

Addiction treatment is everybody's business

Where to from here?



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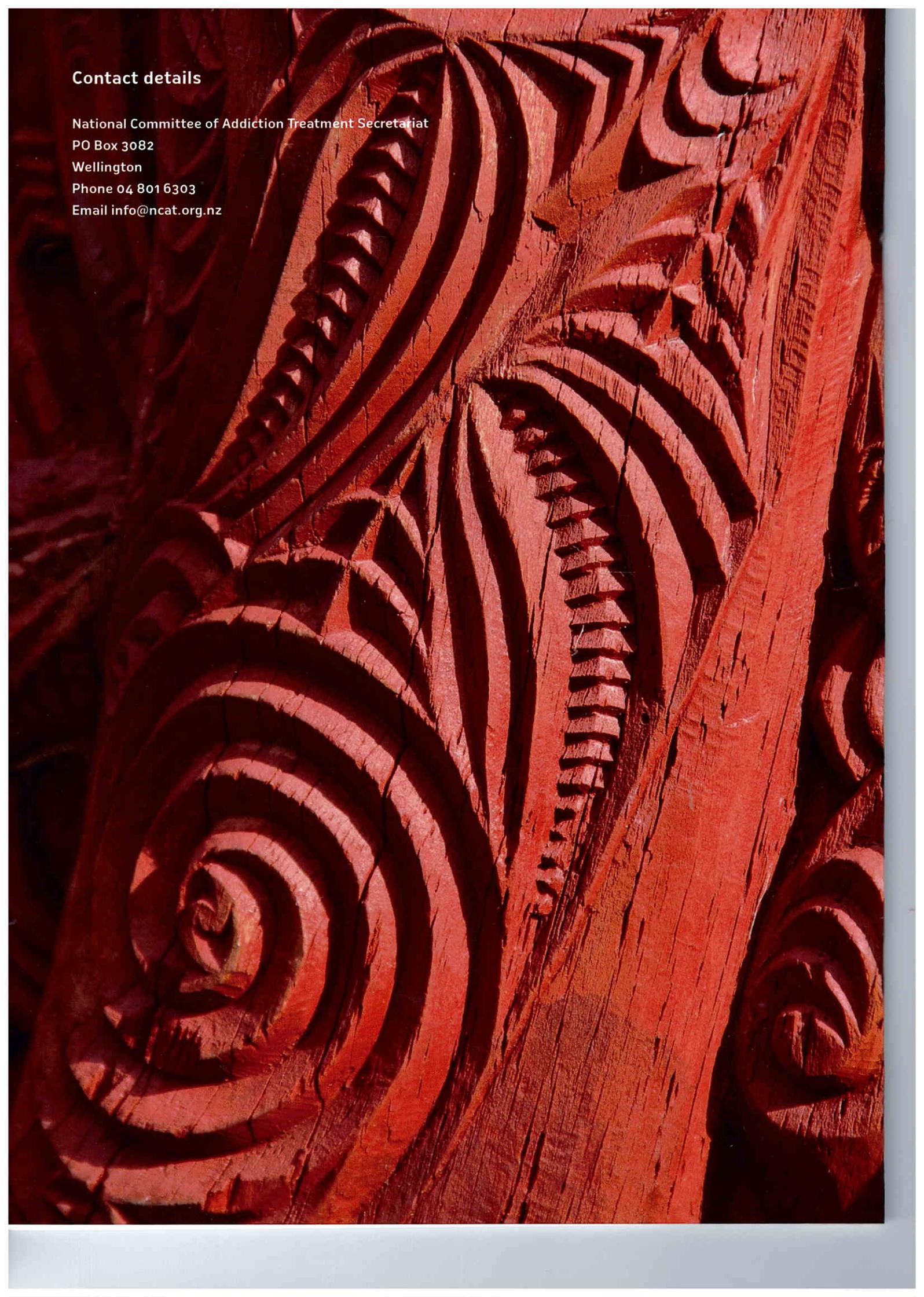
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Alcohol and drug addiction affects everybody in some way. That means addiction treatment is everybody's business. New Zealand's health needs are rapidly increasing and this increase will result in significant changes in the coming decade, including the way we will need to deliver alcohol and drug treatment. This paper outlines the challenges that will be faced by the government, the treatment sector and the people of New Zealand, and what will need to be done to meet those challenges.

Introduction

Alcohol and other drug abuse is the sixth highest contributor to the burden of disease in New Zealand. The World Health Organization says alcohol abuse reduces the health of populations and contributes hugely to avoidable health costs.

Addiction treatment services significantly reduce the burden caused by alcohol and drug use. In 2010/11, services funded by District Health Boards (DHBs) treated approximately 34,000 New Zealanders for addiction related issues, up from around 22,000 in 2002/03. This includes services provided by non-government organisations (NGOs) and a sizeable contribution is also made by workers in departments of Health, Corrections and Social Services, and by volunteers. Approximately 1200 people are employed in the addiction treatment sector.

Driven largely by the Mental Health Commission's 1998 *Blueprint for Mental Health Services in New Zealand*, our annual budget for alcohol and other drug (AOD) services has increased over time. The government currently invests \$1.12b per annum in mental health and addiction services.

The *Blueprint* was the Mental Health Commission's service development plan for meeting the objectives of the government's mental health strategy which sought to develop services to meet the needs of the 3.0 percent of the population severely affected by mental illness, including addiction.

Funding for the *Blueprint* has remained largely unchanged since 2002/03. Over this time, however, the rate of people accessing treatment has risen from 2.2 percent of the population in 2002/03 to 2.8 percent in 2010/11. Fourteen out of 20 DHBs have an access rate of 3.0 percent.

The *Blueprint's* 3 percent access target was based on international epidemiological studies of the prevalence of severe mental health disorders in a population. However, the 2006 *New Zealand Mental Health Survey* found a prevalence rate of 4.7 percent of people with significant mental health disorders, including addictions.

"Addiction treatment services receive just 10.0 percent of total mental health funding yet, in 2005/06, 20.0 percent of all patients treated by the mental health and addiction sectors were treated by addiction services."

The Mental Health Commission's report, *National Indicators 2011, Measuring mental health and addiction in New Zealand*, says the unmet need for help with addiction is significant. Around 50,000 people (1.9 percent of the population aged 16–64 years) want help to reduce their alcohol or drug use every year but do not receive it.

This strongly indicates the need to review the *Blueprint* and to continue some form of mental health and addictions ring-fence to improve access to services. Importantly, the relative funding balance must be addressed. Addiction treatment services receive just 10.0 percent of total mental health funding, yet in 2005/06, 20.0 percent of all patients treated by the mental health and addiction sectors were treated by addiction services.

Increased demand without additional investment

The government's policy documents, *Te Tahuu-Improving Mental Health 2005-2015: The Second New Zealand Mental Health and Addiction Plan*, and *Te Kokiri: The Mental Health and Addiction Action Plan 2006-2015*, provide the policy framework for the development of the addiction treatment

sector. *The Mental Health and Addiction Action Plan 2010* prioritises some Ministry of Health-led activities over the forthcoming period.

This Plan has four prioritised actions:

- moving health resources to increase access to mental health and addiction services and improve health outcomes
- lifting system performance to enhance our communities' mental health and well-being
- tackling alcohol and other drug-related harm
- integrating efforts across government for better mental health outcomes.

In addition, DHBs are required to develop three year strategic plans and District Annual Plans outlining their intentions for the development of mental health and addiction services.

Other government departments have increasingly developed policies and objectives that have raised demand for addiction treatment services, in particular the Justice sector but there has been little agreement between Health and Corrections about how this additional inflow will be resourced.

"...government departments have increasingly developed policies and objectives that have raised demand for addiction treatment services... However, there has been no additional investment in these services..."

The Welfare Working Group suggests that, in the immediate future, the addiction sector will have to contribute more towards reducing long-term welfare dependency.

A significant percentage of DHB funding increases over the years has been absorbed into increased operating costs and has not automatically resulted in increased resources or client volumes.

Key facts and figures

150,000 people needing treatment (3.5% of population)

34,000 people treated by DHB-funded sources in 2010/11

\$120m/year - health budget for alcohol and drug treatment

3.0% - projection of population with mental health disorders (including addictions) targeted in government strategy

4.7% - actual percentage of population with significant mental health disorders

10.0% - proportion of mental health funding allocated to addiction treatment

20.0% - actual percentage of mental health patients treated by addiction services

Six challenges

Growing demand sets at least six challenges for the addiction sector in the immediate future.

Challenge one: supply and demand

The mental health and addiction sector is unlikely to experience the same ongoing boost in Blueprint driven funding that it did over the last decade. The Mental Health Commission is developing a new Blueprint. Whatever shape this takes, it must in some way ring-fence funding for mental health and addiction treatment services. It is also important to realise the original Blueprint was intended as a service plan only for people most severely affected. It is essential that any future mechanism also takes into account those with mild, moderate and severe issues to ensure a whole-system approach to addiction treatment.

Health Workforce New Zealand (HWNZ) estimates that, by 2020, the demand for health services, including mental health and addiction services, will have doubled while funding will increase by only 30.0 to 40.0 percent. In addition, the government has clear expectations that service quality will be maintained while access to addiction services significantly increases.

“Health Workforce New Zealand estimates that, by 2020, the demand for health services, including mental health and addiction services, will have doubled while funding will increase by only 30.0 - 40.0 percent.”

Challenge two: political challenges

The government will recognise that the sector has changed markedly since 2002/03 when the methodology for Blueprint funding was last examined. This could result in a significant redefining of the *Blueprint* as DHBs are pressured to deliver on budget and will consequently have to prioritise expenditure. This may negatively impact addiction funding.

Challenge three: high perception of need

Addiction treatment issues have experienced increased political and public focus over recent years: e.g. the Law Commission’s review of the Sale of Liquor Act and the Misuse of Drugs Act, the Ministry of Health’s review of the Alcoholism and Drug Addiction Act, and the Prime Ministerial Policy Advisory Group’s strategy for tackling methamphetamine. This new focus, which includes heightened media coverage, means there are now higher expectations on the sector to deliver high-quality services despite a constrained fiscal environment.

Challenge four: centralisation

DHBs face increasing pressure to work within a policy framework of regional service delivery and will become much less ‘service’ and more ‘outcomes’ driven. The Ministry of Health’s Service Development Plan will guide DHBs in the planning, funding and provision of addiction services by setting out key service principles, priorities and directions.

It will build on previous documents: the Mental Health Commission’s *Blueprint for Mental Health Services* (November 1998); *Te Tahuhu* (2005); *Te Kokiri* (2006); and the *Mental Health and Addiction Action Plan* (2010). In this way it will better match population needs with current government priorities. This will move the momentum of service development from local services to regionally and

centrally driven approaches. Without a clear framework, the addiction sector is at risk of being pulled in different directions as DHBs struggle with financial constraints and government departments seek increased treatment capacity.

Challenge five: primary health focus

“Better, Sooner, More Convenient” and the Primary Health Strategy put greater emphasis on health interventions in primary care and in other settings, such as Work and Income. Frontline health and social service workers are expected to undertake early and brief interventions to more quickly identify people needing help. While there is promising evidence for the success of this approach, concerns remain about whether those at the frontline are sufficiently skilled to do this.

Challenge six: integration

It is an emerging priority for the government to offer a ‘whole of government’ approach. Unmet mental health and addiction needs are the single largest contributor to poor health and social outcomes at the client, family, whānau and population levels. If the government aims to reduce the burgeoning Corrections and Welfare budgets, an increased role will be expected from the addiction sector. This will require new interfaces with organisations including: the Ministry of Social Development; Corrections; Police; ACC; Courts; Probation; Education; Child, Youth and Family services (CYF); and primary care organisations.

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

These may include new funding and reporting arrangements and will pose challenges to existing clinical pathways into treatment. But they may also include new service configurations as the focus of future policy objectives moves away from current service delivery models. Greater integration between the addiction services sector and Corrections, Welfare and primary care organisations may need to be considered.

Challenges to the sector

1. Increased demand for services without increased funding
2. Future funding uncertain
3. Higher expectations upon the sector
4. Pressure to focus on regional targets instead of on core services
5. Sustained contribution from primary health care uncertain
6. Integration between services must be significantly improved

How wicked is the problem?

Serious alcohol and drug misuse and addictions affect 3.5 percent of the total population or around 150,000 New Zealanders. For youth aged from 16 to 25 years this figure rises to 9.6 percent. While substance related disorders are easy to diagnose and amenable to treatment, access to treatment has remained low and has not been sufficiently focused on those with less severe conditions.

The New Zealand Mental Health Survey (2006) identified that many people delayed seeking help for their mental health and addiction problems, or did not seek help at all. The most common reasons for delay were:

- "I wanted to handle the problem on my own" (79.3%)
- "I thought the problem would get better by itself" (63.2%)
- "The problem didn't bother me very much at first" (48.9%)

This suggests a key message needed from the sector is that sufferers should seek help early, and that advice on how to access help must be immediate. Addiction services must be accessible the moment someone is motivated to seek information or help, or an opportunity is lost. ALAC estimates 29.0 percent of the adult population regularly consumes alcohol at levels which result in significant harm to individuals and their families. Much of New Zealand's family violence and drink-driving is linked to binge drinking.

Half a percent of New Zealanders meet the diagnostic criteria for cannabis dependence and methamphetamines

are used by 2.5 percent of the adult population each year. For 18 to 24-year-olds, this rises to 8.7 percent. While overall availability of methamphetamine has been reduced in the community, a 'hard core' of users seems entrenched in this destructive cycle of addiction.

Around 1.0 percent of the adult population will misuse opiates each year and the addiction sector has anecdotal evidence that the misuse of prescription medicine is rising. It is estimated just half of the New Zealanders dependent on opioids are receiving opioid substitution treatment.

New Zealand needle-exchange programmes distribute 2,000,000 syringes annually; 0.8 percent of New Zealanders report they have injected drugs. While effective public health initiatives have prevented the spread of HIV, hepatitis C is endemic amongst intravenous drug users.

In summary: 150,000 New Zealanders have addiction problems; just 34,000 receive some form of treatment.

Addiction problems impact on individuals, whānau, friends, employers, colleagues and communities. It is estimated that at least four others are negatively affected by one person's problems with alcohol or other drugs. By extension, treatment can positively improve life for those same individuals.

A majority of people caught up in the criminal justice system has problems with alcohol and other drugs, and offending is often linked to alcohol and drug use. The lifetime prevalence for alcohol abuse or dependence for prison inmates is around 76.0 percent, for cannabis 55.0 percent, and for other drugs 40.0 percent.

The Law Commission's issues paper on the reform of New Zealand's liquor laws and its review of the Misuse of Drugs Act identify that the misuse of alcohol and drugs impacts negatively on health, education, police, courts, prison and welfare expenditure through illness, accidents, lost productivity, violence, poor educational performance, arrests and convictions. Cost estimates run into the billions of dollars.

Māori and Pacific people are significantly impacted by alcohol and drug abuse and low socio-economic communities generally experience higher levels of alcohol and drug related problems.

Brief historical overview of the addiction sector

Concerns in New Zealand about the use of alcohol and drugs go back to Victorian society when alcohol and drug abuse was defined as a social problem, or the result of a lack of willpower. Churches and the temperance movement advocated for removing alcohol from society entirely, or at least restricting its availability.

For example, until the 1950s, Māori people were unable to purchase alcohol in the King Country and only Chinese people were allowed to visit Auckland's opium dens. Treatment for end-stage alcohol dependence or drug addiction was, without exception, through long-term institutionalised care (including facilities operated on remote islands) run by the state or NGOs such as the Salvation Army.

In the 1950s Alcoholics Anonymous (AA) became established as structured community-based support for people wanting to overcome alcohol addiction. It was based on a 'disease model' in contrast to the previous period which defined addiction from a social and moral perspective. From this model gradually developed a semi-professional approach to addiction.

Early workers were often volunteers who largely practised on the basis of their own life experiences. Their interventions came from concepts in AA's Big Book. From the 1970s onwards, they were gradually organised into multiple small, semi-professional NGOs, usually with a local focus. They were often under-resourced, operating in relative isolation from the Health, Welfare and Justice sectors.

AA's influence on applied treatment models meant recovery from alcoholism and addiction became more broadly defined, though it did not yet embrace pharmaceuticals or pharmacotherapy. Objectives included abstinence, developing a meaningful existence, a pro-social belief system, honesty, critical self-analysis and helping others.

Until the 1980s, addiction treatment was mainly abstinence based, and was provided by NGOs and a few (mental) hospital clinics. It was delivered by staff without specialist qualifications, and sometimes with few qualifications at all, working mainly on the basis of their own experience. Throughout the 1980s the sector became more professional and Māori began advocating

for culturally specific interventions. As a result of the HIV epidemic, the sector learned that the harm reduction approach was a very necessary addition to its options of care.

From the late 1990s, the sector was driven by the Mental Health Commission's Blueprint which sought to develop and expand addiction services. The sector became more aligned with secondary and tertiary health, while many Māori redefined their services as part of the renaissance of their cultural identity. The sector's links with law enforcement, primary care, education, social services, community development and public health remained underdeveloped.

Over time, the addiction sector has become more professional through the development of the Addiction Practitioner's Association Aotearoa New Zealand (DAPAANZ) with its own code of ethics and competencies framework.

By the end of the first decade of the 21st century, the sector has been challenged to reconsider its direction under pressure from: increasing referrals from Corrections; integration between DHB community alcohol and drug services and community mental health centres; Whānau Ora initiatives; the increased role of the primary care sector in health services delivery; welfare reform; and a re-emerging public health perspective.

The addiction sector as a service delivery system

Internationally, addiction services delivery systems have major design differences. In some countries the mental health sector plays the major role (Ireland), while in others it is the social services sector (Sweden), probation services (Netherlands), primary care (France), self-help (Iran), law enforcement (China), or specialised residential care for chronic AOD dependency (Russia).

People with addictions have a proud history of creating self-help recovery organisations that are self-sustaining. Self-help initiatives will continue to make a significant contribution towards population health. By definition, self-help is empowering for participants; it is also free of charge. Professional service delivery systems need to maintain close links with the self-help movement to maximise gains.

The current delivery of addiction services in New Zealand is driven by historical arrangements. In an environment of resource constraint, questions arise over the allocation of resources and the best mix of services for managing alcohol and drug disorders and maximising the positive impact on population health.

Access

For patients, there are multiple access points into the treatment system, each with unique admission criteria and treatment processes. Unfortunately, many people are required to go through multiple assessments before finding the assistance they need.

“To provide the maximum benefit to society, addiction services delivery systems must become more efficiently organised with agreed case mix targets, equitable access, and efficient and effective programme design.”

To provide the maximum benefit to society, therefore, addiction services delivery systems must become more efficiently organised with agreed case mix targets, equitable access, and efficient and effective programme design. This is a complex task that needs to be achieved

within constrained budgets and within the capacity of the current workforce (at least in the short term).

Towards a more ‘effective’ system

The term ‘effective’ refers to the impact services have in a standard clinical or community setting.

In a population health approach it is the total impact of addiction and substance abuse on life course and consequences that counts.

However, many elements of the health sector consider only the immediate problem for which help is being sought, and from their own provider perspective alone. This is a major cause of fragmented service delivery and it is a major challenge to achieve integration across the addiction sector itself, and with other sectors (primary care, Corrections, Welfare and Education) to maximise the effect on population health.

Effective services are expected to provide interventions that range across the spectrum, including abstinence, harm reduction and relapse prevention, while addressing addiction related problems such as marginalisation, poor mental health, family violence, welfare dependency, criminal behaviour, and educational underachievement. These outcomes cannot depend on addiction service interventions alone; they can be achieved only within a partnership framework that includes the Welfare, primary care, Education and Corrections sectors.

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

When applied to how services are delivered to a population, ‘effective’ includes the impact on patients, as well as on their family and whānau and on local communities. An effective addiction treatment sector will have a cumulative impact on a range of population health indicators including health, disability, welfare dependence, crime, family violence and education.

In order to deliver effective services, it is essential that client pathways are integrated between the addiction sector and the Justice and Welfare sectors in particular, so service delivery is equitable and efficient.

For example, research shows the delivery of effective interventions to recidivist drink-drivers requires routine alcohol and drug testing, shared treatment objectives between the sectors and swift intervention from the court if participants fail to adhere to agreed treatment plans. This requires the collaboration of frontline staff, their managers, their funders and their policy-makers. This is important, because to make any impact at a population level, the volumes of referrals to the addiction services will need to be large.

Optimising the structure of the sector to broaden the impact of treating substance disorders over multiple expected outcomes provides a significant challenge because many health services have developed in isolated response to historical and local trends and needs.

Funding the sector

Financial incentives and contracting practices play major roles in how health service systems are developed and maintained. The broadening of the addiction sector's role into New Zealand's health, justice, welfare and education policies has put significant pressure on funding mechanisms. Traditional health funders may find new objectives such as sector integration inconsistent with their own objectives, while other sectors expect 'Health' to pick up new funding responsibilities.

This trend was compounded by the 1998 Blueprint which suggested addiction service estimates per 100,000 population specifically exclude populations being targeted by current government policy (Justice, Social Welfare, primary care and institutionalised patients). Underinvestment in the sector consequently became institutionalised.

Increasingly, it will become less important who it is that holds the budget for addiction services (Justice, Health or Welfare) as long as they are able to coordinate population-based health objectives effectively across all stakeholders. In the current uncoordinated funding environment, services are under pressure just to survive.

Addiction services in many regions attempt to fix funding problems locally, developing solutions that depend on a few individuals negotiating local arrangements which have no impact on overall contracting and funding settings. When these individuals move on, such informal arrangements tend to disintegrate.

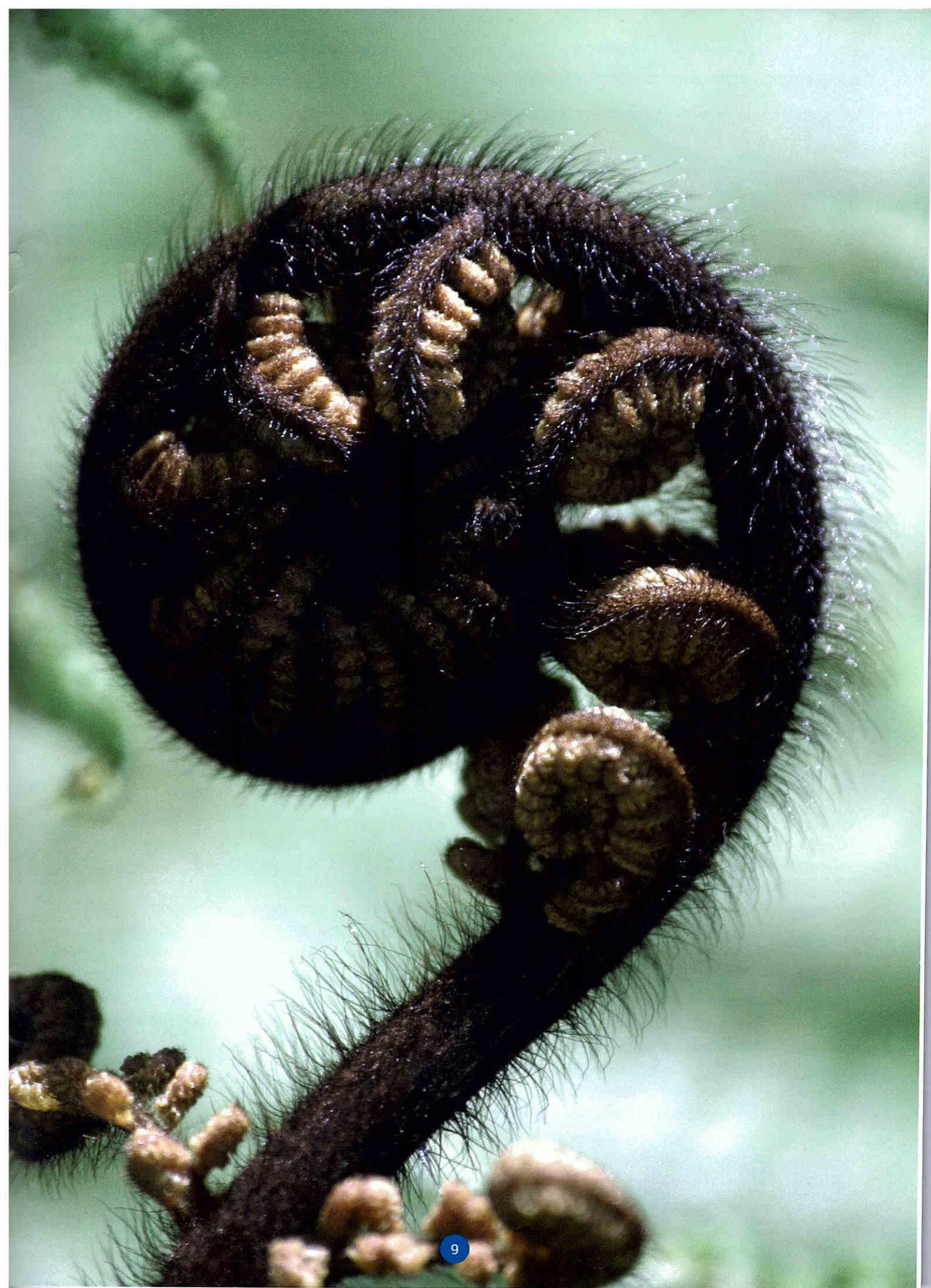
Ultimately, under pressure, services redefine their case mixes and interventions to what they believe they can deliver, rather than as part of a well-coordinated service infrastructure system that is able to make gains at a population health level.

Our current and future addiction workforce

The addiction workforce in New Zealand is heterogeneous and comprises a range of different disciplines working in a variety of roles and settings. The development of a specialist skilled workforce is therefore essential for the provision of accessible and effective addiction services.

- **Specialist practitioners** who work in specialist addiction services or in addiction programmes within non-addiction-focused organisations. The 2008 National Telephone Survey indicated the specialist addiction workforce was made up of counsellors (58.0 percent), nurses (15.0 percent), social workers (16.0 percent), psychologists (2.0 percent) and medical practitioners (2.0 percent).
- **Generalist workers** who are professionals in other areas of health such as primary care and mental health, or from the Corrections, Education or Social Services sectors. They are required to intervene, helping people deal with the consequences of their addiction-related behaviours and provide screening, brief interventions, lifestyle advice and referral to specialist services.

There has been significant growth in the professionalism of the specialist workforce over the last 15 years with the establishment of the Addiction Practitioners' Association Aotearoa New Zealand (DAPAANZ) and the increase in numbers of staff gaining postgraduate addiction qualifications.



“There has been significant growth in the professionalism of the specialist workforce over the last 15 years...”

In the future, more people with addiction problems will be managed in primary care and other allied health and community settings. This shift will mean the specialist workforce will require the development of new roles to provide expertise to the generalist workforce.

Addiction specialty clinical skills and knowledge remain essential. Working within a specialist addiction service will provide the necessary training for an in-depth understanding of the various addiction service user sub-populations and a unique opportunity for skill development. Within allied services such as mental health, Corrections or Social Welfare alone, an addiction worker will not have the opportunity to develop the minimum skill base and understanding to be effective.

The workforce needs to reflect local communities in order to be effective and the need to train more Māori, Pacific and Asian people into the addiction workforce is substantial. As the average age of the current workforce is over 50, recruitment of young people with a commitment to the sector is essential.

There is a solution!

New Zealand’s National Drug Policy 2007-2012 supports reducing the harms caused by alcohol and other drugs based on three strategies:

- supply control
- demand reduction
- problem limitation.

Supply control seeks to reduce the availability of alcohol and drugs through regulations and restrictions. Laws governing the availability of alcohol and drugs in the community are currently under review. Targeted public health interventions, such as increasing the price of alcohol and reducing marketing, have a substantial impact on alcohol related harm.

Demand reduction involves a wide range of activities to prevent or delay the uptake of alcohol and drugs at a young age, and creates awareness of the risks involved. These activities are typically delivered through educational programmes, local community action (e.g. CAYADs) and media campaigns (ALAC).

Problem limitation seeks to reduce the harms resulting from alcohol and drug use through treatment and public health initiatives.

“The National Committee for Addiction Treatment wants a significant increase in the addiction sector’s capacity to treat people with moderate to severe AOD disorders through smarter and better coordinated investment.”

The National Committee for Addiction Treatment (NCAT) wants a significant increase in the addiction sector’s capacity to treat people with moderate to severe AOD disorders through smarter and better coordinated investment.

There is opportunity for the sector to work towards a more coordinated approach to delivery.

At a service level this may come via a shift from individual treatment towards group based interventions, internet and telephone interventions, greater focus on client engagement, better alignment with the self-help movement and peer support initiatives, a treatment system based on stepped care with easier access and the development of family-inclusive interventions.

Family and whānau involvement is key to making services more effective, and strong family and whānau connections are important predictors of recovery.

New laws have created greater opportunities for offenders to receive diversion from the criminal justice system and to enter treatment. There is robust evidence for the effectiveness of treatment as an alternative to punishment.

New Zealanders are concerned about the ‘hard core’ of recidivist drink-drivers. The provision of rehabilitation

programmes integrated with the legal system will address reckless behaviour and make our communities safer.

“There is robust evidence for the effectiveness of treatment as an alternative to punishment.”

General practitioners and emergency departments treat many people as a consequence of their alcohol and drug use. The sector is committed to working with doctors and nurses to increase opportunities for interventions in primary practice and emergency care. Such interventions, delivered as part of medical care, take little time and, when repeated at each entry point in the Health, Corrections and Welfare systems, can be highly effective for those with mild to moderate problems. They also make a significant impact at a population health level.

The group aged from 18 to 29 years has the highest rates of alcohol and drug related mortality as a proportion of all mortality, the highest rate of hospital presentations for alcohol and drug related injuries, and the highest rate of offending after consuming alcohol. A survey of midwives found that 82.0 percent of pregnant teenagers drank alcohol during pregnancy. To address the problems associated with young people’s use of alcohol and drugs, the sector is developing ways of working with local communities, hospitals and secondary schools.

“Māori are approximately twice as likely to experience problems with alcohol and drugs.”

The development of local specialist addiction services that can engage, treat and support young people with moderate to severe problems as a result of alcohol and drug use, and their families, is a priority. The scientific evidence is compelling that unaddressed substance disorders in early years will have profound negative effects in later life. Addressing the high incidence of these disorders in adolescence and early adulthood is an opportunity to avoid developing long-term, deeply entrenched addictions. The strengthening of interventions for this target group is clinically and economically effective over long and short time frames.

Māori are approximately twice as likely to experience problems with alcohol and drugs. Effective treatment services need to engage local Māori communities and interventions need to be delivered by people from these communities who have an understanding of Tikanga and Te Reo as much as possible.

Similarly, Pacific and Asian communities require services where staff members can communicate in the appropriate languages and understand cultural values.

Many of these communities are poor and have a low deprivation index. The sector is committed to reducing disadvantage and promoting equality in opportunity by providing targeted addiction services in low socio-economic communities. This includes supporting people exiting long-term welfare dependence.

Given the size of the alcohol and drug problems in New Zealand and funding constraints, a robust public health initiative remains essential to reduce harm.

Key priorities to improve access to addiction services

The priorities for the addiction sector to improve access to treatment are targeted at five broad initiatives.

Priority one: improve access to current addiction services

Addiction treatment is delivered through residential and community-based services. The Ministry of Health’s *National Service Framework for Addiction Service Specifications* provides the overarching expectations for all specialist mental health and addiction services. It includes a Tier 2 service specification and fourteen Tier 3 service specifications. The Tier 2 service specification describes the overall addiction-service standard, while Tier 3 provides additional service-specific detail.

Currently, NCAT estimates 34,000 people are treated annually through the addiction services sector. Access to services varies according to region due to differing entrance pathways and service configurations. In addition, 174,000 people call the Alcohol and Drug Helpline each year. Improved coordination between

service providers and allied sectors will increase addiction services' capacity

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

There is a risk of addiction-service delivery being fragmented because it is provided through a maze of services, each with different ways of operating. The sector needs to develop a system-wide perspective on the client journey. This will require a collaborative approach between health professionals, service users and organisations.

Services will need to strike a careful balance between creating an efficient client journey within the constraints of the financial resources currently available, while also supporting staff. Successful engagement and treatment of clients will continue to depend on the treatment relationship and clinical skills of staff.

At the core of the treatment provided by addiction services is a system of stepped care in which people with less serious conditions are first treated with the least intrusive intervention which progressively escalates as interventions fall short of treatment objectives. If serious dependence is present, patients are referred to the most appropriate service for them as quickly as possible.

The development of addiction services for young people and their families has greatest priority.

Priority two: improve access for people involved in the criminal justice system

Front line

Addiction services in prisons are delivered through the 500 beds in the drug treatment units and addiction rehabilitation groups are provided by self-help and community-based organisations. The capacity for treating addictions in prison can be significantly increased to reach a targeted population by building on these programmes and better supporting re-integration.

Nurses in police stations can facilitate brief interventions

and referral to addiction services. This improves the interface between Police and the addictions sector.

Community alcohol and drug services provide treatment for people referred through the Community Probation Service and a wide range of other Corrections, Police and Court referral sources. Improving integration and referral pathways between the addiction sector and these referrers will increase the effectiveness and volume of referrals that can be made.

There is a clear connection between criminal behaviour and addiction. Community Probation Services is considering developing greater expertise in the management of offenders with histories of substance abuse who are on supervision orders. This will provide greater opportunity to intervene with a group of people who would otherwise continue abusing alcohol and drugs. Enhanced capability within Community Probation Services will also improve the interface with addiction services and provide better-integrated referral and information pathways.

Greatest priority should be given to juvenile offenders. Almost all this group will have substance-abuse disorders. Remand prisons and Youth Justice residential facilities urgently need to develop standardised programmes in their facilities that engage young offenders and their families and whānau.

Therapeutic communities

Therapeutic communities for addiction treatment can be extended in the wider community so judges have more options for sentencing offenders to community based interventions. Therapeutic community interventions not only focus on the treatment of addictions, but also include social, psychological, behavioural, educational and employment dimensions in their programmes. Whole families are admitted into some programmes, allowing everybody to benefit.

Halfway houses for released offenders with little social and psychological support and a histories of addiction improve recovery outcomes. The addiction treatment sector has a long track record of providing these services.

Drug Courts

The Law Commission has proposed a scheme which would trial Drug Courts. Access for offenders who struggle with addictions will depend on special criteria. While these

interventions are very resource intensive, NCAT supports Drug Courts for targeted groups of offenders, particularly where the oversight of a judge can enhance treatment outcomes. Clear and immediate consequences for failing to comply with treatment plans improve the possibility of community-based rehabilitation for offenders who would otherwise be incarcerated. Alcohol and drug counsellors who are based in the Drug Courts will need to be integrated in local community addiction services for maximum benefit to the offender, the Drug Court and addiction services.

Priority three: improve access for people with alcohol and drug problems to other public frontline services

People with addictions tend to be high users of health and social services, presenting to service providers via multiple access points.

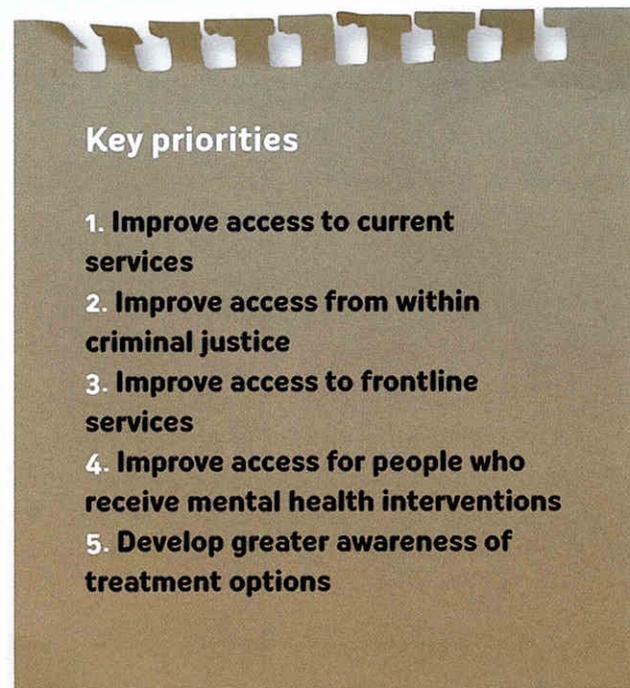
Primary health care

Primary health care organisations are logical places for strengthening addiction interventions, though much will depend on how these interventions are organised and who will deliver them. Service delivery by general practitioners may be too expensive and time constrained other than as brief interventions during regular health consultations. Care will be needed in designing systems that can provide addiction interventions in primary care. A greater role for practice nurses is most likely the way forward and a close liaison between the primary care provider and the local community alcohol and drug service is essential. Addiction interventions can be delivered through integrated family health centres.

Long-term opioid substitution treatment (including methadone maintenance) in primary care is suitable for most patients. This will require greater collaboration between the addiction services and primary care providers, particularly where primary care providers are unwilling to accept patients on methadone treatment.

Emergency care

Each week, during certain time periods, DHB emergency care centres experience high demand from people with addictions and substance-use problems who are injured. Many will be intoxicated. Nevertheless, interventions with this target group are possible. Given the very high volume of patients nationally, interventions would need to be efficiently delivered. The current trial of the National Alcohol



and Drug Helpline contacting these patients after they are discharged could be extended to cover all emergency care centres. These referrals provide a pathway and draw people into treatment services.

Welfare and Whānau Ora

It is estimated that a high percentage of long-term beneficiaries have substance disorders or other mental health problems that prevent a return to work. An effective interface between welfare and addiction services will assist in helping people address their use of substances and return to work. This will require welfare and addiction services to work together, and an increased capacity for welfare agency staff to identify addiction issues.

Addictions will also be part of the Whānau Ora initiative so staff and service providers will require greater capability in recognising substance disorders, in providing brief interventions and in referral in order to improve Whānau Ora objectives.

Children

Tragically, child abuse and neglect is also linked to addictions and substance abuse. In severe cases families where this happens are reported to CYF and care plans are put together. Improved collaboration between specialist mother-and-addictions services could make the difference between the child being placed outside the home and the mother being able to continue to care. Developing services

that promote the well-being of mothers and their unborn children or small babies has a high priority.

Most secondary schools employ counsellors and this provides a unique opportunity for these professionals to support teenagers and adolescents who have problems with alcohol and other drugs. The safety net for these children can be strengthened by training school counsellors in brief interventions for substance abuse disorders, and improving the interface between schools and addiction service providers. Some addiction service providers focus on this interface and not only achieve a reduction in alcohol and drug intake, but manage to keep children at school, engage their families and reduce petty crime.

Priority four: improve access for people who receive mental health interventions

A significant percentage of patients treated for mental health disorders will also have substance abuse disorders which further impede their progress. Mental health services need to become more capable of treating addictions as well as mental disorders. With only 10.0 percent of the total mental health and addiction budget spent on addiction services, it is clear that the bulk of the expertise of treating substance disorders needs to be developed within the mental health sector where the other 90.0 percent of resource is allocated.

A huge amount of effort has gone into improving the capacity of the mental health workforce in treating substance disorders and some addiction services are fully integrated with mental health services. This interface will continue to develop.

However, it is important to consider that the group of patients with substantial mental health disorders as well as substance disorders, often treated by mental health services over long periods, is different from the populations treated by most community based addiction services, where contacts tend to be shorter and patients much more independent. Ignoring this difference results in a mismatch of service design and can result in over as well as under-treatment of patients.

Priority five: develop greater awareness of addiction treatment options

Stigma

Significant stigma remains attached to addictions so many people are reluctant to engage in treatment. Research also indicates that people are often unclear where to go to receive such treatment. Public broadcast and internet applications could play an important role in de-stigmatising people with drug, alcohol and gambling problems, and in educating the public on addictions and about various treatment options. TV advertising, websites and helplines are efficient ways of reaching large populations. Continued investment in these activities is required to reach target populations.

Needle exchange

Needle exchange programmes will continue to play an important part in containing infectious diseases and improving population health. Mental health and addiction services' staff should make great efforts to remain informed about blood borne viruses and about the products and services available within needle exchange services.

Public health programmes

Finally, addictions are situated in a societal context and there are clear factors that drive addictive behaviours in society. Public health programmes should be used to address these issues.

A public health campaign to increase awareness about (and thereby reduce) alcohol related harms is described in the Law Commission's recommendations. It includes a number of components to change the way society thinks about alcohol including:

- increasing the price
- restricting advertising
- restricting availability
- raising the purchasing age
- lowering the adult drink-drive limit and improving drink drive interventions and enforcement.

How much will it cost?

The addiction sector is calling for a review of the funding of alcohol and drug services. Current funding is spread over many government departments and DHBs. Greater coordination will improve efficiencies in service delivery and increase people's access to treatment.

“Doubling the sector’s capacity would suggest that around 70,000 people would be treated for addiction disorders annually.”

NCAT estimates that 34,000 people are treated through the addiction sector annually. Doubling the sector’s capacity would suggest that around 70,000 people would be treated for addiction disorders annually. But an increase in capacity to address addictions will not be achieved through the traditional addiction sector alone. It is likely addiction interventions will be provided within other settings as well.

Currently, people being treated for addiction are not receiving equal access to services throughout the country due to different regional configurations. Strategies to increase the number of people in treatment will need to address how services are geographically spread.

Where to from here?

During the next decade, demand for services will grow and there will be significant pressure to find resources that will increasingly need to come from outside health funding.

The challenge will be for the sector to embrace the new environment as an opportunity to offer treatment for people and their families affected by addiction.

The next milestones in this journey are the development of the following documents, which will set future governmental direction:

- *Towards the Next Wave of Mental Health and Addiction Services and Capability: Workforce Service Review Report* (Health Workforce New Zealand)
- *National Mental Health and Addiction Services Plan* (Ministry of Health)
- *Revised Blueprint* (Mental Health Commission).

The Health Workforce New Zealand and Ministry of Health reviews will be completed by late 2011 and the Mental Health Commission review by mid 2012.

The government has signalled that organisations like ALAC and the Mental Health Commission will disappear and the Ministry of Health’s role will be significantly refocused on high-level policy development and monitoring.

It is essential for the health of the sector that current service providers remain active in the consultation process as these reforms are pushed through, in the first instance from a high-level service delivery system perspective but, increasingly, at a local operational level. Successful implementation of these reforms will take a long-term perspective, especially if the workforce needs to be (re)trained and new funding arrangements need to be designed.

“During the next decade demand for services will grow and there will be significant pressure to find resources that will increasingly need to come from outside health funding.”

About the National Committee for Addiction Treatment

The National Committee for Addiction Treatment (NCAT) is the national voice for the addiction treatment sector. NCAT provides expert advice on treatment for alcohol, other drug, and problem gambling.

The membership of NCAT reflects the work and diversity of the Addiction Treatment Sector in New Zealand. NCAT is a group of service leaders, educators, representative groups and elected individuals who provide leadership to the alcohol and other drug (AOD) and problem gambling treatment sector and its stakeholders.

Our vision for the addiction treatment sector is:

- High quality treatment that is responsive to the needs of consumers, their whanau/families, and the wider community.
- Services capable of assessing and treating co-existing addiction and mental health problems; a skilled workforce providing complementary assessments and integrated interventions.
- A broader range of services to provide treatment for alcohol, other drug, and/or gambling problems and increased flexibility in combining treatment options.
- Improved access to treatment i.e. capacity to provide treatment for at least one percent of New Zealanders most severely affected by addiction.
- Readily available culturally responsive services in a range of settings.
- An addiction treatment sector that supports recovery and wellness incorporating both harm reduction and abstinence approaches.
- Strong consumer leadership in treatment planning, delivery and evaluation; a strong consumer workforce with peer support services available in every district health board (DHB) area in New Zealand.

