Canterbury
District Health Board
Te Poari Hauora ō Waitaha

# CANTERBURY

# ALCOHOL AND DRUG

# PROJECT

Planning and Funding
27 May 2009

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## 1. Introduction

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

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

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

## 2. Alcohol and Other Drug Service Development

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

## 3. Residential Treatment

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

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

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

## 4. <u>The South Island Review</u>

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

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

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

## 5. <u>Canterbury DHB Direction</u>

**Health Services Planning**

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

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

Implications of Health Services Planning are:

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

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

## 6. Current AOD Services

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

## 7. The AOD Project

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

### 7.1 Scan

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

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

## 7.2 **Focus – Phase 1**

A small group (design team), with added expertise as required, worked with these identified issues to develop a model for an ideal AOD system for the Canterbury District. The following is a summary of the key concepts that emerged from the design team meetings.

### 7.2.1 **Community Based, Flexible, Responsive, Consumer and FamilyWhanau Focused Services**

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

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

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

### 7.2.2 **Resource Centre/One-Stop Shop**

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

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

### 7.2.3 **Screening/Brief Intervention**

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

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

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

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

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

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

### 7.2.4 **Peer Support/Consumer Roles**

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

Peer support will play a critical role in supporting consumers and their family/whanau at all stages of their journey. The consumer and their family/whanau will be able to choose who

they want as their ‘navigator’ through the AOD system and one option will be a peer support worker.

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

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

### 7.2.5 **Assessment and Referral**

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

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

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

### 7.2.6 **Specialised Treatment Services**

Specialised treatment based on harm minimisation will be available to people who need this level of intervention. The emphasis will be on short periods of intensive treatment with long term community based follow up. A wider range of options is required so that packages of care can be developed based on consumer and whanau need, rather than service need. New models will be developed that are based on a ‘whole of system’ approach with capacity to

bring together what is needed rather than fit people into what is available. Programme lengths, both outpatient and residential will be flexible and able to accommodate individual need, including when this involves ongoing substance use. Packages of care will be based on 'blocks' of up to 12 weeks, with flexibility for individual need as required; for example, at the end of the period the consumer, family/whanau and workers will decide whether to a transition to a different level of care/treatment, continue at the current level or exit the system.

Options will include care/support for people with enduring addictions who may have had a number of admissions to treatment programmes previously. This will include support to find and maintain suitable accommodation and achieve other goals identified by the consumer and their family/whanau.

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

#### 7.2.7 **Aftercare/Ongoing Support**

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

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

#### 7.2.8 **Collaboration**

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

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

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

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

#### 7.2.9 **Workforce**

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

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

#### 7.2.10 F**unding**

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

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

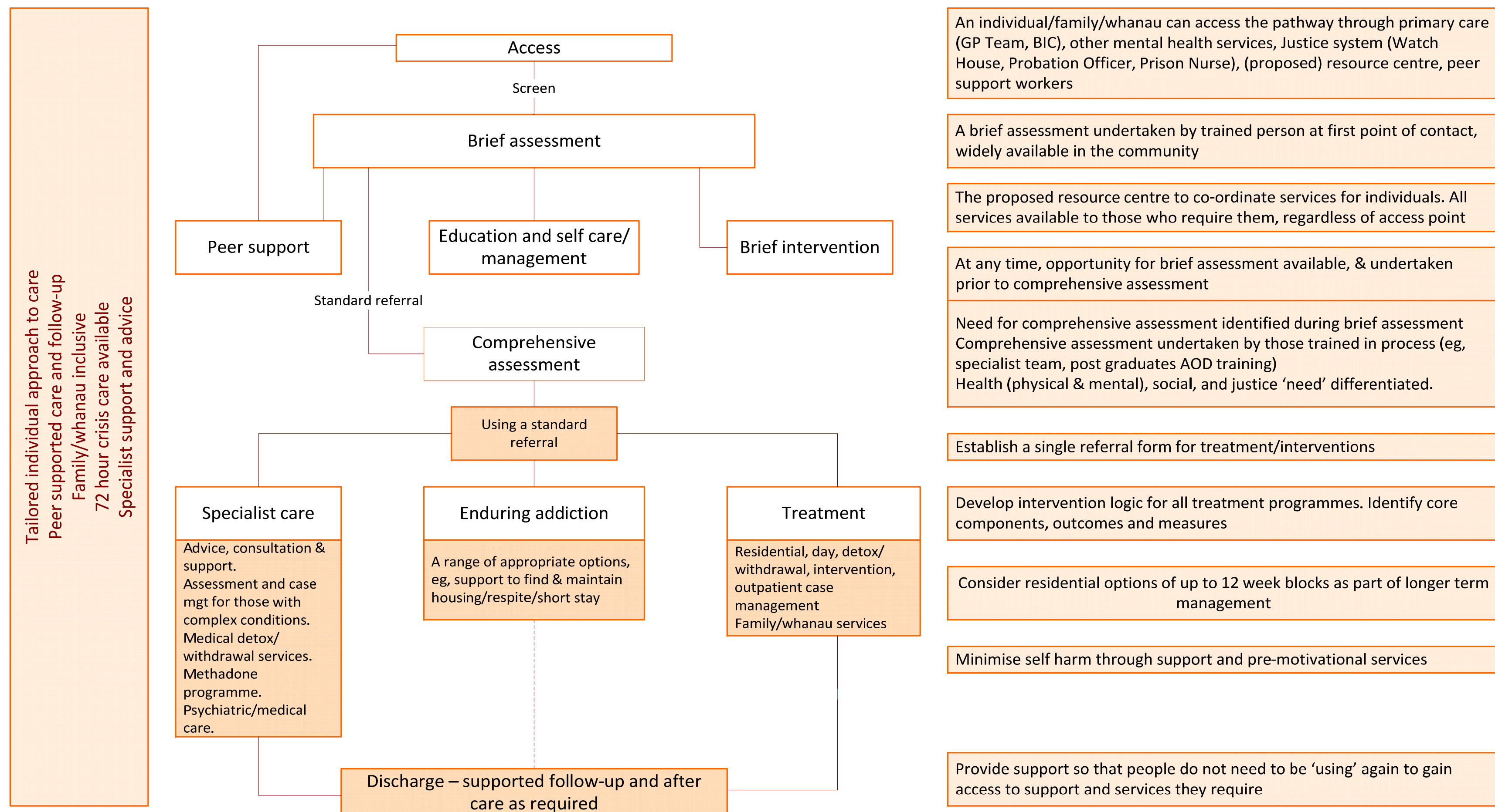
### 7.3 Proposed Pathway

The following diagram is a proposed AOD Care Pathway based on work to date.

## Proposed Pathway

### Proposed Alcohol and Other Drug Care Pathway

May 2009




An individual/family/whanau can access the pathway through primary care (GP Team, BIC), other mental health services, Justice system (Watch House, Probation Officer, Prison Nurse), (proposed) resource centre, peer support workers

A brief assessment undertaken by trained person at first point of contact, widely available in the community

The proposed resource centre to co-ordinate services for individuals. All services available to those who require them, regardless of access point

At any time, opportunity for brief assessment available, & undertaken prior to comprehensive assessment

Need for comprehensive assessment identified during brief assessment
Comprehensive assessment undertaken by those trained in process (eg, specialist team, post graduates AOD training)
Health (physical & mental), social, and justice 'need' differentiated.

Establish a single referral form for treatment/interventions

Develop intervention logic for all treatment programmes. Identify core components, outcomes and measures

Consider residential options of up to 12 week blocks as part of longer term management

Minimise self harm through support and pre-motivational services

Provide support so that people do not need to be 'using' again to gain access to support and services they require

### 7.4 Focus – Phase 2

This document will be widely circulated for review and comment. Once there is general agreement on a pathway, a number of working groups will be established to develop descriptions of the components of the system. Underpinned by the concepts outlined in this paper, the work will have a narrower focus and provide the detail required to develop an implementation plan.
The working groups will address:

- Screening/early intervention
- Assessment (brief and comprehensive)
- Standardised referral
- Treatment/interventions
- Options for people with enduring addiction
- Peer support

## 8. <u>Contact</u>

Please send any comments or feedback to:

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