol and drug assessment (especially a comprehensive assessment) may be sufficient intervention for someone who has substance use related problems. Others will require access to interventions ranging in intensity and duration according to the severity of their dependence and the complexity of their needs.

Because patterns of access can influence the clinical outcomes of treatment services, people with substantial to severe dependency may do better if they have access to particular types of treatment programmes or services. This may involve developing outreach or marae-based services, out-of-hours services, or services for specific age group, gender, sexual orientation or ethnicity. Such initiatives can be provided within an overall framework of core services if they are not already part of core activities. The tension is in meeting the needs of those special population or at-risk groups most in need of access to specialist services without compromising the development, responsiveness and delivery of core alcohol and drug treatment services.

In those areas where population demographics and socioeconomic indicators would indicate a need for specific intervention types or programmes, alcohol and drug treatment services could respond by making their services more accessible.

6.1 Referrals to specialist services

Factors that may influence referrals to specialist alcohol and drug treatment services include:

- shifting norms about the seriousness of problems
- general attributions of problems to substance use
- treatment capacity
- the marketing and advertising of treatment services
- geographic and economic access to treatment services
- the effects of the growing availability of population-specific programmes, such as those focused on women, youth, Māori and Pacific peoples

- the policies and practices of other organisations
- changes in the relations between substance abuse treatment systems and other systems of services.

In some instances other government and social service organisations can offer brief treatment interventions themselves (including motivational work) or provide appropriate referral to alcohol and drug treatment services.

The ongoing development of this broad spectrum of services will have a direct impact on the ability of consumers/tangata whaiora to access substance abuse treatment from a wider range of health and social service agencies and the capacity of the specialist alcohol and drug services to deal with increased rates of referrals from this sector.

Increasingly, offenders are being referred for assessment or for treatment because they have been identified by Department of Corrections staff as having substance abuse problems. Some of these offenders are motivated to receive treatment and some are 'coerced'. This increase in criminal justice referrals has not been accompanied by an increase in capacity (within the correctional or health sector). The long-term outcomes for this special population coerced into treatment and the resultant impact on access for the 'traditional' alcohol and drug consumer/tangata whaiora group is unknown.

Recommended actions:

- work towards a consistent system of referral and contracting for those accessing specialist alcohol and drug services from other areas and or regions (DHBs and regional alcohol and drug consortiums)
- continue to liaise with the Department of Corrections regarding a potential increase in the number of referrals from Corrections, as any such increase will affect access for non-offenders seeking treatment (Ministry of Health).

6.2 Residential services

Access to appropriate non-residential alcohol and drug treatment is generally possible at all points of the wider health and social services system, by either self-referral or referral from another service. However, actively promoting the availability of alcohol and drug specialist services, could increase the demand for services – including non-residential services – beyond their capacity to cope.

Recently there has been a greater focus on non-residential based treatment services over residential ones. This is partially because non-residential services offer a greater ability to reach an expanded and diverse clientele, and for many they can be more cost effective. The Mental Health Commission *Blueprint* resource guidelines indicate that nationally there are more residential beds currently than are necessary. However, many argue that in particular geographical areas and for specific programme types (such as kaupapa Māori in the Te Tai Tokerau and reintegration houses in the Waikato) there is in fact a shortage of beds.

Currently, residential programmes in New Zealand vary in duration, often reflecting the complexity of the residents they are treating. Length of stay can vary from days to weeks in the case of detoxification (medical and social) or respite care. In the case of some therapeutic communities (TCs), residence can be up to a year or more. With the advent of improved after-care options, some TCs have been able to reduce the length of their programmes and become far more flexible in the services they offer.

It is generally accepted by most of the alcohol and drug sector that residential treatment is not the first treatment of choice for most people with alcohol and drug-related problems. For many, one indicator that residential treatment might be most appropriate is when there have been a number of previous attempts at non-residential treatment.

Inconsistent access and entry to alcohol and drug services, especially for residential alcohol and drug services, has arisen from historical service development – including the different service models of the four previous Regional Health Authorities. These arrangements have mostly continued despite the HFA's work on national consistency. There needs to be national consistency for entry criteria to all types of treatment interventions available in the DHB regions. The regional consortiums could be an appropriate forum to consider standardising entry criteria to programmes and services to support clinicians who make treatment-matching decisions.

Substance dependent youth may, in special circumstances, require specialist residential alcohol and other drug treatment. Alternatively, they may need the time-out and detoxification aspects of residential care, followed by day programmes in their local area. As a general principle, long-term treatment is best conducted in the local community and will involve considerable inter-service and intersector collaboration.

Recommended actions:

- create national consistency in residential services through best-practice guidelines and standardised entry criteria to all types of alcohol and drug treatment services (Ministry of Health, DHBs and regional consortiums).

6.3 Aftercare

It is important that aftercare or re-integrative services are accessible to people who have been part of an intensive programme or who are returning to their community from residential alcohol and drug treatment. This is particularly so in areas where there are no local residential services and consumer/tangata whaiora are referred out of the area.

Aftercare can take different forms and may include such services as 'dry' or re-entry houses, support groups, or simply having someone to assist with accessing community supports such as budget advice. Aftercare can also include support and information for the families and caregivers of people with alcohol and drug-related disorders. However, aftercare services are all principally focused on helping consumers/tangata whaiora reduce the likelihood of relapse and on consolidating the gains made in treatment. Continuity of care means there must be an active relationship between case management, discharge planning and re-integrative services.

The added advantage to consumer/tangata whaiora of after-care services is that it allows continuity of care across the spectrum of service types. Evidence on the impact on rates of relapse as a result of this service development would be useful for the sector when considering issues regarding continuity of care.

Recommended actions:

- develop a strategy to address the lack of aftercare services for some consumers/tangata whaiora returning to their local communities following residential treatment (DHBs and the regional alcohol and drug consortiums). The development of a co-ordinated system of care that specifically includes a range of readily accessible relapse prevention programmes would support consumers/tangata whaiora to build on the gains they have made in treatment.

7 Consumer and Family Participation

Objectives and targets

National Objective 3.2 of *Moving Forward*:

To improve the responsiveness of mental health services to consumers.

Target 3.2.2 of *Moving Forward*:

By July 1998, all contracted providers will demonstrate involvement and participation of consumers including, for major providers, employment of consumers (or will have a process in place to achieve it by 1999).

Desired outcomes

- An alcohol and drug sector that is responsive to the views of consumers/tangata whaiora.
- An alcohol and drug sector that is inclusive of consumers/tangata whaiora.
- All alcohol and drug and planning processes incorporate consumer/tangata whaiora perspectives.

The concept of recovery for some consumers/tangata whaiora with substance use related problems is different to that of others in 'mainstream mental health'. Essentially the difference relates to the enduring nature of mental health disorders where the condition is managed, whereas for some with substance dependence, treatment is often seen as a cure and therefore 'staying in recovery' a choice. However, this difference should not impede efforts to find ways to increase the involvement of consumers/tangata whaiora in the activities of the sector.

There is a clear requirement in Standard Nine of the National Mental Health Standards for consumer/tangata whaiora participation in the planning, implementation and evaluation of mental health services. This also includes the alcohol and drug treatment sector, and some alcohol and drug treatment providers are uncertain if the model that operates in mainstream mental health services for consumer involvement will work as well in the alcohol and drug sector.

The concept of formal consumer participation at a variety of levels is still new to many in the alcohol and drug sector. This is despite promotion by the New Zealand Accreditation Board for Alcohol and Drug Services Standards and the *Guidelines for Clinical Process Self Evaluation in Alcohol and Drug Services*. There are a number of strong consumer groups in some services, and recovery or whānau groups in some areas. However, there is no identifiable national alcohol and drug consumer network, apart from the one operating under the auspices of the Alcohol and Drug Association of New Zealand (resourced by the Ministry of Health) in the South Island.

There is increasing evidence that the inclusion of family/whānau and significant others can result in improved treatment outcomes. Providers who have dedicated consultation/liaison roles can also greatly assist families to cope with children, parents, partners, friends and/or family members in recovery from alcohol or drug abuse.

One of the biggest barriers to recovery is discrimination, and intervening in the stigmatisation cycle is part of making it work. While the scope of mental health incorporates alcohol and other drug disorders, destigmatisation campaigns have not specifically addressed the stigma and discrimination experienced by both alcohol and drug consumers/tangata whaiora and, by association, the alcohol and drug treatment workforce. Mental health practitioners also report a form of discrimination operating through what is viewed as a hierarchy of mental health disorders, with opioid dependency occupying the lowest end.

Co-operative planning between providers, funders and other key stakeholders (including consumers/tangata whaiora and families) will ensure that planning, service delivery and future service development meet the needs of the local communities. Particular attention will need to be directed at prioritising services for Māori, Pacific peoples and youth.

Recommended actions:

- develop alcohol and drug consumer advisor positions, with these positions linked into existing mental health consumer networks (DHBs)
- actively recruit and support the inclusion of consumer advice that is representative of the alcohol and drug consumer voice (Ministry of Health, regional alcohol and drug consortiums and DHBs)
- utilise consumer expertise (alcohol and drug education programmes)
- make self-help resources available in the community, and support efforts to destigmatise the problem, because many people with alcohol and drug problems change their behaviour without professional assistance (DHBs)
- continue to develop flexible and responsive services, promote best practice and research, maintain an active profile in the local community, and develop leadership and advocacy from within its own ranks (alcohol and drug sector)
- support the development of an integrated treatment system that acknowledges work with families and significant others and recognises this group in regional service development planning (DHBs and regional consortiums).

8 Research and Development

Objectives and targets

National Objective 6.7 of *Moving Forward*:

To improve the health status of New Zealanders and enhance the quality of mental health decision-making by providing up-to-date knowledge based on research information.

Target 6.7.1 of *Moving Forward*:

This target has been met, in that a mental health research and development strategy has been agreed on and is currently focused on three main areas of interest: outcomes, case mix and epidemiology. Now that these projects are well under way, there is an opportunity for alcohol and drug issues to be placed on its agenda.

Desired outcomes

- Treatment interventions that are evidence based.
- Funding decisions that are evidence based.
- Additional knowledge with which to guide the development of alcohol and drug treatment services and the alcohol and drug workforce

The National Drug Policy highlights the need for further research in many areas associated with alcohol and other drug use and treatment. Significant research in alcohol and drug treatment is being conducted by a few key agencies in New Zealand, but there is a need for national co-ordination around research and development of the alcohol and drug treatment sector, particularly in relation to mental health research funds that are available through the Health Research Council, the Mental Health Research and Development Strategy and the Alcohol Advisory Council of New Zealand (ALAC).

More research information is required about the type of treatments and interventions that work best for Māori and Pacific peoples. The limited information on the prevalence of alcohol and other drug problems and what constitutes best practice for these and other special populations continues to be a stumbling block in building a high-quality, research-based treatment sector. This critical area requires innovative research that involves Māori and Pacific peoples in the design and implementation of research programmes, and in the dissemination of findings.

Research needs to be cultivated, co-ordinated and targeted to have the biggest impact. There are only a few researchers in New Zealand consistently undertaking alcohol and other drug treatment-related research, so a national alcohol and drug research strategy needs to consider

how to best use the limited resources currently available and how to develop research capacity further in the future.

A national alcohol and drug research strategy would establish a mechanism for prioritising research activity as well as assisting the sector to incorporate the best of what is currently known in the field into current service delivery. Advances in knowledge of what constitutes best practice will need to be incorporated into alcohol and drug treatment service delivery at the local, regional and national levels.

Staff education and training opportunities help with changes in clinical practice, but there is also a need to measure consumer outcomes. This is a useful tool for reinforcing good assessment practices, choice of treatment interventions and treatment-matching decisions. For outcome measures to be widely adopted and routinely used by a large range of alcohol and drug treatment providers, they need to be relevant and acceptable. Knowledge advances in this area could increase national consistency and provide a platform to improve the future planning, funding and delivery of alcohol and drug treatment services in New Zealand.

Given the increasing pressure to demonstrate effective outcomes and efficient use of resources while at the same time providing high standards of care, it is important that ongoing quality improvement initiatives include the evaluation of current treatment interventions as a normal part of the business. The outcomes from these evaluations should inform the changing nature of alcohol and drug knowledge and practice as much as ongoing adherence to 'tried and true' models of treatment delivery.

It is critical that the alcohol and drug sector be able to offer the best of what is within allocated resources available. Outcome evaluation will contribute to people with substance abuse problems being offered treatment interventions that consider and respond to the different needs and different perspectives of consumers/tangata whaiora, caregivers, communities and funders alike.

There is increased recognition that any evaluation of outcome in New Zealand health services must recognise Māori involvement in terms of process, conceptualisation, design, implementation and dissemination if they are to be useful to Māori. Service specifications in the future may explicitly identify indicators of evaluation, quality assurance and related competencies. This is another area that the alcohol and drug sector consortiums may offer to develop.

Recommended actions:

- develop an alcohol and drug research strategy under the Mental Health Research and Development Strategy which has clear priorities and details how research outcomes link to service planning and delivery (Research and Development Steering Committee)
- prioritise New Zealand-based research focused on treatment outcomes, with special attention to optimal treatment interventions for Māori, Pacific peoples and children and youth (HRC, Research and Development Steering Committee)
- evaluate treatment programmes to determine the factors that promote improved outcomes for various groups (DHBs and service providers)
- investigate the attitudes of Pacific peoples towards alcohol and other drug use, explore underlying causes and patterns of drinking and drug use, and establish the prevalence and severity of alcohol and drug problems among Pacific peoples (Ministry of Health)
- ensure that the outcomes of research are formally linked to alcohol and drug treatment services at the local and national level so that practitioners have up-to-date information on best practice (service providers and DHBs)
- identify and implement outcome indicators that can be used to improve service delivery, assessment and consumer/tangata whaiora matching (service providers)
- develop outcome indicators that are relevant and applicable to a range of groups; for example, Māori in kaupapa Māori services, youth in residential or non-residential services, or Pacific peoples (Ministry of Health)
- promote research evaluating the use of brief interventions for different age groups, genders and ethnic groups (Ministry of Health and DHBs).

9 Capacity Building

Capacity building is essentially the process of developing abilities and resources in order to solve problems and achieve outcomes. It is people organising themselves, and in the end it is about empowerment.

9.1 Illness prevention and health promotion

Public Health funded initiatives targeted at activities for mental health promotion and illness prevention tend to be based on the Ottawa Charter with effort focused on the broader determinants of mental health at both individual and environmental levels. This means that programmes are designed to impact on environments, which can include reducing stigma, creating supportive social policies and looking at issues such as housing and unemployment.

Te Pae Mahutonga (the Māori concept of total wellbeing) is equally applicable to the needs of intervention and treatment as it is to prevention. As a guiding strategy to build capacity within our communities and workforce, it can be a useful framework for both Māori and non-Māori. It emphasises the need to develop and foster an environment or climate in which human and organisational potential can be realised.

9.2 Expanding specialist alcohol and drug treatment services

‘Capacity’ covers much more than simply skills, people and plans. It includes commitment, resources and all that is brought to bear on a process to make it successful. The alcohol and drug sector infrastructure requires further development and strengthening. Here ‘capacity’ is about strengthening alcohol and drug treatment services to enable them to deliver high-quality services in a way that best meets the needs of their local communities. The first consideration is sustainable funding that recognises the need for future growth and service development.

The Mental Health Commission benchmark figures for core alcohol and drug services show that there are a number of service provision gaps. (The total resource gap for New Zealand is included as Appendix 4). The Mental Health Commission benchmark guidelines were only ever intended for the estimation of the services required at the national level and for regional populations. So while DHBs will use them as part of their planning process, they have not been applied to the DHB level here.

Having identified a funding gap, the range of appropriate evidence-based services required for each regional community remains to be identified. There are currently local and regional variations in services — often as a result of the specific needs of those various communities and historical patterns of service provision.

In 1996 the Mason Report recommended a substantial increase in the funding for mental health services. Alcohol and other drug services were excluded from the scope of that report and they have not benefited directly from this injection of additional funds, except through child and youth alcohol and drug services. As part of the Government’s June 2000 budget announcements additional funding has been allocated to mental health over the next four years. This funding will be used for ‘new’ and/or additional services. The level of additional funding specified for alcohol and drug services is shown in Table 1.

Table 1 : Additional funding for alcohol and drug services in the June budget

Alcohol and drug services	\$M (GST incl)	\$M (GST excl)
2000/01	2.34	2.08
2001/02	4.38	3.89
2002/03	0.01	0.009
2003/04	1.97	1.75
TOTAL	8.70	7.73

The MHC Blueprint and future funding path for mental health advised by Government in the Budget 2000, together provide the framework for the development by the Ministry of Health of a national Blueprint implementation action plan. Regional networks and districts will use the national Blueprint implementation action plan as the framework for their 3-5 year service development plans and annual funding plans. These plans will show how available funding for mental health will be allocated, and incremental progress made towards service levels indicated in the Blueprint. (Mental Health Commission 2000)

The current total estimated expenditure on core alcohol and drug treatment services for 2000/01 in each of the four HFA regions is included as Appendix 3.

Recommended actions:

- develop and implement a purchasing framework for the alcohol and drug treatment sector (DHBs, with appropriate consultation)
- promote quality assurance and improvement initiatives, especially those that are sector driven (service providers and DHBs)

9.3 Workforce capacity

Objectives and targets

National Objective 6.6 of *Moving Forward Next Steps*:

To improve the skills and competence of the alcohol and other drug workforce.

Target 6.6.2 of *Moving Forward Next Steps*:

By July 2002, 50 percent of contracted alcohol and other drug services which employ clinical staff will include staff members with postgraduate speciality training in drug and alcohol treatment.

Desired outcomes

- A culturally responsive alcohol and drug workforce.
- A trained and competent alcohol and drug workforce.
- A career pathway for alcohol and drug workers.

While developments in recent years have increased the number of qualified staff, only 3 percent of the existing workforce have an alcohol and drug-specific postgraduate qualification, and only 16.3 percent have postgraduate qualifications of any sort (Sellman et al 1998). Clearly these survey results indicate that the workforce is made up of four main groups:

- those with no tertiary qualification
- those with minimal alcohol and drug-specific qualifications
- those with some tertiary-level qualifications
- those with postgraduate qualifications, including a small number with alcohol and drug-specific postgraduate qualifications.

To meet the *Moving Forward* target of 50 percent of alcohol and drug services including staff with a specialist postgraduate qualification, additional focus is required to develop the skills and competencies of the first three workforce groups.

Many alcohol and drug services report difficulties in attracting and retaining skilled specialist staff and are experiencing problems in maintaining high quality services without the advantage of some funding parity with their mental health counterparts.

In response to the move to develop the sector's ability to address alcohol and drug issues (including the delivery of methadone) throughout the mental health services and in primary and community settings, the previous HFA has funded the development of a number of specialist

alcohol and drug courses or course components, either through the Clinical Training Agency (CTA) or regional offices. These initiatives are detailed in Goal 6 of the HFA *Mental Health Workforce Plan 2000-2005: Tūtahitia te Wero: Meeting the Challenges*.

The development and implementation of any additional alcohol and drug training initiatives requires central leadership. For this reason it is recommended that a national alcohol and drug treatment workforce development group be established (possibly through existing forums expanding their membership and their mandate). This group would be specifically tasked with the development of a co-ordinated and targeted response to the issues facing the alcohol and drug treatment workforce.

Alcohol and drug workforce development is a long-term investment and it is unlikely that any significant change can be made within five years. It is critical that any future development is well co-ordinated and understood by all participants in the field, including policy-makers, funders and key stakeholders, as there is the potential for *ad hoc* responses to dominate future decisions on the funding of various courses. The goal for alcohol and drug services must be the employment of a workforce with competencies and skills that are aligned to an educational framework which forms a career pathway and reduces alcohol and drug-related harm. Once this is attained, it will become possible for the sector to seek accreditation as a recognised professional body with a recognised professional workforce.

There can be no expansion of services without a skilled and qualified alcohol and drug workforce being available to take up new positions. The phasing of any new service development needs to take into consideration the parallel development required of the current and future alcohol and drug treatment workforce in terms of clinical competencies, cultural competencies and the managerial and business acumen required to successfully operate an expanding service.

Building capacity within the alcohol and drug sector will allow the sector to establish itself as a specialist service with its own specialist skills and competencies and to adopt a professional profile in the community that it services.

Recommended actions:

Actions for the Ministry of Health

The Ministry of Health needs to work with the DHBs, CTA and identified training providers in a co-ordinated way to develop a national alcohol and drug workforce development strategy that aims to:

- establish a national alcohol and drug workforce development group
- develop a skilled workforce that can deliver effective, evidence-based alcohol and drug treatments
- identify those training courses evaluated as relevant and effective to the alcohol and drug sector
- promote the development of specialist workforce training programmes for those working with child and youth (and their families/whānau) with alcohol and drug related problems
- promote the implementation of training programmes for the assessment and management of co-existing disorders
- incorporate up-to-date alcohol and drug modules into the training courses for all health-related disciplines.
- increase the clinical and cultural competencies of mainstream alcohol and drug treatment workers over the next 5–10 years to respond better to the cultural needs and substance abuse issues of Māori
- increase the clinical and cultural competencies of mainstream alcohol and drug treatment workers over the next 5–10 years to respond better to the cultural needs and substance abuse issues of Pacific peoples
- develop and implement a system whereby the qualification levels of Māori alcohol and drug workers are increased by targeting places on current undergraduate and postgraduate courses
- phase in delivery of training that enables Māori working in community, primary care and social service settings to be able to recognise, assess and intervene with mild to problematic alcohol and other drug use
- focus in a co-ordinated way on the development of a skilled workforce which can deliver effective, responsive interventions to Pacific peoples
- increase the qualification levels of Pacific alcohol and drug workers by targeting places on current undergraduate and postgraduate courses
- promote the delivery of training that enables more Pacific peoples working in community, primary care and social service settings to be able to recognise, assess and intervene with mild to problematic alcohol and other drug use.

Action for National Alcohol and other Drugs Workforce Development Group

- promote the skills and competencies required for the current alcohol and drug workforce
- identify and support training and courses that upskill alcohol and drug workforce
- promote the development of a marketing strategy for attracting and training new recruits to the alcohol and drug field
- promote the development of career paths whereby alcohol and drug clinicians can become accredited
- consider and support the development of training required for alcohol and drug consumer/tangata whaiora representatives to enable them to fully participate in alcohol and drug service planning and evaluation.

Actions for the District Health Boards

- ensure that specialist treatment services provide a support role for the delivery of early and brief intervention strategies for reducing alcohol and other drug related problems
- develop meaningful performance requirements based on outcomes
- identify and support the development of leadership in the alcohol and drug sector
- develop a skilled workforce that can deliver effective, evidence-based alcohol and drug treatments
- identify training needs of alcohol and drug workers.

Actions for service providers

- ensure staff are encouraged to take up opportunities for training and development
- work to become integrated within a wider network of other community health and social service agencies (community-orientated specialist alcohol and drug treatment services)
- increase service responsiveness to special populations and local community needs
- implement quality improvement initiatives
- implement evidence-based practice
- increase the positive profile of alcohol and other drug specialist services
- identify and support the development of leadership in the alcohol and drug sector
- identify, recruit, train, support and involve individual consumer/tangata whaiora representatives so that they can become involved in service planning and evaluation
- improve access to training for workers in community and primary health care settings that will enable them to recognise, assess and intervene with mild to problematic alcohol and other drug use, particularly Māori and Pacific workers
- increase training which enables people in communities and primary care settings to recognise and refer severe alcohol and drug problems to specialist services.

Glossary

Accredited clinician: specialist alcohol and drug clinician who meets specified standards detailing the agreed clinical and cultural criteria and competencies required of an accredited clinician.

Alcohol and other drugs: this term acknowledges the psychoactive nature of alcohol as a drug.

Brief intervention: a session within treatment services of about 15 minutes which, as a minimum, contains some of the following therapeutic components: feedback of use and risks, comparisons with norms, objective evidence of alcohol related harm, establishment of goals, emphasis on personal responsibility and monitoring of progress. Much shorter opportunistic interventions also occur in the primary setting, typically involving techniques of motivational interviewing.

CAMHS: specialist child and adolescent mental health services provided by hospital based mental health services.

DHB: District Health Board.

Generalist: a helping professional in the areas of health, justice, education and social services whose main focus of work is not on alcohol and other drugs.

HFA: Health Funding Authority.

Mainstream: other mental health services (excluding alcohol and drug), particularly statutory agencies. For many Māori, 'mainstream' refers to non-Māori services and systems.

MHC: Mental Health Commission.

Primary interventions: those interventions applied in primary and community health care settings, emphasising early interventions and brief therapies.

Specialist alcohol and drug services: those services whose main focus of work is on alcohol and other drugs. It is expected that these specialist treatment workers will be able to provide more sophisticated and complex levels of intervention than those required at the primary level. It is also expected that some specialist alcohol and drug services will have additional expertise and will be able to provide a training, consultation and liaison role to both specialist and generalist services.

Appendix 1

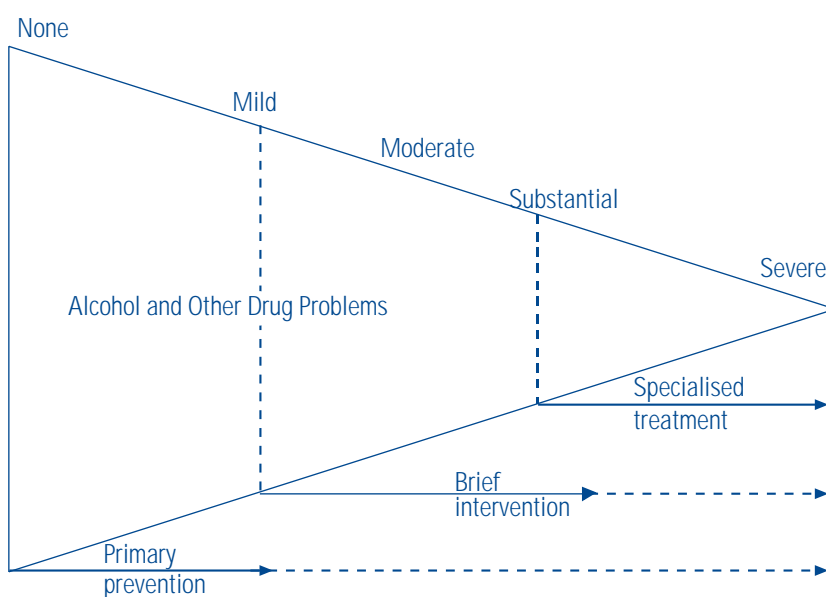
The Prevention of Alcohol and Drug Problems

The Mental Health Commission's 1997 *Blueprint for Mental Health Services in New Zealand* noted the need for primary health services, led by general practitioners, to take an increasing responsibility for assessment, treatment and management of less severe, moderate and mild mental illness. They were also seen as being important in the identification and referral of people with serious mental illness.

The 1998 *Blueprint* continues and strengthens this direction, noting that primary health services need to recognise their responsibility to provide treatment and support for the majority of people affected by mental illness. The Commission also noted the responsibility of public health services to design programmes that promote mental health and offer prevention programmes for those at risk. Mason Durie emphasised that public health and wider social policy responses are critical to lowering the number of young Māori becoming affected by serious mental illness (including substance use related disorders).

Figure A1 describes the range of responses to alcohol and drug problems. The continuum of care maps to the continuum of use, thus the more severe the problem the more intensive the intervention needed. The availability of a range of intervention approaches that are appropriate for different points along this continuum is critical.

Figure A1: Relationship between the severity of alcohol and drug problems and the type of intervention needed



Source: Adapted from Institute of Medicine, p 212.¹

¹ Institute of Medicine (1990) *Broadening the Base of Treatment for Alcohol Problems*, Washington, DC: National Press Academy.

The area within the triangle represents the general population. The base of the triangle corresponds with health promotion and illness prevention activities. The area in the middle of the triangle corresponds to moderate use and the delivery of brief interventions at the level of primary health care. The apex of the triangle represents that small section of the population with substantial to severe substance related problems for whom the Mental Health Directorate of the Ministry of Health (the funder) currently has the mandate to fund specialist alcohol and drug treatment services.

Movement along this continuum is not just one way, and at various points people 'exit' and no longer require external intervention. Another aspect of this triangle is made up of maintenance, aftercare and recovery.

Public health

Health-funded activities specific to reducing alcohol and other drug-related harm include \$4 million (GST exclusive) of Ministry of Health public health funding focused on prevention (excluding tobacco). These activities are aimed at the less severe end of the continuum of use and include:

- public health advocacy
- increasing community awareness and action
- strengthening strategic alliances, skills and knowledge
- monitoring and surveillance
- public health regulation.

Public Health is also responsible for funding of the Needle Exchange Programme. This programme aims to reduce the harmful effects on health (HIV and other blood borne diseases such as Hepatitis C) that result from intravenous drug use.

Primary health

People at risk of developing severe alcohol and drug problems, or who already have severe problems but do not present to treatment services, may be assisted by less intensive levels of intervention intended to halt the progression towards a more severe problem.

To achieve a shift towards including community resources as part of the spectrum of care, primary care/generalist providers (such as GPs, social workers, community workers, police officers and probation officers) will need to become better informed about the potential usefulness of early intervention and brief interventions. They will need to be better able to recognise, assess and refer more complex problems to specialist treatment services.

The Australian monograph 20 series *An Outline for the Management of Alcohol Problems: Quality assurance project* states that early intervention is a proven effective method for reducing the alcohol consumption of excessive drinkers who are detected in primary health care and other health care settings. It suggests that these interventions should be delivered in as many of these settings as possible as a matter of urgency.

Brief interventions

Brief interventions can be a low-cost, effective type of intervention for alcohol and drug related problems. They are time-limited, promote self-efficacy and self-help, and utilise preventative strategies to promote reductions in substance use in non-dependent consumers / tangata whaiora. All types of brief intervention place a great emphasis on readiness for change and taking personal responsibility for change.

The evidence for the effectiveness of opportunistic brief interventions in settings that are not affiliated with specialised treatment programmes is much stronger than for brief interventions in specialist settings for those seeking help. If the evidence is not to be misinterpreted by policy makers and purchasers of services, differences between the kinds of brief interventions must be borne in mind.

We are describing a complementary set of services within a continuum of care, not the establishment of a cheaper primary care model at the cost of availability and access to much needed specialist services. If it is proven that the overall cost of this comprehensive approach will result in greater population health gains and at the same time substantially reduce the social cost to the community, then we need at least to consider an investment in early intervention pilot programmes.

It is also important to examine differences in effectiveness in the treatment-seeking population as opposed to the area of opportunistic interventions in the non-treatment-seeking population. It will also be necessary to review the effectiveness of brief interventions with priority groups such as Māori, Pacific peoples and youth.

The majority of studies examining brief interventions have typically looked at alcohol use, and more research into the effectiveness of such brief interventions with regard to other substances should be encouraged.

Recent progress

Initiatives in mental health primary care since 1997 that may affect treatment of substance abuse disorders include the production of best practice guidelines for *Recognising, Assessing and Treating Alcohol and Cannabis Abuse in Primary Care* (National Health Committee 1999).

The full implementation of these guidelines in primary health care settings requires additional resourcing for the development of standardised training packages, as well as the actual training of personnel in a way that increases the uptake of that training.

It also needs to be recognised that there is no evidence that the numbers of people with a severe disorder will decrease with good early screening and identification of problems. In fact the numbers of people being referred to specialist treatment services will probably increase in the short term as more people are identified by primary care services as requiring specialist intervention. In order to initiate early intervention strategies simultaneously, it is important that the level of services for people with a severe disorder are maintained and enhanced. This may be through the development of new specialist services where there are currently none or by increasing the effectiveness of existing specialist services.

Appendix 2

National Advisory Group Members – National Alcohol and Drug Services Funding Strategy

Name	Organisation
Pam Armstrong	Northland Health and Nga Manga Puriri
Basia Arnold	Ministry of Health
Halo Asekona	PIDAS and Pacific peoples' Network
David Benton	Lakeland Health and chair of the Methadone Providers Network
Dr Gavin Cape	Methadone, A&D Services, Healthcare Otago and University of Otago
John Challis	Odyssey House and National A&D Treatment Forum Executive
Phillipa Gaines	HFA Mental Health Project Team
Heather Hapeta	Southern A&D Consumers Network, ADA
Ann Hobby	Ko Te Poumanawa Oranga (MDO), Blenheim
Terry Huriwai	External consultant (NCTD)
Te Pare o Waitaha Kingi	Te Atea Marino, Regional A&D Service, Waitemata Health
Dr Fraser Todd	Acute Inpatient Services, Health-Link South and NCTD

Morehu Kara (Te Atea Marino) represented Te Pare Kingi on one occasion and Vicki Crarer (Health Waikato) did the same for John Challis.

Appendix 3

Estimated Ministry of Health Expenditure for Alcohol and Drug Treatment Services

Table A1

Ministry of Health office	Estimated 2000/01 expenditure (\$M)	Estimated 1999/00 expenditure (\$M)	Estimated increase (\$M and %)
Auckland	20.8	17.7	3.1 (18%)
Hamilton	9.5	8.7	0.8 (9%)
Wellington	11.6	10.5	1.1 (10%)
South Island	4.2	13.1	1.1 (8%)
Total	56.1	50.0	6.1 (12%)

Appendix 4

Estimated Current Volumes against MHC Blueprint Guidelines

Table A2

Ethnicity	Number	Description of service	Resource guideline for this population	Estimated dedicated current volumes	Resource gap (volumes)
Māori ¹	589,000	Community – FTE	27–78	71	
Minimum (30%)	176,700	DD – FTE	6–18	7	
Maximum (85%)	500,650	DD – beds	4–13	0	
Average (75%)	441,750	Methadone – places	265–751	49	
		Residential – beds	13–38	76	
		Detox – FTEs	1–4	0	
		Detox – beds	5–15	0	
Pacific ²	202,800	Community – FTE	9–27	10	
	60,840	DD – FTE	2–6	0	
	172,380	DD – beds	2–4	0	
	152,100	Methadone – places	91–259	0	
		Residential – beds	5–13	1	
		Detox – FTEs	0–1	0	
		Detox – beds	2–5	0	
Total population all ages ³	3,873,000	Community – FTE	600	360	240
		DD – FTE	136	32	104
		DD – beds	97	0	97
		Methadone – places	5810	3581	2229
		Residential – beds	318	689	-371
		Detox – FTEs	29	0	29
		Detox – beds	116	14	102

For the year 2000, total population of 3,873,000

Notes: ¹ The proportion of Māori who would use Māori alcohol and drug services as they are currently funded are estimated at three levels: a minimum (30%) means that it is considered that no less than 30 percent of Māori would use these services and similarly that no more than 85 percent of Māori would use these services, the average is what is expected to be the proportion of Māori who would use Māori services. The resource guidelines are therefore stated as a minimum/maximum range.

² As for Māori.

³ Resources identified for the above Māori and Pacific services are included in total population figures.