

**Substance Abuse Legislation Model of Care for the
BAY OF PLENTY, LAKES, TARANAKI AND WAIKATO DHBS**



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Executive Summary

The new Substance Abuse Legislation (SAL) 2016 requires a collaborative Midland health and social sector response to ensure that people residing in this region are able to access assessment and treatment under the Act; and have their needs met appropriately and in a timely manner.

The purpose of this document is to outline the Midland Sub-Regional Mental Health and Addiction's new model of care for Addiction services, consistent with the requirements of SAL as requested by the Ministry of Health.

A stocktake and gap analysis was undertaken that confirmed the Addiction service provision in each of the District Health Board (DHB) areas. The Midland region is the only one who used a bottom up approach to gather information for this document. Furthermore it identified opportunities for investment and development. These opportunities include:

- Service configuration/development and facilities across the continuum
- Capacity and capability of the Addiction workforce
- Promotion and communication to manage SAL expectations

This new model of care has been developed regionally and incorporates opportunities for investment and development as enhancements. This model is personalised, promotes choice where possible, and provides assessment, treatment and support in a respectful and dignified manner. It engages people and their whānau on a journey to wellness, facilitating smooth access to services delivered as close to home as practicable. The new model does not provide the detail but provides the region with a framework to hang local development off. The detail will be further developed as the funding envelop becomes clearer.

Given the nationwide impact of SAL we expect the Ministry of Health (MOH) to coordinate communications at a national level to ensure the public understand the implications of the Act and what services will be available. The Midland Region will advise referrers of the new model of care and its associated processes via the Midland Mental Health and Addiction Network website.

There are some risks in implementing new legislation such as this. These risks have been carefully considered and mitigating strategies will be deployed to minimise any impacts.

Overall the SAL and the new enhanced model of care will offer improved and evidence informed Addiction services for the people of the Bay of Plenty, Lakes, Taranaki and Waikato districts which is delivered by a skilled workforce.

Four of the five Midland DHBs have signed off in principal to the proposed Model of Care.

Hauora Tairāwhiti will be submitting separately as requested by the Head of Department. They have recently completed an internal Addiction Stocktake and will need to determine their service design before they can fully respond. The Hauora Tairāwhiti Non Government Organisation (NGO) sector has been fully engaged in the thinking and workshops that has been undertaken over the past two years. The information provided by the Hauora Tairāwhiti NGO sector has been included in this report as a placeholder for their future development.

1. Introduction

The purpose of this document is to introduce the Midland Sub-Regional new model of care for the assessment and treatment of substance addiction. This model will need to be implemented in order for the Midland Sub-Regional DHBs to meet the legislative requirements of The Substance Abuse Legislation (SAL) 2016.

2. Background

Legislation governing substance use and addiction was last reviewed in 2010 by the New Zealand Law Commission. The Review confirmed that the Alcoholism and Drug Addiction Act 1966 was no longer relevant for the current context in terms of legal and clinical matters. The Act was also not aligned to current philosophy and practices. Subsequently a new framework was recommended resulting in the development of The Substance Addiction Compulsory Assessment and Treatment (SACAT) Bill 2016.

The rights, dignity and health and safety of people who experience substance addiction are central in this new Bill with an expectation that the compulsory components of assessment and treatment will be managed appropriately in the least restrictive way.

The Act “provides for compulsory treatment of persons with severe substance dependence for the purpose of protecting them from harm and restoring their capacity to make their own decisions about their future substance use”.

The Act details threshold criteria and the processes required to achieve a positive outcome for the person experiencing substance addiction. It also identifies key roles and responsibilities to ensure that processes are implemented (with mana and respect) by personnel with the right skills in the right place. Processes such as an assessment is facilitated, treatment and treatment planning is applied, informed decision making is supported, and the pathway to voluntary treatment is supported.

3. Current Situation

A stocktake of current service provision in the Midland Region of alcohol and drug services was undertaken. This information is available in a report commissioned by the Midland Regional Network. See [Appendix 1](#) – Midland Region AOD Residential Review Summary Report 2016.

This report identified that the existing addiction services are sufficient for the region but further work and investment was needed in developing services to address the following gaps:

- Managed withdrawal services: a continuum of service is needed including integrated community, residential and inpatient options. The aim would be to achieve increased access and equity of access across the region.
- Compulsory assessment and treatment options closer to home: this is required as a matter of urgency and spans managed withdrawal services, residential treatment and community addiction services.
- Supported accommodation: this option is required in those areas that currently have no access or no local access including Taranaki, Bay of Plenty, Lakes and Tairāwhiti. Effective use of supported accommodation provides a step-up and step-down option for residential treatment and residential managed withdrawal.

- Support for families and whānau: to ensure they are included in treatment for their loved one and supported in their own right i.e. a whānau-centred approach. This requires system wide investment and leadership locally and across the region.

Based on the review findings¹, the following recommendations were made for consideration by the Midland Regional Network: Mental Health and Addiction. The recommendations are aimed to strengthen regional consistency across the adult addiction continuum. All recommendations will require further investment in resources and workforce development to support an effective implementation.

It is recommended that the Midland Regional Mental Health and Addiction Network:

1. Retain the range of residential treatment programme options and continue to monitor utilisation to assist in refining volumes required.
2. Implement local referral management systems for all referrals to regional residential treatment programmes to assist regional consistency in relation to equity of access, efficient use of resources and ongoing monitoring.
3. Promote the regional principles and shared goal identified in this review to support service delivery that realises the collective aspirations of stakeholders.
4. Work towards building a stepped care model, beginning with initiatives that will address areas of greatest urgency and need in the following order:
 - a. Develop an integrated stepped model of **managed withdrawal** which provides integrated community, residential and inpatient options and achieves more equity of access across the region. Confirm and/or develop clear criteria and pathways in and out of services; facilitate co-provision by DHB and NGO services; address key gaps and issues such as access to residential managed withdrawal services in areas where this is unavailable and care coordination for those requiring inpatient managed withdrawal.
 - b. Concurrently with 4.a (above) develop a treatment pathway for those who require **compulsory treatment** which reflects an integrated and coordinated approach i.e. local care coordination, access to inpatient and social residential managed withdrawal and tailored residential treatment programme options (in-region and out-of region).
 - c. Develop **pathways and criteria for all services** across the continuum; ensure services for families and whānau are included (as per 5 below); include services from other sectors as appropriate (e.g. whānau ora services).
5. Either as part of 4c above or as a stand-alone initiative, develop an integrated approach to providing services for families and whānau in each DHB to ensure families and whānau are included in treatment processes and can access support in their own right. Ensure there is opportunity to share resources, information and approaches across the region to support consistency. Additionally, there could be scope for regional leaders to advance issues nationally for example, resolving issues relating to recognition of families and whānau as a legitimate service user group in service specifications, funding, reporting structures and patient record systems.
6. Strengthen access to local supported accommodation or community options for those areas with no local access (i.e. Bay of Plenty, Taranaki and Tairāwhiti) and consider expanding supported accommodation and or community options capacity across the region to maximise step-up and step-down options into and out of residential AOD treatment and managed withdrawal services.

Since the report was written each of the Districts have undertaken work on their local continuums of care in preparation for the SAL.

¹ Midland Region AOD Residential Review Summary Report, 2016

4. Gap Analysis

Two workshops were held in September and November 2016 that specifically focused on readiness for the implementation of the SAL. The gaps and issues identified and workforce implications for each District are displayed in [table 1](#).

Table 1: AOD Services Gap Analysis

Waikato	
Gaps	Workforce
<ul style="list-style-type: none"> Understanding of pathway lacking. Misuse of Act. Families' expectations may not be realistic. What we can or cannot do? Legal challenge by clients. Treatment setting. Staffing needs. 	<ul style="list-style-type: none"> The point at which capacity should be tested Standardised tool needed Training staff for capacity assessment. Up-skilling of all staff needed Bio psycho social interventions - resource implications (not just medical) Social Workers Peer Support Wider sector to understand the process of the assessment What are the requirements for the assessor? Training the assessor More training - improve the engagement Family therapists Psychologists Occupational therapists
Bay of Plenty	
Gaps	Workforce
<ul style="list-style-type: none"> Need for best practice standards (in motion in BOP) – R x S need to be across all our areas Formalised R x S What is the use of workforce development if we have nowhere to send them??? Assessment re capacity to make decision Stocktake re Addiction Specialist in our own role?? BOP facilities - inadequate (cells/MH wards). Risk of community facilities/safety? Beds Urban vs. rural perspectives Contractual flexibility to enable MDT intentions – integrated locally? Utilising different organisations - existing best practice links RX with Government Agencies Resource Assessment Centres be “win/win” medical and MTT links - capabilities Concerns re flooded with assessments and complex clients 	<ul style="list-style-type: none"> Regional Role - DI's - to have addiction knowledge Deducted/training SMO in our role Working with Whānau Mana Enhancing Peer support workers to be trained re “post” People will be referred for assessment (whether they meet Act criteria or not) Assessment - Cognitive check AOD/MH, all HXS, management plan Current workers familiar with current AOD Act?
Taranaki and Tairāwhiti	
Gaps	Workforce
<ul style="list-style-type: none"> Lack of cohesion in local sector Perceived difference in status Models of treatment = difference 	<ul style="list-style-type: none"> Public information/communication Agreed assessment pathways (e.g. clinical workstations)

<ul style="list-style-type: none"> ▪ Dominant MH perspective - inadequate service provision including assessment for AOD ▪ Non reduction of beds (Utuhina) ▪ Medical ▪ Lack of specialist resources ▪ Workforce shortage professional development at local level ▪ Funding - assessment increase - client holding place - pathways access 	<ul style="list-style-type: none"> ▪ Cognitive/capacity assessments ▪ Person centred/involved and specialists ▪ MDT - holistic assessment treatment pathways ▪ Whānau inclusion work
Lakes	
Gaps	Workforce
<ul style="list-style-type: none"> ▪ No detox in Taupo: <ul style="list-style-type: none"> ▫ Send to A & E) 1 x Bed on Psych Ward ▫ Community Detox) 1 x Bed on Medical Ward ▫ Access to General Practitioner (GP) ▪ No formalised pathway) Lack of Communication ▪ Need to build relationships ▪ Framework around sub-regional need to communicate persons who may meet criteria - local depository 	<ul style="list-style-type: none"> ▪ Medical Ward Staff <ul style="list-style-type: none"> ▫ Understanding of behavioural issues. ▪ GP <ul style="list-style-type: none"> ▫ Practice Nurses ▫ Training and understanding around AOD ▪ Specialist Services ▪ Skilled and trained assessors

The gaps identified in these workshops as displayed in [Table 1](#) appear to fall into three broad categories:

1. Service configuration/development and facilities across the continuum
2. Capacity and capability of the workforce
3. Promotion and communication to manage expectations

5. New Model of Care

This new model of care proposed for implementation provides a range of options to best meet the needs of eligible² people experiencing severe substance addiction. This includes managed and medically supervised withdrawal and supportive interventions and treatments in hospital and community environments in the Midland region. The new model leverages off the existing continuum of care. This has been enhanced to ensure that those entering under the Substance Abuse Legislation have access to the full range of service treatment options once they are capable to agree to ongoing treatment.

5.1 Aim

This model of care aims to provide a structured framework to guide clinicians and managers in the delivery of care and treatment for people experiencing severe substance addiction consistent with SAL criteria.

² Eligible person has a severe substance addiction, with severe impairment of capacity to make informed decisions about treatment

5.2 Principles

This model of care will:

- Respect the person and protect their mana and dignity – this includes recognising their identity from the cultural, gender, sexuality, language, age and religious perspectives
- Protect the rights of the person
- Ensures maximum whānau/social support involvement and are engaged in the process in order to protect the service-user's autonomy
- Recognise and value the contribution of the person where possible, their family and whānau as partners in care
- Engage the person in voluntary assessment and treatment in the first instance resorting to compulsion in the least restrictive way as needed
- Utilise and strengthen Peer Support approaches
- SAL will be considered in the last possible instance, once other opportunities for voluntary engagement have been exhausted

This model of care is made up of a number of service components that will be delivered by different providers including DHB, NGO and other agencies e.g. WINZ. These service components will be delivered as close to a person's home and community as practicable, considering the variables specific to rural or urban locations.

Access to local pathways will be via a single point of entry. This will be connected and smoothly linked between providers and other stakeholders within the model of care. The primary aim is to maintain a person in active treatment until completion.

A multi-disciplinary team approach will be embedded with clinical and support staff working in collaborative manner providing evidence informed treatments, interventions and decision making. Refer to [Section 7](#) regarding workforce as an enabler.

Shared learning will be strengthened with a regional workforce development emphasis. This will include an information/data repository accessed via Midland Regional Mental Health and Addiction Network website for specific information pertaining to SAL and its requirements.

5.3 Values

The following values underpin services delivered in this new model of care.

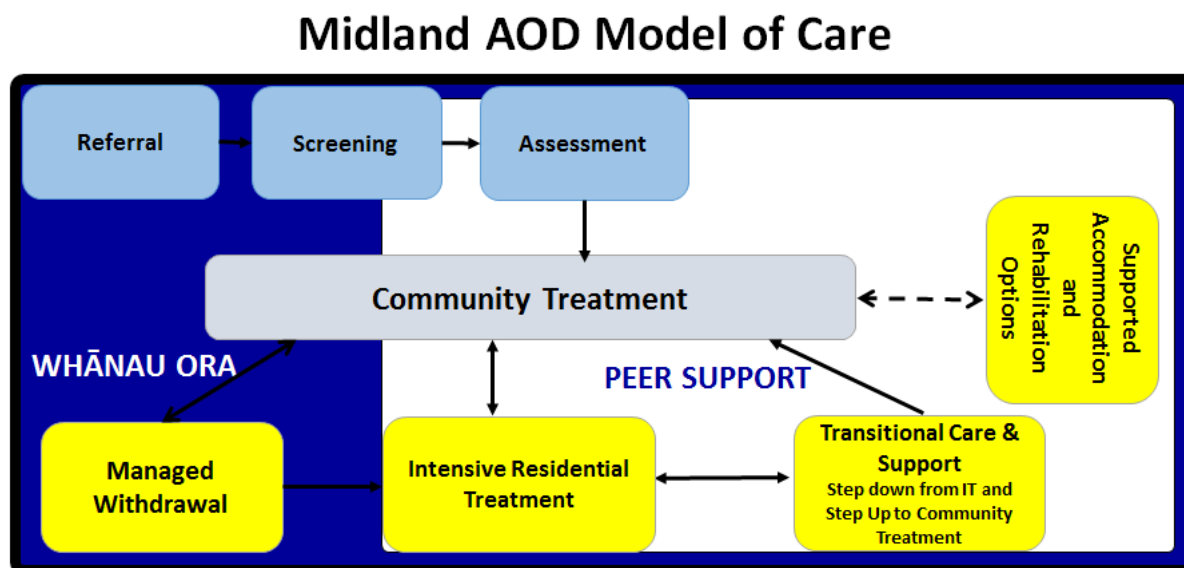
- Person centred and whānau inclusive
- Mana enhancing
- Promoting where possible choice and personal preference
- Demonstrating empathy

5.4 Model of Care Components

This model of care incorporates a number of service components as described in [Figure 1](#).

Pathways within the model will differentiate voluntary and involuntary status of people accessing services.

Figure 1: AOD Service Components



5.4.1 Peer Support

Support from a lived experience perspective underpins peer support models which will be utilised to strengthen the service response. The peer support worker will walk with and alongside the person in their journey. They will participate in peer support groups promoting reciprocity.

5.4.2 Whānau Ora

Engaging with whānau is recognised as beneficial to recovery and support. Service planning, care and support will involve whānau and will incorporate reconnection with whānau and significant others. Education and support will be offered to whānau.

5.4.3 Cultural/Spiritual Identity and Equity

Holistic approaches in treatment and support will promote identification of cultural and spiritual needs and develop connections in order for needs to be met in a culturally appropriate manner. Service provision, specific programmes and assessment and treatment tools will incorporate cultural models and frameworks as required. Strategies will be developed to address issues of equity in service delivery.

5.4.4 Crisis or Acute Cases

In a crisis, acute case or medical emergency, Community Alcohol and other Drugs services may refer to emergency services, the person's General Practitioner or specialist inpatient managed withdrawal services.

5.4.5 Medical Detoxification

Acute medical services will be accessed as required with liaison with Hospital based medical services.

A secure environment may be required however it will be managed safely using minimal restrictive practices. Intensive input including care and monitoring will be required during detoxification. Service level agreements will support these arrangements.

5.4.6 Managed Withdrawal

Assessments for managed withdrawal will be undertaken by community based clinicians in accordance with clinical guidelines. There is specific guidance for managed withdrawal in Substance Withdrawal Management Guide, Matua Raki, 2011.

5.4.7 Intensive Residential Treatment

This service is for people that require a more structured or supported treatment environment, and may also require ongoing medication prescribed as part of a comprehensive management plan and or experience co-existing mental health problems. This service will be available within inpatient settings, using safe and the least restrictive practices. Staffing will be respond to the clinical needs and safety needs of the client. There will be rehabilitative activities offered as part of a structured daily routine while there is an intensive treatment aspect to the service provided; people are supported to live an everyday life³. This includes attention to physical and mental health needs. This service will also include pre-engagement and post-discharge support. Flexible options may be offered as part of an individualised package of care according to need. Options to extend treatment if warranted should be offered for example from involuntary to voluntary status⁴. On discharge from intensive residential treatment, after care and follow up or transitional care arrangements will be required to ensure the gains achieved in treatment are not lost. Relapse prevention groups will be established drawing on peer support models of delivery.

5.4.8 Transitional Care and Support

Sometimes people will require assistance stepping up or stepping down from a more intensive residential treatment programme and environment. This will be a short term option with specific goals to achieve. Transitional care can provide this assistance and is community based with supports provided from either a designated facility or a mobile team.

5.4.9 Supported Accommodation and rehabilitation options (from a range of locations)

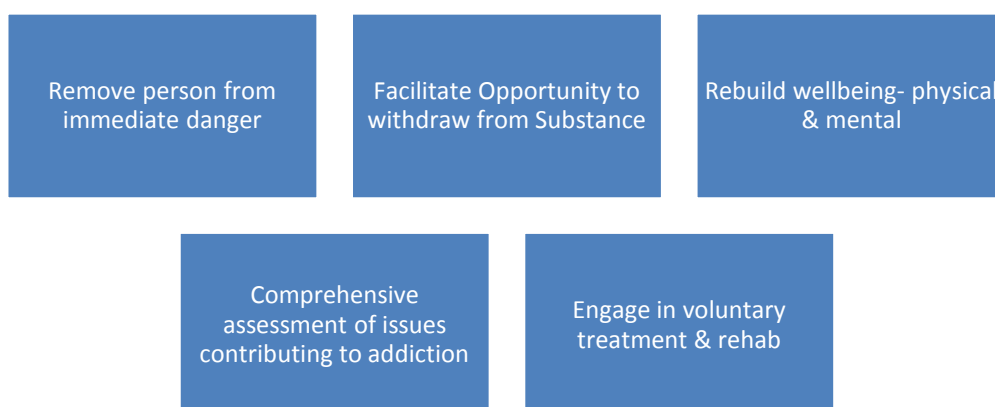
On completion of a treatment programme people and their whānau will have different requirements for ongoing support and rehabilitation. An assessment including activities of daily living, and cognitive functioning will assist with matching the person with the most appropriate option; be it for the short term or the longer term, to their own home or supported accommodation. It is expected that the more severe the Addiction problems, the longer the stay and requirement for support. Cognitive impairment such as in Wernicke's encephalopathy, alcohol related brain injury (ARBI) or alcohol related dementia (ARD) will require careful assessment and management. For some conditions capacity may be restored to some degree as health improves. Once an option is in place, formal assessment and review processes will be conducted regularly and changes made to arrangements as indicated.

Refer to [Appendices](#) for descriptors of Referral, Screening and Assessment processes, and Community Treatment

³ Service objective in Ministry of Health AOD Service Specification for Intensive Residential Treatment

⁴ NOVA Odyssey model

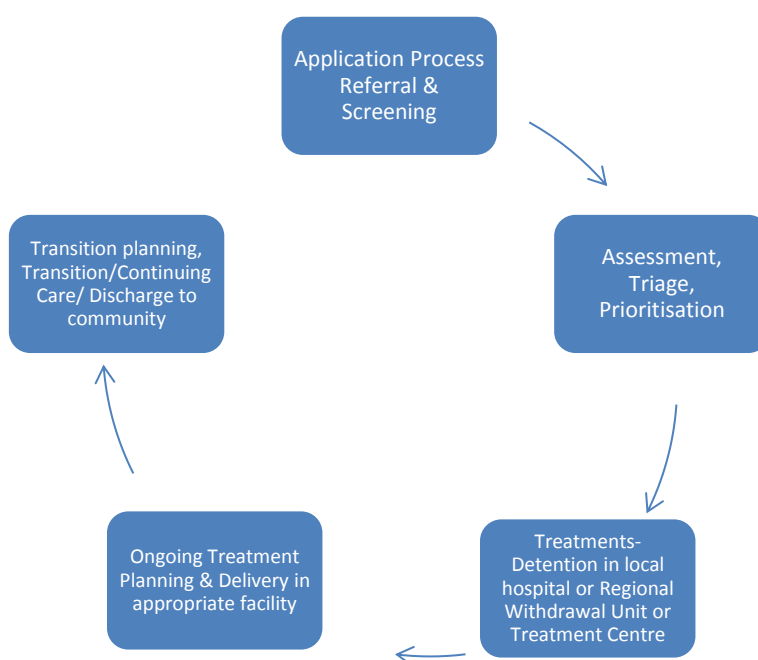
Figure 2: Staged Approach



6. Model of Care Pathway

The [pathway](#) is made up of processes as described [in figure 3](#). A brief description of each pathway process is provided and assumes that the reader has read the Substance Abuse Legislation 2017.

Figure 3: The Pathway Processes



6.1 Application Process

Anyone who believes that a person has a severe substance addiction may apply for an assessment under SAL. The application must meet certain criteria: the applicant must be 18 years of age or over and must have personally seen the person within the last 5 days immediately before the date the application is made. The grounds for the assessment must be stated and; be accompanied by a medical certificate under section 17 or a memorandum under section 18.

The applications/referrals are logged by the receiver, recording the time, date and details of the application/referral in line with reporting requirements. A written acknowledgement of the application/referral must be provided to the applicant/referrer within a working day of receiving the application/referral.

An application/referral form is used that captures as many details as possible about:

- The person, demographic details, clinical and social history, current presentation
- Details of the applicant/referrer
- The person's GP and any other health professionals, agencies/services involved with the person (if known)

The application process for compulsory assessment and treatment is administered by local Authorised Officers (professionally registered personnel) employed by a provider within each of the Midland DHB catchment areas. A Director of Addiction Services in the Midland Region is responsible for appointing the Authorised Officers.

The Authorised Officer will review all applications and determine whether the application should be progressed to a detailed assessment by an approved specialist. The Authorised Officer may also seek Cultural advice from a Cultural Advisor. Peer Support/Whānau Support workers locally based will be available to support the person through the pathway from point of application.

6.2 Assessment process

Two approved specialists will conduct the assessment of the person in order to receive a compulsory treatment certificate, the mandate for compulsory treatment. The approved specialists will be qualified health professionals employed by a local Addiction service provider. A Director of Addiction Services in the Midland Region is responsible for appointing the Approved Specialists. A screening and information gathering checklist will support this process. This includes a comprehensive and well documented risk assessment to determine risk to self or others, including risk of suicide, risk to dependent children and of domestic violence.

If the compulsory treatment certificate is declined, the reasons for this are documented and communicated to the applicant/referrer, along with options of alternative treatment or interventions such as how to keep the person safe.

If the compulsory treatment certificate is accepted, this confirms that the criteria has been met and the certificate is issued. The Approved Specialist will arrange placement in Hospital if acute medical treatment is warranted or in the Regional Facility for managed withdrawal and support.

If a Second Opinion is sought the Area Director appoints a second Approved Specialist to conduct the assessment.

6.3 Treatments and Locations

A Responsible clinician will be appointed by The Director of Addiction Services to coordinate treatment and treatment planning in the nominated facility in collaboration with the multi-disciplinary team. The responsible clinician will be professionally registered under DAPAANZ, HPCAA or SWRB. They will develop in collaboration A Managed Withdrawal and Compulsory Treatment Plan and complete the legal process to obtain a Compulsory Treatment Order. The Treatment Plan will be implemented. During this time a Peer Support/Whānau Support/Cultural Support worker will be available to support the person and whānau. There is an expectation that the length of stay for this compulsory treatment phase is short term.

Treatment providers are gazetted DHB and NGO residential addiction services and are located in the Midland Region. Multi-disciplinary teams are made up of medical, clinical, allied health, peer and whānau advisors and support workers.

Table 2: Key Questions

Is the person suffering from severe substance addiction?
Is their capacity to make informed decisions about their treatment impaired?
Is compulsory treatment necessary?
Is appropriate treatment available?
Has the person had an opportunity to engage in treatment voluntarily?
Is Voluntary treatment unlikely to be effective?

The person may be transported to the agreed location for their medically supervised withdrawal immediately upon issuing of the certificate, or as soon as practically possible. Transportation options will be determined at the time a certificate is issued, in discussion with the person, their whānau/carers/guardian and authorised officer/local AOD clinician from referring DHB. People can be transported to the gazetted facility by family members, carers, clinicians or support workers as appropriate.

6.4 Ongoing treatments

Ongoing treatment is reviewed and care is co-ordinated across different settings as warranted until compulsory treatment is no longer required and the Compulsory Treatment certificate is discharged.

6.5 Transition Planning

The intention is for the person to be transitioned to voluntary community care and support which will decrease in frequency and intensity as the person's wellbeing improves.

7. Enablers

A key enabler for the successful implementation of the SAL is an accessible workforce skilled and experienced in alcohol and other drug intervention, treatment and support. The current numbers of staff are considered insufficient for the expected increase in volume of people accessing services. A multi-disciplinary team approach will ensure a strong combination of expertise in clinical and non-clinical support.

It is likely that the Responsible Clinician (RC) role will be undertaken by AOD specific Nurse Practitioners or AOD Medical Specialists.

New roles and responsibilities⁵

- Director of Addictions
- Authorised Officer
- Approved Specialist
- Responsible Clinician
- Support Worker (peer/whānau/cultural)
- Cultural advisor
- Administrator

DHBs have identified additional workforce needs at the local DHB level as described in [Table 3](#). Further to this is DHB overwhelming support for a Midland Region wide collaborative workforce education and development programme addressing the SAL specific knowledge, peer support

⁵ Definitions of new roles detailed in [Appendix](#)

approaches, skilled assessment and diagnostics including physical health, cultural competency, clinical competency (including capacity testing), family therapy/inclusive engagement/motivational approaches, and Coexisting Problems.

Table 3: DHB Specific Workforce Needs

DHB	Workforce needs
Bay of Plenty	Clinical staff, AOD nurses experienced with management of withdrawal, GPs experienced in management of withdrawal and CEP
Lakes	Clinical staff, AOD nurses experienced with management of withdrawal, GPs experienced in managed withdrawal and CEP
Taranaki	Clinical staff, AOD nurses experienced with management of withdrawal Designated officers, approved specialists, Addiction specialists Administrative support for new processes
Tairāwhiti	Clinical staff, AOD nurses experienced with the management of withdrawal, GPs experienced in managed withdrawal and CEP Designated officers, approved specialists Addiction specialists Peer and whānau support
Waikato	Clinical staff: Drs, Nurses, Nurse Practitioners, Psychologists, Peer, family support.

8. Linkages and Collaboration

Implementation of the SAL will require significant collaboration across traditional boundaries and services to ensure service provision is connected. The nature of the linkage and collaboration are described in [table 4](#).

Table 4: Nature of Linkage & Collaboration

Who	Nature of Linkage and collaboration
GPs, Primary Health Care, PHOs	Referral in and discharge processes Shared Care arrangements Application of Map of Medicine Establishment of liaison protocols
DHBs, Mental Health Services	Confirmed in local service level agreements
DHBs, Emergency Services	Confirmed in local service level agreements
DHBs, Medical Services	Access to medical detoxification Confirmed in local service level agreements
DHBs, Tertiary Services	Access to Specialist Intensive withdrawal and treatment services Confirmed in a regional service level agreement
Housing NZ	Establish liaison and collaboration protocols
Work and Income	Establish liaison and collaboration protocols
Police	Establish liaison and collaboration protocols
Depart of Corrections	Establish liaison and collaboration protocols

9. Costs

The implementation of the SAL will require new investment and development in resource and workforce. Some costs will sit at local DHB level, at the Midland Region level or at the national level. It is expected that the workforce development costs such as training and education will be managed regionally.

It is assumed that the Ministry of Health will promote the SAL implementation nationwide with a comprehensive communications campaign. Midland local and regional services will be detailed in a directory on the Midland Regional website to assist referrers.

New investment in resources and development will be required by DHBs. Costs have been allocated according to the components and processes required by each DHB and the individual DHBs readiness. Population projections have been included in [Appendix 13.3](#).

9.1 Overall Cost

Table 5: Costs by DHB

DHB	Price
Bay of Plenty	\$1,488,686.91
Lakes	\$2,805,700.00
Taranaki	\$2,808,841.00
Waikato	\$1,921,364.00
Midland Workforce Development	\$ 200,000.00
Midland Total	\$9,224,591.91

Without new investment Midland will not be able to implement the new legislation.

See [Appendix 13.4](#) for a detailed cost break down. The costing's includes:

9.2 Referral Management

This includes the receipt of referral, triage, prioritisation, waiting list management, primary care liaison with secondary care, and coordination with other providers. It is expected that an increased volume of referrals will require additional resource in terms of administrative capacity at local DHB level.

9.3 Assessment

Assessment processes as per the SAL will require additional designated workforce at the local DHB level.

9.4 Managed Withdrawal

Managed withdrawal as previously discussed may take place in a number of facilities including community based or in a person's own home depending on the severity and complexity of the addiction. DHBs have identified a requirement for additional resources to support current provision along a pathway from least complex to most complex. Impacts on acute services (General and Emergency medicine) will need to be considered and included in projections.

9.5 Intensive Residential Treatment

There is an expectation that this level of care will be provided nationally from 2018 and over time facilities will be established closer to home in the regions. Midland Region has forecast the bed requirements for intensive residential treatment at 5 beds utilising the New South Wales projections.

9.6 Transitional Care and Support

DHBs have identified a need for this level of service delivered flexibly at a local level.

9.7 Supported Accommodation

Most DHBs signalled unmet need in their districts for supported accommodation that was suitable for people identified under the SAL.

9.8 Regional Workforce Education and Training

Midland DHBs support a regional approach to achieve a consistent standard of skills and competence in the management of Alcohol and Drug problems in the Midland Region. The regional programme will require a coordinator and resources to support delivery. Access to online training modules and resources will be facilitated in partnership with Matua Raki and Te Rau Matatini.

Table 6: Workforce Education and Training Costs

Workforce	Resources	Workforce
Midland Region Workforce Coordination	Allocated Budget (\$) 50k	0.5 fte
Midland Workshops	Allocated Budget (\$) 150k	Venue's in each DHB for: <ul style="list-style-type: none"> • CEP workshops (intro, intermediate and practitioner) • Capacity workshops (intro, intermediate and advanced)) • Cognition workshops (intro, intermediate and advanced)) • SAL Act workshops • Assessment workshops • E-Learning Tool for Peer Support & Whānau workers • Mana Enhancing Care (intro)

10. Risks

Implementation of the new legislation and a new model of care with the associated service components and processes present a number of risks. These range in likelihood from unlikely to very likely, and in level of severity from less severe to most severe. Mitigation strategies have been developed to reduce the likelihood and/or severity of these risks as displayed in [table 6](#).

Table 7: Risk Severity and Likelihood Matrix

Risk Type/Description	Likelihood	Severity	Mitigation Strategies
Person and Whānau Heightened anxiety about new legislation and what this means for whānau	Very likely	Moderate	Improved communications Health literacy Media campaign Development of clear pathways and model of care
Service Providers Lack of clarity re what is intended by new legislation and inclusion criteria, access pathways by service providers	likely	Moderate	Pathways determined and agreed with Service providers. Documented and communicated Roles, responsibilities and accountabilities are clearly defined
Facility	likely	Moderate	Comprehensive planning approach

Facility requirements are not prepared ready for implementation in 2018			with contingencies in place Consultation involves all parties involved in the use of the facility
Volume Demand for services is greater than expected ⁶	likely	Moderate	Projections based on available data Opportunities to adjust delivery according to demand at local DHBs levels and draw on support from other DHBs within the region.
Workforce Specific skills and competencies required beyond current regional capability	Very likely	Moderate	Roles identified and advertised Recruitment processes Workforce development and training programme established
New Funding New funding is needed to enhance the existing model of care. Midland DHBs have stated that the MoC needs to be cost neutral	Very likely	High	Midland will only implement what can be funded. Everything else will be wait listed until funding is made available

11. Quality, Monitoring and Reporting

The effectiveness of the services provided can be measured by establishing outcome measures from the outset of the service. Information provided by services in New South Wales, Australia recommend the following measures collected at baseline, 1 month, 3 months and 6 months.

- **MOCA** (Montreal Cognitive Assessment)
- **ADOM** (Alcohol and Drug Outcome Measure)
- **SDS** (Severity of Depression Scale)

Additional to this, facility based services collect HONOS, Client satisfaction (Real Time Feedback) and service engagement.

Some potential options for the Midland Region include:

Option 1 – Utilise the sections of the new act to identify the group. While this is the easiest option available it is probably the least functional. This would only give information for the period that the person was actually under the act for. E.g. Person placed under act for first 8 week period then off act but continues receiving service. They would be lost to other Alcohol and Drug service delivery.

Option 2 – Create new activity codes within the PRIMHD data set. This would be to add one or two new T code activities which would clearly identify as a direct input for this group of service users. E.g. T99 – SAL specific intervention. T100 – SAL specific bed night. While this option gives the greatest details in terms of identifying the activity it still does not allow aggregation of the data very easily.

Option 3: New team type – A new national team type could be set up with the characteristics being specifically for this group of service users. This would allow all activity to go against specific SACAT teams. The big disadvantage of this approach is that smaller DHBs may find the overhead required to set up and maintain the reporting structure difficult and could be reluctant to create new teams

⁶ NSW experienced a steady flow of referrals

when the number of service users who may go through this team could be minimal (even less than 20 per year perhaps).

Option 4: Create a new Health Specialty code – While this is an option it would not be of any great benefit simply because Health specialty is not one of the data elements within PRIMHD.

Option 5: Nationally, have all service users who come under the SACAT be given one particular diagnosis or within a range of agreed diagnosis. While this would certainly give a common point the level of diagnosis capture across the country is not good at all and clinicians would probably not favour this.

Option 6: Create a new service activity setting. By creating the new service setting of “SACAT” this would allow any team to utilise this service setting and would immediately make identifying this group easier. The down side is that SACAT is not a service setting in line with all the other service settings within PRIMHD.

Option 7: This option involves utilising a combination of new T codes activity types, team types and legal status code sets. This would be the most preferred option as it allows a much richer analysis of the data collected and would be aligned with other data elements within PRIMHD.

In looking at the Results Based Accountability performance measures – some suggestions made would be inadequate with some not being measurable within existing national data collection systems e.g. number of people who reported their support worker did not turn up and number of complaints that have been received.

Some measures could be captured such as:

- number days on act
- re-referrals within 90 days

An agreement will need to be reached prior to implementation of the new model of care of the suite of outcome measures to be collected for the Midland Region in regards to SACAT.

12. Conclusion

The Midland sub-regional model of care for the assessment and treatment of substance addiction consistent with the legislative requirements of the Substance Abuse Legislation (SAL) 2016, will ensure the capacity and capability of the region are enhanced to better meet the needs of people and their whānau accessing care and support. However, this model of care will require additional investment in infrastructure, workforce and other resources. Furthermore, it will require people in services to work more collaboratively to deliver more connected and holistic care.

13. Appendices

13.1 Midland Region AOD Residential Review Summary Report 2016



Midland Review of Adult Residential Alcohol and Other Drug (AOD) Continuum: Summary Report & Recommendations April 2016



Prepared for: Midland DHB Stakeholders

Prepared by: Paula Parsonage on behalf of the Project Steering Group.

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All contributing stakeholders are thanked for their generous contributions to this review.

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Disclaimer

This report relies substantially on information provided and views expressed by key stakeholders. Care has been taken in gathering and presenting the information herein to ensure accuracy, however no warranty is given that the information supplied is free from error or omission.

Introduction

The Midland Region adult residential alcohol and other drug (AOD) service continuum has been reviewed to provide clarity regarding current access to adult residential AOD services, how services meet the needs of Midland service users and their families and whānau and whether the Midland Region adult residential AOD service continuum is fit for purpose. The overall aim is to inform future service planning and funding. Key drivers for the project outlined in the project scope included:

- Significant under utilisation of some services alongside demand for other services that cannot be met within contracted volumes.
- The Better Public Services agenda with its focus on service efficacy and effectiveness and alignment of clinical pathways.
- The pending introduction of a new legislative framework for compulsory addiction treatment, replacing the Alcoholism and Drug Addiction (ADA) Act (1966).⁷

The Midland Region

The Midland Region comprises five DHBs: Bay of Plenty, Lake, Tairāwhiti, Taranaki and Waikato. The population of each DHB and the regional percentage population distribution are shown below in Table 1. Further information on the DHB populations and characteristics of each district can be found on each DHB website.

Table 1. Midland Region DHBs

DHB	2015 population*	Regional % population
Bay of Plenty	222,235	25%
Lakes	103,920	12%
Tairāwhiti	47,603	5%
Taranaki	118,560	13%
Waikato	391,770	44%
Midland Region	884,088	100%

*Population figures sourced from Ministry of Health <http://www.health.govt.nz/new-zealand-health-system/my-dhb> retrieved December 2015.

⁷ During the course of this review in December 2015 The Substance Addiction Compulsory Assessment and Treatment (SACAT) Bill was introduced to Parliament.

Review process

The review took place from 14 October 2015 – 30 April 2016. Project consultant Paula Parsonage, HSD, was engaged to coordinate the review with the oversight and support of a Project Steering Group. A list of Project Steering Group members is provided in Appendix 1. Key processes included: review of relevant documentation, a Stocktake of adult residential AOD services, review of relevant data, and consultation processes with stakeholders. The latter included consultation workshops held in each of the five Midland DHBs and distribution of a *Discussion Paper* for stakeholder feedback to confirm or otherwise the issues identified through the workshops and other processes such as interviews and data analysis. Stakeholders included service users, families and whānau, community and residential service provider representatives (AOD and Co-existing Problems (CEP) services) and those responsible for funding and planning.

This Report

This report presents a summary of the overall findings of the project and recommendations for consideration by the Midland Regional Network: Mental Health and Addiction.

For further information on the findings that have informed this report the reader is referred to the following:

1. *Midland Region Adult Residential Service Continuum Review Discussion Paper (Discussion Paper)*: this paper sets out important contextual information, initial stocktake findings and key themes from consultation workshops.
2. *Midland Region Adult Residential Service Continuum Review Consultation Feedback Report (Feedback report)*: this summarises stakeholder feedback on the *Discussion Paper*, including feedback on the service development options presented.

These are available at: <http://www.midlandmentalhealthnetwork.co.nz>

Residential AOD services defined

Residential AOD service is an umbrella term and can be variously understood. For clarity in this review three service types are included and these are briefly defined below.⁸

Residential AOD treatment programme

Residential treatment involves provision of a structured 24/7 treatment programme provided within an AOD-free living environment that enables a focus on a programme of intensive recovery activities. Models of care vary from programme to programme. Many (not all) New Zealand services provide services based on a Therapeutic Community model.

Residential treatment is recognised as an important component of the AOD treatment continuum (Lubman et al, 2014; National Treatment Agency for Substance Abuse, 2012; National Treatment Agency for Substance Abuse, 2006). The difficulties in researching residential treatment are well documented and include the variety of models of care making valid comparison difficult, difficulty in isolating the impact and outcome of residential service (from other AOD, health and social services

⁸ See *Midland Region Adult Residential Service Continuum Review Discussion Paper* for detailed information on each service type and the models of care within service types.

provided) and difficulty in demonstrating the value of residential treatment as compared with less intensive community options (Reif et al, 2014a). In a recent comprehensive review, Reif et al (2014a) conclude: *Residential treatment is suited to those who need medical care, safe and stable housing, or a structured 24-hour recovery environment* (p302).

Literature suggests that client choice is a key factor in providing effective residential treatment. Location of residential services is a complex issue; some people benefit from attending treatment out of area away from social networks and environments that have supported the development of their AOD issues. However services must address the challenges of reintegration to families, whānau and communities and maintain effective links with local communities (National Treatment Agency for Substance Misuse, 2006).

Managed withdrawal treatment

Withdrawal management is primarily aimed at minimising the withdrawal syndrome associated with substances, providing safety and as much comfort as possible for the service user. Services also provide opportunity for engagement, planning and coordination of post-withdrawal treatment (Matua Raki, 2012). Withdrawal management services offer supportive care in a range of settings (ie, home, community, residential and hospital) and with or without medical management. Some services utilise complementary therapies such as mirimiri and rongoa. Settings and types can overlap, see Appendix 2 for more detail. The least restrictive and most economical options for the individual should be selected based on the person's clinical (including social) needs.

AOD supported accommodation

AOD supported accommodation (or recovery housing) services typically provide AOD-free, time-limited residential and other health and social support, often pre and post intensive residential treatment programmes (ie, as a step up and step down). Staffing is generally minimal (although this can vary from service to service) and is often provided in some part by peers who are more advanced in their recovery process.

A review of evidence by Reif et al (2014b) reports positive outcomes for decreased AOD use and improvements in functioning, including employment and criminal activity.

AOD service continuum in context

Government policy and priorities

As articulated in the New Zealand Triple Aim there is a clear requirement to ensure that our overall health system and its components aim to achieve:

- Improved quality, safety and experience of care
- Improved health and equity for all populations
- Best value from public health system resources (Midland District Health Boards, 2015: 21).

Common themes in relevant national documents which set the direction for the mental health and addiction sector include expectations that the sector that is recovery focused, demonstrably responsive to service users addressing the needs of the whole person, inclusive and supportive of the role of families and whānau, more innovative, achieving greater efficiency and providing value

for money. A stepped care approach is advocated, to provide the least intensive means of achieving the best possible outcomes (Mental Health Commission, 2012a). Clear and accessible pathways between specialist and NGO services are strongly advocated (Mental Health Commission, 2012b).

The New Zealand Health Strategy (New Zealand Government, 2016) outlines five strategic themes: People-powered; Closer to home; Value and high performance; One team and Smart systems.

New Zealand's Māori Health Strategy, He Korowai Oranga continues to set the framework to guide the health sector to achieve the best health outcomes for Māori. He Korowai Oranga aims to achieve the vision of Pae Ora (Healthy Futures), building on the foundation of Whānau Ora (Healthy Families) to include Mauri Ora (Healthy Individuals) and Wai Ora (Healthy Environments). Key directions in the strategy are:

1. Māori aspirations and contributions: achieving these aspirations is a critical part of improving outcomes for Māori.
2. Government aspirations and contributions: the health system needs to demonstrate that it is achieving as much for Māori as it is for everyone else. Accordingly DHBs need to reduce disparities between population groups; improve Māori health and ensure Māori are involved in both decision-making and service delivery.

Recently developed addiction sector frameworks

Two key recent addiction sector frameworks should be considered in relation to any development within the sector. These include Te Hau Mārire: Addiction Workforce Strategic Framework for people working with Māori experiencing addiction related harm (2015-2025) and Kaupapa Māori Mental Health and Addiction Services: Best Practice Framework. Both frameworks provide crucial guidance, on workforce and service development respectively, in equipping and strengthening the sector to support whānau ora.

Review of the Alcoholism and Drug Addiction Act (1966)

The *Substance Addiction Compulsory Assessment and Treatment (SACAT) Bill (2015)* has been introduced to parliament. Changes signalled in the Bill will impact across the AOD service continuum including community services, residential treatment programmes and residential managed withdrawal services (including inpatient). It is estimated that approximately 200 people per year nationally, compared with the current 70 - 80 people, could become subject to the proposed new compulsory treatment regime (Ministry of Health (undated): 4). Duration of compulsory treatment will be limited to a maximum of 56 days with a further 56 days for those with suspected brain injury. The proposed requirements suggest a need for well integrated flexible residential options including provision for accessible managed withdrawal treatment (medical and non-medical), and ongoing care as close as practicable to the person's community. Integration with community services will also be required.

Proposed devolution of methamphetamine withdrawal management funding

The Ministry of Health is considering devolving funding to the DHBs for residential methamphetamine withdrawal management (currently managed nationally). This funding would be applied to support all adults requiring withdrawal management (rather than being limited to those with methamphetamine related issues) in one or more of the following ways:

- To support existing social managed withdrawal service provision and/or pathways.
- As part of any re-modelling of withdrawal management care.
- To assist DHBs to respond to updated compulsory addiction assessment and treatment legislation anticipated to be introduced in the near future.

The current Midland share of this funding is \$254,040⁹. However, the Ministry of Health has indicated that devolved funds are likely to be re-allocated on the basis of identified need rather than necessarily at current funding levels or on a population share basis.

Issues confirmed

There is agreement in principle from Midland stakeholders that residential AOD treatment programmes are for people experiencing problems relating to severe AOD dependency, including those with co-existing mental health problems, who require a period of time in a structured AOD-free living environment to support their recovery. The group of people requiring a residential treatment programme is diverse and access to a range of options is optimal.

Midland stakeholders value the current range of residential treatment programmes and there is general agreement that there is sufficient volume of residential treatment programmes provided. However under utilisation and stakeholder feedback indicate that there is insufficient management of access to residential treatment programmes to ensure service users get the right level of support when they need it; this includes preparation for residential treatment and continuing care beyond the period of residential treatment. Feedback strongly supports the need for development of shared criteria, clear pathways to support an experience of an integrated treatment journey for service users (and their families and whānau).

There is also a need for a consistent and adequate approach to including families and whānau in treatment for their loved one and in supporting families and whānau in their own right ie, a more whānau-centred approach. This is a universal theme in stakeholder feedback throughout the region.

There are further gaps in other service types in the residential service continuum (ie, other than residential treatment programmes), which relate to withdrawal management services, supported accommodation and compulsory assessment and treatment. For example there is:

- Variable access to managed withdrawal services of varying intensity and insufficient coordination between community AOD services and inpatient managed withdrawal services. Feedback confirmed that withdrawal management services are managed variously in each Midland DHB reflecting historical development patterns. There is lack of clarity in terms of pathways and criteria for managed withdrawal services and language describing treatment settings and types is not used consistently. Feedback suggested that access can be particularly difficult for those not living in main centres.
- Lack of access to local supported accommodation in Bay of Plenty, Taranaki and Tairāwhiti (Note Tairāwhiti have access to two beds in Lakes DHB which is used to support people pre and post their participation in a residential treatment programme). Stakeholders report that where supported accommodation is available it supports a period of stability prior to a residential treatment programme (including the time between withdrawal and residential treatment), builds readiness for participation in intensive treatment and helps service users to cement gains post treatment.

⁹ Ministry of Health communication provided by Jenny James, Portfolio Manager Taranaki DHB, December 2015.

- No in-Region residential treatment programme for those undergoing compulsory assessment and treatment. This and the issues in access to residential managed withdrawal treatment will be a significant gap when the compulsory treatment legislation changes take effect, potentially within the next 12 months.

Underlying all of the above is a need for ongoing leadership and development of the workforce. Feedback suggests that among the workforce there is a lack of common understanding about the overall residential treatment continuum and the function of residential treatment programmes. There are gaps in understanding of the differences between residential options and how these might meet the diverse range of needs within the service-user group. As noted above the guidance provided in *Te Hau Marire: Addiction Workforce Strategic Framework for people working with Māori experiencing addiction related harm (2015-2025)* is highly consistent with the goals, principles and suggested actions within this report.

Shared goal

Review findings indicate that stakeholders share a goal of strengthening the adult AOD residential service continuum to ensure that it provides service users and their families and whānau with an integrated and effective recovery-focused treatment experience.

In practice, to deliver an integrated care experience for the service user and their family and whānau, services work together and operate from shared understandings. Linkages are well defined and local and regional structures and processes enable services to work together.

To achieve the goal of integrated service delivery there is overall support for working towards a stepped care model. This would aim to provide service users with treatment at the lowest level of intensity and least restrictive level to meet their needs. Care coordination and ongoing monitoring are integral to the model to ensure the appropriate treatment and level of treatment intensity is being provided. This is consistent with an outcomes focused approach.

In the context of Midland region adult AOD services, a stepped care model provides a way of organising and linking services of varying intensity, with agreed and well understood criteria for each step or service type. Figure 1 below provides one example of a basic framework for a stepped care model showing key adult residential AOD service components (in white). Note that community and primary services are shown in the model in recognition of the crucial linkage between primary, community and residential services.

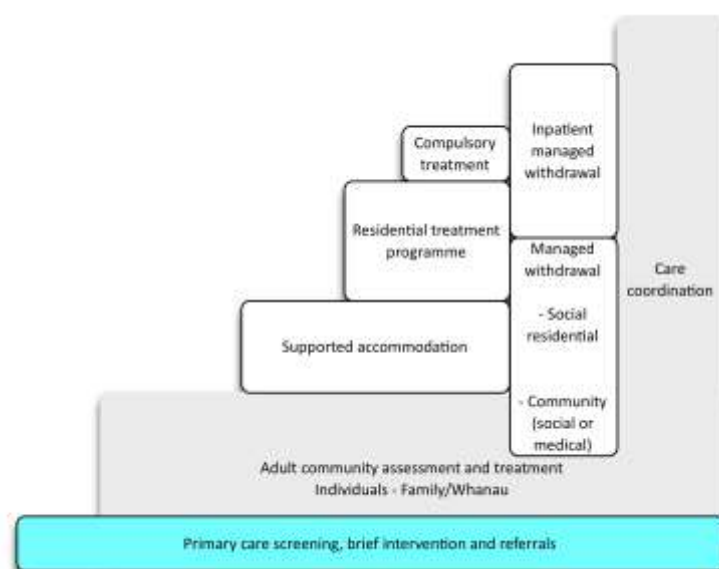


Figure 1. Example of basic framework for a Stepped Care Model

Stakeholders agree that service users and families and whānau must be involved in developing the model. The process for this would include developing the framework, mapping pathways and linkages and identifying criteria for each step and related service. Services and support for families and whānau would need to be included in the model.

Guiding principles

The following key principles to guide the adult residential AOD service continuum for the region have been confirmed by stakeholders:

- **Recovery-focused:** supporting service users in creating a meaningful self-directed life that includes building resilience and having and achieving aspirations, regardless of challenges faced.
- **Family and whānau inclusive and whānau centred:** working in partnership with families and whānau and supporting whānau ora.
- **Connected to community:** acknowledging the importance of community; working together to harness community strengths and support the health and well-being of local communities.
- **Reflecting the principles of Te Tiriti o Waitangi:** the principles of Te Tiriti o Waitangi are central to all that we do.
- **Integrated service:** all stakeholders working together to provided an integrated treatment pathway.
- **Accessible best care:** timely, high quality, holistic treatment and support is accessible wherever people live; close to home where possible, mindful of the preferences of service users and their whānau.
- **Least restrictive, flexible, supporting choice:** treatment and support that is least restrictive, flexible to respond to individual need, and provides choice for service users and whānau.

Stakeholder feedback suggests there remains an ongoing challenge to ensure that principles are reflected in practice. The principles could be applied to inform service funding, development and

delivery throughout the region. There is an opportunity to promote underpinning principles in all local and regional service development and delivery.

Stocktake findings

A Stocktake of adult residential AOD services available to residents of the Midland Region was undertaken as part of the review. A comprehensive account of Stocktake findings is provided in Appendix 2.

Key points highlighted in the Stocktake are summarised below.

Adult AOD residential treatment programmes

There is a range of residential treatment programmes available, providing access to 35 regional beds. The programmes are:

- Te Whare Oranga Ngākau, Te Utuhina Manaakitanga Trust, Rotorua
- Salvation Army Bridge Midland, Hamilton
- Springhill, Napier
- Nova Lodge, Christchurch.

Te Whare Oranga Ngākau and Salvation Army Bridge Midland are located in the Midland Region and account for 28 (80%) of the total regional beds. The programmes offer different models of treatment and are of varying duration and intensity as summarised in Table 2 below. Services that residential treatment programmes provide for families and whānau are varied, generally not well understood by stakeholders and not easily accessed by families and whānau when the programmes are distant from home. Note that for residents of the Bay of Plenty and Tairāwhiti all adult AOD residential treatment programmes are provided out of area. Information on features that are common to all programmes is provided on page 21 and information on outcomes for each of the programmes, as available, is provided in Appendix 3 *Detailed summaries*. Utilisation rates are outlined on pages 13 - 15 below.

Table 2. Summary overview of Regional adult residential AOD treatment

Programme	Location	Midland Bed Capacity	Duration	Age range	Model of care	Utilisation rate 1 July 2010 – 30 June 2015	Points of difference
Te Whare Oranga Ngākau	Rotorua	15	12-weeks (longer if indicated)	18+	Therapeutic community (TC) Kaupapa Māori	67% Decreasing trend for the last two years; 2014-15 rate is 47% ¹⁰	Kaupapa Māori (for Māori & Non-Māori) Access to whānau ora workers Short /no wait time
The Salvation Army Bridge Midland	Hamilton	13 ¹¹	8-weeks	18+	Evidence based model 4 key elements (see p 32)	74% Increased 2014-2015 year to 89% from 67% in previous	Less intensive than TC Residential managed withdrawal

¹⁰ Te Utuhina Manaakitanga Trust suggests data from last quarter may be under-reported.

¹¹ Excludes Taranaki DHB.

						year	(social) part of programme if needed
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Springhill Treatment Centre ¹²	Napier	3	8-weeks (longer if indicated)	19+	Therapeutic community (TC)	92% Trends by DHB are variable but should be interpreted cautiously due to small numbers	Intensive “mainstream” DHB staffing Exclude Court directed referrals
Nova Lodge ¹³	Christchurch	4	12 – 26 weeks (reviewed at 12 weeks)	20+	Work-based programme – lower intensity	94%	Provides compulsory treatment Alcoholism and Drug Addiction Act 1966 (only provider to the region) Work-based programme

Local DHB provision of residential treatment programmes expands access to some types of programmes for example Co-existing Problems (CEP) and parents programmes. Tairāwhiti service users have no access to these programmes.

For people whose primary drug of dependence is methamphetamine there are 54 adult residential AOD treatment packages of care funded nationally by the Ministry of Health. These are in addition to the regional and locally funded programmes. The programmes are accessible regardless of where a person lives. Nine of these packages are provided by services located in the Midland Region.

Managed withdrawal treatment

There are two regional residential non-medical managed withdrawal (‘social detox’) beds, provided by The Salvation Army and located in the Waikato DHB area.

In addition there are six methamphetamine-related social managed withdrawal beds, funded by the Ministry of Health. These are located as follows: two in Waikato, two in Lakes and two in Taranaki. Plans to devolve funding, as outlined above, may impact on these beds.

Arrangements for and access to residential and inpatient managed withdrawal differ for all DHBs. Access to inpatient services is reportedly difficult across the region with pathways in and out not well understood and coordination of care being sometimes fragmented. Stakeholders report a need for more integration between community AOD services and inpatient services.

¹² DHB managed programme provided in a community-based facility that is managed by a Trust. Parameters and processes are specified in a Service Level Agreement (2013). See pp34-36 for detail.

¹³ Provided under Service specification: *Alcohol And Other Drug Services - Community Support Service With Accommodation* (generally applied to supported accommodation services)

Tairāwhiti service users have no access to non-medical managed residential withdrawal (social detox). Bay of Plenty service users access Waikato non-medical managed residential withdrawal services. In Lakes DHB local beds are funded for those withdrawing from methamphetamine.

Service users in Taranaki DHB area have access to a range of community, residential and inpatient managed withdrawal services effectively provided in a stepped care approach, co-managed by DHB and NGO providers. The Taranaki service model appears promising in delivering the range of managed withdrawal services required in the most efficient way.

Supported accommodation

Supported accommodation is provided in Lakes DHB area (12 beds) and Waikato DHB (9 beds). Tairāwhiti service users currently have access to two supported accommodation beds provided in Lakes as a step-up and step-down to an adult residential AOD treatment programme. Bay of Plenty and Taranaki residents have no access to supported accommodation.

Utilisation rates

Detailed utilisation data for regional residential adult AOD services for the period 1 July 2010 – 30 June 2015 is provided at:

<http://www.midlandmentalhealthnetwork.co.nz/file/Midland-Projects/Addictions-Residential-Project/appendix-1-utilisation-data.pdf>.

Summary information is as follows.

Trends in utilisation across the residential treatment programmes are variable. For example in the 5-year period from 1 July 2010 – 30 June 2015 rates vary from 67% annual average occupancy to 94% (for the different regional treatment programmes), as shown in Table 3 below.

Table 3. Residential treatment programme 5-year utilisation rates

Residential Programme	Treatment	Utilisation rate 1 July 2010 – 30 June 2015	Overall utilisation trends
Te Whare Oranga Ngākau		67%	Decreasing trend for the last two years; 2014-15 rate is 47%
The Salvation Army Bridge Midland		74%	Utilisation increased in 2014-2015 year to 89% from 67% (2013-2014)
Springhill Treatment Centre		92%	Utilisation by DHB is variable but should be interpreted cautiously due to small numbers
Nova Lodge		94%	As above

Utilisation of treatment programmes by each DHB is variable as summarised below and shown in Table 4. Note that these population proportions only provide a broad indicator and do not account for variations in demographics which may account for greater levels of need for residential treatment between DHBs.

- Waikato DHB utilisation of The Salvation Army Bridge Midland is higher than the regional population proportionate share (58% utilisation compared with 44% of the regional population) and utilisation of all other programmes is lower than the population % share.

- Taranaki DHB utilisation of The Salvation Army Bridge Midland is very low because the DHB has a local Salvation Army Bridge Programme and exited the regional funding arrangement in 2012. Taranaki utilisation of all other regional residential treatment programmes is close to the regional population share.
- Hauora Tairāwhiti utilisation of Te Whare Oranga Ngākau and Springhill Treatment Centre is close to regional population share (6% and 5% respectively compared with 5% of regional population), while utilisation of The Salvation Army Bridge Midland is low (1%). Utilisation of Nova Lodge is higher at 8%.
- Lakes DHB utilises a significantly higher share of Te Whare Oranga Ngākau (23% compared with 12% of the regional population) and also Springhill Treatment Centre (21% compared with 12% of the regional population).
- Bay of Plenty DHB utilises slightly more than the regional population share of The Salvation Army Bridge Midland (29% compared with 25% regional population share) and Springhill Treatment Centre (31%).

Table 4. Residential treatment programmes 5-year utilisation rates by DHB

DHB	% Regional pop 2015	% utilisation 2010-15			
		Te Whare Oranga Ngākau	The Salvation Army Bridge Midland	Springhill Treatment Centre	Nova Trust
Waikato	44%	33%	58%	26%	41%
Taranaki	13%	16%	1%	16%	11%
Tairāwhiti	5%	6%	1%	5%	8%
Lakes	12%	23%	11%	21%	13%
Bay of Plenty	25%	22%	29%	31%	27%

Year to year data indicates the following trends in utilisation by DHB:

- Waikato DHB: decreasing trend in utilisation of Nova Trust with utilisation dropping each year. Utilisation of all other regional residential treatment programmes is variable over the 5-year period.
- Taranaki DHB: variable trend for all programmes except The Salvation Army Bridge Midland as noted above.
- Hauora Tairāwhiti: variable trend for all programmes.
- Lakes DHB: decreasing trend in utilisation of Nova Trust with zero utilisation in the 2014-2015 year. Variable trend for all other programmes.
- Bay of Plenty DHB: data show decreasing utilisation of Te Whare Oranga Ngākau in the last two years and variable trend for all other programmes.

Regional residential non-medical managed withdrawal beds are fully utilised. Data on utilisation by DHB show that Waikato is a high user of this service, using 63% of the total available bed nights. Taranaki DHB has not used this service in the period for which data are shown. Hauora Tairāwhiti and Lakes utilisation are lower than regional population proportionate share, and Bay of Plenty is slightly higher. Data are shown in Table 5 below.

Table 5. The Salvation Army Bridge Residential Managed Withdrawal % utilisation 2010-15 by DHB

Waikato		Taranaki		Tairāwhiti		Lakes		Bay of Plenty	
<i>utilisation</i>	<i>Pop%</i>	<i>utilisation</i>	<i>Pop%</i>	<i>utilisation</i>	<i>Pop%</i>	<i>utilisation</i>	<i>Pop%</i>	<i>utilisation</i>	<i>Pop%</i>
63%	44%	0%	13%	2%	5%	8%	12%	27%	25%

Year to year data indicate that Waikato and Lakes utilisation is variable, Hauora Tairāwhiti utilisation is trending down and Bay of Plenty trending up.

Overall, data show that proximity to a programme positively influences utilisation. They also indicate significant variability in utilisation, likely to be linked in part to small bed numbers ie, small variations in service user numbers result in relatively large changes in % utilisation rates. Feedback from stakeholders adds to the picture, suggesting that high demand leads to long wait times and over time this leads to lower demand which paradoxically leads to periods of under-utilisation. Feedback also indicates that managing access is a shared responsibility between community and residential providers. There is wide support for more management and coordination of access at the DHB level to maximise usage of these programmes.

Options for strengthening the service continuum

A range of options were presented in the *Discussion Paper*. Those options that were supported by stakeholder feedback to strengthen service provision and address key gaps and limitations are set out below, along with further analysis.

Options supported by feedback

A. To strengthen integration across the service continuum and improve access to treatment:

- A.1. Formalise a regional stepped care model which includes treatment steps and criteria, and pathways into and out of each step. Include services and support for families and whānau in the model.
- A.2. In each DHB, implement a referral management approach to regional adult residential AOD treatment programmes.
- A.3. Develop or strengthen options for ongoing communication, information sharing and mutual learning between community and residential providers e.g. a regular clinical forum.

B. To strengthen support for families and whānau:

- B.1. Support stakeholders in each DHB to develop an integrated approach to working with families and whānau to ensure they have access to support regardless of where they live and whether or not their loved one attends treatment locally, out-of-area or out-of-region. This may include recognising whānau as a legitimate service user group in service specifications, funding and reporting structures. It may also include developing group options including peer-led options. Partnership arrangements with other services such as whānau ora and peer services could be included.
- B.2. Work with AOD residential treatment providers to ensure they provide real options to support out-of-area families and whānau.

C. To enhance the continuum of service to address identified gaps and needs:

- C.1. Provide supported accommodation options across the region to support transitions into and out of intensive residential treatment and managed withdrawal treatment.

C.2. Ensure access across the region to flexible managed withdrawal treatment in an AOD-free environment with and without medical monitoring. Ensure provision of step-up and step-down options in each DHB with clear criteria and pathways in and out of each step. Address areas of greatest need as a priority.

C.3. Develop viable residential options for compulsory treatment under new legislation, including some that are closer to home. Those services that have indicated an interest provide a starting point. NB this will also require consideration of the additional roles and structures outlined in the Bill that do not necessarily sit within the residential setting.

Analysis of supported options against key criteria

Further analysis of the above options was undertaken to assist with prioritisation and decision-making. Options were assessed against key criteria including the New Zealand Triple Aim, principles generated by Midland stakeholders, cultural responsiveness and the impending change in compulsory treatment legislation. Analysis suggests that all options, if pursued, are likely to enhance the Adult AOD Residential service continuum for the Midland Region. Some options are likely to provide greater benefits related to the selected criteria as discussed below.

A. Integration of services across the continuum and improved access to treatment

To strengthen integration across the adult residential AOD service continuum and improve access to treatment option *A1. Develop a regional stepped care model* is most likely to achieve the most benefit against criteria given that it requires comprehensive consideration of services across the continuum, including those for families and whānau. As noted, ongoing monitoring of treatment outcomes is an integral requirement of the approach¹⁴. An outcomes focus aligns well with government directions in commissioning health services. The development of a regional stepped care model is a medium to longer-term strategy and would require leadership and resources.

Option *A2. Implement a local DHB referral management approach to regional adult residential AOD treatment programmes* is likely to improve access to residential service but will be less likely to support integration across the continuum and by itself may not impact at all on services for families and whānau. It is likely to require significantly less resourcing than option A1. and could be taken as an interim step in conjunction with B1. below.

Option *A3. Enhanced communication, information sharing and mutual learning between community and residential providers* is likely to be similar to the above, and could carry workforce development benefits, however it is also likely to carry some additional cost. There is a risk that for the smaller DHBs cost would be a barrier to participation.

B. Services for families and whānau

Option *B1. DHB Integrated approach to working with families and whānau* is most likely to deliver significant benefit against the criteria and addresses a significant concern for all stakeholders. Option *B2. Enhance services from residential providers* if taken alone is less likely to achieve equitable access for families and whānau who are distant from services and will not necessarily enhance family and whānau inclusive practice for those in community services or those whose loved ones do not remain engaged in residential programmes. Both options would require resources and leadership.

¹⁴ See *Feedback Report* p 20 for discussion of the *Partners for Change Outcomes Monitoring System (PCOMS)* which was recommended in stakeholder feedback as a validated and easily applied outcomes monitoring tool that can be used to monitor treatment progress.

C. Enhancing the continuum of service

In relation to C. Enhancing the continuum of service to address identified gaps and needs, all options will deliver benefits relatively equally; these are:

- *C1. Provide Supported accommodation across the region*
- *C2.Flexible residential managed withdrawal*
- *C3.Residential options compulsory assessment & treatment*

Options C1. C2. and C3. potentially provide important steps in the Adult Residential AOD service continuum and all inter-link. When all three options are integrated and working effectively, access and efficiency are improved. There could be a risk of perpetuating inefficiency and inequity without investment in a level of integration. There are also risks that services for family and whānau will not be enhanced if the above options are pursued in isolation. However there is a degree of urgency associated with C2. and C3. generated by the impending changes to compulsory treatment and this must be considered with some priority.

Implementation of options C1. C2. and C3. would require additional resources. Devolved Ministry of Health funding could assist with this. There may be scope to develop option C3. Compulsory assessment and treatment by negotiating some flexibility with residential providers where a residential treatment programme is under utilised. Clearly programme development and integration with other parts of the service continuum would be needed as part of this. Similarly, there may also be scope to expand access to existing supported accommodation for those areas with no or low levels of access, however local supported accommodation options are also needed. Development of supported accommodation options would provide step-up and step-down options from managed withdrawal and residential treatment programmes which would benefit service users and provide flow on efficiency in both of those service types.

Finally, the analysis above does not specify workforce development needs. These should be a key consideration in relation to current service provision and any further development, as noted above.

Conclusions and recommendations

Midland stakeholders share a goal of strengthening the adult AOD residential service continuum to ensure that it provides service users and their families and whānau with an integrated and effective recovery-focused treatment experience underpinned by shared principles.

There is agreement that residential treatment is required for a minority of service users experiencing severe addiction related issues. The time in a residential treatment programme represents a relatively small component of the recovery journey and therefore overall coordination and integration of treatment between community and residential services is needed. Development of shared criteria across the region and local referral management would assist in ensuring that people are offered treatment at the right level of intensity in the least restrictive way and would assist in managing equity of access and provide efficiency. Along with this ongoing attention will be required to ensure that the addiction workforce have up to date understanding of the residential treatment programmes available.

Midland stakeholders value the current range of residential treatment programmes available and there is general agreement that there is sufficient volume of residential treatment programmes provided, however as noted above there are gaps in other parts of the residential service continuum ie, managed withdrawal, supported accommodation and compulsory treatment. There is agreement in principle that development of a stepped care approach could be beneficial.

There is a need to invest in developing services to address the following gaps:

- Managed withdrawal services: a continuum of service is needed including integrated community, residential and inpatient options. The aim would be to achieve increased access and equity of access across the region.
- Compulsory assessment and treatment options closer to home: this is required as a matter of urgency and spans managed withdrawal services, residential treatment and community addiction services.
- Supported accommodation: this option is required in those areas that currently have no access or no local access including Taranaki, Bay of Plenty, Lakes and Tairāwhiti. Effective use of supported accommodation provides a step-up and step-down option for residential treatment and residential managed withdrawal.
- Support for families and whānau: to ensure they are included in treatment for their loved one and supported in their own right i.e. a whānau-centred approach. This requires system wide investment and leadership locally and across the region.

Based on the review findings, the following recommendations are made for consideration by the Midland Regional Network: Mental Health and Addiction. The recommendations are aimed to strengthen regional consistency across the adult residential AOD continuum. All recommendations will require that resources are invested and that workforce development requirements are addressed to support effective implementation.

It is recommended that the Midland Regional Network: Mental Health and Addiction:

1. Retain the range of residential treatment programme options and continue to monitor utilisation to assist in refining volumes required.
2. Implement local referral management systems for referrals to regional residential treatment programmes to assist regional consistency in relation to equity of access, efficient use of resources and ongoing monitoring.
3. Promote the regional principles (p10) and shared goal (p8) identified in this review to support service delivery that realises the collective aspirations of stakeholders.
4. Work towards building a stepped care model, beginning with initiatives that will address areas of greatest urgency and need in the following order:
 - d Develop an integrated stepped model of **managed withdrawal** which provides integrated community, residential and inpatient options and achieves more equity of access across the region. Confirm and/or develop clear criteria and pathways in and out of services; facilitate co-provision by DHB and NGO services; address key gaps and issues such as access to residential managed withdrawal services in areas where this is unavailable and care coordination for those requiring inpatient managed withdrawal.
 - e Concurrently with 4.a (above) develop a treatment pathway for those who require **compulsory treatment** which reflects an integrated and coordinated approach ie, local care coordination, access to inpatient and social residential managed withdrawal and tailored residential treatment programme options (in-region and out-of region).

- f Develop ***pathways and criteria for all services*** across the continuum; ensure services for families and whānau are included (as per 5 below); include services from other sectors as appropriate (eg whānau ora services).
- 5. Either as part of 4c above or as a stand-alone initiative, develop an integrated approach to providing services for families and whānau in each DHB to ensure families and whānau are included in treatment processes and can access support in their own right. Ensure there is opportunity to share resources, information and approaches across the region to support consistency. Additionally there could be scope for regional leaders to advance issues nationally for example, resolving issues relating to recognition of families and whānau as a legitimate service user group in service specifications, funding, reporting structures and patient record systems.
- 6. Strengthen access to local supported accommodation or community options for those areas with no local access (ie, Bay of Plenty, Taranaki, Tairāwhiti) and consider expanding supported accommodation and or community options capacity across the region to maximise step-up and step-down options into and out of residential AOD treatment and managed withdrawal services.

Appendix 1 – Project Steering Group Members

Klare Braye	Project Leader, Matua Raki
Pania Hetet	General Manager, Tuhoe Hauora
Dr Graeme Judson	Addiction Medical Officer, Taranaki DHB
Donna Leger	Clinical Services Manager, Raukawa Trust, Waikato
Eseta Nonu-Reid	Regional Director – MH&A, HealthShare
Rachel Poaneki	Portfolio Manager, Waikato DHB
Brian Thomas	Manager Family Link, Tauranga and Chair of Te Ao Whānau
Sally Whitelaw	Clinical Lead, Addiction Service, Bay of Plenty DHB

Appendix 2 – Withdrawal Management Service Types

Type	Setting	Medical/ Non-medical	Interventions	Provider	Suitability
Community/ home based withdrawal management	Service users home (or proxy home eg respite facility; social withdrawal facility with additional support etc)	Can be either	Ongoing assessment and monitoring Support and clinical advice Treatment planning/ referral Medication (if required)	AOD specialist service; typically nursing staff; may work with general practitioner or specialist prescriber	People who are well supported in a home environment (or proxy home) that is drug and alcohol free Low risk of health complications
Residential Social withdrawal management	Community service eg Social 'detox' service; Respite facility	Non-medical	Ongoing assessment and monitoring 24 hour supportive care and clinical advice Treatment planning/ referral	AOD specialist service; may include nursing and non-nursing staff	People who need a supportive AOD free environment and do not require medication for safe withdrawal ie low risk of health complications
In-patient withdrawal management	Hospital based or Dedicated inpatient unit	Medical	Ongoing medical assessment and monitoring Medication 24 hour supportive care Treatment planning/ referral	Hospital medical and nursing staff (may or may not be AOD specialist) AOD specialist service; medical and nursing staff; may include non-nursing staff	People with severe AOD use and/ or complicating factors eg: <ul style="list-style-type: none"> • history or high risk of withdrawal related seizures • historical or current withdrawal related complications such as dehydration • use of multiple drugs (including alcohol) • co-existing mental health problems • co-existing physical health problems • risks to the individual or community

Appendix 3 – Stocktake

Regional adult residential AOD treatment programmes: overview

There are four Adult residential AOD treatment programmes funded regionally these are:

- Te Whare Oranga Ngākau, Te Utuhina Manaakitanga Trust, Rotorua
- Salvation Army Bridge Midland, Hamilton
- Springhill, Napier
- Nova Lodge, Christchurch.

The following are common to all of the regional programmes:

- Provision of a 24/7 abstinence-based structured programme in an AOD free environment.
- Holistic approach inclusive of physical, mental, social and spiritual well-being.
- Targeted at men and women experiencing severe AOD-related issues, co-existing mental health problems and other complicating health, psychological and social issues.
- The referral pathway is via community-based AOD services (both DHB and NGO) after a comprehensive assessment has been completed to ensure residential treatment is appropriate.
- There is an expectation that service users will be supported pre and post-treatment by community-based AOD services to build readiness and achieve continuing care as needed.¹⁵
- 12-Step principles and links to 12-step fellowships (such as Alcoholics Anonymous and Narcotics Anonymous) and other peer-based networks are embedded to support development of ongoing AOD-free support networks post residential treatment wherever the person lives.
- Emphasis group based approaches, supplemented with 1-1 counselling and/or case management and support (NB. Nova Lodge is more of a work-based programme see p37).
- Service users pay a weekly accommodation charge normally funded by Work and Income New Zealand (WINZ).
- Staffing is a mix of clinical (eg, Registered AOD Practitioners, Nurses) and non-clinical (eg, Support workers).
- All address physical and mental health needs either directly or by coordination with community and other health services.
- All work from whānau inclusive philosophy; levels of services and support for whānau vary (See detailed summaries below).
- All maintain relationships with referrers in a variety of ways e.g. intermittent “road shows”, regular telephone contact and emails. All note the challenges in keeping the Midland community AOD workforce informed about their service.

An overview is provided in Table 6 below.

¹⁵ For Te Whare Oranga Ngākau and the Salvation Army Bridge the community-based service may be part of their own organisation.

Table 6. Summary overview of Regional adult residential AOD treatment

Programme	Location	Midland Bed Capacity	Duration	Age range	Model of care	Utilisation rate 1 July 2010 – 30 June 2015	Points of difference
Te Whare Oranga Ngākau	Rotorua	15	12-weeks (longer if indicated)	18+	Therapeutic community (TC) Kaupapa Māori	67% Decreasing trend for the last two years; 2014-15 rate is 47% ¹⁶	Kaupapa Māori (for Māori & Non-Māori) Access to whānau ora workers Short /no wait time
The Salvation Army Bridge Midland	Hamilton	13 ¹⁷	8-weeks	18+	Evidence based model 4 key elements (see p 32)	74% Increased 2014-2015 year to 89% from 67% in previous year	Less intensive than TC Residential managed withdrawal (social) part of programme if needed
Springhill Treatment Centre ¹⁸	Napier	3	8-weeks (longer if indicated)	19+	Therapeutic community (TC)	92% Trends by DHB are variable but should be interpreted cautiously due to small numbers	Intensive “mainstream” DHB staffing Exclude Court directed referrals
Nova Lodge ¹⁹	Christchurch	4	12 – 26 weeks (reviewed at 12 weeks)	20+	Work-based programme – lower intensity	94%	Provides compulsory treatment Alcoholism and Drug Addiction Act 1966 (only provider to the region) Work-based programme

In consideration of the above the following points are made:

- Service users are able to access a range of residential treatment options providing opportunities for matching treatment to individual need and providing some real choice.
- Two services are located in-region and two out-of-region. From a service user perspective even in-region services may be considerably distant from home.
- Currently there is only one option for those under compulsory treatment orders; this is an out-of-region option. There appears to be no provision for 18 and 19 years olds who may need this treatment.

¹⁶ Te Utuhina Manaakitanga Trust suggests data from last quarter may be under-reported.

¹⁷ Excludes Taranaki DHB.

¹⁸ DHB managed programme provided in a community-based facility that is managed by a Trust. Parameters and processes are specified in a Service Level Agreement (2013). See p34 for detail.

¹⁹ Provided under Service specification: *Alcohol And Other Drug Services - Community Support Service With Accommodation* (generally applied to supported accommodation services)

- Trends in utilisation are variable. Feedback suggests that high demand leads to long wait times and over time this leads to lower demand which paradoxically leads to periods of under-utilisation.

Regional residential managed withdrawal service (social detox)

There are two residential managed withdrawal beds (social) available to service users in the Midland region provided by the Salvation Army, Waikato in Hamilton. Taranaki DHB does not use the service but accesses the local Taranaki Salvation Army service.

Service users are referred via community AOD services. Generally the service is used to support and stabilise a person prior to a period of treatment, typically intensive treatment. The service may also be used as a step-down from medical inpatient managed withdrawal services.

Data indicate that this service is utilised to capacity and is mainly accessed by Waikato and Bay of Plenty service users.²⁰ There is no local access to residential managed withdrawal beds (social) in Tairāwhiti; in Lakes DHB, local beds are funded for those withdrawing from methamphetamine.

National methamphetamine residential packages of care

The Ministry of Health funds 54 residential treatment packages of care for adult methamphetamine users. These packages are additional to regional and locally funded residential treatment and can be accessed by Midland service users who are seeking treatment for methamphetamine use. Service volumes and locations are provided in Table 7 below.

Table 7. Methamphetamine Adult residential packages of care

Region	Location	Provider	No.
Northern	Auckland	Odyssey House – Auckland	10
Northern	Auckland	Higher Ground Drug Rehabilitation Trust	8
Northern	Auckland	The Salvation Army New Zealand Trust	6
Northern	Auckland	Raukura Hauora O Tainui Trust	8
Midland	Hamilton	The Salvation Army New Zealand Trust	3
Midland	Rotorua	Te Utuhina Manaakitanga Trust	2
Midland	New Plymouth	The Salvation Army New Zealand Trust	4
Central	Wellington	The Salvation Army New Zealand Trust	2
Southern	Christchurch	Odyssey House – Christchurch	2
Southern	Dunedin	Downie Stewart Foundation (Moana House)	7
Southern	Dunedin	The Salvation Army New Zealand Trust	2

Data provided by the Ministry of Health show the numbers of Midland service users accessing the above packages per calendar year over a five-year period from 2011- 2015. Numbers accessing these packages appear to be trending up, as shown in Table 8 below. Data per DHB of domicile were not provided.

Table 8. Midland access: methamphetamine Adult residential packages of care 2011-15

Calendar Year	2011	2012	2013	2014	2015
No of people	79	84	92	104	113

²⁰ Note that this service also provides two methamphetamine managed withdrawal beds contracted by the Ministry of Health and currently under consideration for funding devolution

Sub-regional adult AOD residential treatment programmes

Adult residential AOD treatment

Some Midland DHBs fund residential ‘beds’ additional to the regional beds. Key summary findings are presented in Table 9 below.

Table 9. Summary overview of sub-regional adult residential AOD treatment

Programme & location	Bed Capacity per DHB	Duration	Age range	Model of care	Utilisation	Points of difference
Salvation Army Bridge, Taranaki New Plymouth	3: Taranaki ²¹	8-weeks	18+	Evidence based model 4 key elements (see p32)	1 July – 30 June 2015 Variable utilisation from 15-90% across residential and managed withdrawal beds	Less intensive than TC Residential managed withdrawal (social) and community medically monitored withdrawal part of programme if needed
Odyssey Auckland	6: Waikato 2: BOP 1.5: Lakes 1: Taranaki	Varies	18+	TC	1 July 2013 – 30 June 2015 66% overall	3 programmes: 1. <i>Adult</i> 2. <i>Family centre</i> : for parents and children 3. <i>Co-existing problems</i> Tailored as needed for young adults Includes components provided within kaupapa Māori framework Withdrawal management part of the programme (no pre-treatment) Not all Midland service users are referred by AOD referrers (see below)
Higher Ground Rehabilitation Trust Auckland	6: Waikato	18-weeks	18+	TC	94% (1 July 2010 – 30 June 2015)	Kaupapa Māori component Extensive family and whānau programme Focus on evidence-based talking therapies; excludes some medications Requires face-to-face interview pre-admission

In consideration of the above the following points are made:

²¹ This service also provides seven Methamphetamine residential treatment beds that are available nationally

- Local DHB provisions provide further choice for service users from those DHBs. For example, Odyssey provides a unique parents programme and a programme tailored to address CEP.
- There are no additional treatment services other than regional for Tairāwhiti service users.
- A significant number of service users are referred to Odyssey by Corrections and many have no connection with AOD services in their area i.e. they form part of the Midland utilisation statistics but they are not visible to the local addiction services. For this group the referral happens in reverse i.e. Odyssey is the referrer to local services. This cohort can have high needs and reportedly it can be difficult to get local services to take them on.
- Those in the Tairāwhiti DHB area have no access to Odyssey programmes; all other DHBs have access.

Supported accommodation

There are two supported housing/accommodation services providing services to some Midland DHBs. Information is summarised in Table 10 below further information is provided on pages 46 and 47.

Table 10. Summary of supported accommodation

Service & Location	Bed Capacity /DHB	Summary information
Alcohol and Drug Community Support Trust Hamilton	9: Waikato DHB	19+ age Recovery house. Not TC programme, but operates within guidelines consistent with a TC model 3 groups of service users that access the service: 1. Pre-treatment: stay for 3 – 6 weeks prior to treatment 2. Post-treatment: stay for 1-month minimum; the focus is on transition back to the community 3. Respite: people who have been through residential treatment several times and who do not need further residential treatment House is not supervised 24/7 see p 42 for detail
Lifewise Rotorua	12 Social Development NGO Managed via NASC referral Available to Lakes and Tairāwhiti service users	Provide supported accommodation for adults with mental health and/or addiction issues; Typically pre and post treatment in Lakes DHB; 2 beds available to Tairāwhiti service users accessing adult residential AOD treatment in Lakes DHB (on pilot basis).

Local DHB residential managed withdrawal services

Residential, including inpatient, managed withdrawal is provided in a different configuration in each DHB. Services that are **additional** to the regional arrangements outlined above are as summarised in Table 12 below.

Table 12. Local DHB arrangements for residential managed withdrawal services

DHB	Local managed withdrawal arrangements	Comment
Waikato	2 inpatient medical beds in the Henry Rongomau Bennett Mental Health Inpatient	Unplanned withdrawal in hospital setting is a key concern for local

	Unit	stakeholders. This is a high risk service user group who are not engaged with AOD services
Tairāwhiti	1 inpatient medical bed for those requiring medical management	Social managed withdrawal is home-based only Significant gap for those whose home environment is not suitable
Taranaki	Inpatient medical bed/s accessed as needed 1 managed withdrawal community bed 2 social managed withdrawal beds	Managed withdrawal is shared care arrangement with CADS and Salvation Army, can include medical monitoring and medication Stakeholders report this model is working well
Bay of Plenty	1 dedicated inpatient bed in Whakatane Inpatient Mental Health Unit Bay of Plenty Addiction Service (BOPAS) nurse provides coordination of admission	Unplanned withdrawal is sometimes managed in Tauranga Hospital Madison Centre Respite Service can be accessed sometimes for people with CEP
Lakes	2 beds in hospital medical unit 1 bed in inpatient medical withdrawal bed is funded in the MH unit	Access to medical beds via ED or GP Inpatient mental health service accessed via a lead clinician Access is difficult; pathways unclear Sharp increase in unplanned presentations to mental health unit of high concern; opportunity for engaging at risk group in AOD services but resources need to be available to support this. Key concern for stakeholders

Methamphetamine residential managed withdrawal services

The funding for methamphetamine managed withdrawal beds that is likely to be devolved to the region in 2016/17 is applied within services within the region as shown in Table 13 below.

Table 13. Methamphetamine managed withdrawal services²²

Region	Location	Provider	No. of Detox Beds
Midland	Rotorua	Te Utuhina Manaakitanga ²³	2
Midland	Hamilton	The Salvation Army New Zealand Trust	2
Midland	New Plymouth	The Salvation Army New Zealand Trust	2

Any changes to the funding of the above will likely have an impact on both regional and local managed withdrawal services, as these services are generally co-provided.

Detailed summaries

Te Whare Oranga Ngākau: Te Utuhina Manaakitanga Trust, Rotorua

Capacity	15 beds ²⁴ for Midland
Duration	12-weeks (longer if clinically indicated)
Target pop	Māori and non-Māori adults aged 18 years and older Long-term AOD dependency along with other related health, social and justice related problems (often described as 'complex needs')
Model of care	Kaupapa Māori therapeutic community (TC) programme: grounded in Te Ao Māori, reflects Māori values and aspirations and integrated with principles of TC model: i.e. addiction is viewed as affecting the whole person and the community itself is a key instrument for supporting change and development Emphasis on group therapy supplemented by 1-1 counselling and care co-ordination
Staffing	1 full time equivalent (FTE) Registered Nurse; 2.5 FTE clinicians and 8 FTE Support Workers; part of larger NGO
Other health care	General health care via Community General Practitioner, dentistry and mental health care (via DHB services) coordinated as part of the programme; (Physical health care and dentistry often key area of need for service users)
Whānau involvement	Whānau are encouraged to engage with the referring providers and or Whānau Ora providers in their community Visits to the programme are encouraged and supported Whānau therapy and whānau support are integrated into programme. Participation is encouraged Additional Whānau Support via two Whānau Ora workers shared across the NGO. Whānau Ora worker follow up with whānau and whānau in their

²² Other than the reported general under-utilisation of the methamphetamine social withdrawal beds nationally detailed data on utilisation of the above in the Midland Region has not been available for consideration in this review.

²³ Now Manaaki Ora Trust.

²⁴ There are two additional methamphetamine beds available nationally and two social managed withdrawal beds via MOH methamphetamine contract.

	<p>community for up to 12 months to ensure they engaged with referring service</p> <p>Local whānau are more likely to engage as there are no travel/accommodation issues.</p>
Outcomes	<p>Utilises the ADOM (Alcohol and Drug Outcome Measurement tool) – no reports available</p> <p>Quality management via routine contract and surveillance auditing, internal auditing processes and regular client satisfaction surveys. Two consumer satisfaction reports were provided:</p> <ol style="list-style-type: none"> 1. July – Dec 2014, n=21 2. January –June 2015 n=14 <p>Both reports indicate a very high level of consumer satisfaction with few negative comments and no themes among these.</p> <p>The response rates for these surveys are not reported.</p>
Wait time	Varies, generally short; no wait time when this data gathered in November 2015
Utilisation	<p>Data from 1 July 2010 – 30 June 2015 shows average utilisation rate is 67%</p> <p>Overall decreasing trend for the last two years; 2014-15 rate is 47% (Note Te Utuhina Manaakitanga Trust suggests data from last quarter may be under-reported)</p> <p>Lakes DHB service users account for 23% of service utilisation and 12% of the region's population; Tairāwhiti DHB utilisation is also higher than population share</p>

Salvation Army Bridge Midland, Hamilton

Capacity	13 beds for Midland (excluding Taranaki DHB)
Duration	8-weeks
Target pop	Women and men who are 18 years of age and older Severe AOD dependency along with other related health, social and justice related problems
Model of care	<p>Less intensive than a TC. Four key elements:</p> <ol style="list-style-type: none"> 1. Partnership: working with each individual; commitment to Treaty of Waitangi and cultural sensitivity 2. Community Reinforcement Approach (CRA): evidence-based approach based on cognitive-behavioural principles; works with person in consideration of their social context; focus on community integration 3. Twelve-Step Recovery Journey: incorporates the twelve-step approach 4. The Salvation Army: Christian philosophy emphasises love and concern, spiritual dimension and practical help.²⁵ Includes Recovery Church – ongoing beyond residential treatment <p>Emphasis on group psycho-education supplemented by 1-1 AOD case work including individual treatment planning and support to achieve other social goals such as accommodation and employment</p> <p>Residential managed withdrawal (social) provided as part of programme as needed (includes step-down from medical-inpatient withdrawal management as required). This is provided by registered nursing staff</p>
Staffing	Residential programme is provided by DAPAANZ registered practitioners, and those in support work roles working towards registration
Other health care	Full health assessment and access to health care professionals included
Whānau involvement	<p>Family/whānau and cultural inclusive practice embedded in treatment model</p> <p>Clients have the option to consent to whānau involvement which includes:</p> <ul style="list-style-type: none"> Family/whānau visits Family group sessions Couples sessions Family education nights <p>Clients are encouraged to utilise weekend leave to maintain whānau support</p> <p>Work is being done to see how family/whānau can be supported better where distance is an issue</p>
Outcomes	<p>Patterson et al, 2015 conducted an extensive evaluation of the Bridge and concluded that the approach reflects evidence based and recommended best practice principles and compares favourably with other programmes</p> <p>As a result of the Otago research, work is currently being conducted to develop a set of validated outcomes measures for Bridge residential services</p> <p>Quality management via routine contract and surveillance auditing, internal auditing and review processes; consumer consultation ongoing</p>
Wait time	Varies; at the time this data gathered referral numbers were high (November 2015)

²⁵ Patterson et al, 2015

Utilisation	<p>Data from 1 July 2010 – 30 June 2015 shows utilisation rate is 74%</p> <p>Service utilisation has increased in the 2014-2015 year rising to 89% from 67% the previous year</p> <p>Utilised more by Waikato and Bay of Plenty; recent increase appears to be accounted for by an increase in Bay of Plenty referrals</p>
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Springhill Treatment Centre, Napier²⁶

Capacity	3 beds for Midland; usage is mandated via <i>Service Level Agreement (2013)</i> between Hawkes Bay DHB and the Midland Region (on behalf of the five Midland DHBs) which specifies an <i>Approved Midland Referrer List</i> and that referrals are accepted on the basis that local treatment options have been exhausted
Duration	8-weeks (can be extended if clinically indicated)
Target pop	Women and men who are 19 years of age and older Co-existing problems i.e. Moderate to severe AOD issues and mild to moderate mental health problems; Judicial direction is a specific exclusion criterion
Model of care	TC (modified) supplemented by individual therapy and family work; integrates a range of evidence based modalities; comprehensive recovery action plans implemented on entry, reviewed in week six with the service user, whānau and professional supports; cultural assessment is included as required; services are put in place to ensure cultural support provided Generally people are not discharged if relapse – managed carefully to provide learning opportunity Expectation that withdrawal is managed prior to entry; support people who are still experiencing withdrawal on entry but not the ideal as delays programme participation
Staffing	Multi-disciplinary team, 11 FTE including AOD counsellors, occupational therapists, social worker, medical officer and night time/weekend supervisors. All clinicians are registered practitioners with clinical expertise in mental health and addiction treatment. Regular input from senior DHB management, a consultant psychiatrist, medical practitioner with special interest in addictions provides medical oversight
Other health care	As above access to health care professionals included All service users are reviewed medically and have access to psychiatric review if necessary
Whānau involvement	Families and whānau are involved in recovery planning Regular family day (every 8 weeks) includes education and individual family sessions; this is an opportunity for out-of-area families to participate. Feedback is collected from those attending; this is reviewed by the team to inform practice and make improvements as needed The service user can have a family session at any stage of the programme and for those who cannot travel are able to have a family session via teleconference Family systems group is part of the programme; there is a focus on reducing family violence; TC creates a family system in itself, so provides opportunity to work on family issues
Outcomes	Currently re-looking at options for outcome monitoring. The service was utilising the ADOM (Alcohol and Drug Outcome Measurement tool), is no longer using it, as it is not validated for use in residential treatment settings. However this under re-consideration as it is a Ministry of Health requirement and may be useful for post-treatment follow-up. There are logistical and resource issues related to this that will need to be worked

²⁶ This is DHB managed programme provided within a community-based facility that is managed by a Trust.

	<p>through.</p> <p>Also considering using The World Health Organisation, Quality Of Life outcome measure. Permission has been obtained from Auckland University to use their modified version of the WHOQOL; now at the stage of getting this approved by DHB health record standards committee.</p> <p>The service routinely collects patient feedback on groups, professional support and self-efficacy. This information is collected at the point of discharge. Feedback is reviewed by the team and where themes are identified the information is used to make programme improvements eg, programme activities were widened to include art, stone carving, gardening, sports and weekend outings on the basis of feedback which indicated that the programme was “too cognitive”.</p> <p>There is a specific feedback form for Māori patients to gain feedback on access into residential treatment, cultural / spiritual needs and family inclusive approach.</p> <p>Springhill has a strong focus on retention to support programme completion. Newton-Howes and Stanely (2014) reported retention rates are higher in Springhill than similar programmes with 62% of all service users completing 8 weeks. In 2015 retention rate was 66% (as reported by Springhill). NB retention rates are not Midland specific.</p> <p>There is ongoing monitoring of retention rates to track attrition and examine trends in why and what stage of the programme people leave. The findings inform clinical practice regarding referral process to ensure that people are prepared before admission. In addition, having noticed a trend in people leaving at week six a clinical review with the patient, family and referrer to discuss post treatment plans was implemented at that point in the programme. Retention and attrition rates are also examined for sub-groups of patients eg, Māori, young adults.</p> <p>Quality management via routine contract and surveillance auditing, internal auditing processes</p>
Wait time	<p>Can be lengthy due to high demand and limited capacity (i.e. 3 beds only as per contract); once Midland beds are allocated for the month no further referrals can be accepted until the bed is vacant (as per Service Level Agreement)</p>
Utilisation	<p>Data from 1 July 2010 – 30 June 2015 shows utilisation rate is 92%</p> <p>Trends in utilisation by DHB are variable. Small numbers mean trends should be viewed with caution</p> <p>As specified in the Service Level Agreement once the Midland beds are allocated for the month, no further referrals are accepted until the bed is vacant. It is required that a waiting list is reviewed monthly with referrers. This system was initiated to address past problems with over-utilisation whereby the annual allocation was exhausted within six months. The experience has been that long wait times lead to lowering of demand, which paradoxically leads to under-utilisation. In the past there have been periods of close and flexible management of the allocation by Midland which reportedly worked well to maximise access</p> <p>It was noted in feedback that barriers to access relate to the referral management system rather than the inability of Springhill to provide service.</p>

Nova Lodge, Christchurch

Capacity	4 beds for Midland
Duration	3 – 6 months (reviewed at 3 months)
Target pop	<p>Women and men who are 20 years of age and older; suited to mature people (In 2014 the average age was mid-late 40s)</p> <p>Severe and chronic AOD dependence, under Section 8 (voluntary committal) or Section 9 (compulsory treatment order) of the Alcoholism and Drug Addiction Act 1966</p>
Model of care	<p>A work skills and activities programme is provided along with AOD-related education groups and case management; some 1-1 counselling is provided</p> <p>Service users can achieve a tertiary-level qualification if they choose to. This is Primary ITO training in horticulture and is affiliated with NZQA.</p> <p>Focus on retaining person to support sufficient wellness to return to community; relapse is viewed as learning opportunity and does not usually result in discharge; linked to range of self-help peer networks; ideally referring agency will provide assertive follow-up on return to the community</p> <p>Lower therapeutic intensity than residential programmes above; Provided under Service specification: <i>Alcohol And Other Drug Services - Community Support Service With Accommodation</i> (generally applied to supported accommodation services); however must have accommodation to go back to</p> <p>Service users undergo medically managed withdrawal process prior to admission</p>
Staffing	24 staff in the following roles: two cooks, night supervisors [mental health support work qualifications], admissions officer, social worker, counsellor, peer support worker, general manager, nurse, horticultural/farm workers [technical skills and experience, not a clinical role], lodge supervisor, administration officer, accounts clerk, internal auditor [part time], quality consultant [part time]
Other health care	General practitioner provides general health care via weekly clinic; Support for co-existing mental health problems provided by local mental health services; those with brain injury supported via the local Burwood Hospital service
Whānau involvement	<p>Nova recognises the importance of family links and strives to support these links for all service users on an individual basis. This is reflected in policy and procedures. For example, there is a <i>Family/whānau Involvement policy</i> in place which sets out how Nova involve and support families and whānau, and how Nova seek advice and input from families and whānau. Nova's <i>Visitor's policy</i> also sets out provisions for overnight stay available under certain circumstances</p> <p>There is a procedural form which facilitates discussion about family involvement with the service-user at the point of admission and family involvement can form an integral part of the treatment plan.</p> <p>Whānau and family are involved via telephone contact all the way through the treatment if service user consents, reportedly 50% do so. Where service user consent is not given case managers re-visit the issue as the person settles into the programme and becomes more well</p>

	<p>Family/whānau members may be invited to participate in decision making and also in treatment and/or review sessions</p> <p>Residents are encouraged to keep in touch with family and whānau themselves and are supported to do so</p> <p>Family visits encouraged</p> <p>Access to education and support is facilitated by Nova Trust for family/whānau and significant others, in a format best suited to meet their needs</p>
Outcomes	<p>Quality management via routine contract and surveillance auditing, internal auditing processes</p> <p>The service uses the “Recovery Star” which is an outcomes tool for adults managing mental health issues. The Mental Health Recovery Star covers ten key areas:</p> <ol style="list-style-type: none"> 1. Managing mental health 2. Physical health and self care 3. Living skills 4. Social networks 5. Work 6. Relationships 7. Addictive behaviour 8. Responsibilities 9. Identity & self-esteem 10. Trust and hope <p>In addition, once discharged service users are followed-up via telephone (after two weeks) to monitor indicators such as attending appointments with services; data are analysed.</p>
Wait time	Varies
Utilisation	<p>Data from 1 July 2010 – 30 June 2015 shows utilisation rate is 94%</p> <p>Variable use by DHB for example Waikato DHB use is relatively low while Taranaki and Bay of Plenty is relatively high. Small numbers mean trends should be viewed with caution</p>

Salvation Army Bridge, Taranaki, New Plymouth

Capacity	3 beds for Taranaki DHB; 7 Methamphetamine beds available nationally
Duration	8-weeks
Target pop	Women and men who are 18 years of age and older Severe AOD dependency, at times, alongside other related health, social and justice related issues
Model of care	<p>Four key elements:</p> <ol style="list-style-type: none"> 1. Partnership: working with each individual; commitment to Treaty of Waitangi and cultural sensitivity 2. Community Reinforcement Approach (CRA): evidence-based approach based on cognitive-behavioural principles; works with person in consideration of their social context; focus on community integration 3. Twelve-Step Recovery Journey: incorporates the twelve-step approach 4. The Salvation Army: Christian philosophy emphasises love and concern, spiritual dimension and practical help.²⁷ Includes Recovery Church – ongoing beyond residential treatment <p>Emphasis on group psycho-education supplemented by 1-1 AOD Case Work including individual treatment planning and support to achieve other social goals such as accommodation and employment</p> <p>Residential managed withdrawal (social) provided as part of programme as needed (includes step-down from medical-inpatient withdrawal management as required). This is provided by registered nursing staff. Residential managed withdrawal managed co-operatively by Hospital Detox and Centre support staff, alongside social detox managed by centre clinical and support staff.</p> <p>NB 1 additional managed withdrawal bed more intensive than social withdrawal but less intensive than inpatient; Salvation Army provide full time case worker and supportive environment, TDHB provide medical/nursing management</p>
Staffing	.2 FTE Registered Nurse; 2.8 FTE AOD Practitioners Support Workers 4pm – 8am daily and 24 hour weekends
Other health care	Full health assessment and access to health care professionals managed as part of the treatment
Whānau involvement	<p>Family/whānau and cultural inclusive practice embedded in treatment model</p> <p>Clients have the option to consent to whānau involvement which includes: Family/whānau visits Family group sessions Couples sessions Family education nights</p> <p>Clients are encouraged to utilise weekend leave to maintain whānau support</p> <p>Referral to more specialist service providers for restorative family assistance when requested.</p> <p>Work is being done to see how family/whānau can be supported better</p>

²⁷ Patterson et al, 2015

	<p>where distance is an issue</p> <p>“ You and your family in recovery” session provided regularly by Alcohol and Drug Family Advisor, Taranaki DHB</p>
Outcomes	<p>Patterson et al, 2015 conducted an extensive evaluation of the Bridge and concluded that the approach reflects evidence based and recommended best practice principles and compares favourably with other programmes</p> <p>As a result of the Otago research, work is currently being conducted to develop a set of validated outcomes measures for Bridge residential services</p> <p>Quality management via routine contract and surveillance auditing, internal auditing and review processes; consumer consultation ongoing</p>
Wait time	No wait time when this data gathered in February 2016
Utilisation	<p>Utilisation rate has varied over the past 12 months between 15-90%</p> <p>(This is across Programme and Managed withdrawal beds)</p>

Odyssey Auckland

Capacity	<p>Waikato DHB 6 beds</p> <p>Bay of Plenty DHB 2 beds</p> <p>Lakes DHB 1.5 beds</p> <p>Taranaki DHB 1 bed</p>
Duration	Tailored to the individual; generally longer term
Target pop	<p>3 programmes can be accessed by Midland service users:</p> <p><i>Adult residential</i>: people aged 20 – 65; includes a programme designed specifically for young adults (i.e. early 20s)</p> <p><i>Family centre</i>: for parents and their children</p> <p><i>Co-existing problems</i>: people with co-existing addiction and mental health problems</p>
Model of care	<p>TC model; 24/7 abstinence-based structured programmes in an AOD free environment; Odyssey kaupapa Māori framework includes learning opportunities in te reo Māori and cultural practices such as pepeha, tikanga Māori, basic knowledge karanga and whaikorero, kapa haka mahi raranga (weaving); Ngāti Whātua Orākei provides guidance and support</p> <p>No “pre-treatment” phase. Withdrawal management (all levels except inpatient medical) is provided; shared care with CADS Community and Home Managed Withdrawal Service as needed</p> <p>Strong focus on retention; Aftercare provided, including some supported accommodation</p>
Staffing	Clinical staff (nurses, addiction practitioners, social workers, psychologists) and peers (Odyssey graduates). Input from psychiatrists and medical doctors; Kaumātua and Kuia guidance
Other health care	Medical and psychiatric assessment and treatment is included
Whānau involvement	<p>Weekend visits and additional visits which are arranged as required</p> <p>Attendance at monthly community dinners</p> <p>Participation in treatment planning and case review sessions</p> <p>Participation in multi-family therapy sessions and education groups (on request)</p> <p>Participation and support for out-of-area families is facilitated in various ways including:</p> <ul style="list-style-type: none"> • SKYPE sessions to connect with families • Use of NTA (national travel assistance). For example, to cover the cost of accommodation for visiting families or cover the cost of sending a service user out of area to enable a family visit • Assisting families to find suitable accommodation while visiting • Accommodating visiting family in Odyssey residences where there are special circumstances that make this a preferred option eg, a medical condition • Flexibility to allow leave from the programme to be with family where needed as part of the therapeutic process or in response to a significant family event • Cultural team members travel with residents to significant family events or family meetings

Outcomes	<p>Utilises the ADOM (Alcohol and Drug Outcome Measurement tool) and Real Time Feedback</p> <p>Additional feedback processes are under development</p> <p>Quality management via routine contract and surveillance auditing, internal auditing and review processes; consumer consultation ongoing</p>
Wait time	Varies
Utilisation	<p>Utilisation for the period 1/07/2012 - 30/06/2015 is 66%</p> <p>NB. There are three groupings of clients from Midland:</p> <ol style="list-style-type: none"> 1. Those with CEP referred by Midland community AOD service providers. 2. Service users referred by Midland community AOD service providers. 3. Service users referred by Corrections. A significant number of people in this group have no connection with addiction services in their area i.e. they form part of the Midland utilisation statistics but they are initially not visible to the local addiction services. For this group Odyssey is the referrer to local services. This cohort can have high needs and reportedly it can be difficult to get local services to take them on.

Higher Ground

Capacity	6 beds Waikato DHB
Duration	18 weeks
Target pop	18 and older, severe AOD dependency, including co-existing problems
Model of care	TC model; 24/7 abstinence-based structured programmes in an AOD free environment; inclusive of 12-step recovery principles; range of evidence based therapies include cognitive-behavioural therapy, dialectical-behavioural therapy, motivational interviewing, moral reconnection therapy, trauma therapy, psycho-education and relapse prevention; Māori whānau group uses Māori symbolism and activities to build identity and support recovery (for both Māori and non-Māori service users); Focus on evidence-based talking therapies; excludes some medications; Continuing care includes groups and 1-1 counselling (Supported accommodation not included for Waikato service users; provided by local Alcohol and Drug Community Support Trust)
Staffing	Clinical staff (addiction practitioners, social workers, psychotherapists, nurse) and night supervisors who are often graduates of the programme
Other health care	Overall health care needs are managed throughout treatment; local GP supports programme; dentistry arranged; additional mental health care provided by local community mental health service
Whānau involvement	<p>Involvement and support of family and whānau members is an important component of the Higher Ground programme. Family includes all of those who are important to the resident and those who have a personal commitment to him/her. For each individual, 'family' is determined by the individual themselves.</p> <p>Higher Ground aims to:</p> <ol style="list-style-type: none"> 1 Engage the family and whānau in treatment to support the resident 2 Educate family and whānau members in relation to addiction and its impacts 3 Provide support and strategies to promote family whānau well-being. <p>The following principles of family inclusive practice underpin the Higher Ground approach:</p> <ol style="list-style-type: none"> 1 Families and whānau are part of the recovery process. Recovery can be enhanced when residents are not treated in isolation to the people who are significant in their lives 2 Every family and whānau is valued for their expertise 3 Supporting family and whānau members is part of our work; we provide direct support, and we assist family members to access support from other groups and services. <p>The Higher Ground programme is also underpinned by Te Whare Tapa Wha, a Māori model of health comprising four dimensions of well being; within this model Taha whānau is one of these four dimensions. This recognises the individual within their social system and focuses on the capacity to belong, to care and to share.</p> <p>Whānau participate at the individual admission interview (aprox. 50% attend from Waikato). Sometimes Waikato services support the whānau to attend. Higher Ground reports good relations with NGO and</p>

	<p>DHB services from Waikato.</p> <p>The following groups are provided:</p> <p><i>Whānau and Friends Introductory Education Group:</i> this includes three sessions for ‘family’ members from the time the person becomes resident at Higher Ground. The group provides education on the Therapeutic Community approach, addiction, family and addiction dynamics and communication. All participants are required to be alcohol or other drug free on the day of the meeting. Family members typically attend the Education Group before attending the Multi- Family Group. Family and whānau are invited to have dinner and have an option of an overnight stay</p> <p><i>Multi-family groups for up to 16 weeks.</i> The group integrates ‘family’ into the treatment process of the resident, providing family and the resident an opportunity to explore issues in a supportive environment. Group dynamics are used to make people feel safe, communicate that they are not alone in their feelings, help families in the healing process and explore the role of the family when the resident leaves Higher Ground. Staff ensure appropriate cultural protocols are observed. The size and composition of the group is monitored by staff to ensure manageability and optimum group functioning. Following each group the facilitator can be contacted by the family members.</p> <p>Up to two individual family counselling sessions per resident</p> <p>Service users’ children can visit and weekend stays are frequent (as part of treatment plan)</p> <p>Whānau are encouraged to use National Travel Assistance provisions as needed.</p> <p>It was reported that Family/ whānau from the Waikato often attend the groups though distance and night travel can be an issue. Sometimes, the family can stay with friends and at times they are accommodated at HG</p> <p>Family and whānau from Waikato more readily attend individual family therapy during the day</p>
Outcomes	<p>Formal outcomes monitoring programme (See King, 2014; Raymont, 2013) includes specific evaluation of Māori whānau group (see Waight, 2012). Findings support effectiveness of programme. Reports available at: http://www.higherground.org.nz/research/</p> <p>Utilises the ADOM (Alcohol and Drug Outcome Measurement tool) and range of other validated outcome measurement tools</p> <p>Quality management via routine contract and surveillance auditing, internal auditing and review processes</p>
Wait time	Can be lengthy due to high demand at the time of data gathering for this report 2.5 months (December 2015)
Utilisation	Utilisation rate from 1 July 2010 – 30 June 2015 is 94%.

Alcohol and Drug Community Support Trust Supported Accommodation

The Alcohol and Drug Community Support Trust is funded by Waikato DHB to provide nine supported accommodation AOD free beds for people who are pre or post residential treatment living in the Waikato DHB catchment area.

The Trust views the service as a recovery house. It is not a TC programme, but operates within guidelines and rules that are consistent with a TC model.

The referral pathway is mandated in the service contract; service users must have a referral from a community AOD clinician. The service user group is diverse socio-economically and there is a broad age range from 19 years and older.

There are three broad groups of service users that access the service:

1. Pre-treatment: stay for 3 – 6 weeks prior to treatment.
2. Post-treatment: stay for 1-month minimum; the focus is on transition back to the community e.g. housing, family, attending to any outstanding legal issues etc. When it becomes a matter of the support being accommodation only then the person is required to move on to independent living. Most stay 2 – 3 months. Previously people stayed for up to six months but increasing pressure on beds has led to shorter stays.
3. Respite: typically for people that have been through residential treatment several times and who do not need further residential treatment but do need some respite and support. This meets the need of a small group and is not commonly accessed.

The service is staffed for 40 hours per week Monday – Friday and four hours on Saturdays and Sundays (the Sunday staffing is self-funded by the Trust). Staffing includes a Director/clinician (.5 clinical and .5 management; dapaanz registered) and 1.1 non-clinical House coordinator (support worker). There is no on-site staffing overnight and for much of the weekend; staff are an on-call. There is a House Host (service user) who receives a small payment to act as a link to paid staff should there be issues to sort out when there are no staff members on duty.

Trust representatives note that there is risk associated with the low level of staffing cover and there is risk of closure of the service due to this. Service users are presenting with higher levels of risk e.g. serious physical health problems, psychological such as memory loss, Korsacoff syndrome and other conditions which require more intensive support. There is also a need for greater staffing resource to support greater levels of family engagement.

Lifewise Mental Health and Addictions Services Supported Accommodation

Lifewise is an NGO, based in Rotorua providing supported accommodation for adults with mental health and/or addiction issues. The service has a 12-bed capacity. There is provision for families and whānau to be accommodated.

Access is via a NASC assessment.

The focus is on housing first, ie, for people who need a place to live while they are addressing their mental health and addiction issues. Along with the accommodation Lifewise provides a recovery-focused programme, *Te Ara Ora, the Pathway to Wellness*. This programme includes supporting residents in their recovery including facilitating connection with whānau/families and their community.

Lifewise provides 24/7 support. There are 22 staff, of these 21 are support workers and 1 holds a clinical lead position.

Lifewise Support Workers work closely with the Lakes DHB Needs Assessment Coordination, Te Utuhina Manaakitanga Trust, Taupo AOD services and Te Ngako Mental Health Services.

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13.2 Appendix Two: Workforce Roles

Ministry of Health (2016) Draft SACAT Act- Service Specification

Role	Requirements	Summary of Responsibilities
Director of Addiction Services	Appointed by the Director-General of Health	Responsible for the general administration of the Act Designates Directors of Area Addiction Services
Director of Area Addiction Services (Area Director)	Appointed by the Director of Addiction Services	Responsible for administration of the Act in a geographical area Designates other officers and roles Provides oversight Receives initial applications Assigns key roles associated with an individual's care
District Inspector	Lawyer appointed by the Minister for a term of 3 years	Ensures patient rights are upheld; must visit treatment centre for purpose of inspection at least once during patient's period of detention and treatment and report to the Area Director within 14 days
Authorised Officer	Health professional designated by the Area Director. "The Area Director must be satisfied that the health professional has undergone appropriate training and has appropriate competence in dealing with persons who have severe substance addictions." (Clause 91).	Assists applicants to make the application (if required) If medical certificate cannot be obtained, must investigate and if satisfied that there are legal grounds for the application develop a memorandum to explain absence of certificate and support the application
Approved Specialist	A health professional who has significant experience in the treatment of severe substance addictions and is suitably qualified to conduct specialist assessments and reviews. Designated by Area Director	Assesses the person to ensure criteria and conditions for compulsory treatment are met Issues a Compulsory Treatment Certificate (CT Cert) effective immediately for a period of 7 days Notifies Area director of CT Cert
Responsible clinician	An Approved Specialist who is assigned to the patient by the Area Director Wherever practicable the person should not also be the Approved Specialist	Responsible for treatment planning and care co-ordination, including coordination of the administrative requirements set out in the Act Within 7 days of CT Cert being signed, must: <ul style="list-style-type: none"> • Develop a treatment plan • Arrange admission to a Treatment Centre • Apply to the Court for a review of compulsory status The Court issues the Compulsory Treatment Order
Approved Provider	Designated by the Director to detain and treat patients	Approved providers must be certified under the Health and Disability Services (Safety) Act 2001, to provide mental health services; they must have the capacity and resources to detain and treat patients in accordance with the Act in places that are suitable for that detention and treatment
Treatment Centre	A place, or part of a place, that is operated by an Approved Provider	Provides treatment for those subject to the Act "Intended to be a specialised residential alcohol and drug treatment centre or a medical detox facility (usually an inpatient hospital bed)"(The Ministry of Health <i>Regulatory Impact Statement</i> p11)

13.3 Appendix Three: Population Projections

Population projections prepared by Statistics NZ 2016

Northern Region		18+ population	
		2016/17	2019/20
		1,393,464	1,502,882
		NSW rate per 100,000	Estimated number for Northern Region
		2016/17	2019/20
Episodes referrals (not unique)	2.7	38	41
Referrals (unique)	2.24	31	34
Unique service users	1.44	20	22
Accepted	1.07	15	16

Midland Region		18+ Population	
		2016/17	2019/20
		670,850	696,565
		NSW rate per 100,000	Estimated number for Midland Region
		2016/17	2019/20
Episodes referrals (not unique)	2.7	18	19
Referrals (unique)	2.24	15	16
Unique service users	1.44	10	10
Accepted	1.07	7	7

- Population projections based on experience of NSW per 100,000 of the population.
- Projections for 2016/17 based on the following assumptions: 7
- Projections for 2019/20 based on the following assumptions: 7

13.4 Appendix Four: Proposed Funding Models by DHB

Bay of Plenty

Activity	Existing resource	Proposed new resource	UOM	Unit price	Total price	Comments
Area Director	Clinical Director					Current Clinical Director role
Authorised Officer	BOPAS/SORTED	.4 clinical FTE required	FTE	\$110,194	\$44,077.60	Addition to BOPAS/SORTED teams
Responsible Clinicians	Range of NGOs/BOPAS					Within current providers
SACAT Administration	in Provider Arm	.1 Administration/.1 data analyst required	FTE	\$81,200	\$16,240	BOPAS (as per MH Act admin)
Approved Specialists		1 FTE SMO	FTE	\$218,906.66	\$218,906.66	
Legal Advisory Services	Within DHB					In-house
SACAT flexifund			Programme		\$100,000	Flexifund used for transport/family/whānau engagement and the purchase of culturally appropriate pre & post accommodation options on a fee-for-service basis
Peer Support service	.25 FTE at Hanmer	1.75 FTE WBOP/.5 EBOP	FTE	\$81,200	\$182,700	
Family/whānau service		1 FTE for BOP	FTE	\$81,200	\$81,200	
Workforce Development						Regional and/or national
Managed Withdrawal service	1 medical detox bed	1 additional medical detox bed	Bed night	\$1,118.61	\$408,292.65	The funding level reflects the current model of care within our psychiatric inpatient unit (an open ward) which will require individualised staffing arrangements
Intensive residential treatment	Nil	Access to between 3 - 5.8 beds p.a.	Bed night	\$1,118.61	MIN = \$1,224,877 MAX = \$2,368,097	Initial estimates indicate that 19 BOPDHB clients will proceed to treatment annually. If all clients remain in treatment for the full 8 week + 8 week period, then this amounts to the equivalent of 5.8 beds p.a. If clients only remain for the first 8 weeks then the need decreases to access to 3 beds p.a. A higher bed rate is utilised to reflect the inclusion of around 20% of clients being referred due to methamphetamine use.
Continuing care - additional beds	4 beds WBOP/2 EBOP	BOPDHB based facility	Bed night	\$158	\$346,020	BOPDHB based facility for pre & post support/long-term supported accommodation and potential respite

Activity	Existing resource	Proposed new resource	UOM	Unit price	Total price	Comments
AOD Respite	2 beds		Bed night	\$125	\$91,250	May also be based in facility but kaupapa Maori options for EBOP maybe funded through fee-for-service
SACAT Data system development	PRIMHD	National data system to be developed				MOH
SACAT Implementation Evaluation		National SACAT Implementation Evaluation				MOH
TOTAL					\$1,488,686.91	

Lakes

Activity	Existing resource	Proposed new resource		Unit price	Total price	Comments
Referral management	Lakes DHB operates a SPOE with infrastructure to support referral intake and assessment co-ordination	0.2 FTE local Director	SMO	\$ 340,000.00	\$ 68,000.00	
		0.2 FTE administrator	Admin	\$ 60,000.00	\$ 12,000.00	
Assessment	As per above	2.0 FTE Authorised Officer	Nursing	\$ 124,000.00	\$ 248,000.00	
		0.4 FTE Responsible Clinician	SMO/NP	\$ 340,000.00	\$ 136,000.00	This role will also support local treatment options
Managed withdrawal	Medical withdrawal occurs in the medical unit of Rotorua Hospital. There is no transparency of process regarding access or surety that Medical Consultants see withdrawal management as core business. Each case needs to be individually negotiated and is often driven by medical crisis rather than best practice.	1 bed in medical unit	Bed day	\$ 830.00	\$ 302,950.00	Purchasing bed day capacity will ensure that the pathway for medical withdrawal is supported as business as usual. Two options for purchase exist 1) Fee for service arrangement (with ability to also purchase packages of care for specialising or 2) Capacity funding (which then precludes packages of care)
	It has been our experience that sometimes people can be challenging during withdrawal management and require specialising for periods of time.	Packages of care	Fexifund	\$8,160.00	\$40,800.00	Packages based on five care episodes with each needing specialising support of up to 240 hours at \$34.00 per hour. Not required if bed days in medical unit are capacity funded.
	Lakes DHB does not currently have community withdrawal options	2.0 FTE Clinician	Nursing	\$ 124,000.00	\$ 248,000.00	

Activity	Existing resource	Proposed new resource		Unit price	Total price	Comments
	Lakes DHB has a facility based service provider with potential capacity to offer community withdrawal within a supported accommodation setting. The current staff configuration does not allow for clinical cover in the afternoon shifts.	1.0 FTE Clinician	Nursing	\$ 124,000.00	\$ 124,000.00	Lakes DHB is negotiating with the NGO provider and the DHB Provider Arm to have the clinical FTE with this service delivered under partnership
Intensive residential treatment	No current service	1.2 beds	Bed day	\$ 1,118.00	\$ 489,684.00	Site to be determined
Transitional care and support	Lakes DHB has a Provider who currently operates a residential AoD program for the Midland Region. They have a new facility with potential to offer transition for the region. This would require a dedicated staff configuration.	2.0 FTE Clinician	Nursing	\$ 124,000.00	\$ 248,000.00	If transition were for the Lakes DHB only, additional FTE of 1.0 clinician and 2.0 Support Workers required
		4.0 FTE Support Workers	Non regulated	\$ 85,000.00	\$ 340,000.00	
	No capacity currently to provide follow up for those clients returning to their homes	1.0 FTE Clinician	Nursing	\$ 124,000.00	\$ 124,000.00	FTE would also provide interface between transitional placement and return to community where appropriate
		0.4 FTE Clinician	SMO	\$ 340,000.00	\$ 136,000.00	If regional transition service were delivered this resource would need to be 0.8 FTE
	Lakes DHB has an 0.5 FTE Consumer Advisor role and 0.5 FTE Family Advisor role based with an NGO provider. The service also consists of 3 FTE peer navigators.	2.0 FTE Peer Support	Non regulated	\$ 85,000.00	\$ 170,000.00	1.5 FTE to provide peer support/navigation services and 0.5 FTE peer leadership
Supported accommodation	Lakes DHB has a Provider who currently operates a facility based service for people experiencing AoD issues. 3 beds could be immediately converted to deliver longer term supported accommodation for this client cohort.	2.0 FTE Support Workers	Non regulated	\$ 85,000.00	\$ 170,000.00	This resource would enable delivery of day activity program and other activity that supports community participation
		1.0 FTE Clinician	Nursing	\$ 124,000.00	\$ 124,000.00	Supports more robust roster than current
Workforce development	It is intended that Lakes DHB participate in training via a regional approach co-ordinated by the Midland Regional MH&A Network	Fixed funding - Lakes DHB share 11% of PBFF			\$ 11,000.00	
Total					\$ 2,992,434.00	

Taranaki

Activity	Existing Resource	Proposed new resource	UOM	Unit price	Total price	Comments
Referral management	Covered by 7.0 Counsellors and 1.0 RN FTE and some SMO time. Includes Administrator input	0.3 FTE local Director	SMO	\$ 340,000.00	\$ 102,000.00	
		0.3 FTE administrator	Admin	\$ 60,000.00	\$ 18,000.00	
Assessment	As above	2.4 FTE Authorised Officer	Nursing	\$ 124,000.00	\$ 297,600.00	
		0.5 FTE Responsible Clinician	SMO/NP	\$ 340,000.00	\$ 136,000.00	This role will also support local treatment options
Managed withdrawal	Managed by hospital ward by negotiation - no surety. Currently no provision for specialising or packages of care 0.5 FTE RN. 1 Managed withdrawal detox bed with salvation army managed by 0.5 FTE RN	1 bed in medical unit	Bed day	\$ 830.00	\$ 302,950.00	Purchasing bed day capacity will ensure that the pathway for medical withdrawal is supported as business as usual. Two options for purchase exist 1) Fee for service arrangement (with ability to also purchase packages of care for specialising or 2) Capacity funding (which then precludes packages of care)
		Packages of care	Flexifund	\$ 8,160.00	\$ 40,800.00	This will support detox and specialising in the ward where needed
		2.0 FTE Clinician	Nursing	\$ 124,000.00	\$ 248,000.00	Additional supports in the home
Intensive residential treatment	Should be regional	1.3 bed	Bed day	\$ 1,118.00	\$ 530,491.00	Assumption this is regional and we require 1 bed
Transitional care and support	Sent out of region - no formal transition in place may be picked up by key worker - re-presents to AOD services. No residential beds currently in place for transitioning back. AOD services do not currently have peer support workers.	1.0 FTE Clinician	Nursing	\$ 124,000.00	\$ 124,000.00	If transition for clients back to the region additional FTE of 1.0 clinician 2.0 Support Workers and 0.4 SMO and 1.0 Peers support worker.
		2.0 FTE Support Workers	Non regulated	\$ 85,000.00	\$ 170,000.00	
		0.4 FTE Clinician	SMO	\$ 340,000.00	\$ 136,000.00	
		1.0 FTE Peer Support	Non regulated	\$ 85,000.00	\$ 85,000.00	1.5 FTE to provide peer support/navigation services and 0.5 FTE peer leadership
Supported accommodation	Salvation Army - 4 meth residential, 1 meth social detox, 1 AOD residential, and 1 managed withdrawal.	2.0 FTE Support Workers	Non regulated	\$ 85,000.00	\$ 170,000.00	This resource would enable delivery of day activity program and other activity that supports community participation
		1.0 FTE Clinician	Nursing	\$ 124,000.00	\$ 124,000.00	Supports more robust roster than current
		3 bed	Nursing	\$ 84,000.00	\$ 252,000.00	Requirement for 'home for life' beds

Activity	Existing Resource	Proposed new resource	UOM	Unit price	Total price	Comments
Workforce development	Participation in training via regional approach co-ordinated by the Midland Regional MH&A Network	Fixed funding - Lakes DHB share 13% of PBFF			\$ 12,000.00	
Project Management		1.0 FTE Project Manager for 6 months		\$ 120,000.00	\$ 60,000.00	Implementation would require 6 months of 1.0 FTE project manager.
Total					\$ 2,808,841.00	

Waikato

Activity	Existing resource	Proposed new resource	UOM	Unit price	Total price	Comments
Area Director	Senior Medical/clinician	1 FTE	FTE	\$140,000	\$140,000	
Authorised Officer	Senior Clinicians / ITLOs	2 clinical FTE required	FTE	\$108,000	\$216,000	
Responsible Clinicians	Senior Clinicians	2 clinical FTE required	FTE	\$108,000	\$216,000	
SACAT Administration	Administration/non-clinical	1 FTE	FTE	\$84,000	\$84,000	
Approved Specialists	Senior Medical/GP	1 FTE	FTE	\$140,000	\$140,000	
Approved Specialists (POC)	Senior Medical/GP	200	POC	\$240	\$48,000	
Legal Advisory Services	Lawyer	300	Programme	\$240	\$72,000	
SACAT flexifund						Included in Package of care funding
Peer Support service	Non-clinical;	1 FTE	FTE	\$75,000	\$75,000	
Family/whānau service	Non-clinical;	1 FTE	FTE	\$75,000	\$75,000	
Assertive Outreach Search / Support Hours service (Clinical / Social Work	Social Work/ Clinical	1FTE	FTE	\$54,000	\$54,000	
Culturally competent workforce	Workforce Development					This is a requirement of any staff working in the sector.
Workforce Development	Medical, Clinical and Non-clinical					Assumed to be nationally developed and implemented prior to go-live
Managed Withdrawal service	Medical and Social Detox	220	Bed day	\$888	\$195,360	

Activity	Existing resource	Proposed new resource	UOM	Unit price	Total price	Comments
Establishment fund for new builds etc	Facility etc					Note - capital contributions for new build to be calculated based on the additional inpatient capacity for approx 2 additional available medical detox beds
SACAT Managed Withdrawal (Treatment) Service	MDT approach	1012	Bed day	\$317	\$320,804	Estimate based on an average of 46 bed nights per person (10in detox) . This is average reflecting that some clients may have 2 periods of 56 days
Continuing care - additional beds	MDT approach					Included above
Continuing care - harm reduction options for treatment; maintenance	MDT approach	1012	Hours	\$150	\$151,800	Assumption of increased demand (flow through of additional referrals post the compulsory phase)
Respite Care Service - for people who have moved to voluntary	MDT approach	70	Bed day	\$120	\$8,400	
SACAT Data system development	Data System	1	Programme	\$25,000	\$25,000	
SACAT Implementation Evaluation	Research and Evidence	1	Programme	\$100,000	\$100,000	Evaluation and quality improvement (1 off)
TOTAL					\$1,921,364	

13.5 Appendix Five: Action Plan

Implementation of the SAL requirements will occur in two phases.

Phase one will commence in 21st February 2018 and will include the establishment of a national intensive residential treatment service. All other service components will be developed locally at DHB level. Workforce education and development will be provided regionally.

Phase two will see the devolution of the national service (intensive residential service) to the regions in five years time.

13.6 Appendix Six: SAL Flow Chart

