

**Canterbury**

District Health Board

Te Poari Hauora o Waitaha

**CANTERBURY**

**ALCOHOL AND DRUG**

**PROJECT**

**Summary Document**

**September 2009**

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## 1. Introduction

Alcohol and other drug (AOD) related harm impacts on our communities in a significant way and this harm is expected to continue increasing. People working in addiction services report overwhelming demand and estimate that double the current number of treatment services are required for people severely affected by addiction. However, resources are finite and doing more of what is currently being done is no longer an option. Population demographics, workforce capacity and the economic situation have created an urgent need to find new ways of responding to people with AOD issues.

Canterbury District Health Board (CDHB) initiated a participatory process with stakeholders to develop a reconfigured AOD system that builds on existing strengths, addresses identified weaknesses and faces the fiscal reality.

Undertaking such a process can create an unbalanced view of work to date as the focus naturally falls on what is not working well. However there is much to celebrate as over past years significant improvements in all areas of AOD service delivery have been made and the intention of this project is to accelerate this progress.

## 2. Alcohol and Other Drug Service Development

AOD services in Canterbury have developed over many years. In addition to the services located in the hospital and specialist mental health services, a range of community based treatment and support options has evolved. Initially most treatment services were residential and people were encouraged to engage with 12 step peer support. In response to new knowledge, modifications have been made to original approaches and new services have emerged, including a wider range of outpatient options. The community sector (still termed non-government or NGO) tends to be the domain of helping agencies with a Christian philosophy or organisations that grew in response to individual or family experience of addiction. Over time these services have become professionalised, both in response to contractual requirements and developments in the field generally. The AOD workforce has people with great passion and commitment and there are a number of local champions that continue to advocate strongly for this sector. There is now a range of tertiary education providers offering undergraduate and postgraduate AOD training throughout the country. Competencies have been developed for the workforce and there is a professional regulatory body, Drug and Alcohol Practitioners Association Aotearoa New Zealand (DAPAANZ), which offers varying levels of membership.

## 3. Residential Treatment

In 1998 the Mental Health Commission, through the Blueprint, identified that Canterbury had an oversupply of residential beds. Outpatient services had developed but there remained an over-reliance on residential treatment. A centralised assessment process was trialled as a way of ensuring that consumers were independently assessed (including eligibility for residential treatment) and referred appropriately. The Health Funding Authority contracted agencies to have 'authorised assessors' with functions and processes supported by the Ministry of Health infrastructure.

The provider arm Community Alcohol and Drug Service (CADS) had the largest role in assessment and referral but there were also NGO equivalents, albeit on a much smaller scale.

This centralised process has remained as the pathway to residential treatment although in our current DHB system there is no process to 'authorise' the assessors. Some of the administrative tasks undertaken by the role are still required to ensure payments are processed.

## 4. The South Island Review

In 2004 a South Island review of AOD services was undertaken by the South Island Shared Services Agency (SISSAL) on behalf of the South Island DHBs. The report from this review is a significant document as it pulled together current thinking and placed it in a local context. The recommendations included:

- Improving access overall
- Making more service options available in primary care settings, particularly screening and brief intervention
- Developing more flexible responsive services/models of care
- Reviewing current models of practice
- Having a quality referral system to residential treatment
- Increasing culturally appropriate services
- Increasing service options for women
- Improving responsiveness to family/whanau
- Increasing capacity to provide for people with complex and/or enduring needs
- Strengthening aftercare/ongoing care options
- Strengthening consumer participation
- Workforce development
- Negotiating with Corrections regarding the needs of offenders

In 2008 SISSAL undertook a review of progress on the implementation of the recommendations. There was significant progress reported from the sector with acknowledgement of further work to do, particularly regarding the development of an outcome framework which would support future planning.

## 5. CDHB Direction

### 5.1 Health Services Planning

The recommendations of the 2004 South Island AOD Review sit comfortably within the principles currently underpinning health services development in Canterbury as follows:

- A person and whanau centred approach based on individual, whanau and community enablement
- A point of continuity based in the community/primary care with a trusted relationship
- Consideration of the wider determinants of health
- An individually tailored approach with a holistic focus
- Evidence based practice
- Clinical responsiveness
- Management of the interaction between episodic intervention and ongoing care
- A viable and sustainable service

Implications of Health Services Planning are:

- Development of services that support people/whanau to take increased responsibility for their health and wellbeing
- Development of primary health care and community services to support people/whanau in a community setting and provide a point of ongoing continuity
- Release secondary care based specialist resources to be responsive to episodic events and provision of support to community and primary care

In Canterbury all health services are in a process of transformation. Continuing to provide services as they are currently structured is not sustainable, partly due to changing demographics. The economic situation increases pressure to find smarter ways of working and while this is a time of uncertainty it is also a time of opportunity.

## 5.2 Current AOD Services

Local AOD services continue to provide the best services they can within their current frameworks. With reconfiguration under discussion it is important to acknowledge the achievements made every day in the sector by people dedicated to their work. However, there are ongoing issues and the current pressures provide an opportunity to create an improved system that meets the needs of more people within existing resources. There are a number of organisations involved in the provision of AOD services, all with their own facilities, staff etc. The way forward relies on these resources being viewed as belonging to the AOD system as a whole, rather than being 'owned' by individual organisations. Thinking in this way creates many options and will potentially result in a more effective and efficient system for consumers and their family/whanau.

## 6. The AOD Project

A Scan/Focus/Act model was used to meet the goals of the project.

### 6.1 Scan

The project began with a 'scanning' workshop which a wide range of stakeholders attended. The purpose of the workshop was to engage sector stakeholders/leaders, consumers and experts to assist in a 'system wide' scan to identify what is working well/not working well and where the gaps are. Through a participatory approach, the following key themes were identified as areas for service development:

- Ease of access to support and services
- People and whanau centred community based approach
- Care tailored to individual need
- Specialist services to support the sector to support the individual
- Focus on prevention and early intervention
- Intra-sector collaboration
- Inter-sector collaboration
- Information systems and education
- Workforce development
- Funding mechanisms designed to meet individual need

## 6.2 Focus – phase 1

A small group (design team), with added expertise as required, worked with these identified issues to develop a model for an ideal AOD system for the Canterbury District.

The group brought together a variety of perspectives from consumers, providers and clinicians, including Specialist Mental Health Services, Primary Care and related sectors such as Corrections. The following is a summary of the key concepts that emerged from the design team meetings.

### 6.2.1 Community Based, Flexible, Responsive, Consumer and Family/Whanau Focused Services:

Whenever a person/s makes contact with the AOD system, a timely response based on presenting need will be provided. Flexible systems will be in place to wrap support around people according to their particular circumstances. Capacity to offer services that will work for the individual and their family might mean providing support/services at their home at a time that allows them to maintain employment/care for children/attend to other commitments, including legal matters.

The least intrusive options will always be considered before facilitating access to more specialist services. Broadening the capacity for issues to be addressed in primary care and other front line settings will reduce the need for specialist services in the long term. However, there will continue to be high demand for these services in the short term and reconfiguration is necessary to have any chance of meeting growing demand. Increasing overall access is likely to result in higher numbers of people identified with AOD problems. Broadening the range of less intensive options will allow consumers to make choices about the direction they wish to take, before placements in structured environments are arranged. While always being mindful of risk, people will be encouraged and supported to access information, community groups and/or peer support. This will be all that is required for some people, while others may require a package of care that includes, but is not limited to, physical health services, respite care, managed withdrawal, pharmacotherapy, residential care, aftercare/ongoing support, advocacy/support to deal with financial issues (eg WINZ), accommodation, life skill development etc. One or many agencies may be involved in the provision of this care but the consumer and/or family will experience a coordinated approach facilitated by a key person or 'navigator'.

Kaupapa Maori services will continue to be available but all services will be equipped to offer a culturally appropriate response. Women will be able to access gender appropriate services with childcare provided. Services will be family inclusive and there will also be support available specifically for family/whanau in their own right. People of all ages will be able to access age appropriate services. People living in rural communities will be able to get support they need through telephone and internet services, as well as face to face with mobile workers.

### 6.2.2 Resource Centre/One-Stop Shop

An easily identified central point is needed to ensure anyone can access the AOD system for information and access to the full range of AOD services. This will be available to everyone (individuals, family/whanau, other agency workers, general practice teams etc) and will respond to people in a timely way. Tasks undertaken by this central point will include facilitating access to information, AOD resources, peer support, community agencies as well as screening, assessment and intervention services.

There are a variety of ways the central point could be provided and it does not necessarily involve a fixed location; i.e. it could be a virtual front door provided from existing locations/services. The essential elements are ready access, immediate response, coordination and facilitation.

### 6.2.3 Screening/Brief Intervention

AOD screening and brief intervention means different things to different people. As with any discipline, AOD has particular functions that are part of standard training. While developing this expertise is important, it can result in a 'mystification' that prevents the application of a common sense approach by people without extensive training.

Basically, AOD screening is about finding out whether there is an AOD issue. There are standardised tools to use for this purpose but the approach is best determined by the setting, level of skill of the worker etc. Simply asking about a person's AOD use may be adequate to determine whether further investigation is justified.

Similarly with brief intervention, there is a clinically oriented standard process that is part of AOD training but a non-clinical brief intervention can also be provided without extensive expertise. This may be as straightforward as giving the consumer some accurate feedback about their substance use (e.g. compared with safe drinking guidelines, potential risks etc) and some practical suggestions about stopping/cutting down. Having a relationship with the consumer may be the most influential aspect of providing a brief intervention and this needs consideration when deciding who should do this work.

Broadening capacity and capability to screen and provide brief interventions in the community is essential to meet the increasing demand from people with AOD issues. AOD experts will provide training to probation, primary health, peer support and other frontline agencies to support workers to undertake these functions competently and continue to be extended through professional development.

Telephone and internet services have an important role in the provision of screening/brief intervention. Building on existing capacity will enhance opportunities for people to access information and support.

Peer support groups are another way of providing these functions while also encouraging self-management and facilitating peer leadership.

### 6.2.4 Peer Support/Consumer Roles

The consumer workforce will grow and with this will come increased opportunities for people rebuilding their lives to engage in meaningful activities. Partnerships between clinical services and peer support services are essential to weave together packages of care that truly reflect consumer need. Using peer support more extensively will also strengthen the AOD systems capacity to meet the increasing demand. An important feature of this workforce development will be adequate training, mentoring, supervision and support for people in consumer roles.

Peer support will play a critical role in supporting consumers and their family/whanau at all stages of their journey. The consumer and their family/whanau will be able to choose who they want as their 'navigator' through the AOD system and one option will be a peer support worker.

Peer support will be part of initial contact and there is great potential to do screening and brief intervention via this relationship. For some people this may be all they require to make desired changes.

Regular peer support groups in the community, that provide education, information and activities will promote self-care/management. It may lessen the need for more intensive interventions and also provide ongoing care/support as part of long term management. Peer support should be part of the health continuum but not all peer support should be formally funded services. AOD has a strong history of independent peer support programmes through 12 step movements.

### 6.2.5 Assessment and Referral

AOD comprehensive assessment, as taught by specialised training providers is a standardised clinical process which focuses on AOD diagnosis and identification of other issues including co-existing physical and mental health disorders, family and personal history, other relevant information (e.g. legal history and current status) mental state and risk. This information can be gathered in a variety of ways, depending on the training and expertise of the clinician, the service/agency approach and the level of information required to develop a plan for the next step. A cultural assessment may also be added or woven in throughout the whole process. Similarly there is a standardised clinical brief assessment process that is a shortened version of the above.

While engagement is an important aspect of assessment, the critical part is using the information to develop a plan with the consumer. Ideally assessment will be a staged process that only gathers the information required to inform care/support planning for a particular stage. Approaches need to be standardised and training provided to ensure workers at each step of the process are competent at the level they are required to be.

More discussion and debate is needed regarding the appropriate time for a clinical approach versus a more generic 'whanau ora' approach. While it is important that people get access to clinical services when they are needed, it is equally important that people get an opportunity to utilise the resources they have within themselves, their family/whanau and the wider community before they enter specialist treatment services. Transparency and accountability are required to ensure consumers are offered the best options for their needs and this involves challenging existing ways of working. For example, referring people directly to long term residential services because they have legal pressure is not adhering to the current principles underpinning health service provision. People involved in the justice system will have equal access to the AOD system; services however will not be structured to meet the specific needs of justice clients (e.g. containment).

### 6.2.6 Specialised Treatment Services

Specialised treatment based on harm minimisation will be available to people who need this level of intervention. The emphasis will be on short periods of intensive treatment with long term community based follow up. A wider range of options is required so that packages of care can be developed based on consumer and whanau need, rather than service need. New models will be developed that are based on a 'whole of system' approach with capacity to bring together what is needed rather than fit people into what is available. Programme lengths, both outpatient and residential will be flexible and able to accommodate individual need, including when this involves ongoing substance use. Packages of care will be based on 'blocks' of up to 12 weeks, with flexibility for individual need as required; for example, at the end of the period the consumer, family/whanau and workers will decide whether to a transition to a different level of care/treatment, continue at the current level or exit the system.

Options will include care/support for people with enduring addictions who may have had a number of admissions to treatment programmes previously. This will include support to find and

maintain suitable accommodation and achieve other goals identified by the consumer and their family/whanau.

Outcome evaluation will be an essential part of monitoring and reviewing the models of care.

### 6.2.7 Aftercare/Ongoing Support

With a wider range of community based options and more flexible approaches, aftercare and ongoing support will be integrated into long term management rather than being seen as a separate function. Individual and group support will be available and access to short periods of more intensive support (eg respite care) as required. Support with housing and other everyday activities will be provided either from within the AOD system or by facilitating access to related sectors. Ongoing support for families will also be available.

While maintaining the emphasis on self management and the utilisation of resources within the family/whanau and wider community, people will be able to access support at a level that prevents them having to repeat another cycle through the AOD system if they are having difficulty.

### 6.2.8 Collaboration

All the agencies/organisations involved in AOD work need to work together in the best interests of the consumers and their family/whanau as well as meet their respective mandates and accountabilities.

This includes inter and intra sector collaboration. The workforce focus needs to be on providing what people want/need rather than determining whether they 'fit' a particular programme. Respectful and trusting relationships are required to achieve this level of cooperation. Information systems are needed that allow ready access to information while maintaining consumer privacy. Organisations with a role in the AOD system will facilitate access to other parts of the system regardless of whether it is within their own organisation or not. Outcome measures will be in place so there is transparency about what is being achieved and the whole system will be accountable.

AOD consumers often have issues that involve a number of sectors, including Work and Income, Child Youth and Family, Community Probation, Courts, Prison etc. In adopting a consumer focussed approach the AOD system will comfortably interface with these related sectors, while continuing to provide services that target health outcomes. For example, consumers in the justice system will have access to the AOD system but services will not be structured around their legal needs.

Establishing good relationships with other sectors and developing agreement for how to work locally will resolve many of the existing difficulties.

### 6.2.9 Workforce

A coordinated approach to workforce development is required and this will involve working with training providers and utilising local expertise to access the various levels required. Broadening the capacity of the health and social services sector to screen and do brief intervention work will involve basic training and ongoing support. Incorporating more emphasis on recovery principles in clinical training is important, as is the provision of a wider range of models of care, including family/whanau inclusive ways of working. All AOD clinicians will be equipped to identify co-existing

disorders and provide or access, appropriate follow up. All this training is available currently but the co-ordination is lacking.

With the development of a wider range of peer support services there will need to be more training developed for this workforce. People who wish to pursue a career as a consumer advocate/advisor/peer support worker should have the chance to engage in training that leads to formal qualifications and further opportunities.

#### 6.2.10 Funding

Funding mechanisms will be developed to enable and support the AOD system to provide more services to more people within existing resources. While there is unlikely to be new money for the foreseeable future, opportunities exist to begin reconfiguration.

In the current environment a total transformation to achieve the 'ideal system' is not realistic. However, moving in this direction will provide opportunities to trial different ways of doing things while evaluating the impact of the change.

### 6.3 Feedback

The principles developed by the focus group and a proposed care pathway were widely circulated for review and discussion.

Feedback at forums and in written submissions were received from:

- Consumers – current/past service users and people employed in consumer roles
- National Addiction Centre
- Maori involved in the sector, including representation from He Oranga Pounamu
- Canterbury Alcohol and Drug Managers Advisory Group
- Individual AOD Service Providers and Practitioners
- Primary care

The comments and concerns are recorded below.

#### 6.3.1 Community Based, Flexible, Responsive, Consumer and Family/Whanau Focused Services:

There was overwhelming endorsement of this, particularly from consumers. Having services that attempt to 'fit' consumers rather than making consumers 'fit' services is seen to be a positive direction.

Consumer choice having equal or more value than clinical judgement was questioned as was the capacity of the proposed system to meet the needs of people of different ages, cultural groups, gender and legal status.

#### 6.3.2 Resource Centre/One –Stop Shop:

There was support, especially from consumers and professionals outside the AOD treatment sector, for a central venue/location that would be easily identified as an access point. People had suggestions about what this could involve and a recommendation was made for peer support/activities/groups to be coordinated at this central location. Having Maori workers was identified as essential to ensure responsiveness to Maori.

There were questions about whether a central venue would restrict current access points if it became a single point of entry. Some submissions suggested that this could limit consumer choice. Concern was also expressed regarding the possibility of a single access pathway becoming narrow in focus (eg adopting one particular approach to recovery) and not offering a range of options to consumers.

### 6.3.3 Screening/Brief Intervention:

Increasing the availability of screening and brief intervention across primary care and other community venues (for example, health and social services, Community Probation Service) was strongly supported.

Capacity for Kaupapa Maori services to undertake screening in culturally appropriate ways was identified as important.

There was some concern expressed about whether broadening availability would result in too wide a variety of approaches being used. Questions were also raised about whether people with complex needs would get the level of specialist care they require if they were initially seen by people without specialist AOD skills.

### 6.3.4 Peer Support/Consumer Roles:

The ongoing development of consumer roles, including peer support is endorsed although the point was made that it is important for people to have a choice about this involvement. Suggestions were made for peer workers to act as navigators and also undertake screening, brief interventions and run groups. Peer support that coordinated outings, activities, sport etc was considered a priority by consumers. It was recommended that this could be available to people in treatment services or living in the community, before, during or after treatment.

Workforce development, supervision and support was seen as important for people doing this work. Ensuring that peer support workers were not used for functions outside their skill set was also noted.

### 6.3.5 Assessment and Referral:

A staged assessment process was generally supported. Important in this was the need for a 'building on' approach so that each stage did not involve starting from the beginning again. Consumers said they were tired of being assessed each time they accessed a different part of the system.

It was considered important that, people who require a comprehensive assessment are identified early so they can access the specialist services directly.

Cultural competencies were raised as a need for Maori consumers, including capacity to refer to Kaupapa services appropriately.

The current system of assessment and referral was seen as needing consistency; ie either all services can assess and refer or only independent (separate from residential/day treatment) agencies should have this function.

### 6.3.6 Specialist Treatment Services:

Support was expressed for flexible individualised treatment management that may involve combinations of outpatient and residential services. There was also support for new ways of working with people who have enduring addictions and continue to use substances, although more detail about what this might involve was wanted.

Although consumers favoured more flexible and shorter residential options, concern exists that specifying 12 week blocks of residential treatment is a means of 'capping' length of stay and making it difficult for people to access longer periods of treatment.

Kaupapa Maori services were endorsed as essential and cultural responsiveness was seen as a priority for all services. A suggestion was made that routine cultural audits are implemented into the overall system.

### 6.3.7 Aftercare/Ongoing Support:

Consumers were enthusiastic about increasing peer support options as part of a wider network of aftercare/ongoing support. There was a mixture of responses regarding aftercare as a separate function provided across the system versus aftercare provided by each individual organisation.

Concerns were raised that aftercare was not adequately addressed in the work to date with wide acknowledgement of the importance of aftercare/ongoing support.

Aftercare for Maori was described as belonging to a community of people and having the choice of remaining involved.

### 6.3.8 Collaboration:

The high level of collaboration that occurs currently was acknowledged by providers. Consumers stated there are still many gaps. Concern was expressed about a perceived lack of collaboration with stakeholders by CDHB Planning and Funding and the lack of trust this has generated.

It was queried whether the process had involved experts in the field and whether there was adequate information to base reconfiguration decisions upon.

Maori participation throughout the process was also questioned as was the appropriateness of the principles for youth.

### 6.3.9 Workforce:

Attracting more Maori into the AOD workforce was recommended and more extensive training on co-existing disorders was considered important.

Training and the development of career pathways for peer support workers/consumer roles was also noted.

### 6.3.10 Funding:

Concern was expressed about reconfiguring within existing resources and whether this will involve withdrawing funding from current services to provide more AOD responsiveness in primary health settings.

The development of a transition pathway with allocated resources was recommended.

### 6.3.11 Summary:

The general concepts and principles identified for a Canterbury AOD system were supported, particularly by consumers. Because this stage of the project involved the broader conceptual framework there was some uneasiness regarding how these principles and concepts would be operationalised.

There were positive comments about the participatory process, led by Planning and Funding, by people who have enjoyed the challenge of thinking 'outside the box'.

## 6.4 Focus – Stage 2

A second working group was established and provided with the framework and the feedback. A series of key questions was used to guide the group through a process of developing detail for a revised AOD system. While the framework and principles apply to all groups, further focussed work is required to adequately address the needs of special populations.

The key areas discussed were:

- Screening and early intervention
- Assessment (brief and comprehensive)
- Peer Support
- Intervention services
- Evaluation

### 6.4.1 Screening and Early Intervention:

Prevention was acknowledged as being an important aspect of the AOD system and accurate AOD information must be available in a wide variety of settings.

Broader screening and early intervention can be achieved by ensuring access to the right information for people working in primary care and other 'frontline' roles. Resources and support are readily available via ALAC and the Alcohol Drug Helpline. Healthpathways, a web-based resource for Primary Care, now has information on alcohol screening, brief intervention and referral pathways. A clear pathway for referral on and/or access to specialised support needs to be available via a central point and/or mobile team of clinical, non-clinical and peer support workers.

There are standardised tools: eg DAAS, SACS, AUDIT, but asking the following questions is useful:

1. Have you used drugs or drunk more than you meant to in the last year?
2. Have you felt that you wanted to cut down on your drinking or drug use in the past year?

**If yes to either question then:**

3. Is this something you would like help with?

There are different requirements for different target groups and different setting so a standardised process is not realistic.

A screen is followed by further enquiry to determine severity of the problem. Ideally this will follow within the same setting; however some people may need to refer elsewhere.

The pathways from here include:

1. Information about safe use (eg alcohol: 14 standard drinks per week and no more than 4 on one occasion for women/ 21 standard drinks per week and no more than 6 on one occasion for men) and strategies to reduce/control use
2. Further engagement and motivational work, pending a more comprehensive assessment
3. Specialist assessment and intervention (significant risk and/or co-existing disorders present)

These steps can occur across the whole system – primary care, other health and social services, NGO services and CDHB

Training packages, with ongoing support, need to be available to people with the interest and capacity to undertake these functions. Once screening and brief intervention is widely undertaken, consumers should get support at an earlier stage and demand for specialised AOD services should ultimately reduce. This will free up AOD specialists to support work done in other settings at an earlier stage of problem development.

#### 6.4.2 Assessment:

A brief assessment immediately follows screening (unless a brief intervention is undertaken) and is used to help identify what the next step should be. A brief assessment template has been developed previously for the sector but questions were raised about the amount of information this contains and whether there is a way of undertaking a simpler version that could also form the initial part of a more comprehensive assessment, if this was required.

There was discussion about the value from a consumer perspective of comprehensive assessments being routinely undertaken.

Another perspective is that brief assessment is to determine whether there is:

1. Mild dependence which indicates a brief intervention is appropriate; or
2. Moderate to severe dependence which indicates a lifestyle change is required

It was generally agreed that an assessment process requires:

- engagement
- determining the consumers expectations/desires/needs
- building motivation and readiness for the next step

Therefore, spending several sessions completing this task may be most appropriate rather than attempting to achieve all aspects within one meeting. Alternatively, for people in crisis there needs to be the option of streamlining entry through a comprehensive assessment into the appropriate setting such as withdrawal management or respite care.

People trained in AOD assessment and treatment planning and competent to provide this function should be undertaking comprehensive assessments – eg. DAPAANZ registered. It was generally agreed that all specialist AOD settings (CDHB and NGO services) could provide comprehensive assessments as long as there is a robust process to ensure consistency and transparency.

This could involve any or all of the following:

- A multi-agency team approach where assessments were reviewed
- A triage system at a central point (telephone/web-based/face-to-face) where consumers are matched to the most appropriate service for assessment
- A resource centre/one stop shop that coordinates access to assessment as required (ie brings the service to the person)
- Outreach clinics where assessment is provided
- A peer review process (eg as per ACC assessments by GPs) to ensure accountability
- Peer support workers to guide and navigate
- Specialist services to be available to provide mentoring/support and assessment/intervention for people with co-existing disorders/significant risk

#### 6.4.3 Peer Support

Peer support, from people with a shared experience of AOD/addiction, can potentially provide:

- Walking beside/navigating
- Information/education – individual and group
- Screening

- Brief interventions
- Activity based support
- Ongoing support/aftercare – individual and group

A basic training package for peer support would include core competencies required for any support role, with the addition of managing role conflict (personal/professional). In addition to this people should be able to access training for other functions (eg. screening, brief interventions) according to their aptitude. This would enable these functions to be fulfilled from a peer perspective.

#### 6.4.4 Specialised AOD Intervention Services:

There continues to be a perception that if there were adequate services, people with AOD issues would want to use them to address their problems. The reality is that there are many people who, despite numerous opportunities to change, do not change their drinking or drug use patterns. Added to this, many people are identified as having addiction issues and directed to treatment, when in fact their problematic behaviours (offending, violence etc) precede their engagement in problematic substance use. While not wanting to lose the potential window of opportunity that crisis can sometimes provide, services need to be based on reality and resources used wisely to get the greatest gain for the community.

The revised AOD system will provide wide access to education, information and brief intervention but will reserve treatment services for those who are most likely to benefit from them. It was agreed that more use should be made of education and information (to people at all stages of dependence) with time allowed for consumers to reflect on their options. This was in keeping with earlier discussions that promoted a gradual pathway of engagement prior to specialist assessment and subsequent intervention.

Addiction can deny people sound decision-making opportunities. However, after an initial period of ambivalence, to remain in treatment services, consumers must have some motivation to engage in change. If this does not occur there may be alternative options available that continue to allow motivation to develop but this should not be considered ‘treatment’.

- Education/Information:

Increasing the availability of community support, education and motivational opportunities is important. This could involve primarily peer support workers and be based at a central location such as an AOD resource/education/support centre. Specific groups could be developed according to current need and access to clinical services facilitated as required. Activity based options could also be available.

- Community Team:

A team from potentially a range of services could be developed to provide community AOD assessment and interventions. This team would have a range of skills from specialist medical to people equipped to provide brief interventions. Consumers would be provided with the level of intervention required by a suitably skilled person. The functions could be provided from a centralised location, outreach clinics and in consumers own environments.

- Withdrawal/Detox/Respite Care:

Withdrawal management needs to be an integrated part of a consumer’s journey, although it may also be necessary at times for crisis respite. Medical aspects of withdrawal management should be

integrated with non-medical and there should be an easy pathway between residential options and home-based options. Immediate access to a safe environment that has capacity to manage straightforward withdrawal should be available to people presenting in crisis.

- Intensive Outpatient:

Intensive non-residential programmes should be available to people that require a higher level of intervention than peer support and/or counselling. Again this should initially involve a journey to build motivation and work through the immediate concerns for the consumer and their family. People should not be immediately placed onto programmes and the components of the programme need to be flexible and consumer focussed. This should involve providing tailored programmes based on the needs of particular groups as they emerge.

- Housing/Supported Accommodation:

Short term residential/accommodation options are needed for people as they are moving through a change process and longer term options may be required for people who are maintaining change. There is a need for housing for people with enduring addictions, who are unlikely to make significant change but require suitable environments and some support. Institutional settings are not supported for any group and recycling people through treatment services is not considered useful.

- Residential Treatment:

Flexible residential treatment is considered an important part of the service continuum. This needs to be consumer focussed and well integrated with other parts of the AOD system. Programmes of up to 12 weeks are supported with options for people to remain longer if this is the best direction for them and they are motivated to continue. Transitioning to other parts of the system that promote more self responsibility should always be considered in the context of a review situation.

- Justice Clients:

Legal pressure can sometimes result in people reflecting on their situation. Information, education and brief intervention is appropriate at this point and should be provided by primary care, probation officers, prison staff etc. with the support of AOD specialists.

AOD assessment and treatment will be available to those who require it and are able to engage. People waiting for sentence will be able to access community groups (education, building motivation etc) and collaboration with corrections may result in joint initiatives for this group. Once sentencing is completed entry into specialist AOD services will be viable for those who remain in the community.

Long-term treatment programmes to provide sentencing/prison release options for people in prison is not viable. AOD services funded by corrections to meet the needs of the prison population are supported and linking is required to ensure adequate transition planning for release into the community.

As per the agreement that exists between health and corrections, reports required for Courts and Parole Boards will be funded by these bodies. AOD services will provide support for prisoners due for release, although this is unlikely to be the provision of direct access into containment type facilities. The support may be best provided through collaborative work with prison release staff and will not necessarily involve comprehensive assessment and subsequent reports.

- Family/Whanau:

Services that support family/whanau to manage their own lives are endorsed. This has potential to result in the person with the addiction also engaging in change and the family more able to support this.

Ensuring all services are working in a family inclusive way is considered important.

- Other Special Population Groups:

There is immense diversity of need across all groups experiencing AOD difficulties. Creating a flexible consumer and family focussed approach and a clear pathway should address some of the barriers that currently exist but there is more work required to ensure equitable access for all groups.

- Ongoing Support/Care:

There needs to be a range of flexible options for people who have been in a treatment service or are managing themselves in the community. Peer support groups, including those involving activities, community support workers and ongoing opportunities to remain connected to a positive recovery network are important. Easy access to additional support such as respite care and counselling must also be available and people should not have to be using substances to get this help.

#### 6.4.5 Evaluation:

There was general agreement that a simple follow up questionnaire should be implemented for all service users at a specific time after exit. This should include questions that evaluate current status in the following domains compared to before entry to the AOD system:

- AOD use
- Overall wellness
- Employment
- Accommodation
- Social connectedness

#### 6.5 Feedback:

The summary of discussions from the phase 2 working group meetings was circulated for discussion and comment.

The main areas of concern were:

- The lack of explicit connection to research literature and expertise
- Concern that consumers in the justice system will be disadvantaged
- The lack of specific focus for youth, older people and people with opioid dependence
- The use of unstandardised questionnaires for evaluation/follow up
- Concerns that a new system will be implemented immediately without further discussion

There was also significant endorsement of the work to date.

#### 6.6 Act

In response to concerns raised a statement was circulated for clarification, including the following information:

- *all the work being undertaken sits within the wider scope of international research and best practice but the focus is finding local solutions for Canterbury and using the extensive expertise from local consumers, clinicians and other stakeholders*
- *justice clients were the focus of discussion during one working group meeting and this is reflected in the written information. The intention is to provide the same access for justice clients as provided to other members of the community and this is focussed primarily on engagement with the hope that this will result in better outcomes*
- *the lack of specific focus on youth, older people and those with opioid dependence is noted in the written information and future work will address this*
- *the process is iterative and this sometimes results in a lack of clarity regarding next steps, timeframes etc. With the information from the last working group meetings and the feedback, the care pathway will be revised with descriptions for the functions involved, including:*
  - *Task*
  - *Competencies required to undertake (workforce implications)*
  - *Expected outcome*

*This work is expected to be completed by 31 October 2009 and presented to the appropriate committees, boards and groups by the end of the year.*

*If the direction of re-orientation is approved, a 'roadmap' will be developed to outline planned action over the coming years. This will involve working with the sector over a period of time to prioritise and implement the recommended changes.*

The care pathway from the first round of working group meetings has been revised to incorporate new information (Diagram 1).

Accompanying the care pathway is a table (table 1) summarising :

- Functions
- Expected outcome
- Where/who provides
- Competencies required

Diagram 1: Proposed Alcohol and Other Drug Care Pathway

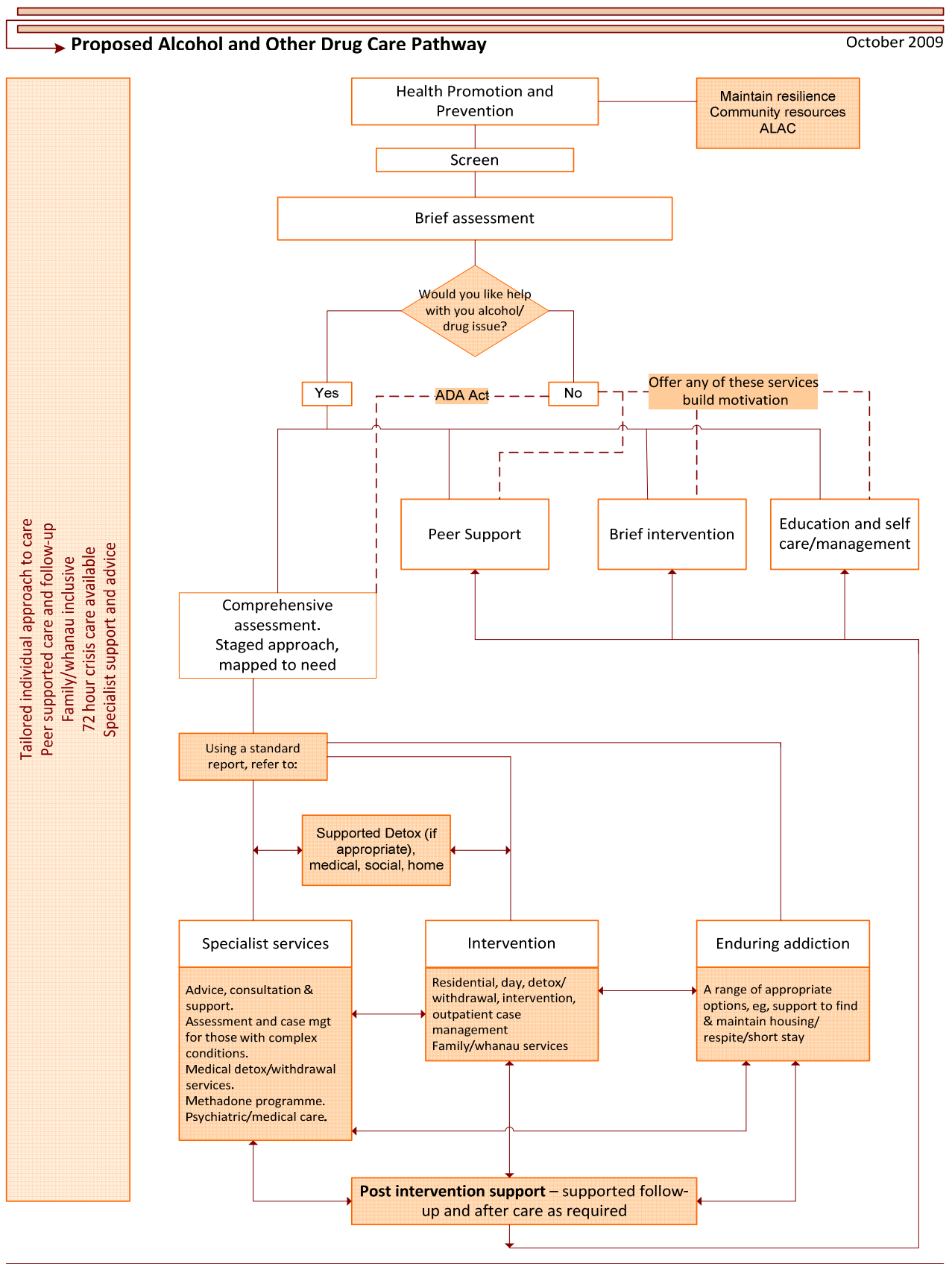


Table 1: Functions of Care Pathway

**Key:** Red indicates significant change required.  
 Orange indicates moderate change required.

TASK	EXPECTED OUTCOME	PROVIDED BY	COMPETENCIES REQUIRED
Health Promotion and Prevention	Reduce AOD use	All levels of health, ALAC, Education, Justice, MSD	Public health focus Ability to influence national strategy Resources based on factual information
Screening – ask the following questions: ‘Have you used drugs or drunk more than you meant to in the last year?’ ‘Have you felt that you wanted to cut down on your drinking or drug use in the past year?’ <b>If yes to either question then:</b> ‘Is this something you would like help with?’ <b>OR</b> Follow Healthpathways instructions <b>OR</b> Ask person to complete a screening instrument (eg DAAS, SACS, AUDIT)	Identify at risk and/or problematic AOD use and provide or refer for appropriate follow up, including: - Brief intervention - Engagement/motivational work - Crisis response	Primary care – GPs Practice Nurses, BICs etc AOD Resource Centre – peer support workers, AOD workers Alcohol Drug Helpline – telephone counsellors ALAC website Frontline staff in other settings: eg prison, probation, MSD	Access to Healthpathways and/or training in AOD screening (half day training with ongoing support/supervision)
Brief Intervention – using a motivational approach further explore AOD use and consequences. Then provide: feedback regarding current AOD use (eg alcohol safe drinking limits 4/14 and 6/21)	People at risk of developing problems associated with AOD use stop or reduce use People with problems associated with AOD use get an immediate response and an opportunity to engage in discussion about further	Primary care – GPs Practice Nurses, BICs etc AOD Resource Centre – peer support workers, AOD workers Alcohol Drug Helpline – telephone counsellors ALAC website	Access to Healthpathways and/or half day training on brief intervention with ongoing support/supervision

<p><b>and</b> information about risks associated with ongoing use</p> <p><b>and</b> information (written and verbal) about how to cut down or stop</p> <p><b>and</b> offer a follow up appointment and/or referral options</p>	options (motivational work)	Frontline staff in other settings: eg prison, probation, MSD	
<p>Assessment – a family inclusive staged process based on:</p> <ul style="list-style-type: none"> <li>- engagement</li> <li>- building motivation and readiness, determining the consumers desires, expectations and needs.</li> </ul> <p>Information gathered includes:</p> <ul style="list-style-type: none"> <li>- Immediate concerns (safety/risk)</li> <li>- AOD use and impact</li> <li>- Mental health</li> <li>- Physical health</li> <li>- Personal/family circumstances</li> </ul> <p>This information will be discussed with the consumer and family/whanau (as appropriate) and agreement reached about the next stage.</p>	<p>Consumer needs identified. Family/whanau needs identified. Plan formulated with consumer and family/whanau for the next stage. Assessment report completed and used as referral document.</p>	AOD Services and includes a mobile team working from the AOD Resource Centre that has capacity to meet consumers and family/whanau in setting of their choice	<p>AOD practitioner - graduate degree or equivalent (in nursing, occupational therapy, social work etc or AOD) with specific AOD training</p> <p><b>Or</b> Training and under supervision of an experienced AOD practitioner</p>
Peer support – walking alongside consumers and families, providing education/information/support/social and leisure activities from a shared experience perspective	Consumers and families/whanau have the option of engaging with people who have shared experience of addiction	AOD Resource Centre, AOD Services, Consumer Services	People with experience of addiction and AOD service use with training in peer support (eg Blueprint) and/or MH support work (eg Cert in MH Support Work)
Medical Withdrawal Management –	Consumers can access the level of	Specialist Mental Health Services	Medical training including

safe timely withdrawal from substances with comprehensive medical support, includes combinations of either hospital based and/or home based	care they require to safely withdraw from substances in a timely manner	– medical withdrawal (hospital based and outreach nursing care for home withdrawal)	withdrawal management. AOD practitioners.
Residential and/or home based care for uncomplicated withdrawal, support following medical withdrawal and/or respite care	Consumers can access a residential support facility and/or community support to undertake an uncomplicated withdrawal, maintain themselves after medical withdrawal and/or have a period of up to one month ‘time-out’.	Community residential and outreach facility with AOD practitioners, community support workers, peer support workers and access to medical specialists as required.	(Clinical oversight provided by specialist services.) Well versed in basic AOD information Core support work training (eg MH support work certificate) <b>OR</b> Peer support training (eg Blueprint) <b>AND/OR</b> Group facilitation Activity based support Training and under direct supervision of experienced PSW, CSW, AOD practitioner
Community Support - Education/information/motivational work/aftercare/ongoing support either individually, family groups or open groups	Provide opportunities for people to: <ul style="list-style-type: none"> <li>- gain information</li> <li>- self-manage</li> <li>- join a support network</li> <li>- maintain changes</li> <li>- access more intensive support readily</li> </ul>	AOD Resource Centre Helpline Non-funded networks eg AA, NGO AOD services (peer support, CSW, AOD practitioner)	Well versed in basic AOD information Core support work training (eg MH support work certificate) <b>OR</b> Peer support training (eg Blueprint) <b>AND/OR</b> Group facilitation Activity based support Training and under direct supervision of experienced PSW,

			CSW, AOD practitioner
<p>Specialist Care – a multi-disciplinary team approach (psychiatry, psychology, social work, occupational therapy, nursing, AOD practitioner) that provides:</p> <ul style="list-style-type: none"> <li>- assessment and long-term case management for people with complexity (incl. co-existing, opioid dependence)</li> <li>- medical withdrawal – hospital and community based</li> <li>- clinical support/training/mentoring (to primary care, AOD NGOs and other sectors)</li> </ul>	<p>CDHB specialist services are accessible for consumers that require them and community services are well supported with specialist expertise</p>	<p>Specialist MH Services</p>	<p>Trained in relevant discipline with specific AOD training <b>OR</b> Under direct supervision of AOD specialist</p>
<p>AOD Counselling – community based, non-residential counselling for individuals and families</p>	<p>People can access counselling to address their AOD use while maintaining other areas of their life such as employment, family responsibilities</p>	<p>NGO AOD services Private Counsellors</p>	<p>Trained in a relevant discipline with specific AOD training <b>Or</b> Training and under supervision</p>
<p>AOD Intensive Programmes – community based, non-residential flexible programmes for individuals and families that require more than counselling to achieve their desired change</p>	<p>People have access to more comprehensive group based programmes that address AOD use and other aspects of life that will assist to maintain change.</p>	<p>NGO AOD Services – AOD practitioners, CSWs and Peer Support Workers</p>	<p>As above</p>
<p>Housing/Supported Accommodation- Accommodation for people: Engaged in self-directed change</p> <ul style="list-style-type: none"> <li>- undertaking counselling or a programme</li> <li>- completed a programme with</li> </ul>	<p>People can access the level of care and support they require to achieve their desired changes and people with enduring addiction have an opportunity to live with dignity and support</p>	<p>Housing services in collaboration with NGO AOD services</p>	<p>Housing specialists CSWs</p>

enduring addiction issues			
Home based support – support for people maintaining change in their own community and support for people with enduring addiction issues	Ensuring people have adequate support in their own environments	NGO AOD and Other Support Services	Support work training eg Cert MH Support Work
Residential treatment – flexible variable length programmes that are live-in and can accommodate individual and family need	Consumers that require and want them can access residential programmes as one part of an integrated care package	NGO AOD Services	AOD practitioners as described above Support workers as described above
Childcare – options that allow parents to access the appropriate level of support	Parents are able to access treatment and support with appropriate care for children	NGO services and childcare specialists	People trained and qualified to provide childcare
Aftercare/ongoing support – see community support	As for community support	As for community support	As for community support
Outcome Evaluation – a basic means of determining whether consumers report improvement in AOD use, family relationships, living situation and employment after exit compared to before entry	Information from consumers is available regarding their post intervention outcome	All services with informed consent from consumers to make contact post exit	Familiar with the questions to be asked and able to record responses systematically

## 6.7 Requirements:

To achieve the expected outcomes identified throughout the project the following is required:

- Training in AOD screening and brief intervention for primary care teams, and related frontline workers (eg peer support, other MH, prison, probation, MSD)
- Widespread implementation of AOD screening and brief intervention in primary care and other 'frontline' settings
- Development of an AOD Resource Centre
- Development of a mobile AOD team for assessment and support
- Further development of peer support, including education/support groups and activities
- Assessment undertaken as part of a staged process of engagement and motivation to determine consumers needs
- Streamlining of withdrawal services (hospital and community based) to improve timely access and ongoing support
- Respite care to follow withdrawal and/or provide short term (up to 1 month) 'time-out'
- Increased community support options including education, information, support, motivational groups for consumers and family/whanau
- Specialist services providing support/mentoring/training to primary care, AOD NGOs and other sectors
- More community based AOD counselling
- More flexibility in community based intensive programmes (residential and non-residential) – individually tailored options
- Housing options, including supported accommodation readily available for people engaged in a change process or with enduring addiction issues
- Home based support available
- Childcare available
- Aftercare/ongoing support readily available via community support, peer support, home-based support, respite care, accommodation and supported housing.
- Basic outcome evaluation implemented

## 6.8 Resources:

Currently there is approximately \$14,129,138 of funding provided for CDHB specialist AOD services and community or 'non-government' organisations. The revised system is anticipated as being achieved mainly through appropriate reallocation of resources.

## 6.9 Next Step

Endorsement for the proposed direction will be sought from the various committees and advisory bodies within the CDHB. If this is obtained a detailed implementation plan will be developed with the sector and worked through during the 2010/11 and 2011/12 financial years.

## 7. APPENDIX

### 7.1 Reference Documents

The Canterbury AOD Project was informed by the following documents;

Te Tahuhu – Improving Mental Health 2005-2015: The Second New Zealand Mental Health and Addiction Plan. Wellington: Ministry of Health

Te Kokiri – The Mental Health and Addiction Action Plan 2006-2015. Wellington: Ministry of Health

Te Haererenga mo te Whakaoranga 1996-2006 The Journey of Recovery for the New Zealand Mental Health Sector. Wellington: The Mental Health Commission

Investing in Addiction Treatment – A Resource For Funders, Planners, Purchasers and Policy Makers. New Zealand: National Committee for Addiction Treatment (NCAT)

District Annual Plan 2009/2010. Canterbury District Health Board

Health Services Planning 2008. Canterbury District Health Board

Stepping Forward – Improving Addiction Treatment in British Columbia (2009). British Columbia: British Columbia Medical Association

Drug Treatment at the Cross Roads (2009). London: Drugscope

Alcohol and Public Policy Group (2003). Alcohol No Ordinary Commodity – a summary of the book . *Addiction*, 98: 1343 – 1350

Reducing Alcohol Harm: Health Services In England For Alcohol Misuse (2008). London: Department of Health

Opportunities for Alcohol and Drug Advice in the GP Consultation (2009). University of Otago

Models of Residential Rehabilitation for Drug and Alcohol Abusers (2006). London: National Treatment Agency for Substance Misuse

McLelland,A; Chalk,M; Bartlett,J (2007). Outcomes performance and quality – whats the difference? *Journal of Substance Abuse*, 32: 331-340

Thematic Review of Peer Supports (2008). Wellington: Mind and Body Consultants Limited

Orford,J (2008). Asking the right questions in the right way – the need for a shift in research on psychological treatments for addiction. Society for the Study of Addiction.

Signs for Improvement – reducing alcohol related harm (2009). London: Department of Health

Hancock,S (2007). Evidence based practice interventions for the treatment of alcohol and drug abuse – an annotated information package. Christchurch: Department of Public Health and General Practice

Towards a New Blueprint for Alcohol and Other Drug (AOD) Treatment Services a discussion paper. Melbourne: Department of Human Services

Recovery Management and Recovery Oriented Systems of Care (2008). USA: Substance Abuse and Mental Health Services, Centre for Substance Abuse Treatment