

S O U T H I S L A N D
A L C O H O L A N D O T H E R D R U G
S E R V I C E S R E V I E W

DISCUSSION DOCUMENT

and

**STRATEGIC FRAMEWORK
FOR
SERVICE DEVELOPMENT**

May 2004

Canterbury
District Health Board
Te Poari Hauora o Waitaha

Otago
District Health Board
Poari Hauora-ā-rohe ki Ōtāgo

Nelson Marlborough
District Health Board

Southland District
Health Board
Te Poari Hauora o te Rohe o Marilolau

South Canterbury
District Health Board

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Te Poari Hauora a Rohe o Tai Poutini

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Principal Author: Paul Rout
Project Manager
Mental Health
South Island Shared Service Agency
PO Box 3877
Christchurch

Phone: 03 372 1000

DDI: 03 372 3025

Fax: 03 372 3058

Email: paul.rout@cdhb.govt.nz

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1 INTRODUCTION

1.1 Background

The Review has been carried out by the South Island Regional Mental Health Network on behalf of the six District Health Boards in the South Island to assist in the implementation of the goals and objectives in the South Island Regional Mental Health Strategic Plan. The Network is a forum of planning representatives from the six DHBs and is assisted in its work by personnel from the South Island Shared Service Agency Ltd (SISSAL).

1.2 Purpose of the Review

The purpose of the Review was to develop a plan for the development of specialist alcohol and other drug treatment services in the South Island over the three years ending 30 June 2007 within the resources available. Because many of the most intensive treatment services including residential treatment and inpatient detox are South Island wide in coverage, the Review takes a regional perspective that builds on district needs and services

The Review has established service development objectives for the full range of specialist AOD services. This includes assessment, referral and case management, home, community, social and medical detox, outpatient counselling, day treatment programmes, residential treatment, supported living services, methadone treatment, aftercare/reintegration and relapse prevention.

Specialist mental health services for co-existing disorders are included as a specific issue. However the breadth of issues overall has prevented a comprehensive analysis of co-existing disorder needs within the Review time frame. Consequently a decision has been made to address these issues as part of a separate sub-project due for completion in 2004/05.

As well as looking at the need for specific types of service the Review also examines the inter-relationship and integration of services within the AOD treatment system and with other sectors to ensure coordinated service delivery and continuity of care for service users.

The Review sought to identify needs of specific population groups including:

- Maori;
- Pacific Peoples;
- Adolescents;
- Women;
- Co-existing disorders;
- Older people;
- Opioid users;
- Offenders with alcohol and drug problems (health funded services primarily);
- Family/whanau members.

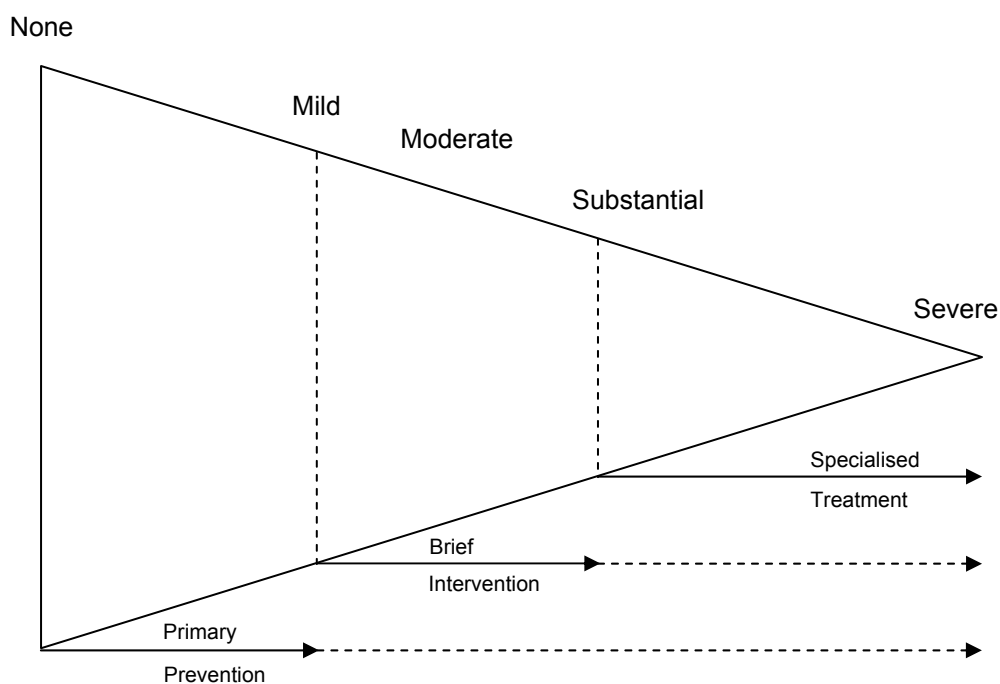
Intervention for tobacco dependency is excluded from the scope of the Review.

1.3 The AOD Intervention Context

In practice a broad integrated strategic approach is needed to effectively reduce substance related harm. It is now recognised that there are many different degrees of alcohol and other drug problems along the continuum of use, that require a range of responses in a variety of settings that are appropriate to the severity of the problem (see Fig 1 below).

This includes health promotion and public health strategies to prevent people developing substance related problems, brief interventions for mild to moderate problems in primary settings such as general practices and social services, and specialist secondary and tertiary interventions for substantial to severe levels of problem.

Figure 1: The relationship between the severity of alcohol and other drug problems and the type of intervention needed.¹



While the Review recognises the importance of a comprehensive strategy to address AOD problems the focus in the Review is primarily on intervention in the specialist AOD treatment sector for people who are substance dependent.

1.4 Review Project Membership

A Project Team was appointed by the SIRMH Network to develop the project plan and methodology, monitor progress, and formulate the review's final recommendations. Team

¹ Source: Adapted from the Institute of Medicine. 1990. *Broadening the Base of Treatment for Alcohol Problems*. Washington DC; National Academy Press.

members included a Ministry of Health representative in recognition that at the inception of the project a significant South Island AOD service – the former Hanmer Clinics – was managed by the Ministry.

A Review Reference Group as a formal advisory group to the project was established. The Reference Group's role was:

- To provide expert advice to the project team on service development needs and best practice principles and models.
- To provide a small group forum to work through specific planning issues associated with the project.

Project Team

Jane Cartwright (Project Sponsor)	Planning Manager, CDHB
Paul Rout (Project Manager)	Service Manager, Mental Health, SISSAL
Terry Huriwai	Project Manager, Alcohol and Drug, Ministry of Health
Tony MacDonald	Financial Analyst, SISSAL

Project Reference Group

Name	Role in AOD Sector	Stakeholder Links
Eileen Varley	Manager AOD Service, NMDHB	Clinical, Provider Arm
Roger Morgan	Psychiatrist, CADS, CDHB	Psychiatrist, Provider Arm
Sandy McLean	Manager (former), Odyssey House, CDHB	Clinical, NGO
Karen Watson	Co-ordinator, Familial Trust, CHCH	Family, NGO
Lesley Donaghy	Manager AOD Service, SCDHB	Clinical, Provider Arm
Roger Berwick	Manager AOD Service WCDHB	Clinical, Provider Arm
John Caygill	Manager AOD Service ODHB	Clinical, Provider Arm
Anila Paul	Team Leader, Rhanna Clinic, SDHB	Clinical, Provider Arm
Gail Payne	Southern Regional Manager, ALAC	Alcohol Advisory Council of NZ
Lynn Iti	Regional AOD Consumer Adviser (former), ADANZ	Consumer
Takarangi Metekingi	Cultural Therapist, Moana House, Dunedin	Clinical, Maori, NGO
Gilbert Taurua	Business Development Manager, He Oranga Pounamu	Maori, NGO

1.5 How Information Was Obtained For the Review

To enable the construction of service development objectives that accurately reflected the needs of the South Island population and reflected best practice guidelines the Review team gathered information in the following ways:

- District information gathering forums to identify needs and suggestions for service development. Eight were held in total.
- Written submissions based on a structured questionnaire from individuals and groups. Over thirty were received.
- Key informant interviews with individuals who have acknowledged expertise from a research and evaluation base. These included staff from the National Addictions Centre and ALAC.
- A service profile questionnaire that included questions on utilisation data and staff profiles.
- Strategic directions from national guidelines such as the National Strategic Framework for Alcohol and Drug Services².
- Expert knowledge of clinical practice and local needs from members of the Project Reference Group;

A draft report including proposed service development objectives was completed in June 2003 and distributed to stakeholders for comment as part of the DHB consultation process. Over 20 written submission were received and consultation forums held for providers and consumers/tangata whaiora by DHBs. Feedback was also received from providers at the ALAC Southern Regional Managers Forum and from Maori at the South Island Alcohol and Other Drug Hui held at Rehua Marae. Following this, detailed discussions on the financial and service implications of the recommended objectives were held with the funding and planning sections of each DHB.

The Review reports outlining the recommendations and rationale behind them have been publicly released and widely distributed by DHBs. The reports provide the guide for the implementation of the Review findings by each DHB both individually and collectively.

The following final report documents are available on request from South Island District Health Boards or the South Island Shared Service Agency. Copies of these reports are also available on DHB web sites.

- a) A Summary of the Findings plus the Strategic Framework For Service Development objectives.
- b) Discussion Document (This report): Detailed analysis of the key issues along with the Strategic Framework For Service Development.

1.6 Funding Assumptions

No significant additional funding is likely to be available through District Health Boards for the delivery of alcohol and other drug treatment services in the short to medium term. The only exception to this is the announced allocation of central government funding for intensive AOD youth and kaupapa Maori day programme/accommodation services.

² Ministry of Health, 2001.

DHBs who are comparatively under-spending on alcohol and other drug services may choose to increase funding against Blueprint guidelines. However in general, apart from a small to modest shift in resources from other mental health spend to AOD services in some DHBs, it has been assumed that any additional funding can only be sourced from a re-configuration of existing alcohol and other drug service resources. Consequently the proposed service development objectives have been developed within the limits of what is considered feasible in terms of the resources projected to be available in the next three years.

The Mental Health Commission Blueprint resource guidelines are assumed to set the current parameters for the total resources available for alcohol and other drug treatment in each DHB. The Blueprint resource levels for individual service components are treated as guidelines but it was accepted that some variance from the Blueprint would occur in response to evidence from the needs analysis.

While the service configuration and associated resource levels may change, the intention of the Review is to maintain as a minimum, the number of people currently being effectively treated by specialist alcohol and other drug services.

For the purposes of the Review it is assumed that all residential treatment services including supported living services (except for Caroline House, Timaru), in-patient medical detox and residential social detox are regional services in terms of the area served.

Final decisions on the funding and configuration of alcohol and other drug services remains the prerogative of each DHB.

1.7 Acknowledgements

The Project Team gratefully acknowledges the significant contribution that many people and organisations have made to the successful completion of the South Island AOD Services Review. In particular:

- Members of the Project Reference Group.
- Clinicians, providers, consumers/tangata whaiora and family/whanau members who attended consultation meetings and made submissions.
- DHB Planning and Funding, and General Managers.
- Members of the SISSAL Information and Analysis and Mental Health Teams.
- Key informants including the National Addiction Centre staff.
- ALAC.
- Ministry of Health.
- ADANZ staff including the Regional AOD Consumer Advisers.

Paul Rout
Project Manager

Jane Cartwright
Project Sponsor

Terry Huriwai
Ministry of Health

2 DISCUSSION OF KEY ISSUES

2.1 Prevalence Data

Significant sections of the New Zealand population regularly consume alcohol and tobacco, and use products containing caffeine. An increasing number are also using illegal drugs and misusing prescription medicines. The most commonly used drug is alcohol, followed by tobacco and cannabis. Other drugs such as opiates (heroin, morphine etc), stimulants (amphetamines, cocaine) and hallucinogens are used to a lesser degree.

While the majority of people use drugs such as alcohol and cannabis without significant harm, the misuse of alcohol and/or other drugs does come with considerable human and financial costs. These include physical and mental health problems, injury and death on the roads, drowning, violence, foetal abnormalities, absenteeism and impaired work performance and criminal offending. As a consequence, untreated substance abuse and dependency has a significant flow-on impact on expenditure in the health and justice sectors in particular.

The following table represents the best current estimates for NZ of six month prevalence rates³.

Table 1: Estimated NZ six month prevalence rates for alcohol and other drug problems.

DSM IV Diagnosis	% of the Population in a Six Month Period
Alcohol abuse	10%
Other drug abuse	2%
Alcohol dependence	5%
Other drug dependence (Other drug is 90% cannabis)	1%

Dependency rates for Maori are estimated at 8%⁴.

Services in the scope of the Review primarily work with people in the dependent category, however in the absence of effective intervention in the primary sector, outpatient services also see a significant number who fall in the abuse category.

2.2 Changes Occurring in the Treatment Population

Clinicians on the project reference group and key research informants for the Review identified the following changes that have occurred over the last five years to the population accessing alcohol and other treatment services. Some changes reflect actual changes to the population profile, while others may indicate a raised awareness and consequently increased

³ Based on Oakley-Browne MA, Joyce PR, Wells JE, Bushnell JA and Hornblow AR. 1989. Christchurch Psychiatric Epidemiological Study. Part II: Six month and other period prevalences of specific psychiatric disorders. *Australian and NZ Journal of Psychiatry* 23(3): 327-40; and the Australian National Drug Strategy Household Survey.

⁴ *National Strategic Framework for Alcohol and Drug Services* (p3).

screening for certain client features such as coexisting disorders or Foetal Alcohol Syndrome that need to be taken into consideration in developing a treatment plan.

- Increased level of cannabis use in association with alcohol.
- Higher levels of poly-substance abuse in general.
- Clinicians expect to see the impact of the significant increase in methamphetamines on the population seeking treatment in the next few years with associated psychiatric complications. However at present large numbers are not being referred for treatment in the South Island.
- A slow increase in opioid use in the general population and a steady increase in opioid related hospital admissions is increasing the number of opiate dependent clients seeking opioid substitution treatment.
- Fewer service users are self-referring.
- There is a higher number of Justice referrals including on release from prison and clients on home detention. The establishment of a new 360 - 600 bed prison at Milton, Otago is expected to accentuate this trend in the South Island.
- Higher number of referrals from the mental health sector often with a forensic component.
- Growing complexity of clients in terms of:
 - More severe levels of dependency.
 - Presence of co-existing mental health disorders including anti social personality disorder and psychotic disorders.
 - Multiple drug use.
 - Criminal offending.
 - Other health and disability issues Eg. Hep C, Diabetes, T.B., Drug related injuries, organic brain damage.
 - Greater rehabilitation needs.
- Higher levels of chronic alcohol caused intellectual disability are being identified due to increased screening for Foetal Alcohol Syndrome and Foetal Alcohol Effects.
- Gradual increase in the number of women referred to treatment with attendant issues around parenting and child care responsibilities.
- Gradual increase in the number of young people receiving treatment. Average age is dropping and the majority of service users are in their teens or twenties.
- Earlier onset of alcohol and other drug disorders (related to earlier onset of mental health issues e.g. depression). This may contribute to the reduction in average age.
- Increasing number of clients identifying as Maori. This partially reflects the higher number of Justice referrals.
- An ageing population indicates an increasing need in older persons (65+). However the extent of need is unclear as few people in this age group are seeking treatment.
- Clinicians report clients are more likely to meet criteria for alcohol and/or other drug dependency, however this varies between DHB's.

2.2.1 Implications for Service Delivery

Changes occurring to the treatment population are having an impact on the ability of the alcohol and other drug treatment system to respond to the resulting needs. Key implications for service delivery include:

Workforce Development

A shift in the skill base of AOD workers is required to address changing needs, particularly with regard to interventions for cannabis abuse and in the future for methamphetamine abuse, assessment and treatment for co-existing disorders and working with young people. Training programmes are required to address these issues for existing workers.

Recruiting suitable staff to work with specialist populations such as youth justice clients, co-existing disorders and Maori will be difficult given the workforce shortage in the AOD field as a whole and with regard to these population groups in particular. The workforce shortage is being exacerbated by the high turnover of staff in the AOD field.

Integration of Mental Health and Alcohol and Other Drug Services

Recognition of the high levels of co-existing disorders in AOD clients raises significant issues for how mental health and AOD services work together to ensure comprehensive treatment and rehabilitation within an integrated case management model.

Intersectoral Collaboration

Higher numbers of young people and justice referrals reinforce the need for collaborative efforts between the health, justice, welfare and education sectors to ensure comprehensive intervention approaches are developed which meet the full range of the individuals needs and improve client outcomes. This could include joint planning, funding and service delivery with Child, Youth and Family or Corrections.

Adapting Services to Meet the Needs of Young People

Higher numbers of young people especially via sources such as the Youth Drug Court have a number of implications for services. Including:

- Significant engagement/motivation issues for 14 to 19 year olds in particular. Few young people are self motivated to reduce their drinking and other drug use at this age. Consequently services need to allow a longer period of time for client engagement, set realistic treatment goals and work within a longer timeframe than for adults.
- Collaboration with Child, Youth and Family in addressing care and protection and youth justice issues alongside the treatment of AOD disorders.
- Involvement of family/whanau in treatment is critical.
- The need for a social-ecological approach that focuses on the systems young people interact with, including family, school, work, peers and community and social institutions. Youth worker and social worker roles support this approach.
- The value of developing specialist treatment streams for young adults (20 to 25 years) in adult services.

Adapting Services to Meet the Needs of Justice Clients

Increasing numbers of Justice clients has implications in terms of:

- More severe AOD problems and higher more complex needs in treatment.
- Pressure on intensive treatment options especially long term therapeutic communities.

- Need for better transition between prison and residential treatment.
- Need for better co-ordination between Corrections and AOD interventions and sentencing.
- Majority of clients will be Maori increasing the need for culturally appropriate services.
- Significant number of Maori women.
- Increased demand on assessment services for Court and Parole Board reports.

Adapting Services to Meet the Needs of Women (and Children)

Increasing numbers of women has implications in terms of:

- The limited availability of residential services for women.
- The provision of child care while receiving treatment.
- Care and protection issues for children that may involve Child, Youth & Family.
- The need for women only programmes including for safety.
- Problems with eligibility for WINZ benefits while in residential treatment if have an employed partner.
- Poor pregnancy outcomes particularly for women who use opiates.

The Impact of More Complex Disorders

A greater number of people with more complex disorders is requiring the delivery of more comprehensive, flexible services, more specialist services for specific populations, a multi-skilled workforce, more complex treatment planning and case management involving a greater range of services, greater pressure on intensive treatment options and more extensive longer term aftercare and rehabilitation services.

This has significant implications for the integration and coordination of the components that make up the treatment system as a whole. It also highlights the need for the ongoing review of models of care and clinical pathways with the aim of ensuring the best possible outcomes within the current resources.

2.3 Best Practice Guidelines

The Review has developed the following key best practice guidelines that should underpin future service development. They are based on the results of the key informant interviews with recognised treatment research experts, the views of the Project Reference group and the guidelines in the National Strategic Framework for Alcohol and Drug Services.

- a) Use of new pharmacotherapies. There was widespread agreement amongst researchers and medical clinicians that the development of new pharmacotherapies for addiction utilising drugs such as Naltrexone, Acamprosate and Buprenorphine offered significant opportunities for improving treatment outcomes. They were seen as particularly useful for people with problems with discontrol i.e. who engaged in binge drinking. The new pharmacotherapies help establish a pattern of abstinence and can potentially reduce the level of recidivism and the length of intensive treatment required.

The difficulty with accessing these new pharmacotherapies is the high cost to the consumer for those not yet subsidised by Pharmac. However in a significant development Naltrexone has recently been placed on the pharmaceutical schedule and will be available at a subsidised price for people undergoing AOD treatment in New Zealand.

- b) Earlier intervention in the natural history of the disorder. The aims being to minimise the potential harm of the disorder to the individual and others and reduce the need for longer term, more intensive treatment.

In practice this will require a greater focus on screening and problem identification in the primary and allied sectors and better access to assessment and referral services in community based settings.

- d) Utilising motivational approaches was considered very useful in engaging people in the treatment process.
- e) Family based approaches which include ‘significant others’ in the treatment process from assessment onwards, was viewed as a best practice model that should be given much greater emphasis in treatment. This has significant implications for services in terms of a culture change in treatment philosophy and the need to upskill clinicians in family based approaches.

Whanau based treatment was strongly supported by Maori and Pacific Peoples who were already applying these approaches within their own cultural context.

An extension of the family model is the social network approach which involves the use of treatment allies.

- f) Compulsory and voluntary treatment orders under the Alcohol and Drug Act was seen to have a place especially for older recidivist males (40+) who would benefit from a period of enforced abstinence. However in practice the Act is used more for women than men.
- g) There was support for social-ecological and environmental action support models that treated people in the context of the interchange between the individual and their key social systems including family, peers, school, work recreation and community and cultural institutions. There was good evidence for the social work and community support work approaches which drew on this model.
- h) Efficacy of individual counselling compared to more structured outpatient programmes as the main intervention was questioned.
- i) Treatment evaluation research indicates that residential treatment does not have better outcomes than intensive outpatient treatment for mild to substantial dependency. However treatment in a long term therapeutic community was considered the optimum treatment modality for people with substantial to severe dependency especially for service users with a criminal offending history and anti-social personality disorder diagnosis. In general the longer this group is retained in treatment the better the outcome however these programmes typically exhibit higher drop out rates.
- j) Long term residential rehabilitation services were also indicated for the recidivist with high and complex needs who has few positive environmental supports.
- k) There was support for the greater use of short term residential treatment (1 to 4 weeks) in conjunction with intensive outpatient options for less complex disorders. On this basis there was room to significantly reduce the average length of medium term residential treatment (8 to 12 weeks). There is some evidence that a treatment period of three months is the optimum length of treatment for an individual across all modalities for the moderate to severe dependency group.

Some clinicians and researchers suggested short lengths of intensive residential treatment with outpatient follow up could be effective for moderate to severe dependency.

- l) Engagement is a critical issue in achieving retention and motivation in treatment. This is primarily related to staff attributes. A pre-treatment step-up engagement approach is being trialed in the North Island to help deal with the high drop out from residential treatment. Although the efficacy of this for chaotic clients was questioned.

- m) Referrals to outpatient assessment services should be seen within 24 hours. There is typically a very high drop out rate before both first and second appointments.
- n) The need for a spiritual component to treatment is being increasingly recognised.
- o) Some evidence that 12 step follow-up has better outcomes in residential treatment and that cognitive behavioural therapy has better outcomes for co-existing disorders and offenders.
- p) Enabling women to continue to live with their dependent children while undertaking residential treatment improves outcomes.
- q) Some argued for separate treatment for criminal offenders because of the sub-cultural issues. Including therapeutic communities in prison.
- r) Better management of clients and co-ordination of services at each step of the clinical pathway.
- s) Longer term follow-up with open ended access was promoted by one key informant. In general the reference group strongly supported the role of aftercare in relapse prevention.
- t) More holistic approach to health of methadone clients.
- u) Primary care services have potential to have a much greater role in treatment and support across the severity spectrum.

2.4 Waiting Times

One of the most significant barriers to accessing treatment that was identified was the waiting time individuals had to undergo before accessing key points in the treatment system. Results of the service profile survey indicated significant waiting times existed for the following service types:

- a) Assessment services. Average time from referral to first appointment varies from one to five weeks depending on DHB and service.
- b) Methadone treatment. Average waiting time varies from one to eight months depending on DHB.
- c) Long term residential treatment especially for clients with major criminal offending issues (4-8 weeks) and recidivist alcoholics under Section 8 or 9 of the AOD Act (5-8 weeks).

The level of engagement of the service user in the treatment process was considered a critical factor in successful treatment outcomes. Typically there is a high drop out rate (up to 30%) between referral to a specialist AOD assessment service and a high drop out between first contact and the second appointment. While there may be a number of reasons for this, any delay is likely to exacerbate the problem, particularly if weeks in length.

At the beginning of the intervention process individuals tend to be ambivalent regarding behaviour change with regard to their alcohol and drug use and therefore about treatment. As motivation for change waxes and wanes over time, missing the 'window of opportunity' by delaying assessment runs a risk of people withdrawing from the intervention process during the waiting period.

Significant delays in access to treatment following assessment runs a similar risk but also raises safety issues if support is not available in the interim. For high and complex needs at the severe end of the spectrum, other health or justice related events can quickly intervene and negatively change the course of intervention.

Waiting times are one indication of unmet need that could either indicate the need for an increase in resources in a particular service area, or the need to identify strategies to use existing resources more efficiently.

2.4.1 Implications for Service Delivery

The Review has attempted to address waiting lists by recommending a number of strategies.

- a) Set a benchmark target for individuals seeking assessment of an initial contact with within one working day of referral to the assessment service and a full appointment within five working days. It is recognised that this will take time to achieve and a more efficient use of resources.
- b) Utilise telephone contact with basic screening for initial contact as an interim measure before first face to face appointments.
- c) Introduce a stepped assessment model in community assessment and referral services to more effectively use the resources available and therefore increase the service capacity. This model reserves comprehensive assessment for the most severe disorders and focuses on screening and brief assessment for mild to moderate problems. Christchurch is the district expected to benefit most from this approach.
- d) Develop a greater level of intensive outpatient services in conjunction with short term residential services that should increase the flexibility and availability of other options.
- e) Improve identification of clients for whom shorter lengths of intensive treatment would be appropriate.
- f) Utilise primary care services better for mild to moderate AOD problems.

Specific waiting list issues for methadone maintenance treatment will be addressed as part of the Methadone Service Development Project in 2004/05.

2.5 Needs of Specific Populations

2.5.1 Key Service Delivery Issues for Maori

A number of issues were raised by Maori at both the information gathering and consultation stages of the Review. The issues outlined below are primarily a summary of the issues raised by the Maori members of the project reference group in conjunction with the comments made in individual submissions by Maori AOD workers and agencies. Issues include:

- a) The degree to which the current national kaupapa Maori mental health and alcohol and drug service specifications limit the development of broader Maori holistic sectoral or intersectoral approaches that support the development of Whanau Ora.
- b) The degree to which the Privacy Act and Health Information Privacy Code restrict a whanau based approach, or whether it is their interpretation which is the main problem. If the latter then training is required.
- c) The need for more kaupapa Maori services and programmes and the need to address the cultural and clinical effectiveness of some existing outpatient programmes for Maori. The retention of a residential service dedicated to Maori was a very high priority and of considerable concern.

The main gaps identified for kaupapa Maori AOD services in the South Island were the need for an adult and youth outpatient service in Dunedin, a day treatment programme for males in Christchurch, a youth outpatient service in Christchurch and the development of a regional residential service preferably based in Christchurch.

The Review also proposes the trial of weekend/weekday wananga as means of offering an alternative to individual counselling or medium term residential services, especially in districts where intensive outpatient day programmes are not viable (See section 2.6.3 for further discussion of this model).

A preferred model for developing a regional kaupapa Maori residential service based in Christchurch was to link supervised accommodation for people requiring a residential setting with a day programme which would provide the core therapeutic component. This is seen as a more viable and flexible option given the limited resources available and the numbers and diversity of potential clients.

At the time of the consultation Maori were not aware of the proposed closure of the Taha Maori programme at Hanmer Springs. Support for the Taha Maori service varied from those who wanted to see it retained and its mana strengthened to those who believed the time had come to use the resources to establish a new Maori residential treatment programme, operated by Maori for Maori as a true kaupapa Maori service in the South Island. Many of the tangata whaiora who participated in consultation forums emphasised the importance of the Taha Maori programme and its location in their healing and recovery.

- d) Comments from individual Maori also reflected the debate as to what constitutes a true kaupapa Maori service. There was agreement that this was at least defined as ‘by Maori for Maori’ but debate was evident about whether particular services employed a true cultural model and the degree to which all Maori clinicians were comfortable working in a kaupapa Maori context. This tends to reflect the diverse realities of both Maori staff and tangata whaiora.
- e) Disjunction between treatment planning based on the cultural assessment and treatment planning based on the clinical assessment. The mismatch of the two processes tends to devalue the cultural assessment and produce poorer quality treatment planning. A more integrated approach to treatment planning is required within services especially with regard to the mainstream delivery of services to Maori.
- f) Workforce development is a major issue for all alcohol and other drug services but there are even greater workforce challenges for the delivery of services for Maori. These include:
 - Problems with obtaining quality clinical and cultural supervision for Maori AOD workers.
 - Not enough Maori AOD trainers.
 - Lack of funding for workers to undertake training.
 - Need for greater support for the organisational development of Maori agencies.
 - Significant problems in retaining skilled Maori AOD workers – need for succession planning.
 - Lack of skills around cultural assessment and safety for mainstream workers.

The National Alcohol and Drug Strategic Framework notes that it is crucial that the Maori alcohol and drug workforce (both in kaupapa Maori and mainstream services) continues to develop complementary clinical and cultural training and capacity building.

- g) In practice a significant number of tangata whaiora will continue to need or choose to be treated in mainstream agencies. Thus non-Maori staff in all services need to be well trained and culturally aware to provide a culturally friendly and safe environment. For many Maori the starting place for the delivery of appropriate services to Maori was the

need for all agencies to acknowledge cultural diversity for all clients and respond accordingly.

- h) While there was support for mainstream agencies employing Maori workers to provide appropriate cultural care for tangata whaiora accessing mainstream services, submissions from Maori highlighted the need for adequate cultural support and safety structures to be put in place for individual workers.
- i) The need to better review and monitor the responsiveness of all services, kaupapa and mainstream, for Maori was identified. One core mechanism for addressing this need is through the DHB audit framework. A culturally appropriate audit tool, focused on eliciting responsiveness to Maori for Kaupapa and mainstream needs to be developed in conjunction with national initiatives currently underway.
- j) More research funding for Maori AOD issues is needed.
- k) Poor cohesion, communication and collaboration amongst Maori agencies within AOD services, and with other mental health services and agencies working in non-health sectors. Initiatives such as the development of a regional Maori AOD service network and the Canterbury Maori Mental Health Provider Network are examples of mechanisms which seek to achieve greater collaboration and development.
- l) Assessment/outpatient services need to be located around access points for Maori to improve accessibility and to reduce stigmatisation issues. It would be useful to survey what those points should be.
- m) The sustainability of Kaupapa Maori AOD services in terms of development and quality improvement was raised. Suggested strategies to secure the capacity and capability of services over time included collaborative arrangements with other kaupapa Maori services and partnerships with mainstream services.
- n) There was a call to improve delivery for Maori by incorporation of whakawhanaungatanga – Whakapapa, Rongoa, Mirimiri, Tohunga – in treatment. The inclusion of rongoa (Maori healing practices) in treatment, in particular for detox and for opioid users, was viewed as under utilised.
- o) Consultation indicated general support from Maori for the proposed service development objectives in the consultation document. However there was widespread criticism of the DHB methods for consultation with and participation by Maori in developing the objectives. There was consequently a strong call for DHBs to actively involve Maori stakeholders in each district in the ongoing planning required to implement the final objectives in detail.

It is recognised that the AOD Review cannot resolve nor should it attempt to resolve all the issues raised above. It is important that processes are put in place which enable Maori, in partnership with DHBs, to develop culturally appropriate solutions to the challenges facing service delivery for the Maori population.

Summary of Review's Strategic Directions for Addressing Issues for Maori

- Mainstream alcohol and other drug services improve responsiveness to Maori.
- A more extensive range of kaupapa Maori services and programmes.
- Include responsiveness to Maori as a key focus of future AOD service audits.
- Integral participation of Maori in all service planning and development.
- Increased access to training for Maori AOD workers.
- Collaborative service development arrangements.

- AOD service delivery to be a core consideration in regional and district Maori health planning initiatives.

2.5.2 Co-existing Disorders

Significant numbers of clients in AOD services present with another co-existing mental health disorder (over 77%)⁵. Significant numbers of clients presenting to other mental health services also present with an AOD disorder (over 50%)⁶.

The National Strategic Framework for Alcohol and Drug Services advocates for an integrated approach to the treatment of people with a dual diagnosis ie. Substance abuse and mental health disorders. Todd and colleagues in ‘The Assessment and Management of People with Co-existing Substance Use Disorders’ (1999) guidelines describe the key principles of treatment for co-existing disorders whether in alcohol and drug or mental health settings. The difference between the two settings is mainly the level of complexity being presented.

Key principles of the treatment of co-existing disorders:

Safety	Of themselves and others
Stabilisation	Of symptoms and living conditions
Comprehensive assessment	An individualised formulation of current problems, psychosocial functioning (including variables) leading to an ongoing process of re-evaluation
Treatment planning	Needs to be considered in the short term, medium term and long term
Clinical case management	Insuring treatment is integrated and co-ordinated
Integrated treatment	Treatment is cohesive and complementary

The National Strategic Framework notes that in practice many presenting at AOD services with co-existing disorders may not warrant a referral to a specialist mental health team and similarly there are many in mental health services with a substance abuse issue that does not warrant a referral to an alcohol and drug treatment service. In both cases there may not be a referral to a specialist dual diagnosis team. DHB Provider Arm Community Alcohol and Drug Services are increasingly developing a co-existing disorder consult/liason service for other AOD services.

Submissions to the Review varied in regard to whether specialist dual diagnosis services particularly residential services should be established, or whether the effective coordination of mental health and alcohol and drug services was the solution. The consensus of the Project Reference Group was in favour of the latter strategy. The South Island currently purchases a 0.7 dual diagnosis bed from Odyssey House Auckland.

Community based specialist dual diagnosis services for co-existing disorders (‘Mental Health’ and ‘Alcohol and Drug’) are not included in the AOD resource guidelines in the Blueprint as

⁵ Adamson, S; (April 2003). *Naturalistic Treatment Outcome Project (NTOp)*. Final Report to the Alcohol Advisory Council. Produced by the National Addiction Centre.

⁶ For a detailed review of prevalence rates see Todd, F. Sellman, JD and Robertson PJ. (1999). *The Assessment and Management of people with Co-existing Substance Use and Mental Health Disorders*. Wellington; Alcohol Advisory Council, Ministry of Health and Mental Health Commission.

they as they are mapped to the 'Community Mental Health' summary code. Volumes for these services are summarised in the following table.

Table 2: Community Mental Health Service Levels for Co-existing Disorders Compared with 2010 *Blueprint* Targets: Specialist Expertise and Community Teams Combined

	CDHB	NMDHB	ODHB	SCDHB	SDHB	WCDHB	Regional Total
2003/04 Volumes	1.3	0.0	0.0	0.0	0.0	0.0	1.3
2010 Target	16.4	4.6	6.2	1.8	3.5	1.1	33.6
% Achieved	7.9%	0.0%	0.0%	0.0%	0.0%	0.0%	3.9%

No specific service development objectives have been developed for co-existing disorders at this stage of the Review. Instead a separate sub-project will comprehensively review strategies for this population group in 2004/05.

2.5.3 Pacific Peoples

The South Island has a small Pacific Peoples population (1.4%) compared to the North Island. This means that little further development of stand alone specialised AOD services for Pacific Peoples is feasible. The exception to this is the proposed development of an authorised Pacific Peoples assessment and referral service, and expanded community youth service in Christchurch.

The Review had limited opportunity for a review of Pacific Peoples needs however the following priorities for Pacific People were established.

- a) To increase the training and capacity of the Pacific Peoples AOD workforce.
- b) To increase the responsiveness of mainstream services.

The current audit programme for AOD services does include assessment against the National Mental Health Sector Standard 2 regarding services for Pacific People.

2.5.4 Children and Youth

The key priority for the development of services for children and youth has been the establishment of a residential treatment service for 14 to 18 year olds. Currently the only service available to the South Island is the Odyssey House youth programme in Auckland. This is viewed as highly unsatisfactory by clinicians as the long travel distance means that many young people are unwilling to attend and the separation from family and community causes many problems.

The piloting of the Youth Drug Court in Christchurch has highlighted a service gap and there has been considerable pressure from local political leaders to address the need. In 2002 the Associate Minister of Health, Jim Anderton called for proposals for a youth residential service with a view to advocating for funding in the next budget round.

In November a meeting of South Island adolescent clinicians was convened to progress a proposal by the DHBs. The model developed proposed linking supervised accommodation to the current youth day programmes in Blenheim, Christchurch and Dunedin. The bulk of the resource would be for a specialised accommodation service in Christchurch developed in conjunction with expanded day programme resources.

In April 2003 the Minister announced funding for a regional intensive day programme/accommodation AOD treatment service based in Christchurch. Odyssey House Christchurch won the tender for the new service and is expected to begin receiving male and female clients from June 2004.

As over 40% of the service clients are likely to be Maori it is important that Maori with clinical and cultural competence are active participants in the design and delivery of the new service.

2.5.5 Women

The National Strategic Framework notes that differences between men and women have been found in the development of substance use related problems, treatment seeking and responses to treatment. Failing to understand the possible impact of gender may result in inadequate assessment and poor treatment matching.

Consultation expressed concern over the impact on women of the proposed reconfiguration of residential services to outpatient services. There is currently no long term therapeutic community services available to women in the South Island apart from two specialist beds at Odyssey House Auckland. The closure of nineteen publicly funded beds for both men and women at Hanmer Springs has had a bigger impact on women than men due to the limited number of other residential services that can be accessed by women.

Christchurch is the only centre offering specialist day treatment programmes for women.

The Review objectives have focused on increasing the level of specialised day programmes for women in Dunedin and Christchurch, the need to investigate options for access to childcare while in treatment, improving the responsive of services to women and ensuring minimum access to residential treatment.

It was noted that the issue of equitable access to residential care was not necessarily about offering beds for women across all residential services but ensuring there were sufficient numbers of women in residential services that accepted females to offer support and safety. For this reason it may be more feasible for specific services to develop a greater specialisation for women than other services.

In the current funding environment it is not considered feasible to develop long term therapeutic community beds for women with severe disorders and typically a significant history of criminal offending. As an alternative means of addressing this service gap the Review proposes investigating the need for and feasibility of a therapeutic community day programme for women that could be developed in conjunction with short to medium term treatment options.

Access to childcare while receiving treatment is a significant barrier for women with children seeking assistance. The Christchurch 'Circles of Change' residential pilot for women is seen as a successful model for enabling women to receive treatment while living with their children. In the pilot women requiring residential treatment are accommodated in existing women's supported living services with their children and attend day treatment while their children attend school and day care. However expanding this model to other areas in the short to medium term will be difficult due to the shortage of women's day programmes and supported living services.

2.5.6 Older People

Anecdotally there is some indication of a growing number of older people with substance abuse problems, however the actual prevalence of problems is unknown. The Review has not made any recommendations specifically regarding services for older people. As part of

devolution to DHBs of Disability Support Services funding for people over 65 and the implementation of the primary health care strategy, DHBs will need to consider the provision of AOD services for older people.

2.5.7 Criminal Offenders

As noted earlier, increasing numbers of convicted criminal offenders are being referred to AOD services for assessment and treatment. The number of correctional institutions in the southern region relative to the North Island is skewing demand for AOD services in the South Island and Canterbury in particular. Southern prisons have a significant number of North Island inmates who may remain in the district on release. The increased use of home detention as an alternative to incarceration is also impacting on the demand for community and residential AOD services. The proposal to locate a large new prison in Milton will increase the impact on the southern region and Otago in particular.

The development of the youth drug court pilot has highlighted the need for effective residential and non residential intensive treatment options for young people. The possible expansion of the Drug Court to other main centres will put additional pressure on youth treatment services in other districts in the future.

Historically the Dept of Corrections contributed funding to NGO services providing AOD treatment for Corrections referrals. However over the last few years this has largely been withdrawn with an expectation that Health was responsible for picking up the gap.

The Review has focused on five issues in particular.

- a) The pressure on assessment services to provide pre-sentencing and parole reports. Clear boundaries need to be set to determine what is a Justice responsibility and what is a health responsibility as stated in the National Mental Health Service Specifications.
- b) The need to maintain as a minimum the current utilised bed volumes for long term therapeutic communities which target Corrections clients.
- c) The need for a regional youth intensive day programme/accommodation service which meets the needs of youth with both substance abuse and offending issues.
- d) The need for better integration and transition between AOD services in prison and those in the community.
- e) A proposed review of models of care and clinical pathways for criminal offenders with a severe AOD disorder in collaboration with the Department of Corrections that also negotiates funding boundaries.

The Review advocates for the development of a partnership between Health and Corrections that shares resourcing responsibility, coordinates service development and ensures continuity of care for justice clients. The absence of an agreed Memorandum of Understanding between the Ministry of Health and Department of Corrections is making resolution of this difficult.

2.5.8 Family/Whanau

Two issues arose regarding the needs of family/whanau members. Firstly the involvement of family/whanau members as an example of a best practice guideline. Secondly the provision of support for family/whanau members independent of the service user. This issue proved a point of debate in the project reference group with differing views as to whether AOD resources should be used to offer increased support to family members or whether community social services should be the primary vehicle for support.

The National Mental Health Service Specifications include support for family members as a target group. In practice in smaller DHBs, Community Alcohol and Drug Services do provide

counselling and referral to community support services for family members, but only limited support is available in Christchurch and Dunedin.

The Review has struggled to fund significant development of services for family members without new funding. The focus is on ensuring that support is available for family/whanau members independent of the substance user in the Community Alcohol and Drug Service in Dunedin and allocate specific FTE resource in Christchurch for services for family members. However the Review recognises that support beyond this will be primarily the function of social service and community counselling agencies.

There was strong support for increased services for family/whanau members in consultation feedback received from family/whanau stakeholders.

2.6 Balance of Resources Across the Treatment Continuum

2.6.1 Assessment and Referral Services

While a range of Community Alcohol and Drug Services exists the waiting time in many areas for the first full appointment is seen as a barrier to access. Improved efficiency in terms of processes such as stepped assessment is viewed as the main mechanism for reducing waiting times.

The evolution of the specialist assessment role of the Christchurch Community Alcohol and Drug Service as the largest assessment and referral service in the South Island will help increase the assessment capacity in Christchurch. However the Review does not support the establishment of a 'one stop shop' for all assessment or the location of services on the same site as inpatient mental health services.

2.6.2 Detoxification Services

Against the Blueprint resource guidelines the region is most significantly under delivering on the level of inpatient detox services. Kennedy detox in Christchurch offers a regional specialist medical inpatient service and is likely to remain the main viable means of providing a specialist inpatient service anywhere in the South Island given the size and geographical spread of the southern population. However transporting clients to Kennedy from other districts does incur travel costs and staff supervision time.

Most other districts utilise general medical wards for medical detox but this is often unsatisfactory for the following reasons:

- Access is not guaranteed.
- Care is often undertaken by staff without specialist training in detoxification.
- Problems with coordination of care with the Community Alcohol and Drug Service.
- Consumers are reluctant to display withdrawal symptoms in front of other medical patients.

The level and potential means of resourcing service improvements will make resourcing higher levels of detox services difficult in the next three years. However there is room for the better use of existing resources. In particular the development of inter-service protocols between general medical wards and AOD services to improve the quality of care along with training for medical staff. Ideally with CDHB providing a specialist detox consult/liaison training service. There are also opportunities for better utilising Thorpe House Social Detox Service in conjunction with Kennedy Inpatient medical detox.

Work also needs to be undertaken on what are the maximum bed numbers that could be provided in Kennedy Detox service within the current resources.

2.6.3 Outpatient Services

The development of outpatient treatment options, particularly more structured group work and intensive day programmes has been identified as a priority for service development. The ability to resource this has been enhanced by the devolvement to the region of funding previously attached to the now closed Hanmer Clinics contract.

A moderate shift in resources is proposed for the treatment of moderate to severe dependency with lower level needs and less complex disorders. Specifically a much greater focus on day programmes in conjunction with short term treatment (1-4 weeks). Encouraging the development of services which provide both will assist in offering flexible treatment options for a diverse cliental and maintains the benefits that even a short term in a residential setting can provide. This is reflected in the innovative models being proposed for new intensive treatment services which consist of a day programme linked to supervised accommodation. This model enables consumers and clinicians to have a choice of day or residential or combinations of both.

Both the Project Reference Group and National Addiction Centre staff interviewed agreed there was considerable room for reducing the length of residential treatment for the moderate to severe dependency group with less complex disorders.

However travel distances involved and the low relative demand at any one point in time makes the delivery of ongoing day programmes problematic in rural and smaller DHB urban centres. The Review proposes an innovative model for the delivery of intensive outpatient services in these areas. The model consists of the provision of one off weekday or weekend(s) treatment retreats or wananga in settings such as camps or marae and organised through a regional contract. This model would offer intensive treatment for short periods in conjunction with the outpatient counselling currently provided. The advantages of this model is that it can be provided as needed, can be adapted to meet the needs of specific groups such as women, Maori or youth and minimises travel costs and time for the client. It also avoids the costly establishment of permanent facilities and staffing.

There is also potential for linking this model to new developments in online computer based treatment and support.

In undertaking these service developments the value of evaluating new approaches is recognised.

2.6.4 Residential Services

The National Strategic Framework for Alcohol and Drug Services states that 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.

The Background Paper to the Framework quotes the findings from Hall (1997)⁷. who reviewed the results of a number of well-conducted randomised controlled clinical trials and concluded that:

⁷ Hall W. 1997. *Opinion on Consensus Development Report on the Treatment of People with Drug and Alcohol problems*. Wellington: National Advisory Committee on Health and Disability Services.

'Evidence for usual alcohol and drug treatment delivered in an in-patient or residential setting being superior to treatment delivered on an out-patient or non-residential basis was not strong.

In-patient residential care remained most suitable for specific sub-populations of alcohol or drug dependent individuals, such as those requiring closely supervised detoxification, respite care, or who because of the severity of dependence or complexity of problem may require an intense form of supervised intervention.'

One of the benefits of residential treatment, short or long, reported by service users is that it assists them to make a clean break from negative environments and social contacts e.g. drug suppliers.

On this basis the Review has concluded that more effective use of intensive treatment resources is possible. This includes increasing the capacity of medium term residential services by reducing the average length of treatment and introducing short term treatment and respite options. The Review also concluded that there is room for a modest reduction in the volumes of medium term beds and reconfiguring the resources to intensive day treatment options linked to residential services. However there are limitations to the extent this would be practical or clinically acceptable for the following reasons:

- The southern region has lost nineteen medium term beds with the closure of Queen Mary Hospital. This has put additional pressure on other intensive outpatient and remaining residential services. In the twelve months ending 30 September 2002 there were 129 admissions to the Hanmer mainstream programme and 79 admissions to the Taha Maori programme from the South Island. These beds are currently in the process of being replaced by new providers on the basis of the needs of high priority population groups in the region. i.e. youth and Maori.
- There is a need to maintain a relative distribution of beds across DHBs. There are good clinical reasons for locating, where viable, residential services as close as possible to where people live. These include the need to include family participation in treatment, and to integrate residential care with intensive outpatient services and aftercare. There is therefore an argument for maintaining bed levels in Nelson/Marlborough and Otago/Southland areas and focusing any reduction on services located in Christchurch.
- Reductions in beds in Blenheim and Dunedin would put the viability of the remaining beds at risk.
- Alternative day programmes are not viable in smaller DHB and rural areas because of numbers of clients and travel distances involved. Therefore there will always be a lower threshold for referral to residential services from these areas.
- Reductions in medium term beds will have a greater impact on women than men given the lack of access to long term therapeutic communities for female consumers.
- There are a limited number of workers trained in delivering intensive outpatient services.

One of the difficulties with any reconfiguration process is the community's perception of residential always being the optimum form of treatment.

The Review does not recommend any reduction in the level of long term treatment beds including supported living services for clients with severe dependency and high and complex needs unless there is clear evidence of under utilisation. Waiting lists would indicate that in general the current service levels are not meeting demand for these services in the Southern region. It is generally considered that the Blueprint resource guidelines underestimated the need for residential services including re-entry houses for this end of the severity scale. With the exception of the youth intensive day programme/accommodation AOD treatment service

the absence of major new funding for the AOD sector as a whole limits any significant increase in long term residential beds over the next three years.

2.6.5 Aftercare

It is important that aftercare or re-integrative services are accessible to people who have been part of an intensive inpatient or outpatient treatment programme, particularly if returning to their community from residential alcohol and drug treatment from outside their district. Increased aftercare may enable shorter periods in residential treatment.

An increased emphasis on aftercare is a priority for service development in the Review. In particular the utilisation of community support work and social work roles for high and complex needs clients that focus on the supports people require in the community to maintain recovery and meet rehabilitation goals. These include support networks, healthy recreation opportunities and vocational needs. There was strong support for the transfer of the mental health community support worker concept to the AOD field. The focus of this role is to provide support and monitor needs to people in a practical way while living in the community. The aim is to identify people at risk of relapse and develop solutions that don't require a return to intensive treatment again.

As already stated the development of half way houses will be difficult in the medium term given the resourcing issues. One alternative strategy is to offer crisis respite stay (up to one week) for people who need a period of intensive support to avoid relapse or regain their abstinence goals. This could be provided as part of the proposal for short term treatment in conjunction with day treatment programmes.

2.6.6 Methadone Treatment

Waiting lists for access to methadone are a significant issue in many districts. The Review is strongly of the view that this issue should be primarily resolved by changes to the way the service is delivered rather than by increasing resources overall. The key strategy is to increase the level of treatment in the primary health sector. The South Island Methadone Service Development Project will be addressing these issues in detail in 2004/05.

A key issue the Methadone Project needs to address is the problems encountered for clients transferring between districts. At the moment clients on the methadone programme in one DHB do not automatically qualify for continuation of treatment if they transfer to another DHB for reasons such as employment. This makes little clinical sense and puts clients rehabilitation at risk.

The Review was also of the view that clients on the methadone programme with significant rehabilitation needs should qualify for access to intensive treatment programmes on a day or residential basis. Traditionally this has not been the case but many residential providers are now accepting clients on methadone and treating it as another form of medication. This will require the development of policies on managing these clients by providers, service co-ordination with methadone services and the introduction of this group into contract specifications.

2.7 Integration of the AOD Treatment System

The Review identified the following key strategies for improving service integration:

- a) Development of effective case management models.
- b) Building stronger links with primary health and other allied sectors especially for identification and brief intervention for mild to moderate substance abuse problems.

- c) Developing treatment partnerships between different components and services in the system to co-ordinate care for the individual in a way that provides a more seamless integrated approach for the service user. Critical partnerships include between:
- Detox services and intensive treatment services.
 - Residential services and intensive outpatient services.
 - Residential services and aftercare outpatient services.
 - Medical, social and home detox services.
 - Authorised assessment and referral services in the same city.
 - Provider Arm and NGO services.
 - Mainstream and Kaupapa Maori services.
 - Specialist AOD services and primary health care.
 - Mental health and AOD services.
 - Corrections and AOD services.

2.8 Case Management Models

The Review evaluated the two alternative case management models suggested by the National Strategic Framework for Alcohol and Drug Services for ensuring continuity of care across the range of service options that could make up a treatment package.

- a) A single individual designated to fulfil this function (a care or case manager).
- b) Strategies involving structured interrelationships among components of the treatment system.

The ideal model for case management was considered one where a single case manager was responsible for co-ordinating, monitoring and reviewing care for all treatment components in the continuum including aftercare. The strengths of this model were that it assisted good integration of services and care and offered a route of accountability across the whole treatment package. One option was to have a separate assessment, referral and case management service independent of any other form of treatment.

The consensus of clinicians and community service managers on the project reference group was that the main difficulty with this model was that current resourcing is insufficient and caseloads too high in community assessment and referral services in the two largest DHBs to maintain such a role effectively.

For this reason the preferred option of the reference group was a model that relied on structured relationships between services that ensured effective hand-over of the client to the next treatment component. This would require established protocols between services, quality communication of client needs at each stage and close liaison particularly between residential service providers and providers of aftercare around discharge planning.

The role of community assessment and referral services in case management will vary in practice. They are likely to be the primary case management service for service users needing less intensive interventions. For more severe disorders the assessment service would establish the initial treatment plan and then usually pick up responsibility for the clients aftercare following discharge from an out-of-district residential service. For service users attending a residential programme in their own domicile area, in practice the residential service often continues with the aftercare role rather than the assessment/referral agency.

A structured relationship model does not negate the need for case reviews to involve the range of agencies that will support the client in the future and to link to the case management and service co-ordination functions undertaken by other key agencies associated with the client. In particular Child, Youth and Family for adolescents, mental health for people with co-existing disorders and Corrections for criminal offenders.

However feedback in the DHB consultation round indicated broad opposition to the structured relationship model from consumers/tangata whaiora who valued the benefits from having one person they could contact whenever they required help to access assistance. There was a mixed response from clinicians with opposition from smaller DHB areas in particular. In the end the reference group was unable to develop a clear consensus on a recommendation for a single model for the whole region. Consequently it was recommended that the reviews of models of care and clinical pathways for key groups should incorporate a review of case management models. It was expected that a mixed model is likely to eventuate in the region with the two largest centres operating modified forms of the structured relationship model.

The development of a case management system that will ensure comprehensive continuity of care for people with co-existing disorders needs to be addressed specifically as part of the proposed co-existing disorder sub-project.

2.9 Authorised Entry to Residential Services

The current system for authorising referral to residential AOD services is a continuation of the one developed by the southern office of the previous Health Funding Authority (HFA). This consists of specific community assessment and referral services being permitted to carry out assessments and make referrals to residential treatment programmes using credentialed clinicians. Clinicians were nominated by the Agency to the HFA who approved the nominated individual. These are the only authorised routes for service users to access health funded beds in residential programmes. At the time of the inception of this model the selection of assessment and referral providers was largely made on who applied at the time.

The Nelson/Marlborough area under the HFA operated under a AOD Council Funding model which also used community assessment services but was more complex because these services also had a nominal budget holding capacity. With the advent of DHBs the Council model became defunct and the district now operates under the same model as the rest of the South Island.

The Review was tasked with evaluating the current system for authorised entry and recommending a system for DHBs. Submissions varied in the support of the model with some residential agencies seeing the system as a barrier to accessing residential treatment and wanting to go back to residential services being able to assess and refer to their own services. However community assessment and referral services strongly preferred the current system as it reinforced their role in matching treatment to the assessed needs for all service users. The Project Reference Group identified the following strengths and weaknesses of the current system.

2.9.1 Strengths

- Neutral/independent assessment.
- Assessors act as a gatekeeper for scarce resources.
- Helps ensure quality assessment.
- Promotes good follow up/aftercare as contact has already occurred.
- Reinforces proper matching – to a range of services, in- and out-patient.

- Encourages residential agencies to maintain standards if they are to receive referrals.
- Use of CADS clinical teams ensures multidisciplinary teams are available to provide comprehensive assessment with testing.
- Straight forward process for audit path.
- Offers an overview of what services are needed and what is best practice.

2.9.2 Weaknesses

- Waiting time for assessments can act as a barrier to residential treatment.
- Potential for bias towards certain treatment or services in some clinicians.
- Duplication - people can obtain multiple assessments from different agencies if seeking a different outcome.
- Limits choice of assessment services in smaller DHB's.
- Not all authorised assessment agencies are independent of a residential service which means they are able refer to their own residential service.
- Referrers need to be fully informed regarding treatment services and systems for it to work.
- Difficult for new players to break into the market.

2.9.3 Recommended Changes

The project reference group recommended that the current model be maintained but with the following changes:

- a) Authorised agencies can appoint their own designated clinicians according to regionally determined skill, and qualification accreditation criteria.
- b) All authorised agencies should be independent of residential treatment services. This has implications for the Christchurch Bridge Programme.
- c) Make room for better liaison and fast tracking for referrals where contact has already been made with a residential agency and the referral is appropriate.
- d) Limit assessment to what is needed to refer to residential for high complex needs requiring long term treatment – shared assessment role with the residential service.

2.10 Reviews of Models of Care and Clinical Pathways for Key Population Groups

The final Review report has a much stronger emphasis on the need for any change to service configuration to be underpinned by a comprehensive review of models of care and clinical pathways. This has the potential to change the nature of service delivery and challenge traditional models. This is particularly important in the current funding environment where there is a drive to utilise resources in the most efficient and effective way possible.

The AOD Review has begun this process for some groups and work has been carried out recently on models of care and clinical pathways for young people as part of the development of a proposal for a youth residential programme. The priority special population groups for review are:

- People with co-existing disorders.

- Severe substance dependants under the Alcohol and Drug Addiction Act. The high level of recidivism in this group and the high demand they are placing on services out of proportion to their numbers requires a re-evaluation of the current treatment and support approach.
- Criminal offenders with severe AOD problems. To be effective any review needs to be linked to interventions for criminal behaviour and involve the Department of Corrections.

2.11 Ministry of Health's Access Benchmark and Blueprint for Mental Health Services Resource Guidelines

In 1994, the Government launched *Looking Forward: Strategic Directions for the Mental Health Services*⁸. This strategy indicated a major shift in direction from services dominated by psychiatric hospitals towards community mental health services and teams. The strategy also set a benchmark i.e. a target for the level of mental health services to be provided based on the percentage of the population who need specialist mental health services. The strategy acknowledged that separate benchmarks needed to be developed for alcohol and other drug services.

In order to ensure the implementation of *Looking Forward*, in 1997 the Ministry of Health published *Moving Forward: The National Mental Health Plan for More and Better Services*. The Mental Health Plan confirmed a target population of the 3% (initially 5% for children and young people but now also 3%) who have serious, ongoing and disabling mental illness requiring treatment from specialist mental health services. This included alcohol and other drug disorders and services.

In November 1998, the Mental Health Commission released the *Blueprint for Mental Health Services in New Zealand*. The *Blueprint* is a national mental health service development plan which sets out the qualitative and quantitative changes needed (the kinds and levels of service there need to be for different groups of people) to realise the 3% access objective and other qualitative objectives.

However there has been widespread criticism within the alcohol and other drug field including from researchers and providers as to the accuracy of the 3% benchmark value as an indication of the proportion of the population with severe alcohol and drug disorders who require specialised treatment. This has significant implications for the accuracy of the *Blueprint* resource guidelines for the level of alcohol and other drug services required to meet demand.

Concerns are based on the following arguments:

- Estimates of six month prevalence rates for alcohol and/or drug dependency are 6% for the general population and up to 8% for Maori. The AOD field argues that dependency indicates the presence of a severe mental health disorder that should primarily be treated in a specialist AOD service.
- The *Blueprint* Resource Guidelines do not recognise the increasing numbers and level of complexity and need of those with severe dependency. E.g. Multiple drug abuse, the presence of coexisting disorders, association with significant criminal offending.
- In the absence of effective screening and brief intervention for mild to moderate alcohol and drug problems from allied professionals in primary health care, justice, education and social service sectors, specialist community alcohol and drug services are providing

⁸ Ministry of Health, 1994.

significant levels of service for this group which falls outside the 3% target. Currently the nation-wide service specifications for alcohol and drug services reflect the broader range of the target group.

- 40% of the South Island population is located outside of main urban centres (i.e. 30,000+). Rurality increases the cost of service delivery and lowers access against the available resource. It also means that only main centres are often able to provide intensive treatment options. Consequently clients may require accommodation to enable their attendance at day programmes.
- Individual variables within each DHB impact on the level of need in any one district. Eg. The presence of three prisons in Christchurch significantly increases the number of high and complex needs alcohol and drug clients resident in Canterbury.

In recent months the Mental Health Commission has downplayed the application of the Blueprint Resource Guidelines in a rigid fashion, recognising the importance of quality district based needs assessments as the basis for service development objectives.

One of the significant problems with developing resource guidelines is to distinguish between need and demand. While approximately 18% of the population may need intervention for substance abuse or dependency in any six month period, only a portion of that population are screened and referred to specialist AOD assessment and treatment services. As identification and screening for AOD problems occurs in non-specialist settings so the demand for specialist services is likely to increase.

The AOD Review acknowledges the validity of many of the criticisms and supports the need for the national review of the benchmarks for AOD services and consequently the Blueprint Resource Guidelines relative to other mental health services. A new mental health epidemiological survey that will form the basis of a review of the guidelines is underway by the Ministry of Health but will not be completed before 2006. However in the interim the Mental Health Commission has contracted an assessment of the Blueprint as it applies to AOD service delivery. In the meantime DHBs are likely to continue to use the Blueprint resource guidelines as an indication of the total resource level required for AOD services but accept variations in the need for particular service types on the basis of local needs analysis.

The Review views the Blueprint Resource Guidelines as 'guidelines' not 'tramlines'. On this basis they offer a minimum regional 'line in the sand' overall but do not necessarily reflect the true extent of need for any one DHB or the region as a whole.

2.11.1 Blueprint Analysis

Table 3 on the following page compares current contracted service delivery volumes with the Blueprint resource guidelines along with the impact of the service developments recommended in the Strategic Framework for Service Development.

Table 3: Summary of the Impact of Service Reconfiguration on DHB Performance Against the Blueprint Volume Benchmarks For AOD Services

	Canterbury	Nels/Marl	West Coast	South Cant	Otago	Southland	Total
Community FTEs							
Benchmark Volume	79.6	23.5	5.1	8.8	30.7	18.1	165.8
Actual Contract Volume	52.4	21.0	5.7	6.1	25.3	15.2	125.7
Volume Gap	27.2	2.5	-0.6	2.7	5.4	2.9	40.0
Gap as %	34%	10%	-13%	31%	18%	16%	24%
Reconfigured Actual Volume	62.4	21.8	5.9	7.4	29.1	15.9	142.5
New Volume Gap	17.2	1.7	-0.8	1.4	1.6	2.2	23.2
New Volume Gap as %	22%	7%	-17%	16%	5%	12%	14%
In-patient Detox Beds							
Benchmark Volume	14.6	4.3	0.9	1.6	5.6	3.3	30.3
Actual Contract Volume	5.9	1.7	0.5	0.6	2.2	1.3	12.2
Reconfigured Actual Volume	6.9	2.0	0.4	1.1	2.6	1.5	14.5
New Volume Gap	7.7	2.3	0.5	0.5	3.0	1.8	15.8
New Volume Gap as %	53%	53%	54%	34%	54%	54%	52%
Residential Treatment Beds							
Benchmark Volume	48.7	14.3	3.1	5.4	18.7	10.9	101.0
Actual Contract Volume	54.4	15.9	3.3	9.9	20.8	12.9	117.2
Reconfigured Actual Volume	50.3	14.7	5.1	7.4	19.2	12.0	108.7
Additional Non-Blueprint Beds	10.7	3.1	0.7	1.2	4.0	2.4	22.0
New Actual Volume All Beds	61.0	17.8	5.8	8.6	23.2	14.4	130.7
New Volume Gap All Beds	-12.3	-3.6	-2.7	-3.2	-4.5	-3.5	-29.8
New Volume Gap as %	-25%	-25%	-89%	-61%	-24%	-32%	-30%
Methadone Places							
Benchmark Volume	730.4	213.6	45.6	80.2	280.7	163.2	1513.6
Actual Contract Volume	694.2	187.0	41.0	90.0	275.0	65.0	1352.2
Reconfigured Actual Volume	694.2	187.0	41.0	90.0	275.0	65.0	1352.2
New Volume Gap	36.2	26.6	4.6	-9.8	5.7	98.2	161.4
New Volume Gap as %	5%	12%	10%	-12%	2%	60%	11%

Table Notes: (see next page)

- Figures for actual contract volumes are accurate as at May 2004.
- Figures based on regionalised residential service model and maximum feasible volumes proposed in service development objectives.
- Volumes include nominal volumes for the new youth and kaupapa Maori day programme/accommodation services. These services are outside both Blueprint and Population Based Funding.

Figure 2: Impact of AOD Review on South Island Service Volumes

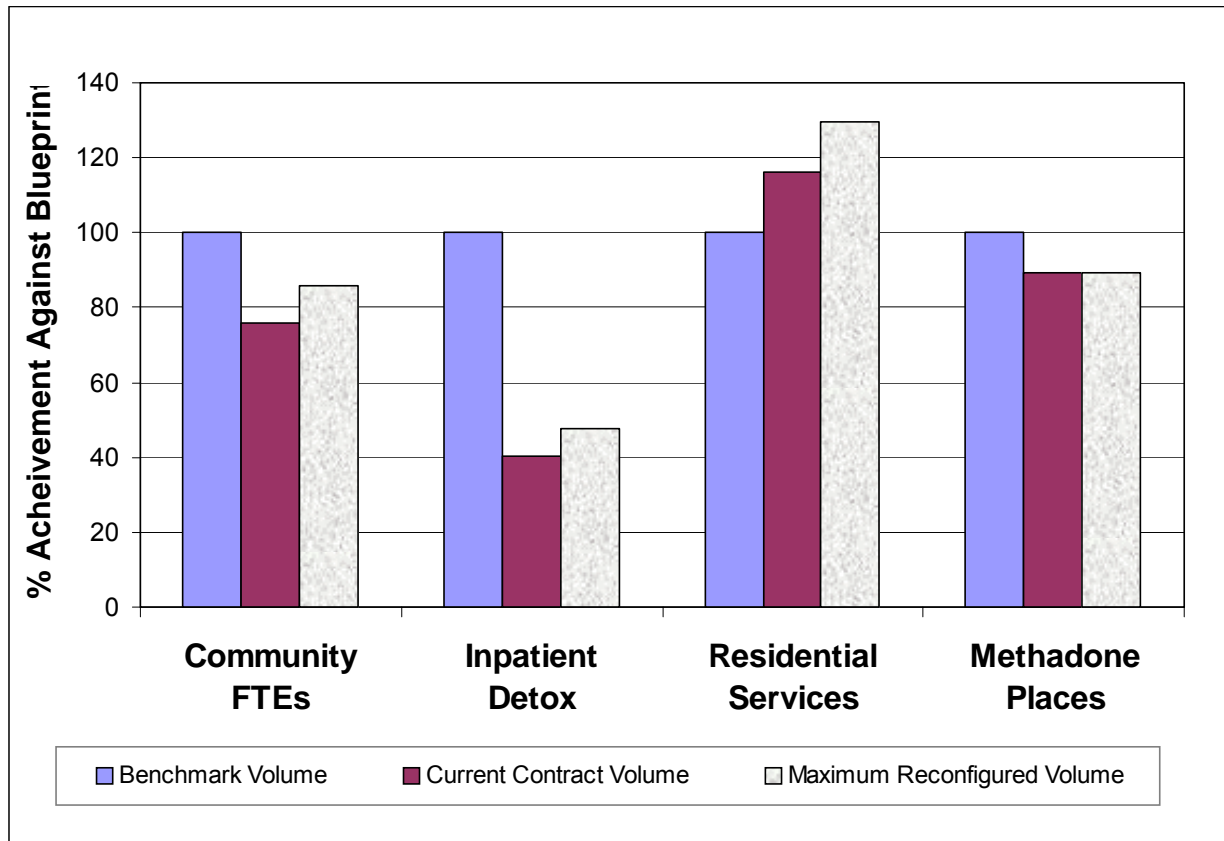


Figure Notes: Benchmark volume is based on the Mental Health Commission Blueprint resource guidelines for the South Island population. Figures assume maximum volumes for reconfiguration.

3 Summary of Identified Alcohol and Other Drug Service Needs

The needs identified in the following summary (see next page) are a distillation of the service issues identified in the stakeholder submissions and consultation forums, the information supplied by district health board appointees on the project reference group, the waiting list analysis and a regional analysis comparing the district stocktakes with the ideal range of services if a comprehensive and effective alcohol and other drug system is to be delivered. The ideal range of services reflects the best practice framework established from key informant interviews, clinical experts on the reference group, research overviews and national strategic policy documents.

Gaps were only included if they affected a significant number of people. The summary offers a starting point for services that were considered in establishing priorities for service development. However given current and future resource limitations it is unlikely to ever be feasible to address all the needs identified.

Unless otherwise stated needs refer to specialist alcohol and other drug services only.

3.1 Summary of Identified South Island Alcohol and Other Drug Service Needs and Issues

Nelson Marlborough	Canterbury	West Coast	South Canterbury	Otago	Southland	Regional
Assessment and Referral						
Childcare Dedicated Maori Health Worker in Provider Arm AOD Service Rural access Services targeting middle class and elderly	Waiting times – greater resource required Kaupapa Maori services for adults and child and youth Pacific peoples authorised assessment/referral service Additional resources to cover Corrections clients Services targeting middle class and elderly	Greater resource required Dedicated AOD Maori Health Worker Rural access Services targeting middle class and elderly Childcare Travel and accommodation assistance for rural clients	Dedicated AOD Maori Health Worker Rural access (Mt Cook, Twizel) Childcare	Greater resource required Rural access (Central Otago) Childcare Kaupapa Maori Service	Rural access Services targeting middle class and elderly	
Medical/Social/Home Detox						
Waiting List for Kennedy Detox Social detox Access to general medical ward detox	Waiting time for Kennedy Up-skilling social detox staff for medication management	Waiting time for Kennedy Access to general medical ward detox Home detox	Waiting time for Kennedy Poor AOD liaison with general medical ward detox Home detox Social detox with medication	Waiting time for Kennedy Local medical detox in general medical ward Longer length of stay in Richmond beds	Home Detox	Greater access to Kennedy medical detox in CHCH Training and consult liaison for other districts

Nelson Marlborough	Canterbury	West Coast	South Canterbury	Otago	Southland	Regional
Family/Whanau Support						
Increased support for family/whanau members from existing services	Family/Whanau Advocacy/Support out-patient service	Increased support for family/whanau members from existing services	Increased support for family/whanau members from existing services	Increased support for family/whanau members from existing services	Increased support for family/whanau members from existing services	Regional AOD Family Adviser
Outpatient/Day Treatment						
Day treatment programmes for mainstream Community support worker/social work positions More structured group work Dedicated Maori Health Worker in Provider Arm AOD Service Childcare	Insufficient day treatment programmes. Including for: <ul style="list-style-type: none"> • Women with high complex needs. (TC) • Men. • Maori men • Middle class Week day/weekend treatment retreats for young people. Community support worker/social work positions More structured group work Childcare	Day treatment programmes for all groups Week day/weekend treatment retreat More structured group work Dedicated AOD Maori Health Worker Childcare	Day treatment programmes for all groups Insufficient development of community support worker/social work roles More structured group work Dedicated AOD Maori Health Worker Week day/weekend treatment retreat Childcare	Day treatment programmes for all groups Insufficient youth resource Community support worker/social work positions Structured group work and day treatment especially for women Kaupapa Maori Service Week day/end treatment hui for Maori Childcare	Respite/accommodation while on day programme Community support worker/social work positions More structured group work Childcare	Regional contract for regional week day/weekend treatment retreats

Nelson Marlborough	Canterbury	West Coast	South Canterbury	Otago	Southland	Regional
Residential Treatment Services						
Transport and accommodation assistance to attend out of region treatment	Short term (1-4 weeks)			Short term (1-4 weeks)		<p>Youth residential in South Island</p> <p>Kaupapa Maori residential</p> <p>Therapeutic community for women</p> <p>Residential treatment for younger people with mild to moderate organic brain damage.</p> <p>Insufficient beds for older recidivists with severe alcohol dependence under AOD Act</p> <p>Secure beds for recidivists with very poor impulse control (e.g. Rotoroa Island)</p>

Nelson Marlborough	Canterbury	West Coast	South Canterbury	Otago	Southland	Regional
Supported Living Services						
Halfway house Supported Landlord Service Community Residential services for co-existing disorders Supported accommodation with higher medical support for chaotic clients needing stabilisation	Halfway house Supported Landlord Service Community Residential services for co-existing disorders	Halfway house Supported accommodation while awaiting access to residential treatment Supported Landlord Service Community Residential services for co-existing disorders	Access to Supported Landlord Services for AOD clients Community Residential services for co-existing disorders	Halfway house Supported Landlord Service Community Residential services for co-existing disorders Accommodation for women and children while mother attending day treatment	Halfway house Supported Landlord Service Community Residential services for co-existing disorders	Long term residential (Homes for Life) for older recidivist clients
Methadone						
Waiting list	Waiting list	Waiting list		Waiting list Rural access		Access to outpatient and residential treatment services Inter-district transfer access

Nelson Marlborough	Canterbury	West Coast	South Canterbury	Otago	Southland	Regional
Aftercare						
Significant gap overall	Significant gap overall	Significant gap overall	Significant gap overall	Significant gap overall	Significant gap overall	
Community support worker/social work positions	Community support worker/social work positions	Community support worker/social work positions	Community support worker/social work positions	Community support worker/social work positions	Community support worker/social work positions	
Vocational rehabilitation	Vocational rehabilitation	Vocational rehabilitation	Insufficient focus on Vocational rehabilitation	Vocational rehabilitation	Vocational rehabilitation	
Links to therapeutic recreation	Links to therapeutic recreation	Links to therapeutic recreation	Links to therapeutic recreation	Links to therapeutic recreation	Links to therapeutic recreation	
Access to crisis and planned respite	Access to crisis and planned respite	Access to crisis and planned respite	Access to crisis and planned respite Poor liaison between residential provider and referrer re discharge planning Inadequate use of community resources	Access to crisis and planned respite	Access to crisis and planned respite	

4 Summary of Key Strategies to Improve Service Delivery

The South Island AOD Services Review represents the beginning of a new wave of development in the AOD treatment sector in the South that aims to:

- a) Provide high quality treatment that is comprehensive and flexible.
- b) Develop a treatment system that is able to be responsive and adaptive to the needs of the individual.
- c) Reflect the Treaty relationship with Maori.
- d) Equip service users with the skills and environmental supports necessary to maintain recovery in the real world.
- e) Promote collaboration and cooperation in service delivery.
- f) Implement best practice principles and research.
- g) Utilise resources effectively, efficiently and equitably.

4.1 Key Strategies

For full details of the strategies see the attached recommended Strategic Framework for Service Development objectives in Section 5 of this document.

Assessment and Referral

- Improve access to assessment/referral services by:
 - Implementing a stepped assessment approach in authorised agencies to use resources more efficiently.
 - Improving the level of interventions in primary and allied settings for mild to moderate AOD problems.
- Maintain a system of independent authorised assessment and referral agencies as the means for accessing residential services.

Detoxification Services

- Use existing detox resources more effectively through establishing protocols and stronger linkages between services.

Services for Maori

- Improve the responsiveness of mainstream services to Maori.
- Extend the range of kaupapa Maori services and programmes. Specifically a regional kaupapa Maori intensive day programme/accommodation AOD treatment service and adult and youth community based services in Dunedin and Christchurch.

Outpatient Treatment

- Increase the level of intensive outpatient programmes in conjunction with short term residential programmes.
- Trial weekend or weekday intensive treatment retreats or wananga for rural localities and smaller DHB districts.

- Investigate the potential of computer and internet based treatment programmes and support.

Residential Services

- Reduce the volume of medium term beds in Christchurch by a small amount to help resource increased outpatient options.
- Develop short term options in standard medium term residential treatment services.
- Maintain the current level of long term treatment beds being utilised for adults.
- Develop regional residential services for youth and Maori consisting of supervised accommodation linked to day programmes.

Special Population Groups

- Increase family participation in treatment.
- Offer greater support for family members independent of the service user.
- Develop dedicated outpatient services for women.
- Develop an authorised assessment service and expanded youth service for Pacific Peoples in Christchurch and workforce development in general for Pacific workers.

Aftercare

- Increase emphasis on aftercare and reintegration, in particular using a community support work and/or social work model.

Improving the Treatment System Overall

- Increase the capacity of the treatment system to deliver flexible individualised treatment packages for consumers.
- Develop partnerships with other sectors and between different treatment components to integrate service delivery.
- Review models of care and clinical pathways for key groups including those with the most severe problems.
- Increase the capability of the workforce by offering intermediate level training for priority areas.
- Negotiate funding responsibilities and boundaries with Corrections.
- Strengthen the participation of consumers/tangata whaiora in service development planning and evaluation of services.

5 RECOMMENDED STRATEGIC FRAMEWORK FOR SERVICE DEVELOPMENT

5.1 Proposed Service Development Objectives for the Three Years Ending 30 June 2007

Please Note:

- a) The objectives are ordered from regional to district under each service need.
- b) Objectives refer to Alcohol and Other Drug (AOD) Services only unless otherwise specified.
- c) Service development objectives are based on what is considered feasible in the next three years within the resourcing restraints and the final outcomes regarding service configuration. As there are many factors which could influence the eventual configuration of resources, in some cases a range of additional volumes are specified from minimum to maximum feasible levels.
- d) Final decisions regarding the implementation of the recommendations are the prerogative of each District Health Board both individually and collectively. DHBs may also choose to undertake AOD service developments outside those recommended in the Review.

Service Development Objectives	Additional Resources Required	Means of Resourcing and Implementation Issues
Service Need 1 Increase the level of screening and brief interventions in primary settings		
a) Develop strategies for improving the level of interventions in primary services for people with mild to moderate alcohol and other drug problems.	-	Include as an objective in DHBs' development of primary health care.
b) Build linkages with the primary sector by piloting where viable, the establishment of assessment, referral and counselling outreach services in primary agencies in conjunction with primary care initiatives.	-	Utilise existing service resources and link to new primary funding initiatives.
Service Need 2 Improve access to assessment/ referral /counselling services		
a) Set a benchmark target of an initial contact being made with individuals seeking assessment within one working day of referral to the assessment service and a full appointment within five working days.	-	Benchmark acts as a measure of progress. Would require additional resources to achieve in full.
b) Implement a screening, stepped assessment and triage model in each authorised referral service to reduce waiting times.	-	Improves access by better allocation of resources.
c) Undertake work to integrate cultural assessment fully into the comprehensive assessment model.	-	Assessment agencies in conjunction with workforce development initiatives.

Service Development Objectives	Additional Resources Required	Means of Resourcing and Implementation Issues
d) Negotiate regionally with the Department of Corrections payment for all pre-sentencing and parole assessment reports being undertaken by DHB funded AOD services. <ul style="list-style-type: none"> • Incorporate in a wider discussion regarding inter-sectoral collaboration in meeting the needs of criminal offenders with AOD problems. 	-	Increases funding available to services. (Some services are already receiving payment)
e) Negotiate regionally with LTSA a charge rate based on actual costs for Ministry of Transport drink driving assessments being undertaken by DHB funded AOD services.	-	Increases funding available to services.
f) Pilot where viable the establishment of outreach services within primary and allied settings by operating regular community alcohol and other drug clinics in facilities such as medical practices, Maori health services, Corrections offices, etc. <ul style="list-style-type: none"> • Including settings for older persons and professional and other groups who traditionally resist attendance at AOD clinics. • In partnership with primary care providers. 	-	Utilise existing service resources and link to new primary funding initiatives. Neutral impact on funding.
g) All major assessment and referral services offer an evening and/or Saturday morning service.	-	Provide within existing resources as viable. Limit to early evening if necessary to avoid extra staff costs.
h) Investigate options for providing child care facilities for the period women or men attend outpatient services.	-	DHB/SISSAL planning resources with assistance from regional support position.
i) Develop a kaupapa Maori AOD assessment, referral and outpatient counselling service in Christchurch for youth.	1 FTE	Reconfigured CDHB district AOD resources.

Service Development Objectives	Additional Resources Required	Means of Resourcing and Implementation Issues
<p>j) Implement steps towards establishing a culturally appropriate Maori Community AOD service in Dunedin for adults and youth.</p> <p><i>Step 1:</i> Continue the provision by the Community Alcohol and Drug Service and Te Oranga Tonu Tanga of targeted services to Maori and extend the consult/liaison role with the Maori NGO sector.</p> <p><i>Step 2:</i> With additional resources expand the service.</p> <p><i>Step 3:</i> In the longer term devolve the service to a Maori provider when their capacity and capability are sufficient to maintain the service.</p>	1 adult FTE and 1 youth FTE	<p>Utilise and eventually reconfigure existing CADS/TOTT personnel/resources (2 FTE) as part of the proposed total of 3 adult FTE.</p> <p>Expansion by one adult and one 1 youth FTE made available through the strategic recommendations in the 'Review of Mental Health Service Provision in Otago'.</p> <p>Step 3 may occur outside the three year time frame.</p>
<p>k) Establish an authorised cultural and clinical assessment and referral service within a Pacific People's Agency in Christchurch.</p>	1.1 FTE	Review existing Pacific Peoples AOD resources to reconfigure funding.
<p>l) Expand the capacity of assessment, referral, case management and counselling services for Pacific youth in Christchurch.</p> <ul style="list-style-type: none"> • Upgrade FTE to an authorised assessment and referral position. • Include consult/liaison role for mainstream services. 	0.5 FTE	Expands existing 0.5 FTE resource to full FTE position.
<p>m) Increase the capacity of the Christchurch DHB Community Alcohol and Drug Service to undertake assessment, referral/ case management and consult/liaison services.</p>	1 - 2 FTE	Re-establish disestablished position already in volumes. Plus one position from reconfigured district funding if final resource re-configuration permits.

Service Development Objectives	Additional Resources Required	Means of Resourcing and Implementation Issues
n) Develop the role of the Christchurch DHB Community Alcohol and Drug Service primarily as a specialist assessment and referral service offering consult/liaison, training and supervision to NGO treatment services. <ul style="list-style-type: none"> ▪ Key role for high and complex needs including co-existing disorders. ▪ Retain NGO assessment services. ▪ Develop the case management/ treatment role of NGO treatment services in parallel. ▪ Maintain the current role for methadone clients. 	-	Increases assessment capacity within CADS.
Service Need 3 Improve access to detoxification services		
a) Reduce waiting times for access to the regional Kennedy Medical Inpatient Detox Service by increasing capacity to an average of seven to eight beds.	1-2 beds	Utilise existing spare capacity associated with minimum staffing requirements. These beds are currently being used for overflow from the acute inpatient unit. Neutral impact on AOD funding.
b) Continue to build a collaborative service model between Thorpe House Social Detox Service and Kennedy Medical Detox Service in Christchurch. <ul style="list-style-type: none"> • Develop a more seamless integrated approach between all detox services. • Enable suitable clients to access the social detox service while on medication through medical supervision from CADS. • Investigate the benefit of centralising assessment for access to all detox services. 	-	Utilise existing service resources.
c) Formalise the Kennedy Medical Inpatient Detox Service consult/liaison and training role for the southern region.	-	No additional resources required. Already completed through Regional Mental Health Access Project.

Service Development Objectives	Additional Resources Required	Means of Resourcing and Implementation Issues
d) Develop an inter-regional charging mechanism for patients referred to Kennedy medical detox from outside the South Island.	-	Increases funding available to service.
e) Improve access to medical detox in general medical wards in Nelson, Blenheim, Greymouth, Dunedin and Invercargill by formalising current ad hoc arrangements. Specifically by developing protocols with the wards regarding: <ul style="list-style-type: none"> • Guaranteed minimum access. • Detoxification for drugs other than alcohol. • Provision of suitable facilities. • Co-ordination of care with community alcohol and drug service. • Ensuring trained medical staff are available to supervise medical detoxification. 	-	Utilise existing medical ward and CADS resources. Neutral impact on funding.
f) Establish a detox nurse position to backup detox in the general medical ward and provide a home detox service in Invercargill.	0.5 FTE	Reconfigure from existing CADS resources when staff vacancy occurs.
g) Provide access to social detox by reconfiguring the current AOD supported accommodation service in Timaru. <ul style="list-style-type: none"> • Clinical and medical support provided by Provider Arm A&D Service. 	130 days per annum (Estimate only)	Reconfigure existing contract. Final number of days determined by need.
Service Need 4 Provide a greater emphasis on intensive outpatient options for people with moderate to severe dependency who have lower level needs and less complex disorders		
a) Contract current standard medium term residential providers to deliver, either individually or in shared service arrangements with others, comprehensive and integrated flexible service packages that include short to medium term residential treatment, day programmes, crisis respite and outpatient aftercare services. <ul style="list-style-type: none"> • Limited development of outpatient services at St Marks. 	-	Reconfiguration of existing service resources.

Service Development Objectives	Additional Resources Required	Means of Resourcing and Implementation Issues
b) Build in formative, process and outcome evaluation into proposed changes to service delivery. In particular the use of short term residential treatment in conjunction with day treatment.	Unknown	Work with the National Addictions Centre to apply for funding support from ALAC and the Health Research Council.
c) Free up resources for intensive day treatment programmes in conjunction with residential (as in 4a) by reducing the number of standard medium term residential beds located in Christchurch. <ul style="list-style-type: none"> • Reduce in two stages. Stage one: 5 beds followed by review of change before any further reduction. • Stage two: Up to further 4.7 beds if indicated. • Undertake reconfiguration in the context of a collaborative review of all adult mainstream intensive outpatient services, medium term residential AOD services and supported living services attached to these agencies. 	-	Enables same number of clients to be treated but with greater focus on outpatient modalities. Reconfiguration within current providers to maintain service viability. No cost savings unless overall treatment length is reduced.
d) Trial a regional contract for week day/end treatment retreats or wananga. <ul style="list-style-type: none"> • Specific streams for Maori, women and young people if viable. • Targeted at rural areas and small DHBs where intensive outpatient programmes are not viable. • Investigate utility of incorporating computer and internet based treatment and support programmes. 	2.0 FTE [0.86 NMDHB 0.32 SCDHB 0.18 WCDHB 0.65 SDHB]	Resources available from reconfiguration of regional residential services.
e) Treat people with mild to moderate dependency primarily in out-patient settings.	-	Utilise existing and new outpatient services.

Service Development Objectives	Additional Resources Required	Means of Resourcing and Implementation Issues
f) Develop additional intensive outpatient and/or day treatment programmes in Christchurch and Dunedin. <ul style="list-style-type: none"> • Include a programme for women specifically in Dunedin and expand capacity for women in Christchurch. • Investigate the need for and feasibility of a therapeutic community day programme in Christchurch for women with severe AOD disorders and significant criminal offending history. • Includes day programmes developed in association with existing medium term residential programmes. 	6 - 6.9 FTE CHCH 1.8 FTE Dunedin	Resources available from reconfiguration of regional resources. Including reduction in standard medium term beds in Christchurch. Plus utilisation of CADS staff in Dunedin to assist the development of a women's day programme.
g) Develop kaupapa Maori day treatment programme for both men and women in Christchurch in association with a Kaupapa Maori residential accommodation service.	1.5 – 2.0 FTE	Utilise government funding for new intensive kaupapa Maori day programme/accommodation service. Funding outside Blueprint and PBFF.
h) Develop flexible, comprehensive community support packages in Timaru through reconfiguring the existing AOD supported accommodation service. Including: <ul style="list-style-type: none"> • Home based day support. • Day support programmes at service. • Clinical support provided by Provider Arm AOD service. • Linked to development of respite care, social detox and short to medium term supported accommodation. 	1.0 FTE (equivalent care packages)	Reconfiguration of existing resources plus additional mental health funding for the expanded service.
Service Need 5 Increase the capacity of treatment services within current resources		
a) Implement a screening, stepped assessment and triage model in each authorised referral service to reduce waiting times.	-	Repeat of service development objective 2(b).

Service Development Objectives	Additional Resources Required	Means of Resourcing and Implementation Issues
b) Reduce the average length of all existing standard medium term intensive residential services by also incorporating shorter flexible term treatment options within the current services offered. <ul style="list-style-type: none"> • Improve identification of clients for whom short term options (1-4 weeks) would be sufficient to achieve their treatment goals. • Treatment length determined by clinical need. 		Increases capacity of services.
c) Review average treatment lengths within all intensive treatment modalities as part of the reviews of models of care and clinical pathways. <ul style="list-style-type: none"> • Review and set average and maximum treatment lengths for medium term services as a priority. 		DHB/SISSAL planning resources with assistance from regional support position.
d) Develop more structured group work options in outpatient services. <ul style="list-style-type: none"> • Reduce emphasis on individual counselling. 	-	Increases capacity of services.
Service Need 6 Increase the level of gender appropriate services for women		
a) Set a minimum regional access level for women that would equate to 30% overall for short to medium term residential services and supported living services. <ul style="list-style-type: none"> • Investigate opportunities for individual providers to develop a greater focus on women within the overall target. 	-	SISSAL/DHB planning and contract management resources in conjunction with providers.
b) Develop intensive day treatment programmes for women. <ul style="list-style-type: none"> • Including a dedicated day programme for women in Dunedin. • Investigate the need for and feasibility of a therapeutic community day programme in Christchurch for women with severe AOD disorders and significant criminal offending history. • Expand capacity of day programmes for women with moderate to severe disorders in Christchurch. 		Volumes incorporated in service development objective 4(f).

Service Development Objectives	Additional Resources Required	Means of Resourcing and Implementation Issues
c) Investigate options for providing child care facilities for the period women or men attend outpatient services.	-	Repeat of service development objective 2(h).
d) Consider the needs of women specifically in the implementation of all proposed service development objectives including reviews of models of care and clinical pathways.	-	Utilise regional service development support position in conjunction with sector planning groups and DHB/SISSAL planning resources.
e) Include responsiveness to the needs of women as a key focus in future AOD service audits.	-	DHB/SISSAL audit programme.
Service Need 7 Increase the emphasis on aftercare/ reintegration services		
a) Establish community support worker and/or social work positions in major outpatient services in Christchurch. <ul style="list-style-type: none"> • Focusing on community based aftercare and relapse prevention support. • Include a kaupapa Maori position in CHCH. 	1 - 3 FTE (CDHB)	Resources available from reconfiguration of district services in Christchurch and reconfiguration of regional resources.
b) Offer short term (1 week max) crisis respite services in all existing residential services and supported accommodation services to assist people in recovery who are at significant risk of immediate relapse. <ul style="list-style-type: none"> • Include residential respite in re-configuration of existing AOD supported accommodation service in Timaru. 	Up to 5% of bed days in any one service.	<p>Incorporate in existing bed day volumes for residential services.</p> <p>Neutral impact on funding.</p> <p>Number of bed days in Timaru to be determined by need.</p>

Service Development Objectives	Additional Resources Required	Means of Resourcing and Implementation Issues
c) Develop intensive short term follow-up aftercare reinforcement programmes either on an outpatient or weekend/day retreat model in Christchurch.	0.8 – 1.0 FTE	Utilise reconfigured regional funding. Enables shorter intensive treatment lengths.
d) Enable greater access to mental health planned respite resources for people with co-existing disorders.	-	Utilise existing mental health resources.
e) Enable access to existing supported landlord mental health services in all districts by stable AOD clients.	-	Enable access to existing mental health services.
f) Improve the level of joint discharge planning between residential services and referral agencies offering the aftercare service.	-	No additional resources required.
g) Provide a greater emphasis on vocational rehabilitation in aftercare/reintegration services.	-	Link clients with suitable mental health and community training and employment services.
h) Establish supported AOD accommodation linked to the proposed residential Mental Health Rehabilitation Service in Greymouth.	2 beds	Utilises spare capacity in proposed rehabilitation service with some AOD district funding.
i) Provide aftercare respite and community support services as part of the reconfiguration of the existing AOD Supported accommodation service in Timaru.		Incorporated in objective 4(h).
j) Investigate opportunities for providing self-funding AOD supported living services (half way houses) in conjunction with current mental health community residential services in Dunedin and Invercargill. <ul style="list-style-type: none"> • Including supported accommodation for women and children in treatment in Dunedin. 	-	DHB planning resources in conjunction with providers.

Service Development Objectives	Additional Resources Required	Means of Resourcing and Implementation Issues
Service Need 8 Increase the level of culturally appropriate services for Maori		
a) Increase the participation of Maori in the planning and development of both kaupapa and mainstream AOD services in DHBs through forums such as the South Island Maori Mental Health Network and district structures such as the Canterbury Maori Mental Health Provider Network.	-	Utilise local DHB consultation/participation mechanisms and existing planning resources and structures.
b) Develop strategies within health and with other sectors for the integration of a range of AOD, health and other services that meet the holistic needs of Maori.	-	Utilise existing planning resources and structures within health and other sectors. Incorporate objective in other relevant district and regional planning projects.
c) Strengthen the development and quality of Kaupapa Maori AOD services, and outpatient services in particular, through: <ul style="list-style-type: none"> • Collaboration between kaupapa Maori organisations. • Partnerships with mainstream AOD services. 	-	Utilise existing resources.
d) Include responsiveness to Maori as a key focus of future audits of alcohol and drug services.	-	Incorporate in existing audit programme.
e) Include specific cultural safety and cultural assessment criteria in all future audits of AOD services.	-	Incorporate in existing audit programme.
f) Develop an audit tool for assessing the responsiveness to Maori for both mainstream and kaupapa Maori AOD services as part of a broader tool for all mental health services.	-	Develop within DHB audit programme.
g) Undertake work to integrate cultural assessment fully into the comprehensive assessment model.	-	Assessment agencies in conjunction with workforce development initiatives.

Service Development Objectives	Additional Resources Required	Means of Resourcing and Implementation Issues
h) Establish a regional kaupapa Maori intensive day programme/accommodation treatment service located in Otautahi/Christchurch. <ul style="list-style-type: none"> • Day programme linked to supervised accommodation model enables clients who live in the locality choice of outpatient or residential treatment or combinations of both. • Specific elements to meet the needs of Maori women. • Include Marae based components. 	9 - 10 beds	Utilise announced new government funding of \$517,000 for service. Funding outside Blueprint and PBF.
i) Trial week day/end treatment wananga for Maori as a means of providing non-residential intensive outpatient treatment in smaller DHBs if sufficient resources become available.		Incorporated in volumes for service development objective 4(d).
j) Include Rongoa (Maori healing practices) in major treatment services especially detox and residential treatment. <ul style="list-style-type: none"> • Extent limited by capacity of resource. 	-	Utilise existing Ministry of Health contracts for delivery of Rongoa services.
k) Appoint a dedicated Maori AOD health worker in Nelson/Marlborough and West Coast DHB Provider Arm outpatient services. <ul style="list-style-type: none"> • Ensure worker is linked to other Maori personnel (MH/AOD) to avoid isolation and ensure safety. 	-	Reconfigure existing resources as staff vacancies occur.
l) Develop a kaupapa Maori AOD assessment, referral and outpatient counselling service in Christchurch for youth.	1 FTE	Repeat of service development objective 2(i).
m) Develop kaupapa Maori day treatment programme for both men and women in Christchurch in association with the proposed Kaupapa Maori residential accommodation service.	1.5 – 2 FTE	Repeat of service development objective 4(g).
n) Develop a kaupapa Maori aftercare community support work service in Christchurch.	0 - 1 FTE	Repeat of service development objective 7(a).

Service Development Objectives	Additional Resources Required	Means of Resourcing and Implementation Issues
o) Increase the level of kaupapa Maori outpatient assessment/referral and counselling in Christchurch.	1 FTE	Reconfigure within current contract from current mainstream funding in existing Maori AOD agency. Neutral impact on AOD funding.
p) Establish a kaupapa Maori AOD consult/liaison service for mainstream AOD services in Christchurch	0 - 0.5 FTE	Utilise reconfigured regional resources.
<p>q) Implement steps towards establishing a culturally appropriate Maori Community AOD service in Dunedin for adults and youth.</p> <p><i>Step 1:</i> Continue the provision by the Community Alcohol and Drug Service and Te Oranga Tonu Tanga of targeted services to Maori and extend the consult/liaison role with the Maori NGO sector.</p> <p><i>Step 2:</i> With additional resources expand the service.</p> <p><i>Step 3:</i> In the longer term devolve the service to a Maori provider when their capacity and capability are sufficient to maintain the service.</p>	1 adult FTE and 1 youth FTE	Repeat of service development objective 2(j).
Service Need 9 Provide residential treatment for youth in the South Island		
<p>a) Develop a regional youth intensive day programme/accommodation treatment service located in Christchurch for 14 to 18 year olds in collaboration with Child, Youth & Family.</p> <ul style="list-style-type: none"> • Day programme linked to supervised accommodation. This model enables clients who live in the locality choice of outpatient or residential treatment or combinations of both. • Male and female. 	10 beds	<p>Central Govt funding from 2002/03 budget announcement (\$551,111).</p> <p>Implementation project underway with Odyssey House as provider.</p> <p>Possible additional funding from Child, Youth & Family.</p>

Service Development Objectives	Additional Resources Required	Means of Resourcing and Implementation Issues
b) Actively include mana whenua and other Maori in the planning and delivery of the service model.	-	No additional resources required.
Service Need 10 Reduce waiting lists for methadone treatment post assessment to a maximum of four weeks in all DHBs		
a) Develop strategies for reducing waiting times within current resources.	-	Develop as deliverable in South Island Methadone Service Development Project.
b) Increase the level of methadone clients being treated in the primary care sector.	-	Primary health funding (User fees and general medical subsidy).
c) Develop a system for clients on methadone programmes to transfer between districts.	-	Resource from existing methadone funding. Develop as objective of S.I. Methadone Service Development Project.
d) Provide access for methadone treatment clients to existing AOD day and residential treatment programmes.	-	Allow access to existing services within current resources.
Service Need 11 Improve access to treatment services for rural areas		
a) Trial a regional contract for week day/end treatment retreats/wananga as a means of providing intensive outpatient treatment.		Repeat of service objective 4(d).
b) Investigate the potential use of computer and internet based treatment and support programmes for rural consumers.		DHB planning resources.

Service Development Objectives	Additional Resources Required	Means of Resourcing and Implementation Issues
c) Include the delivery of AOD services to rural areas in the work DHBs are undertaking to develop primary health care services.	-	DHB planning resources.
Service Need 12 Increase the level of Concerned Significant Other involvement in the treatment of all service users		
a) Include the encouragement of family/whanau participation in treatment as a key focus of future service audits.	-	Incorporate in existing audit programme.
b) Offer short course workforce development training courses on working with family/whanau participation treatment models.	Unknown	See service development objective 18(a).
Service Need 13 Improve support to family/whanau members independent of the service user		
a) Ensure all major assessment/outpatient services are offering information and support to family members.	-	Utilise existing service resources.
b) Ensure all major treatment services are offering support for family members of service users. <ul style="list-style-type: none"> • Support groups as a minimum. 		Utilise existing service resources.
c) Investigate how access for AOD family/whanau members to existing mental health family advocacy services can be improved.		Utilise existing DHB planning and contract management resources.
d) Assist the establishment of family/whanau education and support outpatient services in Christchurch.	1 FTE	Utilise reconfigured regional resources.

Service Development Objectives	Additional Resources Required	Means of Resourcing and Implementation Issues
e) Provide education and support services for family/whanau members as part of the reconfiguration of the existing AOD supported accommodation service in Timaru.		Volumes incorporated in objective 4(h).
Service Need 14 Improve outcomes for older recidivist substance dependants with significant rehabilitation needs		
a) Review models of care and clinical pathways for older recidivist substance dependants, particularly those under the A&D Act. <ul style="list-style-type: none"> • In collaboration with Disability Support Services. • Including length of residential care, reintegration services and community support. 	-	Utilise regional service development support position in conjunction with DHB planning resources.
Service Need 15 Improve integration and flexibility of service delivery		
a) Develop a seamless treatment service by establishing service partnerships between individual service components to deliver more integrated and flexible service packages. Particularly between: <ul style="list-style-type: none"> • Detox services and intensive treatment services. • Residential services and intensive outpatient services. • Residential services and aftercare services. • Medical, social and home detox services. • Authorised assessment and referral services in the same city. • Provider Arm and NGO services. • Mainstream and Kaupapa Maori services. • Specialist AOD services and primary health care. • Health and other sectors. 	-	Utilise existing provider resources.
b) Establish working protocols and memorandums of understanding between key services to facilitate effective service integration.	-	No additional resources required.

Service Development Objectives	Additional Resources Required	Means of Resourcing and Implementation Issues
c) Recognise service partnerships in provider agreements.	-	No additional resources required.
d) Review case management models in any reviews of models of care and clinical pathways.		See service development objective 21(a).
e) Encourage the development of multi faceted service providers who offer both intensive outpatient and residential treatment options.	-	See service development objective 4(a).
f) Collaborate with the Department of Corrections to review models of care and clinical pathways for criminal offenders with alcohol and drug problems.		See service development objective 21(a).
g) Negotiate with Corrections the development of integrated service models with residential treatment providers. Specifically between initial engagement pre-programme work in prison before entering long term therapeutic communities.	Unknown	Dept of Corrections fund prison treatment component. Community services maintained as present. Neutral impact on DHB funding.
h) Develop strategies within health and with other sectors for the integration of a range of AOD, health and other services that meet the holistic needs of Maori.	-	Repeat of service development objective 8(b).

Service Development Objectives	Additional Resources Required	Means of Resourcing and Implementation Issues
Service Need 16 Develop a model for ensuring quality referral to residential treatment		
a) Maintain the current model of assessment and referral to residential services by designated clinicians in authorised agencies. <ul style="list-style-type: none"> • Restrict authorised referral agencies to those independent of residential treatment agencies. • Enable authorised agencies to approve their own designated clinicians. • Establish minimum qualifications and skill levels for designated clinicians and incorporate in service agreements. • Audit agencies compliance against new policy. 	-	Policy developed by SISSAL/DHBs in consultation with clinicians. No additional resources required. Incorporate compliance monitoring as part of routine service audits.
Service Need 17 Strengthen the participation of consumers/tangata whaiora in the planning and evaluation of services		
a) Review the management support structure for the regional AOD consumer advisor positions.	-	CDHB contract management with provider.
b) Review the role and function of regional AOD consumer advisors in relation to the role of local consumer advisors and AOD providers.	-	DHB/SISSAL planning and contract management resources in conjunction with consumer networks and providers.
c) Develop local AOD specific consumer advisor positions in DHB provider arm services.	To be determined by each DHB.	Where practical, as vacancies occur, dedicate a portion of the mental health consumer advisor FTE resource to a specific AOD position.
d) Investigate ways of making existing advocacy services for health consumers more accessible to AOD service users.	-	DHB/SISSAL planning and contract management resources.

Service Development Objectives	Additional Resources Required	Means of Resourcing and Implementation Issues
Service Need 18 Increase the capability of the alcohol and other drug service workforce		
a) Offer intermediate level AOD workforce development training on the following subjects in order of priority: <ul style="list-style-type: none"> • Treatment of co-existing disorders. • Family/whanau inclusive treatment approaches including family therapy. • Kaupapa Maori models and practice. • Intensive structured outpatient treatment including group work. • Use of new pharmacotherapies. • Cultural assessment and safety practices. • Treatment of cannabis problems. • Treatment of methamphetamine addiction. • Intensive treatment for youth. • Consumer participation in service audits, planning and evaluation. • Motivational interviewing. • Programme evaluation. 	Unknown	District, regional and national workforce development funding. Inter-agency collaboration for in-house training Actual range and number of training subjects offered will depend on future workforce development funding levels. Some subjects could be incorporated in generic mental health training.
b) Include the needs of the Pacific Peoples AOD workforce in the CDHB programme for Pacific workforce development.	-	CDHB planning resources.
Service Need 19 Make new pharmacotherapies for AOD dependency available for treatment		
a) Advocate with PHARMAC for inclusion of a wider range of new pharmaceuticals for treating addiction on the subsidised Pharmacy Schedule. <ul style="list-style-type: none"> ▪ Naltrexone already approved. 	-	No additional resources required.

Service Development Objectives	Additional Resources Required	Means of Resourcing and Implementation Issues
Service Need 20 Improve access to and the quality of treatment for co-existing disorders		
a) Undertake a separate follow-up sub-project to develop strategies for improving service delivery for co-existing disorders.	-	SISSAL/DHB planning resources.
Service Need 21 Develop an integrated planning and funding process for South Island AOD treatment services		
a) Undertake reviews of models of care and clinical pathways for key groups in conjunction with key service developments. Particularly for: <ul style="list-style-type: none"> • Recidivist substance dependents under the A&D Act. • Moderate to severe dependency with lower level needs and less complex disorders as part of re-configuration. • Criminal offenders (In collaboration with Dept of Corrections). • Co-existing disorders (Sub project deliverable). 	-	Utilise regional service development support position in conjunction with sector planning groups and DHB/SISSAL planning resources. Disability Support Services involvement in A&D Act clients with brain damage. Support from Dept of Corrections for criminal offenders review. Potential for inter-regional collaboration.
b) Establish AOD sector planning groups in each district to promote collaboration between services, develop service integration and to co-ordinate service reconfiguration and development objectives. <ul style="list-style-type: none"> • Include Maori, consumer and family participation. • Work closely with DHB planners and funders. • Link to existing planning structures where practical. • Groups task focused and time limited. 	-	DHB/SISSAL planning resources with assistance from regional support position as required.

Service Development Objectives	Additional Resources Required	Means of Resourcing and Implementation Issues
c) Establish a regional service development support position to assist services in each district to collectively implement the review recommendations. In particular: <ul style="list-style-type: none"> • Reviews of models of care and clinical pathways. • Reconfiguration of services and development of shared service models. 	0.6 FTE	Reconfigure the current regional ADANZ information/liaison/ policy advice contract plus some additional resources from regional funding.
d) Explore the establishment of standardised benchmark prices to assist DHBs in the future purchasing of residential AOD services.	-	DHB planning and funding resources. Increases in price limited to FFT funding and demographic adjustment funding available.
e) Release resources for prioritised service developments by no longer purchasing services that will either be redundant because of the announced funding for new residential service developments or have very low utilisation rates. Including: <ul style="list-style-type: none"> • Youth beds located in Auckland. • Parent and child bed in Auckland. • One long term therapeutic community bed in Christchurch. • Existing youth day programme in Christchurch (Final level of reduction yet to be determined). 	-	Releases resources for higher priorities.
f) Advocate for devolution of all South Island AOD service contracts to South Island DHBs.	-	Provides DHBs with greater flexibility and control over the use of South Island resources for service development objectives. Specifically Salvation Army Bridge Programme contract.

6 PRIORITISATION PRINCIPLES

In determining the service development objectives for the next three years the Review gave regard to the following principles which are adapted from those which DHBs use for all health services:

a) Effectiveness

The extent to which the objectives would contribute to the minimising of harm caused by excessive alcohol and drug use and would enhance the recovery of service users. This draws on current knowledge of best practice principles.

b) Affordability

The total costs of services were considered together with the capacity to fund the objectives within the potential level and means of resourcing available.

c) Equity

Consideration was given to the degree the objective improved outcomes for populations with the worst health and ensured equitable access to services for special populations and communities. This also included equity of AOD service resources across South Island DHBs in allocating regional funding.

d) Maori Health

In making recommendations, the Review acknowledges the Treaty of Waitangi, and encourages Maori participation in providing and using services. This principle builds on the principles of Equity, Effectiveness and Feasibility and focuses on the degree to which:

- a) Maori will benefit from the service.
- b) Maori will take up the service.
- c) The service will reduce disparities between Maori and Non-Maori.
- d) The service is appropriate and acceptable to Maori.

e) Feasibility

This relates to the ability of existing or new providers to reduce, re-configure, expand or develop new services within the budget and three year time frame. For example, service development may be constrained by workforce development issues.

f) Acceptability

The degree to which the priority given to an objective matches the values and expectations of:

- a) District Health Board members.

- b) Consumers/Tangata whaiora.
- c) Maori.
- d) Providers and clinicians.
- e) The Ministry of Health.

6.1 Priority Areas for Service Development

The Review has identified the following objectives as the priority areas for development:

- Development of intensive outpatient programmes.
- Increasing the capacity and capability of kaupapa Maori services including a regional intensive day programme/accommodation AOD treatment service.
- Family participation in treatment and increased support for family/whanau members.
- Increased aftercare/re-integration services.
- Provision of a regional youth intensive day programme/accommodation AOD treatment service.
- Workforce development across the spectrum of health workers in the AOD treatment sector.
- Improved integration and flexibility of the treatment system.
- Reviews of models of care and clinical pathways for key population groups.
- Increasing the level of gender appropriate services for women, including women with dependent children.
- Establishing standard benchmark prices for residential services.

7 RESOURCING THE OBJECTIVES

The service development objectives recommended in the Review can be divided into two general categories. Firstly those which will require additional resources to implement. Secondly those which are primarily qualitative in nature and involve delivering services in a different way within existing contract volumes.

In terms of obtaining additional resources for service development, the following list outlines the means for resourcing the recommendations. Funding of new service developments for the delivery of alcohol and other drug treatment services in the short to medium term is restricted to the following sources:

- a) New funding outside both the Blueprint benchmarks and population based funding (PBF) from the Ministry of Health for targeted service developments. Specifically:

\$551,111 p.a. for the regional youth intensive day programme/accommodation AOD treatment service.

\$517,000 p.a. for a regional kaupapa Maori intensive day programme/accommodation AOD treatment service. Including initial development support costs.

- b) \$815,000 p.a. devolved to the southern region following the termination of the Hanmer Clinic's contract. While this funding was already nominally allocated to individual DHBs in the South Island, for the purposes of the Review this funding has been placed in the pool of AOD funding available for regional reconfiguration. This funding will assist with the development of expanded intensive outpatient and aftercare services in Christchurch, developing a day programme in Dunedin and the piloting of weekend/day treatment retreat /wananga for Nelson/Marlborough, West Coast, South Canterbury and Southland DHBs.

- c) Reconfigure existing residential service volumes. This includes the following:

A limited reconfiguration at both district and regional levels of existing DHB AOD resources. This includes reducing volumes for medium term residential beds in Christchurch by five beds initially and redirecting resources into intensive day programme treatment in conjunction with short term residential treatment. Reductions of two long term therapeutic community beds, one located in Christchurch and one in Auckland, are also proposed as provider monitoring returns indicate very low utilisation rates for these beds.

While this re-configuration permits clients who would have otherwise been treated in residential services to be treated in combinations of short term residential treatment and intensive day programmes, in itself it does not free up resources for re-allocation to other services unless the average length of intensive treatment in any modality is reduced. The reason for this is that the full cost of residential care is subsidised by user fees via WINZ benefits which pay for food and lodging expenses. Consequently while re-configuration may cut some 24 hour staffing costs the WINZ funding component is lost.

Under the above scenario the proposed reduction of five beds at \$70 per bed day would equate to 1.8 FTEs and 9.7 beds to 3.4 FTEs at an FTE price of \$72,000. For these services to remain viable it is recommended that reconfiguration collectively occurs only within the services effected.

The capacity of medium term services can be maintained despite the small reduction in volumes by reducing the average length of intensive treatment. Clinicians acknowledged there was potential for reducing the average length of treatment following work on

reviewing models of care and clinical pathways but opposed setting arbitrary reductions at this stage in the process.

If a service is established for both young men and young women the current contract with Odyssey House Auckland for 1.5 youth beds will be redundant. This would free up resources of approximately \$54,750 or the equivalent of 0.76 FTE.

In recommending re-configuration within residential services the Review has been cognisant of the risk of partially reducing volume levels in any one service to the point the remaining volumes are no longer viable and of the need to maintain a distribution of residential services across districts in the South Island.

Increased flexibility and diversity of services within residential treatment modalities is a key feature of the Review recommendations. However current prices paid for similar residential services vary considerably between providers. Providers at the lower end of the price scale will struggle to offer a comprehensive range of services and improve practice overall. In response to the Review, DHBs have agreed that all AOD residential treatment and inpatient detox services are regional in nature. Therefore to help ensure all agencies have sufficient resources to develop their services as proposed, the Review recommends that the development of standard regional benchmark prices for the future purchasing of residential services in the South Island be explored.

- d) A modest reconfiguration of other mental health resources to developments in the AOD sector. This is proposed in the West Coast, Otago and South Canterbury DHBs. Total amount is \$222,739.
- e) Utilisation of existing treatment resources for the substance user to provide support and information for family/whanau members. Particularly by offering support through CADS in Dunedin. Additional resource for family support is recommended for Christchurch.
- f) Corrections funding for pre-sentencing court reports and parole reports. Currently a mixed model exists for charging for these assessment reports when conducted by community alcohol and drug services. Non charged time currently allocated to these reports is estimated at approximately 2-4 FTE for the region as a whole. The Review argues that assessments for the purpose of the Courts or Parole Boards are the responsibility of the Department of Corrections not Health and should therefore be funded by Corrections. Charging for assessment reports would free up resources to meet the high level of demand for assessment/referral services.

A similar issue exists for Ministry of Transport drink driving assessments being undertaken by DHB funded AOD services. The current payment rate is well under the real cost of delivering this service. A more realistic charge rate would avoid the current situation where mental health funding is subsidising the associated costs.

Any cost savings from increased payment rates have been allocated in the Review to increasing the capacity of existing assessment and referral services.

- g) Utilise non-AOD services. In a number of limited situations, particularly with regard to rehabilitation services, it would make more sense for AOD clients to access existing mental health or other community services rather than setting up specialist AOD services. Examples include vocational rehabilitation services, access to supported landlord services and increased utilisation of primary health care services for mild to moderate alcohol and other drug problems.
- h) Utilise existing services more efficiently. For example establishing a 'stepped assessment' model in authorised assessment and referral agencies permits a more effective allocation of resources to those with the highest and most complex needs and doesn't 'over assess' those with lower level needs. This should increase the capacity of the service overall.

- i) Contract slippage. E.g. Under-utilisation or under-delivery of volumes. This cannot be used as an ongoing sustainable source of funding but could assist with transition and establishment costs associated with service re-configuration in any one year.
- j) Central and regional mental health workforce development funding. Particularly intermediate level training. The most efficient means of delivering AOD workforce development is to link it to regional and national initiatives.
- k) Inter-agency collaboration on in-house issues. Providers developing joint strategies to more cost effectively undertake tasks that the individual provider is expected to complete as part of their service agreements. E.g. supervision or workforce development. The development of district alcohol and drug networks such as CADMAG and the existence of LOAD meetings offer forums to facilitate this.
- l) Inter-sectoral collaboration with funding of services. This would apply to services specifically for youth and adult justice clients who are alcohol and drug dependent. Work needs to be undertaken in particular with Child, Youth and Family and the Department of Corrections to progress this.

DHB funding issues have been further complicated by the implementation of population based funding (PBF) models. Under these scenarios Central Government is allocating funding to DHBs on the basis of a formula that recognises the relative size and health status of each DHB population. In the South Island Canterbury, Otago and West Coast Boards are facing over-expenditure under population based funding and are therefore unlikely to receive any of the annual South Island allocation of new mental health Blueprint funding, as it would increase the size of their funding deficit overall.

In 2004/05 the South Island is expected to be allocated only about \$1 million new Blueprint funding because of the relative position of mental health funding in the South Island compared to DHBs in the North Island. This amount has already been allocated to the development of other mental health services in the three DHBs without over-expenditure under PBF. New mental health funding is likely to be at a similar minimal level in subsequent years and will be allocated primarily to DHBs with relatively lower per capita expenditure on mental health and health expenditure in total.

In practice these realities have impacted on the prioritisation process and constrain the type, quantity and location of AOD services that can be developed.

In allocating district and regional funding the Review used the following principles:

- Resources within district only services are retained within that district.
- Regional resources released by reconfiguration should be allocated on two criteria:
 - I. The need to ensure all DHBs have intensive outpatient alternatives to meet the demand created by the reduction of standard medium-term mainstream beds including the residential programme at Hanmer Springs.
 - II. The relative gap for each DHB against the priority Blueprint volume benchmark for AOD Community FTEs.
- If because of implications for expenditure an individual DHB is unable or is unwilling to accept new funding their allocation is returned to the regional pool to be redistributed to other DHBs.

It should be noted that South Canterbury District Health Board have indicated that their current level of mental health funding is sufficient to meet their district based AOD service development needs. Therefore no funding from the regional pool has been allocated to SCDHB for district only initiatives.

Final decisions on the funding and planning of alcohol and other drug services remain the prerogative of each DHB both individually and collectively. Individual DHBs may choose to undertake further AOD service developments outside of the Review.

See Table 4 (p.67) and Table 5 (p68) for a summary of the impact of the Reviews recommendations on DHB expenditure and Table 3 (p.29) for the Reviews impact on DHB service volumes.

Table 4: Summary of Current and Proposed Expenditure on Alcohol and Other Drug Services in South Island DHBs

DHB	Estimated Total Funding to Achieve Blueprint for AOD	Current AOD Contracts Value	Value of Gap to Achieve Blueprint	Proposed Contract Value in Review	New Per Capita AOD Spend	Value of Proposed Gap	Impact of Review on Increases in AOD Expenditure	New Residential Funding Outside Blueprint & PBF
Nelson/Marlborough	\$3,142,160	\$2,634,547	\$507,614	\$2,670,175	\$19.2	\$471,985	\$35,628	
Canterbury	\$10,446,697	\$7,606,322	\$2,840,375	\$8,251,427	\$17.3	\$2,195,270	\$645,105	
West Coast	\$743,411	\$725,705	\$18,706	\$750,041	\$25.5	-\$6,630	\$25,336	
South Canterbury	\$1,206,641	\$997,104	\$209,537	\$1,052,088	\$20.3	\$154,553	\$54,985	
Otago	\$4,318,866	\$3,514,400	\$804,467	\$3,765,205	\$21.1	\$553,661	\$250,805	
Southland	\$2,487,516	\$1,824,545	\$662,971	\$1,185,424	\$17.5	\$637,092	\$25,879	
South Island Region	\$22,345,291	\$17,301,622	\$5,043,670	\$18,339,361	\$18.7	\$4,005,931	\$1,037,739	\$1,068,111

Table Notes:

- Costs are GST exclusive and represent calculations for May 2004.
- Figures assume the regionalisation of all residential treatment and inpatient detox services.
- 'Current AOD Contracts Value' does not include the funding devolved from the closure of the Hanmer Clinics or the temporary contract with CDHB for services previously provided by the Christchurch Hanmer Outpatient Clinic.
- 'Impact of Review on AOD Expenditure' includes the allocation of the devolved Hanmer funding.
- 'Current' and 'Proposed' AOD 'Contracts Values' contain AOD expenditure that does not map to AOD Blueprint categories (\$390,020 and \$397,204 respectively).
- 'Proposed Contract Value in Review' does not include the MOH funding for the intensive youth and kaupapa Maori day/accommodation programmes which are outside the Blueprint and population based funding.

Table 5: Summary of DHB Expenditure on AOD Service Categories for Current and Reconfigured Contracts

Service Category	Contract Values	Nelson/ Marlborough	Canterbury	West Coast	South Canterbury	Otago	Southland	Total
Community FTEs	Current Value	\$1,592,063	\$3,833,325	\$479,585	\$471,895	\$2,083,452	\$1,205,200	\$9,665,520
	Re-configured Value	\$1,662,180	\$4,596,744	\$494,373	\$562,950	\$2,378,482	\$1,257,169	\$10,951,898
In-Patient Detox Beds	Current Value	\$183,005	\$627,798	\$64,249	\$68,003	\$234,664	\$138,435	\$1,316,155
	Re-configured Value	\$183,005	\$627,798	\$38,272	\$74,003	\$234,664	\$138,435	\$1,296,177
Residential Beds	Current Value	\$355,458	\$1,219,395	\$74,967	\$200,340	\$468,750	\$294,795	\$2,613,705
	Re-configured Value	\$319,950	\$1,097,587	\$111,279	\$157,891	\$423,219	\$267,935	\$2,377,860
Methadone Places	Current Value	\$446,326	\$1,679,182	\$99,007	\$244,715	\$685,609	\$161,383	\$3,316,222
	Re-configured Value	\$446,326	\$1,679,182	\$99,007	\$244,715	\$685,609	\$161,383	\$3,316,222
Non-Blueprint AOD Categories	Current Value	\$57,695	\$246,622	\$6,896	\$12,150	\$41,925	\$24,732	\$390,020
	Re-configured Value	\$58,714	\$250,117	\$7,111	\$12,529	\$43,231	\$25,502	\$397,204
All Categories	Current Value	\$2,634,547	\$7,606,322	\$724,705	\$997,104	\$3,514,400	\$1,824,545	\$17,301,622
	Re-configured Value	\$2,670,175	\$8,251,427	\$750,041	\$1,052,088	\$3,765,205	\$1,850,424	\$18,339,361

Note: These figures do not contain \$1,068,111 AOD expenditure outside Population Based Funding.

8 Implementation of the Service Development Objectives

As there are a number of variables with regard to resourcing the objectives which will change over time, a separate implementation planning process will need to be developed that sets and reviews service development objectives and budgets for each DHB on an annual basis.

A mechanism for co-ordinating district developments that require inter-district collaboration and co-ordination will also need to be developed. Particularly with regard to the reconfiguration of regional residential services, the development of new regional residential services for Maori and youth, negotiations with the Department for Corrections, the trialing of weekend/day treatment retreats and reviews of models of care and clinical pathways.

Because the AOD Review service development objectives are focused primarily on using existing resources better and collaboratively improving the quality of practice, the successful implementation of the review will be dependent on good will and ownership from all parties. This will require positive leadership and the active participation in the planning process from all stakeholders including DHB planners and funders, clinicians, providers, Maori consumers/tangata whaiora and family/whanau.

Providers and clinicians have expressed a commitment to progress change but are seeking positive leadership from DHBs and the opportunity to develop the objectives in partnership with DHBs. However stakeholders recognise that the final decision making authority regarding funding of services lies with DHBs.

For this reason the Review recommends that each DHB sets up its own AOD sector planning group with involvement of key stakeholders to progress the objectives in line with its own planning needs and structures. These groups should be time limited, task focused and not duplicate existing planning structures.

Both DHBs and providers have limited capacity to support the proposed changes. Historically, provider liaison and coordination activities have been supported by the regional Alcohol Drug Association of NZ contract. It is proposed that the current contract be refocussed to create a service development support position that can assist providers to work with DHB planners and contract managers to implement the objectives. In particular developing shared service models, the collective reconfiguration of services and reviews of models of care and clinical pathways.

One major contract for AOD services critical to the Review is not directly managed by South Island DHBs, i.e. the Salvation Army Bridge Programme. The Review recommends that DHBs seek the unbundling and devolvement of this contract to the southern region to enable DHBs to align the agreement with the needs established for building integrated service delivery and to establish a more effective relationship with the provider.

8.1 Timeline

The draft timeline outlined below provides indicative timeframes for implementing the Reviews recommendations. All DHBs will need to develop their own action plans as part of implementing the Review.

KEY DEVELOPMENTS		Target Completion Date
Regional	District	
Establish youth day programme/supported accommodation (residential) service in CHCH.	Set up AOD planning groups as required.	DEC 04
Reduce regional beds as proposed.	Expand day programmes in CHCH.	
Establish contract for inter-district treatment retreats/wananga.	Expand aftercare resources in CHCH.	
Advocate for the devolvement of Bridge programmes contract to region.	Establish day programmes in Dunedin.	
Establish regional service development support position.	Establish kaupapa Maori youth position in Christchurch.	
Establish kaupapa Maori day programme/supervised accommodation (residential) service.	Establish first level of AOD CSW positions in Christchurch.	
Incorporate recommendations for services for Maori into audit programme.	Establish home detox position in Invercargill.	JUNE 05
Develop more flexible outpatient/crisis respite options in residential treatment.	Develop new role of CADS in CHCH.	
Undertake methadone service development project.	Establish family support position in CHCH.	
Undertake co-existing disorders sub-project.	Establish dedicated Maori Community AOD positions in NMDHB and WCDHB provider arm services.	
Explore the development of regional benchmark prices for residential services.	Reconfigure current Maori AOD service to full kaupapa Maori programme.	
Implement one priority for AOD workforce development training.		
Set up new system for authorised residential referral.		

Continued next page.

Negotiate funding boundaries with Dept of Corrections.	Establish supported AOD accommodation in Greymouth.	JUNE 06
Review models of care for criminal offenders.	Establish Pacific peoples authorised assessment service in Christchurch.	
Better integrate social and inpatient detox services in CHCH.	Consolidate and expand community services for Maori in Dunedin.	
Review the role of AOD consumer advisers.		
Implement one priority for AOD workforce development training.		
Review models of care for recidivist clients under the A&D Act.		JUNE 07
Implement one priority for AOD workforce development training.		

9 APPENDIX: Profile of Services in the South Island

AOD Service Profile –South Island													
DHB	Assessment and Referral Outpatient Counselling	Medical Detox	Social Detox	Home Detox	Day Treatment Programme	Short Term Residential	Medium Term Residential	Long Term Community Residential	Supported Accommodation	Methadone Programme	Dedicated Family Service	AOD Consumer Adviser	Other
Nelson/Marlborough	16.85 FTE		0.96 Beds	0.5 FTE	4.00 FTE		9.00 Beds			187.0 Places		0.21 FTE 0.57 Prog	1.07 FTE 0.28 Prog
West Coast	5.70 FTE	0.10 Beds								41.0 Places		0.04 FTE 0.12 Prog	0.01 FTE 0.06 Prog
Canterbury	43.45 FTE	6.00 Beds	5.00 Beds	1.00 FTE	7.41 FTE		35.90 Beds	26.9 Beds	22.0 Beds	694.2 Places		0.73 FTE 1.95 Prog.	1.54 FTE 1.97 Prog
South Canterbury	5.52 FTE				0.60 FTE				4.00 Beds	90.0 Places		08 FTE 0.21 Prog.	0.03 FTE 0.11 Prog.
Otago	20.30 FTE		0.22 Beds	2.00 FTE	3.00 FTE		7.00 Beds	11.00 Beds	1.38 Beds	275.0 Places		0.27 FTE 0.73 Prog	0.09 FTE 0.36 Prog.
Southland	15.20 FTE									65.0 Places		0.16 FTE 0.43 Prog	0.05 FTE 0.21 Prog.
Regional Totals	107.02 FTE	6.10 Beds	6.18 Beds	3.5 FTE	15.01 FTE		51.90 Beds	37.90 Beds	27.38 Beds	1352.2 Places		1.5 FTE 4 Prog	2.79 FTE 3.0 Prog

Tables Note: Services are assigned to DHBs on the basis of location or who holds the contract for services outside the region, not access. Where a service is regional and therefore accessed by all six DHBs this is noted in the table for the DHB the service is located in.

Service Profile - Nelson/Marlborough

Provider	Assessment and Referral Outpatient Counselling	Medical Detox	Social Detox	Home Detox	Day Treatment Programme	Short term Residential	Medium Term Residential	Long Term Community Residential	Supported Accommodation	Methadone Programme	Dedicated Family Service	AOD Consumer Adviser	Other
St Marks Society Inc			0.96 Beds				9.00 Beds						
Horizon Trust					3.00 FTE (Youth)								
Nelson Marlborough Provider Arm	9.10 (Adult)			0.5 FTE						187 Places			1 FTE Forensic Youth with AOD component
Te Rapuora O Te Wai Harakeke	3.25 FTE (Maori)												
Te Makatea Hauora	1.60 FTE (Maori)												
Alcohol & Drug Association												.21 FTE (Regional) 0.57 prog. (Networking/Support)	.07 FTE (Policy support) & 0.28 prog. (LOAD & Newsletter)
Ngati Koata Rangitoto	2.50 FTE (Maori)				1 FTE (Maori Youth)								
Total	16.45 FTE		0.96 Beds	0.5 FTE	4.00 FTE		9.00 Beds			187.00 Places		.21 FTE 0.57 Prog.	1.07 FTE & 0.28 Prog.

AOD Service Profile - West Coast													
Provider	Assessment and Referral Outpatient Counselling	Medical Detox	Social Detox	Home Detox	Day Treatment Programme	Short term Residential	Medium Term Residential	Long Term Community Residential	Supported Accommodation	Methadone Programme	Dedicated Family Service	AOD Consumer Adviser	Other
West Coast Provider Arm	5.7 FTE (1.50 FTE Youth, 4.20 FTE Adult)	0.1 Bed								41 Places			
Alcohol & Drug Association NZ												.04 FTE (Regional) 0.12 prog. (Networking/Support)	.01 FTE (Policy support) & 0.06 prog. (LOAD & Newsletter)
Total	5.70 FTE	0.10 Beds								41.00 Places		0.04 FTE 0.12 Prog.	0.01 FTE 0.06 Prog.

AOD Service Profile - Canterbury

Provider	Assessment and Referral Outpatient Counselling	Medical Detox	Social Detox	Home Detox	Day Treatment Programme	Short term Residential	Medium Term Residential	Long Term Community Residential	Supported Accommodation	Methadone Programme	Dedicated Family Service	AOD Consumer Adviser	Other
Canterbury Provider Arm	21.50 FTE (18.50 FTE Adult and 3 FTE YSS)	6 Beds								694.2 Places			
Christchurch City Mission	3.00 FTE (1 FTE Women, 1 FTE Youth & 1 FTE Adult)		5.00 Beds	1.00 FTE	1 Prog. (0.56 FTE equivalent, Women)								
Odyssey House					3.6 FTE (Youth)			20.00 Beds (Male)					
Pacific Island Evaluation Inc.	1.60 FTE (1.1 FTE adult, 0.5 FTE youth, Pacific Island)												
Salvation Army Bridge Prog	4.47 FTE						8.00 Beds	3.70 Beds (3.7 beds Women, Dual Diagnosis)	6.00 Beds (Level II)				1.3 FTE (Womens Dual Diagnosis)
Vincentian Recovery Centre Trust					1.00 FTE (Women)		13.90 Beds (Male)		8.0 Beds (4 Level II Female, 4 level 1 Male)				
Waimakariri District Community Development Trust	1.00 FTE (Youth)												
Nova Trust							14.00 Beds		8.00 Beds (4 level I & 4 level II)				
Odyssey Trust - Auckland								3.20 Beds (0.7 bed Dual Diag, 1.5 bed Youth, 1 bed Parent &					

								Child)					
Ashburton Community Alcohol & Drug Service Inc	3.60 FTE				1.00 FTE								
Te Rito Arahi	4.00 FTE (1 FTE mainstream, 3 FTE Maori Services)				1.25 FTE (Women)								
St John of God Youth and Community Services - Waip	1.00 FTE (Youth)												
Alcohol & Drug Association												.73 FTE (Regional) 1.95 prog. (Networking/Support)	.24 FTE (Policy support) & 0.97 prog. (LOAD & Newsletter)
Joint Salvation Army & Vincentian	1.00 FTE (Circles of change)												1 respite program
Adventure Development Ltd - Dunedin	0.78 FTE (2 programmes includes outdoor component)												
Youth Health Trust	1.50 FTE (Primary Care)												
Total	43.45 FTE	6.00 Beds	5.00 Beds	1.00 FTE	7.41 FTE		35.90 Beds	26.9 Beds	22.00 Beds	694.20 Places		0.73 FTE 1.95 Prog	1.54 FTE 0.97 Prog. & 1 Prog.

AOD Service Profile - South Canterbury

Provider	Assessment and Referral Outpatient Counselling	Medical Detox	Social Detox	Home Detox	Day Treatment Programme	Short term Residential	Medium Term Residential	Long Term Residential Community	Supported Accommodation	Methodone Programme	Dedicated Family Service	AOD Consumer Adviser	Other
South Canterbury Provider Arm	5.40 FTE (1.60 FTE Youth, 3.80 Adult)				0.60 FTE					90.00 Places			
Adventure Development Ltd - Dunedin	0.12 FTE (0.5 programmes includes outdoor component)												
Alcohol & Drug Association												.08 FTE (Regional) 0.21 prog. (Networking/Support)	.03 FTE (Policy support) & 0.11 prog. (LOAD & Newsletter) (All regional)
Caroline House									4.00 Beds				
Total	5.52 FTE				0.60 FTE				4.00 Beds	90.00 Places		0.08 FTE 0.21 prog.	0.03 FTE 0.11 prog.

AOD Service Profile - Otago

Provider	Assessment and Referral Outpatient Counselling	Medical Detox	Social Detox	Home Detox	Day Treatment Programme	Short term Residential	Medium Term Residential	Long Term Community Residential	Supported Accommodation	Methadone Programme	Dedicated Family Service	AOD Consumer Adviser	Other
Otago Provider Arm	14.5 FTE (1.00 FTE YSS, 13.50 CADs)									275 Places			
Downie Stewart Foundation Charitable Trust	1 FTE							11 Beds (Regional, male offenders)					
Salvation Army Bridge Programme	1.3 FTE						7 Beds (Regional)						
Adventure Developments Ltd	1.5 FTE (3.5 prog. includes outdoor component)												
Richmond Fellowship NZ			.22 Beds (Regional)	2 FTE									
Alcohol & Drug Association NZ												.27 FTE (Regional) 0.73 prog. (Networking/Support)	.09 FTE (Policy support) & 0.36 prog. (LOAD & Newsletter) All regional)
Aroha Ki Te Tamariki Charitable Trust	2.0 FTE (Youth)				3 FTE (Youth)				1.38 beds (linked to youth day prog 0.92 SDHB 0.46 ODHB)				
Total	20.30 FTE		0.22 Beds	2.00 FTE	3.00 FTE		7.00 Beds	11.00 Beds	1.38 beds	275.00 Places		0.27 FTE 0.73 prog	0.09 FTE 0.36 prog.

AOD Service Profile - Southland													
Provider	Assessment and Referral Outpatient Counselling	Medical Detox	Social Detox	Home Detox	Day Treatment Programme	Short term Residential	Medium Term Residential	Long Term Community Residential	Supported Accommodation	Methadone Programme	Dedicated Family Service	AOD Consumer Adviser	Other
Southland Provider Arm	7.3 FTE (1 FTE Youth and 6.3 FTE Adult)									65 Places			
Salvation Army Bridge Programme	0.80 FTE												
Gore and Districts Community Counselling Centre In	1.5 FTE												
Adventure Development Ltd - Dunedin	0.6 FTE (2 programmes includes outdoor component)												
Alcohol & Drug Association												.16 FTE (Regional) 0.43 prog. (Networking/Support)	.05 FTE (Policy support) & 0.21 prog. (LOAD & Newsletter)
Te Huarahi Ki Te Oranga Pai Trust	5 FTE (Maori 1.0 youth, 4.0 adult)												
Total	15.2 FTE									65.00 Places		0.16 FTE 0.43 Prog.	0.05 FTE 0.21 Prog.